Geriatrics and Extended Care Goal-Oriented Shared Decision Making Initiatives for Veterans

Empowering Veterans and the Nation to overcome the challenges of aging, disability, or serious illness

September 25, 2015
Presentation Goals

• Describe the vision, mission, and scope of Geriatrics and Extended Care (GEC) programs within the Veterans Health Administration (VHA)

• Provide an overview of GEC efforts to promote goal-oriented shared decision making initiatives for Veterans

• Summarize status of VHA efforts to ensure goals of care discussions occur in the context of serious illness
Honor Veterans’ preferences for health, independence, and well-being in the face of aging, disability, or illness by advancing expertise, programs, and partnerships.
Veterans Health Administration (VHA) Health System

- **21** Veterans Integrated Service Networks (VISNs)
- **150** Medical Centers
- **985** Outpatient Clinics
  - **820** Community-Based
  - **150** Hospital-Based
  - **9** Mobile
  - **6** Independent
- **300** Vet Centers
- **70** Mobile Vet Centers
- **104** Domiciliary Residential Rehabilitation Programs
- **135** Community Living Centers

Serving 8.9 million enrolled Veterans, half of whom are age 65 years or greater

Source: FY 2014 1st Quarter Pocket Card
Projected Enrollees Over 65 Years Old P1a Doubles in Next Decade

The graph shows the projected enrollees age 65+ from 2013 to 2033. The enrollees are categorized into two groups: All other priorities and Priority 1a. The enrollees show a steady increase from 2013 to 2018, with a significant jump in the next decade, indicating that the enrollees age 65+ will double in the next decade.
Total number of enrollees ≥ age 65 will increase from 4.1 to 4.7 million and number of priority1a Veterans will increase from 500K to 1.0 million between 2013 and 2023.
GEC ABC’s - Strategic Priorities

- **ACCESS**: Optimize the health, independence, and well-being of Veterans by ensuring access to Geriatrics, Palliative Care, and long term services and supports (LTSS) in facilities, home and community-based settings.
- **BALANCE**: Honor Veterans’ preferences by increasing the delivery of long term services and supports (LTSS) in home and community-based settings, thereby reducing preventable hospital and nursing home stays and emergency department visits.
- **CARE COORDINATION**: Improve care quality, safety, and enhance the experiences of Veterans facing the challenges of aging, disability or serious illness by supporting optimal care coordination and management, especially when home care is needed or during transitions between care settings.
GEC OPTIMIZES THE HEALTH, INDEPENDENCE, AND WELL-BEING OF VETERANS BY ENSURING ACCESS TO PALLIATIVE CARE, GERIATRICS AND LONG TERM SERVICE AND SUPPORTS

GEC Continuum of Care

Independence  Dependence  End of Life

Portfolio of Geriatrics and Extended Care (GEC) Programs

<table>
<thead>
<tr>
<th>Ambulatory Care</th>
<th>Inpatient Acute</th>
<th>Home &amp; Community Based LTSS*</th>
<th>Facility Based LTSS*</th>
<th>Palliative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Evaluation &amp; Management, Geriatric Primary Care (Geri-PACT), Outpatient Palliative Care</td>
<td>Geriatric Evaluation and Palliative Care Units, Geriatric and Palliative Care Consults</td>
<td>Adult Day Health Care, Home Based Primary Care, Homemaker &amp; Home Health Aide, Community Residential &amp; Medical Foster Care, Respite, Skilled Home and Palliative Care, Veteran Directed Care</td>
<td>VA Community Living Centers, Community Nursing Homes, State Veterans Homes</td>
<td>Outpatient Teams, Inpatient Teams, Home Hospice, Palliative Care Units</td>
</tr>
</tbody>
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Transitional Care; Healthcare Workforce Development; Geriatric Research, Education, and Clinical Centers (GRECCs): GEC Field Programs and Resource Centers

Mandated GEC Programs for all enrolled Veterans: Adult Day Health Care, Geriatric Evaluation, Hospice & Palliative Care, Home Based Primary Care, Homemaker Home Health Aide, Purchased Skilled Care and Respite. Nursing home care must be purchased or provided for ≥ 70% service connected Veterans or for service-related disability care.

*Long term services and supports
Example of Innovative Program
Shared Decision Making

SDM is a **collaborative** process for awareness, planning and decision making that supports the **Veteran as the decision maker** for **preference-sensitive** choices such as long term services and supports (LTSS). SDM for LTSS demonstration sites located in VISNs 9 and 20, with additional sites in FY16.

**Criteria for successful SDM process include:**

- Veteran, family/caregiver, provider(s) and social worker or nurse care manager involved in discussions.
- Veteran and family/caregiver given information and tools that facilitate participation in the process.
- All parties feel their preferences and rationale were heard.
- All parties accept the decision.
GEC Internet Site Supports Shared Decision Making

- **Key source of information** about: LTSS, especially HCBC; paying for LTSS; well-being; advance care planning, locating services and resources for Veterans and family/caregivers
- Provides **SDM overview and tools** – self-assessment worksheets for Veterans and caregivers
- **Showcases** many of GEC’s innovative programs
- About 40K visits per month

[www.va.gov/Geriatrics](http://www.va.gov/Geriatrics)
Folders contain **worksheets** – Veteran’s Shared Decision Making Worksheet and Caregiver’s Self-Assessment Worksheet; **handouts** – Services and Supports, Well-being and Advance Care Planning, and a **wallet card**
Focus on Home and Community Based Care

In-Home Care & Community Eldercare Options for Veterans

These services help chronically ill or disabled Veterans of any age remain in their homes. You can receive more than one service at the same time.

- Adult Day Health Care
- Home Based Primary Care
- Homemaker and Home Health Aide Care
- Hospice and Palliative Care
- Program of All-Inclusive Care of the Elderly (PACE)
- Respite Care
- Skilled Home Health Care
- Telehealth Care
- Veteran-Directed Care
Home Based Primary Care

What is Home Based Primary Care?

Home Based Primary Care is health care services provided to Veterans in their home. A VA physician supervises the health care team who provides the services. Home Based Primary Care is for Veterans who have complex health care needs for whom routine clinic-based care is not effective.

The program is for Veterans who need skilled services, case management and help with activities of daily living. Examples include help with bathing, dressing, fixing meals or taking medicines. This program is also for Veterans who are isolated or their caregiver is experiencing burden. Home Based Primary Care can be used in combination with other Home and Community Based Services.

What services can I get?

How do I decide if this is right for me?

What do Veterans and caregivers say?

Video about Home Based Primary Care

Watch the video to hear what Home Based Primary Care providers, the Veterans they care for, and their families have to say about this program.

Return to: Home and Community Based Services
Well-Being for All

Well-Being

Well-being is the combination of mental health, physical health, spiritual health—also called mind, body, and spirit. Find community resources to enhance your well-being at your own VA medical center and greater community.

Stay Active  Stay Safe  Find Balance

Eat Healthy  Watch the Video  Sleep Well

Maintain Relationships  Nurture Your Spirit  Lower Stress
Advance Care Planning

**What is Advance Care Planning?**

**How do I do it?**

Advance Care Planning is a process of clarifying your values and health care choices for use at a future time if you are no longer able to make decisions for yourself.

**How do I get started with Advance Care Planning?**

1. Think about the types of medical treatments you would choose to have, or refuse, if you were ill or injured and could not make those choices for yourself. This Values Worksheet can help you.

   - Or, visit PREPARE, an interactive online program that can help you identify what is important to you in life. It also covers how to make medical decisions for yourself and others, how to talk with your health care providers and how to get the medical care that is right for you.
Implementation of SDM for Veterans and Family Members takes an **educational** and **ecological** approach (L.W. Green, 1992). Good information is needed, but is rarely sufficient to change behavior. So we provide/support:

- **Orientations** for key VAMC leadership and ALL clinic staff
- **Training** for social workers and other key facilitators including video scenarios designed to integrate SDM into existing practice
- **Policy and Program Changes** to address gaps in availability and access to services in urban and rural settings
- **Tools and Information** in hard copy and online, that facilitate Veteran and caregiver empowerment
Feedback from Veterans, Family Members, and Providers

My go-to resources are the worksheets. They’re great conversation starters. I often learn something new and then I hone in on their main concern. ~ VA SOCIAL WORKER

This stuff needs to be discussed because it is important to address early on. I was glad to have (SDM) tools for me and my family. Also, I had no idea there are so many services available. ~ VETERAN
Goals of Care Initiatives for Veterans with Serious Illness

• VHA Life Sustaining Treatment Policy Directive will mandate goals of care conversations with seriously ill Veterans
• Documentation of these conversations will be accomplished using a specific template in the computerized patient record system (CPRS)
• The documentation template builds a life-sustaining treatment order set that incorporates goals of care directly in the care plan
• Goals of care training has been launched nationally
• Aligns with Choosing Wisely Campaign - Don’t delay palliative care for a patient with serious illness who has physical, psychological, social or spiritual distress because they are pursuing disease-directed treatment.
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