DEPARTMENT OF VETERANS AFFAIRS (VA)

Geriatrics and Gerontology Advisory Committee
Meeting Minutes
April 10-11, 2024

GGAC Members:

David Gifford, M.D., MPH, Chairman
Harvey J. Cohen, M.D., Vice-Chairman
Barbara Smith, Ph.D., GGAC Member
Carmen Morano, Ph.D., GGAC Member
Fayron Epps, Ph.D., RN, FGSA, FAAN, GGAC Member
Jeannie K. Lee, Pharm.D., BCPS, BCGP, FASHP, AGSF, GGAC Member
Joseph Ouslander, M.D., GGAC Member
Julie Stanik-Hutt, CRNP, Ph.D., GGAC Member
Lori Gerhard, ex-officio GGAC Member
Richard Browdie, GGAC Member
Roland J. Thorpe, Jr., Ph.D., GGAC Member
Stephen Combs, LPC, NCC, CCTP, GGAC Member
Tamara Baker, Ph.D., GGAC Member

VA Staff:

Alexandra Caley, MN, RN-BC, PHCNS-BC, Chief, Community Living Centers, Veterans Health Administration (VHA) Office of Geriatrics and Extended Care (12GEC)
Antonio Laracuente, Director of Field Operations, VHA Office of Research & Development
Barbra Swann, Health System Specialist, GEC, VA Central Office (VACO)
Carolyn Stoesen, Director, Office of Enrollment and Forecasting, VHA
Catherine Kelso, M.D., Deputy Executive Director, GEC, VACO
Cheryl Schmitz, M.S., RN, CNS-BC, NE-BC, Deputy Executive Director, GEC, VACO
Christine VanBilderbeek, Health System Specialist, National Surgery Office, VACO
Christopher Bever, M.D., Deputy Chief R&D Officer for Investigators, Scientific Review and Management with the Office of Research and Development, VACO
Cynthia Johnson, National Director, DAQIR, GEC, VACO
Daniel Hall, MD, MDiv, MHSc, FACS, Core Investigator, CHERP Staff Surgeon, GRECC Affiliated Investigator, VA Pittsburgh Healthcare System
Dawn Fuhrer, BA, Designated Federal Officer, GRECC, Pittsburgh VA Healthcare System
Janice Horton-Rainsbury, Health System Specialist, VACO
Jeffrey Moragne, Advisory Committee Management Office (ACMO), VA
Lauren Crotts, MSN, MBA, RN, CLNC, GERO-BC, FNP-C, Chief, State Veterans Homes , VHA Office of Geriatrics and Extended Care (12GEC)

Marianne Shaughnessy, PhD, AGPCNP-BC, GS-C, FAAN, National GRECC Program Director, Designated Federal Officer
Russ Peal, Director, Workforce Recruitment & Retention (VHA/WMC)
Ryan Weller, LCSW, APHSW-C
Sarah Bender, Program Analyst, Enrollment and Forecasting, VHA
Scotte Hartronft, M.D., MBA, FACHE, Executive Director, Geriatrics and Extended Care (GEC), VACO
Thomas Edes, M.D., Senior Medical Advisor, GEC, VACO
Tonya Page, OCC- CI RN, VACO

Guests:

Alexandra Thornton, Consultant, Guidehouse
Amanda Simon, Consultant, Guidehouse
Barbara Hyduke, Consultant
Corey Siebers, Maxim Healthcare Services
Danielle Armbruster, Maxim Healthcare Services
Drake Martin-Greene, Maxim Healthcare Services
Ed Harries, Vice President, National Association of State Veterans Homes
Hannah Davis, Consultant, Guidehouse
Julianna Holt, Veterans of Foreign Wars (VFW)
Karan Kaushal, Consultant, Guidehouse
Rebecca Reeves, Consultant, Guidehouse
Rene Campos, Military Officers Association of America (MOAA)
Renee Golden, Maxim Healthcare Services
Rose Dunaway, BSN, RN, Kindred at Home
Taiwanna Billups, Contractor, Guidehouse
Tracy M. Schaner, LNHA, LRCA, SHRM-CP, PHR, President, National Association of State Veterans Homes

Marianne Shaughnessy, PhD, AGPCNP-BC, GS-C, FAAN, National GRECC Program Director, informed attendees that she is the Designated Federal Officer for today's meeting and that the meeting will be chaired by Dr. David Gifford. Dr. Shaughnessy announced that during the meeting members of the public are not allowed to ask questions or make comment while the meeting is in session. Questions and comments from the public will be taken during the public comment period scheduled for later in the day. In addition, attendees were informed that written comments should be sent to Dr. Shaughnessy's attention for inclusion in the meeting minutes.

The Geriatric and Gerontology Advisory Committee (GGAC) meeting was called to order at 8:30 am by Chair, Dr. David Gifford. Members were welcomed through videoconferencing. Committee members then viewed a public service announcement video for all advisory committees from the Secretary of Veteran's Affairs.

Jeffrey Moragne is the Director of the Advisory Committee Management Office (ACMO) for the Department of Veteran Affairs (VA). He presented on the Federal Advisory

Committee Act of 1972. He shared GGAC's history of being a statutory committee designated by Congress. He also provided information regarding opportunities for GGAC to interact with other Federal Advisory Committees. Mr. Moragne informed the committee that they can hold meetings on Capitol Hill and can reserve meeting space in Washington DC and invite staffers and congressmen to the meeting. Dr. Gifford expressed the committee's interest in pursuing this for a future GGAC meeting. Dr. Shaughnessy will reach out to Mr. Moragne to further this discussion.

Dr. Shaughnessy provided Special Government Employees annual ethics training to GGAC members and meeting participants. GGAC Members were encouraged to contact the Designated Federal Officer (DFO) or ACMO if there are any additional questions.

The Committee first met with Scotte Hartronft, M.D., MBA, FACHE, Executive Director, Office of Geriatrics and Extended Care (GEC), VACO. Dr. Hartronft provided a VHA Offices of Geriatrics & Extended Care update. He provided the specifics of VA mandatory Nursing Home care eligibility and the differences in Veteran population in the Community Living Centers (CLC), Community Nursing Homes (CNH), and State Veterans Home (SVH). Data presented on the nursing home program comparisons included the number of Veterans treated per year, average length of stay, and average daily census. Dr. Hartronft explained the differences in the 'Prevailing Rate' versus the 'Basic Rate'. He also provided a Prevailing (Priority 1a) rate for SVHs versus CNH baseline per diem comparison. The Prevailing Rates SVH and CNH daily and yearly comparison, based on the US SVH Average, has shown that VA is paying $280.45 more per day ($102,364 per year difference) to SVHs than CNHs. In addition, VA provides additional resources to SVH, including local sharing agreements for discounted medications and services, 65% of construction costs, remodeling grants and nurse retention grants, that are not available to CNHs. When discussing the Basic Rates for SVH versus CNH baseline per diem comparison, Dr. Hartronft explained the SVHs receive $138.29 per day. They can concurrently bill insurance, Medicare, Medicaid and the Veteran residents. Almost all Veterans can get their medications covered by the VA He shared the SVH Nursing Home per diem annual rate adjustments for FY22, FY23, and FY24. Dr. Hartronft then discussed CLCs, which can't be compared apples to apples because CLC residents require significantly higher intensity/acuity care and CLC calculated costs include sharing many of the infrastructure and staffing costs form their associated facilities. Dr. Hartronft shared that they have been working closely with SVH for Adult Day Healthcare which also has a prevailing rate and a basic rate. VA is paying an average of $411.83 per day for the prevailing rate and $110.18 per day for the basic rate. Lastly, Dr. Hartronft provided the per diem rates data per VISN.

Dr. Cohen thanked Dr. Hartronft for providing so much information. He asked for clarification on what drives the length of stay difference between the CNHs and the SVHs. Dr. Hartronft responded that part of it can depend on how much the local Chief of Staff uses CNHs for non-mandatory Veterans who are Medicaid pending to increase their acute care flow. The data in the presentation included both long stay and short stay lumped together for all three programs. SVH tends to admit more long stay. He added

that one program will never replace the other. It is all about finding the Veteran the right place for the right services and at the right location. Dr. Cohen pointed out that it was helpful that he was pointed out that the costing for CLC is driven by a higher intensity of care and their cost includes costing across the whole facility which may artificially make the CLC look a lot more expensive. Dr. Ouslander questioned the high cost of SVHs and if that was regulated. Dr. Hartronft explained that SVHs are highly regulated and that the current average across the country for SVH prevailing rate is $520 versus the same Veteran in the same city across the street in CNH, VA would pay an average of $239. SVH payments are bundled so they are expected to provide Veteran medications. Dr. Ouslander asked Dr. Hartronft for his vision about the “rights” for Veterans. He shared that it is working in partnership with not only our states but also with our CNHs to find the best fit for the Veteran. Dr. Cohen asked whose budget those payments come from. Dr. Hartronft responded that SVH money is taken off the top of the whole VA budget and administered at the national level through the VISNs and VAs. He also added that in the FY25 budget, the SVH will be close to $1.9 billion, not including construction grants, remodeling grants and nursing recruitment grants. Dr. Lee questioned the bundle payment and that the prevailing rate includes payment for medications. She asked if case by case has ever been an option even if the Veteran is not using high cost medications. Dr Hartronft responded that they are paying a premium for every Veterans at the prevailing rate to help cover medication. He added that each SVH can have a medication sharing agreement with their local VA and get their medications at a significantly discounted rate. He also added that SVH has requested additional payment for certain high costs medications. Dr. Cohen pointed out the physical difference in look between the SVHs and other types of facilities. They tend to mimic the small housing model. Dr. Hartronft shared that VA does pay for 65% of construction costs and provides remodeling grants to the SVHs. Ms. Gerhard asked about occupancy rates. Dr. Hartronft shared the VA CLC’s are over 80% on occupancy. Dr. Cohen thanked Dr. Hartronft for the data he provided on the comparison between the SVH and CNHs.

GGAC met with Tracy Schaner, NASVH President and Ed Harries, NASVH Vice President. Ms. Schaner began by sharing the National Association of State Veterans Homes (NASVH) vision, mission, and purpose. She provided the structure of their Executive Committee and shared their meeting and conference schedules. Ms. Schaner provided the NASVH website and provided a list of information/resources that can be found there. She provided SVH Program data for 2024 and stated that there are 165 SVHs across all 50 states and the commonwealth of Puerto Rico totaling close to 30,000 beds. They provide 3 levels of care,158 Nursing Home Care Programs, 47 Domiciliary, and 3 Adult Day HealthCare’s. Approximately 75% are CMS certified. They anticipate they will have 13 new SVHs in calendar year 2024. She also provided VA reimbursement for Basic rate, Prevailing rate, Domiciliary rate, and ADHC rate. Ms. Schaner provided SVH Program statistics for 2023 and reported that SVHs provide 50% of the VA’s long-term care workload at less than 20% of the VA’s total FY2024 expenditures for Veterans long-term care. CLCs have accounted for the largest share of VA nursing home expenditures in which the VA pays for the full cost of care for Veterans. For SVHs, 80% of Veterans receive VA’s basic per diem rate, which covers

only about a quarter of their care costs. Mr. Harries provided data on the average number of residents/days, the average rating comparison between Veterans Skilled Nursing and Non-Veteran Skilled Nursing, the average Nursing staff hours per resident per day, the average total nursing staff turnover, the average number of facility reported incidents, the average number of substantial complaints, and the average number of citations from infection control inspections.

Dr. Gifford asked if they have been looking to see if when CMS and VA inspect SVHs within close proximity, what the correlation is because there is concern that the VA may be doing duplicate work. Ms. Schaner reported that they have looked at that. She reported that they are highly regulated with oversight. It does create burdens and confusion and she felt that they do have a duplicate survey process. She reported that the VA does look at different things from CMS. They did do a comparison cross walk between CMS regulations versus VA and found that 98% of the VA was the same as CMS. VA does look at fiscal and administrative items that CMS does not. Dr. Gifford asked for real data on the difference and outlining what VA does differently than CMS. Dr. Hartronft added that the reason why they have to do two surveys is because 25% of the SVHs are not CMS accredited versus 100% of their contract nursing homes that are. Dr. Gifford asked Dr. Hartronft to provide the committee with a copy of the regulations pertaining to VA oversight of SVHs for their review. Dr. Ouslander thanked Ms. Schaner and Mr. Harries for their presentation. He also asked if there was any formulary oversight for the high-cost medications. Ms. Schaner replied that most of those medications are for cancer treatments and even when SVHs have agreements with VA to get the prime vendor rates through VA formulary, the medications are still very high cost. Dr. Ouslander stated that it would be helpful to this committee to see the data on that. Ms. Schaner reported that they are in the process of collecting it.

GGAC met with Daniel E. Hall, MD, MDiv, MHSc, Staff Surgeon at VAPHS. Dr. Hall spoke about The Surgical Pause: Measuring Frailty and Doing Something About It. Surgical Pause is an initiative that uses a Risk Analysis Index (RAI) to screen Veterans for frailty in 30 seconds, effectively flagging high risk Veterans so the surgical team can ensure the proposed treatment plans both mitigate known risks and align with the Veterans' overarching life goals. Surgical Pause has been adopted by the VHA National Surgery Office and there are 50 sites actively utilizing RAI. There are currently no active randomized trial but two are pending. Dr. Gifford applauded Dr. Hall for such a great presentation. Dr Gifford then asked how they engage the GRECCs in this program. Dr. Hall responded that he has not had a formal way to engage the GRECC at this juncture but welcomed ideas from the committee. Dr. Gifford reiterated that part of the GRECCs work is to do evaluation as well as clinical demonstrations and they can assist in that manner. Dr. Gifford asked Dr. Shaughnessy to follow-up with Dr. Hall on opportunities to work with the GRECC. Dr. Ouslander thanked Dr. Hall for a fantastic presentation. He reiterated that GRECCs should be used to help with dissemination of programs like this and he encouraged him to submit a summary of this program to the Journal of American Geriatrics Society. Dr. Gifford applauded him for looking at the outcome beyond mortality. Dr. Morano asked if they integrated Social Workers in this process. Dr. Hall responded that Social Workers are integrated formally in the PAUSE trail. Dr.

Cohen echoed the issue of the shortened time in hospital as a possible great outcome and something we should be striving for. He also asked Dr. Hall how much attention the surgery field is putting into not just the idea of 30-day recovery but immediate post op recovery and being out of the hospital to avoid the issues that hospitalization creates. Dr. Hall responded that he didn't have a clear response about that at this time. Dr. Hall did talk about how the Surgical Pause did decrease length of stay by 1 day at the University of Pittsburgh Medical Center.

Dr. Harvey Cohen, Vice-Chair, GGAC, is also the GRECC Advisory Subcommittee (GAS) Chair and provided a report for deliberation. He reported that there did seem to be recurring issues discussed by the subcommittee's surrounding hiring, but no issues rose to the national level.

GGAC met with Alexandra Caley, MN, RN-BC, PHCNS-BC, Chief, Community Living Centers, VHA Office of Geriatrics and Extended Care. Ms. Caley provided a Community Living Center overview. Ms. Caley displayed a visual depiction of programs across the continuum of care. She shared the mission statement and the VHA CLC Policy. She discussed the variety of services offered in CLCs and reported that there are 134 CLCs across the continental US and in Puerto Rico and that there were 28,000 unique Veterans receiving care in the CLCs in FY2023. Ms. Caley shared FY19-24 year to date CLC operating and unavailable bed trends. She followed by discussing the Unannounced Survey process, CLC Compare, CLCs ongoing national Center for Enhancing Resources and Training (CONCERT) Quality Assurance Performance Improvement (QAPI). She discussed the scope and severity of deficiencies, CLC compare, and CLC overall star rating trends. Ms. Caley discussed CLC Quality Assurance and Performance Improvement (QAPI), the 5 QAPI elements, and implementation of QAPI. Next Lauren Crotts, MSN, MBA, RN, CLNC, GERO-BC, FNP-C, Chief, State Veterans Homes, VHA Office of Geriatrics and Extended Care provided a State Veterans Home program overview. Ms. Crotts began by discussing the SVH timeline including how it began, federal funding, expansion, scope, modernization and current state. She shared the mission statement and vision statement and discussed the three major components in GEC that manage and have oversight of the national SVH Program. They include SVH Construction Grants, SVH Clinical and Survey Oversight, and SVH Grant Per Diem Program. She provided background and discussed the growth of SVH since 2008 and shared the occupancy rates for FY22-23. Ms. Crotts continued by discussing the Cleland-Dole Act Section 162 (c)Transparency. She reported that they are currently implementing the transparency portion of 162(c) with oversight of inspections. She then shared SVH VA Survey Report Deficiency trends, SVH NH deficiencies by scope and severity, SVH NH top survey deficiencies, SVH Domiciliary deficiencies by scope and severity, SVH Dom top survey deficiencies, and SVH immediate jeopardy numbers. Dr. Gifford thanked our speakers for the comprehensive overview and comparison and for sharing the trend data. He asked if they could pull data together that looks at how often VA and CMS do their surveys within a 4–6-month period. He also asked what parts of the survey process that VA does that CMS does not do. Ms. Crotts shared that their survey teams for SVH are in the facilities every 12 months and CMS is more on the average of about 18 months.

She will look and compare when they have been in facilities for their contracted agency and look at the CMS deficiencies. Dr. Gifford also ask for confirmation that they are not using a contractor that also does CMS surveys. Ms. Crotts will investigate that. Dr. Cohen asked how many SVHs are affiliated with Indian Tribes. Ms. Crotts will get that information and believes that there isn't a SVH built yet in official Tribal lands. Dr. Cohen also asked what the requirements were for a patient to be admitted to a SVH versus a Domiciliary home. How is the determination made? Ms. Crotts replied that the Domiciliary program admits Veterans with a higher level of function but still need oversight for medications Mr. Combs asked if anyone has ever tried to see if they can align the VA and CMS inspections for SVHs. Ms. Crotts responded that they have done a crosswalk and there is a very high percentage that is similar. Mr. Combs suggests that it seems it would be more efficient to make one slightly more comprehensive survey then 2 separate surveys that cover a lot of the same material. Dr. Hartronft reiterated that not all SVHs are CMS-certified and VA has oversight requirements that go beyond what CMS does. In addition, feedback from external parties, such as Congress, has been that VA should not defer any of its oversight to other parties. Dr. Gifford then followed by asking if they time their surveys so that they are off cycle. Dr. Hartronft acknowledged the committees concern and indicated that they are looking for the best way to address it. Ms. Gerhard asked for general insight on what seems to be the theme with the life safety citations. Ms. Crotts responded they fall under fire control panels, fire drills, and the barriers for the fire and smoke. Dr. Gifford concluded by complimenting the presenters on their work and reminding everyone that the SVHs and CLCs are taking care of the frailest Veterans and we need to make sure all the providers are not just meeting the minimum standards but excelling above and beyond that and he acknowledged that they play a very vital role in that.

GGAC met with Cheryl Schmitz, MS, RN, CNS-BC, NE-BC, Deputy Executive Director, VHA Office of Geriatrics and Extended Care. Ms. Schmitz shared news of recent legislation affecting VHA's Office of Geriatrics and Extended Care. The presentation included discussion of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022. The presentation focused on the following sections 1) SEC. 161. Strategy for Long-Term Care for Aging Veterans, 2) SEC. 162. Improvement of State Veterans Homes, 3) SEC. 163. Geriatric Psychiatry pilot program at State Veterans Homes, and 4) SEC. 165. Secretary of Veterans Affairs Contract Authority for Payment of Care for Veterans in Non-Department of Veterans Affairs Medical Foster Homes. For SEC 161 GEC provided a strategy for LTC for Veterans. Ms. Schmitz reported that their report was presented to Congress last December. It provided the current state and vision for the future needs for Veterans. So far, they have received positive feedback. Ms. Schmitz continue by adding that SEC 162 is related to State Veterans Homes. They are working to implement a standardized sharing agreement process between State Veterans Homes and the local VA medical centers. Additionally, they recognize a regulatory change is necessary to work through the standardization that needs to happen. She reported that for SEC 163 – The Office of Mental Health and Suicide prevention is leading this portion of the legislation. VA began a 2-year pilot program in December, 2023 to provide mental health assistance to Veterans living in State Veterans Homes using a telehealth platform. The Office of

Mental Health and Suicide Prevention has partnered with the different VISNS (1 & 23) to work with their Clinical Resource Hubs to expand existing geriatric mental health services to two State Veterans Homes in each region. So far there has been positive feedback provided to the Office of Mental Health. For SEC 165, they have been directed by Congress to provide an avenue or pilot program for VA to pay for a Medical Foster Home. The Medical Foster Home program is currently a program that is being expanded to all VA Medical Centers that provide a nursing home level of care to Veterans in a homes with paid caregivers..

In addition to Cleland-Dole, Ms. Schmitz wanted to talk about an Executive Order that was signed about a year ago tasking VA to expand the Veteran Directed Care program to all VAMCs by the end of this fiscal year. In that same Executive Order, VA was also directed to add 75 home based primary care teams, which they are in the process of doing. Finally, the Executive Order directed VA to design a pilot Home Health program using a co-employer option, or a pilot for home care that is a cross between Homemaker/ Home Health Aide Program and the Veteran Directed Care program. They have partnered with one of the innovation offices within VA to put in place an app-based program where providers are on the app and the Veterans can select the persons to come into their home to provide care based on when the providers are available and when the Veteran wants care. Dr. Cohen asked when these strategies and recommendations were made were they accompanied by realistic financial projections of what additional funding would be necessary to carry them out? Ms. Schmitz responded that at this point they did not provide the financial projections for the projects included in the Executive Order but anytime they are asked by Congress to provide technical assistance they are very careful to include any financial implications. Mr. Browdie pointed out how there are currently shortfalls in funding and new asks for the development of new models of care and wanted to know if these are in any way intended to substitute for one another? He also asked if a shortfall winds up stalling things like staffing, how does this work out when you're trying to figure out what is going to land on the calendar? Ms. Schmitz responded that many of the programs that they are talking about right now are a component of the aging in place initiative and the goal is to delay or prevent nursing home care.

GGAC met with Scotte Hartronft, M.D., MBA, FACHE, Executive Director, Office of Geriatrics and Extended Care (GEC), VACO. Dr. Hartronft presented on VHA Enrollment and Forecasting Office Data. He provided updated VHA demographic projection trends, a VA VISN map with enrollee ages 85 & older projections, Outpatient Ambulatory Geriatric Medicine Utilization projections, VA Enrollee Demographics by Age, Non-Institutional Care Growth Trend, Home & Community Based Services Utilization projections, VA Community Living Center projections, Community Nursing Home Utilization projections, and Long-Term Services & Supports Balance. Dr. Hartronft also followed-up from his earlier presentation and provided nursing home accreditation differences, occupancy rates, and discussed the SVH survey burden issue. He stated that we could reach out to NASVH to provide a detailed list of specific SVH's that had a CMS and VA survey in the same month or same quarter to understand how often this is happening. Ms. Sarah Bender from the Office of Enrollment and Forecasting reported

that every few years they try to collect enough data from the SVHs to start modeling it. Mr. Browdie asked how much the staffing issues impact the floor of the data being used. Dr. Hartronft responded that when it comes to actual occupancy, 7% of beds are out of service due to staffing. Ms. Bender added that what goes into the projections is the actual utilization, not number of approved beds. They model based on the experience. Ms. Gerhard asked if the 71.2% occupancy from Oct to Feb in 2024 FY for the SVH was a result of staffing needs or a demand for beds. Dr. Hartronft reported that a lot is due to staffing ability. Ms. Schaner also added that it is the staffing that they are having problems with. The SVH census has dropped, and many facilities have long waiting lists. Dr. Ouslander noted that they have excess bed capacity and asked if they have matched that up with the projected need? Dr. Hartronft responded that it is hard to tell because of regionality and availability. They do know the SVH number of facilities is expected to increase and the number of CNH beds is expected to increase to 8,000 through contract expansion. Dr. Cohen pointed out that they need to factor in some sensitivity analysis around staffed beds and staffing needs. Dr. Lee asked about HBPC growth projections and if they are based upon the capacity of HBPC and if there are any plans to expand HBPC with the thought that older adults want to age at home. Dr. Hartronft responded that they do have HBPC at every VA now. One of their expanded aging in place initiatives is adding 75 new teams to HBPC programs in the field subsidized by VACO and encouraging additional teams at the local level. Mr. Browdie asked if the state decides to add to their inventory is the VA obligated to use the home? Is the VA able to influence where they are built and encourage them based on other factors? Dr. Hartronft responded that the state initiates a new facility, and they decide where and how many beds and then it comes to VA as an application. It is a partnership, but state initiated. In the regulations there is a way to factor how many nursing home beds are needed in that state. Ms. Schaner commented that when the states apply for a construction grant, they must do a feasibility assessment and a study based on demographics and it cannot be within a 2- hour radius from another facility. Dr. Gifford challenged GEC to push their data people to look at the question around individuals that need facility-based care are not the same as the ones getting care at home. Even if you can cut the utilization in half, it still means that you will be expanding the use of institutional care and there is concern that we are doing analysis that fit our philosophical view and it will not make us adequately prepared to meet the Veteran’s needs. Dr. Hartronft clarified that they are projecting an increase in CNHs, CLCs, and SVHs but just doing more home care then they have in the past.

Dr. Gifford reported that what seems to be interpreted across the field is that there is an FTE cap and a hiring freeze and how each center is interpreting this is causing some challenges that are going to cause unintended effects to the Veterans. He asked Dr. Hartronft if there was indeed an FTE cap and hiring freeze. Dr. Hartronft responded that at this point the discussion has been around strategic hiring. Dr. Gifford pointed out that the memo is being misconstrued in the field. He suggested better communication out to the staff in the field. The other thing clearly coming through is differences in how they count their FTE, specifically trainees and grant funded positions. Dr. Gifford added that there needs to be instruction from VACO that those should not be counted in the FTE

cap. Dr. Hartronft will provide feedback to VACO that better communication is needed out to the field.

There was a public comment period from 3:30p-4:00pm in which no public comment was submitted. Since no public comment was received, the GGAC deliberated during that time, at which time the meeting adjourned at 4:00pm.

The GGAC Committee re-convened at 8:30 am EST on the morning of April 11, 2024. Dr. Shaughnessy reported that she received an email from Ms. Tracy Schaner after the meeting adjourned yesterday. The subject of the email was Prevailing & All-Inclusive Per Diem Rate Clarification. Text from the email is provided in Appendix A.

GGAC met with Christopher Bever, M.D., Deputy Chief R&D Officer for Investigators, Scientific Review and Management (ISRM), Office of Research and Development (ORD), VACO. Dr. Bever provided an update on the reorganization. He discussed the ORD Enterprise Transformation, how ISRM will function in a portfolio structure, and how aging research will be integrated into the program. He discussed the problems that the Enterprise Transformation is designed to address which included but was not limited to contracting, hiring and other HR actions, gaining IT support, and infrastructure improvements. Dr. Bever reported the following accomplishments thus far including centralized contracting for large contracts, HR MACS, ORD representation in IT planning, ORD representation in infrastructure planning, establishment of an ORD office for strategy, expansion of policy support for the field, expansion of the Central IRB, and development of a plan to shift funding from discipline related services to portfolios of Veteran need. He further discussed the capabilities of the Broad Portfolios and of the Actively Managed Portfolios. Dr. Bever also discussed Aging in the Scientific Review Groups. He reported that Health Systems Research has Long Term Care & Aging & Support Services, Rehabilitation Research has Chronic Medical Conditions & Aging, Medical Health and Aging has Cellular & Molecular Medicine, Geroscience and Frailty, and Brain, Behavioral & Mental Health has Alzheimer's Disease, dementia, aging brain, neurodegeneration and cognitive dysfunction. Dr. Bever also shared the structure and functions of the Aging Research Integration Workgroup. Mr. Browdie asked if in the AMPs, are there individuals designated that will have the responsibility and some authority to see that coordination of goals and others are actively pursued. Dr. Bever responded that the AMPs will have a Director who is the senior portfolio manager who will be responsible for making sure that the goals and objectives of the AMP are implemented and that they are not working in isolation and that they have two major sources of input and each AMP has an executive steering committee which includes both program office representation and also other relevant members to provide guidance to the AMP. The AMP Director would be supervised by the Director of Research Integration. Dr. Cohen commented on two things that are often heard in the field. Some programs are still struggling with research hiring and more recently a complication that has made the even more difficult. Funded research positions in some centers have gotten caught up in the hiring cap/freeze. Dr. Bever reported that when the issue with caps was established it was applied to research positions inappropriately. They do have something in writing from the Secretary's office now that research

positions are exempt from this and are now working to get that information out the field. They feel that situation will be resolved within the next few days. Dr. Cohen mentioned the issue of eligibility for non-clinician investigators. Dr. Bever reported that eligibility has been broadened and will probably change again later this year when they go to the new structure. Dr. Shaughnessy will stay in contact with Dr. Bever as those changes unfold. Dr. Bever was asked if Health Systems Research included a long-term care housing and workforce in which he responded that yes there would be research on social isolation and loneliness in the matrix. Dr. Bever was also asked where the GRECCs fit in. He replied that Dr. Shaughnessy has agreed to serve on the research integration work group on aging. She will be able to provide input on behalf of and advocate for the GRECCs. He added that GRECCs are a huge commitment on the clinical side of the VA to support aging related research. Dr. Gifford asked Dr. Bever to think about how GRECCs and GEC programs train a lot of professionals but that the retention rate varies tremendously and is overall low. He asked if it is possible to think about in scoring ,that applicants who trained in the VA system, get some priority bump. He added that many who have trained in VA are going elsewhere and asked how we can create further incentives. Dr. Bever thanked Dr. Gifford for that suggestion. Dr. Gifford thanked Dr. Bever for his presentation.

Marianne Shaughnessy, PhD, AGPCNP-BC, GS-C, FAAN, National GRECC Program Director, Designated Federal Officer, introduced members to a toolkit with resources for understanding VA GEC programs, GRECC programs and performance requirements, and Veterans Equitable Resource Allocation (VERA) reimbursement. Dr. Shaughnessy briefly reviewed these documents and informed the members that she would be emailing them to all members for their reference.

GGAC met with Antonio Laracuente, Director of Field Operations, VHA Office of Research & Development. Mr. Laracuente discussed the ORD realignment timeline. He discussed the Phase II and Phase III centralization efforts initiated and pending actions. He talked about ORD ePerformance and shared the number of appraisals processed including the number still pending. Mr. Laracuente shared the statistics on ORD recruitments between February 2023 and 2024 and the actions they have taken to clean up records. He shared classification metrics for year 1 and reported that triage will close this month. They have established VISN teams. The teams will be staffed according to the workload data from the last 12 months. They will develop a communication plan and training on the ORD service restructure. Dr. Gifford expressed the committees support of this move and the direction taken and asked when will they be at baseline? Dr. Cohen then asked what the expectation is, today, to get a new position filled. Mr. Laracuente responded that they will be at baseline in the next few weeks. To answer Dr. Cohen, Mr. Laracuente added that once the investigator goes into Just-In-Time, they need to start working with the research office on hiring. Dr. Lee asked what are some positions that you can non-competitively hire for and how do they differ from the competitive hiring process. Mr. Laracuente responded that anything that is technical and tied to a research project can be hired under non-competitive authorities. Mr. Laracuente added that as the GGAC is in the field and hears feedback from the GRECCs on whether the hiring is getting better and faster to pass that feedback on to

him. He also added that they rely on the research offices to help the GRECCs and MIRECCs process these activities. He added that knowing the GRECCs relationships with their research offices is important to him. Mr. Laracuente answered another question by adding that they have not provided any training to the GRECC Directors and that they rely on the research offices to do that. Dr. Shaughnessy thanked Mr. Laracuente for always being very responsive to inquiries from the field.

GGAC met with Russ Peal, CPRP, CMSR, Director, Workforce Recruitment & Retention, VHA Workforce Solutions, Workforce Management & Consulting. Mr. Peal began by reporting that VHA hired 61,940 new employees in FY23. He added that VHA's workforce grew by 11,474 employees in the first five months of FY2024 and that VHA experienced a lower employee attrition rate in FY23 than its average over the past 6 years. The AUSH published a memorandum in February 2024 to mitigate impacts of rescinded offers on the workforce and WMC/National Recruitment Service is currently providing alternative placement support of physicians, dentists, APNs, CRNAs, PAs and psychologists. He also discussed the impact of VHA programs focused on Health Professional trainees. Dr. Gifford commented that it is nice to see how HR has evolved over the years that he has been on the GGAC. He continued by adding that we continue to hear about challenges with employee transfers between VISNs and similar with hiring trainees who have already gone through HR approvals and have to go through them again. This results in them leaving VA. Dr. Gifford asked how many of the VA funded trainees are being retained within the VA System? Mr. Peal responded that has been one of their objectives on the WMC side. One thing they launched last year was the codification of the position of the physician advanced practice provider recruiter role and occupation as an official occupation with its own performance measures and its own position description. They are engaged with trainees very early on to find placements for them 12-18 months from their actual completion of their training. What has not been codified yet is a commitment from each VISN that a certain percentage of their new direct patient care hires be health professions trainees. Dr. Lee asked about Health Profession Scholarship Program. She asked how broad is that program and also asked how mission critical is defined for the Educational Debt Reduction Program. Mr. Peal responded that most of the target occupations for their scholarships align with the OIGs mission critical occupations list. For EDRP, its more of a local or VISN decision. Funds are given to the VISNs who distribute the funding to the facilities to fund the participants. Dr. Shaughnessy mentioned that at the last GGAC meeting Mr. Shane Stoltz spoke about the issue of the gap between when a trainee completes their training and the time that they are licensed, and that the VA had no authority to do anything with them in terms of hiring in that space. She asked if there has been any movement on that. Mr. Peal responded that there has been but not as fast as they would have wanted to see. He did report that they will continue to talk about it because they feel it is important to seamlessly transition our trainees into the work force.

Marianne Shaughnessy, PhD, AGPCNP-BC, GS-C, FAAN, National GRECC Program Director, Designated Federal Officer discussed the FY 24 GRECC Site Visit and Upcoming GGAC Schedule. The GGAC will site visit the following GRECCs in FY24: Minneapolis, Palo Alto, and San Antonio. The GRECCs that are due for site visits in

FY25 are Birmingham-Atlanta, Durham, Gainesville, and Greater Los Angeles. The Fall GGAC meeting is scheduled for September 17-18, 2024. Dr. Shaughnessy will send out a poll to committee members to confirm dates for the Spring 2025 and the Fall 2025 meetings.

Following discussion and deliberations, the GGAC Committee complimented VA on the success of the Surgical Pause Program and encouraged VA to continue its development, evaluation and spread. The Committee also expressed satisfaction on ORD's integration of Geriatrics and aging's place within it. They were pleased at seeing the use of data for planning for the future needs of Veterans and the improving quality in the LTC sectors. Finally, they noted the improvements in the research hiring process and the forthcoming memo clarifying the FTE cap on research positions.

The Committee agreed on the following recommendations:

1) The Committee appreciates the use of data for anticipating future needs for older Veterans, however it is critical with these projections, assumptions on demand, workforce availability, staffing, and other costs are clearly defined and factored in with some type of sensitivity analysis. While historical data is helpful, careful decision-making also requires inclusion of fixed costs of existing services.
2) More information is needed on the survey process in State Veterans Homes regarding possible duplicative assessments. GGAC recommends that GEC and NASVH work together to study the frequency of proximate surveys and comparability of processes conducted by State and VA surveyors as well as the comparability of results and report back to GGAC as necessary for additional recommendations in the future.
3) The Committee recommends that Workforce Management Consulting develop and implement a plan to ensure that VHA retains trainees at all levels and converts them whenever possible to VHA employees, maintaining a tracking dashboard for this purpose.

Respectfully submitted:

/s/David R. Gifford, M.D., MPH
Chair, VA Geriatrics and Gerontology Advisory Committee
September 26, 2024