

UNIFORM GERIATRICS AND EXTENDED CARE SERVICES IN VA MEDICAL FACILITIES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states policy for Geriatrics and Extended Care (GEC) services purchased by the Department of Veterans Affairs (VA) or provided in VA medical facilities.

2. SUMMARY OF MAJOR CHANGES: This directive:

a. Adds roles and responsibilities to the Under Secretary for Health, Assistant Under Secretary for Health for Patient Care Services, Assistant Under Secretary for Health for Operations and Veterans Integrated Services Network (VISN) Rehabilitation and Extended Care Integrated Clinical Community Lead (see paragraph 5).

b. Updates responsibilities for the Executive Director, GEC and VISN Director (see paragraph 5).

c. Updates VA programs overseen by GEC (see paragraph 6).

d. Reduces and removes paragraphs and language not reflected in current VHA policy.

3. RELATED ISSUES: VHA Directive 1140.04, Geriatric Evaluation, dated November 29, 2017; VHA Directive 1140.09, Geriatrics Consultation, dated June 28, 2017; VHA Directive 1140.07(2), Geriatric Patient Aligned Care Team, dated March 23, 2021; VHA Directive 1140.08, Geriatric Research, Education and Clinical Centers, dated January 12, 2022; VHA Directive 1411, Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017; VHA Directive 1141.02(1), Medical Foster Home Program Procedures, dated August 9, 2017; VHA Directive 1141.03, VA Operated Adult Day Health Care, dated November 9, 2020; VHA Directive 1144, Hospital in Home Program, dated January 19, 2021; VHA Directive 1140.01(1), Community Residential Care Program, dated April 1, 2020; VHA Directive 1140.12, Dementia System of Care, dated October 18, 2019; VHA Directive 1139, Palliative Care Consult Teams (PCCT) & VISN Leads, dated June 14, 2017; VHA Directive 1601SH.01(1), State Home Per Diem (SHPD) Program, dated November 15, 2016; VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers (CLC), dated August 13, 2008; VHA Directive 1440, VHA-Provided Palliative and Hospice Care Workload Capture, dated February 19, 2021; VHA Handbook 1140.5, Community Hospice Care: Referral and Purchase Procedures, dated March 1, 2005.

4. RESPONSIBLE OFFICE: The Office of Geriatrics and Extended Care (12GEC) is responsible for the content of this directive. Questions may be addressed to VHA12GECAction@va.gov.

5. RESCISSIONS: VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, dated October 11, 2016, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of March 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Beth Taylor, DHA, RN, FAAN, NEA-BC
Assistant Under Secretary for Health
for Patient Care Services/CNO

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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UNIFORM GERIATRICS AND EXTENDED CARE SERVICES IN VA MEDICAL FACILITIES

1. PURPOSE

This Veterans Health Administration (VHA) directive states policy for Geriatrics and Extended Care (GEC) services. This directive informs Department of Veterans Affairs (VA) medical facilities of the programs overseen by GEC including those for all enrolled Veterans in the VA medical benefits package. **AUTHORITY:** 38 U.S.C. §§ 1710A, 1710B, 1717, 1720, 1720B, 1720C, 7301(b).

2. BACKGROUND

a. In 1998, the Federal Advisory Committee on the Future of VA Long-term Care report, "VA Long-term Care at The Crossroads" resulted in several new requirements for VA to provide extended care services to Veterans under P.L. 106-117, The Veterans Millennium Healthcare and Benefits Act. This included:

(1) Nursing home care to any Veteran in need of such care for a service-connected disability or who is in need of such care and has a service-connected disability rated at 70% or more (see 38 U.S.C. § 1710A); and

(2) Extended care services (38 U.S.C. § 1710B) as part of the VA medical benefits package (see 38 C.F.R. § 17.38).

b. Since the implementation of the requirements of P.L. 106-117, VHA's geriatrics and extended care services have expanded dramatically due in part to the aging of the Veteran population. In fiscal year (FY) 2019, 48% of all VHA enrollees were age 65 or older and 59% of VA expenditures were spent on Veterans age 65 or older. Between FY19 and FY39, Veterans age 85 or older are expected to increase by 38%, demonstrating the need for VHA to provide a variety of GEC services to support the aging Veteran population. VHA must provide access to GEC services either at VA medical facilities or by purchasing services in the community.

c. As VHA modernizes systems of care, GEC has increased use of telehealth services for GEC.

3. DEFINITIONS

a. **Extended Care Services.** Extended care services refer to the range of residential and community-based programs available for supporting, individuals who have compromised self-care ability due to chronic conditions, injuries and disability, regardless of age.

b. **Geriatrics.** Geriatrics refers to the care of aging and older adults. Geriatrics focuses on improving health, maintaining independence and quality of life while also minimizing the impact of chronic conditions associated with advanced age. Geriatrics

programs may also be appropriate for younger Veterans with complex care needs due to chronic conditions, injuries and disability regardless of age.

c. **Integrated Clinical Community.** Integrated Clinical Communities (ICCs) create streamlined communication flows that amplify the voices of frontline employees and allow for efficient decision-making. ICCs provide a structure to endorse and consistently implement best clinical practices.

d. **Telehealth or Telemedicine.** Telehealth or telemedicine is the use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health or health administration at a distance.

e. **Respite Care Services.** Respite care services are intended to relieve a caregiver. These services are of limited duration and available on an intermittent basis to caregivers of Veterans with chronic illness that reside primarily at home. Respite care may be provided in a VA Community Living Center (CLC), Community Nursing Home (CNH) or in the Veteran's home as a personal care service or as skilled home health care, depending on the needs of the Veteran.

4. POLICY

It is VHA policy that eligible Veterans may receive GEC services described in the VA medical benefits package if it is determined by appropriate health care providers that such services are needed to promote, preserve or restore the health of the Veteran and is in accord with generally accepted standards of practice.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall compliance with this directive.

b. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for supporting GEC with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

d. **Executive Director, Geriatrics and Extended Care.** The Executive Director, GEC is responsible for:

- (1) Ensuring compliance with this directive through appropriate monitoring activities.
- (2) Overseeing continuous quality assessment of GEC programs to include program structure, care processes and Veteran outcomes.
- (3) Tracking access to GEC programs using available VHA data, including clinical consults, to ensure fair and equitable access to GEC programs and services.
- (4) Monitoring costs and workload associated with GEC programs using the Rehabilitation and Extended Care Integrated Clinical Community (RECICC) dashboard, and collaborating with forecasting, fiscal and other VHA program offices to determine potential and actual costs associated with GEC programs and services.
- (5) Ensuring the RECICC dashboard is completed on a quarterly basis and sending associated GEC reports to the VISN RECICC Lead.
- (6) Strategic planning concerning VA's current and projected management of Veterans with complex care needs due to aging, disability or disease.
- (7) Establishing national GEC policies in accordance with Veterans' needs and the needs and priorities of VA.
- (8) Allocating dedicated resources for enterprise-wide analytics, quality improvement and research initiatives.
- (9) Developing guidance for VA medical facilities to align GEC programs so that extended care services are coordinated and provided to eligible Veterans.

e. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

- (1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.
- (2) Communicating national GEC policies, guidance and other GEC-related information to VA medical facilities within the VISN, as shared by the Assistant Under Secretary for Health for Operations.
- (3) Communicating information from VA medical facilities to GEC.
- (4) Reporting workload information specific for each GEC program or service as described by the Medical Cost Accounting Office.
- (5) Appointing a VISN RECICC Lead.
- (6) Fulfilling any GEC-related performance expectations set in the annual VISN Directors performance plan.

f. Veterans Integrated Services Network Rehabilitation and Extended Care Integrated Clinical Community Lead. The VISN RECICC Lead is responsible for:

- (1) Acting as a liaison between the VISN and the GEC program office.
- (2) Collaborating with VISN and VA medical facility ICC leadership to spread strong practices, facilitate quality improvement and support internal and external research and educational activities.
- (3) Ensuring that leaders and points of contact for all GEC programs within their VISN are informed of or participate in national, VISN and VA medical facility-level geriatric program activities, including those that are functionally located in non-GEC reporting structures.
- (4) Disseminating GEC reports received from the Executive Director, GEC, as appropriate.

g. VA Medical Facility Director. The VA medical facility Director is responsible for:

- (1) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.
- (2) Ensuring adequate staffing, funding and support for mandated GEC programs.

6. PROGRAMS OVERSEEN BY GERIATRICS AND EXTENDED CARE

a. The VA medical benefits package includes a variety of VA-provided and VA-purchased programs overseen by GEC, described in greater detail in paragraphs 7-12 and listed below. GEC services may be provided by appropriate VA medical facility staff, by telehealth modalities, by referral to other VA facilities or through community care programs to the extent that the Veteran is eligible. **NOTE:** *Some programs and services overseen by GEC and described herein are not available at all VA medical facilities.*

- (1) Adult Day Health Care.
- (2) Community Nursing Homes.
- (3) Community Residential Care.
- (4) Geriatric Consultation.
- (5) Geriatric Evaluation. **NOTE:** *GE may be delivered through the Geriatric Patient-Aligned Care Team (GeriPACT), Home-Based Primary Care (HBPC) and other programs.*
- (6) Geriatric Patient-Aligned Care Team.
- (7) Home-Based Primary Care.

- (8) Homemaker/Home Health Aide.
- (9) Hospital in Home.
- (10) Medical Foster Home.
- (11) Palliative and Hospice Care (in all settings).
- (12) Program of All-Inclusive Care for the Elderly.
- (13) Skilled Home Health Care.
- (14) State Veterans Homes.
- (15) VA Community Living Centers.
- (16) Veteran-Directed Care.

b. VA is obligated to pay the full cost of nursing home care to any Veteran in need of such care for a service-connected disability, and to any Veteran who is in need of such care and who has a service-connected disability rated at 70% or more (see P.L. 106-117). VA-provided nursing home care for all other Veterans is based on available resources.

7. GERIATRIC EVALUATION, CONSULTATION AND GERIATRIC PATIENT-ALIGNED CARE TEAM

a. **Geriatric Evaluation.** GE consists of a comprehensive, multidimensional assessment and development of an interdisciplinary care plan for Veterans with complex medical and psychosocial needs. GE is provided in both outpatient and inpatient settings, through a face-to-face encounter, or via telehealth technology. **NOTE:** *Full program standards can be found in VHA Directive 1140.04, Geriatric Evaluation, dated November 29, 2017.*

b. **Geriatrics Consultation.** Geriatrics consultation is an inter-professional care approach that addresses a range of interacting health and biopsychosocial concerns which may be provided in multiple settings and through face-to-face encounters, telehealth or e-consult. **NOTE:** *Full program standards can be found in VHA Directive 1140.09, Geriatrics Consultation, dated June 28, 2017.*

c. **Geriatric Patient-Aligned Care Team.** GeriPACT provides longitudinal primary care management of the health and care needs of a spectrum of particularly vulnerable, predominantly elderly, at-risk Veterans, most of whom live with complex chronic disease, functional dependency, cognitive decline and psychosocial challenges. The care is provided by a VA interdisciplinary team that coordinates and oversees the intensive case management needs of this vulnerable population. Many of the Veterans who make up this population subset are significantly impacted by social determinants of health, including but not limited to adequate financial resources to meet basic needs,

safe and stable housing and access to health care and other services. Age should not be a defining determinant of the target population; however, many of the syndromes reside primarily in the geriatric population. **NOTE:** Full program standards can be found in VHA Directive 1140.07(2), Geriatric Patient-Aligned Care Team, dated March 23, 2021.

8. VA HOME AND COMMUNITY-BASED GERIATRICS AND EXTENDED CARE SERVICES

a. **VA Home Based Primary Care.** HBPC is a model of home health care that is different from Federal and State programs such as Medicare and Medicaid in its target population, processes and outcomes. The HBPC model prioritizes persons with complex chronic diseases providing comprehensive, longitudinal and interdisciplinary care. HBPC provides primary care, palliative care, rehabilitation, disease management and caregiver support in the Veteran's home. The HBPC team consists of: Medical Director, Primary Care Provider (Doctor of Medicine, Nurse Practitioner, or Physician Assistant), Nurse, Social Worker, Rehabilitation Therapist, Dietitian, Clinical Pharmacy Specialist and Mental Health Professional (Psychologist or Psychiatrist). **NOTE:** Full program standards are described in VHA Directive 1411, Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017.

b. **Community Residential Care.** Community Residential Care (CRC) is an important component in VA's continuum of care. CRC is a form of enriched housing that provides health care supervision to Veterans not in need of acute hospital care but who are unable to live independently due to medical or psychosocial health conditions and who have no available family to provide care and support. CRC may be referred to or take place in a range of settings including medical foster homes (MFH), assisted living, personal care homes, family care homes and residential care homes. VA provides case management and oversight to those Veterans living in the CRC program facilities. **NOTE:** Full program requirements are described in VHA Directive 1140.01(1), Community Residential Care Program, dated April 1, 2020.

c. **Medical Foster Home.** MFH is a unique form of CRC for Veterans with medical complexity and disability who are eligible for nursing home care and require interdisciplinary primary care in the home. The MFH program combines VA placement in a personal care home of no more than three Veterans, with an interdisciplinary HBPC or Spinal Cord Injury Home Care (SCI/HC) team. **NOTE:** Full program standards are described in VHA Directive 1141.02(1), Medical Foster Home Program Procedures, dated August 9, 2017.

d. **Hospital in Home.** Hospital in Home (HiH) offers intensive time-limited home care for acute or complex chronic conditions with the goal of reducing hospital admissions and decreasing length of stay allowing Veterans to discharge from the hospital earlier, with the goal of reducing readmissions, decreasing adverse events and improving outcomes. **NOTE:** Full program standards for implementation and management of HiH programs are described in VHA Directive 1144, Hospital in Home Program, dated January 19, 2021.

e. **VA Adult Day Health Care.** VA Adult Day Health Care (VA-ADHC) is a medical model ADHC program operated by VA staff at VA medical facilities that provides coordinated interdisciplinary interventions from a variety of team members (e.g., nursing, rehabilitation, social work and nutrition) with a focus on recreation and socialization. ADHC can provide a defined period of respite, education and support for family caregivers. VA also offers a Mobile ADHC program where VA staff provide ADHC services in the community through partnerships with Veteran Service groups and others. (See paragraph 9.c. for further information regarding Community Adult Day Health Care (C-ADHC)). **NOTE:** Full program standards can be found in VHA Directive 1141.03, VA Operated Adult Day Health Care, dated November 9, 2020.

9. PURCHASED HOME AND COMMUNITY-BASED GEC SERVICES

a. **Skilled Home Care.** Skilled Home Care consists of four VHA-paid in-home services: Skilled Home Health Care, Home Infusion Services, Home Palliative and Hospice Care, and Community Outpatient Palliative Care. These services are designed to promote, preserve or restore the health of the individual in accordance with generally accepted standards of practice.

(1) **Skilled Home Health Care.** Skilled Home Health Care provides a wide range of services in a Veteran's home, including nursing, rehabilitation therapists and medical social workers. Skilled Home Health Care can be used to provide short-term and intermittent care, longitudinal care to a Veteran with ongoing needs or caregiver respite. The intent of Skilled Home Health Care is to provide services that will support a Veteran's ability to remain safely at home.

(2) **Home Infusion Services.** Home Infusion Services allow Veterans who require regular intravenous treatments to receive this care within the comfort of their own home. The items covered include medications, including Total Parenteral Nutrition IV therapy supplies and any durable medical equipment related to the infusion services.

(3) **Home Palliative and Hospice Care.** Home Palliative and Hospice Care (PHC) is comfort-oriented care for Veterans with life-limiting illness provided in the Veteran's home. VA-purchased routine and continuous hospice care covers hospice diagnosis-related home visits, medications, supplies, biologicals, durable medical equipment and ancillary services. (See paragraph 12). **NOTE:** Full standards for referral and purchase of hospice services can be found in VHA Handbook 1140.5, Community Hospice Care: Referral and Purchase Procedures, dated March 1, 2005.

(4) **Community Outpatient Palliative Care.** Community Outpatient Palliative Care is comfort care that focuses on relieving suffering and controlling symptoms, so Veterans may continue to do what is most important to them. Palliative care aims to improve the quality of life and can be combined with treatments aimed at curing or controlling disease processes. It can be started at the time of diagnosis and continue throughout the course of the illness. (See paragraph 12.) **NOTE:** A VA medical facility that offers VA outpatient palliative care is not precluded the from also using community

outpatient palliative care (e.g., distance may prohibit the Veteran from traveling to a VA medical facility).

b. **Program of All-Inclusive Care for the Elderly.** Program of All-Inclusive Care for the Elderly (PACE) provides both skilled and personal care services to Veterans who have been assessed by VA staff and determined to require comprehensive PACE services. These services are largely delivered through a day care center model by a team of professionals made up of primary care providers that may include a physician, Advanced Practice Registered Nurse (APRN), physician assistant, registered nurse, social worker, health aide, transportation personnel, rehabilitation therapist, dietitian and recreational activity personnel.

c. **Personal Care Services.** Personal Care Services (PCS) include three VHA-paid programs that help with activities of daily living (e.g., bathing, dressing, toileting). PCS are provided to Veterans to reduce nursing home utilization. The goal of PCS is to improve the quality of life in the home and offer caregiver respite.

(1) **Homemaker/Home Health Aide.** A Home Health Aide provides personal care services, the primary focus of this program, to Veterans in their place of residence. A Homemaker Aide can also provide additional support to maintain a safe and clean home. A Homemaker/Home Health Aid serves Veterans who require assistance over a long period of time, Veterans with short-term needs following a procedure and Veterans whose caregivers need respite.

(2) **Community Adult Day Health Care.** Community Adult Day Health Care (C-ADHC) provides extended therapeutic services in a congregate setting. Services may include nursing care, rehabilitation, social services, nutrition, personal care, recreation activities, socialization and case management. C-ADHC may be used to provide respite care for a family caregiver.

(3) **Veteran Directed Care.** Veteran Directed Care is a self-directed model of extended PCS. With the help of trained counselors, Veterans (or a representative) manage a budget to hire caregivers and purchase selected goods and services.

10. FACILITY-BASED CARE

a. **VA Community Living Centers.** CLCs are owned and operated by VA. CLCs reflect VA's commitment to provide care that is resident focused and enhances Veteran preferences and choice. CLC teams provide integrated, interdisciplinary care to address Veterans' interacting medical, functional and psychosocial needs by staff with training and commitment to optimize resident quality of life. VA CLCs offer a dynamic array of services geared toward assisting Veteran residents to achieve the highest level of function or experience dignity and comfort in dying. **NOTE:** Full standards can be found in VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, dated August 13, 2008.

(1) Staffing requirements for CLCs vary according to case mix and Veteran turnover, in accordance with VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017.

(2) CLC teams promote Veteran emotional well-being through collaborative assessment and treatment of mental disorders and addressing behavioral symptoms, often a reflection of unmet needs, through a balance of Veteran-centered behavioral, environmental and pharmacological interventions. Each CLC should be operating according to VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

(3) Nursing home services in a VA CLC may be long stay (101 days or more) or may be short stay (100 days or less). Long stay is generally for dementia care, continuing care, mental health recovery and spinal cord injury. Short stay is generally for respite care, rehabilitation, restorative care, continuing care, mental health recovery, dementia care, GE and management, skilled nursing care and hospice (which may exceed the 90-day limit). Workload capture in CLC is according to the Treating Specialty to which the Veteran was admitted, as described in VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers, dated September 2, 2012; and VHA Handbook 1142.03, Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS), dated January 4, 2013.

b. **State Veterans Homes.** State Veterans Homes (SVHs) are owned and operated by the State in which they are located. VA has no authority regarding the management or control of SVHs providing any care. Each State defines its own admission requirements for Veterans, spouses and Gold Star parents. SVHs may provide nursing home care, domiciliary care or adult day health care, or any combination of the three programs.

(1) States may apply to VA for grants for purchase, construction and renovation of SVHs, for which VA may pay up to 65% of allowable costs (see 38 C.F.R. Part 59).

(2) Following the construction of a new SVH, the State requests recognition as an SVH. Recognition makes the SVH eligible for per diem payments from VA that are approximately one-third of the cost of care.

(3) VA pays a higher per diem for certain highly service-connected Veterans and Veterans in need of nursing home care for a VA adjudicated service-connected disability. **NOTE:** Full program standards and operational procedures can be found in VHA Directive 1601SH.01(1), State Home Per Diem (SHPD) Program, dated November 15, 2016.

(4) VA surveys SVHs to ensure that VA standards are met and that the host State remains eligible for continued per diem payments. **NOTE:** Full policy requirements can be found in VHA Directive 1145.01, Survey Requirements for State Veterans Homes, dated February 18, 2021.

11. VA PURCHASED FACILITY-BASED GEC SERVICES

a. **Community Nursing Home.** CNH provides a broad range of nursing home services, including short-stay rehabilitation, skilled nursing care, respite, hospice and extended care in community facilities. These nursing homes are available in many communities nationwide, enabling a Veteran to receive care near their home and family.

b. **Traumatic Brain Injury – Residential Rehabilitation.** Traumatic Brain Injury – Residential Rehabilitation provides rehabilitation, nursing and support services for Veterans who require extended care and residential rehabilitation due to a recent or remote history of traumatic brain injury. The care needs of these Veterans cannot be met in a nursing home, outpatient or home and community-based services program.

c. **Inpatient Hospice Care.** Inpatient hospice care provides symptom management for Veterans choosing hospice and having a terminal illness as determined by a VA physician that cannot be safely cared for in the home setting. Inpatient hospice care is provided in a VA medical facility or purchased in the community as part of the contract nursing home program, in a free-standing hospice facility, or in a hospice unit within a community-based hospital. These inpatient hospice stays are often short-term in nature and include an inpatient respite benefit that can be used when the Veteran's caregiver requests short-term inpatient respite. For Veterans to receive VA-purchased inpatient hospice care in a contract nursing home, the Veteran must be placed by VA in the contract nursing home for the purpose of hospice care (i.e., VA does not assume the ongoing costs of nursing home care if the Veteran's residence at the time of hospice designation was in a nursing home). If the Veteran's residence is determined to be in a nursing home and the Veteran requires hospice care, it is the Veteran's preference as to payor (e.g., Medicare, VA or insurance) for the routine home hospice care but VA will not cover the cost of the ongoing nursing home care.

12. PALLIATIVE AND HOSPICE CARE

a. PHC is a continuum of comfort-oriented and supportive services for Veterans with advanced life-limiting disease. PHC's goal is to achieve the best possible quality of life through relief of suffering, control of symptoms and restoration of functional capacity to the greatest extent possible. PHC programs offer comprehensive management of the physical, psychological, emotional, social and spiritual needs of the Veteran, and they offer support and bereavement counseling to eligible individuals under 38 U.S.C. § 1783. **NOTE:** *Full policy requirements for coding and workload capture of PHC can be found in VHA Directive 1440, VHA-Provided Palliative and Hospice Care Workload Capture, dated February 19, 2021.*

(1) Palliative care emphasizes quality of life and symptom control for life-limiting illness but does not require a time-limited prognosis.

(2) Hospice is a subset of palliative care for Veterans diagnosed with a prognosis of less than 6 months.

b. VA medical facilities are required to have an interdisciplinary Palliative Care Consult Team (PCCT). PHC services are a covered benefit for all Veterans as authorized in the VA medical benefits package and should be provided on equal priority with other medical services (e.g., emergency department). VA must offer to provide or purchase PHC services as determined by Veteran need; this includes inpatient, outpatient and home services. **NOTE:** For more information see VHA Directive 1139, *Palliative Care Consult Teams (PCCT) & VISN Leads*, dated June 14, 2017.

13. CROSSCUTTING GERIATRICS AND EXTENDED CARE PROGRAMS AND INITIATIVES

a. **VHA Dementia System of Care.** VHA Dementia System of Care is an integrated service delivery network that provides primary and specialty care to Veterans with dementia. Care is provided in all care settings including outpatient, home, community and inpatient settings. There are no separate VHA eligibility criteria for dementia care; standard eligibility criteria apply. **NOTE:** Full program standards and operational guidelines can be found in VHA Directive 1140.12, *Dementia System of Care*, dated October 18, 2019.

b. **Care for Patients with Complex Problems.** The Care for Patients with Complex Problems (CP)² Program is a national initiative to improve inpatient care for Veterans with cognitive impairment, mental illness or substance use disorders, or co-morbid chronic medical conditions who are at risk for behaviors disruptive to their care. The program is supported by an inter-program office Steering Committee including senior leadership from GEC and the Offices of Mental Health and Suicide Prevention (OMHSP), Primary Care, Care Management and Social Work Services, Nursing Services, and Rural Health. The key components of the (CP)² program include:

(1) Identification, dissemination and supported implementation of promising practices for Veterans with complex care needs.

(2) A national learning collaborative.

(3) The Centralized Technical Assistance Coordination Team (C-TACT), which supports sites as they implement the promising practice models.

c. **Clinical Innovations.** GEC facilitates continual program improvement through the development, evaluation and implementation of clinical innovations designed to improve care practices and outcomes for older Veterans (see paragraph 15 and https://www.va.gov/GRECC/pages/Clinical_Projects_Disseminated.asp for more information).

14. EXTERNAL PARTNERSHIPS

a. **Veterans Community Partnerships.** Veterans Community Partnerships (VCPs) are a coalition between VA staff and community partners developed to provide improved access and choice to services, benefits and care for all Veterans (regardless of their service-connected disability status). VCP activities include educating community

providers on VA resources; educating VA staff on community resources; promoting seamless transitions of care; educating Veterans, families and their caregivers about services available within VA; and collaborating on barriers to care, services and benefits for Veterans. VCP began in the GEC program office but is supported by the National Center for Healthcare and Partnerships, Office of Rural Health, Office of Care Management and Social Work, Office of Caregiver Support, OMHSP and the VA Center for Development & Civic Engagement. To learn more, visit the VCP website at <https://www.va.gov/healthpartnerships/vcp.asp>.

b. **Hospice Veteran Partnerships.** Hospice Veteran Partnerships (HVPs) are networks of community hospice and VHA professionals, Veterans, volunteers and other organizations working together to optimize access to quality services for Veterans through the end of life. HVPs provide leadership and technical assistance to improve Veterans' access to PHC across all sites and levels of care by:

(1) Educating State, county and local hospice providers about Veterans' special needs and about VA services and benefits;

(2) Maintaining awareness of community-based public and private palliative and hospice care assets, particularly with respect to Veterans and their families;

(3) Developing models for coordinating services for Veterans and families (e.g., sharing agreements, co-location of staff, providing telemedicine consultation); and

(4) Addressing issues regarding transfer of Veterans requiring hospice care from community hospitals and extended care facilities. To learn more, visit <https://www.wehonorveterans.org/partners/hospice-veteran-partnerships/>.

15. GERIATRIC RESEARCH, EDUCATION AND CLINICAL CENTERS

a. VHA initiated the Geriatric Research Education and Clinical Centers (GRECC) Program in 1975 as part of a larger strategy for preparing to meet the challenges of the rapidly growing older Veteran population and this age group's particular health care needs. GRECCs were introduced to attract scientists, clinicians and health professions trainees to the field of geriatrics; increase pre-clinical and applied knowledge of aging and geriatric health service delivery; develop, test and implement new models of care for geriatric and frail Veterans; and transmit this newly acquired knowledge to health professionals who provide care to aging Veterans.

b. GRECCs generate knowledge to provide cutting edge clinical practice to the growing population of aging Veterans within VHA. They play a crucial role in helping VA address the existing and worsening shortage of an adequately trained geriatric health care workforce and ensure the training of future generations of clinicians and researchers. **NOTE:** *GRECC programs' purpose, authority, background, scope and goals, program standards, staffing and quality management are covered by VHA Directive 1140.08, Geriatric Research, Education and Clinical Centers, dated January 12, 2022.*

16. GERIATRICS AND GERONTOLOGY ADVISORY COMMITTEE

The Geriatrics and Gerontology Advisory Committee (GGAC) advises the Secretary of Veterans Affairs and the Under Secretary for Health on all matters pertaining to geriatrics and gerontology. The GGAC assesses the capacity of VA medical facilities (including VA medical facilities with a GRECC) to respond with the most effective and appropriate services possible to the medical, psychological and social needs of older Veterans as well as advancing scientific knowledge to meet identified needs by enhancing geriatric care for older Veterans through research, training and development of improved care models. The committee is authorized by statute, 38 U.S.C. § 7315, and operates under the provisions of the Federal Advisory Committee Act. Additional information can be found online at <https://www.va.gov/ADVISORY/Geriatrics.asp>.

17. TRAINING

There are no formal training requirements associated with this directive.

18. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

19. REFERENCES

- a. P.L. 106-117.
- b. P.L. 96-330.
- c. 38 U.S.C. §§ 1710A, 1710B, 1717, 1720, 1720B, 1720C, 1783, 7315.
- d. 38 C.F.R. §§ 17.111, 17.36, 17.38, part 51, 17.61, 17.73.
- e. VHA Directive 1139, Palliative Care Consult Teams (PCCT) & VISN Leads, dated June 14, 2017.
- f. VHA Directive 1140.01(1), Community Residential Care Program, dated April 1, 2020.
- g. VHA Directive 1140.04, Geriatric Evaluation, dated November 29, 2017.
- h. VHA Directive 1140.07(2), Geriatric Patient-Aligned Care Team, dated March 23, 2021.
- i. VHA Directive 1140.08, Geriatric Research, Education and Clinical Centers, dated January 12, 2022.

- j. VHA Directive 1140.09, Geriatrics Consultation, dated June 28, 2017.
- k. VHA Directive 1140.12, Dementia System of Care, dated October 18, 2019.
- l. VHA Directive 1141.02(1), Medical Foster Home Program Procedures, dated August 9, 2017.
- m. VHA Directive 1141.03, VA Operated Adult Day Health Care, dated November 9, 2020.
- n. VHA Directive 1144, Hospital in Home Program, dated January 19, 2021.
- o. VHA Directive 1145.01, Survey Requirements for State Veterans Homes, dated February 18, 2021.
- p. VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017.
- q. VHA Directive 1411, Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017.
- r. VHA Directive 1440, VHA-Provided Palliative and Hospice Care Workload Capture, dated February 19, 2021.
- s. VHA Directive 1601SH.01(1), State Home Per Diem (SHPD) Program, dated November 15, 2016.
- t. VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers, dated August 13, 2008.
- u. VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Center, dated September 2, 2012.
- v. VHA Handbook 1142.03, Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS), dated January 4, 2013.
- w. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.
- x. Federal Advisory Committee on the Future of VA Long Term Care. VA Long Term Care at the Crossroads. Washington, DC: June 1998.
- y. U.S. Department of Veterans Affairs. Geriatric Research Education and Clinical Center (GRECC).
https://www.va.gov/GRECC/pages/Clinical_Projects_Disseminated.asp.
- z. U.S. Department of Veterans Affairs. National Center for Healthcare Advancement and Partnerships. <https://www.va.gov/healthpartnerships/vcp.asp>.

aa. We Honor Veterans. Hospice-Veteran Partnerships.
<https://www.wehonorveterans.org/partners/hospice-veteran-partnerships>.