Geriatric Research Education and Clinical Centers
United States Department of Veterans Affairs
GRECC Honoring Veterans as They Age
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GRECCs: Clinical Innovations Benefitting Veterans of All Ages in All Settings

…what follows is a small sampling from over one hundred clinical innovations and demonstrations currently underway in VHA's Geriatric Research, Education and Clinical Centers (GRECCs).

Cleveland GRECC's Geriatric Emergency Room: Older Veterans represent about 45% of the patients seen in VA emergency rooms and generate many revisits and admissions. "GERI-VET" adds a comprehensive geriatric evaluation (CGE) performed by "intermediate care technicians" (former military corpsmen) to ER visits for Veterans older than age 75. Follow-up to address issues identified through the CGE is intended to prevent ER revisits and hospital readmissions. Over 250 Veterans have participated in GERI-VET to date outcomes confirm the program's effectiveness in reducing rates of hospitalizations and ED re-visitations in this high-risk group.

Tennessee Valley GRECC Improves Care in Intensive Care Units through:

- Their ABCDE delirium prevention bundle results in less time on ventilators, 50% delirium reduction, 30% mortality reduction, more than a two-fold reduction in long term cognitive impairment, and reduced ICU and hospital lengths of stay. ABCDE achieves these impressive results by employing **A**wakening and **B**reathing trials through **C**oordinated efforts of nursing and respiratory therapy; **D**elirium surveillance, prevention, and treatment; and **E**arly mobilization and ambulation.
- The THRIVE ICU Support Group: served ICU survivors and family members in 33 sessions offered October 2016 - July 2017. Of those surveyed, 93% felt emotionally supported, 91% learned from others, 77% now understand common situations related to prolonged ICU stay, 86% would strongly recommend group participation to a friend, and 42% expressed interest in volunteering to provide peer support to others
- ICU Diaries were kept by 29 staff in 2017. On a 100-point scale, diary knowledge increased from 38.8 to 71.85, belief that diaries are beneficial rose from 62.74 to 76, and comfort level with educating family from 44.4 to 78.46. Benefits noted included increased family engagement, enhanced communication, and an enriched frame of reference for hospitalization.

Puget Sound GRECC: Memory Support for Older Adults with Post-Traumatic Stress Disorder [PTSD] (MSOAP) provided an outpatient PTSD group the means to enhance memory skills and PTSD self-management. Alterations of attention/memory are among the diagnostic criteria for PTSD, and is a risk factor for dementia in older Veterans. After participating in the groups, questionnaires assessed PTSD symptoms, cognitive complaints, sense of self-efficacy, satisfaction with the group experience and materials, feedback on group improvement and indices of quality of life. Analyses demonstrate overall satisfaction, decreased depressive symptoms, no increase in PTSD symptoms, and increased sense of self-efficacy.

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RHIO-Enhanced Care Transition Intervention Program Bridges Care for Older Veterans Who Utilize Non-VA Acute Care

Patients who transition from acute care to primary outpatient care are at high risk for adverse outcomes such as readmissions and medication errors. Primary care patients at the VA who utilize non-VA acute care services are at particularly high risk for these adverse outcomes due to lack of coordination between non-VA and VA sites. The Bronx Regional Health Information Organization (RHIO), a community electronic health information network system, provides an opportunity to improve care coordination between non-VA and VA sites by providing a platform for sharing clinical data among facilities. The VISN 2 GRECC, based at the James J. Peters VA Medical Center, has developed a Care Transitions Intervention (CTI) to serve Veterans who are recently discharged from a non-VA hospital, utilizing push messages from the RHIO system for notification. Upon notification of the acute care event, a CTI is delivered by a care transitions coach through a home visit and telephone follow-up calls. The intervention contains a structured protocol of monitoring and retrieval of non-VA hospital and emergency department discharge information using the Bronx RHIO, coordination of urgent and follow-up appointments, condition specific patient education and communication, medication reconciliation, and provider communication. The project has led to improved communication between care teams and identification and meeting unmet care needs for Veterans during transitions of care. The project has also helped inform the transitional care program at the VA Hudson Valley Health Care System, and the use of push messages has disseminated to the Indianapolis VA Medical Center. A rigorous evaluation using a randomized study approach is ongoing at the Bronx and Indianapolis sites. Related journal article: Hung WW, Morano B, Moodhe N, Boockvar K. Regional Health Information Organization (RHIO): its potential uses to improve veteran health care. Federal practitioner. 2011 Jan 1; 28(3):33-36.

For more information about the Care Transitions program at JJP VAMC, contact Nicholas Koufacos, Care Transitions Coordinator at (718) 584-9000, ext. 3851.

GRECCs: VHA's Centers of Excellence focusing on vulnerable Veterans through the advancement and integration of research, education and clinical innovation in geriatrics and gerontology within the VA healthcare system. There are currently twenty GRECCs located nationwide with the common mission of improving the quality of care for older Veterans. For more information please visit us at http://www.va.gov/grecc.

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