

VA Geriatrics and Gerontology Advisory Committee (GGAC)
April 9-10, 2008

Participants:

Itamar Abrass (Chair)
Norman Abeles
Adrian Atizado
Robert Carbonneau
Jeffrey Halter
James Higgins
Joann Damron-Rodriguez
Richard Veith
Mary Jane Koren (via telephone)
Richard Della Penna
Janette Warsaw
Terry Fulmer (via telephone)
Terry Dolan
John Derr

Staff:

James Burris
Susan Cooley (via telephone)
Ken Shay

Guests:

Rob Winconski (ORD)
Phil Riggin (Office of the White House Liaison)

The meeting began with the introduction of Janette Warsaw, newest addition to GGAC. She is recently retired from the Durham VA, where she was the Associate Chief Nurse and greatly involved in home care issues. She is a 1942 graduate of the Medical College of Georgia. Also new at this meeting, although appointed 9/07, is James Higgins: CEO of the Bon Secours Healthcare System, which has facilities in St. Petersburg and New York serving approximately 2000 residents in nursing home, assisted living, and hospice. He is charged with long-term care and geriatrics programming for this healthcare system.

Office of Geriatrics and Extended Care (Dr. James Burris)

Dr. Burris began by noting that the new Secretary of Veterans Affairs, James B. Peake, MD, is a wounded combat veteran, a thoracic surgeon, a past Surgeon General of the Army, and a Lt. General (retired). He was newly appointed in December 2007. He clearly has the Dole-Shalala report on Walter Reed Hospital as his top priority, with mental health issues as a second driver. Since he has been appointed, there has been a great deal of action and attention paid to all parts of VA with the strongest focus on the returning veterans. Of approximately 1.5 million who have served in the Middle East, 800,000 have been discharged and of these, 300,000 have received care in VA. Approximately 32,000 of these have substantial needs for care. GEC needs to be concerned about this because there are extended care needs among the most seriously wounded. Prior to OEF/OIF, 25% of long-term care patients were under age 65 and this is expected to grow. Much of the heightened activity on the part of Secretary Peake clearly reflects awareness of the election cycle political overlay: its is expected that there will be change in leadership within the year no matter who wins the 2008 presidential election.

At present funding for VA is posing few restrictions. The president's proposed budget for FY08 included an increase and Congress added significant funds to that. FY 09 looks even better. GEC is hoping to take advantage of the current situation with the expansion of Medical Foster Home: a program that combines small group homes (6 to 20 beds) with the use of Home Based Primary Care input and supervision of a significantly more medically complex patient population. This was initiated in Little Rock and then expanded to two sites in Florida. The supplemental funding

sought should increase the program to 30 sites, as well as supporting a dedicated national director. This is being embraced for its greater appeal to one-to-one situations and younger veterans. Tom Edes is leading this initiative.

Another area for expansion is hospice and palliative care. The current growth is being sought to provide VA and Network-level leadership, drive infrastructural change, and expand educational opportunities to establish and maintain competencies. Particular growth in this includes non-institutional and home-based hospice and palliative care services, as well as increased staffing and infrastructural improvements.

A third approach capitalizing on the current fiscal climate is to expand the number of GRECCs. Currently the Executive Decision Memo proposing this is being finalized before submission to the National Leadership Board for eventual approval by the Under Secretary for Health. Foci that will be emphasized for the new programs will include translational research, younger/TBI veterans with extended care needs, rural geriatric health, and Associated Health Professions in geriatrics. There is concern that the current surge in funding will not last and therefore it is important to put in place programs that can become self-sustaining.

The final item of interest for GGAC was the State Of The Art conference in GEC, held in Virginia March 25-27. The charge to the conference was to look at the needs of the population and of the office over the next 5 to 10 years. The history was that in the 1970s, VA recognized the approaching age wave and initiated GRECCs and geriatric fellowship programs. In the 1980s, VA started building options in non-institutional care. By the mid to late 1990s, Under Secretary Kizer had reorganized VHA, and long term care was taking a disproportional "hit" in response to the new fiscal allocation model. VA appointed a Blue Ribbon Panel that furnished the "Crossroads" report recommending "VA must expand access to community-based extended care options". This set the stage for the Millennium Act in 1999.

The time has come to once again examine what the needs and the trajectory for GEC and VA should be. The conference consisted of plenary presentations and panels, as well as experts and thought leaders, including the Secretary, Under Secretary for Health, Ken Kizer, Robert Kane, Robyn Stone, Bob Dole, and Christine Cassel. For Dr. Burris, there were several take-home messages:

1. clearly there is high level support (especially from the Secretary) for geriatrics
2. there is continued need for strong geriatric research, education, and clinical program development that can benefit all age cohorts
3. the VA has many lessons to offer on these topics
4. there is a need for improvement in internal and external communications
5. VA's emergent responsibility for younger veterans means that all aspects of the agency need to adapt
6. caregivers are of prime importance, and have been significantly overlooked by VA. This is a major difference with the Department of Defense (DOD), where there has historically been a great deal of family emphasis and access.
7. there is a severe shortage of geriatricians and all professionals with training in care of the elderly.
8. 70% of geriatricians in the US have trained in VA. Yet the VA is severely under populated by these specialists.
9. There is a core of special programs in VA, directed toward geriatrics, including GRECC and geriatric fellowships. VA needs to maintain and strengthen these.

Overall, the conference left participants challenged, hopeful, and energized.

Dr. Halter noted that next week, an Institute Of Medicine (IOM) report will be issued addressing the needs of the healthcare workforce for aging America. It seems as if it would be timely and appropriate, in light of VA's historic link to geriatrics, for VA to take a stand on the importance of

this report and its recommendations. Dr. Burris responded that the Chief of Academic Affiliations, Dr. Cox, had characterized the situation regarding training in geriatrics as "we have built it but they are not coming". Because of salary problems and intrinsic image issues ("not glamorous"), it is difficult to build the needed workforce. Terry Fulmer, one of the principal authors on the report, noted that the committee responsible for its drafting had met with funders who are aware of the responsibility they bear on this issue.

Dr. Burris continued talking about the SOTA. Following the conference, Ken Shay and VISN 23 Director, Robert (Randy) Petzel, MD, were appointed by Dr. Agarwal as co-chairs of the steering committee to develop a new GEC Strategic Plan in time for the new administration in 2009. In December of 2006, Congress dictated that a LTC strategic plan had to be developed by the Office of GEC. The timeframe for its development was inadequate for anything but a relatively superficial product, and therefore the Office of Geriatrics essentially wrote a background statement reviewing the status of care of the elderly in VA, and then describing the 10 major ongoing program areas already in effect. This has been furnished to the Congress as the new strategic plan, reflecting much broader perspectives and more effort, is finalized.

Dr. Abrass made the observation with respect to physician workforce and geriatrics: only 54% of residents are US graduates. Many are on J1 visas. Following their training, they are obligated to return to the country of origin, although they may avoid that by serving in medically underserved areas, such as prisons and rural towns. Often they do not return to geriatrics. If VA could address this by getting its health facilities to be designated as shortage areas, much of the geriatrician shortfall could begin to be addressed. A second measure for addressing this could be through opening up the NIH loan forgiveness program to participants in the VA advanced geriatric fellowships.

Joann Damron-Rodriguez noted that a bill recently introduced in the Senate by Barbara Boxer (D-CA) proposes expanding loan forgiveness for those in geriatrics, but Dr. Abrass pointed out that this would not benefit VA in as much as it stipulates that eligible graduates must be practicing in the private sector. Dr. Halter noted that in its own way, while this law might benefit the overall field, it would serve as an additional disincentive for involvement in the VA special fellowship programs which were designed to build faculty expertise and thereby provide a longer-term solution to the limited geriatrician numbers.

Dr. Halter also noted that if VA could agree to identify geriatrics as a "scarce specialty" this might help, by adding some salary incentives. Dr. Abrass noted this should be feasible in nursing and social work as well. Dr. Burris concurred, noting that on GGAC Site Visits, it is clear the potent role that GRECCs can play in nurturing prospective geriatric leadership, but the numbers are small, and in many cases the incentive for the trainee to remain in the system is lacking. Dr. Dolan noted that these same issues face dentistry: was this discussed at all at the SOTA? Dr. Damron-Rodriguez stated that she had included it in her discussion of Associated Health professionals.

Mr. Higgins noted that turnover is always a problem. As such, it should be looked at as a "pipeline issue" with focus on recruitment and retention. Dr. Veith pointed out that this had been part of the original thrust behind the GRECCs in the 1970s. Ralph Goldman had seen that the need for bricks and mortars was both to investigate the field and to grow it by creating experts in it. Yet with an absent incentive at the end of the "pipeline" medical students will go elsewhere, seeking disciplines that offer more reasonable reimbursement. The strategic quest should be "how can you influence the market to provide higher-level reimbursement for geriatric services?" At the medical school level, this is influenced through faculty support. He gave the example that at the University of Washington, currently "global health" is a well supported thrust because of the generosity of the Bill and Melinda Gates Foundation. VA represents an unparalleled form of support to medical schools and could conceivably represent a means for supporting faculty expansion in this area. Yet it has not played this card.

Dr. Burris noted that medical school programs are currently expanding, particularly osteopathic ones. Possibly the increased numbers in the next decade will begin to address this. Dr. Fulmer noted that the similar problem in nursing, however, was inadequate infrastructure, limiting the number of faculty, and thereby limiting the number of students who can be prepared. Dr. Dolan noted that in dental education, there is expansion going on in for-profit osteopathic schools of medicine. Yet graduates are matriculating with increasing debt, compelling them to move away from public health and geriatrics. The absence of specialty recognition in geriatric dentistry has further exacerbated this problem. Mr. Derr noted a similar trend in pharmacy. Expansion of the profession is ongoing, but the concern is whether or not graduates are "professionals or just technicians". Work at pharmacies pays more than in healthcare settings such as nursing homes. The American Society of Consultant Pharmacists has advanced certification, but this has done little to stem the trend.

Dr. Damron-Rodriguez shared that she had been at the SOTA, and had spoken on labor force development in Associated Health professions. An examination of GRECC training of Associated Health professionals from 1999-2007 showed almost no growth in any areas and limited interaction in certain fields. Her own experience with Geriatric Education Centers is that they focus much more on continuing education programs because to do so is less labor-intensive and can deliver larger numbers of trainees, which is important for annual reports and resubmissions for funding. Yet it likely has less influence on creating the sort of leadership in geriatrics that is required to grow or even to sustain the fields.

Dr. Abeles noted there are approximately 77,000 psychologists in the US but only 0.25% are certified in geriatrics. Yet the Number One employer of gero-psychologists is the VA.

Mr. Carbonneau turned the discussion back to Medical Foster Home. He asked Dr. Burris how many are presently in operation and what is their goal? Dr. Burris noted that there are presently 3 sites each with approximately 6 homes involved in placements. The goal is 30 sites within a year. There will be another national training session in 2009, and there have previously been three. The program offers much, but also carries great risk: with family caregivers, there are problems of potential abuse, neglect, and fiscal predation. As such, sites must be selected very carefully.

Mr. Carbonneau then inquired about expansion of the GRECCs: will adequate numbers of qualified people be found to staff them? The group has frequently heard of persistent vacancies; might this presage failure in the attempt to expand GRECCs? Dr. Burris responded that most vacancies have been due to withheld authorization to recruit locally, but the point is well taken, in light of the limited numbers of people with advanced expertise in the field. Dr. Halter noted that one success area among the GRECCs has been their track record in attracting good people from outside of geriatrics and then encouraging and supporting them to refocus their investigations into aging areas. He suggested that in light of the IOM study, and the need for non-physician experts in geriatrics, maybe 2-5 new GRECCs is too modest a goal. Maybe there should be at least two such programs per VISN, or even one for every highly academically affiliated VA?

Dr. Veith concurred on the important role of GRECC in multidisciplinary training. He suggested that if the GRECC could be involved in health faculty training for non-physicians (e.g., dental, psychology, pharmacy, OT, nursing) to the same degree that they focus on physicians, very possibly they could begin to turn the current workforce situation around. For instance, at the GGAC site visit to Palo Alto, it was clear how internal academic policies make it very difficult to nurture junior faculty. But GRECCs nurture this sort of professional growth. Perhaps the GRECCs need to expand in this direction? Dr. Burris noted that this is often heard from trainees at GRECC: this is the only place with interdisciplinary experiences, and many of them seek employment in VA following completion. Ms. Warsaw observed that one of the difficulties with nurses in geriatrics is that newer graduates are drawn to more technological and "flashy" disciplines. The maturation that often leads to an interest in geriatrics and other disciplines, coincides with an age at which many nurses can no longer address the physical demands of front-line geriatric nursing.

As a final observation, Dr. Abrass noted that the authorization to expand the GRECCs did not automatically mean that there would be adequate expertise available in the geographic areas currently lacking such programs. Sites that do not presently have GRECCs does not necessarily mean they have not been interested. There have to be the necessary strengths available.

Discussion then turned back to the Strategic Planning effort stemming from the SOTA conference. Dr. Shay noted that there had been a great deal of ground work leading to the current effort, and much of this will inform the work of the steering committee. Included among this is the output of the Dementia Steering Committee (Susan Cooley), the GEC/polytrauma task force (Tom Edes), the Institute of Medicine report, the Dole-Shalala recommendations, and data on long-term care projections flowing from the Office of the Associate Deputy Under Secretary for Health for Policy and Planning.

GRECC Performance 2007 (Dr. Shay)

Dr. Shay then reviewed with the GGAC the results of the 2007 Annual Reports. The total amount of research grant expenditures actually slightly declined, but was still over \$108 million for the year. The number of FTEE has declined, which is somewhat worrisome. Vacancies persist, although Mr. Feeley has been very responsive in reminding VISN Directors to fill positions as they become open; yet he has to date been unwilling to offer similar incentives for addressing long-standing vacancies. Dr. Shay presented information on trainee numbers, as had been requested by Dr. Damron-Rodriguez last fall, and demonstrated essential stasis in the numbers and disciplines involved, although a steady increase in numbers of psychologists trained can be observed. Dr. Abrass cautioned that proposals for expansion of this aspect of the GRECCs should not be undertaken without the resources to support them. Dr. Veith suggested a potential recommendation from this group might be to increase the number of FTEE at each GRECC by (e.g.) 2-3, in order to facilitate hiring of doctoral level Associated Health professionals who in turn would then drive increased numbers and broaden the scope of training in associated health professions.

The number of publications from GRECCs annually continues to grow, although as Dr. Halter pointed out, an uncertain number of these may not be directly related to aging. On the topic of vacancies, Dr. Abrass reminded the group of the analysis that Dr. Shay had conducted two years ago, demonstrating higher productivity on the part of GRECCs that have lower and less prolonged core staff vacancy rates. As such, he expressed concern that the addition of only two GRECC might be inadequate to the task of turning the workforce issues around.

Dr. Halter and Dr. Abrass also revisited the issue of publications not related to aging. At a recent site visit, concern was raised regarding the extremely diverse research interests at the GRECC, although the quality of the research was not questioned. Dr. Abeles characterized this as the result of "opportunity hires" in that the academic affiliate of this particular program has a fixed number of faculty slots available to it, and therefore reserves faculty slots for proven, high-level academic successes. As such, it had proven more expedient to recruit and retain leaders in their own disciplines, than to pursue either entry- or senior-level investigators on a more limited number of topics.

Discussion then turned to the possibility of employing the Performance Measures to drive some of the desired changes in the GRECCs. Mr. Higgins suggested a stronger correlation between the vacancies and the Performance Measures might be appropriate. Mr. Atizado wondered whether Performance Measures might be correlative to clinical outcomes, but Dr. Shay pointed out that the clinical activities of GRECC tended to be limited to clinical demonstrations. Yet Mr. Atizado persisted, pointing out that the clinical accomplishments of the network or the facility should be related to the activities of the GRECC. Dr. Veith acknowledged the potential utility of this, but recommended caution: some of the educational activities of GRECCs have local impact, others Network, and others national. If there were some way of looking at the impact on clinical through these diverse outcomes, it would probably be subject to a great deal of criticism. Dr. Halter noted that this was the essence of translation research, and accounted for why expansion in that

particular area should be an important focus for all GRECCs. Dr. Shay suggested that one clinical outcome might be performance on the "ACOVE" supporting indicators, but again acknowledged that demonstrating a correlation between educational efforts and clinical outcomes was a relatively difficult task. Dr. Halter noted that VHA's Office of Research and Development doesn't include aging and geriatrics in outcomes that they publicize (in reference to a recent publication by that office that was circulated among GGAC membership); maybe the Office of GEC should develop publicity analogous to that disseminated by ORD, demonstrating the positive contributions of GRECC.

Ethics Briefing

John Gurland of the Office of General Counsel provided a required briefing on ethics, conflicts of interests, standards of conduct, and related issues pertaining to members of federal advisory committees.

Office of Care Management and Social Work Services (Kristen Day, LCSW)

Ms. Day noted that VA employed 4,200 social workers before the current Middle Eastern conflict; now there are over 6,000. They are responsible for over 60% of the mental health counseling in VA. VA has long been one of the largest employers of social workers nationally. Currently one of the greatest challenges to this service is in leadership, because there are so many new entries to the discipline.

Additionally, changes with service lines in VHA in the past decade undermined social work at many stations. Reorganization disseminated social workers among care lines and at lots of stations the leadership pipeline was lost. Fortunately, this trend has reversed. Prior to those reorganizations VA was 100% discipline-specific services, but this dropped to 35% in the case of social workers at their lowest ebb; it has now climbed back to over 70%. The need for such professionals is huge; for instance, West Los Angeles alone has 150 social work staff.

Caregiver support is a huge need that is growing more acute. There are pockets of excellence which tend to be those that require particularly intensive input, such as SCI. Yet as a result, there is undersupply within Primary Care and other system wide programs. Recently this office has hired a national coordinator for caregivers and there are eight pilots underway. The greatest challenge is that current VA authority does not include provision of care to non-veterans, which must be dealt with at every level of programming.

Another emerging program within this office is the Fisher House program. Each Fisher House requires approximately \$3.5 million in order to establish a setting in which families from veterans being managed for polytrauma rehab, spinal cord injury, etc. may reside while the family member receives care. Currently there are nine in VA, each with 21 units. Current plans are to expand the nine to 35, and eventually to have one co-located with every VAMC. These are cost-sharing undertakings: the community raises the funds, and then the Fisher Foundation matches the donation, builds the facility, and donates it to the VA; who then staffs it. Generally these run at 100% occupancy.

Another major change is the name of the service. "Case management" has not been well received in VA, because few people want to be regarded as "cases" and no one wants to be "managed". Therefore it is now being referred to as care management, and consists of the three programs described. A highly visible one at present is the care transition from DOD to VA. In 2006, prior to the adverse publicity at Walter Reed, a single social worker was sent to interface with DOD at that Army Hospital. Now currently there are 15 social workers charged nationally with this sort of duty and all are interfacing with DOD on behalf of the most severely injured. There are weekly conference calls between VHA liaisons, DOD, the battlefield, and Langstühle. In many cases, the liaisons' prevailing interactions are with the families, who receive multiple and not always complementary input from well-intentioned agencies and professionals on the topic of their injured veteran. The presence of the social worker liaison can be very helpful in assisting families to sort out needs, desires, and opportunities. It is unique in VA's history to be so engaged

with families: traditionally VHA providers are accustomed to adult children and elderly spouses. The more typical presentation presently is a young wife with child and parents in their 50s. The latest job classification for addressing this are the transition patient advocates and peer counselors, who number approximately 100. They work seamlessly between VHA and VBA to partner on facilitating information transfer and continuity. Because these are not clinicians, their input is not documented within VISTA; yet this peer support is greatly appreciated by both spouses and veterans. It was set up last spring, in response to needs flowing from the Polytrauma Rehab Centers.

An additional role of social work has been facilitating the building of teams at the Polytrauma Resource Centers. Many of these facilities are peopled by individuals with broad expertise in their own disciplines, yet little experience in interacting with the other disciplines. Enhancing collaboration has been a priority. The prediction is that 2,500-3,000 veterans eventually will go through the Polytrauma Rehab Centers. To date approximately 600 have. Most of these are complicated by Traumatic Brain Injury, with the result that their management is very difficult, due to impulsive behaviors. Growing numbers of veterans are asking for these services, as are their families. Ms. Day noted that in time, the goal is to transition most of the patients into extended care programs of the Office of GEC. She noted that VA had put into place prior to Dole-Shalala their care management program to assist counterparts in Army, Air Force, Navy, and Marines. The resources flowing from Dole-Shalala then resulted in establishment of the "Federal Recovery Coordinators" (FRC). These are designed to facilitate the transition needs of those other than the ones involved with the Polytrauma Rehab Centers. For instance, everyone who goes through Bethesda Naval Hospital or Walter Reed is approached by no fewer than 38 different well-intentioned post discharge service representatives. Some assistance in prioritizing and educating with respect to these opportunities is required.

The FRCs are jointly DOD/VA. They are having to be adept in both technological and terminological systems. They anticipate lifetime commitments to many of the veterans, most of whom are not even enrolled with or visible to the VA. However they are establishing an electronic library of state, federal, and local resources and in addition to partnering with VA and DOD, work with the Departments of Labor, and Education. Each veteran will have an individual care plan developed by an FRC and create a relationship with that counselor. The FRCs are best viewed as "air traffic controllers" that don't actually deliver the services, but they have the plan, can deal with the unexpected, and can muster resources as needed. Recovering veterans cannot be counted on to be ready for all the information that they receive right away. The FRCs will be there when the veteran is ready. For instance, the state of Connecticut is giving every discharged veteran a free education. The vocational rehab and DOD benefits will need to be coordinated with this opportunity, and the FRCs will facilitate that. Currently there are six FRCs. It is anticipated that 10 will be ready by next month and eventually 67 who are presently enrolled will receive training as well. Mr. Derr inquired about their backgrounds. Apparently they were selected from among 170 applicants. They average over 20 years in clinical care, largely from social work and nursing. They also come from both VA and DOD backgrounds and all have had active duty. Dr. Veith inquired whether there was any opportunity for GRECC to play a role in the FRC program or any other programs involved with this office. Ms. Day responded that any input from the GRECC would be greatly appreciated. Dr. Veith outlined the scenario of involvement in advanced training and qualification in geriatrics for social workers and Ms. Day concurred that this seemed reasonable and potentially valuable. She noted that VA trains about 45% of the approximately 1500 social work graduates each year. Of the approximately 700 trained in VA, 600 received a level of stipend. She noted that social workers as a group view mental health as more prestigious than GEC in VA which is unfortunate. But VA continues to be an attractive career trajectory, inasmuch as a social worker can be employed for up to three years without yet completing their license.

Dr Della Penna inquired what performance metrics were tracked for the Office of Care Management. Ms. Day responded that timeliness of transition was the original one, but because this in many cases is out of the control of the VA, now there is a multifactorial spreadsheet of

challenges and when those challenges have been resolved.

Updates from the Office of Geriatric Programs. (Dr. Shay)

Dr. Shay reported that at the upcoming scientific session of the American Geriatrics Society there would be recognition of the 30th anniversary of the VA Geriatric Fellowship programs. A number of the original program Directors and early trainees will be present. Dr. Yoshikawa (former GGAC member, former Chief Consultant GEC, presently Director, GLA GRECC) generously advanced funding to pay for a breakfast to ensure the greatest possible participation in this event.

Dr. Shay reported that the Geriatric Primary Care Handbook, which is largely intended to codify the need for such programs to have smaller panel sizes and be relieved of some of the Performance Measure burdens of General Primary Care, has been put into concurrence. GGAC members took some issue with the lumping of geriatric consultation as a version of "Geriatric Primary Care"; Dr. Shay acknowledged that this would need to be modified. He also presented the White Paper, on which this handbook was originally based, pointing out the significant differences between General Primary Care populations and those populations treated in Geriatric Primary Care.

Purchased Care/Long-Term Care Programs (Mr. Schoeps)

Dan Schoeps reported he has worked in the Office of GEC since December of 1980. He currently "herds" Purchased Long-Term Care services for the office. VA has been buying care since 1965, with the first authorization of the Community Nursing Home (CNH) program. Payment for services that in non-VA settings are provided by "visiting nurses", termed "Purchased Skilled Home Care" began shortly thereafter. In the 1980s, purchase of Adult Day Health Care was started and in the last 10 years, Homemaker Home Health Aide and Hospice care has been authorized for purchase.

There is a great deal of local flexibility in these programs, because Mr. Schoeps has deliberately avoided putting Directives into the federal regulations (because these are too difficult to change, and the fluidity of demand and indications requires greater flexibility). He does work closely with the program managers, and attempts to have fairly consistent interpretations of policy. He's also responsible for measuring the degree to which care is being delivered, as well as tracking certain indices pertaining to procedure and outcomes. There is a unique interest in the unit cost for the programs, because these are purchased programs.

Finally, he noted that there are cares that are purchased that are not highly visible or publicized. These are becoming more common with the younger veterans new to long-term care who are demanding higher level care delivered in the home. Fortunately, although not explicitly authorized, this tends to be allowable under a blanket authorization.

Dr. Della Penna inquired what the highest priced services were. Mr. Schoeps responded that home ventilators were one example and that in general, the more a service is provided, economies of scale allow the price to drop. Mr. Carbonneau also asked more about the "unit cost:" is there an explanation for why there is such variation? Mr. Schoeps responded that there is a great deal of internal discussion on the merits of certain cares versus the adverse publicity associated with refusing them. For years, VA had an attitude of "we will provide the service; you send us the bill". But beginning four years ago, caps were imposed. This was necessary in order to make resources go as far as possible, and to allow for equity in the system. He did note that the increasingly liberal interpretation of guidelines in the face of the public relations pressures from OEF/OIF is in turn raising expectations for geriatric veterans as well.

Dr. Damron-Rodriguez asked for an explanation for purchasing Home Hospice, Adult Day Health Care, and other programs that VA could offer. Mr. Schoeps characterized this as a matter of choice, pointing out that VA has always offered both in-house and purchased services in many domains. Dr. Halter noted that VA "can't be everywhere". Also, Mr. Schoeps pointed out, that VA nursing home care is very expensive because of the infrastructural costs and that Adult Day

Health Care, also because of its location on VA grounds, is similarly much more expensive than what can be purchased in the community. In contrast, home care can be purchased for far less than it can be provided. Mr. Derr inquired about assisted living. Mr. Schoeps responded that it is currently not authorized and yet for many years, individual cases have been reviewed and it has been provided for specialized services, particularly for TBI veterans. This is likely regarded as a growth area because of the number of returning veterans who experienced TBI. It is unclear whether there will be spillover to geriatric veterans or not.

Dr. Dolan inquired about maintenance and continuity of the medical record in the face of the patchwork of purchased and VA provided care. Mr. Schoeps acknowledged that information security has made this particularly difficult, and there are also considerations for accreditation: the more input VA has into the plan of care, the greater is the likelihood that JCAHO will insist on reviewing organizations from which VA purchases its services. Mr. Atizado noted that this was a large concern of DVA, and that having a VA-wide Deputy Secretary for IT, rather than VHA IT, has made progress particularly slow.

Mr. Schoeps then spoke of growth in these Purchased Care Programs since the Millennium Act 10 years ago. Homemaker Home Health Aide has grown by 100%, Adult Day Care by 40%, contract nursing home by 21%, and home hospice by 236%. He noted that 45% of all home care provided is and has remained in PSHC; this proportion has not changed. The cost of all of these in aggregate is very small in long-term care, representing only 13% of the total budget. And yet 52% of the work load is in these non-institutional programs. The intention of the Crossroads report was to diminish institution-based extended care while growing non-institutional care. The latter has occurred, but the former has not. Furthermore, the Millennium Act requirement for maintaining nursing home census at 1999 levels has also worked counter to diminishing the budget expended on the high-cost CLC programs.

In contract nursing home, there are four foci for developing relationships with care providers: access, choice, costs, and quality. Discussion followed among Mr. Higgins, Dr. Abeles, Mr. Schoeps, Dr. Della Penna, Mr. Atizado, and Dr. Veith, concerning the relative strength of congressional authorization, versus use of existing infrastructure, and availability of alternative services. Mr. Derr pointed out that 10 years ago, there was a drive to get patients out of acute care because of its expense and this drove a tendency toward admission to skilled nursing facilities. Now it seems we're trying to get away from skilled nursing facilities because of their extreme costs. Mr. Higgins noted that about 20% of residents in nursing homes in the private sector could be served as well in alternative settings. But Mr. Derr noted that Medicaid fosters maintaining them in the nursing home because of the greater reimbursement and the absence of reimbursement for funding non-institutional care. Mr. Schoeps acknowledged that the prematurely institutionalized group is the most worrisome. They often go into nursing homes under Medicare and yet when that benefit is exhausted, they then are compelled to expend their own resources until they have spent enough to become eligible for Medicaid—whereupon, in many cases, they longer have a home to return to if they were ever discharged. If VA could assist with this transition, perhaps by paying short term for non-institutional services and obviating the need for nursing home placement, the government ultimately would not have to assume the higher costs in Medicaid.

Dr. Damron-Rodriguez inquired about the Olmstead Act and whether VA had been subjected to sanctions for continuing to place veterans, who might otherwise remain in community settings, in nursing homes. Mr. Schoeps noted that to his knowledge, this has not become an issue with VA at present. Ms. Warsaw noted that in many cases, the veteran wishes to reside closer to home. Yet other veterans may prefer to stay in a VA. Staying at home requires a caregiver and a suitable environment which may or may not be available. Mr. Higgins noted that home care and community-based care also is very reliant on care management, in order to identify and select most favorable choice, costs, access and quality.

Mr. Schoeps also noted that respite care is relatively less utilized than it should be, and as such,

will be receiving increased emphasis in the coming years. The greatest potential growth area is Respite provided within the home. Another area of looking appealing is Cash and Counseling, an AOA-developed program in which funds for care are provided to a client and a care worker is made available to develop a budget and to identify and procure services that are paid for under that budget. This maximizes choice, particularly in rural areas and particularly for those with non-traditional requirements for extended care, such as younger veterans.

Another recent boon has been obtaining permission to begin using provider agreements rather than contracts. This has reduced the need for an 80-page agreement obligation to 4-6 pages. This is being trialed in seven different markets. There's been good cooperation from CMS. Dr. Abrass suggested that this might help to facilitate broader use of respite. He noted that in the UK, respite is combined with reassessment and rehabilitation in a very GEM-like program. Often this can be advance scheduled, and the patients are not merely waiting around but are being rehabilitated and conditioned. He noted practices of offering this service, for instance, once per month, and thereby obviating the need for longer periods less predictably. Mr. Schoeps noted that VA has done well in implementing such programs, although this is not broadly practiced.

Mr. Atizado brought up an important point: that the non-institutional care numbers were originally intended as a "floor." That is, this was the minimum that VA should be delivering. But in reality, these have been regarded in the field as "ceilings"-numbers not to be exceeded, because to do so raises costs in this otherwise less-preferred means of expenditure.

Ms. Warsaw noted that respite in VA, when provided in NHCU (CLC), usually does result in a reevaluation and medication reconciliation. But she acknowledged that rehabilitation is usually not included and this was an excellent example.

Community Living Centers (Dr. Hojlo)

Dr. Hojlo reported that shortly all nursing home care units will be renamed "Community Living Centers". This is being done in order to get away from the stereotype of the "nursing home" and to drive change in the paradigm with the changed image. This has been reviewed all the way up to the Under Secretary for Health. It is consistent with the definition of nursing homes as a "dynamic array of services".

She then spoke of the "FIX" (Flow Improvement Initiative) program. This came about because of the increased costs due to increasing lengths of stay and increasing use of hospital diversion in VA settings. The root causes of this are that discharge planning from ICU, emergency room, operating room, and acute care tends to be erratic. Utilization review is after the fact. There is specific relevance for GEC in this, inasmuch as a very popular discharge destination is primarily the CLC, and secondarily the non-institutional cares in the community. There is a greater emphasis on continuity of care in the private sector but the amount in VA merits improving. Acute Care approached the Office of GEC for input on enhancing throughput and Dr. Hojlo is the representative for that. She has attempted to combine the cultural transformation of the CLC and FIX/throughput for this reason.

In order to work, admissions have to be:

1. **Appropriate.** This means that admissions to CLC need to be characterized according to what is expected for the patient. Will it be short-term (rehabilitation, other skilled nursing, awaiting placement)? Or will it be long (dementia care, SCI, chronic mentally ill, etc.).
2. the admission must be **medically, surgically, and psychiatrically stable.** As such, it is important that every admission be prescreened for suitable intent. How long will the patient be in? Where will they be going post discharge? Doing this identifies functional issues and guides the appropriate services. However admission to the nursing home also carries with some expectations. It does not mean Q2-4 vital signs, blood draws in the middle of the night, new hyper alimentation, no vasopressors, and no new trachs or ventilators. Mr. Higgins inquired who ultimately has the decision of where the patient is placed after acute care? Dr. Della Penna suggested it would be up to the discharging

- physician but Dr. Hojlo pointed out that the nursing home needs to have the final decision because they have to manage the patient. She also pointed out that there would be variation between different CLCs because it is not right to have a ventilator patient if the nurses do not have competencies. Currently CMS is using something analogous to the GEC Referral Form as a model for its "Continuity of Care Document". This was introduced in January of 2007, although it is not being broadly used. The intention is that it is handled by the discharging acute-care service, in order to ensure that ongoing treatments will be provided. But it also serves as a useful admission document, inasmuch as it identifies what are the expectations of the new trajectory of care. Historically this has been the role of the admission screening committee or the admissions coordinator. Having it in writing can be extremely helpful, inasmuch as it screens inappropriate patients out, and identifies those who might otherwise not have been thought to be appropriate but in fact are.
3. the admission must also be **efficient and timely**. If it is known in advance of patient is coming, beds can be made ready through other discharges if possible. This has to be a two-way street. Acute care cannot discharge without warning, and must not expect CLC to be able to admit without warning.
 4. CLC must be **effective**. But this means that they are not merely residences but there must be active treatment provided. Because the ultimate goal will be discharge to another setting, and preferably one that is community-based, patients must not be deconditioned. Just because it is not a particular focus of the treatment, rehabilitation strategies should nevertheless be included in almost all cases. This also will lower the absent sick in hospital rate. Part of cultural transformation is ongoing cueing from staff to the patients that "you are well". Therefore patients need to be dressed, have choice over how their days are filled, and are not inactive. Patients' rooms are called "resident bedrooms"- because the patients live somewhere other than that room. Dr. Halter inquired whether it was known whether these interventions, such as changing shifts to adapt to sun downing or introducing physical measures (e.g., foot soaks, massage) as alternatives to psychotropics, are effective. Dr. Hojlo responded that the discharge plans conform to expectations and that this was proof enough. Dr. Halter inquired about the admission plan, noting that generally a plan for a patient in a CLC is established only after the full assessment. He did not see how determining goals of care was feasible prior to admission. Dr. Hojlo responded that a rough estimate can be established and later fine-tuned. She noted that this is a paradigm shift for VA, but that waiting extensively before initiating any care, in the spirit of having all the information together, is disadvantageous to the patient who deconditions in the meantime. In the private sector, this would be intolerable if only for cost considerations.

Dr. Della Penna noted that Kaiser uses a "predictive modeling system" to manage its 20,000 patients in extended care. He noted that usually the admitting facilities have a very good idea as a result of information provided them by the current treatment team. He noted this is also good for the family. Dr. Hojlo noted that much of the benefit of the different admitting codes ("treating specialties" e.g., long stay dementia, short stay rehab, etc.) assists in this effort. Furthermore, Rehab service is good to emulate, because with them it is assumed that the inpatient will be participating in rehabilitative activities as much as possible during the stay. Ms. Warsaw noted that completion of the GEC referral and examination of the chart generally does a fairly good job of predicting a discharge date. The team meeting then refines that and puts more details into the plan of care. Dr. Della Penna concurred on the merits of the system that Dr. Hojlo was describing. In Kaiser, post acute care for hip fracture patients who have cognitive decline proceeds differently than for those who are not cognitively impaired. By increasing the amount of rehabilitation in this subgroup, the outcomes are equivalent. It does require a longer length of stay but the ultimate benefit is the same. Without the expectation for discharge, and careful tracking, this might not have been realized.

Dr. Damron-Rodriguez again raised the Olmstead decision, and wondered about patient choice in terms of placement. Dr. Della Penna pointed out that Olmstead refers to long-term care, and

probably would not be relevant to post acute placements. Mr. Atizado asked what the inducements and sanctions were for cooperating with the proposed FIX and cultural transformation. Dr. Hojlo's response was "peer pressure:" data are being captured and quality measures demonstrate who is in compliance and who is not. Dr. Veith noted that last time Dr. Hojlo had addressed this group, questions had been raised about measures to reflect that the paradigm shift is successful. Have these been introduced? Dr. Hojlo noted that CMS has "artifacts of cultural change tool" and this has been added as a Performance Measure. It is captured twice a year and reflects the degree to which different particular components of cultural transformation are being instituted. In addition, there is the ongoing program of unannounced surveys and the action plans from those make clear what has and what has not been initiated. There are also indirect measures of effectiveness, such as absent sick in hospital (ASIH).

GGAC Site Visit Follow-ups (Dr. Abrass)

Dr. Abrass then engaged the GGAC in consideration of prior site visits and their impact on the local programs.

San Antonio: the two major remaining concerns regard an absence of space for the education and evaluation program and recruitment of the Associate Director for Clinical. The history is that the education and evaluation program, which is shared with the South Texas Geriatric Education Center, had been located in university space. With the cessation of Title VII funding, the university would no longer support this. Yet the VA was not providing adequate space to the GRECC. The GEC has now been funded and the University-based space restored, but the medical center has still not made space available. They have proposed a fix that should be seen within 18 months. This will be revisited.

The situation with the Associate Director for Clinical has persisted for over 10 years. What has made it worse is that the Associate Director for Research is soon to retire; and the Director retired in December. There are three different investigators who are located up to 5 miles away and have questionable involvement with the GRECC. If they are denied their office space, it is likely they will move over to the university side. An active recruitment for a Director is underway but no clear progress has been reported.

Dr. Halter inquired whether threatening the program with potential closure was a possibility. Dr. Abrass responded that discussions with the Chief of Staff had lately been rebuffed. Dr. Halter suggested that a process for re-competition might send an important message. Dr. Abrass countered that a repeat site visit might be far less labor-intensive, both for VACO and for the site, and yet might be more effective. This had proven to be the solution in the New England area. Mr. Carbonneau noted that the site visit evaluations have often shown significant shortcomings, even to the point of noncompliance. And yet it is unclear what consequences exist for underperformance. Dr. Abrass suggested that when Dr. Kussman comes to speak with GGAC, perhaps the group should get his reaction to the possibility of re-competing or otherwise sanctioning (even closing) an underperforming. Dr. Dolan suggested that a program receiving a single warning should expect a particular response; a second warning is a harsher one etc. Dr. Abrass concurred, although noted that those in charge of VHA change identity periodically and each new administration's stance on this has to be gauged. Dr. Della Penna suggested that GGAC should consider defining a process for how it does its business, and then codifying it. Dr. Damron-Rodriguez suggested that, should a mini-site visit to San Antonio be required, some time should be spent with the AD/C and/or Director search committee, to ensure that appropriate expectations of potential candidates are properly communicated.

Cleveland: Dr. Shay then reviewed for GGAC the status in Cleveland. Presently, the AD/C, Tom Hornick, has been acting Director for over five years. At the site visit, it was clear that the GRECC was more conceptual than real. Only five or six FTEE are filled. The affiliate has virtually no activity in geriatrics. The network seems interested in preserving the program, although the support of local leadership, while vocalized, has not been reflected in action. Dr. Abrass noted that Robert Bonomo, one of the investigators and the Chief of Infectious Diseases and acting

AD/R, seemed to get the message. In Cleveland's initial response to the GGAC site visit report, it was suggested that Dr. Bonomo would be appointed as Director, and agreed that a full fledged plan for revitalizing the GRECC would be provided for review to GGAC in October. Dr. Dolan inquired why the programs were not required to re-compete. The answer was that for each GRECC there had been capital investment of over \$1 million. There is no immediately apparent resource to tap for those equivalent resources for a new site; nor is there a mechanism for withdrawing those resources from a non-renewed one.

Bronx/New York Harbor: Dr. Shay then brought up two questions that he had informally been asked by the Bronx/New York Harbor GRECC. One question had to do with the name: when originally designated, the affiliate, which was then a consolidation of Mount Sinai School of Medicine and the NYU Medical School, made it necessary to include both the Bronx and the New York Harbor VAs, as well as furnishing the needed resources expected of a GRECC. Yet shortly after initial funding was awarded, the affiliate split into its two component parts. Presently only a 0.25 FTEE support is provided to New York Harbor. GGAC members had no objection to a proposal to rename the program "the Bronx GRECC". Dr. Shay was directed to invite VISN 3 to communicate to the Office of GEC their desire for renaming. The second issue concerned their involvement in basic science research. Currently the Bronx GRECC has a great deal of activity in health services research, and is growing a program directed toward clinical demonstrations. But the very modest program in basic and clinical research is extremely modest and not aligned with any of the other priorities in the program. By leadership's own admission, the scientists involved and responsible for that activity have little to nothing to do with GRECC itself. Dr. Shay inquired whether requirements for GRECC needed to specify the activity in a minimum number of domains or whether a program with clear superiority in one area would be adequate. Dr. Halter suggested that the same group that is going to rewrite the GRECC Program Guide should examine and decide on that issue. Dr. Veith suggested that "GRECC" means the whole program: research, education, and clinical. Dr. Shay clarified that there was no ambiguity on that point; only on what the necessary components of the Research program needed to be.

Palo Alto: Dr. Shay then reported on the recent site visit by himself, Doctors Halter, Veith, and Abrass, and Mr. Derr to the Palo Alto GRECC. A prominent feature was the local environment and its unique academic status. Stanford University has a great deal of funds but due to a century-old commitment to the surrounding community, is limited in the number of faculty that it is allowed to appoint. As such, there are incentives to recruit more senior faculty rather than to commit to junior level faculty who may or may not fulfill their promise. When the current Director, Dr. Goldstein, took her position, her predecessor, Dr. Rando, had received 4-5 "billets". Yet these were in departments over which he had no control. So he recruited the best he could in the different disciplines because each billet is so valuable. However the coin of the realm is independent success; and the result of this has been a "center" of extremely diverse although very high-quality research programs, that interact little to not all. They've been funded long-term. However they have stretched the definition of aging research to include diseases that may be seen in the elderly whether or not they have anything to do with their components in aging, such as multiple sclerosis and rheumatoid arthritis. By their own admission, the GRECC has 15 "foci" and in reality everyone does their own thing. Dr. Halter suggested that the same group charged with the GRECC Program Guide should define what is "aging research" and can include this in the requirements for GRECCs. Also Dr. Halter thought that one approach might be to clarify expectations for those investigators who blend aging research with non-aging research, as far as how much of their GRECC time should be devoted to the aging research. Dr. Abrass suggested that the pendulum is swinging in terms of local control versus central control for the GRECCs. He reminded the group that Dr. Kizer had dealt quite directly with the Boston and Bedford aspect. But the prior Under Secretary (Perlin) was not so willing to engage. Again this should be raised with Dr. Kussman to determine whether or not he will support recommendations of the GGAC.

Office of Care Coordination/Tele-health (Dr. Darkins)

Dr. Darkins described his program as focused on those who want to stay at home, have chronic care needs, and/or are of increasing age. The concept of care coordination home tele-health with

electronic devices stemmed from a three-year pilot in VISN 8 that resulted in decreased emergency room use. In time three additional sites found corresponding outcomes. Currently the program follows over 32,000 patients nationally. Each provider has a panel of approximately 150 general medical or 90 mental health patients. The patients are closely monitored via these remote sensing devices. The most useful among the devices are simple messaging units that can monitor vital signs and provide patient reminders. There are four categories of care including non-institutional care, chronic care, acute (under four weeks), and health promotion/disease prevention. Only the non-institutional care portion count toward the non-institutional care numbers dictated by the Millennium Act.

The group has adopted a "continuum of care form" which has been abstracted from the GEC referral form. It has a relationship with tracking the non-institutional care referral criteria, and is repeated for every patient at six months. It follows the outcomes as well as the admitting characteristics. The hope is to track transitions through the continuum of care. Dr. Dolan inquired whether all patients were elderly and the response was not at all. The prominent diagnoses are diabetes, congestive heart failure, PTSD, and depression. The program is offered in all 21 VISNs. 52% of the patients are in the non-institutional category (the ADC is approximately 13,000).

Dr. Darkins stressed that this is not merely passive monitoring but that active engagement occurs as well with both patient and caregivers. For instance, in Puerto Rico fully 10% of long-term care patients are managed through a video in the home. Interventions are always based on particular patient needs and capabilities. The intention is to link the care seamlessly for "snowbirds". There needs to be a robust technology because patients grow dependent and may be resistant to change. The work is closely matrixed with the medical record, other services, and prosthetics delivery. Each VISN currently has a lead and prosthetics pays for the equipment. Overall there has been a 37% decrease in Bed Days of Care for patients relative to their pre-CCHT involvement. Currently they are tracking this for hemoglobin A1C and expect to see a corresponding improvement in that as well. Dr. Della Penna inquired whether individual expectations are set for patients or whether they were strictly program-wide. Dr. Darkins responded that it was a blend of both. Certainly there were goals of care for individuals. Another challenge is that there are a range of different technologies used. This allows for enhancing the technology by looking at particular features in their advantages, but it also detracts from the degree to which national data can be rolled up. Dr. Veith inquired what was being done with respect to depression. Dr. Darkins responded that there is an attempt to follow established published protocols. There seems to be 90% satisfaction at 90 days with the approach that has been adopted. Patients regard tele-health as a lifeline. Mr. Derr inquired whether it would be feasible to hook in a treadmill at home. Currently that is not being done, although scales and blood pressure cuffs are involved. Mr. Carbonneau inquired what sort of caregiver support was involved and Dr. Darkins noted his staff is working with Ms. Day and her staff. Initially there was a caregiver burden tool that had been developed by Marcia Goodwin and Tom Edes but this level of assessment is no longer undertaken. Mr. Carbonneau inquired whether spouses were involved and could validate improvements seen on the part of veterans. Dr. Darkins noted that this was a privacy issue, inasmuch as the patient's medical record is often involved. Mr. Atizado inquired about compliance, and learned that approximately 10% issued the devices do not keep them and then are cared in more national manners. 2-3% initially don't like the devices but adapt to them in time; the remainder do very well. Some people find the repetitive questions irritating. Dr. Damron-Rodriguez concurred with the point raised about leveraging this technology on behalf of caregiving, but Dr. Darkins again emphasized the privacy aspects that limit adaptation at present. Dr. Darkins noted that there is a national training center complete with certification. It is affiliated with the University of Florida. Ms. Warsaw shared her experience that patients really like the contact and appreciate the interpersonal aspects of care coordination. Dr. Della Penna inquired whether cognitive deterioration is currently a focus of any of the tele-health protocols. The response was that not at present. There is promise of doing sequential cognitive testing, as well as a screening for TBI. However at present, the devices are used for cognitive aid: reminders, trending and tracking, etc. as well as caregiver support.

Geriatric and Aging Research in the Office of Research and Development (Dr. Paxton)

Dr. Paxton began by pointing out that the Aging and Clinical Geriatrics Merit Review subcommittee (AGCG) had not received adequate numbers proposals for a few rounds. Nevertheless, a great deal of aging related research has been reviewed in other review subcommittees. He reported that by his estimation, approximately \$223 million in annual research expenditures went to aging related programs. On further questioning, it was clear he was including all cancer, diabetes, and cardiovascular disease in addition to other more focused topics. The GRECCs themselves are currently responsible for 117 Merit Review Awards, of which 53% are in biomedical lab research and development, 16% in clinical science research and development, 17% in HSR&D, and 14% in RR&D. Dr. Halter suggested that a prime factor in the underrepresentation in AGCG was because aging was not getting fair reviews and therefore investigators were deliberately directing their studies to different study sections. An example of this has been seen lately at a site visit, in which GRECC investigators are discouraged from even focusing their investigations on aging research, choosing instead to focus on "aging-related" research such as multiple sclerosis and rheumatoid arthritis. He noted that in the past both GGAC and the GRECCs had worked with ORD to define aging research and to identify suitable topics that should be reviewed by the AGCG. Dr. Halter also felt very strongly and expressed this that GGAC was charged with advising the Under Secretary and the Secretary on aspects of aging, geriatrics, and gerontology. He did not think it was appropriate for ORD to be defining aging research without some level of input from the aging research community or the geriatric academic community.

Dr. Abrass had less concern about the figure for research expenditures that Dr. Paxton had quoted but was very concerned about the shift in peer review. The concern is not what the proposal is called but that adequate peer review is provided. Often proposals that focus on aging, that are then reviewed in an organ- or disease-based review committee, do not receive adequate attention to the aging aspects of the proposals. If these aspects are the dominant part of the proposals, then the grant may be rejected. If they are not a dominant part, there is less assurance that concerns typical of aging research are being properly addressed.

Dr. Paxton pointed out that in the review process, there is always the ability to appeal a decision. Furthermore, it is extremely difficult to get reviewers, and therefore those who have expertise in multiple topics are always sought. Dr. Abrass noted that it was difficult to defend someone having the "right credentials" if there was not an existing guidance document that defines what that meant. He noted that ad hoc review is one approach, but it has shortcomings inasmuch as there is not institutional memory or comparison involved.

Dr. Paxton pointed out that the standing committee member names are published. The ad hoc may not show up until afterwards and he acknowledged that there were problems associated with that.

Dr. Halter then asked about the proposed request for proposals in aging research. He knew that activity had begun with cooperation between Mark Supiano and Joe Francis. However Dr. Francis has since transferred to the Office of Quality and Performance. Dr. Halter asked when that Request for aging Proposals is likely to come out. Dr. Paxton suggested that he would expect a fall announcement and therefore that the call would go out before August. Dr. Shay suggested it would be important to identify members of the review committees, for example AGCG, now in order for them to mark that time off on the calendar. Dr. Paxton reiterated that the call for proposals should be out by August. But he noted it would be outside the Merit process, in order to eliminate the current limits on the size of awards. It also will likely review outside of the regular cycle.

Dr. Veith inquired whether ORD had made much progress in including aging researchers in its review committees, since it seemed more in favor of expanding "aging expertise" on disease and organ specific committees, than having a free standing aging research committee. Dr. Paxton acknowledged that on several occasions the Office of GEC has provided lists of such names. But

he noted that those he had initially contacted had not proven to be available.

Under Secretary for Health (Dr. Kussman)

Dr. Kussman shared with GGAC that VA's budget seemed to be in good shape. He acknowledged this largely has to do with the needs of the OEF/OIF veterans. But he also noted that while there were abundant resources, they are sometimes not allocated to the right programs. Specifically, he noted that Congress currently provides the VA allocation in 4 non-transferable funds: medical services, medical administration, medical facilities, and information technology. Most of the demand of course tends to be in medical services. But a lot of the needs in VA currently are in IT. Yet the challenges involved in getting some medical service or other funds reprogrammed into IT are extremely difficult. The presidential request for FY09 is approximately \$41.2 billion, although there is speculation that Congress may add an additional \$2 billion. His hope is that relatively soon, both the medical administration and medical services allocation may merge. But there still will be difficulties if the IT and facilities funds are underrepresented and what can be done should that occur.

He then described for GGAC his four priorities for his tenure as Under Secretary. They include patient care, leadership, quality, and business.

Patient care is an obvious driver. Obviously VA is very invested in clinical, educational, and research enterprises- much like DOD- and while all are important, both research and education need to be in the support of clinical care. Currently VHA is being forced to focus on an entirely different group. He expressed his appreciation to the Office of GEC for adapting and clarifying the concepts of long-term care on behalf of those managing veterans coming from the Middle East. The transposition of geriatric concepts is critical. Yet the current veterans have very different skills, awareness, expectations, and family involvement. They represent maybe 5% of the current VA population, yet are getting a great deal of attention. At the same time, the agency cannot ignore that over half of its patients on any given day are over age 65. Fortunately, VA is not overwhelmed by this but it is compelling reallocation of resources in different ways.

His focus on **leadership** circulates around succession planning. Much of VA is led by people who will be eligible for retirement soon. The military has 250 years experience in grooming its leaders over a career. Yet VA has never had a formal system for this. Currently new programs are being developed to ensure that there is adequate leadership at all levels of the organization. An advantage of this as well ought to be greater standardization and uniformity of programmatic offerings nationally.

The focus on **quality** is not a shift from the status quo. Overall, VA offers excellent quality but there are still outliers where it is falling short. The shift to outpatient care was accompanied by demonstration of excellent outpatient quality but excellence in inpatient service is proving more challenging. Even the outpatient measures may be incomplete and require further attention. What are outcomes? How are transitions handled? How can the system be improved? He gave the example of VA primary care providers being excellent at checking occult fecal blood but has this resulted in timely follow-up of positive results, diminished cancer morbidity and mortality? The same is true with the use of chemotherapy, hip replacements, and cataracts.

Number four is **business**. VA spends many billions of dollars and it is reasonable to ask what is being obtained in return. This is a socially driven system rather than a financially driven one. Historically it has not tracked and hasn't had to track the expenditures. This must change. Care costs money, but resources for establishing systems to optimize the care have not been forthcoming. But because of the growing expenses of healthcare a time for avoiding that has passed. There is ongoing concern that if VA can't justify its expenditures it could be outsourced.

There are GEC/long-term care parts of each of the preceding four drivers. Dr. Kussman expressed his appreciation for the movement toward non-institutional care.

Dr. Halter introduced himself as a product of the VA and multiple educational and career opportunities within it. He pointed out that VA has been singular in providing leadership in geriatric medicine and medicine in general. He emphasized how proud VA should be of the role that it has played in the maturation of US medicine. Dr. Kussman responded in agreement but cautioned that resting on laurels would not serve the agency well. He again stressed that the current focus on 5% of veterans could be misinterpreted as under emphasis on the other 95% and stressed that GGAC input was vital to guide how that group was not overlooked.

Dr. Damron-Rodriguez noted that she had spoken at the SOTA on the labor force shortfalls and Associated Health professions in geriatrics. She was wondering what VA is likely to do in order to address the shortfalls reported in the IOM report. Dr. Kussman responded that 114 is working with OAA on this. They're hoping to improve retention rates once people have been attracted. He noted that physician pay while still imperfect has much improved from several years ago. And he also cited mental health as an example of a program that is undergoing deserved expansion and speculated that in time GEC would as well.

Dr. Veith concurred with Dr. Kussman's points about business and accountability. On that topic, he asked for guidance for GGAC on how to address underperformance of the GRECCs. Dr. Kussman assured the group that reopening competition, closing GRECCs, and whatever else was recommended would be appropriate. He did not agree with the idea that a program could be a "GRECC for life".

He concluded his remarks by again thanking GGAC for their input and providing needed outside perspectives on how VA is treating its older veterans. He also noted that the country was rather upset with aspects of how the war had been handled, but fortunately the public was differentiating the war from the warrior. He speculated that TBI may be a very prominent factor in future cohorts of veterans, because we don't fully appreciate the long-term care implications of it. As such, a national registry is essential for following patients.

Hospice and Palliative Care (Dr. Shreve)

Dr. Shreve spoke of the multiple challenges involved in dying patients: curative versus palliative care, acute versus chronic care, hospital versus home-based care, reduction of care to reduce costs versus improvements that result in reduction in excessive costs. He characterized the mission of hospice and palliative care in VA as honoring veterans' preferences at the end of life. He noted that access, quality, and expertise issues are key and he noted that the National Leadership Board is considering a sweeping increase in support nationally for these programs.

At last year's American Academy of Palliative Medicine it was reported that 25% of US hospitals have hospice and palliative care programs whereas 100% of VA facilities do. These sites each have teams with providers and purchasers of care. By FY07 40% of inpatient veterans who died in VA facilities had seen a palliative care consult team within 30 days of death. Currently 27% of veterans die in inpatient hospice beds and this has passed the percent that die in intensive care units. Currently VA paid hospice and palliative care, purchased in the community, is rapidly growing: over 30% per year. Currently ADC is approximately 700. About 6-10 times as many as these are referred out for management through Medicare and other payers.

The need to continue to increase access requires designation of beds, improvement of units within existing facilities, and an active palliative care consult team. In addition, hospice veteran partnerships, which are between VA providers and non-VA providers of hospice and palliative care, with the intent of optimizing transitions and access, has expanded broadly nationally. Integration at the VISN level is the next step. Another challenge remaining is outreach to the 40% of veterans who are considered rural. The quality challenge will require VISN-level oversight and guidelines. Another component is management of the bereaved family. After two years of effort, Dr. Shreve's program has a quality survey approved that will be administered through phone. Seven VISNs will undergo this particular survey which will be led by the CHERP and Philadelphia. To enhance expertise, the program is working closely with EPEC (Education for

Palliative and End-of-life Care) which offers monitoring and leadership. The plan is to incorporate VA principles and faculty through modification and optimization of the curriculum. He's also hoping for a full-time palliative care coordinator at each network, leading into an evaluation outcomes center nationally. There will also be a Mentoring and Leadership Center, associated with the CAPC.

Dr. Dolan inquired what role the GRECCs have played in this activity. Dr. Shreve reported that he was aware of different GRECC palliative care programs, there is a palliative care research consortium that has participation by GRECC personnel, and Dr. Shay described programs at Gainesville, Pittsburgh, Bronx, and Palo Alto that are very involved with hospice and palliative care. He also noted that a subgroup of GRECC AD/EE were in touch with Dr. Shreve and available for assisting in any educational initiatives that his group undertakes.

Dr. Halter asked how many of the special fellowships in VA on palliative care were in place. Dr. Shreve responded that there were six official ones, but that additional slots were being approved on an ad hoc basis, including a recent one in Ann Arbor. Dr. Abrass pointed out that when ACGME accredits hospice and palliative care programs there will be official fellowship status. Currently it is awaiting formalization so that it will not be exclusively in the VA any longer.

Dr. Della Penna inquired what is done to educate those not currently working in hospice and palliative care about the topic? Dr. Shreve recounted a variety of programs and expressed his interest in establishing those relationships and programs more broadly. Ultimately, each facility should have weekly rounding to enhance those collaborations. Dr. Della Penna inquired whether there were explicit competencies for this form of care. Dr. Shreve stated that originally he and others had not wanted it so limited, inasmuch as all providers should have skills in these areas. Yet as the field has evolved there are acknowledged needs for explicit training.

Ms. Warsaw noted that the growth of palliative care within medical centers was one of many unfunded mandates originally. The requirement to devote quarter FTEE in nursing, social work, medicine, and chaplain was not accompanied by additional FTEE, resulting in over commitment on the part of professionals. Dr. Shreve acknowledged this, and suggested that this was a great part of the impetus for the new initiative for expanding staffing and advocacy at the VISN level. Mr. Atizado inquired how families reacted to suggestions for palliative care. Dr. Shreve acknowledged that family education is key. Diane Meyers at Mount Sinai Medical School states that families should be a major focus for any marketing efforts, even more than MDs. Dr. Shreve closed by extending an invitation to the GGAC to share any ideas they had with him via email.

Open Discussion

- Dr. Veith suggested he would like to hear more about different outreach programs.
- Dr. Della Penna asked for exposure to different sorts of care systems.
- Dr. Halter noted that he felt there had been inadequate time for GGAC reactions to presentations, and requested that Dr. Shay specify to future presenters to limit their presentations to one third of the full-time, permitting two thirds of the time to be devoted to Q&A.
- Dr. Shay suggested that the next sites that needed to be visited would be Bronx, Minnesota, Salt Lake City, and Birmingham/Atlanta.
- Dr. Abrass reviewed the activities of the day and pointed out that two different committees had been suggested for GGAC input:
 1. GGAC input into the new Program Guide, with particular focus on research expectations, definitions, and commitment; also Associated Health education.
 2. GGAC input into Performance Measures.