WHO WE ARE

Geriatrics & Extended Care (GEC) helps to optimize the health and well-being of Veterans with chronic conditions or life-limiting illness. GEC serves Veterans of any age who are disabled or frail due to disease, aging or injury. Please note eligibility and available services may vary from VAMC/HCCs.

- Services at Home and in the Community
- Residential Settings at the VA/CLC and Nursing Home
- Rehabilitation and Skilled Therapy Treatments
- Caregiver Support
- Advanced Care Planning

We proudly serve the Veterans and their families to fulfill President Lincoln's promise *"To care for him who shall have borne the battle, and for his widow, and his orphan."*

National Geriatrics VA Website: www.va.gov/GERIATRICS

Geriatrics & Extended Care

A description of VA Services that are available for you to live a quality life, as independently as possible, for your health goals.

VA CONTACT INFORMATION:

Geriatrics & Extended Care ..... www.va.gov/GERIATRICS

Enrollment and Eligibility ..... www.va.gov/health-care/eligibility

Veteran's Health Library ..... www.veteranshealthlibrary.va.gov

Telehealth ..... www.telehealth.va.gov

Myhealthevet..... www.myhealth.va.gov/mhv-portal-web

Whole Health ..... www.va.gov/wholehealth

Caregiver Support Program ..... 1-855-260-3274 & www.caregiver.va.gov

Help for Homeless Veterans..... 877-4AID-VET *or* (877) 424-3838

Mental Health ..... www.mentalhealth.va.gov

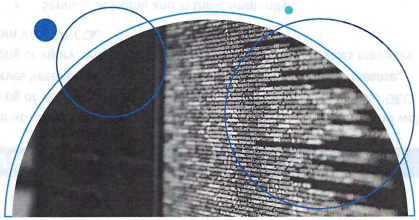
Veterans Crisis Line..... *dial* **988 (press 1)** *or* **1-800-273-8255 (press 1)**

PTSD..... www.ptsd.va.gov

VA Forms ..... www.va.gov/find-forms

VA Benefits..... 1-800-827-1000 & www.ebenefits.va.gov

Survivors' Benefits..... www.benefits.va.gov/BENEFITS/docs/VASurvivorsKit.pdf



NON-VA GERIATRIC COMMUNITY RESOURCES

PACE: Program of All-Inclusive Care for the Elderly

- **Service:** PACE provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals. An interdisciplinary team of health professionals provides PACE participants with coordinated care. For most participants, the comprehensive service package enables them to remain in the community rather than receive care in a nursing home. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. Individuals can leave the program at any time. **www.pace4you.org**
- **Eligibility:**
  - Age 55 or older
  - Live in the service area of a PACE organization
  - Eligible for nursing home care
  - Be able to live safely in the community

National Council on Aging..... www.ncoa.org

Medicare ..... www.medicare.gov

Find and Compare Nursing Homes ..... www.medicare.gov/care-compare

NIH National Institute on Aging ..... www.nia.nih.gov

Eldercare Locator ..... 1-800-677-1116..... www.eldercare.acl.gov

National Domestic Violence Hotline 1-800-799-SAFE (7233)

Locate Ombudsmen ..... www.theconsumervoice.org/get_help

Locate Elderly resources . www.hhs.gov/aging/state-resources/index.html

Justice in Aging..... www.justiceinaging.org

AmeriCorps Senior Volunteering ..... www.americorps.gov

Health information about Aging ..... www.healthinaging.org

Transportation Resources ..... www.nadtc.org

ADVANCE DIRECTIVES & CARE PLANNING

The Final Gift

Discussion and filling out your personal wishes/desires are done with your PACT team, GEM Clinic, Social Worker, Hospice & Palliative Care Team and/or during your hospitalization by the clinical providers.

www.va.gov/GERIATRICS/pages/advance_care_planning_topics.asp

Life Sustaining Treatment

The aim of the initiative is to promote personalized, proactive, patient-driven care for Veterans with serious illness by eliciting, documenting, and honoring their values, goals, and preferences.

Advance Directives & Care Planning

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.

MOST Forms

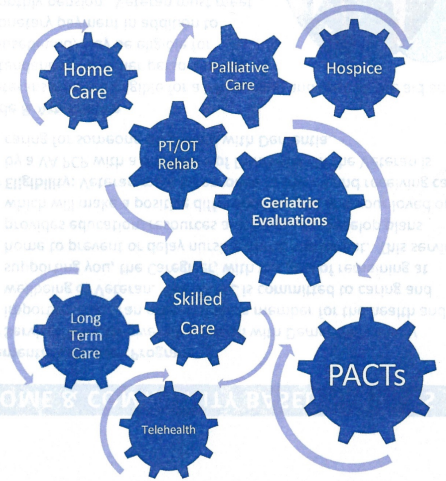
Medical Order for Scope of Treatment (MOST) forms are for use by physicians and other licensed healthcare facilities to assist in providing information relating to a patient's desire for resuscitation or life-prolonging measures. Several states recognize them as voluntary end-of-life planning tool designed to give those who are seriously ill or frail the opportunity to make known their health care wishes.

OUR MISSION

Geriatrics and Extended Care (G&EC) is committed to optimizing the health, personalized goals and well-being of Veterans with continuity of services through their transitions of life.

Services for the different stages of care needs:

Each service is based on the individual needs, eligibility and integration with a complement of services available. These services work together for improved care and independence.



COMMUNITY LIVING CENTER (CLC)

The Community Living Center (CLC) is focused on working as a team to provide personalized Veteran-centered care in a comfortable, supportive and safe setting for the following in-patient services:

Short Term Rehabilitation Care

This service is for post hospitalization for surgery or significant illness where the Veteran needs strengthening for independent living. Examples: after an amputation, gait training, cardiac surgery, stroke, heart failure, hip/knee replacement, falls/debility, etc.

- **Services:** Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), & Recreation Therapy (RT).
- **Eligibility:** Veteran has been screened by a multi-disciplinary team and needs in-patient rehabilitation service (can tolerate at least 1 hr of therapy per day), and demonstrates active participation in their PT/ST/OT. Non-Service Connected (NSC) and 0% Service Connected (SC) Veterans must fill out a 10-10EC form prior to admission to the CLC.

HOME & COMMUNITY BASED SERVICES

Dementia Caregiver Program

- **Service:** The Caregiver of a person with Dementia is a very important and is an essential team member for the health and wellbeing of Veteran. The VAMC is committed to caring and supporting you, the Caregiver, with the goal of remaining at home to prevent or delay nursing home placement. This service provides education, resources and helps you develop plans which will make a positive difference for you and your loved one.
- **Eligibility:** Veteran must be enrolled in the VA and receiving care by a VA PCP with a diagnoses of Dementia OR the Veteran is caring for someone diagnosed with Dementia.

Aide & Attendance

Veterans who are eligible for a VA pension and require the aid and attendance of another person, or are housebound, may be eligible for monetary payment in addition to monthly pension. Veteran must meet one of the following conditions:

- Require the aid of another person for daily activities, OR Be bedridden, OR
- Have eyesight corrected to 5/200 or less in both eyes, OR Be house bound

Please contact your local Veteran Service Officer.

Veteran-Directed Care

This program is for Veterans who need personal care services and help with activities of daily living. Examples include help with bathing, dressing, or fixing meals. This program is also for Veterans who are isolated, or their caregiver is experiencing burden. Veterans in this program are given a budget for services that is managed by the Veteran or the Veteran's representative. With the help of a counselor, Veterans hire their own workers to meet their daily needs to help them live at home or in their community.

HOME & COMMUNITY BASED SERVICES

Referrals: are made by your Physician, NP/PA, Nurse or Social Worker
Considerations: Non-Service Connected (NSC) and 0% Service Connected (SC) Veterans must fill out a 10-10EC form which determines if a VA co-pay may apply.

Adult Day Health Care

Service: Eligible Veterans can attend an adult day health care facility during the day for socialization, support, and assistance with activities of daily living. Based on cognitive and/or functional needs, a Veteran may attend from 2 to 5 days per week. This program assists with isolation and also provides respite for the caregiver.

Skilled Home Health Care

Service: The VA works with community skilled home health agencies to provide time-limited medical care in the home. Skilled care may include nursing care, physical therapy, occupational therapy, speech therapy, or social work. Skilled home health care that is coordinated and paid for by the VA must be ordered by a VA Provider. The goal is to teach the skill to the Veteran or to the caregiver. The VA may also set up skilled home health using Medicare as a payer source.

Homemaker Home Health Aide

This service is available to assist Veterans with personal care such as feeding, dressing, bathing, grooming, light housekeeping chores, and meal preparation. If eligible, the VA arranges care with agencies to provide services based on the Veteran's assessed needs.

Respite

Service: to give caregivers a break from the daily care they provide to a loved one. Respite may be set up for "In-home Respite" or "Community (nursing home) Respite." Typically, if eligible, Veterans are eligible for a maximum of 30 days per year.
Eligibility: If a Veteran has been recently hospitalized, there is a 30 day waiting period before using either In-home or CLC respite. Veterans may use 30 days of Respite per year, either In-Home, in a CNH, or at CLC or in combination.

Short Term Skilled Care

- **Service:** Utilized for Veterans requiring daily skilled nursing care for wounds, long term IV antibiotics, chemotherapy/radiation management when unable to care for themselves in the home.
- **Eligibility:** Veteran has been screened by a multi-disciplinary team and needs nursing level of care. Non-Service Connected (NSC) and 0% Service Connected (SC) Veterans must fill out a 10-10EC form prior to admission to the CLC.

Long Term Care in the CLC

Eligibility: Veteran requires skilled nursing care and is unable to function and care for him/herself independently. Additionally, Veteran is eligible if he/she is 70% SC, or 60% and is deemed unemployable by VBA, or requires dependent skilled care related to a Service Connected Disability.

Hospice In-patient Care in the CLC

Many VAMCs offer in-patient Hospice Unit within that focuses on the comfort and the goals of care of the Veteran. Eligible Hospice Veterans receive optimized end of life symptom management for their disease by a specialty trained multi-disciplinary team that includes provider, nursing, nutrition, social work, chaplain, pharmacy, and recreational therapy support.

If CLC or VA facility in-patient Hospice not available in your area, many local community Hospice agencies partner with VA facilities for in-patient admissions or emergency respite stays for Home Hospice Veterans. Ask your social work office for additional information.

GERIATRIC EVALUATIONS

Comprehensive team evaluations by medical provider, social worker, and nurse. Many sites also include pharmacist, geriatric psychologist and occupational therapist (OT) in one location. Geriatric consultations may be provided via face-to-face encounter, telehealth, or e-consult. Referrals are made by your Physician, NP/PA, Nurse or Social Worker. VAMC/HCC may include the following types of Geriatric Evaluations:

- **Geriatric Evaluation & Management (GEM):** Geriatric syndromes (Memory/Dementia, Delirium, Falls, Bowel and Bladder Problems Associated with Aging, Weight loss, Complex Medical Care of Advanced Age, and/or mental health issues with aging condition).
- **Peri-operative Optimization of Senior Health (POSH)** Goal: to evaluate and decrease post operation complications such as confusion & delirium. Veterans and families are informed of risks, alternatives and pre-operation knowledge to prepare for surgery. Medical team involves the anesthesiologist, surgeon, a geriatric medical provider, pharmacist, geriatric psychologist, social worker, nurse and OT.
- **Palliative Care Clinic:** Specialized medical care for people with serious illness with focus on relief from the symptoms, quality of life, pain and stress of serious illness.
- **Inpatient Geriatric Evaluation:** Comprehensive Geriatric review during admission to hospital.

DID YOU KNOW?

Whole Health Program at VA

Whole Health is VA's cutting-edge approach to care that supports your health and well-being. Whole Health centers around **what matters to you**, *not what is the matter with you.* This means your health team will get to know you as a person, before working with you to develop a personalized health plan based on your values, needs, and goals. **www.va.gov/wholehealth**

GRECC: Geriatric Research, Education and Clinical Centers

GRECCs are VA geriatric centers of excellence focused on aging. They were established by Congress in 1975 in order to improve the health and health care of older Veterans. They are located at 20 medical centers across the country and each is connected with a major research university. The GRECCs have three main missions:

1. To build new knowledge in geriatric care through research.
2. To improve health care for older Veterans through the development of innovative clinical models of care.
3. To provide training and education on best practices in caring for older adults for students in healthcare disciplines and VA staff.

Gerofit www.va.gov/GERIATRICS/pages/gerofit.Home.asp

Gerofit is an exercise program that promotes health & wellness for older Veterans. Started in 1986, Gerofit is a great way for Veterans to stay active by using a variety of strength and aerobic exercises which can include group classes like tai chi, dancing, walking, and balance. All veterans are given a personalized exercise prescription and guidance in carrying out the exercise program by trained exercise staff such as a physiologists, nurses or physical therapists. Now offered at 30 different VAMC/HCCs.

RESIDENTIAL SETTINGS

Community Residential Care

- **Service:** for Veterans who do not need hospital or nursing home care but cannot live alone because of medical or psychiatric conditions. This type of care takes place in a number of settings including Assisted Living facilities, Personal Care Homes, Family Care Homes, Group Living Homes, and Psychiatric Community Residential Care Homes. These places – more than 550 of them across the country – are chosen by the Veteran.
- **Eligibility:** for Veterans who have no support person who can provide monitoring, supervision or help with activities of daily living (e.g., bathing, getting dressed, preparing meals).

Veterans pay for their rent from VA compensation, VA pension, Social Security or other retirement or income sources.

Traumatic Brain Injury- Residential Rehabilitation (TBI-RR)

Service: TBI-RR is a residential rehabilitation program that VA purchases on behalf of veterans with TBI and other brain injuries. Veterans must need neurobehavioral treatment in a protective environment and their care needs cannot be met in a nursing home or on an outpatient basis. VA purchases the services provided in these facilities but is prohibited from paying for the full cost. The Veteran is responsible for payment of room and board, which is generally $30 to $40 per day.

Adult Family Homes or Assisted Living

Are places where Veterans can live in a rented room. Adult Family Homes are usually 6 or less residents per home. Assisted Living Facilities are places where Veterans can live in a rented room or apartment. There are some shared living spaces, common areas used by all residents.

There is a trained caregiver on duty 24/7, who can assist with activities of daily living. VA may also be able to provide a health professional (such as a nurse) to give the Veteran extra care. The VA does NOT pay for rent.

GERIATRIC PRIMARY CARE (PC) SERVICES

Geri-PACT: Stands for Geriatric-Patient Aligned Care Team. Provides healthcare for Veterans with more than one chronic disease and with declining mental and physical capabilities.

Eligibility: Geriatric Syndrome: Dementia or cognitive decline, or trouble with falls, and/or incontinence.

- 75+ years of age with a geriatric syndrome (age may differ between VAMC/HCC).

- **How to Enroll:** contact your primary care team for consultation for possible enrollment.

Home Based Primary Care (HBPC):

- **Serves:** Veterans who have complex and chronic diseases and who are at higher risk for hospitalization or nursing home placement.
- **Eligibility:** Live within the area service by the HBPC team, Veterans may live alone or with caregivers.
- **How to Enroll:** Contact your doctor, social worker or HBPC office.

Primary Care and Women's Health/GYN:

- **Serves:** primary care for eligible enrolled Veterans in a PACT (Patient Aligned Care Team)
- **Eligibility:** Through enrollment in VAMC and maintained yearly exams.
- **How to Enroll:** after confirmed eligibility, you will be assigned a primary care provider and team.

VA-COMMUNITY PARTNERSHIPS

Contracted Community Nursing Homes (CNH)

- **Serves:** Veteran requires skilled nursing care and is unable to function and care for him/herself independently. These are skilled nursing facilities with contracts with the VAMC. Oversight for quality of care is provided by VAMC staff monthly.
- **Eligibility:** Veteran is eligible if he/she is 70% SC, or 60% and is deemed unemployable by VBA, or requires dependent skilled care related to a SC disability and is no longer able to reside at home.
- **Enrollment:** Referral by Social Worker (SW) & approval by G&EC Screening Committee.

State Veterans Home (SVH)

- **Serves:** Long Term Care (typically for Veterans with ≤60% Service Connection) & Short Term Rehab/Short Term Skilled, some site have Domiciliary & Adult Day Care.
- **Eligibility:** Screening & Insurance

Medical Foster Home(MFH)

- **Service:** Private homes in which a trained caregiver provides services to eligible Veterans in a family setting. The VA inspects and approves all Medical Foster Home Programs. Monthly monitoring by Medical Foster Home Coordinator and HBPC staff. Serves as an alternatives to a nursing home.
- **Eligibility:** Must be enrolled in HBPC, and is private pay by the Veteran.
- **Enrollment:** By referral from SW, community partners and Veteran self-referral for screening by the MFH program.

VA-HOME & COMMUNITY SERVICES

Home Hospice

Service: Hospice is a benefit that the VA offers to qualified Veterans who are in the final phase of their lives, typically six months or less. This multi-disciplinary team approach helps Veterans live fully until they die. The VA also works very closely with community and home hospice agencies to provide care in the home.

Palliative Care

Service: Palliative Care uses comfort care with a focus on relieving suffering and controlling symptoms so that you can carry out day-to-day activities and continue to do what is most important to you. Palliative care aims to improve your quality of life – in your mind, body and spirit. Palliative Care can be combined with treatment that is aimed at curing or controlling your illness with your current team of clinical providers & physicians. It can be started at the time of your diagnosis and may be provided throughout the course of the illness.

Telehealth

Service: Telehealth technologies provide easier access to care by connecting you with your VA Care teams and specialists, no matter the distance. VA Telehealth can reduce travel and allows you to meet with VA providers virtually via telephone, tele-visits (video connections), remote monitoring, and/or mobile apps. **Remote monitoring** communicates your health data such as diabetes blood glucose levels or blood pressures with your informed consent. VA assigns you a Home Telehealth remote monitoring care coordinator. Your care coordinator contacts VA hospitals and providers and helps you arrange treatment changes, clinic appointments and hospital admissions.