

VA Geriatrics and Gerontology Advisory Committee Meeting  
April 25-26, 2007

Participants:

Norman Abeles, PhD  
Itamar Abrass, MD (Chair)  
Adrian Atizado  
Robert P. Carbonneau  
JoAnn Damron-Rodriguez, PhD  
Richard Della Penna, MD  
John Derr, RPh  
Jade Gong, RN, MPPA  
Mary Jane Koren, MD  
Richard Veith, MD  
Tom Yoshikawa, MD

Ex-Officio:

Judith Salerno, MD, MS

Staff:

James Burris, MD (VACO staff)  
Susan Cooley, PhD (VACO staff; via teleconference)  
Ken Shay, DDS, MS (VACO staff)

Guests:

Madhu Agarwal, MD (Chief Officer, Patient Care Services)  
Kathleen Charters (My-Health-E-Vet)  
Malcolm Cox, MD (Office of Academic Affiliations)  
Thomas Edes, MD (Office of Geriatrics and Extended Care)  
Joy Hunter (EES)  
Joel Kupersmith, MD (Office of Research and Development)  
Pat G. Lay (EES)  
Jim Martin (American Legion)  
Tim O'Leary, MD (Office of Research and Development)  
Kathleen Painter (My Health-E-Vet)  
Terry Ross (Executive Career Field Trainee)  
Gretchen Stephens (Poly-Trauma Program)

Dr. Abrass convened the meeting at 8:35am on April 26 and began by introducing the newest member of GGAC: Richard Della Penna, MD. Dr. Della Penna is a geriatrician who has worked for Kaiser Permanente for 30 years and has served as Director of their aging program for the last seven years. He characterized the organization as having 950,000 "older members". Other GGAC members introduced themselves and briefly reviewed their backgrounds as well.

**Announcements**

Dr. Abrass asked for announcements; Mr. Derr announced that he has accepted a position as the CIO for Beverly (now Golden Ventures) and is charged with establishing an electronic health record. He has approximately 120 IT people reporting to him and is located in Fort Smith, Arkansas.

Dr. Yoshikawa announced that, on or about June 1, 2007, he will be resigning from GGAC and assuming the position of Director, Greater Los Angeles GRECC.

Itamar also announced that there is a second new GGAC member, James Higgins, MD, of the Bon Secours Health Care System, who was unable to attend this meeting.

### **Office of G&EC**

James F. Burris, MD, Chief Consultant, Geriatrics and Extended Care, reported that the G&EC Office has been weathering a difficult period in regards to personnel due to job changes, health problems, and illness. Nevertheless, people have risen to the challenge and through extensive cross coverage national conferences for Geriatric Leadership, GRECC Directors, State Veterans Homes Survey, Nursing Home Care Unit Cultural Transformation, and Hospice Palliative Care were all being held in the next few months.

**Budget.** There appears to be an additional \$2.56 billion for VA Healthcare in the FY08 budget, representing a 7.4% increase over FY06 (FY07 was based on FY06, due to the Continuing Resolution). There is also a discussion underway for an approximate \$3 billion supplemental in FY07. This is due, in large part, to the expected increase in workload from the up to 250,000 veterans from the OIF/OEF conflict. For 2008 it is projected that there will be approximately 5.7 million active veteran patients out of nearly 8 million that are enrolled. The current amount proposed for Long Term Care is approximately \$4.4 billion (Dr. Burris noted \$3.9 billion was spent in 2006). Of this, \$442 million will go toward Non-Institutional Care (which does not include Spinal Cord Injury or Care Coordination/Home Tele-Health). This is an \$80 million increase (22%) over the previous year, and represents approximately 10% of the total Long-Term Care budget. Dr. Burris pointed out that Performance Measures for the VISNs now require that a minimum of seven Non-Institutional Care programs be provided. In addition, there are numeric thresholds for both Spinal Cord Injury and CCHT as well. At the moment there are approximately 25,000 veterans receiving CCHT and that number is steadily and steeply increasing.

**State Homes.** The number of vets is projected to peak in 2011 and decrease after that. Nevertheless, the number of very elderly vets will continue to grow. More than half of the VA's census for institutional Long Term Care of elderly veterans is within the State Veterans Homes. 12 State Veterans Homes have recently been constructed with 800 to 900 beds, and the ADC in State Veterans Homes is approaching 18,000 (representing 52% of the Long Term Care population of VA). Approximately \$85 million is budgeted to build new State

Veterans Homes in FY08. By way of contrast the only new VA Nursing Home Care Unit is in Las Vegas, and there are approximately 11,500 patients in VA NHCUs with approximately 4500 in Community Nursing Homes. Mr. Derr noted that one of the likely new State Veterans Homes would be in Los Angeles, on the grounds of the Wadsworth VA. He inquired whether this was a first, or whether there were other State Veterans Homes that were contiguous with VA facilities. Dr. Burris responded that there were some, but this was neither the first instance, nor was it the only one. In many cases Primary Care is provided at the State Veterans Home; and if the residents of the State Home require specialty care or hospitalization they are then managed at the co-located VAMC. Mr. Derr inquired whether State Veterans Homes offered Rehabilitation services, and Dr. Burris pointed out that this was determined by how the state government is organized, which in turn determines where the authority for such matters rest along with the origin of the state-based funding. Dr. Koren inquired whether State Veterans Homes have to be certified. Dr. Burris responded that approximately 40% are CMS certified for which Dr. Koren noted meant that 60% of them then could not receive Medicare or Medicaid. Mr. Derr inquired as to quality of care in the 60% of homes that are not CMS-certified. Dr. Koren noted that all were licensed, but that only a minority was certified. Dr. Burris confirmed this and noted that all State Veterans Homes are inspected at least once a year, and if deemed necessary there are more frequent inspections by the closest VA. There is a potential for a Conflict Of Interest here, inasmuch as the nearest VA could likely be dependent on the State Home as a discharge destination, but there are also state agencies that do inspections, monitor correction plans, etc.

Dr. Burris pointed out that these are state-administered programs and they vary across the country. For instance, Georgia only allows combat veterans, and while the VA allows for up to 25% of the occupancy of the State Veterans Home to be spouses, dependent children, and Goldstar parents; only some State Veterans Homes follow this particular practice. Dr. Burris went on to point out that both the National Association of State Veterans Homes Directors and the National Association of State Veteran Agencies are active groups that meet annually in Washington, DC, and the Office of Geriatrics and Extended Care always sends representatives to those meetings. At the spring 2007 meeting, Secretary Nicholson appointed a taskforce to look into growing Non-Institutional Care in State Veterans Homes. Currently, federal authority only permits Adult Day Health Care and as a consequence State Veteran Home representatives had relatively little interest in other forms of NIC.

Mr. Derr inquired whether the Electronic Health Record (VISTA) is available at State Veterans Homes. Dr. Burris noted that again there is variation from state to state. Some have full access; while some have read only access. He also noted that not all State Veterans Home residents have to be enrolled with VA, so not all of them necessarily have their health records in VA system. In addition, privacy issues obstruct the possibility of a full and free interchange because legal separation is required. The Department of Health and Human Services has

established an intergovernmental taskforce to reduce the barriers between different governmental health care agencies; however, all the different agencies grew their own separate systems and no one agency is willing to incur the cost of having to conform to the others.

Mr. Derr inquired if the State Veteran Homes were considered equivalent to Assisted Living under the Mil Act, to which the answer was no. Out of the 119 State Veteran Homes only 8 offer Adult Day Healthcare; there are approximately 30 more such programs in various stages of planning. Domiciliary services are also provided at a number of State Veteran Homes.

Ms. Gong noted that a number of the Adult Day Healthcare programs in State Veteran Homes have prohibitively tight criteria for admission and are therefore failing due to non-enrollment. She felt there is a need to reevaluate regulations for these very soon. Dr. Burris concurred and pointed out that this was the same conclusion reached by the recent meeting of State Veteran Home representatives. Other issues they felt require regulatory changes include offering a supplemental for recruitment or retention of nurses, and reexamination of the policy that VA incurring the full costs for veterans be limited to those who are 70% or more Service Connected. Mr. Derr inquired who in the GEC Office was responsible for State Veteran Home activities. Jackie Bean is responsible for the per diem program; Christa Hojlo and Tydette Tisdell are responsible for quality in State Veterans Homes; and Frank Salvas is in charge of the construction program. Dr. Damron-Rodriguez inquired as to the occupancy rate, and Dr. Burris reported that overall it is approximately 85%. He noted that some were less occupied (such as Barstow, in eastern California, that runs up a 60%) and others run well over 90%. Ms. Gong inquired as to whether the Armed Forces Veterans Homes were part of this system and was told that they were not. There are only two Armed Forces Veterans Homes remaining; one in Washington, DC, and one in Biloxi, which was destroyed by Hurricane Katrina in 2005. Another former Armed Forces Veteran Home is now under the authority of a nonprofit organization and is no longer run by DOD.

**GRECCs.** Dr. Burris began to review a number of the different program areas and noted that the increase in GRECC site visits by GGAC was having positive results. Nevertheless, vacancies persist, and Dr. Shay, in conjunction with GGAC, is concerned about this. Mr. Derr inquired whether there was any possibility for increased funding to the GRECCs, to which Dr. Burris responded that that would be entirely up to the VISNs inasmuch as all funding to the GRECCs is their responsibility, and Dr. Abrass added that this would be discussed extensively later in the meeting. Dr. Koren thought that the handout material for the meeting demonstrated that holding the VISNs accountable for the GRECCs was proving to be worthwhile. Mr. Derr inquired whether it would be beneficial for GGAC to actively lobby at the VISN level on behalf of the GRECCs beyond the GRECC Site Visits. Dr. Abrass countered that, with the new schedule and frequency for site visits, all GRECCs are visited every three to four years.

Mr. Derr suggested that perhaps a structured template raising the need for support from the VISN would help. Dr. Burris suggested that GGAC continue to get the message out in every way possible. He noted a major effort by Dr. Shay to get the message out about how productive and valuable the GRECCs are, citing the recent example of the shingles vaccine clinical trials, which were largely led by the Durham GRECC.

**Dementia Programs.** Dr. Burris then moved on to the Dementia Programs, headed up by Dr. Susan Cooley. A VHA Dementia Steering Committee has been pulled together co-Chaired by Drs. Cooley and Sanjay Asthana (GRECC Director, Madison). This group will oversee the planning, development, and implementation of a variety of care coordination, clinical care, and administrative activities to build up VA's capability for dealing with veterans suffering from dementia. The group has broad VACO and field representation, and Dr. Burris expects them to do an unprecedented job in initiating, and then sustaining, meaningful undertakings to address dementia.

**Non-institutional care.** Dr. Burris then turned to Non-Institutional, Home and Community Based Care. He noted that the VISN Performance Measure previously discussed will continue to expand access, and that he and Mr. Schoeps are intending to set more ambitious Average Daily Census targets for FY08. GEC has buy-in from management and OMB on this. Growth in NIC is "slow but steady", however Dr. Burris noted that GEC still hears reports from the field that resources budgeted for the targeted programs are not getting to them. Dr. Damron-Rodriguez inquired as to the numbers of Non-Institutional Extended Care recipients. Dr. Burris responded that, as of the end of FY06, the ADC was approximately 23,000. He said that the target for FY07 was approximately 31,000, and speculated that the cap for 2008 would be approximately 39,000. He clarified that these numbers do not include CCHT. Nevertheless, he noted that even at this rate, this was only approximately 25% of the projected demand for NIC as based on actuarial modeling that blends age, gender, disabilities, and census data for both institutional and NIC needs.

Dr. Damron-Rodriguez characterized NIC as still being "boutique services" in the medical centers. She acknowledged that there has been significant growth, but it was still insufficient. Dr. Burris concurred, noting that although use of NIC services has more than doubled in the last few years it is still very small. Ms. Gong asked Dr. Burris to specify the "Non-Institutional Care" services provided under that authority. Dr. Burris enumerated: Skilled Home Nursing, Adult Day Health Care, Hospice and Palliative Care, Respite Care, Home Maker/Home Health Aide, and Home Based Primary Care. Dr. Damron-Rodriguez speculated that there were more outcomes than census that merit tracking in order to demonstrate that the VA drive to increase NIC is producing benefits.

Ms. Gong inquired as to the status of the AIC pilot. Dr. Burris responded that the three pilots had ended in 2005, and although one of the sites continues to work

with the local PACE provider on a basis that is within authority, officially the evaluation of the experiment was that AIC was not beneficial so it is not being pursued at this time.

Mr. Derr inquired about collaborations between VA and CMS, both potential and in existence, with particular reference to electronic record-keeping. Dr. Burris noted that RAI/MDS version 3.0 is undergoing beta testing. Mr. Derr inquired whether the "SNOMED" nomenclature system is incorporated in the new version of MDS. Dr. Abrass clarified that while academic centers are consistent with CMS, it seems unlikely that VHA is going to make efforts to change its entire nomenclature system. Dr. Koren also noted that SNOMED is not geared for geriatric diagnoses.

### **Patient Care Services**

Dr. Agarwal, Chief Officer, Patient Care Services, then provided an overview of PCS activities to the GGAC.

**Health Promotion.** One major thrust of her office is increasing patient involvement with their care; she noted the movement of care from VA structures to home and community-based venues (e.g., ambulatory and home-based care) necessitates this. My-Health-E-Vet and Healthier US Vets are two programs addressing this through foci on diabetes, obesity, weight loss, and exercise. Mr. Derr inquired whether there were any data on veterans using electronic media to foster patient education and take more responsibility for their care, for instance in helping to smoke less. Dr. Agarwal responded in the affirmative: preliminary data suggests that the reminders compel patients to ask their physicians for more information. As far as clinical outcomes, she was not aware of any at this point. She gave an example of a strong thrust in obesity/diabetes. 73% of veterans are overweight, 33% are obese, and over 20% carry the diagnosis of diabetes. As such, the MOVE! program has been introduced, in which level 1 represents education, level 2 peer support, level 3 drug therapy, and level 4 inpatient service. Only one VA site offers level 4; however 18 bariatric surgery centers offer level 5 therapy for those that have been unsuccessful at levels 1-4. "Healthier US Vets" is a joint venture of HHS and VA, and includes families and significant others: it is not only limited to the veterans. A widespread promotional activity is underway and recently DOD has asked permission to adopt some of the MOVE! tool kits.

**Access to care.** Patient Care Services is undertaking innovations to increase access. For Primary Care there is the thrust to improve access and reduce wait times to 30 days or less. She also spoke of the Mental Health/Primary Care efforts to enhance Women's Health by exempting co-pay for gynecologic screenings and increase training for Primary Care Providers. Medical centers lacking necessary subspecialty radiologic expertise can nevertheless get those services from other medical centers through teleradiology. In addition there are hub-and-spoke arrangements, such as with

Polytrauma and Spinal Cord Injury. Dr. Agarwal also informed the group about System Redesign, a new term that is now being employed for what used to be called Advanced Clinic Access. This is an effort to optimize resources and quality in the face of growing demand. It was originally initiated in outpatient settings but has been extended into Acute and Long Term Care. She also noted that nearly 60,000 clinicians had recently been trained to conduct TBI screenings in order to identify any problems stemming from the Gulf War experience.

**Quality.** She then gave GGAC some glimpses of emerging Acute Care programs that help build quality and safety in the Intensive Care Unit, Emergency Room, Sterility Processing and Distribution (Infection Control), and Pain Management. With respect to the ICU a standardized data tracking method is being developed. There is an effort to standardize Emergency Rooms nomenclature so as to prevent the inappropriate transport of veterans in emergent situations. There is a great difficulty with this inasmuch as some VA "Emergency Rooms" are in fact Urgent Care within facilities that only offer nursing home care. The SPD focus is on MRSA prevention, modeled on a pilot program in Pittsburgh, characterized by "active surveillance".

**Emerging Programs.** Other emerging programs focus on special populations (Mental Health, Polytrauma, Spinal Cord Injury, frail elderly) and caregivers. With respect to caregivers, she alluded to a recently published RFP, with due dates by mid or late June, which will distribute up to \$5 million among meritorious proposals to caregivers offering innovative services within VA authority. Finally, programs like "translating clinical research into practice" are typified by fostering evidence-based practice, electronically-based decision-support systems, and genomic medicine.

**Polytrauma.** Dr. Agarwal then spoke of the Polytrauma program, in which 92% of patients have Traumatic Brain Injury, 45% suffer from fractures, and 5% from amputation. Polytrauma patients are closely tracked, and the statistics concerning their care are being closely followed. Dr. Veith noted that the information she showed did not include psychiatric findings, and Mr. Derr wondered about Spinal Cord Injury. Dr. Agarwal said that brain injury drives polytrauma care, and characterized the clinical challenges as "brain injury plus". Dr. Salerno inquired into the particulars on how DOD hands off patients to VA, and Dr. Agarwal explained that there are Care Coordinators at each of the polytrauma centers. The transition from the Military Treatment Facilities (MTF) involves a conference call and transfer of information in the medical record. She noted that the four Polytrauma Centers, located in Richmond, Tampa, Palo Alto, and Minneapolis, are characterized as "level 1" of polytrauma care. After the patient has been treated there they are transferred to one of the Polytrauma Network Sites (only 15 are in operation now, eventually there will be one for each VISN) which are considered "level 2". "Level 3" is the Polytrauma Support Clinics, which eventually will number approximately 100. In addition, all VA medical centers are to have Polytrauma Points Of Contact to help deal with these high

utilization patients. CPRS currently has a reminder that prompts evaluations by support level teams. Currently there are close to 360 patients under Polytrauma care, including 80 in Traumatic Brain Injury, and 80 in Blind Rehab. To get some perspective on the potential demands, Dr. Agarwal noted that there are approximately 350,000 OEF/OIF veterans; yet there are 7.2 million VA enrollees and 5.2 million VA users. Clearly this new onslaught will be a significant challenge to the system, and yet the system already has a formidable workload that cannot go unmet in the face of new challenges. For that reason, the tele-health network is proving extremely valuable, inasmuch as it allows extension of expertise into areas where bricks and mortar are not available. Recently, Long Term Care services have been discussed as an option to address the needs of SCI and PT/TBI patients, such as a Medical Foster Home approach to Long Term Care for younger veterans. Dr. Abeles questioned the figure of 360 patients. Was this number correct? Dr. Agarwal confirmed that it was.

A representative of the American Legion, Mr. Martin, noted that approximately 66 patients are on the registry at Dallas VAMC, but some are seen at the DOD, some at the VA. Many go back and forth between DOD or stay in VA. He noted that there is a great need for clarification of the numbers of patients in DOD, those likely to transition from DOD to VA, etc.

Mr. Derr inquired whether the GRECCs are involved with the Polytrauma Centers and Ken Shay relayed to the group that one year ago the then-Principal Deputy Under Secretary, Dr. Kussman, had requested that the GRECCs offer their services as appropriate to the Polytrauma centers. All GRECCs in geographic proximity or co-location with Polytrauma centers were contacted; who in turn contacted their nearby Polytrauma centers. To Dr. Shay's knowledge, none of the Polytrauma centers has followed up on this offer. Dr. Burris noted that there were two ways in which the GRECCs could serve the severe needs of Polytrauma patients. One way was in rehabilitative and restorative therapies, such as are used for stroke patients. The second way is through Extended Care. He noted 25% of veterans in VA NHCUs are under age 65 and as such there's a strong Extended Care mission as well as a collection of expertise and innovation among the GRECCs. A discussion ensued as to the degree to which GRECCs could and should find themselves involved in addressing OIF/OEF efforts. GGAC was of the opinion that adopting clinical care and investigation activities not associated with aging but of importance to returning veterans was probably not appropriate, but leveraging existing expertise and resources on their behalf was certainly within their purview. In addition, Dr. Veith noted that VA has broad expertise that can be brought to bear on this population through HSR&D and other offices.

**Long Term Care.** In regards to the use of Institutional, Non-Institutional, and Care Coordination Long Term Care services on behalf of polytrauma patients, the focus is on recognizing what is needed to close the gap and targeting alternative settings wherever possible. Mr. Derr noted that Rehab services need to be included in all these services, and Drs. Salerno and Agarwal

pointed out that Rehab was included within all these different venues of care, much as Pharmacy and Nursing are. Dr. Yoshikawa asked how Non-Institutional Care fits into VAMCs' organizational structure, such as within Ambulatory Care, Contracting, or Social Work. He noted that at the Greater Los Angeles Healthcare System no single person had a coordinating capacity over all of these services, yet patients frequently move between them. Dr. Agarwal responded that in VACO, Non-Institutional Care is part of GEC. However, the organizational structure at individual VAMCs is up to local management. She noted that the Service Line concept and the All-Geriatric-Service concept had been more popular a decade ago, but at most sites this has been phased out. Dr. Agarwal wrapped up her discussion of GEC programming by mentioning the Nursing Home Cultural Transformation and unannounced surveys, better access to Hospice and Palliative Care, Coordinated Care for veterans with dementia, collaborations with Indian Health Service, and the various GRECC contributions.

Care Coordination was described as another form of "Non-Institutional Care". There are major initiatives within Care Coordination, such as a movement to support Polytrauma, Tele-Mental Health, screening for Retinopathy to include referrals to reading centers, and store-and-forward Teleradiology approaches. Dr. Veith inquired about credentialing and the issues that arise when a clinician in one state is doing radiologic diagnosis on a patient located elsewhere. Dr. Agarwal responded that JCAHO has worked closely with VA, and has decided that if a reading center is credentialed then the clinicians in that center are allowed to make diagnoses for patients in contact with that center.

**Mental Health.** Dr. Agarwal next discussed the Mental Health Strategic Plan, which was developed by a huge taskforce that focused on recovery and rehabilitation. There were 265 recommendations dealing with capacity, access, closing gaps, and transitions.

**Mail-Out Pharmacy.** Dr. Agarwal spoke of the Consolidated Mail Out Pharmacy. There are currently 13 CMOPs and 89% of dispensing in VA is mail out. A clinical pharmacist goes over every patient's drugs at each Ambulatory Care visit. Mr. Derr asked if consulting pharmacists go over drug regimens with patients. Dr. Veith confirmed this, stating that for the past 20-25 years this had been a critical feature in the VA. Mr. Derr strongly favors a certification of pharmacists in geriatrics, and felt that the VA is an excellent site for training. Dr. Agarwal concurred, and added that in addition to their expertise in geriatrics, most Primary Care Clinics in VHA include Pharmacy support. Dr. Koren noted that some of Dr. Agarwal's information had specified a 0.0006% defect rate: what is this? Dr. Agarwal characterized it as either wrong delivery, wrong medication sent, or Social Security Number confusion. Dr. Koren thought this was very admirable, inasmuch as it was procedural rather than medical. Mr. Derr asked for clarification on the prescriptions: are they all electronic? All prescribing in VHA is electronic except for Schedule 2 and Schedule 1 narcotics.

### **Dr. Cross (for Dr. Kussman)**

Gerald Cross, MD, Acting Principal Deputy Under Secretary for Health, thanked the GGAC for their valuable contributions to the Department of Veterans Affairs. He noted that Acting Under Secretary of Health, Dr. Kussman, extended his apologies: he was attending a funeral of a VACO employee's relative who had died in the Virginia Tech campus shooting.

Dr. Cross began by noting "we live in interesting times". The VA culture has a nature of transparency as seen in when the Washington Post story on Walter Reed Army Hospital was printed, the immediate reaction of the Secretary of Veterans Affairs was to do a broad-based survey of all VA medical centers to find out if they "have a building 18". In other words, are all Medical Center Directors forthcoming about the shortcomings that they report? There are approximately 6000 buildings in the VA; as a result of the survey, approximately one in five reported something that had not previously been disclosed. These disclosures varied from bats (in Texas, in an area where this is commonplace) to dust on a windowsill. Dr. Cross's point was that this information, which the Secretary insisted be made available on a website, was VA's way of saying that the agency exists for, and is an agency of, the people.

More recently there have been significant data security issues. Last summer there was a lost laptop (forensic analysis following its recovery demonstrated that identifiable patient data on the hard drive had not been accessed). In January a hard drive was lost at Birmingham which has yet to be found. However, between these two security lapses no patient anywhere has experienced any harm. Nevertheless, VA was forthcoming, reported this to Congress and the American Medical Association, sent letters to all affected veterans, and offered to take full responsibility, including fiscal, for any difficulties incurred. Dr. Cross also noted the recent loss of a "flash drive". These have become a very powerful way to share information, for instance house staff use these to record ongoing inpatient characteristics that are then shared when a patient or the resident changes services. Yet these devices are readily lost and if unencrypted represent accessible private patient information. As a result a Directive limiting use of flash drives was issued. VHA has 117 academic affiliates and issuing this Directive has had a significant impact, inasmuch as many university faculty are then affected. Yet because of its full disclosure approach, VA is being seen less as an alarmist and more like a leader in data security. Currently, AAMC is very interested in following up on this level of oversight and review. They concur (as does VA) that it must be done in a way that is not disruptive. The Directive was never intended to disrupt lectures or presentations at professional meetings, but nevertheless some of the approaches that become immediately necessary once a threat has been identified may cause temporary inconvenience until a fully workable solution is identified. For instance, VA is looking into "extrusion software" which will detect different kinds of information coming into or out of the system. The intent is to limit burdensome restrictions to only those data for which they were intended.

Dr. Cross continued to stress VA's commitment to transparency: there is a monthly report of every patient security violation to Congress. Recently two nurses in a VAMC were overheard discussing a patient, and this got reported.

Dr. Cross went on to discuss some of the implications of the OIF/OEF war. He said the war is certainly controversial, but VA's commitment is to take care of the veterans. He noted the conventional wisdom is that "VA is overwhelmed; and millions are pouring in" but he felt that "stories trump data": meaning Congress likes stories more than it appreciates data. As such, although only 4 - 4.5% of the current workload is related to recently discharged veterans, there is terrific emphasis on this population. Patient satisfaction of these new veterans is on the rise; wait times are down; comparisons to the private sector are very favorable, yet these are meaningless in the face of one bad public relations report. VHA has 50 million encounters per year so even if 99.99% are successful and satisfactory, that means there are thousands of adverse stories.

Dr. Cross went on to characterize the challenges that VA faces in a "shrinking" world. In 1976, the average veteran lived 26 minutes away from a VA. Today, the average is 13 minutes. Much of this is due to the increased presence of Mental Health professionals in VA's 717 CBOCs. Some of it is due to Tele-Health as well. 92.5% of enrolled vets live within 16 minutes of a VA and 98.5% within 90 minutes. If VA continues in the strategic direction of minimizing travel time it will do even better. But how can it do this in areas where there are fewer than seven persons living per square mile? The answer is developing VA outreach clinics in leased space, engage in "circuit riders", and innovations in Tele-Health. As an example of this, he spoke about Home Based Primary Care: originally developed as an urban outreach program there is no reason that it could not work in more rural areas through the CBOCs. As such, HBPC is budgeted for \$175 million in FY 08 and is experiencing steady growth. In Long Term Care, the emphasis is on the least restrictive environment of care. The current trend is to move away from institutionalization. Programs are growing in a way that increasingly allows people to remain in their homes, and as such, this is where the growth is in the Long Term Care budget. Dr. Cross then opened the floor to questions and comments from the committee.

Dr. Yoshikawa offered the opinion that VA has a pattern of going to extremes in response to public relation crises. He has heard that people are unable to use their laptops and noted that if people cannot respond to their email this is a detrimental inefficiency. Dr. Cross responded that laptops which have been encrypted can be used. He noted that even if lost, an encrypted laptop is a property loss but not a data loss, inasmuch as the information will be inaccessible. In the same way, there is VPN, which permits logging in from home using VA encrypted laptops. Dr. Abrass inquired on the progress with encrypted flash drives Dr. Cross responded that the latest estimate for these devices is \$230 each, and that only a few vendors provide these so those that do are

extensively backordered. He also noted that Blackberries are lost now and then, but they can be sent a deactivating message rendering them useless after the loss. Perhaps this sort of technology will become necessary for encrypted drives as well.

Dr. Salerno noted that a major focus of VHA a decade ago was the World War Two veterans. She contrasted that with the present status in which there is tremendous emphasis on returning veterans from the Gulf War. What about Vietnam era vets? How does VHA expect to be able to balance their needs in the face of those of these other needy groups? Dr. Cross responded that he and Dr. Kussman worry about this every day. He went on to note that different generations have different expectations. The injuries of the current generation of veterans characterized as Traumatic Brain Injury are very different from Traumatic Brain Injury due to a bullet trauma. He noted that the current mild to moderate Traumatic Brain Injury patients may be symptom free initially, yet 7-30% is known to have residual symptoms. As a result the VA is screening everyone for TBI and recording the results in the Electronic Health Record. Currently there is no ICD-9 Code specific for this, and VHA will create a registry. We do know that there will be Long Term Care needs; and yet this population is likely to reject the idea of Nursing Home placement and as such new and different Long Term Care options will need to be devised and proliferated. There also need to be environments of care more acceptable to younger, more individualistic veterans. Veterans of the current generation of the military are more vigorous in questioning their MDs and checking assertions on the internet: as such there is internet access at all of the Polytrauma Centers.

In discussion following Dr. Cross's departure, Dr. Salerno noted that if TBI is in fact a risk factor for dementia, as the emerging weight of evidence from epidemiologic studies demonstrates, there will be very high demand for VA services in the future due to dementia emergence. Dr. Abrass concurred, and also commented that he had hoped that Dr. Cross would bring up the issue of GRECC vacancies, which would have been brought up with Dr. Kussman had he not been unable to attend. He thought a letter should be written to Dr. Kussman inquiring on his current stance with respect to the vacancies and centralized funding for GRECCs. Drs. Shay, Burris, and Abrass briefly discussed the best way to go about this while remaining within VA communication regulations, but still representing an unofficial inquiry.

### **GRECC Performance**

Dr. Shay briefed the GGAC on the 2006 performance of the GRECCs. He began by describing the mechanism of the Annual Report: every GRECC is required to file an Annual Report and has been required to do so since the initiation of the program. Originally the Annual Reports were extensive in their narrative and were exclusively self-reported data. In the last few years, through the efforts of Dr. Cooley, submission is now electronic and while there remains a narrative section (consisting of accomplishments and administrative details) it is much

more pointed and brief.

The administrative section specifies the GRECC's research focus in basic, clinical, health services, and rehabilitation areas. It also includes a "crosswalk" to the VHA Strategic Initiatives. Dr. Shay noted that the "crosswalk" was only in its second year, and yet the GRECCs appreciate this reference to these very important drivers in VHA. Dr. Shay has emphasized to the GRECCs that it is not important that every element within the Strategic Initiatives are addressed by every GRECC program. Rather, he wants the GRECCs to repeatedly review the Strategic Initiatives and keep them in mind during program development, and when choosing between emphasizing an area that is relevant to the Strategic Initiatives and one that is not. He shared with the group an example of a particularly informative one, again stressing that "crosswalks" were neither evaluated nor were the GRECCs held to any standard regarding them. The last part of the administrative report consists of minutes from the Advisory Committee Meeting. These again are valuable, both for demonstrating that the meetings occurred and for assessing the membership of the committees, but also for relaying the nature of business discussed at those meetings.

The accomplishments section of the Annual Report lists particularly noteworthy publications, successful grant applications, contributions to the VA and VISN, and clinical activities underway. Dr. Shay stated that for the past two years he has been reviewing both the narrative and the electronic data submission components of the Annual Reports with each GRECC by telephone. He found this valuable for both his familiarization with each program, and to indicate to the GRECCs that these reports matter and that they are being reviewed. Dr. Veith expressed his gratitude to Dr. Shay that this was being done; as a former GRECC Director, Dr. Veith had suspected that the reports often largely went unread. Dr. Shay mentioned that in the past they were frequently consulted in response to external inquiries.

Based on the quantitative data submitted into the electronic GRECC database, Dr. Shay then provided a synthesis of GRECC data from 1999 to 2006. The first area he discussed was the research expenditures of the GRECCs. He stressed that in any given year, the total grant awards were more than the amount of those awards which were actually spent ( in other words, a multiyear award, would only spend in a given year a certain amount, and this is what is tracked). Over \$108 million in GRECC research expenditures occurred in 2006. This represents a steady 8% growth per year since 1999, which is approximately parallel to overall VA research spending during the same time period. Dr. Shay then reviewed how these research expenditures feed into the calculation that results in the "VERA research allocation" that is provided to each VISN the following year. He noted that a comparison of these adjusted research allocations to the operating expenses of each GRECC continues to show that the GRECCs bring in research allocations approximately equivalent to what they cost on a system wide basis. He acknowledged that some GRECCs have a track

record for costing more than they bring in VERA research allocation; but contrasted this with the number of GRECCs that have consistently brought in more research allocations than they cost in operating fees. He also acknowledged that there continue to be discrepancies between the actual VERA allocation for the VISNs and the amount calculated in the GRECC Annual Report. This is because of discrepancies, from medical center to medical center, on what gets reported into the "PROMISE" system. Recently, the Office of Research and Development has given indications that it may articulate criteria it expects all Research Offices to follow for entering data into PROMISE. This will be helpful, although the early indications suggest that the reporting mechanism will be far more restrictive in which expenses it will accept, than the unofficial recommendations in previous years. If that occurs, the playing field will be changed, inasmuch as programs, and particularly GRECCs, that have prominent components of their research portfolios conducted at the affiliated university will no longer be able to include those among their reported research expenditures.

Dr. Shay then reported on GRECC publications, reporting for 2006 nearly 1000 peer-reviewed publications, and approximately 1100 overall. Dr. Yoshikawa noted that this was essentially a flat line for the last eight years, a fact that Dr. Shay conceded. Some discussion ensued; Dr. Abrass noted that there was no particular reason to look for increases in publications, a contention with which Dr. Yoshikawa disagreed: in building a research center, one would anticipate increased numbers and productivity of faculty.

There were approximately \$38 million in operating costs for 2006, and Dr. Shay noted this is the figure which is compared to the VERA research allocations. The costs can be reduced somewhat, in the face of the clinical contributions that each GRECC makes to its parent VA medical center. That is, each GRECC Core Staff member reports how his or her time is distributed among clinical, research, administrative, and educational activities. The clinical activities can be summed up, as adjusted by the FTEE contribution of each employee, to a total of approximately 40 clinical FTEE GRECC-wide. If these FTEE are then valued according to the average salary for GRECC employees, and this total subtracted from the operating expenses, then the GRECC program overall is seen to represent costing less than is returned through VERA. When this same analysis is done for each GRECC, most GRECCs can be characterized as costing their host VAs less than the research allocations they bring in to the host VISN. A review of the benefit versus costs ratio, going back to 1999, shows that in general approximately one third of GRECCs each year cost more than the resources they return to their host medical centers, even when taking clinical contribution into account. Some of this is attributable to the way the VERA research allocation is calculated, because it is dependent on Congressional appropriation for VA research.

### **My-Health-E-Vet**

Kathleen Charters and Katherine Painter shared with the GGAC a program

overview of My-Health-E-Vet, as well as patient education goals, how they sought and received expert input, a description of their Healthy Living Centers, and geriatrics statistics. They defined My-Health-E-Vet as a “web-based project that provides an interactive personal health record to veterans”. My-Health-E-Vet can contain extracts from the VA health record and patients can enter their own information, for instance from their private medical doctor. Furthermore, one does not have to be a veteran to use My-Health-E-Vet.

Dr. Veith inquired why anyone who was not veteran would want to use this. The response was that it is a way for organizing one's personal health record, although non-veterans would not have the ability to coordinate it with a VA health record. Mr. Atizado inquired whether admission and discharge summaries are part of the MHV record. Yes, although there is a “hold for review” function so that certain information can be withheld pending physician review and/or to eliminate certain private issues, such as HIV status. There is also broad access to a range of VA information, such as patient information and VA benefits. The information available is based on recommendations by focus groups made up of subject matter experts, and includes such things as spiritual input, mental health, OIF/OEF, caregiver information, etc. The subject matter experts were recruited from among veterans, physicians, psychologists, nurses, educators/librarians, pharmacists, and social workers. It was noted that three particular MHV Workgroups of interest to geriatric patients are Life Cycle, Caregivers, and Chronic Diseases.

Statistics demonstrate that the largest veteran user group of MHV is the 60 to 64 year age group. In 2006 there were approximately 325,000 registered users; and by 2007 over 400,000. Statistics on the users can be accessed on the website itself. Mr. Carbonneau noted that the peak of veteran users being 60 years of age was consistent with the average age of Vietnam veterans.

The geriatric health issues that the presenters characterized MHV as benefiting included: comorbidities (diabetes, hypertension, chronic obstructive pulmonary disease); activities of daily living (social isolation, sedentary lifestyle, inadequate nutrition); system degeneration (decreased mobility due to arthropathy and neuropathy, decreased visual acuity, and decreased manual dexterity); and the need for healthy living centers.

The presenters provided screenshots of MHV to give GGAC participants an idea of what the website looked like, and encouraged committee members to visit it. They suggested beginning with the “Research Health” menu, which offers library, healthy living, diagnoses, etc. choices. There are also smoking and tobacco cessation links, physical activity and diet links, and links to “common conditions”. A workgroup is currently working to rewrite the clinical guidelines into lay language. It was noted the Healthy Living Centers themselves draw on MOVE!.

The “Patient Action Plan” section facilitates the tracking of health care matters. In

order for this to work, the user must create an account. Soon there will be a new section titled "Your Life, Your Choices". Among other features, MHV can build an advance directive and print it out for the patient's use. Because this is accessible to and from the health care record, this will facilitate fulfillment of advance directives. Another link is the "Diabetes Scenario" which includes information on what to expect with an initial evaluation, follow-up, and clinical reminders. There is also an example of a patient information sheet that can be either downloaded generically or customized by the provider for the patient. Through this link patients can track their blood sugars, as well as facilitate downloading of information in a way compliant with the Freedom Of Information Act. The data that is input can be held up to seven days by the physician so that discussion can precede the appearance of it in the patient's health care record. Some of the information in the medical history can also be entered between appointments by the patients. Mr. Derr characterized this as "no more clipboard for completing in the waiting room", with which the presenters agreed. They also noted that MHV allows users to compare their own lab values to lab values of large groups of patients in order to see where their health indices fell. They can print their prescriptions, and their dates of visits. They can also receive reminders with respect to screening tests.

Under Caregiver Topics, the presenters called attention to the recent caregivers RFP that Dr. Agarwal had described. They stated that they know of at least five groups affiliated with MHV that are interested in tracking diabetes for caregivers and also stroke survivor caregivers. Other topics of interest include advanced illness, chronic pain, chemical dependency, spiritual matters, stress management, Mental Health management, grief, and bereavement. Mr. Derr inquired whether press releases on this valuable asset had been disseminated. The response was affirmative.

### **Polytrauma**

Gretchen Stephens spoke on behalf of Dr. Barbara Sigford, National Director for Physical Medicine and Rehabilitation. Ms. Stephens is currently the Polytrauma Coordinator; prior to this she was the National TBI Coordinator. She began by stressing that Long Term Care is not just for those over age 60 and described the Polytrauma Centers as arising from need for continuity of care for veterans from the battlefield to back to the community. She noted that the more efficiently the necessary set of transitions occurs to accomplish this, the more extensive the injuries can be without resulting in death. Blast injuries that are characteristic of the current conflict involve Traumatic Brain Injury due to explosive shock. Most of the initial referrals, after stabilization in the field and subsequently in Germany, end up in Walter Reed Military Hospital or the Naval Hospital in Bethesda. She noted that the nature of the injuries (severe amputations, brain injury, mental health issues, etc.) coming back from the Middle East and their extent required legislative action to ensure services are within VA authority.

Polytrauma as defined by the VA Handbook is two or more severe injuries, one

of which at least is life threatening. Generally brain injury is the impairment that primarily guides rehabilitation, resulting in the characterization of Polytrauma as "brain injury plus". Dr. Damron-Rodriguez inquired whether advance directives were automatically part of medical record among active military. Ms. Stephens responded that pre-deployment advance directives are offered but not mandatory. She acknowledged that there were some very uncomfortable situations which occur in the absence of advance directives, particularly those involving younger veterans, new spouses and parents.

Ms. Stephens contrasted Polytrauma to Monotrauma (e.g., TBI only). Monotrauma is also seen in the returning veterans, for instance as a result of domestic injuries which can be linked to mobilization history (such as hypervigilance, resulting in traffic accidents). She described the data that has been collected, noting that Congress has been extremely curious to receive this information in order to optimally plan for these challenges. In most cases, stabilization of the brain injury, and rehabilitation in response, is the first order of business. Sometimes the different injuries are managed in sequence or in series; other times they are coordinated. This is a new paradigm of care, and new approaches are being developed and tested at all times.

The mission of the Polytrauma Centers is comprehensive rehabilitative services and family support. At the Richmond, Tampa, Minneapolis, and Palo Alto centers there are teams with broad-based expertise. All are comprehensive with some requiring 20 to 30 consultants per case. Each Polytrauma Center covers a region of the United States and placement is affected by an attempt to keep patients close to their families. There are on occasion regional requests based on relative levels of expertise in certain fields (e.g. only the Palo Alto Center has blind rehabilitation; and Minnesota is in the process of getting Spinal Cord Injury). Each of the facilities has 12 beds, generally they are full but no patients are turned away when sent by the Department of Defense. Currently there is consideration for opening a fifth center, although there needs to be demand in order to keep the high level of expertise necessary. Ms. Gong inquired about length of stay and was told that the average is 46 days, with a range of 7 to 200. The scope of services at the Polytrauma Centers includes comprehensive interdisciplinary inpatient evaluation, comprehensive inpatient rehabilitation, coma emergence, transitional community reentry, and ongoing follow-up case management. Dr. Abrass inquired whether all patients had to be off ventilators; the response was not in all cases.

Dr. Damron-Rodriguez inquired as to whether the potential for rehabilitation was an admission criterion? Dr. Sigford, the Program Director, believes all patients deserve a trial. There is a built-in coma emergence, yet timeliness is very important. Initially, an agreement must be made in questionable cases as to how long an absence of improvement will be maintained. Nevertheless, there are no visiting hours, and many other traditional rules are thrown out in order to foster the involvement and support of the family.

Dr. Yoshikawa inquired about whether the veterans in the Polytrauma Centers were, in fact, VA enrollees or were active military. Ms. Stephens responded that they are all active military. If they are discharged they can't go back to the Military Treatment Facility, and therefore retain their active status. Dr. Abeles inquired what proportion of all polytrauma patients remain in the military versus being treated in the VA. There are a large number of patients that are maintained in Military Treatment Facilities and it is entirely up to the Department of Defense as to how many are transitioned to the VA. Unfortunately, the DOD has not shared the number of patients that have corresponding injuries but have not been transferred. Mr. Atizado inquired as to how this was paid for. The response was that VA gets a per diem payment equivalent to the management of SCI, TBI, and/or blind rehab. There is Specific Purpose funding for all four Polytrauma Centers to fill the gaps between the costs incurred, and the contracted cost received from DOD.

Ms. Gong inquired whether the Polytrauma Centers had CARF accreditation. Ms. Stephens responded that the answer was yes: all were accredited rehabilitation centers. But she noted that the acuity was much higher than at traditional rehabilitation centers; for instance the FIMS scores are very low. Beginning in July of 2007 there will be Transitional Living Centers at all four of the Polytrauma Centers in order to promote return to work, return to duty, etc. Ms. Stephens noted that Mental Health had recently provided significant resources to build Comprehensive Work Therapy Programs. The core team in the Polytrauma Centers comes from Physical Medicine Rehabilitation, Rehab Nursing, Speech and Language Pathology, Occupational Therapy, Physical Therapy, Recreation Therapy, Blind Rehabilitation, Counseling Psychology, and Social Work. She characterized the major change from a traditional CARF-accredited program to the current one as being the acuity of the patients, with more amputation care and more onset of new blindness.

At Walter Reed and the Naval Hospital military treatment facilities (MTFs) there is a strong family presence. This is not traditionally the case in VAs and this required modification. Other modifications include the VA now having uniformed military liaisons present in all of the Polytrauma Centers, which has been observed to be something of a cultural issue; for instance, Marine Corps veterans are particularly sensitive to having a uniformed Marine liaison rather than a liaison from one of the other uniformed services.

Dr. Veith noted that these were extremely high resource services and inquired whether other patients in turn demanded this level of service. Ms. Stephens responded that in many cases the units are relatively isolated and other patients in the facilities don't see them. However, other patients on the unit who were not in combat receive the same level of treatment. There is also a sense of pride on the part of all veterans toward Polytrauma patients rather than resentment. Furthermore, there is a great deal of voluntary service support for these units.

Ms. Stephens noted that two of the Polytrauma Centers have Fisher Houses, and a third one is planned. At the Richmond Center there is no Fisher House but a nearby hotel has donated space for families with the VA providing transportation to and from the hotel. The communities often donate cars, hotels, vouchers for groceries, child care, travel to the site for both extended and immediate family, movie tickets, gift certificates, etc. She noted that these are very difficult times and the families are usually exhausted after having been shuffled to Germany, then to a debarkation center, and then to a Polytrauma Center, etc. Within the hospitals and the Polytrauma Centers there often are concessions to the relative youth of the immediate family members, such as rooms having refrigerators stocked with pizza and other junk food: quite atypical behavior in the medical community.

One of the great unknowns with the Polytrauma patients will be the long-term follow-up. Clearly these patients are going to be lifelong utilizers of extensive healthcare services who will age with their disabilities and provide new challenges for VHA.

Ms. Stephens then outlined the full Polytrauma system of care. Up until now, she had spoken of the four Polytrauma Centers. In addition, there will be Polytrauma Sites, one per VISN, of which 15 are in operation. Then there will be Support Clinical Teams, ultimately close to 100 (currently there are 72). For those VA facilities that do not have Clinical Support Teams there will be a Point Of Contact at each. In addition there will be case management and tele-health services that serve to ensure a common denominator of care for those who cannot return home. She spoke of the interdisciplinary team of care at each site combining PMR, Rehab, Social Work, etc, and noted that the "Polytrauma Network scope of services" was mostly outpatient services for patients who had been stabilized and discharged by DOD and then later came to VA.

Ms. Gong inquired about the 48 bed capacity of the four Polytrauma Centers. Ms. Stephens clarified that "capacity" was based on what DOD asked VA to assume. So far, DOD demand has not exceeded capacity. Dr. Yoshikawa offered the opinion that there were compelling public support reasons for DOD to control unrestricted knowledge of the number of injuries and their extent, and thought that it was highly likely that at some point in the future the numbers of injured from the conflict will be disclosed.

Ms. Stephens acknowledged that there was some dissatisfaction on the part of some of the patients and their families. Although most patients were tremendously satisfied, those that are not voice their complaints, and much of the negative feedback improves the system. The political nature and high visibility of the criticism can be very disheartening, not only for those in administrative roles, but for the frontline clinicians as well. Dr. Yoshikawa noted that the quality of care that she had described was tremendous; but the issue would be how the veteran accesses these services. Ms. Gong concurred, and Dr. Salerno speculated that

this situation could be seen as a funnel where those who make it through to Polytrauma are particularly fortunate but likely a small subset of those needing the care.

Ms. Stephens noted that the new TBI screen will help VA prepare for the future by giving them a sense of how many patients likely to seek VA services will require increased services owing to the long term effects of Traumatic Brain Injury. Dr. Koren noted that for everyone killed there must be some larger percentage that are injured. In light of the over 3000 current fatalities, 391 polytrauma patients (the figure Ms. Stephens provided) seemed very small. The speaker noted that a recent run of diagnostic codes and fewer than 2000 patients had ICD-9 coding consistent with Traumatic Brain Injury.

Dr. Koren noted that having four Polytrauma Centers seemed both inefficient and counterproductive. When the treatment is more complex the outcomes are better, so why are there four centers instead of a single one? The answer was that geographic proximity was very important for family, and that patients generally want to be located nearby. In addition a single center would pose a problem to the great deal of fee-basing that might thereby be called for inasmuch as the private sector is less equipped to handle injuries of this sort than VA. Ms. Stephens characterized the Polytrauma Support Teams as hub-and-spoke arrangements with the points of care at remote sites close to the patient's home. This necessitates a large national trainee effort on the part of the Employee Education Service. Case managers are both nurses and social workers depending on whether clinical or psychosocial needs are the dominant ones in a given case. These professionals monitor implementation of the care plan, assess for emerging issues, look into VA and non-VA resources, ensure that there is ongoing patient and family support, and work to ensure that military transitions continue, particularly if patients transition to TRICARE for life. Ms. Stephens also noted that while the number 391 seemed small, these were the most severely impaired, and that many, many more were reporting to VA medical centers having previously been stabilized and discharged by the military.

Mr. Carbonneau inquired about medical issues that might take more time to develop, such as PTSD or chronic pain. Ms. Stephens acknowledged that there was both terrific potential and great uncertainty on this issue. Polytrauma teams are learning to collaborate in something characterized as a "new paradigm of care", although many GGAC members saw this as a well-known geriatric paradigm or interdisciplinary management. Tele-health has a role to play in Polytrauma treatment, particularly for those who cannot return home, and a workshop in December resulted in a collaborative GEC/PMR workgroup chaired by Dr. Edes that will be looking into the Long Term Care needs of these veterans. Ms. Stephens said that there is more behind this than not wanting young people living with old persons: because the youth of most of these veterans, Polytrauma patients to seek greater independence, home services, life care, and young family adjustment. She acknowledged that there were legislative

authority gaps and that changes in both fee-basis and authorizations were going to become necessary. Dr. Abeles asked of the 391, how many completed care and how many ended up in Long Term Care. Ms. Stephens responded that only a handful had left early, and that only 2% (eight) have required Long Term Care to date. Dr. Damron-Rodriguez responded that it was all the more important to know the total numbers that VA will likely face eventually so that planning can be scaled appropriately.

Dr. Abrass noted that historically GEC has managed a similarly rehab-needy, high-SCI group and in many cases they lived in the NHCUs; and then transferred back and forth between intensive rehabilitation and the Nursing Home. Ms. Stephens noted that there was much more aggressive rehabilitation in Polytrauma, which was understandable in light of the patients' younger ages. She noted that they often need more time and more frequent rehabilitation episodes. She stressed that the recovery trajectory was very long and the complications make it even more so. Discussion continued on the relatively small number patients that VA is dealing with, and the rather sizable resources being leveraged on their behalf. At the same time, GGAC was very concerned that VA was essentially being hampered and left under-prepared by not knowing the magnitude of the potential problem. Dr. Shay inquired whether the committee had interest in developing a White Paper outlining their concerns and recommending fuller disclosure. Dr. Abrass felt that this was premature and discussion on this topic was concluded.

### **Clinical Demonstrations**

Dr. Shay noted that the Associate Directors for Clinical sought to refine the concept of "clinical demonstrations" for the GRECC Performance Measures. Dr. Al Matsumoto, AD/C the Puget Sound GRECC, largely developed the "Clinical Mission of Geriatric Research, Education and Clinical Centers" document. The original intention was to have the GGAC sign off on this document during the September 2006 meeting, but because that meeting had to be rescheduled for this spring, and because there was significant demand for the document, it has already been largely adopted by the GRECCs. At a recent Site Visit to the Puget Sound GRECC, the Site Visit Team Chair, Dr. Yoshikawa, acknowledged in general terms the wisdom of the document's major thrust: that early on, when geriatrics was a new field, it made sense for the clinical mission of GRECCs to be focused on development of new paradigms of care. However, as time has advanced and clinical approaches in geriatrics have matured, it neither makes sense nor is feasible to require each GRECC to develop a new approach to care each year. That said, in reviewing the wording of the document, a number of GGAC members took issue with some aspects of the description. Specifically, Dr. Damron-Rodriguez felt that some timeframes would be helpful: e.g., at what point in the lifecycle of a new clinical undertaking was it time for the GRECC to move onto the next project?

Dr. Koren noted that in several parts of the document there was reference to the

importance of GRECCs in the education of healthcare "professionals". She stressed that education of paraprofessionals is equally important, and requested that "professionals" be changed to "personnel". Dr. Salerno noted that the document, in describing different measures by which the stated requirements could be fulfilled, overlooked a singular opportunity afforded by a large system of GRECCs: specifically to look at the same issues at multiple sites through the expedient of the Electronic Health Record. She felt that the description should include provision for that as well. Dr. Koren felt that the Institute of Medicine's Domains of Quality mandated that clinical improvements not only look at clinical care, but also to look at decreasing disparities, increasing efficiencies, etc. Dr. Veith stressed his belief that the original legislative mandate to "improve system of care" had transformed into "develop new innovations in care". He gave examples of clinical activities in which clinical findings from the laboratory had been applied and resulted in new laboratory studies. He felt that these were indicative of improvements of care, although they might not strictly be "clinical demonstrations". Dr. Yoshikawa concurred with Dr. Veith, pointing to the original legislative language.

Dr. Abrass did not disagree with any of the points raised, and he noted that some "gaming" was a distinct possibility, but he was worried that the thrust of the clinical activity might change to "clinical research". Dr. Salerno disagreed because she thought this could be circumvented by compelling GRECCs to focus on clinical outcomes. Dr. Abrass countered with concern that while the new description suggested that quality improvement activities would meet the requirement for clinical demonstrations, with which he didn't disagree in all cases, he did not feel it was consistent with the original intent to develop or improve systems of care. Dr. Veith pointed out the difficulty of trying to create and identify improvements, but Dr. Abrass noted it was never the intention to only do things that were easy. One of the concerns that both Dr. Veith and Dr. Abrass shared was that under new NIH definitions of clinical research, even strictly bench work that ultimately has clinical applicability is considered "clinical". They both agreed, as did the majority of the committee, that this was not suitable. Dr. Koren suggested that perhaps there could be language stressing the importance of measuring deficits, developing innovations, and then re-measuring. Dr. Salerno suggested, consistent with the NIH definitions, that perhaps a minimum of "T2" be required of "clinical demonstrations"; in other words, the "discovery phase" would not be adequate to fulfill the clinical demonstration requirement.

Dr. Veith offered to take the current wording to authorities at Health Services Research in Puget Sound, but Dr. Yoshikawa stressed that this was not exclusively a Health Services question. Dr. Veith clarified that he was not looking for a Health Services definition but rather a Health Services perspective. Dr. Shay stressed that the Office of Patient Care Services and the Deputy Under Secretary for Operations and Management had both felt very strongly that the GRECC activities must be beyond quality management, and that that was why he had included in the definition a requirement of peer review. In a closing

comment, Dr. Salerno stressed that in the 1970s there simply was no field of geriatrics and feels that GRECCs have gotten into the trap of geriatric syndrome research. She felt that perhaps stressing comorbidities and other issues (in addition to syndromal concerns such as evaluations of falls, incontinence, and dementia) was essential.

Dr. Yoshikawa concurred. He felt that terminology which stressed an objective evaluation was important. Excluding clinical research, and perhaps specifying the demonstration projects, or quality improvement activities, or system improvement activities, would be adequate.

Dr. Abrass acknowledged that it was difficult to define this particular target for GGAC; and pointed out that this was the origin of the difficulty in turn for the GRECCs. At the same time, he noted that the clinical contributions of GRECCs, in fostering new and better ways of caring for over veterans, in conjunction with education, seemed to be the most visible and desired products on the part of VISN Directors. He gave the example of delirium recognition; and of dementia recognition by nurse practitioners in VISN 23. Dr. Veith characterized the need for effective clinical demonstrations as bridging the interface between discovery and dissemination. Dr. Koren suggested that perhaps, when the definition is clarified, it might be useful to educate the GRECCs about different research models. She noted that recently Academy Health had been held in Seattle, and yet she did not believe that there were any representatives from any of the GRECCs, much less the Puget Sound one. She noted that the next meeting of his group will be in Orlando, and asked Dr. Shay to make the GRECCs aware of it. She stressed that this particular session will include a Long Term Care Colloquium, and therefore would probably be of particular interest to the GRECCs.

Drs. Veith, Yoshikawa, Salerno, Koren, and Della Penna offered to work on the document and incorporate the refinements discussed during this session.

### **Research Focus**

Dr. Shay then brought up the question of the research focus. Dr. Salerno noted that the last RFP for new GRECCs, in 2003, had included specific preferred foci. GRECCs are creative enterprises that are self correcting because success is in their best interests. Therefore, as it is becoming increasingly difficult to find people who are gathering and doing good research, in order to fill vacancies, GRECCs often hire the most skilled candidate whether or not their research area is consistent with those foci the GRECC has already chosen. Consequently the research focus of GRECCs should be encouraged to be in three major areas, but not limited to that. Dr. Veith felt that there might be merit in contacting the GRECCs for their "foci". He suggested drawing up a list based on the 2006 Annual Report and circulate it (after removing nearly synonymous terms) to the GRECCs, and ask them to identify topics that diverge from the list. In this way, perhaps some of the terminological diversity can be reduced without reducing or

discouraging the diversity that accounts for much of the richness of the program. He suggested that rather than having a strong statement about something that doesn't seem to be a problem, maybe it was better to identify problems, and identify why they are.

Dr. Abrass concurred with Dr. Salerno, noting that at one point there had been three Alzheimer's disease programs so that it became important to encourage growth in other areas when considering new GRECC applications. At the same time, he thought that it is important to let creative people be creative. He further noted that the extensive distribution of topics identified by the Palo Alto program as being their "focus" could be reduced to a single focus-"biology of aging"; or into "carbohydrate metabolism, and endocrinology of aging".

Dr. Damron-Rodriguez stressed the importance of looking at the "dimensions" of the research program. How much depth is there? She stressed that there needed to be a reason for identifying a focus other than merely convenient communication. Dr. Abrass concurred, noting that focus is not really a problem in most GGAC Site Visits. Usually the greater issue is that the GRECCs stray from the aging paradigm. Dr. Koren agreed, noting that recently, at the Baltimore GRECC, while they were highly productive, a closer look at their publications identified only one out of 50 that was in an aging journal.

Dr. Veith offered the opinion that this was not something that could be solved merely with a definition. He reiterated his point that this might not even be a problem and suggested that one solution might be to develop a list of "aging" topics currently being pursued by GRECCs, and to circulate that for approval and/or amendment by them. Dr. Koren noted that no matter how the focus was defined, there will always be outliers. The question is how to reign in programs that seem to have a diffuse focus? Dr. Veith again made his point that what was more important was a nonproductive research program. If a program has multiple areas of investigation, but they are all productive and respected, it's hard to criticize. In contrast, if a program is not productive, if one of its remediable shortcomings is an excess number in diverse objects of focus, something needs to be done about it.

### **GRECC Site Visits**

Dr. Abrass began the Site Visit follow-ups by pointing out that because Dr. Yoshikawa has accepted the Directorship position of the Greater Los Angeles GRECCs, the status in Los Angeles was at a turning point. He expects to assume his new position in June; GGAC will monitor the needed improvements.

Minneapolis: Dr. Abrass noted that the site visit to Minneapolis, approximately 4 years ago, had resulted in a pledge to fill the AO position in a timely manner. Subsequently, there was difficulty getting a suitable rating for the position that dragged the process on for over a year. When a suitable rating was finally granted by HR, then an approval to fill was on hold for over a year.

Approximately 1 year ago, GGAC wrote a note to the VAMC Director reminding him of his pledge to fill the position. The response was dismissive: with the Director essentially saying that clinical positions had priority, and that the position would not be addressed in the foreseeable future. In the meantime, the memorandum from Mr. Feeley, reminding all VISN Directors of their obligation to keep GRECC positions filled, was circulated. Dr. Shay reported that, most recently, Dr. Dysken (GRECC Director) reported that he had begun advertising for the position, although no local applicants had been appropriate.

Cleveland: Dr. Shay reported that there continue to be significant problems at the Cleveland GRECC. Approximately 6 years ago the founding Director, Dr. Kowal, departed and left bad feelings behind. In the meantime, the Geriatric Medicine Program at Case Western Reserve University has slowly dissolved. Dr. Abrass and Dr. Yoshikawa felt that the time has come to "call the question" on the GRECC. Dr. Shay noted that the acting Director, Dr. Hornick, has predicted that if GGAC draws a line in the sand it is likely that the Network will allow the GRECC to be closed. Dr. Abrass pointed out there really is no other location within VISN 10 for a GRECC and asked Dr. Shay set up a conference call with Abrass, Hornick, and Shay. Their discussion will explore the possibility of strengthening an alliance with the Cleveland Clinic.

St. Louis: Dr. Abrass noted that the Site Visit yielded a sense that the GRECC is well regarded within its Network, and that external opinions to the contrary were of less concern. However, the Network had responded minimally to GGAC suggestions. In particular, the GGAC requested St. Louis to recruit an Associate Chief of Staff for Research, inasmuch as the position is presently filled by the Associate Chief of Staff for Education. The response was disagreement. Dr. Damron-Rodriguez was concerned that the Allied Health Trainee Program had been shrinking, and that there was an absence of clinical research. Dr. Shay noted that recently Dr. Perry had submitted a Letter Of Intent for a Cooperative Studies Program concerning delirium management in the Acute Care setting. Dr. Abrass reminded the group that Dr. Morley's attitude about competitive research funding was atypical, and set the tone for the relatively limited grant application activity at the site. Discussion then turned to succession planning, which Dr. Morley had acknowledged needed to be under consideration, but was not at present underway. Dr. Salerno noted that Washington University has tremendous resources and a very strong geriatrics program, and Dr. Damron-Rodriguez noted the new Dean of the School of Social Work there wants to build an aging focus. However, because Washington University is a nonaffiliated institution and St. Louis University is the institution affiliated with the VA, this poses recruitment difficulties. Dr. Abrass closed this discussion by pointing out that the St. Louis GRECC has an extremely strong education focus with good solid preparation of clinical geriatricians.

San Antonio: the group reviewed the exchanges that had occurred between the San Antonio GRECC and GGAC since the Site Visit last spring. Dr. Katz

continues to suggest that his time as Director is not unlimited (he has a "commuting marriage", with his wife residing in Albuquerque) but no successor has been identified or discussed. One major challenge to the program is that they have been without an AD/C for over 10 years. Meghan Gerety had been a strikingly effective Associate Chief of Staff for Extended Care following a brief period as AD/C, but approximately 1 year ago she relocated to Albuquerque as Chief of Staff. Recruitments are theoretically under way for both the Associate Chief of Staff and the Associate Director for Clinical positions. Since the Site Visit, there was a conflict between the GRECC and San Antonio leadership over leased space for the GRECC's Education Program. In addition, the Director at the time of the Site Visit, who has since retired, allowed the support of non-clinician researchers through clinical funds when they were between funding cycles. The new Director has put his foot down on that practice, resulting in some uncertainty of funding streams for some junior, yet productive, GRECC investigators.

Madison: Dr. Abrass reported that the program was doing very well under the leadership of Dr. Asthana. He received a response to the Site Visit Report, which largely was positive and in agreement with recommendations. However, the recommendation for filling vacant positions elicited a response that the GRECC FTEE had never been fully filled at the 12 level. As such, depending on the program's productivity and the availability of funding, the vacancies might not be filled. The GGAC sent a response that made it plain that this was an unacceptable answer; and this was accompanied by a copy of the memo from Dr. Feeley. Dr. Shay noted that between the VISN 12 MOU for the Performance Monitors and Mr. Feeley's memo to fill vacancies, this response was most unexpected.

Puget Sound: Dr. Yoshikawa reported on the Site Visit which he had Chaired. He thought that Puget Sound has a great basic science program and a very good health services research program, but was concerned over the choice of Suzanne Craft as the Associate Director for Education and Evaluation. He noted that she has a number of highly trained and talented postdocs, but stressed that these really should not be the primary focus of an AD/EE. There are currently no fellows in medicine although there are a number in geropsychology. Dr. Shay noted that some of the shortcomings that the Site Visit Team seemed to identify while in Seattle, such as an absence of residency, medical student, and Allied Health Trainees, apparently was a misrepresentation. Subsequent to the Site Visit Drs. Breitner and Craft corrected the misunderstanding. However, Dr. Shay noted that overlooking the participation of these trainees, even though their participation and numbers were apparently adequate, seemed to underscore that Dr. Craft's priorities as AD/EE were somewhat out of the mainstream. Dr. Abrass felt it was important that this misunderstanding appeared within the body of the report, because it provided an impetus for the GRECC to correct its record-keeping. Dr. Veith noted that none of this was surprising: Dr. Breitner's priorities are predominately around research. He has less experience with the historical

educational outreach and health services research aspects of the program. Dr. Yoshikawa noted that the VISN was very supportive of the GRECC expanding its dissemination activities. He concluded that the program overall was strong and expressed optimism that the identified shortcomings could be addressed without difficulty. Dr. Veith noted part of the reason that Dr. Craft had received the leadership position was because of her long-standing contributions to the program. For instance, she was acting GRECC Director prior to Dr. Breitner's arrival on the scene. Discussion then turned to the significance of the lack of Geriatric Fellows. There was broad agreement that this was a temporary situation, particularly when Dr. Abrass pointed out that recruitments were filled for the program through 2009. He noted that the Seattle program had continued to insist on two years of training, although the ACGME minimum duration is a single year. As such, the program frequently denies participation to qualified but not excellent candidates, inasmuch as shortcomings in fellows translate this into more work for faculty and unsatisfactory outcomes. The accomplishments of Dr. Matsumoto in reframing the clinical mission of a GRECC had previously been discussed during this meeting.

Dr. Salerno inquired about the Special Fellowship Program in Advanced Geriatrics. It is her understanding that all of the GRECCs have experienced some level of difficulty in filling these positions. She is concerned that SFPAG was at risk for discontinuation. Dr. Abrass and Dr. Shay explained that a major disincentive for successful recruitment to the SFPAG is that federal employees are not eligible for participating in the NIH Loan Repayment Program, which is a very attractive benefit worth up to \$35,000 (pretax) per year for several years. Ken reviewed for the GGAC the efforts to have the exception for NIH employees, which allows them (although federal employees) to be eligible for the LRP, apply to VA employees as well. Ultimately, it was not successful this legislative cycle and does not offer much hope for success in the foreseeable future.

Miami: Dr. Abrass reported that in general this program is doing very well. It has a strong clinical interface with the Miami Jewish Home. Research goes on there, students rotate through there, and there is minimal interaction with the University Hospital. Almost all of the geriatric clinical activity is done at the VA; and the section of Geriatric Medicine at the VA and the GRECC are indistinguishable. Their research seems to be focusing its basic science efforts in bone metabolism plus an adult-derived stem cell line that sounds promising, but to date has not shown true application. The education program is very strong with all of the GRECC core faculty doing research and teaching in addition to their clinical obligations. There is a dynamic new Dean and a new Chair of Medicine, both of whom are aware of the GRECC and eager to pursue potential collaborations with it.

Baltimore: Drs. Abrass, Burris, Koren, and Ms. Gong had conducted this Site Visit approximately two weeks ago. They described it as a VA-based geriatric clinical program, in which there is essentially no geriatric section activity at the

affiliated university (although they are physically connected). The major concern that the Site Visit Team identified was the ambiguity regarding the "aging paradigm": nearly none of their publications are appearing in the geriatric literature although the quality of their research is very good. They also have only a one year fellowship, which is purely clinical and does not progress their fellows into a research track. It is hoped that the new SFPAG, which will be filled this year for the first time, will help alleviate that.

Dr. Yoshikawa felt that this was yet another example of the importance of role models. Dr. Abrass noted that all the GRECC medical doctors rotate as attendings, and Dr. Yoshikawa clarified his point: his issue is that attendings should not just be in geriatrics, but should be in general medicine as well. He feels that this establishes geriatricians as capable internists.

### **Geriatric Workforce**

Dr. Edes reported to GGAC on his efforts to address an impending geriatric workforce shortage in VA. He noted that nearly 1/7 of the population is over the age of 65 and characterized the proportion is about three times that in the VA. The number of 85 year olds among the veteran population doubled from 2000 to 2005, and the 2000 figure is expected to triple by 2015. While the cumulative number of geriatricians has climbed, there has been very limited recertification in geriatrics, so that the net numbers have actually peaked and are now in decline. Thus the demographics show an increased demand with less supply. And this not only applies to MDs, but also for RNs, SWs, NAs, etc. who need growth in their numbers as well. He noted that a great deal of effort had been focused on building training programs for medical students, and yet geriatrics continues to fall further and further behind even though from 1991 to 2004 the number of geriatric fellowship positions had increased from 163 to 483.

Dr. Abrass pointed out that a large proportion of the present geriatric fellows are foreign medical graduates who are obligated, for visa reasons, to spend three years in an underserved community if they do not return to their country of origin. As such, many no longer are interested or even able to practice geriatrics after completing their service obligation.

Dr. Edes felt that a major factor in the inadequate VA geriatrician numbers was that, at the medical center level, there is no identifiable leader for geriatrics (ACOS/EC). He noted that 60 out of 87 specialties have no geriatrics requirement and that 21% of the approximately 3000 geriatricians in the US are over the age of 65 years. The problem is beginning to be noticed: the 2005 White House Conference on Aging resulted in two of ten resolutions focusing on geriatric workforce. More recently, Title VII funding for geriatric education was reinstated, but not before more than a year of very uncertain status.

Dr. Edes pointed out that although there is a need for geriatric specialists, there is also a need for non-specialists to receive training as well (e.g., medical

students being required to have training, as they are with pediatrics). This is important because the non-specialists will probably support the bulk of clinical demands. About nine months ago, Dr. Edes, in reviewing these findings with the field advisory group for geriatrics (the Geriatric Task Force), and speculated “what if VA took this issue on?” He proposed a goal of 30% increase in geriatricians employed by VA over the next three years. Why focus on the VA? Because there is a great deal of geriatrics education, a great deal of geriatric need, and the VA isn’t facing many insurmountable forces that are encountered in the private sector (such as financing). As such, VA can do what needs to be done, and in so doing might be able to apply some of its lessons learned outside of its own system. Dr. Veith noted that the graph which showed the numbers of geriatricians closely mirrored changes in reimbursement and the rise of Primary Care, as well as increased debt on the part of medical school graduates. Dr. Edes acknowledged this, as well as the fact that these are factors in the VA as well.

Dr. Abrass inquired as to the current number of geriatricians in VA, and received the answer that there are presently about 500. As such, he noted that approximately 150 would need to be added in the next three years and speculated one way to accomplish this was through exemptions for the J1 visa trainees. This could just be an administrative fix through declaring VA a shortage area. Dr. Edes noted that it was not just a matter of recruiting, but also creating positions within the VA.

Dr. Edes and Dr. Shay are considering creating an Executive Committee to approach this. The committee would consist of highly placed VA individuals who would be able to promote and support change at the highest levels. It would be supported by Coordinating Committees, which in turn would oversee the activities of a number of different workgroups. The workgroups would be concerned with marketing and finance, education and training, community outreach, recruitment/retention, policy, clinical administration, outcome measures, and possibly development of a Federal Advisory Commission. Currently, this last seems to be under consideration through the Institute of Medicine.

Dr. Edes noted that because the VA population is old, complex, and characterized by geriatric syndromes, it is important for the VA to address its shortcomings in the geriatric workforce even as other subspecialties share similar needs. Dr. Damron-Rodriguez noted the recent recommendations of the IOM on the need for medicine to participate in interdisciplinary care might provide valuable input to Dr. Edes.

### **Employee Education System**

Joy Hunter, Dean of the VA Learning Organization, spoke with the GGAC one year ago about EES activities and the need to be partners in workforce recruitment and retention. The major purpose of her presentation this year was to

provide an update on the Learning Management System. The intention of this ambitious project is to create a single access point to which all education information and materials can be indexed. The intent is to have the ability to track local, network, and national involvement in education, as referenced to personal development plans and mandatory training opportunities. The focus of LMS will be less on fulfilling requirements and more on establishing skills and competencies. And in the future they hope to have documented interfaces with IHS and DOD, etc.

Dr. Abrass pointed out that GRECC Directors always want to know whom to train, who is accessing their online learning, where is it being accessed from, and if it is the same people receiving education or new ones? Pat Lay noted that the dataset LMS creates will be able to answer these questions. It will be able to drill down to any level necessary and offer the GRECCs the ability to determine who their target audience is. Ms. Lay characterized the LMS as a flexible and powerful tracking system that allows entry to many aspects of EES. Much of the information that might be obtained from the dataset is dependent on what information will be put in. She clarified for Dr. Veith that needs assessments were definitely part of the suite, but only in reference to individual needs. She was careful to distinguish that the major focus of LMS is to track, train, and tie past records to the catalogue of offerings. She felt that needs assessment, reflecting an aggregate of requested educational offerings, was outside this particular process. Supervisors will be able to add training requirements to employees' plans, as well as the employees doing this themselves. There will be the ability to distinguish between required and optional training. Dr. Shay speculated that this sounded like an ideal platform from which to conduct a broad-based needs assessment, inasmuch as learners are using the instrument and wouldn't it seem logical to ask these same learners what more they are seeking? Ms. Hunter clarified that that seemed ideal, but that this particular instrument could not be everything to everyone. Historically, EES has worked with the program offices to identify needs. How those needs are addressed, how they are rolled out, who takes the courses, how effective they are--this will be the function of LMS. Dr. Abrass noted that a tracking tool such as this would be very good for planning. For instance, if there is high demand for a particular type of training, this could document those requests. Ms. Hunter acknowledged this, but ideally LMS will allow for resource decisions to be made in a more meaningful way. For instance, if a VISN is experiencing an increase in Falls, local managers can examine LMS to learn how much training employees have had in Falls, to see if they need more, or if maybe they need different training. Following the educational interventions, clinical changes may follow.

Dr. Veith restated the issue: if you do large, national obligatory training, do you expect to see an impact? As far as mandatory training is concerned Ms. Hunter made a comment that EES is attempting to move from the "stick" to a more customized approach. For instance, what an MD needs to know about Falls differs from what housekeeper does. Recently, the need for widespread

awareness about Traumatic Brain Injury made it important for widespread training, and yet training which targets MDs is inappropriate for employees with fewer clinical demands and lower educational levels. It is important to get information to employees that will impact what they do on the job, rather than what is required. She closed by emphasizing the importance of integrating educational operations with strategic planning, not just for Geriatrics and Extended Care, but for all of VA.

### **Loan Repayment Program**

A representative of VA's General Counsel met with her counterpart at NIH to discuss a proposal to the Office of Legislative and Congressional Affairs that would extend an exception to the federal employment exclusion, that NIH employees enjoy, to VA employees as well. Unfortunately, following discussion with NIH leadership, it was clear that there was no interest within DHHS to modify this requirement. Dr. Abrass suggested that maybe this is something that AGS and/or GSA could assist GEC with.

### **Office of Research and Development**

Joel Kupersmith addressed GGAC next. He briefly reviewed his background as a cardiologist, health services researcher, and former Head of Clinical Pharmacy at the Mount Sinai School of Medicine when Dr. Robert Butler started the first Department of Geriatrics there. He planned to share with GGAC some organizational comments about the ORD and then some specific programmatic directions to advance science on behalf of veterans. He briefly recounted the impressive history of research within VA in terms of international recognition, as well as widespread therapeutic strategies such as pacemakers, liver transplants, radioimmunoassays, CT scans, clinical trials, as well as successes in the management of tuberculosis, hypertension, and congestive heart failure. Not all VA research is overseen by ORD; for instance, the GRECCs and epidemiologic research occurs independent of it. Dr. Kupersmith's vision for ORD is one focused on goals rather than types of research, and he stressed the importance of deemphasizing names.

Joe Francis is currently the Acting Deputy CRADO; Dr. O'Leary is the head of Biomedical Laboratory R&D and Clinical Science R&D; Mike Selzer will be coming in June to direct Rehabilitation Research R&D. Recently, Seth Eisen was appointed as Director of HSR&D; he is the originator of the Vietnam Twin Registry. Finally, Alex Ommaya is Director for Translational Research.

Dr. Kupersmith noted that the Congressional appropriation currently under consideration is approximately \$411 million, which is about the same as in the previous year and with inflation represents about a 3.5% to 3.8% decline in actual value. In addition to these VA monies, there is approximately \$676 million of NIH funding and about \$200 million in industry and foundation support underwriting VA-based research. While the infrastructure for research was not part of the CARES there are significant infrastructural needs. Congress has

asked for an assessment, and it is hoped that some relief will be forthcoming.

The ERA system for submitting applications to NIH electronically will shortly be adopted by VA. NIH and VA have collaborated on this, with VA watching and learning from NIH experience.

Dr. Kupersmith noted that beginning in September 2007, there will be enough IT expertise in place to allow for a centralized, large-scale study with a single IRB. There will remain significant needs for space and for veteran members to staff the committee once it gets underway. The process will be voluntary rather than mandatory for investigators, and the local IRBs will continue to be part of the process.

He then discussed data security in some measure of detail, pointing out how relatively innocuous-seeming breaches in fact demonstrate a need for closer attention. ORD has collaborated with OIT on a website for questions and answers to alleviate the possibility of conflicting responses and the dissemination of misinformation. ORD has been in contact with AAMC and NIH in order to arrive at approaches that will be acceptable all around. Discussion has also occurred with CMS over concerns about billing and practitioner information. The recent scrutiny of the REAPs has resulted in practices and protections examples that can be emulated in other programs. There have also been some lapses, with some more major than others. He stressed that VA is a pioneer in many of these issues although they never sought that position.

The discussion then turned to Aging as a Designated Research Area for ORD. He noted that there is a peak in the number of the vets of advanced age and demonstrated that the relative distribution of funds allocated for VA research showed that, except for Mental Health, the largest single subject in ORD is Aging. He reviewed several different examples of VA Aging Research, including longitudinal research on aging (such as vascular disease and cognitive decline); deep brain stimulation in Parkinson's disease, robotic management of post-stroke victims, use of stem cells, prostate cancer, and various interventions in diabetes. The State-Of-The-Art Conference in Health Services Research eight months ago had focused on teams and team management as well as patient preferences. There are also research foci within Long Term Care including substance abuse disorders in VA NHCUs, reliance of veterans on Medicare, and End Of Life Planning. He went on to describe a new translational approach, QUERI, which works in areas such as stroke and congestive heart failure. A great deal of rehabilitation focuses on the elderly as most amputees are diabetics with peripheral vascular disease. At the same time, Dr. Kupersmith acknowledged that the complexity of advanced prostheses might make them unsuitable for cognitively impaired older patients. Hearing loss is the most common service-connected condition, and certainly visual changes associated with aging are extremely important as well.

Dr. Kupersmith then addressed some of the concerns that have been raised regarding Geriatric Merit Review. He stressed that small research panels were not cost effective, particularly when there were severe staffing shortages. There are two ways to handle the issue: either have a separate Geriatric Merit Review, or to include Aging expertise on the other standing committees. In light of the diminished numbers of proposals and staffing shortages, the management decision was to put Aging expertise on the Disease-Specific Merit Review Committees.

Dr. Kupersmith suggested a major emphasis in VA Aging Research for the future should be on healthier aging, as well as genomic information that can give insights on identifying at-risk populations and preventing diseases from manifesting themselves. He anticipates that risk assessment and interactions between lifestyle and genome represent approaches to healthy aging that will develop into "personalized medicine". However, this is extremely difficult to study objectively: how do you do a randomized trial on complex care? Most geriatric challenges are multi-disease, and of necessity complex, for which there are multiple models of care, each with their individual differences. The relevance of this research also applies to a growing number of OIF/OEF veterans for things like caregiving, Long Term Care, and chronic dependency.

Dr. Yoshikawa challenged the amount of "Aging Research" expressed by Dr. Kupersmith. He pointed out that ORD has declined to define Aging Research, and therefore the numbers that Dr. Kupersmith were impossible to assess.

Dr. O'Leary described in some detail the method by which proposals suggested for the Aging and Clinical Geriatrics (AGCG) Subcommittee were assigned to review subcommittees. Dr. O'Leary noted that in the latest merit cycle, for spring 2007, there were only eight proposals. Two of these were in basic science and needed enhanced expertise, specifically in oncology. This situation harkened back to Dr. Kupersmith's trade-off between the need to convene an Aging subcommittee and to bring in Disease or Organ-Specific expertise; versus sending Aging expertise to the other review panels. It was also mentioned that given the current percentile basis for funding proposals from different study sections, at best, out of the eight AGCG proposals at most only two of them would be funded regardless of their quality. By redistributing them among several study sections the chance for funding of each is increased. Dr. Yoshikawa asked Dr. O'Leary to clarify how different proposals were sent to review committees other than the ones requested by the investigators. Dr. O'Leary clarified that there is no precise assignment pathway, although he frequently does the first assessment and sends the different proposals to different review groups. He also noted that many Aging proposals in VA are handled in RRD and HSR&D as well. Dr. O'Leary is reluctant to move them from BL or CS because that requires the delay of one grant cycle. Nevertheless, it is hoped that the ERA approach will facilitate and accelerate this process.

Dr. Yoshikawa asked Dr. O'Leary to reiterate the "preview": does anyone with geriatrics expertise actually play a role in this? The answer was no: very few MDs are involved at all, and the MDs who are involved are generalists. Dr. O'Leary suggested that he would be open to the idea of external input, and while it might be challenging to maintain objectivity, he is open to non-VA volunteers. Dr. Kupersmith disagreed: he did not feel that it would make any difference to the success rate of the proposals, and noted that his office does not have the resources to test this. There had recently been questions of Conflicts Of Interest between a small, "inbred", preview group (not geriatrics, however) and investigators submitting proposals. It is important to avoid even the appearance of this. Dr. Abrass suggested that at the next GGAC meeting, scheduled for September 19 and 20th, Dr. Kupersmith's full agenda time could be devoted to discussing this point further, and Dr. Kupersmith was in agreement. Drs. O'Leary and Kupersmith closed by suggesting that there were no hard data establishing proposals reviewed in Organ-Specific Review Committees with Aging expertise had less success than those reviewed by an Aging Merit Panel; Dr. Kupersmith further noted that, even if such data could be found, historical comparison are notoriously subject to interpretation. He is interested in pursuing this discussion further with GGAC if they desire.

### **Office of Academic Affiliations**

The Office of Academic Affiliations has a role in the Graduate Medical Education, Allied Health training program, as well as maintaining the affiliations with the academic affiliates. Dr. Malcolm Cox described his vision for OAA and where it would be going with its programs.

The VA's proportion of GME resident physicians has declined from 11% to 8.5% over the past decade. Dr. Cox suggested that at least 10% was necessary in order for VA to continue to have solid input into how GME is developed in this country. As such, OAA has received support for increasing the number of residency positions by approximately 2000 over the next five years. Several RFPs have been issued, and others will continue to come out. They will be focused on addressing "critical needs" (additional openings in existing residencies; movement of existing residencies into new venues) and "emerging specialties". He reminded the group that approximately 10 years ago VA had cut the number of specialty positions in order to grow Primary Care; but now the pendulum has swung back and more specialty training is required. Dr. Cox believes geriatrics should be included with this. Last fall approximately 350 new positions were awarded and a second call for proposals is currently in effect. He hopes to continue this expansion for four or five years.

A third area for residency position growth is "educational innovation". The VA has a great deal to offer in terms of the electronic health record, patient safety, quality improvement, etc., so medical residents who spend time in VA may learn more about these cutting-edge capabilities than about other areas traditionally part of medical practice. As such, an RFP has been issued to look for transformative

education and clinical care education that include redesign of the clinical system while impacting education. The proposal request is deliberately open ended, although it does require measurable clinical and educational changes. To date, there have been 16 Letters Of Intent, of which 15 have been accepted. There are approximately 100 positions that begin in July 2008. Dr. Cox believes geriatrics is very well suited for transformative program educational innovations. Nevertheless, none of the Letters Of Intent were in geriatrics, although most were about Chronic Care.

Dr. Cox then spoke about the VERA contribution toward education. For each stipend that goes out (averaging about \$51,000) an approximately equal amount goes out to cover "indirects": to account for time spent by clinicians in their teaching duties. He is seeking to educate VAMC and VISN Directors about their need to allot administrative time for faculty development inasmuch as they receive funding to support it.

Dr. Cox then described the Nursing Academy. He noted that approximately 40,000 potential RNs were turned away from nursing schools last year, largely because of inadequate infrastructure and faculty. To address this, VA is soon releasing a RFP that will enhance its affiliations with four nursing programs. The VA has a strong history in this, which was of particular benefit to both medical schools and VA in 1948. The "VA Nursing Academy" will allow VA nursing staff to receive appointments at affiliated nursing schools. In addition VA will provide stipends for new nursing faculty, some of whom will be located at the VAs, others who will be at the schools of nursing. The hope is for 12 nursing schools to adopt this affiliation over the next three years; in return, class size per faculty increases by approximately 4, for a total of 40 new students per year. He also hopes nursing curricula will be modified to take on a greater degree of continuity, which is consistent with trends in medical education. The Robert Wood Johnson foundation is a partner in this effort and will probably undertake the evaluation. The initiative is expected to cost approximately \$80 million over its five-year run.

A Blue Ribbon Panel has been convened to address "burs under the saddle" associated with medical school affiliations. The past few years have seen tensions grow between VAs and their affiliates: nothing terminal, but worthy of clearing the air. The panel will be chaired by Jordan Cohen, President Emeritus of AAMC.

Dr. Cox next discussed the Special Advanced Fellowships, which had recently been expanded and now are offered in geriatrics research through 15 GRECC's. Approximately 200 positions are available through the Special Fellowship program, only some of which are in geriatrics. Dr. Stuart Gilman is the program manager. Dr. Cox stressed that there were many opportunities available through this program, and encouraged creativity in developing new lines of training.

Dr. Abrass asked Dr. Cox his opinion of the NIH Loan Repayment Program

issue. Dr. Cox feels that DHHS is not open to change, and that therefore statutory modification would be necessary. As such, a Federal Advisory Panel might help. He stressed that this was not just an issue of geriatrics and not just an issue for medical doctors either. As such, he felt that multiple constituencies needed to weigh in.

Dr. Damron-Rodriguez asked about the Allied Health trainees: from recent GGAC visits, it was her impression that the number of trainees has declined. Dr. Cox disagreed, and said that his data showed relatively steady numbers, although there had been a marked one-time increase approximately 7 years ago.

### **Certificate of Appreciation**

Dr. Abrass then presented a certificate of appreciation, signed by the Secretary of Veterans Affairs, to Dr. Della Penna for his appointment to the Geriatrics and Gerontology Advisory Committee

### **White Paper**

Dr. Shay briefly noted to the group that the Executive Summary of last year's White Paper was distributed, to serve as a reminder of the major points communicated to the Secretary. Many of the recommendations, while not explicitly fulfilled, were nevertheless areas in which movement had occurred in GEC and in VA.

### **Adjournment**

The committee then concluded with some open discussion.

Ms. Gong inquired about the possibility for increased Home and Community Based Care through the State Veterans Homes. Dr. Burris noted that the Taskforce on State Veterans Homes had looked at this issue, but seemed only interested in ADHC and modifying the criteria. He also noted that the growth in care needs for OIF/OEF has reopened consideration of alternative Non-Institutional Cares, such as PACE and Assisted Living.

Dr. Abrass noted that the legislative liaison for AGS continues to be interested in taking some of the issues in the White Paper forward. The group was in broad agreement with this, and it will be discussed at the upcoming AGS meeting. In addition, the concerns revolving around the LRP will also be shared. The group briefly considered the possibility of developing an updated version of the White Paper, but opted not to do this because of the considerable time involved in moving the communication through VA channels. As such, it was agreed that future discussions concerning the White Paper will use the current document as a springboard.

As a closing comment, Dr. Abrass suggested that any future discussions of what GEC and the GRECC's can contribute toward Polytrauma need to be characterized in a manner that reflects admiration for the efforts to date, rather

than coming across that criticism that the “new paradigm of care” seems to be a reinvention of geriatric assessment.

Next meeting will be September 19 and 20<sup>th</sup>. Meeting was adjourned.