ADDRESSING THE NEEDS OF THE GERIATRIC VETERAN POPULATION
GERIATRIC SERVICES AT PVAHS

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Baby Boomers
60s vs. 00s

- **THEN**
  - **Long hair**
  - **KEG**
  - **Acid Rock**
  - **Hoping for a BMW**
  - **Rolling Stones**
  - **Peace sign**

- **NOW**
  - **Longing for hair**
  - **EKG**
  - **Acid Reflux**
  - **Hoping for a BM**
  - **Kidney stones**
  - **Mercedes logo**

HOME BASED PRIMARY CARE

- Multidisciplinary team
  - Physician
  - Nurse/Nurse Practitioner
  - Clinical Pharmacist
  - Social Worker
  - Clinical Psychology
  - Dietician
- In - home visits for home-bound frail elderly
- 300 Patients with goal of 500

Community Home Care

- Skilled home nursing care
  - IV therapy
  - Wounds
  - Medication management
- Non-skilled nursing care
  - Homemaker services
  - Bathing
  - Personal care
- In Home Respite
- Home Hospice – community partners

Community Living Center

- Residential facility attached to VAMC
- 45 beds
- Short-term stays

  Subacute Rehabilitation

  Wound care

  Inpatient hospice

  Transitional unit (homeless, “social” admits to hospital)

Community Skilled Nursing Home Care

- 125 veterans at private contracted community NH
- 3 star CMS rating or higher
- 70% Service - connected or higher
- 30 days annual respite care
- Hospice/EOL care for up to two months
- Subacute rehab to long-term care
- AZ State Veterans Home

Outpatient Services

- GeriPact (Patient-Aligned Care Team)
  - Primary Care services specific to geriatrics
  - Age >65, dementia, multiple chronic conditions, frailty
  - Multidisciplinary – physician, nurse, social work, pharmacist, PT/OT
  - Focus on maintaining/improving functional status
  - “De-prescribing” – reduce polypharmacy
  - Caregiver support – dementia patients
- Palliative Care
  - Patients with serious/life-limiting illness – cancer, dementia, organ failure (heart, lung, kidney, liver)
  - Focus on goals of care, symptom management
  - Collaborate with community hospice organizations

TeleHealth

- Reduces burden of travel to clinics for frail elderly population
- Simple, VA-provided technology as needed

- Telemedicine – phone/video
- Communication and/or “virtual examinations”
- Primary Care
- Palliative Care
- Specialty consultation

VA LIFE-SUSTAINING TREATMENT DECISIONS INITIATIVE

VA

U.S. Department of Veterans Affairs

Veterans Health Administration
National Center for Ethics in Health Care

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"There's no easy way I can tell you this, so I'm sending you to someone who can."

VA Life-Sustaining Treatment Decisions Initiative

National quality improvement initiative to promote personalized, proactive, patient-driven care for Veterans with serious illness

Desired outcomes:

The values, goals, and life-sustaining treatment decisions of Veterans with serious illness are proactively elicited, documented, and honored

LST Decisions Initiative

- Promotes proactive, high quality goals of care conversations with high risk patients
- Promotes improved documentation of goals of care and life-sustaining treatment decisions

Proactive Goals of Care Conversations

Patients – “high risk”

- At risk for a life-threatening clinical event within the next 1-2 years
- Prior to medical crisis, in the outpatient setting whenever possible
- Can be identified through clinical judgment (“surprise” question) and objective screening tools (e.g., CAN* scores in Primary Care)
- Or patients who express the desire to limit life-sustaining treatment

Clinicians who care for high-risk patients

- Multiple disciplines: discuss values, goals, preferences with patients and surrogates
- Physicians, residents, APRNs, and PAs: confirm LST plan and write LST progress notes/orders

* CAN = Care Assessment Need: indicates risk of hospitalization or death

Questions?