VA Geriatrics and Gerontology Advisory Committee
September 19-20, 2007

Participants:
Norman Abeles, PhD
Itamar Abrass, MD (Chair)
Robert Carbonneau
Joann Damron-Rodriguez, LCSW, PhD
Richard Della Penna, MD
John Derr, RPh (by phone)
Teresa Dolan, DDS, MPH
Terry Fulmer, RN, PhD
Jeff Halter, MD
Mary J. Koren MD, MPH
Michael O'Rourke
Richard Veith, MD, PhD

Ex Officio
Judith Salerno, MD, MS

Staff:
James Burris, MD
Susan Cooley, PhD (by phone)
Kenneth Shay, DDS, MS

Guest:
Andrew Goldberg, MD, PhD

Members Absent:
Adrian Atizado
James Higgins

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Announcements:
Dr. Abrass convened the meeting and introduced the newest GGAC member, Jeffrey Halter, MD, Division Chief of Geriatrics, University of Michigan School of Medicine; Director of the Gerontological Institute; and former Ann Arbor GRECC Director. Dr. Halter expressed his appreciation for the GGAC appointment and noted that his first interaction with the GGAC was when the Ann Arbor GRECC was site visited in 1992. The VA has been key to his career and Dr. Halter is grateful for the opportunity to give back to the Department of Veterans Affairs a fraction of what it has given him.

Dr. Abrass then introduced Dr. Goldberg, the Director of the Baltimore GRECC, who was attending as a member of the public.

Dr. Abrass then announced that Judy Salerno will be departing the National Institute on Aging at the beginning of the new calendar year to become the Executive Director of the Institute Of Medicine. She will be working for Harvey Feinberg, the President of the IOM. Dr. Salerno noted that the NIA Director, Dr. Hodes, will soon be recruiting a new NIA Deputy Director. She felt that her clinical orientation had been extremely useful in that role, and that it complemented Dr. Hodes's laboratory orientation very well. Brief discussion followed concerning the possibility of Dr. Salerno continuing on as a member of GGAC but no longer in an ex officio status.

Minutes of the April Meeting:
Dr. Abrass noted that the minutes had already been reviewed by the membership and that any corrections offered before the meeting had already been incorporated. No additional comments were offered.

Dr. James Burris, Chief Consultant, Geriatrics and Extended Care:
LTC Strategic Plan: Dr. Burris noted an act of Congress in December 2006 mandated that a new Strategic Plan for Long Term Care be submitted by June of 2007. Because of the relatively short time frame involved, the Office of Geriatrics and Extended Care decided to build the plan around the current initiatives that occupy the majority of staff's time. In April the initial draft was submitted for internal review and it is working its way through the department en route to Congress. Because it has not yet been released, Dr. Burris was unable to furnish it in writing to GGAC; but he did describe the 10 major elements of it which included:

- Cultural Transformation
- Grow non-institutional alternatives for extended care
- Incorporation of OEF/OIF veterans into Extended Care programs
- Quality initiatives in State Veterans Homes
- Unannounced site surveys of VA Nursing Home Care Units
- Enhance Hospice and Palliative Care
- Enhance programs for veterans with dementia
- Enhance and affirm contributions of GRECCs to VHA
- Optimize Primary Care for frail elderly veterans
- Integrate geriatrics with Care Coordination/Home Telehealth

Patient Care Services anticipates that Congress will request a follow up implementation plan for the new LTC Strategic Plan. As such, Dr. Burris has convened an Implementation Workgroup, consisting of program office and field representatives, to outline the steps and monitors that are necessary to ensure appropriate progress on the 10 elements of the plan.

Dr. Burris began discussing the Cultural Transformation elements of the Strategic Plan and noted that Dr. Hojlo has been working with Facilities and Construction on new design guidelines for Long Term Care Facilities. These will reflect a different model of care, such as moving away from centralized nursing stations and long hallways toward more personalized environments. Another part of Cultural Transformation is the "FIX" initiative that is intended to streamline throughput in acute care. Nursing Homes will represent a prevalent discharge destination, and freeing up additional Nursing Home admission capability is an important factor of acute care throughput,

therefore attention will be paid to timely NHCU admission and subsequent discharge. Dr. Hojlo has been working with Nursing Service and others to define new Treating Specialties. At present, data are only collected on admissions and discharges to the “Nursing Home Care Unit"; Dr. Hojlo has sought to track the admission, discharge, and length of stay characteristics of 12 subcategories (e.g., short stay, long stay, rehab, etc.) in order to help optimize throughput.

Dr. Halter noted that in the private sector, subacute care is a major growth area and that it occupies a major portion of the Ann Arbor VA NHCU mission. He inquired as to how it fit in with increasing throughput, as well as the "Cultural Transformation" toward a less institutional environment? Dr. Burris responded that at any point in time approximately 70% of patients in VA NHCU are in for Long Term Care, and that the 30% in for short care have a great deal of turnover. Therefore approximately 70% of unique patients treated in Extended Care are for Restorative and Rehabilitative purposes so it has always been an important part of the mission to ensure efficient throughput. Dr. Halter noted that the subacute mission has also been justified on the basis of cost considerations because space costs for hospital-based Long Term Care is expensive, as opposed to freestanding Long Term Care. The advantages of moving patients out of acute care and into a still intensive but less so environment is justifiable. It is also more difficult to rationalize long term care in a hospital-based setting when that care is less intensive

Dr. Abrass asked how transitional or subacute care fits in with the concept of Cultural Transformation. He also noted that GGAC has received communications from VA staff that, while acknowledging the meritorious goals and values of Cultural Transformation, questioned the way in which it was being imposed and its consistency with demonstrated subacute practices. Dr. Burris responded that this is why he had assigned Dr. Hojlo to the FIX Initiative, because there is this perceived disconnect. To both effectively address throughput, and to achieve Cultural Transformation, the solution is appropriate staffing. Dr. Halter thought that adequate MD FTEE is key, <u>but so is appropriate staff training</u>. Patients in long term care are as challenging as acute care patients used to be and he stressed that the Strategic Plan should also include a focus on this.

Dr. Burris then turned to the strategic planning element of integrating recent veteran dischargees into extended care. Because of the complex medical issues involved in the care OEF/OIF veterans, they are expected to have a significant impact on the VA even though their numbers are relatively small (approximately 225 polytrauma patients versus the 5.5 million veteran users and 7.5 million enrollees). There are emerging concerns of subclinical traumatic brain injury for OEF/OIF vets with growing evidence suggesting that both a single exposure and multiple exposures to blast injuries, even absent short-term effects, may have long-term cumulative effects including, but not limited to, early onset of dementia and other degenerative neurologic diseases. Furthermore, many of those injured in combination with TBI may, in time, require long term care placement. This is not unheard of; approximately 25% of VA NHCU residents are presently under the age of 65 years, and the prevalence of younger residents (particularly those under age of 45 years) is expected to increase as the numbers of World War II and Korean War veterans continue to diminish. While the number of Vietnam era veterans in long term care is also increasing, the OEF/OIF cohort is expected to have significantly different expectations and demands.

Dr. Abrass inquired how prevalent TBI is and Dr. Burris stated it is estimated that between 10-15% of OEF/OIF veterans show signs of TBI. With approximately 1.5 million soldiers deployed this raises significant concerns about future TBI care and compensation. Dr. Veith concurred, noting that a profound impact has been seen in the Seattle area. Dr. Abrass inquired whether efforts were underway to perform a longitudinal study. He noted that many of the patients, because of their relatively young age, could outlive the researchers, and as such it is essential to set up protocols and begin collecting data in a manner that will continue for years. He characterized this as an "unfortunate opportunity". Dr. Goldberg thought it was essential to get a panel of patients and agree on standardized assessment, as well as to make the details of that assessment widely available. In addition there should be banking of DNA and blood data for

possible genomic implications. Dr. Burris believes that the Offices of Public Health and of Environmental Hazards have begun registering veterans. Dr. Veith speculated that the Office of Mental Health may know more about this.

Mr. Carbonneau noted that many of the OEF/OIF veterans are resistant to Mental Health and TBI screening because of the possible implications in searching for jobs. This is particularly the case with National Guardsmen and Reservists who are not committed to careers in the military. As such, the VSOs are anticipating a needs bubble in 20-30 years. Another concern about the younger population of veterans is that like the Vietnam era veterans many of them do not have formal marriages to spouses, to a greater degree than was seen in World War II and Korea era veterans anyway. Dr. Halter observed that while there may not be formal marriages they do have partners that are just as involved, however this does raise ethical and legal issues. Dr. Goldberg noted that this is also an emerging concern for the increasing number of AIDS survivors thanks to the wider variety and efficacy of retroviral treatments. He predicted that soon there will be overlays of typical geriatric diseases on top of the lifetime diagnoses of HIV.

Another element of the Strategic Plan is Dr. Hojlo's program of unannounced Nursing Home Care Unit surveys. Six have already been completed and it is hoped that each NHCU will undergo such a visit on an annual basis. This is being done through contracted company for approximately $8 million per year. Dr. Fulmer inquired about the criteria employed for the unannounced surveys, to which Dr. Burris responded that there were 156 standards largely drawn from CMS. He noted that approximately one third of the long term care in VA is in NHCUs, about half is in State Veterans Homes, and the remaining 15% is in contract nursing homes. Dr. Koren asked whether the unannounced survey processes for VA NHCU would be extended to the State Veterans Homes as well. There are no plans for this currently, although it is under consideration. At present, each State Veterans Home has a "Clinic of Jurisdiction", which is usually a nearby VA that is responsible for its inspections. Some VAs have several State Homes; most VAs have none. This means that the inspection teams conduct only a few annual inspections and consistency is difficult to attain. Some homes are surveyed by their state, yet only 40% are CMS certified. Dr. Koren inquired whether the surveys used the same 156 standards as CMS, and the answer was yes. Dr. Koren then asked whether a subcontract with CMS was a possibility, and Dr. Burris responded that this was one of the potential approaches under consideration.

Dr. Halter stated that palliative care needs attention both in terms of a treatment modality and in terms of training needs. Dr. Burris noted that for several years Palliative Care Consult Teams have been required at each VA and that there is a full-time MD and a full-time RN assigned to palliative care in VACO. A number of training sessions have been offered nationally, counseling is provided, and each VISN is required to have Hospice Veteran Partnerships with community agencies in order to facilitate awareness, education, and provision of care between community and VA providers. Part of the Performance Measure for Non-Institutional Care now includes numbers of veterans receiving Hospice Care in the community. The target of this Performance Measure is an Average Daily Census of 15 for each VISN and compliance ranges from ADCs as high as 60 to as low as no workload.

The Dementia Steering Committee is a major effort under the Dementia Care element of the LTC Strategic Plan. One year ago co-Chairs Susan Cooley and Sanjay Asthana (GRECC Director, Madison) brought together a group of representatives from different program offices (e.g., DUSHOM, Mental Health, GEC, Social Work, Nursing, Primary Care, Neurology, etc.) as the "VHA Dementia Steering Committee". The committee in turn selected three workgroups to consider issues regarding the current status, and projected needs, of veterans with dementia. The three individual workgroups will shortly submit their reports to the Steering Committee, who will then furnish their report in January. The report is expected to inform the discussions at the upcoming SOTA conference; as well as to be presented to the National Leadership Board in the spring.

Another priority of the LTC Strategic Plan includes increasing access to Non-Institutional Care.

Dr. Burris noted that this has been a Performance Measure for a number of years, and that the measure has been successful in driving growth for NIC programs. Nevertheless, the growth has been slower than needed based on the projections of the Crossroads Report. The current capacity is an Average Daily Census of about 30,000; the 2011 target, which includes approximately 50,000 Care Coordination Home Tele-health figures, is 110,000. As such this spring the DUSHOM, Mr. Feeley, requested that the Office of GEC work backwards from the 2011 target to inform the targets of the intervening years. These new targets are still being approved, but it is expected that they will be significantly higher than the previous targets for 2008, 2009, and 2010. The 2009 budget already includes additional support for this.

Dr. Halter raised the issue of geriatric workforce. He recommended that the Strategic Plan give serious thought to recommendations that will ensure an adequate workforce, both physician and Allied Health. He inquired whether there was VA representation on the current Institute of Medicine Working Group on Planning for an Aging Society. Dr. Shay noted that Marie Bernard, ACOS/EC at Oklahoma City, is on that committee. He also noted it is Chaired by Dr. Rowe, who had Chaired the Crossroads Report.

GEC Strategic Plan: Dr. Burris went on to note that the current Strategic Plan for the Office of Geriatrics and Extended Care (as opposed to the LTC Strategic Plan mentioned above) reflects the priorities and the intentions of the Crossroads Report and the Millennium Act of 1999. Being a decade out from that last large-scale strategic planning effort a new GEC Strategic Plan needs to be prepared, and therefore a detailed assessment of the current environment, demands, resources, and expectations needs to be undertaken. As such, planning is underway for a State Of The Art (SOTA) Conference, scheduled for March 25-27, in either Washington, DC or Baltimore. The conference is being planned by a group of field representatives from both within and outside of VA, with both clinical and non-clinical expertise. Program staff are deliberately not involved in this in order to bring a fresh perspective to the issues. The GEC Strategic Plan is not the anticipated outcome of the conference, but concepts and ideas developed through the conference are expected to inform it. Ideally the new GEC Strategic Plan will serve as a guide for the new Departmental leadership that is expected to be seated with a new administration in the spring of 2009.

Marsha Goodwin-Beck Awardees: Dr. Burris concluded by noting that in the third cycle of the Marsha Goodwin-Beck Awards for Excellence in Geriatrics, both awardees are from GRECCs, and that this was true for the prior two cycles as well. The Leadership Award went to Ted Hahn, MD, PhD, former Director, West Los Angeles GRECC. The Award for Clinical Care Delivery went to Byron Bair, MD, MBA, former Acting Director and present Clinical Director, Salt Lake City GRECC.

Dr. Burris ended by reiterating his gratitude to the GGAC membership for their sustained and important contributions to VA and to aging veterans.

Dr. Kenneth Shay, Director, Geriatric Programs, VACO Office of G&EC
FY 2007 GRECC Performance: Dr. Shay noted that in 1999 GRECC research expenditures were approximately $50 million and that by 2006 they had grown to over $108 million. During that period of time GRECCs accounted for 8-10% of total VA research expenditures. However, as he has described before, there are problems with pinning down actual figures because of the different ways GRECCs and the Research Office report research expenditures. Despite repeated requests over the last few years by the Office of GEC and others, the Office of Research and Development has not issued formal guidelines as to which competitive research grant expenditures should be reported through the "PROMISE" system. At some VAs all of the research undertaken by VA personnel, whether at the affiliate or at the VA, is managed by the R&D Committee, at others this is not the case. As such, some GRECCs report all the research activity of their staff, whereas others are limited to the research conducted only at the VA. Nevertheless, the Office of GEC has requested that the GRECCs report all of their research activity into the GRECC Electronic Database, and this is why there is a difference between what

is attributed to the GRECCs by the Office of Research and Development and by the Office of GEC. This is of particular importance to VA research allocations through the VERA model because distribution of that allocation is based on the RDIS/PROMISE system.

Dr. Shay went on to note that publications by the GRECC were at an all-time high, exceeding 1100 publications, including over 1000 peer-reviewed articles.

The direct operating costs for the GRECCs have plateaued slightly, decreasing in FY06 compared to FY05. Total operating costs are approximately $37 million per year. In order to compare the operating costs of the GRECCs with the resources they bring to their host VISNs through the VERA allocation system, the total research expenditures for each GRECC are adjusted according the source of those expenditures, as follows:

1. The three categories of research expenditures recognized by VERA are: VA research funding; other federal research funding; and private/foundation research funding.
2. For the VERA formula, each VA research dollar is counted at 1:1; other federal and state research funding (e.g., university funding) is counted at 0.75:1; and foundation/industry funding is counted at 0.25:1.
3. The sum of these figures represents a “discounted total” for each GRECC.
4. A "discounted total" for **all** VA research funding is summed for each VISN every fiscal year, and then summed for all of VHA.
5. That total figure is divided into the Congressional Appropriation for VA research, which is approximately $400 million. The ratio serves as a multiplier for distributing VERA dollars (equal to the figure of Congressional Research Allocation) among the VISNs, proportional to each VISN’s “discounted total”.

When this is done for all the GRECCs, in 2002, 2003, and 2004 the VERA allocation for the GRECCs was greater than the operating costs of the GRECCs, even though individual GRECCs might bring less in VERA allocation to their host VISNs. In FY06, the costs and the research appropriations were approximately equal. However, GRECCs contribute more than just their VERA research allocation to their host VISNs. They offer educational input, they contribute administrative expertise and support, and they perform clinical activities. For the last few years Dr. Shay has assigned a dollar value to the clinical contribution of GRECCs by summing up the amount of time their staff report as clinical care. This is approximately 40 to 50 FTEE per year, and by using the average salary of GRECC employees this is how he assigns a cash value to these activities. While it is a very conservative figure, when it is subtracted from the operating costs of each GRECC the balance between the operating costs of the GRECCs and the total VERA allocation demonstrates that, systemwide, the GRECCs actually return more to their host networks then they cost in operating expenses. Furthermore, this does not even account for the cash value of the education and the administrative contributions.

Dr. Damron-Rodriguez thought that future reports should also show the number of GRECC trainees (dozens/hundreds?) and their clinical contributions. Dr. Halter stressed that there could be a cash value associated with their time. He also felt that, with the increased sophistication of the RVU system VA uses for reporting, an alternative to the FTEE is possible; one that would better reflect the higher value of the (mostly physician) clinical contributions of the GRECC.

Dr. Shay noted that the GRECC Directors have suggested that the annual calculation of "benefit versus costs" should receive less emphasis in the future, inasmuch as the exercise was originally undertaken in order to establish that the GRECCs represent net value-added to VA. Having established that, it seems more valid to answer the question "what have you done for me lately". Therefore the GRECC Directors recommended emphasizing non-cash contributions such as education of staff, introduction of new clinical programs, etc.

GGAC was concerned by the continuing discrepancy between RDIS and GRECC data. Dr. Shay noted that the discrepancy affects not only GRECC, but all research entities. While he agreed

that the Office of Research and Development needs to clearly articulate the criteria for expenditures reported through PROMISE, until that time, in order to optimize the credit that GRECCs receive for their research efforts, he instructs the GRECCs to have their research protocols managed by their local VA R&D Committees whenever possible.

GRECC Vacancies: Dr. Shay noted that vacancies of GRECC Core Staff positions continue to grow in number as well as in duration, although the absolute number seems to have stabilized somewhat. Mr. Feeley was provided with the previous year's vacancy data last December, and since then quarterly updates have been sent to his office. With little or no progress on the vacancy issue GEC's intention is to reengage Mr. Feeley about it. GGAC felt that it would be useful to differentiate between the longest standing vacancies and the more recent ones because the ones that have been vacant for multiple years might skew the data so that, in fact, the vacancy rate overall may not be so serious. Dr. Shay agreed that this was a possibility and will reanalyze the data with that suggestion in mind. It was also suggested that the vacancies be differentiated between those positions that are open because recruitment has not been authorized versus those that were not finding successful candidates. Again, Dr. Shay offered to make that distinction in subsequent presentations of these data.

FY07 GRECC Performance Monitors: Dr. Shay felt the new FY07 GRECC Performance Monitors were relatively successful. In December 2006 all VISNs were required to develop Memoranda Of Understanding with their GRECCs to establish education and clinical program expectations. All VISNs complied with this requirement although feedback from some GRECCs indicates that not all VISNs fulfilled their stated obligations. Nevertheless, this is an important first step, and the Performance Monitors for 2008 are more focused, requiring the VISNs to further outline support mechanisms in order to foster a greater degree of compliance. The 2008 Performance Monitors also included an index of vacancies in order to further compel addressing this concern.

AGCG: Dr. Shay next reviewed the ongoing concerns between GRECCs and ORD. For the past two grant cycles an inadequate number of proposals have been assigned to the Aging and Clinical Geriatrics (AGCG) Merit Review Subcommittee, and this will most likely be the result of the cycle that ended last week as well. Because of this, a subset of GRECC Directors, Research Directors, and Clinic Directors met several times during the summer and worked out a Purview Statement that could be used as a basis for assigning proposals. They communicated this to ORD because for several years ORD had been unable to provide such a statement themselves. ORD acknowledged the utility of the Purview Statement, but declined to acknowledge that they would accept it.

An offer was made by Dr. Francis (Deputy CRADO) during the summer to allow GRECC Directors to participate in the assignment of proposals. Although several GRECC Directors indicated their interest and willingness to do this, the ORD Aging Portfolio Manager has not allowed this.

Given the pattern of assignment of proposals targeting the AGCG by their PIs to non-aging subcommittees, adequate "aging expertise" needs to be accessible to the other review subcommittees in order to provide fair reviews. But attempts to ascertain the "aging expertise" of Merit Review Subcommittees have been unsuccessful. The same group that crafted the Purview Statement also articulated criteria for judging "aging expertise" because, again, although there were repeated requests, a written description of this was lacking from ORD. For several years, Dr. Cooley and other representatives of Aging Research have provided lists of recognized "aging experts" to ORD, but ORD has been unwilling to share who on those lists have been involved in the review process.

Currently, a plan is in place for representatives of the "Blue Ribbon Panel" to meet with representatives of ORD at some time in the fall to discuss these issues in order to seek some level of common understanding. Dr. Halter noted that ORD's reception of these different entreaties was a very strong departure from the way that the National Institutes of Health handles

their business. Specifically, NIH seeks to be "customer focused". It allows investigators to specify the subcommittee that they feel is best qualified to review their work. ORD neither requests this nor, in the case of Aging Research, honors the request. Dr. Halter acknowledged that ORD should have the final word in assigning grants for review, yet who would know better than an investigator which group is most suitable for reviewing his or her proposal? Dr. Fulmer suggested that when GGAC meets with the Office of Research that there be a very clear and consistent message that those deemed to have subject matter expertise are in the best position to assist ORD in addressing these concerns. Dr. Abrass speculated that it might be too late for the latest set of proposals to benefit from such discussions, yet he agreed it was important to set the groundwork. He also felt it would be important to clarify the issue of the RDIS reporting.

Dr. Susan Cooley, Chief, Geriatric Research and Evaluation, Chief, Dementia Initiatives, VACO Office of G&EC

Dementia Initiatives on Staff Education: Dr. Cooley described the Dementia Training Materials Review that had recently been completed. From the results of a web-based survey for VA educators, a workgroup developed an annotated list of reviewed materials and then undertook a gap/needs analysis with recommendations for development of additional materials. A report was submitted to GEC and EES, and further dissemination actions are pending. Another staff education initiative resulted in a May 2007 satellite broadcast concerning the recognition and management of dementia in Adult Day Health Care.

Dementia Initiatives on Clinical Issues and Quality Improvement: Dr. Cooley oversaw a Dementia Safety Workgroup that looked into the issues surrounding driving automobiles and access to firearms among veterans with dementia. The workgroup developed a web-based template for VISNs to voluntarily submit an Annual Report of their activities on these topics. They also developed a Frequently Asked Questions document concerning the legal and ethical issues of driving and access to firearms among veterans with dementia. Last, the workgroup is almost finished with their report to the DUSHOM.

Dementia Initiatives on Care Coordination: Dr. Cooley next presented on the VHA Dementia Steering Committee (SC), a major new effort for FY07. The SC is intended to be a proactive coordinator of multiple projects that will synthesize the available information on key issues, and make recommendations on key elements, for comprehensive, coordinated dementia care. Recommendations will include policy, education/training, and research needs. Twelve VHACO offices (GEC, CCHT, OMH, Primary Care, Neurology, Nursing, Social Work, Pharmacy, ORD, EES, Ethics, and DUSHOM) plus the Indian Health Service and the National Institute on Aging are part of this group. Dr. Asthana of the Madison GRECC co-chairs the committee with Dr. Cooley. The Steering Committee convened for the first time in December 2006 and by early 2007 they had created three workgroups, from over 230 nominations of field and program personnel, to deal with dementia issues in regards to Clinical Care, Care Coordination, and Administrative Issues. A baseline survey of current dementia practices was conducted, although feedback to the field is still pending. Workgroup reports to the Steering Committee are due by October 2007; and the Steering Committee itself plans to issue a report in January 2008. The Dementia Steering Committee's recommendations are expected to inform the SOTA as well as be presented to the NLB in April 2008. Further dissemination of the information is planned for the spring or summer of 2008.

GGAC Feedback: Dr. Salerno inquired whether caregiver recommendations would be included in the DSC recommendations. Dr. Cooley responded yes. She also noted that Congress recently awarded several millions of dollars to VHA for a number of caregiver support pilot projects, which will be administered through the Office of Social Work. One of these pilot projects will focus on dementia caregivers. Dr. Salerno requested that the particular projects, titles, and principal investigators be made available, and Dr. Shay promised to circulate that to GGAC membership.

Dr. Koren noted that AHRQ was not on the list of participants that Dr. Cooley had provided. Dr.

Cooley noted that there were multiple organizations involved, although not this particular one. Dr. Dolan noted that she didn't see dentistry represented and reminded the group how important it is to include this profession in such deliberations. Dr. Abeles inquired whether staffing for dementia care would be considered. Dr. Cooley responded yes, that staffing/workforce issues was one of the topics that the Administrative Issues Workgroup examined. She noted that one recommendation may be for a future Workgroup to look at this issue in greater detail because of its far-reaching budgetary implications.

Dr. Christa Hojlo, Director, Nursing Home Care, VACO Office of G&EC

State Veterans Homes: Dr. Christa Hojlo noted that there are currently 129 state veterans homes in 48 states and Puerto Rico. Individual SVHs vary from 30 to 800 beds, with a total of 29,542 beds throughout the system. There are 54 Doms among the state Veteran homes, as well as a smaller number of State veterans hospitals, and a very small number of Adult Day Health Care programs. She characterized the SVH program as a "grant program" because once a state is approved for a new SVH the VA picks up 75% of the construction costs. In addition, a per diem, that changes annually, is paid for veterans occupying the home.

Although the admission criteria vary somewhat by state, patients are generally light care, although some SVH offer skilled nursing. Many do no dementia care and this means that the per diem costs for SVH are significantly less than for VA NHCU.

Dr. Hojlo noted that the SVH are owned and operated by their host state, although VA does conduct annual inspections. While there are concerns over potential conflicts of interest with regards to the inspections, as well as the skill level of the surveys, the inspections have exposed some serious quality of care issues, frequently concerning privacy and security. Just in the past year there have been several instances in which the per diem payment has been threatened, which is a very serious consideration and usually results in dramatic improvement.

Because of concerns over the survey process there is consideration for restructuring it. At present, surveying the SVHs is a collateral activity for the assigned personnel and the surveyors have varying levels of experience. Some of them act much like JCAHO reviewers; others approach the issues differently. Some surveyors examine only a single home on an annual basis; whereas others look at multiple homes on a more frequent basis. Standards are well-known but the application of them is variable. A major change occurred two years ago when handheld computers, containing the standards, were issued to surveyors.

Dr. Koren inquired whether SVHs record MDS/RAI. Dr. Hojlo responded that they have been required to do so since 2000 but some are still are not doing it electronically, a measure that will be required in new regulations. CMS allows for Quality Indicator comparisons, but with only 40% of VA SVHs CMS certified, a national SVH comparison is not practical.

Dr. Halter inquired how the costs of SVH are met. Dr. Hojlo responded that the VA per diem is based on Congressional Authorization and Appropriation, and cannot exceed 50% of the total cost. For 2007, the maximum per diem is $67.71 per day and the average per diem is $61.13, which is very close to CMS skilled rates. By way of contrast, the Contract Nursing Home (CNH) program has an average per diem of $236 to the SVH program's per diem of $209 (this includes what the VA and the individual states pay). Dr. Hojlo noted that because of the deficiencies identified by the inspections she mentioned earlier, some SVH have had to pay fines as high as $10,000 per day, for months at a time, until the infrastructural changes were addressed. Certainly these are resources better spent on staffing. As such Dr. Hojlo is requesting the minimum Nurse Staff Ratio (NSR) be raised to 3.9 because she believes the current minimum ratio of 2.5 in SVHs is inadequate.

Dr. Halter noted that since SVHs are required to meet state regulations, was it necessary that they also be surveyed by the VA? He speculated that double surveying was inefficient. Dr. Hojlo noted that only 40% are in fact surveyed by Medicaid or Medicare, so it is possible that the other

60% receive their only inspection through VA. The VA plans to continue inspecting all SVHs, although the way the VA conducts the inspections may change. Dr. Abrass noted that this was similar to contract nursing homes, where some are accredited by JCAHO and others are not.

Dr. Hojlo speculated on future plans for this program. She noted that the growth of the program has resulted in increasing levels of support through VACO. Life safety measures have become very prominent, and impending legislation will require VA to pay full cost of care (not just the per diem of $67.71) for veterans who are over 70% service-connected. Additional funding has been proposed explicitly for nurse recruitment and retention in State Homes. She noted that VA has recently adopted a new design guide based on principles of Cultural Transformation, so the new designs coming on line should reflect more contemporary ideology, e.g., shorter corridors, nursing stations that are not enclosed, etc. Several proposed SVH are even considering the "Greenhouse" model of small, connected, and separated "houses"; but there are some architectural concerns where new SVHs are co-located with a VAMC.

Dr. Halter pointed out that SVH employees are state employees and face different pay scales. This could make recruitment and retention difficult where federal salaries are somewhat higher. Dr. Veith inquired what were the incentives offered to state employees in that event? Dr. Hojlo responded that while there is some anecdotal evidence for this there is not enough solid evidence to necessitate a policy change. Mr. Carbonneau inquired whether, when SVHs and VAMCs are co-located, if VA was the more desired employer, and Dr. Hojlo affirmed they were.

Cultural Transformation: Dr. Halter noted that Cultural Transformation made great sense for LTC; and therefore for SVH programs, but VA NHCUs are more often associated with acute care hospitals and how did that fit? Dr. Hojlo's response was that the ultimate intention of subacute care was a return to home and community. As such, it made little sense to wait until the last day of stay to carry forward the message of recovery. If patients are compelled to make independent choices, like dressing in street clothes or engaging in rehabilitative activities more frequently than just when reporting to PT, this reinforces the intent to recover.

Dr. Fulmer suggested that many state regulations for nursing home care might be in conflict with some of the changes that Dr. Hojlo had in mind, but Dr. Hojlo disagreed and said that these trends were changing. Dr. Damron-Rodriguez asked whether there was an evidence basis for undertaking Cultural Transformation, and Dr. Halter asked about an evidence basis for it to be applied to subacute patients. Dr. Koren answered that if people are treated as if they are sick they behave in a sick manner, and she concurred with the need to focus on transitions.

Dr. Hojlo continued by pointing out that rehabilitation provides an excellent example. If a patient undergoes half an hour of rehabilitation per day then a single refusal to participate in therapy results in a full day without it, as opposed to an entire environment that, from the first day of admission on, has a consistent message of getting the patient ready to go home. She noted that four VISNs are making very large changes to bring about Cultural Transformation, and this is the appropriate way to go about it, whereas facilities that medicate patients in order to make them more compliant for bathing are "crazy".

Dr. Fulmer asked if patients insist that they don't want a bath, doesn't it represent assault to compel them to do so? Dr. Hojlo responded that this was correct, but the solution was not to force the patient but rather to negotiate. She noted that the many successes currently taking place in VA NHCUs have convinced her that this is the correct way to proceed.

Another change encouraged by Cultural Transformation is work schedules that rotate around resident circadian rhythms rather than an arbitrary schedule. Dr. Fulmer inquired how staffing worked, knowing that evening staffing is traditionally less robust than morning staffing. Dr. Hojlo's response was to ask why three shifts made the most sense? Maybe 24 shifts would make better sense. For instance, she noted that falls are most frequent around sundown; maybe it makes sense to have higher staffing then, in order to avoid these injuries. Dr. Koren stated there is

evidence based data regarding bathing time and that the interventions Dr. Hojlo was describing made sense, particularly as a means for employing behavioral rather than pharmacotherapeutic means to get desired results.

Dr. Della Penna inquired how Dr. Hojlo would be measuring the impact of Cultural Transformation. Dr. Hojlo responded that the outcomes are as varied as the processes examined, but some positive trends in staffing include reduction in numbers of callouts, over time, and OWCP. There are also encouraging clinical outcomes seen in MDS, restraint use, etc. Family, staff, and resident satisfaction are closely monitored, and the four VISNs that are embracing Cultural Transformation have hired paid consultants to identify opportunities for patient centered care.

Unannounced Site Visits: Dr. Dolan asked to hear more about the unannounced site visits. Dr. Hojlo noted that historically the VA has looked to JCAHO for its surveys, but JCAHO has much more expertise with inpatient hospital care than nursing homes. So she advocated hiring an outside contractor with expertise in CMS processes, and having those processes applied to JCAHO standards. For the last two years she has done the unannounced site visits herself, but she is now at the point of turning it over to a suitable contractor. During the inspection, if there is a negative finding then the standard is cited along with the scope and severity of the issue. A new quality monitor she introduced requires 95% of all VA NHCUs to have either no deficiencies or only deficiencies "in the lower part of the grid". If a facility underperforms it will continue to be scrutinized carefully.

Dr. Veith inquired whether training was being offered to NHCUs so they could become more adept and prepared for unannounced surveys? Dr. Hojlo responded that a standardized outcome was difficult to achieve, particularly in light of the variety of care models available. What she wants to see is changes in environment of care, care practices, family and community, leadership, work place practice, and outcomes. Dr. Veith asked if there were any particular best practices, to which Dr. Hojlo responded there is a long list of these and she is putting them together in a scoring grid. Included among them are palatable food, bathing, nutrition, hydration, undisturbed sleep, etc. She noted that at lunch and dinner, nursing staff alone are unable to provide all the attention that is required. As such, all staff should be involved.

Dr. Tom Edes, Director, Home and Community Based Care Programs

Geriatric Workforce: Tom Edes, Director of Home and Community Based Care Programs, spoke to the group about the geriatric health care workforce. He noted that shortfalls were experienced not just in MDs, but in many other disciplines. Fewer medical students are pursuing careers in geriatrics and while there are increased numbers of geriatric fellowship positions, there is a decrease in the rate of filling them, with the number of new geriatric fellows hovering below 200. There were recent threats to the Title VII funds for HHS-supported geriatric training, and although they were reinstated, its potential demise was a very ominous sign. Currently there are 600 US medical school faculty with training in geriatrics and by some estimates this is less than half what there should be. Also, there has been a decrease in the numbers of Associate Chiefs of Staff/Extended Care within VA, along with very few VISN leadership positions for geriatrics. And this is all after the 2006 White House Conference On Aging recommended efforts to increase the numbers of health providers with expertise in geriatrics, and the need for training programs for those individuals, as two of its top ten resolutions. Dr. Dolan noted that he had not included data on Mental Health and Dental professionals in his presentation; Dr. Edes concurred that these were also critical needs.

In light of all of the above, Tom thought it was important for VA to increase the number of geriatricians by 30% in a short time frame, e.g. 3 years. The focus on MDs is not to minimize the importance of other health disciplines, but rather to acknowledge that physicians in leadership positions are in the best position to direct resources toward Allied Health education, recruitment, and retention. Dr. Abrass speculated that, given the current number of geriatricians in VA (approximately 500), this was not an insurmountable goal, particularly if some of the prevalent

barriers, such as employment exemptions for certain classes of visas, could be addressed.

Dr. Edes would like to see an Executive Council made up of VA and non-VA leaders and policymakers address VA Geriatric workforce, and answerable to this Council would be a series of workgroups, e.g., marketing and finance, education, community outreach, recruitment and retention. Each of these workgroups in turn would consist of internal and external experts looking at potential interventions and the environment. They would make their recommendations to the Executive Council, which, peopled as it is by higher level policymakers, would be in the best position to address issues such as faculty growth, loan forgiveness, mid-career training, incentives for training, etc.

It was thought that there needs to be compelling evidence of the negative impact an inadequate number of geriatricians has on the quality of care, costs, and outcomes. GGAC members pointed out that management of delirium, palliative care, Acute Care for the elderly, falls reduction, PACE, etc. were all made possible, and had demonstrated positive outcomes, owing to geriatrician input. Dr. Abrass noted that falls clinics have had a demonstrably positive impact, much as CHF and endocrine clinics have. When Dr. Veith added that screening alone for depression is inadequate and management of it is necessary; Dr. Salerno concurred and noted that geriatrics is the same, that without follow-up the recommendations alone show no positive impact.

Mr. Carbonneau suggested a feeder program early in young people's careers to track college-age students that enter into geriatrics. Dr. Veith countered that "medical students are smart" and that they go into fields that will afford them good incomes and lifestyle. Dr. Salerno noted that even Internal Medicine is having difficulty getting domestic graduates. Trainees are the backbone of the workforce, and a declining number of them are choosing to go into Primary Care specialties. Dr. Abrass noted that the number of fellows that are US graduates has been consistent, at approximately 75 a year. As such, most increases are from international graduates. If there could be exemptions for those with J-1 Visas so that after their fellowship they were not required to work in a shortage area, or if VAMCs could be identified as shortage areas, this would largely address the issue. Dr. Halter inquired of Dr. Edes as to how GGAC might be able to help? What is a possible timeline? Does there need to be broader support across VA leadership? Is Congressional action required?

Dr. Edes said that support above the VA was crucial. There were other groups that needed to be convinced of the impact, and this impact needed to be demonstrable. He speculated that joining forces with other program areas might be one approach, although that may make it difficult to maintain the focus on physicians. Dr. Koren thought that misdiagnosis anecdotes due to the absence of geriatricians from the Morbidity and Mortality conferences could be very compelling. Dr. Edes asked the GGAC to speculate on potential collaborators from outside the VA that would be supportive. Dr. Fulmer suggested that support from the IOM Committee on Health Care for Aging Population would be essential. Dr. Edes next asked the group whether they were comfortable with the proposed focus on physicians. Dr. Fulmer expressed her support for it because it is an undeniable fact that physician leadership in the current health care system is essential to affect the sort of changes described. She noted that once the physician question was resolved there are other groups that can expand the initiative into the interdisciplinary realm. Dr. Damron-Rodriguez urged Dr. Edes to "focus on the needs of aging veterans" because this would pull in other groups as well as reinforce the need for greater physician support. Dr. Della Penna suggested that if this initiative was successful it would provide a roadmap for using available knowledge to improve mentoring and coaching. Dr. Edes agreed, pointing out that this would be key to retention. Dr. Koren inquired whether there were opportunities for VA geriatricians that were not typically available private sector physicians, e.g., running a Nursing Home, working on a team, or redefining productivity. Dr. Veith suggested that Drs. Shay and Edes look at the "IMPACT“ model in which depression is managed through a care manager and where a virtual team serves a larger group of patients. “IMPACT” has been deployed nationally by the Office of Mental Health and perhaps it could apply itself to geriatric questions as well. As a closing comment, Dr. Halter suggested devoting some of the spring meeting to creating a "frail friendly

system" by way of envisioning additional support for this discussion.

GRECC Site Visits

New England: This two site GRECC was surveyed in spring 2007. One of the major recommendations was that the new AD/C, Dr. Nelson, was in need of a specific curriculum and mentoring to bring her skill level, and the appropriate mix of her time allocation, into line with other AD/C. Another recommendation was for the site to hire additional clerical support in order to help track the whereabouts of GRECC core personnel as they travel between different elements of the program.

Little Rock: Also visited in the spring, this program was found to be a strong one, although its interactions with the Department of Geriatric Medicine seem somewhat non-ideal. In addition, the GRECC's commitment to clinical demonstrations has removed it almost entirely from the visibility of the other clinical geriatric programs at the host VAMC. It was suggested that greater involvement by the fellows and other trainees in clinical demonstration programs would help to address both of these concerns.

Miami: Visited in late winter. There were no substantial recommendations flowing from that site visit.

Baltimore: Also visited in late winter, the major concern there was that an "aging paradigm" was not apparent in much of their research. Almost none of their investigations are reported in aging journals. The program was encouraged to make a concerted effort to share its information with the aging community, even if it meant doing some limited publication in non-peer-reviewed journals.

Cleveland: The Site visit to Cleveland is scheduled after the GGAC meeting, but Dr. Abrass briefly reviewed some of the complexities involving the affiliate, Case Western Reserve Medical School. While Case University Hospital is the VA affiliate, the dominant geriatrics program for the area is at Metro Hospital, and then there is the Cleveland Clinic Foundation, an independent entity. There have been attempts to establish geriatric ties through the university, but because of dynamics that have nothing to do with geriatrics, this is proving difficult. The school experiences considerable debt. Recently a Director for the Center on Aging was recruited, but this person has a limited academic background. Dr. Fulmer noted that there is great strength in geriatric nursing at Case and wondered whether the requirement that a GRECC Director be a physician could be relaxed. Dr. Halter wondered if there were other sites within VISN 10 that might be more suitable for a GRECC, but discussion demonstrated that, while there might be other suitable affiliates (University of Cincinnati, Ohio State University, etc.) the proximate VAMCs did not have the necessary corresponding strengths.

Follow-ups from 2006 Site visits: Madison's response essentially ignored the recommendation for filling positions long vacant. The GGAC responded by saying this was not optional and that immediate attention was required. A similar pattern is emerging in communications with San Antonio. In this case points of contention regard both recruitment of an AD/C and provision of adequate space for the Education program. On both of these issues unambiguous GGAC recommendations have been sidestepped and delayed. Dr. Abrass will continue to communicate with the sites and their host VISNs, and will report back at the next GGAC meeting.

Geriatric Primary Care

ACOVE Measures: Six of the ACOVE (Assessing Care Of Vulnerable Elderly) Quality Indicators developed by UCLA and Rand are being adopted by the VA. The six indicators are: urinary incontinence screening, urinary incontinence history, falls screening, falls history, functional assessment, and advance care planning. The Office of Quality and Performance currently tracks them as "Supporting Indicators", but a specific performance level is not required. However, such indicators have a pattern of being elevated to Performance Measures in time, and therefore merely tracking them tends to enhance their performance. Compelling Primary Care Providers to

focus on these indicators is expected to provide opportunities for GRECCs to offer needed training on them. At the same time, there continues to be significant demand for people with training in geriatrics.

Geriatric Evaluation: The Millennium Act specified “geriatric evaluation” as one of the required services that VA must provide to all eligible veterans. A May 2006 OIG Report noted that VA does not track geriatric evaluation and recommended it identify a metric for doing so. As such, a new secondary “HCPCS" code was added to outpatient care in February, and inpatient care in April, to track instances of assessment and care planning of the S0250 "Geriatric Evaluation" code. One of the requirements is that physicians on the interdisciplinary team must have training in geriatrics; or if such a trained individual is not present, then a nurse practitioner or physician assistant with advanced training in geriatrics can substitute. To some degree this should increase the demand for people with these skills in VA.

Discussion followed regarding the wisdom of initiating requirements to build staff in geriatrics when so few people are pursuing it as a discipline. Dr. Abrass offered the opinion that it was very important to compel Primary Care to think more about geriatrics, and Dr. Shay pointed out that this was the purpose of the Supporting Indicators. Dr. Halter thought that establishing need through the Performance Measures was probably an effective undertaking. In time, when the baseline is reached, then the threshold could be raised to bring about more intense evaluation. He acknowledged that not every veteran needs a specialist, but every care site should have access to such expertise. Dr. Fulmer noted that Marie Bernard is on the IOM workforce and it is important to make sure that she is informed about the geriatrician staffing situation within VA.

Dr. Koren noted that discussions of recruitment needed to also discuss retention as well. She asked what is being done about that.

Dr. Bradley Karlin, Director of Gero-Psychology and Director of Psychological Treatment for VACO Office of Mental Health

Office of Mental Health Strategic Plan: Bradley Karlin, PhD addressed the group on behalf of Dr. Ira Katz, Deputy Chief Patient Care Service Officer for Mental Health, who was unable to attend. He noted that in 2005 the OMH began implementing their Strategic Plan, which among the 265 recommendations included: the “integration of Mental Health into both Primary Care and Geriatrics”; a focus on “Recovery and Rehabilitation” for the seriously mentally ill; and implementation of “Evidence-Based Care”. All recommendations have “equal urgency” and the approach is considered to be transformative, which is what was required by the "New Freedom Commission" that was charged by the President to report on Mental Health across the country. As a result, Congress has directed a generous line item (approximately $2 billion) explicitly for Mental Health initiatives. In addition, the growing focus on the needs of OEF/OIF veterans has allowed for additional funds as well as programmatic expansion into this area.

Dr. Karlin noted that much of the focus is on Primary Care, and to the extent that most of the care for older veterans occurs in Primary Care, that population would benefit from this. He also noted VA Mental Health expenditures have a broad peak in the 45-64 age group.

The concept of "equal urgency" considers Inpatient Care, Acute Care, and Primary Care all to be of equal importance. It also focuses on increasing access to substance abuse disorder treatment and chemical management; Mental Health’s capacity in Community Based Outpatient Clinics (CBOCs); the use of new technology (e.g., telemental health); and services for the homeless.

Dr. Karlin feels the “integration of Mental Health into Primary Care and Geriatrics” is embodied by the recent funding of co-located and collaborative Mental Health Teams in over a hundred sites. 119 Home Based Primary Care programs will each receive their own dedicated Mental Health Provider (mostly a Psychologist) in a program developed in collaboration with Dr. Edes. This is a very exciting development. Dr. Fulmer inquired whether the personnel were being redeployed from other areas, and Dr. Karlin responded that these were in fact new hires since 2005. A total

of 4300 new positions in Mental Health have been created since 2005, of which 3600 have been filled.

Dr. Fulmer inquired how Mental Health was able to get qualified people in the midst of what is essentially a workforce shortage. Besides competitive salaries for Mental Health Providers, education debt reduction was also an incentive, and Dr. Karlin noted that much of the increased workforce has come from the Department of Defense. Initially the field had reacted with some ambivalence toward the new positions because of concerns over them being funded in subsequent years. Nevertheless, that reluctance seems to have passed and now enthusiastic recruitment is going forward.

Dr. Goldberg inquired for more details regarding loan repayment as a recruiting enticement. Dr. Karlin reported that he had worked closely with Management Support and that, using OMH funding, they are able to offer up to $40,000 per hire. Dr. Goldberg next inquired how many of the Psychologists hired had received some training in VA, to which the answer was 70-75%. Dr. Abrass noted that this is often seen during GRECC site visits, particularly in Psychology. Dr. Abeles clarified that much of this is driven by licensure: Clinical Psychologists require 2000 hours in a given site and there is a strong tendency for strong bonds to grow during their training. Dr. Damron-Rodriguez felt that this offered an opportunity to demonstrate GRECC successes in terms of recruitment and retention.

In addition to the new Mental Health Teams, one NHCU per VISN is being assigned a new Mental Health Professional whose focus will largely be in: promoting Cultural Transformation; psychosocial behavior management for patients; and "team hygiene". There is a strong evidence base for favoring behavioral management over pharmacologic management of adverse behaviors.

Dr. Halter inquired how the OMH was going to judge success. Specifically, if only a single NHCU per VISN is receiving this additional staffing, how will a decision be reached that this should be disseminated more broadly? Dr. Karlin responded that these are not pilots; they are permanent staff positions. As such, the hope is that eventually all NHCUs will have this staffing in the future. In addition, MIRECCs and other evaluative resources are turning their attention to these new interventions to judge their success and/or areas for improvement.

Dr. Karlin went on to explain the increased focus on “Recovery and Rehabilitation". Each individual's maximum potential will be stressed through new Recovery Coordinator positions created at each VA Medical Center. There will also be increased staffing for the MICCM programs, with particular emphasis on rural areas, as well a psycho-education.

Initiatives to increase "Evidence Based Care” include: programming efforts in cognitive processing treatment; prolonged exposure treatment for PTSD; cognitive behavioral therapy for depression; and psychosocial rehabilitation for serious mental illness. Dr. Abeles inquired about the effectiveness of different trials, and Dr. Karlin acknowledged that while there was an evidence basis for many of these approaches, it was not true for all at present.

Dr. Karlin also spoke about suicide prevention and noted that the high prevalence of suicide in elderly males makes this very much of geriatric issue. There are now Prevention Coordinators at each VA facility, suicide hotlines, and evidence-based treatments.

Office of Mental Health Line Item: Dr. Karlin then reviewed the $2.4 billion line item to OMH ($2.6 billion is expected in 2008). Of this, approximately $983 million is devoted to Inpatient Care ($1.77 billion in 2008); $1.32 billion for Outpatient Care ($1.38 billion in 2008); and $195 million for Residential Rehabilitation ($196 million for 2008). Significantly smaller figures go to Primary Care and its subset, Home-Based Primary Care. For the Nursing Home program, an original 2007 expenditure of $400,000 will be expanded to $2.7 million in FY08, and HBPC will increase from $7 million in 2007 to $15.5 million in 2008. The Suicide Prevention Program, which was $8.3

million in 2007 will expand to $14.4 million in 2008.

Dr. Halter inquired how much of these resources were going toward elderly patients, to which Dr. Karlin responded that the data were not analyzed in that fashion. He did emphasize that a number of these programs had dominantly geriatric beneficiaries, but Dr. Fulmer noted that the high prevalence of a certain age group did not automatically equate to geriatric patient management. She inquired as to how Mental Health Professionals in VA were being prepared to deal with older patients? Dr. Karlin responded that there are ongoing discussions about training for: front-line professionals; communication; and articulation of policy. There is also required training for the new HBPC hires. National conferences have been held and others are being planned with EES. Dr. Halter acknowledged the merit of these approaches, but inquired about resources going into geropsychiatry training slots. Dr. Karlin responded that there was a significant increase in the number of training spots across the board, not just in Geriatric Mental Health areas. He also knew that there was an increased number of programs with a geriatric focus but could not offer numbers. He suggested that this information could be obtained from the Office of Academic Affiliations.

Dr. Halter inquired whether it was possible to deliberately expand numbers of trainees in Geriatric Programs. Dr. Veith responded that in the past the VA had created incentives and opportunities to expand geriatrics, and that while the present enhanced interest to expand Extended Care Professionals is a positive development, it was sad that there needed to be a war in order to gain interest again. Nevertheless, it is encouraging to see that there are increasing numbers of geropsychiatrists, although the number of geropsychologists may not be keeping up.

Dr. Karlin acknowledged this, commenting that the VA is projected to need approximately 5000-8000 geropsychologists and that presently there are only 800-1000. Dr. Koren noted there are additional benefits to more geropsychologists in addition to treating elderly clients, such as working with teams and conducting home visits. Dr. Karlin concurred, noting that this was part of the drive for incorporating Mental Health Professionals into HBPC programs. Dr. Abeles added that they were also vital for cognitive neuropsychological testing. Dr. Karlin concurred with that as well, stressing the rising importance of screening for TBI. Dr. Koren inquired about the correlation between TBI and dementia, to which Dr. Karlin responded that there was variation. While there were some characteristics shared between non-traumatic and traumatic origins for Alzheimer's disease, there also were differences. Dr. Veith clarified that there was a similar pathophysiology (amyloid plaques) and emphasized that earlier in the meeting, during Dr. Burris' presentation, the point was made to create a longitudinal study and standardized testing in order to identify the genomic characteristics of susceptibility for this. Dr. Abrass again spoke in favor of developing longitudinal approaches and collaborative initiatives. He stressed that some of the subjects will outlive investigators and that it will be essential to have clearly articulated protocols and longitudinal ORD support.

Dr. Veith asked Dr. Karlin what the OMH was recommending with respect to the medical care of the chronically mentally ill who are aging into geriatric status. Dr. Karlin noted that this is an emerging concern and that discussions have begun in the office on this topic.

Dr. Joseph Francis, Deputy Chief Research And Development Officer

Funding for Aging Research: Dr. Joe Francis, Deputy Chief Research and Development Officer, introduced Dr. Ralph Paxton, Scientific Program Manager for the Aging Portfolio. Dr. Paxton holds a PhD in biochemistry and came to ORD from NIH approximately 1 year ago. Dr. Francis expects Dr. Paxton to establish stable contact between ORD and GEC in a manner that has not been seen since the retirement of Todd Martensen. He noted that there has been regular give-and-take between ORD and the GRECC concerning Aging Research and the grant assignment process. Dr. Francis is by and large in agreement with many of the points and concerns raised by the geriatric researchers, although there are some nuanced differences. Every statement ORD provides Congress regarding their VA mission includes comments on aging. The major impediment for a broader Aging Research program has been the combination of a diminishing

budget and increased mandates for OEF/OIF veterans. He noted that ORD had limited working capital through most of FY07 and that although most of the $35 million they were given in May was for OIF programs (TBI, PTSD, polytrauma, etc.), ORD was able to broaden this somewhat through leveraging resources (e.g., women's health, racial/ethnic disparities and needs, older persons in National Guard, etc.). The budgetary picture for FY08 looks quite promising. For the past three years the VA research budget has been $403 million - $411 million, however the Senate and House Appropriations Conference Committee is calling for approximately $500 million in FY08. This has already passed the Senate and the House's version stands at approximately $490 million. As such, Dr. Francis anticipates multiple new initiatives in FY09. Congress is sending strong signals that VA should not be ignoring the older veterans: for instance the increased focus on hearing loss combined with combat exposure plus age, phenotyping and genomic medicine, etc.

He acknowledged that the cancellation of Merit Review Subcommittees over the past few years has sown distrust within Geriatric Research, and he expressed the opinion that what has happened can not be undone but what is important is to move forward. He has had weekly meetings with GEC staff and representatives of GRECCs in an attempt to address these concerns.

Dr. Francis feels that "aging" as a research topic transcends any particular service (e.g., biomedical/lab, clinical science, health services, rehabilitation research) and while this makes sense administratively it is difficult to make it a pragmatic operating principle. He wants to break the current cycle of Merit Review Subcommittee being cancelled due to inadequate numbers of proposals and as such he would like to see proposals that fill needs not already addressed by non-VA funding sources. This would include proposals targeting geriatric syndromes and tie-ins with neurological trauma, mental health, and long term care. He noted it is important for clinical trials to have a component for dissemination. There was a recent joint solicitation between the Nursing and Rehab offices, with awards given to representatives of both groups, and he would like to see more things like that. Dr. Salerno suggested that NIA would be interested in joint announcements for areas of common interest. Dr. Francis agreed with this in principle but suggested that "horse trading" would be necessary to identify what is shared and what is taken on.

Dr. Halter inquired on what basis was ORD deciding which areas in aging research merit their support and attention, and if the same approach was being applied to cardiology, rheumatology etc. He offered the opinion that it seemed to him that aging was being singled out for a particular way of doing business. NIH has a strong focus on investigator initiated proposals and investigator directed reviews, and the VA used to have the same orientation. Is this new way of directing research proposals indicative of a change in attitude? Dr. Francis responded that there was no change in attitude, and that the majority of what is funded is a direct result of the creativity of the investigators. He reminded the group that former Under Secretary Perlin had noted that ORD did not possess the resources to emulate NIH. In order to shape diverse needs into a single enterprise Dr. Francis would like to see the GRECCs become a clinical testing network. Ideally the GRECC programs could move in the direction of Cooperative Studies, where they take research from the laboratory to the bedside and then onto broader dissemination.

Dr. Halter brought the discussion back to his earlier point. He noted that there is a great deal of geriatric expertise both within and outside of VA thanks to the GRECCs, and yet in the face of scarce resources this expertise has not been tapped by ORD for their suggestions. Furthermore a very efficient way to end a research program is to eliminate the review process designed to support it. Dr. Francis disagreed with this last observation, pointing out that the AGCG was merely suspended until there were a sufficient number of proposals. Dr. Halter disagreed, pointing out that if the assignment process were more transparent, and proposals suggested for review by AGCG were in fact were reviewed there, then there might be a sufficient number of proposals.

Dr. Francis noted that even when the AGCG is not meeting, many GRECC proposals are funded. Approximately 35% of the proposals received from GRECCs are funded whereas of the 21 assigned to AGCG over the last few years, only 10% were funded.

Dr. Halter continued with his point that the expertise was not being appropriately applied. He acknowledged that while there had been a great turnover in staff at ORD, one would think this made it even more important for ORD to seek available expertise to help the processes.

Dr. Abrass pointed out that many of the GRECC staff have expertise relative to other Merit subcommittees, yet there is relatively little representation on them. Dr. Halter added that providing a credible review of an Aging Research project is extremely difficult if only one individual on the review subcommittee has the necessary expertise. Dr. Francis acknowledged that GEC had provided names of interested individuals, but he was unable to cite instances where they had been assigned to review subcommittees. In a related note, the Inspector General has been scrutinizing ORD for potential conflicts of interest (not in aging). They have used some sophisticated software to track interactions between investigators and reviewers, and were able to identify a pattern of potential conflicts of interest.

Dr. Salerno noted that there are many junior investigators and Career Development awardees in GRECC, yet most of those for Aging are in HSR&D. Does this reflect some philosophical orientation on the part of HSR&D? Might it not reflect the advantages of having an Aging/LTC review subcommittee? Dr. Francis speculated that this came about because of the strong push toward investigating systems in teams, which fits "geriatric values". In contrast, biomedical is somewhat more tradition bound -- an issue that the prior CRADO, Dr. Wray, had tried unsuccessfully to address. Rehab R&D is also more open to Aging Research questions with the recent appointment of a Director in that area, and with the selection of a full-time QUERI person close at hand he hopes that a LTC QUERI would be an early result.

Dr. Fulmer inquired how many nurses are on the review subcommittees. Dr. Francis responded there are some in clinical science, but apart from that there are relatively few nurse reviewers within health services research and QUERI. Dr. Abrass noted that most VA nurses, even if they have academic appointments, have considerable clinical obligations, while nearly every MD is able to make time to serve as a reviewer because of the differences between Title 38 and Title V. Dr. Francis hoped that the new Nursing Academy initiative from the Office of Academic Affiliations would help address this.

Dr. Francis noted that there is an interest in the role of caregiving for both aging and disease, but that currently VA has a very limited ability to provide services to caregivers. Nevertheless, they can look at alternative ideas for caregiver relief.

PROMISE: Dr. Abrass noted the GGAC's concerns about the way in which grants are reported to the Research and Development Information System (RDIS—also called "PROMISE") and how this is reflected in VERA allocations. Dr. Francis responded that ORD did not want to be in the position of telling Finance how to count resources. At the same time, they also do not want to adversely affect resources being brought in to support research. The major issue is one of liability. When R&D committees manage resources the VA accepts a level of responsibility for the liability incurred. There is also the additional issue of the nature of the resources. Clinical Care funds are not to be used for VA research, but there was a history of GRECCs being paid out of clinical funds and it has been a thorny problem to untangle since the GRECCs are no longer paid out of specific purpose funds.

Non-Clinician Investigators: Dr. Shay asked Dr. Francis to comment on the December 2006 requirement by Biomedical and Lab R&D for non-clinician investigators to be reviewed and approved prior to receiving Merit awards. Dr. Francis noted that this policy was intended to open up Merit funding to investigators with less than a 5/8 VA appointment by allowing them to include their salaries in their applications, so that if they were successful they could become 5/8 VA. It

was pointed out that non-clinician investigators with GRECC appointments already have salary, and therefore should be exempt from this approach, inasmuch as their credentials have already received strict scrutiny. Dr. Shay said he would follow up with Dr. Steve Graham, Director, Pittsburgh GRECC, who had particular concerns about this, and have him contact Dr. Francis.

Follow-up Discussion: Dr. Halter inquired as to how GGAC could interact with the Federal Advisory Committee on VA Research. Dr. Abrass noted that it was within the purview of this committee to communicate via letter. He and Dr. Halter agreed to collaborate on such a communication to express their concerns over the current situation with the AGCG. Other particulars for this letter were then discussed in more detail and there was some discussion as to whether this needed to be brought to the attention of the Undersecretary. Dr. Abrass had hoped that he would be in attendance, but noted Mr. Feeley would be meeting the group instead. Dr. Dolan suggested that the minutes could include recommendations/action items on this, and Dr. Shay said he would go with that approach.

William Feeley, Deputy Under Secretary Operations & Management

GRECC Vacancies: William Feeley, Deputy Under Secretary Operations & Management next spoke with the GGAC. Dr. Abrass raised the issue of GRECC vacancies. Mr. Feeley noted that he had never seen the information just provided to him, although Drs. Shay and Burris noted that it had been furnished to his office on a quarterly basis since December 2006. Nevertheless, Mr. Feeley noted that the nature of the information provided was inadequate for him to undertake action. Other than the number of vacancies he specifically needs to know the numbers that had been denied fill and the history of denial for each. He noted that, in general, there is an 8% vacancy rate in all VAMCs. If, as the data suggests, the GRECCs have twice that rate, there should be an effort to reduce the vacancy rate to at least 8%.

Dr. Halter inquired what Mr. Feeley would suggest to attract people with a clinical background into geriatrics, and noted the GGAC had recently heard of OMH incentives to attract nurses and psychologists. Mr. Feeley felt that that was a challenge for GGAC to address, but he suggested an aggressive marketing plan, and learning from the OMH initiatives. Also GEC might explore leveraging OEF/OIF because it is such a high priority. He also suggested contacting the Management Support Office and Dr. Shay noted that GGAC would be hearing from that office before the end of the day.

Dr. Damron-Rodriguez noted how helpful trainee stipends offered through the Office of Academic Affiliations have been, particularly in her field of Social Work. Mr. Feeley agreed, pointing out that this is the best way to get "new blood" into the system. He reiterated that he felt consultation with Management Support would be wise for the GGAC. An inquiry on the part of Dr. Goldberg regarding how difficult it is to secure loan repayment for geriatric physician recruits was met by a similar response: Mr. Feeley encouraged him to raise this issue with Management Support.

Dr. Abrass noted that close to 70% of the new psychology and psychiatry hires had been trained in the VA and that this demonstrates how important it is to have training as a component of recruitment and retention. Mr. Feeley agreed, and said that one thing he has always admired about the VA is that it permits an employee to go through developmental phases. As such, he has always been impatient with professional staff who are reluctant to devote time to education. Nevertheless, clinical staff are hired to perform clinical work and should not be devoting three quarters of their time to educational undertakings

Allied Health Training: Dr. Damron-Rodriguez noted that several GRECC site visits had suggested to her that there are less training opportunities for Allied Health professionals than before. Mr. Feeley responded that in the course of working with veterans there should be adequate workload in the system to provide abundant case material. He noted that he had accomplished this at the Bedford VA, and that the West Haven VA had seen increased throughput by Mental Health through the use of trainees. Dr. Koren expressed her concern that focusing solely on throughput might be a bit simplistic, especially with respect to the complex

patients managed by geriatricians. Mr. Feeley acknowledged this, but pointed out that while humans are not widgets if a provider is significantly below the average there has to be some sort of accountability. Dr. Salerno asked what measures his office was undertaking to ensure that the focus on OEF/OIF would not result in shortchanging older veterans. Mr. Feeley's response was that since the Vietnam era the VA has been strongly moving toward the geriatric realm. All groups are different with different priorities, and he welcomes input on how to strike a balance.

Mr. Feeley closed by acknowledging the contributions of GGAC.

Follow-up Discussion: After Mr. Feeley's departure, discussion briefly focused on how Dr. Shay and Dr. Burris might more effectively communicate the GRECC vacancies to Mr. Feeley's office. Discussion then turned back to recruitment and retention, and both Dr. Veith and Dr. Halter inquired whether it was possible to designate geriatrics as a "scare specialty". Dr. Salerno thought this unlikely, inasmuch as it is not merely a VA issue but a federal employment issue. She noted that specialties are placed into different tiers depending on market considerations, and that geriatrics is in the lowest tier, along with Primary Care. Dr. Damron-Rodriguez characterized this is a difference between “demand” and “need”. She noted that there is terrific need for geriatricians but not a corresponding demand, and hence the market does not reflect it. Dr. Abrass noted that there are alternative strategies, such as signing bonuses, that might prove effective. He also noted that it would be impossible to change salaries without a change in the job description.

Joleen Clark Director, Deputy Director, Management Support

Succession Plan: Joleen Clark, Deputy Director, Management Support, then outlined for the GGAC a recent, broad reaching, Succession Plan designed to ensure that VA has adequate staffing for the near and distant future. By 2012, 91,700 current VHA employees will be eligible for full retirement, this includes 97% of Nurse-V (leadership positions), 94% of MDs, and 81% of senior executives. It is projected that over 46,000 will retire during that time. As such, the individual VISNs have been asked to draw up plans to ensure adequate succession. Other actions to meet this challenge include: strategic workforce plans with annual updates; technical skill development teams; human resources and recruitment tools for managers; employee satisfaction surveys; legislation and policy; supervisory training; and Performance Measures associated with this. There were recent marketing efforts to increase the number of Mental Health professionals, and she stated there will soon be a similar effort with Geriatrics and Extended Care. For the Mental Health effort, she worked closely with Drs. Zeiss and Karlin of OMH, using the existing Education Debt Reduction Program. She acknowledged that thanks to OMH’s resources this instance experienced a greater deal of success than usual, but the infrastructure used for GEC would be the same.

Dr. Shay speculated that this sounded better than the potential reality, given various administrative impediments to the effective application of the EDRP. Ms. Clark disagreed, noting that no nurses have ever been turned away from this plan, and that many Networks fail to even spend what is allocated to them. Approximately $3 million is divided among the Networks with each VISN managing their own funds. Furthermore medical centers can supplement these funds driving the amount even higher. Mr. O’Rourke inquired which Networks tend to use the resources entirely and/or apply for more; and which used them inadequately. Ms. Clark was willing to share this information because it is not private; in 2006 VISN 8 expended almost none of its resources, whereas VISNs 12, 15, and 22 not only expended their resources but applied to use the unexpended resources of other Networks.

Physicians are the second highest priority occupation for recruitment. She noted that the maximum award for tuition reimbursement was up to $48,000 over a four-year period.

Dr. Dolan inquired whether it was possible for staff to work on degrees in gerontology or public health. Ms. Clark responded that anything is possible using local funds. For national funds employees have to fit into certain vocational categories. Dr. Halter asked for clarification about

how a physician would apply, to which Ms. Clark responded that they can apply up to six months after being hired. Dr. Shay expressed his concerns about the VISN administration of these programs. In his experience more expensive professionals, that take a disproportionate amount of the limited resources, are frowned upon by VISN leadership, inasmuch as it limits the numbers of employees who can be recruited and retained.

Ms. Clark again reiterated her willingness to work with the Office of Geriatrics to put together a plan that would facilitate the application of these resources on behalf of geriatrics.

Caryl Kazen, Chief, Library Service, VACO

Caryl Kazen, Chief, Library Service, VACO is interested in supporting Federal Advisory Committees by making informative materials available to them. She can develop weekly MEDLINE searches for pertinent articles about Geriatrics and Extended Care and the Department of Veterans Affairs if the GGAC thought it would be useful. Some discussion followed regarding the provision of these resources through the use of email, which a number of members saw as less advantageous than doing it via the internet. Unfortunately MEDLINE abstracts can only be provided via email. Caryl also offered to share the Dole-Shalala report when it became available, and can direct GAO and OIG reports concerning geriatrics to the committee if they were interested. She concluded by distributing a copy of the book "the Best Care Anywhere", which was written by an investigative reporter seeking to spotlight high quality health care and was surprised to learn that it was being delivered in VA.

Open Discussion

Dr. Abrass reiterated that Dr. Halter will be drafting a letter to the Federal Advisory Committee on VA Research. He noted that Dr. Edes will investigate potential Loan Repayment Program and EDRP options with Management Support. Dr. Abrass himself will approach both the AGS and GSA Legislative Committees in order to explore ways of addressing the NIH Loan Repayment Program. He noted that the state of South Carolina has successfully instituted state loan repayments in order to recruit physicians and that, furthermore, California is working on this. Dr. Dolan noted that this had been authorized in Florida but it has not been appropriated.

Dr. Damron-Rodriguez suggested articulating a statement on "why would you want to work for the VA". She felt that this would be a reasonable collaboration with Management Support. She also suggested that Dr. Shay work with the GRECCs to track trainees, their destinations, and the pattern of hiring fellowship graduates. Dr. Abrass noted that with the current mode of funding, the Office of Academic Affiliations always seems to have positions available. He feels it is critical to retain those who train in the VA and are enthusiastic about the interdisciplinary interactions. Dr. Koren suggested, in addition to what Dr. Damron-Rodriguez was suggesting, identifying problems different disciplines encounter and how employment in the VA sidesteps these, e.g., billing, time to counsel patients, etc. Dr. Abrass concurred, and said that this information then needs to be disseminated to GRECC Directors in order to assist them as they attempt to attract recent graduates. Ken offered to work with Ms. Clark on Dr. Abrass' suggestion of hiring J1 Visa holders. Dr. Halter thought that this would require either identifying all VAMCs as underserved, or require identifying specific VAMCs as underserved, so they could then serve as employment destinations for these individuals.

Dr. Della Penna asked that Drs. Shay and Abrass re-examine the balance of the meeting content. He felt that too much of this GGAC meeting concerned GRECCs and would like future meetings to be more focused on the delivery of geriatric health care. He had appreciated the discussions of long term care and would like to have seen more. Dr. Abrass acknowledged this and offered to develop future agendas that are more in depth and have fewer presenters. Dr. Della Penna was agreeable to this and felt it would be helpful to hear more about less rather than hearing a little about a lot. Dr. Shay offered to develop a list of choices and circulate it in advance in order for GGAC members to rank topics that will then inform the next agenda. Dr. Veith thought that in order for the GGAC to be effective it was important that they have a finger on the pulse of what was going on with VA. As such, he did not find a large number of topics covered to be

problematic. Nevertheless, he did feel that if there was going to be an increased focus on a limited number of topics, the question of workforce would be a very important one. Dr. Koren would like regular updates on the Strategic Plan; what is the "big picture" and how does VA fit in. Dr. Damron-Rodriguez speculated that it would be important to see the Strategic Plan when it came out in order to identify what the GGAC wants to focus on.

Dr. Koren also suggested that, when site visits go to GRECC, that other programs should be visited such as Mental Health, community clinics, and non-GRECC VAMCs. Dr. Shay promised he would look into the authority and funds for this. Dr. Koren said that she was particularly curious to see examples of the Cultural Transformation. Dr. Halter concurred, and pointing out that during the upcoming visit to the Ann Arbor GRECC there would be an opportunity to look at the Detroit, Saginaw, and Battle Creek VAMCs, and all the differences in their Nursing Homes.

Mr. Carbonneau noted that it had been a long time since this group has re-examined its Charter. He requested receiving a copy of it and Dr. Shay assured the group he would circulate it.

Next Meeting

Dr. Abrass said that the next meeting of the GGAC would be held in late March or early April of 2008. The meeting was adjourned.