Geriatric and Gerontology Advisory Committee (GGAC)

Meeting Minutes

September 20-21, 2022

GGAC Members:

David Gifford, M.D., MPH, Chairman
Harvey J. Cohen, M.D., Vice-Chairman
Tamara Baker, Ph.D., GGAC Member
Judith Beizer, PharmD, GGAC Member
Richard Browdie, GGAC Member
Stephen Combs, LPC, NCC, CCTP, GGAC Member
Vito Imbasciani, Ph.D., M.D. F.A.C.S., GGAC Member
Carmen Morano, Ph.D., GGAC Member
Joseph Ouslander, M.D., GGAC Member
Barbara Smith, Ph.D., GGAC Member
Julie Stanik-Hutt, CRNP, Ph.D., GGAC Member
Lori Gerhard, ex-officio GGAC Member
Marianne Shaughnessy, CRNP, Ph.D., Designated Federal Officer
Sherri DeLoof, LMSW, Alternate Designated Officer

VA Staff

Scotte Hartronft, M.D., MBA, FACHE, Executive Director, Geriatrics and Extended Care (GEC), VACO
Catherine Kelso, M.D., MS, Deputy Executive Director, GEC, VACO
Mary Goldstein, M.D., MS in HSR, National Director, Data Analytics, Quality Improvement, and Research (DAQIR), GEC, VACO
LaTonya Small, Ed.D., Program Specialist, Advisory Committee Management Office (ACMO), VACO
Christopher Bever, M.D., Director, Biomedical Laboratory Research and Development, Office of Research & Development (ORD), VA Central Office (VACO)
Erica Gruber, A-GNP, BCEN, VA Geriatric Emergency Department Core Team Lead
David Perry, Chief Officer, Workforce Management & Consulting, VACO
Lisa Minor, RN, BSN, MSSL, National Director, Facility Based Care, GEC, VACO
Valerie Delanko, RD, Chief, State Veteran Homes (SVH), VACO
Dayna Cooper, MSN, RN, National Director, Home & Community Based Services (HCBS), GEC, VACO
Megan Mathey, MSW, LCSW, National Program Coordinator, Medical Foster Homes (MFH), VACO
Daniel Schoeps, Director, Community Care, GEC, VACO
Kevin Foley, National Program Manager, HCBS, GEC, VACO
Kendra Madison, MSN, RN-BC, CCM, NEA-BCMSN, RN, National Program Coordinator, Purchased Long-Term Care Services and Supports (PLTSS), VACO
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Chandra Penn, MSHI, BSN RN, Program Manager, Home Based Primary Care (HBPC), VACO
Amanda Merski, MSW, LCSW, Program Manager, Quality & Oversight, Community Nursing Home (CNH), VACO
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Scott Shreve, D.O., National Director, Palliative Care & Hospice, GEC, VACO
Kimberly Church, MS, Management Analyst, GEC, VACO
Cicely Robinson, LCSW, MSW, Program Manager for Quality & Oversight of SVH, VACO
Jennifer Hoard, LSCSW, Program Manager for Quality & Oversight of SVH, VACO
Gay "Lynn" Warren, MSN, RN, CNL, National Program Coordinator, PLTSS, VACO
Lisa Stewart, BBA, Health System Specialist, VACO

Shannon Munro, CRNP, Project Manager on detail to GEC, VACO
Barbra Swann, MS, Health System Specialist, GEC, VACO
Kathryn Scott, LICSW, MSW, Program Manager, SVH, VACO
Rodney Irons, MBA, Supervisory Budget Analyst, GEC, VACO

Guests:
Rene Campos, Senior Director, Government Relations, Military Officers Association of America
Rose Dunaway, BSN, RN, Kindred at Home
Adrian Atizado, Legislative Staff, Disabled American Veterans

The GGAC meeting was called to order at 8:30 am by Chair, Dr. David Gifford. Marianne Shaughnessy, Ph.D., CRNP, is the National Director for Geriatric Research, Education, and Clinical Centers (GRECC) and the Designated Federal Officer for this meeting welcomed members and introductions were made for new members and members who hadn't met personally. Dr. Shaughnessy announced that Dr. Beizer and Dr. Smith had one more year of service on the Committee and would be stepping down on September 30, 2023. Recommendations for new members are always welcomed.

The Committee viewed part of a video presentation of a Under Secretary Town Hall meeting held September 8, 2023, in which the new Under Secretary of Health (USH), Dr. Shareef Elnahal outlined his top priorities and strategic enablers for Veterans Health Administration (VHA). Members appreciated that hiring appeared a top priority, as their recommendations have included same for several years.

The Committee met first with Scotte Hartronft, M.D., MBA, FACHE, Executive Director, Office of Geriatrics and Extended Care (GEC) who dialed in virtually to the meeting. Dr. Hartronft reviewed a set of slides that described the update of GEC Transformation plan and expansion of Home and Community-Based Services.

Dr. Hartronft provided an overview of the aging Veteran population and definitions for aging in place. He shared GEC's priorities of helping Veteran age in place, Age-Friendly initiatives, and VHA's GEC Strategic Plan. Part of aging in place brings expansion to Home and Community-Based Care programs; Home-Based Primary Care with 75 new teams, Veteran-Directed Care (VDC) with 70 new sites, and Medical Foster Home (MFH) with 58 new sites. Age-Friendly initiatives are in place at 74 Veterans Affairs (VA) facilities making VHA the largest Age-Friendly Health System in the United States (U.S.) Lastly, the Redefining Elder Care in America Project (RECAP) is being piloted at two VA sites where staff are using predictive analytics to identify Veterans at highest risk for nursing home admission. These Veterans will have a comprehensive assessment completed and offered home and community-based services and coordination of care.

Dr. Gifford asked where the GRECCs fit in to the GEC Transformation Plan. He responded that while GRECCs are not shown in a box of their own, the educational mission (workforce development) and clinical innovation mission are highlighted. Dr. Gifford also remarked that the Age-Friendly movement within VA is spreading well, but that extra efforts should be made to move beyond geriatric care settings, and Dr. Hartronft agreed. Dr. Baker asked about "improving access through technology" and how that would translate into equitable care for rural and minority Veterans. Dr. Hartronft responded that VHA is building a Clinical Resource Hub network that ideally would include geriatric consultative care for Veterans that receive their care in the community and their caregivers. Ms. Gerhard asked if VA facilities are hiring staff in the medical centers to accommodate the expansion of home and community-based services. Dr. Hartronft replied he would get back to her on that. Ms. Gerhard suggested that GEC might consider ramping up services such as VDC in parts of the country where home health agencies are particularly scarce.

Dr. Ouslander noted that geriatric fellows that train in Home-Based Primary Care Programs enjoy the work and could be recruited to VHA. He asked about plans for the Community Living Centers (CLC) and future new builds, noting that many CLCs are old hospital units with long corridors that promote isolation for older adults. Dr. Hartronft replied that we still have the report from the Asset and Infrastructure Review Commission that reflects the age and condition of all current facilities and assured the Committee that new build CLCs will follow the small house model. Dr. Cohen noted that many CLCs are now primarily short-term rehabilitation and asked about the long-stay residents. Dr. Hartronft noted that the GEC Transformation is about figuring out what facilities VHA will need, where and when they will be needed. Dr. Imbasciani noted the State Veterans Homes (SVH) relieve some of the need for long stay beds. Lisa Minor, Director of Facility-Based Care, GEC noted the short stay beds are for off-loading acute care beds, but there will always be long stay, extended care beds in the CLC program.

Next the Committee met with Christopher Bever, M.D., who is the Director of Biomedical Laboratory Research and Development with the Office of Research and Development (ORD). Dr. Bever explained the ORD is currently undergoing a reorganization to address a shift in how research funding gets to the field. He discussed the move toward actively managed portfolios where ORD will be working with clinical operations in VHA

to determine how to improve Veteran outcomes. ORD plans to begin this effort with precision oncology and move onto other high priority areas including toxic exposures, combat-related injuries, post-traumatic stress disorder and aging. Dr. Gifford asked about how the clinical priorities for determining areas of research will be defined. Dr. Bever replied the process is not yet defined. Dr. Gifford stated that transparency about the selection will be necessary.

Dr. Gifford asked how geriatrics is not a priority when 50% of Veterans are over age 65. Dr. Cohen added that statistically most of the care rendered by VA is to older adults and that geroscience or biology of aging should be seriously considered as a top research priority. Dr. Bever responded the focus would be on translational goals to develop roadmaps for managing Veteran health issues, to distinguish VA research from that of the National institute on Aging. He acknowledged that Congress has mandated aging research through the GRECCs and asked why additional funding who be provided. Dr. Cohen shared that Congress is holding hearings about the need for more geroscience research. Dr. Gifford recommended that ORD activities be aligned with congressional priorities. Dr. Hartronft shared that he had recently met with Rachel Ramoni, D.M.D., Sc.D., Chief Research and Development Officer for VHA to discuss promotion of an aging related portfolio. GGAC recommended that ORD adopt a biology of aging portfolio to include supporting GRECC research.

Dr. Cohen provided a brief report on the GRECC Advisory Committees work over the past year. While many of the 20 GRECC advisory subcommittees were still working on arranging meetings and building membership, all meeting reports and recommendations were managed at the medical center and VISN levels. He noted however, that there may be comments in minutes relating to one GRECC site that may be useful for other GRECC sites. He asked Dr. Shaughnessy and Ms. DeLoof to look for any such comments in future reviews.

Next the Committee welcomed Lisa Minor, RN, BSN, MSSL, National Director, Facility-Based Care and Valarie Delanko, RD, Chief, SVH for an update on the SVH oversight project. Ms. Minor started with the observations that the pandemic brought to light opportunities to improve oversight of SVH program. A year ago, GEC put in a request for help with a new oversight plan that was approved by VHA leadership. As a result, the SVH program has hired several staff members to modernize oversight. Ms. Minor explained that previously the SVH Construction Program was under the Office of Facilities Management, the SVH Per Diem Program was in Office of Community Care (OCC) and the Quality and Oversight (surveys, administration and recognitions) were under GEC. All three elements of the program are now back in GEC. The new organization of the program, effective July 2022, organizes the oversight into 4 pods: Northeast, Southeast/Mid-Atlantic, Mid-West and Southwest/West Coast/Texas. The divisions were roughly drawn in accordance with the regions recognized by the National Association of State Veterans Homes and SVH population density. Each pod has a designated point of contact for quality/oversight, per diem and construction along with the CLC's Ongoing National Center for Enhancing Resources and Training (CONCERT) coach.

Where the SVHs were previously overseen by the VA Medical Center (VAMC) of jurisdiction for corrective action plans, the pod managers now run the quality and oversight process. The new organization allows for central management, tracking and monitoring of emerging issues and regular communications between National Association for State Veterans Home (NASVH) regional directors and pod leads.

Mr. Browdie asked about the consistency with other community nursing home standards being applied to CLCs and if any work had been done to reconcile requirements with the Centers for Medicare & Medicaid (CMS) surveys. Ms. Minor responded that the current requirements are outlined in Title 38, Part 51 and that most of those align with CMS. A crosswalk has been completed and areas that do not align include medications and fiscal administration. A project is underway to align those. Dr. Imbasciani asked if NASVH representatives were included in these discussions. Ms. Delanko responded that POD groups meet regularly on TEAMs and include the regional director and all SVH administrators located within the pod.

Dr. Ouslander asked about the type of residents in the SVH and average size of SVH. Dr. Imbasciani noted that each state has its own eligibility criteria. Ms. Minor validated that states vary in admission requirements, but that 75% of residents must be Veterans, with the remainder Gold Star parents or spouses. Ms. Delanko noted there are currently 161 recognized SVH; 154 receive federal grant payment for Nursing Home level of care residents; 49 receive payment for have Domiciliary level of care and 43 receive payment for Adult Day Health Care, which are the only 3 levels of care VA covers in these sites. The total average daily census for SVH is 20,000. Dr. Gifford noted that the SVH he'd seen look like regular nursing homes but are more modernized and newer.

Mr. Browdie asked about the multiple surveys. All SVH have an unannounced survey by a VA contractor every year. Ms. Minor reported that CMS previously refused to accept VA surveys. Dr. Hartronft noted that VA is encouraging all SVH to become CMS certified – at present only 70% have CMS certification. Dr. Ouslander asked about the concordance between VA surveys and CMS surveys in places where both are done annually. Ms. Minor responded VA does not yet have the bandwidth to track this, especially since it is likely that after any survey, some sort of corrective action plan is usually put into place immediately.

Dr. Gifford reported that prior to this reorganization, there was little SVH oversight. He complimented Ms. Minor and her team for their efforts in modernization and standardization. He stated the role of the Program Office oversight is to help facilities stay in compliance with Federal regulations. Ms. Minor validated that is their approach. In addition, her team provides monthly education on topics such as survey preparation, suicide risk assessment, Age-Friendly principles of care and oral care, to name a few recent topics. The Committee thanked Ms. Minor and Ms. Delanko for their presentation.

The Committee next met with Dan Schoeps, Director, Purchased Long Term Services and Supports (PLTSS). He informed the group that the PLTSS team has grown from one contractor to 2 nurses, 2 social workers and one contractor along with the types of projects the team manages. In the past, the group did not have the resources to

standardize management of purchased services and has now adopted the standardization and rigor of the OCC.

In terms of growth, the VDC program started 14 new sites and added one person in VACO. The new sites are finding it hard to hire new staff to manage the program locally, even as the program is fully funded. They are instead redeploying current staff. Approximately 6000 Veterans are currently served in this program. Dr. Hartronft mentioned that VDC is also expanding in 40 of its current 70 sites, with an anticipated additional 7 sites funded to adopt each year in the future. Mr. Schoeps added that if the Elizabeth Dole Act passes Congress, VDC will have to be fully implemented at all VAMCs and all U.S. territories in 2 years instead of the planned 5 years.

There are several other pilot projects the PLTSS group is managing, including one to improve discharge planning (from nursing home to home) in 3 sites: Houston, Cleveland and Salt Lake City. The other pilot is on Managed LTSS.

There is also one other unfunded pilot, which will introduce a self-directed model of respite care for caregivers enrolled in Program of Comprehensive Assistance for Family Caregivers (PCAFC) program. At present, VHA is carefully tracking Senator Tester's proposed legislation on VA Assisted Living pilot program.

This year, a priority has been addressing the improper payment rate which exceeds 10%, primarily due to using non-compliant contracts for nursing home care. VHA is discontinuing those contracts, enforcing compliance, or replacing the contracts with Veterans Care Agreements (VCA). The VCA use a VA-adaptation of Medicare's Patient Driven Payment Model (PDPM) with decidedly mixed results in the first year. Improvements for FY 2023 are in development. Mr. Schoeps also addressed the attempts to standardize home care, underway for the past several years, to increase the hours VAMCs authorize for home health aide and adult day health services.

Next year, PLTSS plans to address staffing methodology for Medical Centers to use for staffing their purchased care programs. As the Committee Members making GEC sites visits have noticed, nurses and social workers staffing the PLTSS programs local have an average case load 354 Veterans per Full-time Employee Equivalent (FTEE), which is too many. They are challenged with the need to use multiple agencies and therefore have more administrative tasks and less for actual care supervision.

Dr. Cohen noted that on site visits he's heard that the funding supports direct provision of care, not administration of the program. Mr. Schoeps agreed this is the case and explained that locally the process is split between program side GEC and administration OCC, now Integrated Veterans Care, (IVC). GEC obtains the consult and sends to contracted agency and the IVC sends the authorization and pays the bill. The problem is many medical center staff on the program side are doing all the work. VA used to have resources to conduct time/motion studies to accurately assess workload and productivity which no longer exists. Mr. Schoeps noted that GEC will have to figure this out or find someone to do it for VA. Numerous State Medicaid programs limit caseload to 125 patients per FTEE.

Mr. Combs asked what the Committee could do to help. Mr. Schoeps responded that this project already has a high priority, but no funding. Additional resources would allow an analysis of the state's models for staffing.

Dr. Gifford asked about the plan for pilots demonstrated to be effective if there was a plan to fund them. Mr. Schoeps responded that a plan is needed for this as there is no current mechanism to disseminate. Dr. Gifford noted that additional advocacy may be required.

Mr. Browdie asked about the division of labor between Optum and VA teams, noting that in some places he's visited, Optum's presence is not helpful. Mr. Schoeps responded that Optum and TriWest only do claims management and pay the bills. Neither agency manages Veteran referrals or care delivery, which fall solely on VA.

The Committee next met with Megan Mathey, MSW, LCSW, National Program Coordinator for the MFH Program. Ms. Mathey provided a presentation that described the program, specifics of eligibility and current status. MFH is operating in 120 VA facilities serving 800 Veterans in 550 MFHs across the country. She described the history of the program and shared research indicating that when compared to nursing homes, MFH had lower cost and were safer for Veterans during COVID. Veterans enrolled in this program are followed by local HBPC teams, so the MFH must be within the catchment area.

Dr. Baker asked for a description of Veterans using the program. Ms. Mathey responded the population is 65-75 years of age, mostly male and unmarried. She offered to return more complete demographic information to the Committee. Dr. Gifford asked if the program was actively recruiting and Ms. Mathey responded the recruiting at present is targeted towards caregivers which holds the biggest challenge, but that active recruitment for Veterans occurs through social media and local Offices for Public Affairs. She concluded that for the most part, finding Veterans for the program is not hard and the homes are usually at full occupancy. Ms. Mathey noted that the administration of the program requires 1.0 FTEE program supervisor, 1.0 program support assistant and 0.5 recreation therapy assistant per 30 MFH residents.

Ms. Dayna Cooper, MSN, RN, National Director, Home & Community Based Services (HCBS), added that an additional challenge is linking the Veterans in the program to the capabilities of the local HBPC teams which can be a limiting factor. Further, the MFH program is self-pay. Legislative efforts are underway to allow VHA the authority to fund this type of care, since all MFH Veterans are nursing home eligible.

Dr. Imbasciani asked what happens if the host caregiver/family wants to take a vacation. Ms. Cooper responded that VHA would provide respite care. Dr. Ouslander asked if there were exclusions for Veterans with serious mental illness, the type of training that caregivers receive and if there had been any instances of physical or financial abuse. Ms. Mathey responded that a careful vetting process is undertaken before placing a Veteran in MFH and any specialized training needed is provided before the Veteran is placed. HBPC teams monitor the sites on their visits in addition to unannounced supervisory visits at least once every month by the local MFH teams. No

instances of abuse have been identified. As long as the caregivers are able to provide care safely, no exclusions have been drawn.

The next presentation was from Erica Gruber, A-GNP, BCEN National VA Geriatric Emergency Department Team Lead, who shared the news that VHA had just been named the largest integrated health care system with specialized geriatric emergency care by the American College of Emergency Physician (ACEP), with 43 VA emergency department (ED) sites achieving Geriatric ED Accreditation. Ms. Gruber shared that VA EDs treated nearly 2,000,000 Veterans each year, with 50% of those Veterans over 65 years of age. She outlined the unique needs of older adults in EDs the accreditation process outline by ACEP. The VA offices of Geriatrics and Extended Care and Emergency Medicine have been working on this effort for some time with formation of an advisory team in 2017 and launch of the first cohort supported by John A. Hartford Foundation and the West Health Institute in 2020. The leadership team is comprised of Drs Luna Ragsdale, Ula Hwang and Colleen McQuown (Durham, Bronx and Cleveland GRECCs, respectively).

Ms. Gruber described the development of the Geriatrics Emergency Department (GED) Leadership Council and the steps taken to implement requirements for GED accreditation. At present 69 of 111 VA EDs in 37 states are engaged in the program, that represent all Veterans Integrated Service Networks (VISN). She shared data that showed GEDs made significantly more referrals for HBPC, durable medical equipment and geriatric care and reduced rates of admission and 30-day hospitalization for Veterans who received their care in a GED. Ms. Gruber closed with plans for a multi-site evaluation and continued implementation of the program to new sites.

Dr. Gifford asked about how GED accreditation lines up with the Age-Friendly Health Systems movement. Ms. Gruber responded that there has been a consistent effort to integrate requirement for Age-Friendly recognition, though Institute for Healthcare Improvement (IHI) does not yet have standards published for the ED setting.

Dr. Cohen asked how many of the Level 2 accredited sites are progressing to Level 1 and how many Level 3 sites are moving to Level 2. Ms. Gruber responded that in the present third cohort, 14 are new sites and 21 engaged sites are seeking to level up. Louisville went from Level 2 to Level 1, Syracuse and Durham are working to achieve Level 1. Manhattan, Brooklyn and Ann Arbor from cohort 2 are seeking to level up as well.

Dr. Ouslander suggested the results of an evaluation study would be of great value to the VA and the community and asked if one was being planned. Ms. Gruber responded that additional funding is being sought from the John A. Hartford Foundation and West Health Institute. No study is currently planned.

Ms. Gerhard congratulated Ms. Gruber on this work and asked if this work was being shared with the community, specifically if any themes had emerged useful to community based EDs. Ms. Gruber noted that several publications have described this work and noting specifically that the EQUiPPED (Enhancing Quality of Prescribing Practices for Older Veterans Discharged from the Emergency Department) program had a significant

impact on prescribing practices. Pain prescribing practices are safer in GEDs, with fewer inappropriate medications.

The Committee met with David Perry, Chief Officer, VHA Workforce Management and Consulting, who gave a brief presentation on the priorities for the Workforce Office that included the Reforming American Immigration for Strong Employment (RAISE) Act and the Promise to Address Comprehensive Toxics (PACT) Act implementation. These legislative acts have led to improvement in processes for hiring and onboarding, hiring and training of Human Resources (HR) specialists and training for VA supervisors. He described the Secretary's priority and specific steps to invest developing the VA workforce with key initiatives and recent accomplishments. He noted the Coronavirus Aid, Relief and Economic Security Act, RAISE Act, PACT Act and the proposed VA Workforce Improvement, Support and Expansion (WISE) Act having supported the work of VHA HR, but that VHA still needs a variety of authorities, policies and investments to fully address VHA's HR and workforce challenges. While awaiting those, Mr. Perry outlined a 60-90-120-180-day goals for improving HR Service, Governance, Customer Experience and Hiring Time. He noted the success of a new initiative: HR Technical Career Field (TCF) program – a 2-year program that hires into permanent positions in critical shortage fields to combine on-the-job training and experiential learning with a preceptor. Beginning in 2023, TCF will shift to a 1-year high volume accelerated training program.

Mr. Perry closed with a mention of the HR focus on the "3Rs" – Recruitment, Relocation and Retention, and that the PACT Act specifically addressed authorities that now permit agency-approved incentives and elimination of incentive caps.

Dr. Gifford complimented Mr. Perry on the progress to date and noted that perceptions by staff in the field is that HR is often blamed as a rate limiting step to hiring. Mr. Perry agreed that the first priority is filling HR vacancies. Dr. Gifford asked about expediting hires of research personnel. Mr. Perry responded that these hires will be consolidated into a single point of service within WMC.

Regarding incentives for geriatricians, Mr. Perry noted the pay table recommendations were approved up the chain and are with SECVA now. Educational Debt Reduction Program for physicians has also been increased from $60,000 to $100,000, which he hopes will help geriatrician recruitment.

Ms. Gerhard referenced a recent situation at the Administration for Community Living (ACL) where they received notice a second employee planned departure was addressed in advance by keeping a certification list open after a selection was made. She asked if VHA can use this strategy. Mr. Perry responded this was permissible only if multiple positions were being filled at once, as current labor agreements required VHA to post each position. He noted that there are continuous posts for high-turnover positions, such as housekeeping. He added that Title 38 positions are required to be posted for 14 days.

Dr. Gifford noted that VA invests in its trainees, and many wish to stay in VA, however a majority don't because of the time required to hire and credential. Also, he noted that transfers between medical centers are put through the same procedures as new

employees and asked if there was a way to expedite processes. Mr. Perry responded that VA offers a position to a resident up to one year in advance, but the field has been slow to embrace an active hiring stance. There is no better candidate pool than residents and trainees. There is no reason not to extend offers to trainees since there will always be more vacancies. Mr. Perry acknowledged that there is a lot of work to be done on the credentialing side. Expedited credentialing is required for transfers. Fingerprints and background checks are compulsory by regulation.

Dr. Gifford also noted that the hiring process is highly variable in the field, explaining that it often depends on the experience of personnel in the requesting office and HR point of contact. The process flows more smoothly for those who are familiar and do it often. Mr. Perry acknowledged that decisions made at VACO do not naturally cascade down for incorporation and compliance at the points of hiring. He mentioned that WMC just published a manual with a step-by- step guide, which is currently out for evaluation in the field.

Following Mr. Perry's presentation, the GGAC deliberated from 3:15-4:00 pm at which time the meeting adjourned.

The Committee re-convened at 8:30 am ET on the morning of September 21, 2022. The agenda for the second day of the meeting focused on educational topics identified during the nine GRECC/GEC site visits conducted in FY2022 for which members had requested briefings. Sherri DeLoof, LMSW, is the Program Manager, GRECC and the Alternate DFO and she reviewed the recently updated GRECC Directive and provided detailed administrative, research, clinical and educational requirements and responsibilities of the GRECC programs. She also highlighted the responsibilities of the host Medical Center, academic affiliate and VISN to assist the GRECC in meeting its mandates. Ms. DeLoof shared the annual GRECC report card template so that members gained a better understanding of the scope of work of GRECCs.

Ms. DeLoof went on to share background of the Veterans Equitable Resource Allocation (VERA) program and explained in detail how the GRECC research and educational activities earned VERA dollars for the host VISNs. VERA is the mechanism for reimbursing medical centers for the care they provide Veterans. In FY21, GRECCs generated a total of $70,705,621 for their research activities and $21,130,417 for their educational activities (full time health professions trainees, advanced fellows and medical residents, making a total of $91,836,039 in revenue for their VISNs. Dr. Shaughnessy and Ms. DeLoof encourage the GRECCs to use these figures to demonstrate their value to their VISNs. The total expenditures for the GRECC program in FY21 were $49,606,422, well below the figure generated by their activity.

Ms. DeLoof next presented the GGAC Guide to Travel for members, as many encountered difficulties with travel to and from the last three face to face site visits and travel for the in-person meeting. Members asked questions and expressed gratitude for briefing on the complexities of government-funded travel. Dr. Shaughnessy suggested that members would be provided with abbreviated versions of these materials to review with other site visit materials for future site visits.

The final presentations of the meeting involved a review of the current procedures for site visit preparation undertaken at the sites and VACO. Dr. Shaughnessy reviewed the current read-ahead materials that include Last fiscal year Annual Report, local GRECC Organizational Chart, most recent VISN/host Medical Center/GRECC memorandum of understanding, Site Self-Assessment, Last GGAC Site Visit Report, VERA recapture from last fiscal year, map of VISN and minutes from last two GRECC Advisory Subcommittee meetings. The content in each of the documents was reviewed and the Committee made suggestions about the components they found the most useful.

Dr. Gifford noted that Dr. Shaughnessy and Ms. DeLoof review all the site visit materials in advance and will highlight areas of concern for the members to explore during the visit. He also noted it is important for site visitors to look for engagement with the GRECCs from local leadership and an active understanding of the GRECCs role and position in the medical center, VISN and academic affiliate. Dr. Cohen noted that GEC and GRECC are separate programs with separate agendas: GEC is clinical services for Veterans, and GRECC is charged with research, education and clinical innovations. GRECCs should not be doing significant amounts of clinical work, as it takes time and effort away from what they're supposed to be doing. Sometimes the two are too far apart and other times too close. Dr. Gifford noted the Committee is responsible for evaluating and making recommendations for both. Dr. Morano asked how the site visit agendas were established. Dr. Shaughnessy replied that VACO sends a generic template with topics and suggestions for interviews and the GRECCs are responsible for securing interviews with VA and affiliate leadership.

Ms. Gerhard noted that GRECCs are on the cutting edge in developing care delivery models and that it was important for the entire country that these models be fostered and disseminated. The experiences of GEC in implementing these care models will inform U.S. Department of Health and Human Services on future policy.

Following discussion and deliberations, the Committee expressed enthusiasm for the progress made to date on the Under Secretary for Health's plan to address hiring and workforce issues and the GEC Transformation Plan expansion of programs and staff (especially MFH and State Veterans Home oversight). The Committee also agreed that the expansion of the Age-Friendly initiative and the Geriatric Emergency Department initiatives demonstrate commitment and progress in improving care for older Veterans.

The Committee also agreed on the following recommendations:

1. GGAC strongly recommends that the Office of Research and Development (ORD) focus efforts on the diverse aging Veteran population across the spectrum of basic, translational, clinical, rehabilitation and health services research. This research should not simply target individual diseases associated with aging, but on the underlying biology and the unique issues presented by physical and cognitive decline and diversity in the context of increasing coexisting chronic conditions.

VHA projections indicate that the number and diversity of aging and aged Veterans will increase substantially over the coming years, to an extent even greater than the general population. The changes in physical and cognitive functional status and their attendant health issues, and the increase in multimorbidity will create the greatest of challenges to

the provision of health care to our Veteran population. Accordingly, a research portfolio that concentrates on these issues is essential to the optimal management of the increasing number of complex older Veterans.

It is increasingly recognized that the underlying biology of aging plays a major role in the emerging diseases and disabilities associated with aging. Thus, it is of the utmost importance that we improve our understanding of basic aging biology and the potential therapeutic targets it may identify, as well as our knowledge of the optimal approach to the management of the complex older Veteran and the optimal systems in which to deliver care. These issues will likely be the most pressing ones facing the VA system over the next few decades.

2. The Geriatric Emergency Department (GED) initiative has gained significant traction across the enterprise; however, we are not aware of concrete plans for evaluation and outcome assessment. The Committee recommends that Health Services Research and Development (HSR&D) fund a trial with a coordinating center and also observational study to evaluate GED outcomes and cost versus. Additionally, HSR&D should issue a request for proposal (RFP) for evaluations of this endeavor.

3. While the Committee was encouraged about the growth of Veterans who can access GEC home and community-based services, concern remains about the lack of administrative and logistical support that does not appear to be commensurate with growing operational demands. Optum and TriWest have roles that seems to be limited to claims processing, leaving the quality monitoring responsibilities to VHA with limited resources. The Committee recommends that GEC generate and publish staffing recommendations for oversight and administrative support of GEC programs in the field.

4. The spread of Age-Friendly principles of care to multiple VA facilities is heartening news, but the Committee has concerns that once a site has a program recognized as Age-Friendly progress to expand to other programs within the site remains slow. The Committee asks the Secretary of Veterans Affairs to support GEC in development and implementation of a plan to extend Age-friendly care beyond traditional GEC care settings and looks forward to a presentation of plans to spread these practices throughout the enterprise since aging Veterans receive care in all areas not just GEC.

Respectfully Submitted,

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