Geriatrics and Extended Care (GEC) is committed to optimizing the health and well-being of Veterans with multiple chronic conditions, life-limiting illness, frailty or disability associated with chronic disease, aging or injury. Our programs focus on maximizing each Veteran’s functional independence and lessening the burden of disability on Veterans and their families/caregivers. Because the course of chronic illness varies, the health care needs of the chronically ill Veteran also change, requiring the services of one, some, or all Geriatrics and Extended Care (GEC) Long Term Services and Supports. GEC programs include:

**Geriatric Programs:** Geriatric Patient-Aligned Care Teams (formerly termed Geriatric Primary Care), Geriatric Evaluation and Management (GEM), a variety of dementia initiatives, and the system of nineteen Geriatric Research, Education, and Clinical Centers (GRECCs) available in 18 of 21 VISNs.

**Extended Care Programs** also known as **Long Term Services and Supports** include hospice and palliative care services, facility based services, and home and community based programs.

All VA medical centers provide a blend of geriatric programs, facility based and home and community-based long term services and supports, including end of life services. The patient-focused approach supports the wishes of most Veterans to live at home in their own communities for as long as possible. At the same time when needed, Veterans may be eligible for facility based services for short or long stay needs.

**Veteran eligibility for Geriatrics and Long Term Services and Supports (LTSS).** All Veterans enrolled in VA’s health care system are eligible for geriatric programs, end of life services, and home and community based LTSS. Clinical indicators and Veteran conditions help VA staff identify the need for these services. Specific eligibility and admission criteria are unique to each of three venues of facility based services. The venues include VA Community Living Centers (CLC), Community Nursing Homes (CNH), and State Veterans Homes (SVH).

**GERIATRICS AND GERIATRIC PROGRAMS**

*Geriatric Evaluation and Management (GEM)*
Older Veterans with multiple medical, functional or psychosocial problems and those with particular geriatric problems receive a comprehensive interdisciplinary assessment resulting in a multidimensional plan of care. GEM services are offered in inpatient units or VA CLCs, in outpatient clinics and in Geriatric Patient-Aligned Care Team (geriatric primary care) clinics. GEM may be offered in Home-Based Primary Care.

*Geriatric Patient-Aligned Care Team (GeriPACT)*
A small percentage (about 2%) of the frail elderly Veterans who would otherwise receive their primary care in VA’s primary care clinics (termed Patient-Aligned Care Teams, or PACTs) are instead followed in GeriPACT (formerly termed Geriatric Primary Care), either in conjunction with a PACT or exclusively by the geriatrics-trained GeriPACT, where their more complex circumstances and involved medical histories can receive in-depth attention. Currently VA operates over 60 GeriPACTs, with additional sites adding this service monthly.

*Alzheimer's and Other Dementia Care*
The full range of VA health care services, is available for Veterans with Alzheimer's or other dementia. Services include home based primary care, homemaker home health aide, respite, adult day health care,
outpatient care, inpatient care, nursing home, or hospice care depending on the Veteran’s needs. Caregiver support is an essential part of all of these services.

**Geriatric Research, Education and Clinical Centers (GRECC)**

GRECCs provide a wide variety of educational activities targeting VA staff and trainees from the full range of health disciplines. GRECCs also contribute to improved quality of care through research and development of new models of clinical services. Each GRECC identifies one or more foci of research in the basic biomedical, clinical and health services area. Begun in 1975, there are now 19 GRECCs in all but three of VA’s health care networks.

**HOSPICE AND PALLIATIVE CARE SERVICES**

All enrolled Veterans have hospice and palliative care as part of their uniform benefits package if deemed appropriate by a VA physician. **Hospice care** provides comfort-oriented and supportive services in the home or in a facility for persons in the advanced stages of disease with a life expectancy of less than 6 months. **Palliative Care** has no associated survival requirement. The goal of both hospice and palliative care is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration or maintenance of functional capacity. Services are provided by a specialized interdisciplinary team of health care providers and volunteers. Hospice services are available 24 hours a day, seven days a week. **Bereavement care** is available to the family following the death of the patient.

**FACILITY BASED SERVICES**

VA provides facility based care through three venues: 134 VA owned and operated Community Living Centers (CLCs), formerly known as VA Nursing Homes; Community Nursing Homes (CNH); or 138 State Veterans Homes (SVH). In fiscal year 2010, approximately 72 % of VA’s facility based care occurred in CNH and SVH.

**Community Living Centers (CLC)**

VA CLCs are located on or near VA Medical Center campuses and offer a dynamic array of short stay and long stay services for eligible Veterans. Since most VA CLCs are co-located on or near a VA Medical Center the mission of the VA CLCs has focused on serving Veterans requiring short stay services post discharge from the hospital and in preparation for home and community based care.

**Community Nursing Homes (CNH)**

VA contracts with over 2,500 CNH. The CNH program has the advantage of being offered in many local communities where Veterans can receive care near their homes and families. VA contracts for the care of Veterans in CNHs approved by VA.

**State Veterans Homes (SVH)**

The SVH program is available in 50 states and Puerto Rico. SVH is a grant program that includes a portion of the construction costs and a per diem for each Veteran. Each SVH has unique and specific eligibility and admission criteria.
Home-Based Primary Care (HBPC)
HBPC began in 1970 and provides long-term primary medical care to chronically ill Veterans in their own homes under the coordination of an interdisciplinary treatment team. HBPC has led to guidelines for medical education as well as use of emerging technology in home care and improved care for Veterans with dementia and their families who support them. In 2010, HBPC programs were located in 140 VA medical centers and more than 120 Community Based Outpatient Centers (CBOCs).

Community Residential Care (CRC)
The CRC program provides room, board, limited personal care and supervision to Veterans who do not require hospital or nursing home care but are not able to live independently because of medical or psychiatric conditions, and who have no family to provide care. The Veteran pays the cost of the CRC. VA provides clinical services and administration which includes inspection of the CRC and periodic visits to the Veteran by VA health care professionals. Medical care is provided to the Veteran on an outpatient basis at VA facilities. Previously focused on Veterans with psychiatric needs, this program will be increasingly focused on older Veterans with multiple chronic illnesses that can be managed in a CRC under proper care and supervision.

Medical Foster Home Program (MFH)
MFH is a type of CRC chosen by the Veteran who is unable to live independently. It is a preferred option for family-style living with room, board, and personal care. The MFH is matched to meet the Veteran’s physical, social, and emotional needs, and supervision and protection. MFH is appropriate for certain Veterans who meet a nursing home level of care, prefer a non-institutional setting for their care, and do not need nursing home care if MFH is available. Currently, 98 VA medical centers in 43 states operate MFH programs.

Veteran-Directed Home & Community Based Services VD-HCBS
VD-HCBS is a consumer driven program that provides Veterans of all ages the opportunity to receive home and community based services in lieu of nursing home care and continue to live in their homes and communities. In VD-HCBS, the Veteran and Veteran's caregiver will: manage a flexible budget; decide for themselves what mix of services will best meet their personal care needs; hire their own personal care aides, including family or neighbors; and purchase items or services to live independently in the community. VD-HCBS is offered as a special component to the Administration for Community Living’s (ACL) Community Living Program (CLP). The ACL-VA joint partnership combines the expertise of ACL's national network of aging and disability service providers with the resources of VA to provide Veterans and their caregivers with more access, choices and control over their long-term services and supports. Currently, 20 states and 40 VA Medical Centers are offering the VD-HCBS program, serving over 1,400 Veterans, including young and severely injured Veterans.

Purchased Skilled Home Care (PSHC)
Professional home care services are purchased from private-sector providers at every VA medical center. The services purchased cover skilled nursing services as well as social services, occupational therapy, physical therapy, and speech-language pathology. All VA Medical Centers offer these time-limited services to Veterans requiring the service.

Adult Day Health Care (ADHC)
ADHC programs are available for Veterans who receive care and services at home. ADHCs provide health maintenance and rehabilitative services to Veterans in a group setting during daytime hours. VA introduced
this program in 1985. In 2010, VA operated 21 programs directly and provided purchased ADHC services at 120 VA medical centers. One SVH provides ADHC services.

**Homemaker and Home Health Aide (H/HHA)**

VA began a program of H/HHA services in 1993 for service-connected Veterans at risk for nursing home care. These services are community based and provided by public and private agencies under a system of case management by VA staff. In 1999, this program was expanded to cover all enrolled Veterans. VA purchased H/HHA services at 138 medical centers in 2010.

**Respite Care**

Respite care provides relief for the spouse or other caregiver of a chronically ill or disabled Veteran at home. In the past, respite care was limited to facility based settings, typically VA nursing homes. The Veterans Millennium Health Care and Benefits Act expanded respite care to home and other community settings, and home respite care was provided at 125 VA medical centers in fiscal year 2010. Currently 136 VA CLCs offer facility based respite. Respite care is usually limited to 30 days per year.

**Telehealth**

For most of VA's home and community based care, home telehealth technology can play a major role in coordinating Veterans’ total care to facilitate maintaining independence. Telehealth offers the possibility of treating chronic illnesses cost-effectively while contributing to the patient satisfaction generally found with care available at home.

**Innovative/Emerging Home and Community Based Alternatives to Nursing Homes.**

Under VHA’s system wide “transformation to a 21st century healthcare system” (T21), a range of innovative approaches to Long Term Services and Supports were piloted throughout VHA in order to provide patient-centered care that paired local resources and local needs. Pilot programs have been initiated at over 150 sites; programs that have been locally sustained and are being disseminated more widely according to perceived need and staff capacity include:

- “Hospital at Home” --substituting intensive, time limited home-care for particular diseases (e.g., congestive heart failure, chronic obstructive pulmonary disease, cellulitis, and community-acquired pneumonia) that would otherwise require hospital admission, thereby saving expense and improving outcomes;
- “Transition Management”—a variety of various proven models focusing psychosocial and medical/nursing supports on the critical time surrounding transfer from the hospital to home or other setting, thereby reducing readmission, reducing costs, and enhancing outcomes;
- “Dementia Case Management”—a variety of approaches focusing on Veterans with dementia and their caregivers, designed to keep the Veteran in the home as long as possible;
- “Program of All-Inclusive Care for the Elderly” (PACE)—VA-contracted services with PACE programs that combine day and primary care with case management to limit the need for facility based care;
- Delirium mitigation through medication reconciliation and nurse staff education/empowerment;
- Geriatric and Palliative Care SCAN/ECHO (remote geriatric consultation and education targeting primary care in CBOCs and virtual geriatric assessment via telehealth;
- Geriatric assessment and management for end-stage kidney disease patients;
- “Pre-hab” - targeting elderly Veterans scheduled for surgery to optimize their physical condition prior to admission, thereby reducing de-conditioning during their inpatient stays; and
- A variety of approaches intended to assist older Veterans and their caregivers to make advance care plans in the face of deteriorating cognitive and physical ability.