

Geriatrics and Gerontology Advisory Committee  
Semi-Annual Meeting, September 14-15, 2005  
VACO Room 230 and American Legion Building, Washington, D.C.

Participants:

Itamar Abrass, MD (Chair)  
Norman Abeles, MA, PhD  
Adrian Atizado  
Robert Carbonneau  
JoAnn Damron-Rodriguez, MSW, PhD  
John Derr, RPh  
Terry Fulmer, RN, PhD  
Jade Gong, RN  
Mary Jane Koren, MD  
Michael O'Rourke  
Judith Salerno, MD, MS (ex-officio)  
Richard Veith, MD  
Thomas Yoshikawa, MD (by phone)

Guests:

Adam Darkins, MD (Care Coordination)  
Thomas Edes, MD (Geriatrics and Extended Care)  
Mary Lou Guihan, PhD (Health Services Research & Development [HSR&D] (by phone)  
Elaine Hickey, PhD (HSR&D) (by phone)  
Michael J. Kussman, MD (Principal Deputy Under Secretary for Health)  
Jonathan B. Perlin, MD, PhD (Under Secretary for Health)  
Patricia Ryan, RN (Care Coordination)  
Pauline Sieverding, PhD (HSR&D)  
Frances Weaver, PhD (HSR&D) (by phone)

Staff:

James F. Burris, MD  
Susan G. Cooley, PhD (by phone)  
Marcia Holt-Delaney  
Kenneth Shay, DDS, MS

Call to Order, Review of Minutes, Chair's Introductory Remarks

Dr. Abrass convened the meeting at 8:30 AM, reviewed the agenda, and asked for approval of the minutes. He then reported to the group on his meeting the day before with Dr. Kussman. Because of the necessary focus of top VHA officials on the unfolding natural disaster in the Gulf Coast region, Dr. Kussman had been unable to review the draft memorandum, specifying the need to keep GRECCs fully staffed, that had been sent his office in advance of the meeting. Dr. Kussman was reluctant to send forth the guidance in the memorandum, a stance Dr. Abrass suggested to him was equivalent to allowing the programs to diminish and ultimately to disappear. Dr. Kussman was unwilling for this to occur and proposed as an alternative that an Executive Decision Memorandum (EDM) be developed that would list options that included the

re-centralization of funding of the GRECCs—an option he said he could not promise but that he felt merited consideration.

Dr. Burris explained that the procedure would be for the GEC office to develop the EDM which would be sent to the National Leadership Board (NLB), where it would first be reviewed by the Health Systems Committee (HSC). HSC would make a recommendation to the full NLB, who would then recommend action on the EDM to Drs. Kussman and Perlin. They would have the option of following the NLB recommendation or not.

*Subsequent discussion concerned whether the abolition of the GRECCs should be included among the options; the possible need for additional central staff for supporting a centralized program; the possibility for expanding GRECCs into the VISNs currently lacking them; competitive review of new applications and existing programs; and performance measures linked to VHA Strategic Initiatives as means for establishing, assessing, and ensuring GRECC accountability.*

#### Update from Chief Consultant, Geriatrics and Extended Care (GEC)

Dr. Burris noted that a great deal of focus in VA over the prior two weeks had been on the natural disaster and human tragedy accompanying Hurricane Katrina. He reported that VHA had performed very well and was pivotally involved in rescue, evacuation, emergency response, and community health efforts. No VA patients died as a result of the storm or flooding. The Gulfport VA was evacuated and then destroyed; and the New Orleans VAMC was evacuated and then flooded, but the Biloxi VAMC remained in operation (of the seven hospitals in the city, only two remained in operation—the VA was one). The costs associated with these efforts are not yet sorted out, so it is unclear to what extent the supplemental funding for FY05 and the anticipated supplement for FY06 may be affected.

The other major dynamic affecting VHA at present is the influx of Afghan/Iraq War (OEF/OIF) veterans. Four poly-trauma centers have been established in VHA to deal with those suffering one or more of blindness, multi-amputation, traumatic brain injury (TBI), spinal cord injury (SCI), and hearing loss. The relatively young ages and severe disabilities of these veterans mean that they are almost certain to represent a new generation of VHA long term care patients.

An internal VHA change is that Dr. Kussman was elevated to Principal Deputy Under Secretary (DUSH). As a result, the offices of DUSH for Health Policy Coordination (Dr. Fran Murphy) and DUSH for Operations & Management (Mr. Max Lewis, Acting) now report through him. Ms. Miller (prior DUSH for Operations & Management) has been detailed to Health and Human Services to assist their development of the electronic health record. The Chief Financial Officer, who previously reported through the DUSH for Operations & Management, now reports through the Principal DUSH. Dr. Burris characterized this change as a return to the alignments under Dr. Roswell [under Roswell or before Roswell? Check with Jim?] and predicted little perceived change in the daily operations of VHA.

Within GEC, there have been few changes since the last meeting. The FY06 budget is not yet finalized. The LTC strategic plan is still in play because of the tension between limited funding on the one hand and the Mill Act pressures to maintain NHCU census and to build non-

institutional extended care census on the other. The compromise that has been the focus for resolution has revolved around limiting the institutional care requirement, but the extent of that limitation is still unsettled. The current proposal limits eligibility for VA-paid nursing home care to Priorities 1-3 and those requiring institutional long term care for "special needs": short term post-acute, TBI, SCI, Serious Chronic Mental Illness, and ventilator dependent.

Shortly following the appointment of Secretary Nicholson, VA leadership developed a new strategic plan; VHA has subsequently done the same; now Patient Care Services is undertaking this process. Dr. Burris described four priorities for GEC: ensuring the survival of the GRECC program, "cultural transformation" in nursing home care, Hospice and Palliative Care, and Educational Loan Forgiveness.

*Discussion followed. Dr. Abrass noted that the destruction of the Gulfport VAMC was causing significant political waves, for although the aged structure had been slated for closing in five years under CARES (Capital Asset Realignment for Enhanced Service—a system-wide appraisal of the status and distribution of VA resources relative to current and projected needs), the loss of the facility at this time may necessitate some immediate response that may be inconsistent with the long-term plans. He also reviewed for the Committee the background of the loan forgiveness issue: that the National Institutes for Health (NIH) have a particularly generous program that was developed to foster the development of a cadre of clinical researchers, but because of statutory exclusion of federal employees from eligibility, VA career development awards and special research fellowship programs were experiencing serious recruitment and retention difficulties. Congressional remedy may be necessary. The Executive Director of the Gerontological Society of America (GSA) will be briefing a Representative involved in the NIH re-authorization bill on this matter; and Dr. Salerno noted that the NIH liaison to VA had agreed to examine this issue as well.*

*Ms. Gong asked for clarification on the differences between state veterans home (SVH) nursing homes and VA nursing homes (NHCU). She was told that each state sets its own admission criteria and that SVH are funded in approximately equal shares by VA, the states, and the occupants' social security benefits. In general, all honorably-discharged veterans are eligible for SVH, although some states require a history of combat. Dependents (spouses and dependent children) may reside in state homes but not in NHCUs. The approximately 32,000 SVH beds are at about 87% occupancy but about 5-600 beds are added each year—whereas the NHCU numbers are stable at about 14,000 beds, of which about 12,000 are in use. Essentially all "entitled" veterans (>70% Service-Connected disability) who seek VA-paid nursing home care are getting it; it is less clear to what extent NHCU beds are also being used for veterans of other status. Dr. Salerno noted that the law specifies a floor for services but that all enrolled veterans could receive needed services "as available"—and the moves toward diminishing existing resources was in essence making the "floor" serve instead as a ceiling. Inasmuch as LTC is usually not a single service, veterans may end up being forced into inappropriate venues of care when they have access to only one part of the spectrum of services. Ms. Gong suggested this point be included in the White Paper that is under development. Dr. Salerno also noted that budget limitations in the face of increased service requirements often cause stations to reduce extent of service for a larger number of veterans—for instance, more veterans are enrolled in Adult Day Health Care (ADHC) but for fewer days per week. Dr. Burris noted that the*

*Government Accountability Office has noted the same trend and is now instructing GEC to track not only Average Daily Census and # of veterans served, but also # visits.*

#### GRECC Activity 1999-2004

Dr. Shay reported on the addition of 2004 data to the analysis he started last year. The data sources are the Office of Finance (as corrected by each VISN, to address instances of inappropriate cost distribution); the GRECCs' self-reported data, and the Research and Development Information System (RDIS). Total GRECC costs continue to increase yearly in a relatively straight trajectory and totaled about \$35M in 2004. Most of this was to support the 272 FTEE, which average 13.7 FTEE/GRECC. Director vacancies are limited to two sites (Cleveland and Ann Arbor) but there has been an increase in the number of sites without an Administrative Officer. Research grant expenditures are just under \$100M although only about \$85M of this is showing up in RDIS, largely due to local incompatibilities between VA and affiliate IRB practices and paperwork. The Veterans Equitable Resource Allocation (VERA) research component that is attributable to GRECCs is over \$38M. Over 1,000 publications are generated by GRECCs annually; of the 900+ articles written in journals over 97% are in peer-reviewed journals. More than \$12M in education training grants was expended by GRECCs in 2004; 16 of the GRECCs reported educational grant activity, up from 12 in 2003. Numbers and disciplines and levels of trainees was not reported but will be provided in future years. Clinical activity based on # of patients and visits and bed days looks drastically reduced in the past two years but this is due to recent clarification of what the GRECCs are supposed to be reporting. Clinical activity based on distribution of time among core staff has been relatively stable at 50 FTEE since 1999. If GRECC expenses are decreased by a conservative cash equivalent attributable to the clinical contribution, the GRECCs as a system brought to their host VISNs in VERA research allocation more than they cost in all six of the years studied. Six sites have done this in all six years; three sites have never once done this during that same period.

*Discussion followed. Dr. Koren suggested that sites whose RDIS matches their self-reported research activity should share best practices with those experiencing difficulties; Dr. Cooley agreed that this could be brought up to the Associate Directors for Research, with whom she will be establishing a monthly teleconference shortly. Dr. Koren also suggested that publication of review articles in non-peer reviewed journals should be seen as meritorious outreach and encouraged because of the broad distribution of this medium; Mr. Derr suggested that some linkages between such publications and the GRECCs might foster both dissemination and awareness of GRECCs at little effort by GRECC staff. Dr. Veith noted that in addition to the tangible assets (e.g., VERA research allocation) that GRECCs bring, the addition of talent and expertise they represent as well as administrative support and educational contribution should be stressed as more important, significant contributions. Dr. Yoshikawa asked about the use of Research Corporations as a means for local VAMCs to retain grant indirects and was told some sites do this—and he encouraged broader adoption of this practice as well as tracking this if possible to further document tangible asset contribution. Dr. Cooley will address this with her group as well. Dr. Abrass and Dr. Veith suggested that further analysis of the research allocation data was warranted, looking at correlations between research productivity and staffing characteristics, vacancies, staff turnover. Dr. Shay noted that he planned to do this, and also to look into the impact of split positions (i.e., staff who have less than 1.0 FTE GRECC commitment) and how fund support from center grants is being reported.*

### Update on Care Coordination

Dr. Darkins presented as requested by the group at the last meeting. He emphasized how the broad array of health care modalities and delivery approaches when linked through the electronic health record allowed for a seamless degree of care coordination. He characterized both outreach (centralized health care system offering its services in a distributed manner such as consultants offering expertise at distant sites without traveling) and "inreach", which was the collection of clinical information and transmission of those data centrally. Currently there are about 8,200 patients enrolled and active in the Care Coordination/Home Tele-health program nationally. The limiting factor is neither staff nor patients but the technological support. The program combines case management, care management, tele-health, health informatics, and advance clinic access approaches with the goal of redesigning health delivery to achieve true continuity of care. Currently tracking patients through different care settings is more a goal than a reality, but it is getting closer. But the recent challenges with Katrina have permitted continuous care for outpatients who have left one area covered by tele-health and relocated into another area with the capability. The absence of the electronic health record outside of VHA makes it impossible to track patient status outside of VHA although some paper tracking is undertaken. As the internal VA systems become increasingly sophisticated, the paper tracking suggests less and less use of non-VA services for chronic management.

Dr. Darkins and Ms. Ryan spoke of some of the diagnoses for which home tele-health dialogs have been developed. Psychiatric diagnoses such as depression and PTSD involve dialogs that ask about symptoms and behaviors but do it in different order each day, and intersperse the questions with different educational messages regarding the disease and its management. Pilot work at the Miami VAMC/GRECC has found that Parkinson's and Multi-Infarct Dementia patients are benefited more than Alzheimer's patients because the latter are often too advanced in their dysfunction to benefit by the time of diagnosis. They noted that their original expectation was that the most technologically sophisticated devices would have the greatest impact, but experience has revealed instead that the greatest successes seem to come from patients who needs simple reminders and lower-tech monitoring—the "just in need" rather than the "just in time" group. The role of the caregivers is key and discussion on how to best support their needs is receiving increasing attention. There is recent penetration into state homes and group homes—Ms. Ryan noted how the daily influx into the ER by state home domiciliary residents at one participating site has dropped significantly.

VA is essentially leading the development of this mode of care because of its electronic health record. There are significant cyber-security issues to address; also standardization of dialogs. Currently there are approximately 1,500 different dialogs—the Care Coordination office would like to reduce this to as few as 12 in time. The infrastructure is also important as illustrated by those patients who were able to use their devices post-Katrina versus those who could not because where they relocated didn't permit them to link into the CCHT carrier. The robustness of the infrastructure is also important because of the massive amount of information that must be constantly updated and constantly accessible—reliable back-up is indispensable. For these reasons VA is at the table with JCAHO to guide the accreditation process.

### Update on Millennium Act Pilot Programs

Drs. Weaver and Hickey began by re-familiarizing GGAC with the characteristics of the three different All-Inclusive Care (AIC) programs. Dayton's program was "VA As Sole Provider" with the VA coordinating and providing all services. Denver offered "VA Partnership" where VA provided inpatient and NHCU care, pharmacy, radiology, and lab; the community PACE organization was responsible for care coordination, adult day health care, home care, and transportation. Columbia (SC) offered "VA As Care Manager" where referrals from VA were to a community PACE who provided all services. Comparisons among the programs were not possible because the trial was set up as three separate demonstrations and only one pilot had a usable control group. Financial conclusions were difficult to reach because only a small subset of participants in each pilot had 12 or more months of Medicare data available, which was important in order to fully account for health service utilization by those in the pilots. One compelling finding was that at the end of the trials, fewer than 20% of participants had been permanently placed in nursing homes whereas inclusion in the study required functional and cognitive status that qualified the patient clinically for nursing home.

Drs. Weaver and Hickey did not present functional outcomes from the studies but did collect that information and it is in the report. Patient and caregiver and provider satisfaction with all models was high. Each program had its strengths and weaknesses. Dayton would be fine for the few VA health systems that have all the needed models of care already in place but was dependent on transportation [unclear what dependent on transportation means]; the broad service area made it difficult to limit non-VA health care use. Denver's program was dependent on a complex IT [spell out IT if not done earlier] tie-in between the PACE partner and VHA—once in place, this was an excellent resource. Columbia's model would be fine for VA Medical Centers lacking many of the component programs but the 100% dependence on non-VA services was difficult for participants to adapt to.

*Discussion followed. Dr. Damron-Rodriguez called attention to the Secretary's cover letter on the report to the Congress that stated that VA already is offering the component services of AIC. She noted that the VA system may have all the services, but that OIG and GAO had noted that not all the services were at all sites; nor were sites utilizing all services to the same extent.*

Dr. Guihan joined the call a bit late and gave a brief overview of the Assisted Living Pilot Program. She then addressed questions concerning the reported contracting difficulties, noting that despite VA's best efforts to simplify the process for small contractors the basic requirements were nevertheless off-putting in many cases. Memoranda of Understanding had been the hoped-for solution but were not allowed; Department of Labor requirements were another disincentive for sites to participate. Dr. Abrass asked GGAC to send additional questions they might have about this pilot to Dr. Susan Hedrick and Dr. Guihan.

### Informal Discussion with the Under Secretary for Health (USH)

Dr. Perlin was able to join the group and expressed his gratitude for their contributions to VHA. He stressed his awareness of the dominantly geriatric patient population that VHA serves and acknowledged his interest to get GGAC's input on what VHA is doing and should be doing. He described his own set of requirements for care: that it be safe, effective, efficient, and not require an advocate to benefit from those qualities for the care.

Dr. Abrass asked the USH if there were particular issues on which he was particularly interested to have the GGAC focus. Three specific topics were noted:

- Non-institutional care:
  - how to optimize the choices VHA offers;
  - how to tie-in the emerging electronic and technologic capabilities
  - how to make it effective 24/7
- Institutional care:
  - How to move VHA closer to a residential/communal living [“home-like”?] model in the face of the current capital assets that VHA has
- How inclusive should VHA try to be with extended care in the face of its limited resources?
  - What is the VA’s relationship with the veteran: contractually, morally
  - How can partnerships be leveraged to make the most of limited resources?

Dr. Perlin concluded by offering some updates on VHA’s actions in the Gulf Coast area. He noted that there were actually two separate disasters; the hurricane and the flooding. He noted that VA Medical Centers in Jackson, Alexandria, Shreveport, Tuscaloosa and Houston had accepted patients transferred from Gulfport and New Orleans. He expressed his admiration for and gratitude to Biloxi staff who continued working despite the fact that half or more of them lost their homes. All VA staff remain on payroll and all 16 CBOCs in the area remain functional. VA was able to contribute \$1.3M in prescription drugs to the affected area. And not only veterans were recipients—in fact equal numbers of veterans and non-veterans received care. Twelve mobile clinics from around the country are arranged in a ring around New Orleans to help address medical needs.

*Discussion followed. Ms. Gong noted that the AIC pilots had delivered rather mixed results but that the model had abundantly proven its worth for several decades outside VA. The USH stated his cautionary approach to “mission creep” and stressed that VHA can’t “be everything to everyone.” He noted that VHA’s LTC facilities were outstanding but that purchasing many other services was more cost-effective. He alluded to the Enhanced-Use Lease arrangements that have been advocated for partnering with non-VA assisted living providers and held this up as an example of partnerships that should be sought for expanding options. GGAC members noted the difficulties encountered with contracting processes and the federal government and Dr. Perlin assured participants that the Secretary was committed to addressing this. Dr. Veith asked the USH about GRECCs—what was his plan for making the most of this valuable resource? Dr. Perlin responded that it was essential for GRECCs to have a visible and active role in developing and disseminating improved approaches for caring for older veterans—both because this was their charge, and also because it ensured ongoing support for the GRECCs by the rest of the system. Dr. Koren asked whether it would be useful for the GRECCs to emphasize that much of what they do informs and improves chronic care management and interdisciplinary care—both of which are approaches that have growing applicability to health care in general. USH emphatically agreed, sharing his criteria for optimal patient-centered-ness: empowerment,*

*prediction of status, and integration. In that context, he felt that it was important to stress the utility of lessons learned about diseases regardless of the age of the patient--and in the same way to link knowledge for addressing aging patients that will bear on care of younger persons.*

#### Status of GRECC Site Visits

Dr. Abrass reviewed the three GRECC site visits that had occurred since the last meetin West LA and Sepulveda; Gainesville; and St. Louis. Draft reports have been distributed to the site visitors for their review and comments before finalizing. Full GGAC vote on the reports will be conducted by e-mail.

The group then turned to identifying which GRECCs should receive a site visit in the coming year: Cleveland, Madison, San Antonio, Durham; and if a fifth site visit is feasible, Little Rock.

*Discussion followed. Dr. Veith stressed how challenging the "clinical demonstrations" requirement is for GRECC Directors to comprehend and conform to. But he noted that in the early days of GRECCs the need to establish a research presence and academic credibility likely allowed the clinical part of the mission to be overlooked if lacking in some way. He suggested that times have changed, the GRECCs have their academic identities, and that they now need to address their promise as sites for clinical innovation and translational activity as the USH described. Dr. Shay noted the role of the performance measures and how with suitable modification they can assist in driving this re-channeling of efforts. Drs. Veith and Koren stressed the importance of sites successful in this way serving as exemplars and mentors for sites experiencing more difficulty—and that every other means for facilitating output and visibility in this area should be identified and employed. Dr. Shay noted that just this week the GRECC Associate Directors for Clinical started a monthly call with exactly that purpose in mind.*

#### Discussion of GGAC White Paper

Dr. Shay reviewed the process and outcome of the paper that he had developed with the guidance of Dr. Koren, Ms. Gong, Mr. Derr, and Mr. Atizado. The paper had two major themes:

- VA's leadership position in geriatrics has eroded although the factors and forces that initially put VA into that position have only become more pressing over time; and
- The great diversity of needs by the large aged veteran population necessitates a correspondingly broad selection of long term care options—and that those options are not necessarily interchangeable.

*Discussion followed. Participants offered additional points they felt would be important to incorporate in the next draft.*

- *Ms. Gong pointed to what the USH had told the group and rephrased it as "we cannot affect the amount of money VHA gets to care for aging veterans, so we need to optimize what is provided so that the largest number of veterans can get the highest quality of care."*
- *Dr. Fulmer noted that the documentation and continuity of care that VHA offers is so superior that accepting purchased care alternatives is equivalent to buying a lower*

- level of care. Mr. Derr pointed out that HHS is working toward a more robust electronic platform so that particular difference may dissipate over time.
- Several members noted that the recommendations at the end of the paper were insufficiently strong.
  - Dr. Abrass suggested close attention to the USH's comments and requested attention be paid to partnership possibilities, strengths, and weaknesses. Dr. Shay pointed out that the "partnership" approach to offering assisted living with VA participation has not yet attracted an appreciable set of participants.
  - Dr. Salerno noted that only extended care services was met with "partnership" suggestions—cardiac surgery isn't; Dr. Veith noted that until lately Mental Health experienced a similar marginalization. Dr. Damron-Rodriguez noted that this marginalization is not original to VHA—all health care systems "partner" to manage long term care.
  - Dr. Abrass advocated suggesting partnership opportunities such as AIC or AL in VA properties under "Enhanced Use Lease" (EUL)—the hope would be that the Secretary's pledge to improve the contracting process might apply to EUL as well.
  - Dr. Salerno reiterated her concern stated previously, that closing infrastructure in response to immediate pressures was removing future possibility to provide services at a time when the demand is most likely to increase. Dr. Damron-Rodriguez and Mr. Atizado pointed out that limiting certain services to a subset of veterans could have the long-term effect of limiting future funding for VA. Mr. Atizado pointed out that within a few years the Korean and Vietnam-era veterans would be demanding VA provide LTC services and VA needs to have its plans in place now—and their numbers will carry greater clout than they are able to at present.
  - Dr. Salerno suggested pointing out that doing "what is right" should be more important than only doing "what is law."

### Second Day Review and Introduction

Dr. Abrass opened the second day of the meeting by reviewing his conversation with Dr. Kussman.

Discussion followed. Dr. Abeles offered the opinion that recentralizing funding might make it easier for VA to end the GRECC program in one sweep. Mr. Carbonneau speculated that it might make better sense to keep successful GRECCs on the current funding approach but move the less successful ones to a centralized model. Dr. Shay noted that with only 20 programs it would be viewed as administratively wasteful to have more than one approach; that centralized funding might be viewed as a reward in which case a reward was given for underperformance; and that many GRECCs have good years and bad years—would their funding streams flip-flop accordingly? Dr. Salerno noted that when the GRECCs were being considered for decentralization, one possible choice was a hybrid model where some of the funding would be guaranteed nationally but the VISNs would be responsible for supporting beyond that baseline level. Dr. Abrass pointed out that re-competing for survival was inadvisable but competing for additional resources might make sense. Dr. Damron-Rodriguez speculated that Performance Measures might serve as a means for additional funding. Dr. Abrass stipulated that regardless of the funding source, the VAMC and VISN director would need to have GRECC Performance Measures added to their performance plan. Mr. Atizado noted that not all VISNs have

*GRECCs—if off-the-top funds were used for support wouldn't that essentially make all VISNs bear the cost? Dr. Abrass pointed out that GRECCs are a national resource and that in any case, there was the possibility for having up to 25 GRECCs.*

*Dr. Veith stressed the importance of approaching the EDM from the standpoint of performance expectations. He acknowledged Dr. Abeles's concern over susceptibility to cutting the full program, but also pointed out that the increased national visibility of a centralized program would reduce the likelihood for such a move. He advocated NOT marketing GRECCs as local "cash cows" or local "plums" but as a valuable national resource. Dr. Abrass raised the point made earlier that GRECCs have much to offer that is not limited to the care of the elderly. He also suggested noting that VHA had tacitly acknowledged the success of the GRECC model by creating PADRECC and MIRECC in its image—but those were still centralized. He noted that this could be played up as illustrating that GRECCs are truly a national resource. Dr. Damron-Rodriguez suggested that one performance measure approach might be to reflect support for any of the "-RECCs"—not just GRECC.*

#### Discussion with the Principal Deputy Under Secretary for Health

Dr. Kussman reviewed his discussion with Dr. Abrass regarding the funding of GRECCs. He acknowledged that it was entirely possible that the decision made in 1997 to decentralize funding was in error, and that the EDM was the suitable way to reconsider the matter. Overall VERA is highly successful but there are some matters that need central support. He empathized with any local manager faced with competing demands and having to select to bypass a GRECC recruitment—but that is why, as a threatened national resource, the GRECCs perhaps should be taken out of that equation. He observed that the VA was not designed as a financially-driven system. It is a socially-driven one that is being forced to adopt behaviors in response to economic pressures and the transition is neither quick, perfect, nor painless.

At Dr. Koren's request, Dr. Kussman offered a longer-term vision for long term care in VHA. He noted the demographic demands the system would be facing and suggested the GRECCs would be essential to meeting the challenges. He advocated identifying and making accessible the services that were in patients' best interests, and noted this was institutional care in only a minority of cases. He described the tensions reviewed the day before by Dr. Burris regarding required census levels for both institutional and non-institutional services. He stressed the importance of differentiating the different patient groups under the umbrella of "long term care," and the important role that NHCUs play in furthering the acute care mission of VA. He gave the example that the average per diem for a veteran in NHCU is about \$400—but in reality there are sub-acute patients who average \$7-800 and long term patients who are closer to the rate in contract nursing homes—about \$200. Ongoing education of lawmakers and the top level of VA is essential and must begin anew with every change in leadership.

*Discussion followed. Dr. Veith noted that significant efforts were underway to ensure a higher standard and greater relevance of accountability on the part of GRECCs. Dr. Kussman agreed that the VISN Directors should have shared responsibility for GRECC performance but that under the current set of performance measures they have other concerns. Dr. Veith asked P-DUSH what GGAC could do to assist him and was told to put recommendations in whatever reports stemmed from GGAC discussions.*

### Update on VHA's Activity in Hospice and Palliative Care

Dr. Edes provided GGAC with background and progress in end of life services. He pointed out the sobering numbers illustrating the large number of veterans dying in VA facilities as well as the number of enrolled veterans dying outside of VA—and how surveys demonstrate that a majority of both groups state their strong preference to die at home. In response there has been significant progress in VHA since 2002 in developing hospice and palliative care programs in inpatient and outpatient settings, as well as linking with community providers through Hospice-Veterans Partnerships. It is now a specific item in the budget; there is a national directive specifying the requirement for offering these services to all enrolled veterans; the need for sustained growth appears in the strategic plan; and a national bereavement policy is under development. He reviewed past and more recent performance in the locations of deaths (ICU vs. NHCU), costs of care for veterans in the different settings, consult requests for palliative care, and number of patients receiving VA-paid, community-provided home hospice services. Future developments will include development of patient and survivor satisfaction surveys, performance measures, and funding for program development.

### Geriatric Workforce Development

Dr. Shay suggested that GGAC spend some time discussing geriatric workforce development. He alluded to the Loan Repayment Program issue as well as the refusal of the Office of Academic Affiliations to reconsider their stance of not stipending trainees undertaking a second subspecialty according to their years of training [this sentence is unclear]. He alluded to the recent policy statement by the American Geriatrics Society on the need to educate primary care physicians about geriatric care because the number of geriatricians is so far behind the current and projected need. At his invitation, Dr. Edes presented information he had developed as part of a White House Conference on Aging recommendation concerning development of geriatrics expertise among physicians, nurses, occupation and physical therapists and pharmacists.

*Discussion followed. Dr. Abrass noted that the VA's Physician Pay Bill will take effect in 2006 and includes incentives to retain certain difficult-to-retain specialties. Under the physician pay bill the salary base will be tied to the 50<sup>th</sup> percentile according to the American Association of Medical Colleges. Dr. Shay noted that the acting GRECC Director at Salt Lake City, Byron Bair, MD, has developed incentive pay criteria for geriatricians that are based to a degree on the ACOVE [spell out acronym] indicators. Dr. Abrass pointed out that full-time geriatric practice in the private sector is not sustainable; only in a managed health setting where the cost of practicing properly is subsidized by more profitable services is it feasible. He cited an example in the Seattle area where a large group practice offered to pay (?) for the geriatrics certification exam for 24 of their family practitioners. Yet none of the 24 chose to recertify (?): as the identified geriatricians they were assigned panels comprised of time-consuming patients that resulted in lower bonuses. Dr. Edes noted that this constituted punishment for caring for the elderly, and was an excellent example of the sort of issue that must be addressed before workforce issues have a chance at resolution. Drs. Veith and Fulmer noted the supply and demand natures of anesthesiology and nursing, respectively, and the resulting impact on pay scales and willingness to enter the field.*

*Dr. Damron-Rodriguez suggested that there was merit in looking at the issue not only from the Supply aspect, but from Demand as well. Job opportunities don't specify the need for professionals with geriatrics expertise. Dr. Fulmer noted that nurse practitioners tend to gravitate toward family and adult certifications, because both allow the nurse practitioners the leeway to seek positions involving broader age groups. Dr. Edes noted that nearly 40% of all professionals with advanced certification in geriatrics are trained by VA; Dr. Shay noted that over half of the geriatric medicine fellowships in the US involve VA experiences. Dr. Edes noted that Dr. Kussman, on learning this information, suggested thinking about characterizing VA as "the educator of choice" in care for older adults. Dr. Abrass concurred—he observed that young professionals are less likely to seek employment with VA if they haven't previously worked in one as part of their training. As such, it seems wise to focus recruitment efforts on those in training.*

*Dr. Edes suggested there might be merit for VA to offer a "job mart" in geriatrics—a web site both for listing (or linking to) opportunities, and where prospective hires could make their resumes accessible. Dr. Shay predicted this would be straightforward—the GEC site has been expanding its offerings over the past year and this sounds like another area for useful growth. He also noted that lately the "GEC Leads" Outlook mail group has served as an informal but useful means for matching people and positions. Dr. Abrass noted that many openings that specify a general internist should be considered by those with geriatrics expertise simply because of the nature of the practice of internal medicine in VA. GRECC-based fellowships should be targeted with announcements and those matriculating from programs should be linked with internal VA needs whenever possible.*

#### GGAC Membership Issues

Dr. Abrass reported that the following GGAC members' terms expire in August 2006:

- Abeles
- Carbonneau
- Fulmer
- Damron-Rodriguez
- Koren
- Yoshikawa

He will be in touch with each in the coming months to discuss their future status on GGAC. He noted that the current membership of the committee has shown an unaccustomed level of participation and engagement.

Dr. Shay noted that a dentistry representative replacement for Dr. Krishan Kapur had not been secured. Dr. Abrass suggested that the application of a previously nominated dentist be reopened.

#### Adjournment

Drs. Abrass and Shay will identify suitable dates for two 2006 meetings and communicate them to members. The meeting adjourned at 12 noon.

Minutes certified by:

A handwritten signature in black ink, appearing to read 'William Abrass', with a long horizontal stroke extending to the right.

William Abrass, M.D.

Chairman, Geriatrics and Gerontology  
Advisory Committee