Geriatric and Gerontology Advisory Committee

Meeting Minutes

April 26-27, 2023

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
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
Roland J. Thorpe, Jr., Ph.D., GGAC Member
Lori Gerhard, ex-officio GGAC Member

VA Staff

Steven Lieberman, M.D., MBA, FACHE, Deputy Under Secretary of Health, VA Central Office (VACO)
Jeffrey Moragne, Advisory Committee Management Office (ACMO), Department of Veteran Affairs (VA)
Scotte Hartronft, M.D., MBA, FACHE, Executive Director, Geriatrics and Extended Care (GEC), VACO
Christopher Bever, M.D., Director, Biomedical Laboratory Research and Development, Office of Research & Development (ORD), VACO
James Rudolph, M.D., Director, Long Term Services and Supports-Center of Innovation (LTSS-COIN), Providence VA Medical Center (VAMC)
Jessica Bonjorni, MBA, PMP, SPHR, Chief, VHA Human Capital Management, Workforce Management and Consulting (WMC), VACO
Gregory Krautner, Program Manager, GeriPACT and Geriatric Evaluation & Management, GEC, VACO
Gay “Lynn” Warren, MSN, RN, CNL, National Program Coordinator, Purchased Long-Term Care Services and Supports (PLTSS), VACO
Catherine Kelso, M.D., Deputy Executive Director, GEC, VACO
Rhonda Toms, DNP, RN, CMGT-BC, GERO-BC, Chief, VHA Community Living Centers (CLC), VACO
Leslie Katzel, M.D., Ph.D., Director, GRECC, VA Maryland Health Care System (VAMHCS)
Beth Hogans, M.D, Associate Director for Education and Evaluation, GRECC, VAMHCS
Jamie Giffuni, Exercise Physiologist, GRECC, VAMHCS
Rodney Irons, MBA, Supervisory Budget Analyst, GEC, VACO
Josea Kramer, Ph.D., Associate Director for Education & Evaluation (AD/EE), GRECC, Greater Los Angeles Healthcare System (GLAHS)

Dayna Cooper, MSN, RN, National Director, Home & Community Based Services (HCBS), GEC, VACO
Daniel Schoeps, Director, Community Care, GEC, VACO
Kevin Foley, National Program Manager, HCBS, GEC, VACO
Jennifer McKenzie, MSW, LCSW, National Program Manager, PLTSS Programs, GEC, VACO
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
Barbra Swann, Health System Specialist, GEC, VACO
Tonya Page, DNP, RN, MHA, CNS-BC, NE-BC, National Director, Home and Community Based and Purchased Care, VACO
Shellena Storey, MSN, RN, GNP-BC, NEA-BC, Chief, State Veteran Home Program, GEC, VACO
Brande Harris, D.O., AD/EE, GRECC, South Texas Veterans Health Care System
Cheryl Schmitz, M.S., RN, CNS-BC, NE-BC, Deputy Executive Director, GEC, VACO
Thomas Edes, M.D., Senior Medical Advisor, GEC, VACO
Sherrie DiFronzo, Health Systems Specialist, VACO
Shawn Clarke, Health Science Specialist, GLAHS
Luis Melendez, Education Program Administrator, GLAHS
Joseph Douglas, Contractor, GLAHS
Chantelle Bartch, Director, Business Operations and Management, GEC, VACO
Wilmino Sainbert, Human Resources (HR) Consultant, WMC, VACO
Sherri DeLoof, LMSW, Designated Officer for GGAC, GEC, VACO
Dawn Fuhrer, BA, Designated Federal Officer, GRECC, Pittsburgh VA Healthcare System

Guests:
Rose Dunaway, BSN, RN, Kindred at Home
Adrian Atizado, Legislative Staff, Disabled American Veterans
Harold Hanson, MPH, CPHQ, Veteran's Healthcare Policy Specialist, Vietnam Veterans of America
Barbara Hyduke, Consultant

The Geriatric and Gerontology Advisory Committee (GGAC) meeting was called to order at 8:30 am by Chair, Dr. David Gifford. Sherri DeLoof, LMSW, is the Designated Federal Office for this meeting. Members were welcomed and guests introduced themselves in-person and through videoconferencing.

Jeff 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. Dr. Gifford asked if this committee could visit Capitol Hill. Mr. Moragne supported that request and replied that it would be an ideal opportunity for GGAC members to meet with congressional staff to learn about current priorities and allow congressional members to learn more about GGAC and its efforts.

Ms. DeLoof provided 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, for the Office of Geriatrics and Extended Care (GEC) in VACO, who dialed in virtually to the meeting. Dr. Hartronft discussed VHA's commitment to the Age-Friendly Health Systems (AFHS), the 4 M's movement, and to the Equitable Access to Home and Community Based Services for Veterans to Age in Place. Dr. Hartronft provided an update of the VHA GEC Strategic Plan, which was followed by discussion of how Home and Community Based Services (HCBS) will be expanded over the next 8 quarters. This expansion will include adding 75 new Home-Based Primary Care (HBPC) teams, 70 Veteran Directed Care (VDC) programs, and 58 new Medical Foster Home (MFH) programs to VA Medical Centers across the country.

Dr. Hartronft explained how the AFHS is an important aspect of VA's Whole Health program and reported that GEC joined the AFHS movement in March 2020. He shared that as of April 2023, 107 VA Medical Centers have earned recognition from the Institute for Healthcare Improvement (IHI) in a total of 217 care settings. Of the 217 care settings, 86 have achieved a Committed to Care Recognition which is ahead of schedule for the multi-year plan that goes through the end of fiscal year (FY) 2025. Dr. Hartronft also commented that the Age-Friendly Community of Practice now includes 1,114 VA staff who meet monthly to learn about becoming age-friendly or share best practices.

Drs. Cohen and Ouslander discussed their concern how VA set a low bar when it comes to Age-Friendly (AF) recognition. They shared their observation of VA facilities receiving recognition even when they have only one component that adopted age-friendly principles, which is usually a geriatrics program that is already age friendly. Dr. Hartronft responded that this is the first wave of AF implementation. He added that VA

has made significant progress and recognizes that there is still more work to do. GEC has added 2 AF FTE within the office to assist with expansion. GEC understands the challenge and recognizes that it is easier for long-term care or geriatric programs to implement. GGAC suggested considering an institution recognized as Age- Friendly when it has more than one component practicing age-friendly principles. GGAC also suggested not including geriatric programs or settings as recognizable components in the recognition process as geriatric care should already be age-friendly and this approach doesn't meet the spirit of the goal.

Dr. Hartronft provided a partial list of GEC related pilots and initiatives. The list included:

- Redefining Elder Care in America Project (RECAP) Pilot available at two (2) sites;
- Homemaker/Home Health Aide (HHA) services for Veterans enrolled in HBPC;
- H/HHA for Veterans not enrolled in HBPC;
- Housing and Urban Development (HUD) vouchers to help Veterans cover room & board in Medical Foster Homes (MFH):
- Partnerships with states for managing purchased long-term services and supports (PLTSS) HCBS;
- Contract Nursing Home (CNH) working with short-stay Veterans to help them transition back to home with the use of HCBS; and
- Hospital to Home offering HCBS for Veterans who are ready for discharge from acute care but need additional services to remain in their homes.

Dr. Hartronft discussed the Centers for Medicare and Medicaid (CMS) and their development of services that were intended to serve individuals in their homes and remarked there may be opportunities for partnerships of one kind or another. Mr. Browdie shared that there are great differences in Medicaid programs among states, and many of their programs are simply contracts with commercial managed care companies. There has led to the development of integrated service provider organizations. As a result, the VA would need to have a way of evaluating any of these arrangements as the outcomes of these plans are not well understood at this time. VA might not be comfortable with the amount of control that would be delegated to managed care entities with a Veteran's care.

Dr. Cohen applauded the expansion of programs that allows Veterans to remain in their homes and asked if the expansion was funded. Dr. Hartronft replied that the VA facilities will receive initial funding for the new programs to hire new staff to expand the number of unique Veterans being served. Dr. Cohen also commented that from past GGAC site visits, members have heard from program coordinators that GEC programs lack administrative support to operate the programs. He asked what GEC knows about the issue, and if so, what they are doing about it. Dr. Hartronft replied that they understand the issues related to hiring and are working on developing staffing guidelines for GEC programs. Dr. Baker asked what has contributed to the 110% increase in the Home Respite program. Dr. Hartronft responded that it is hard to determine. One contribution

is most likely the new Caregiver Support Program (CSP). CSP staff are marketing to caregivers of Veterans that aren't aware of these programs and are proactively working to get them connected. Dr. Morano asked if there is an increase in the use of HCBS across all Veterans populations. Dr. Hartronft replied that the programs are not seeing inequalities based on race or gender rather they are seeing trends in urban vs. rural areas. GEC is looking at HCBS utilization by female Veterans as they age and analyzing trends across different populations, but they do not yet have any publishable data to share with the committee.

Dr. Ouslander appreciated Dr. Hartronft's presentation and the effort from GEC staff to expand integrated programs. Dr. Ouslander asked if GEC is getting a new budget for the Veteran Directed Care (VDC) program and, if so, what are the funds being used for. Dr. Hartronft replied that the funding will be used for staffing of the program. With new staff, the goal is to help Veterans remain in their homes and communities. VDC Coordinators receive consults and work with the Administration for Community Living (ACL) and Area Agencies on Aging (AAA) to assist Veterans with their self-directed budget, care plan, and ensuring the services are available. Dr. Ouslander shared that the VDC program seemed to overlap with the RECAP program, however, Dr. Hartronft noted that these programs complement each other. Dr. Ouslander also expressed concern about discharging Veterans from Community Living Centers (CLC) and transitioning them back to their homes. He felt there is a reason Veterans are placed in long-term care settings. Dr. Hartronft discussed how the Medicaid Money Follows the Person (MFP) program has been successful. Similarly, VDC allows opportunities for Veterans to have additional options to self-direct their care. If a Veteran wants to return home, that should be something they should be allowed to do rather than make them stay in a more restricted environment.

Dr. Gifford asked about rollout of the Electronic Health Record (EHR) and its impact on GEC and Geriatric Research, Education, and Clinical Center (GRECC) programs. Dr. Hartronft replied that none of the five approved sites for implementation have a GRECC, but there is an active GEC EHR counsel. GEC and its partners have over 100 VA staff helping with the EHR initiative. It was recommended that this committee have a subject matter expert come to a future meeting to discuss the EHR implementation in relationship to geriatric programs and services.

Ms. Gerhard asked about the progress of telehealth expansion in rural areas. Dr. Hartronft replied, that during COVID, HBPC conducted combined virtual visits. GEC plans to expand the use of telehealth for specialty care needs in CLCs. Dr. Ouslander asked about access to serious mental illness expertise in nursing homes and is concerned that it does not exist. Dr. Hartronft responded that GEC is working with the Office of Mental Health and Suicide Prevention (OMHSP) on training for CLC staff. He also reported that the Behavioral Recovery Outreach (BRO) program is available in some VAs. Dr. Ouslander suggested that GEC consider interagency collaboration with the Centers for Medicare and Medicaid (CMS).

Dr. Cohen, Vice-Chair, GGAC, is also the GRECC Advisory Subcommittee (GAS) Chair and provided a report for deliberation. The Subcommittee identified two GAS recommendations that did rise to a national level. The first recommendation was to encourage efforts to prioritize the hiring of research personnel especially when grants have been awarded. The second recommendation was to address the salaries of post-docs not being comparable to the National Institutes for Health (NIH). This concern has been referred to the Office of Academic Affiliations (OAA) for action. GAS subcommittee members agreed that additional information on the latter was needed before proceeding with further discussion. Ms. DeLoof felt that the issue was related to the salaries of the Advanced Fellows and not post-docs. She will reach out to the GRECC site that raised the recommendation for further clarification.

GGAC met with Christopher Bever, M.D., who is the Director of Biomedical Laboratory Research and Development with the Office of Research and Development (ORD) at VACO. Dr. Bever discussed the ongoing reorganization within their office. Dr. Gifford asked what the value of the reorganization is. Dr. Bever responded that their difficulty is twofold. The first challenge is focusing resources on translational goals that are part of the VA's Health System, creating cycles of improvement, and using research and data to inform. The second challenge is addressing a lack of transparency on how funding is distributed. He continued to share that Congress frequently asks what ORD is doing about aging, TBI, etc. ORD is charged with creating a funding model that better aligns with the issues that Congress cares about.

Historically, ORD has been organized into four services: Clinical Science, Rehabilitation, Health Services, and Bio-Medical Lab Research and Development. Moving forward the office will transition from services-based research to portfolio-based research. The new focused portfolios include Precision Oncology, Pain/Opioids, Suicide Prevention, and Traumatic Brain Injury (TBI) research and other managed portfolios. Each portfolio encourages collaboration. Dr. Cohen asked what would constitute a broad portfolio. Dr. Bever replied that a broad portfolio would cover all the current projects being funded except for the focused portfolios. The focused portfolios have legislative support behind them and are required to concentrate on specific goals. The focused portfolios have a small number of very focused areas.

Dr. Bever discussed how currently funded projects will transition to the new portfolios. He also shared information about the new application review and project management process. He added that current review committees will not change. Research investigators will apply to Requests for Applications (RFA) and will indicate which review committee(s) they would like their proposal to be reviewed by. A peer review team, staffed with peers of similar disciplines and subject matter expertise, will complete the review. Once the review is completed, the review manager will take the scores and reviews to a funding meeting for the RFA that the applicant responded to. Applications will be ranked and, if funded, will go to the project officer that led the review. This new process is currently in a design and testing phase. Dr. Thorpe asked for clarification on

getting a consultant to work on adjustment factors for scoring to help with the funding. Dr. Bever replied that they already have a consultant to work on adjustment factors for scoring. They don't know yet if an adjustment factor will be needed. They will analyze tabletop exercises to test out what results look like and whether an adjustment factor is needed. As it stands currently, scores appear to compare well.

Mr. Combs asked if the ORD reorganization is for VA only and how it will impact studies that involve VA and non-VA entities. Dr. Bever replied that the reorganization should have minimal impact on joint studies. There are many collaborations with outside organizations, such as the Prostate Cancer Foundation, that work well.

Dr. Gifford noted that GGAC did make a recommendation to the Secretary of VA (SEC VA) asking that geriatric issues be addressed within this reorganization. Dr. Bever shared that Dr. Marianne Shaughnessy has been added to one the reorganization's workgroups. He talked about how the committee overseeing the reorganization includes individuals internal to ORD, Principial Investigators, VISN Directors, Program Office employees, etc. ORD is actively engaged in talking with stakeholders about potential changes. He added that Dr. Shaughnessy has been an active participant in workgroup discussions.

Dr. Gifford noted that Veterans continue to age and major costs to the VA are related to the older Veteran population. He asked how the ORD reorganization will continue VA's focus on aging Veterans. Dr. Bever replied that currently aging research receives $151 million of ORD funding divided among the 4 previous services. Health Service Research & Development (HSR&D), Rehabilitation Research and Development (RR&D), Clinical Services Research & Development (CSR&D), and Bio-Medical Laboratory Research & Development (BLR&D) all support aging research and will continue to do so.

Dr. Bever concluded with asking GGAC members if there are focused areas related to aging research that ORD needs to develop or focus on to improve geriatric care in the VA. He also suggested that ORD will be considering more specific portfolios and want to know what their office can focus on that will have a significant impact on the aging Veteran population.

GGAC heard a presentation from Mr. Browdie, GGAC member and Chair of the State Veteran Home (SVH) Subcommittee. GGAC formed a subcommittee in 2021 to learn more about State Veterans Homes. The group was tasked with looking at the relationship between VA Medical Centers and state-owned Veterans Homes. The subcommittee was tasked to understand the make-up of SVHs and review how quality was being managed. A major concern they addressed was the issue of coordinating annual site visits in a way that would reduce administrative burden on the operators of these facilities. The subcommittee discovered that some SVHs were licensed nursing homes, and some were non-licensed or considered residential. This review identified that the majority of SVHs would be visited annually for inspection by both VA and Medicare, at separate times. Basically, the same information was being asked for by

two different government entities. This often resulted in inconsistency with findings. The GGAC SVH Subcommittee recommended consolidating the Medicare licensing visits and VA reviews using one national contractor to reduce inconsistencies. Unfortunately, it was not possible under the law, as written, to combine visits because SVHs are owned and operated by the states. There are also several facilities that don't have Medicare certifications and are being reviewed by one (VA) contractor. As a result, the workgroup did not see a pathway to resolve the issue of two annual inspections. The committee has disbanded the workgroup. There can be a request to reinstitute the subcommittee if future needs arise.

GGAC met with James Rudolph, M.D., Director of the Long-Term Services and Supports-Center of Innovation (LTSS-COIN) at the VA Providence Healthcare System. The LTSS-COIN is a Health Services Research funded center unique to the VA with a strong focus on LTSS for older Veterans. Their broad goal is to improve access, quality, and value of LTSS for Veterans. They are one of 20 COINs funded by ORD within the VA.

Dr. Rudolph reported that the COIN is currently funded by HSR&D, and focuses on disability, function, long-term care, and aging. Dr. Rudolph highlighted the work of the LTSS-COINs faculty, which included their role in the declassification of Military Deployment Data to study long-term health impacts from exposure to open burn pits; participation in the White House Report on Mental Health Research Priorities; and collaborative research with the Heart Failure Network. He discussed the mentoring and career develop of their LTSS investigators and their Summer Undergraduate Research Program (SURF). Dr. Rudolph discussed Research Impacting Veterans Using LTSS and Experiencing Transitions (RIVULET) and the LTSS Networks unique relationship with the Center for Disease Control.

Dr. Gifford asked what the relationship is between the COIN and GRECC. Dr. Rudolph replied that each COIN is independent. COINS are centrally funded, and the reporting structure goes through ORD. Dr. Thorpe applauded the mentorship and informing policy but questioned if everyone is not represented is everyone benefiting from these policies. Dr. Rudolph replied that VA has a large population of men and that there is some diversity among men with a larger percentage of black Americans compared to the broader population. Dr. Rudolph added that their work is probably under capturing the full diversity of the VA population. Dr. Thorpe also asked, if in the sample, if the LTSS-COIN is stratifying analyses and if they are providing the type of analyses that can be reflected in the research. Dr. Rudolph replied that they do stratify their analyses. In addition to race, there are other factors that they could do a better job at capturing, i.e., economic diversity and sexual orientation. Dr. Thorpe recommended that VA look at the Veteran population as represented today.

Dr. Cohen asked for Dr. Rudolph's thoughts on the COIN being added to a broad portfolio for aging research. Dr. Rudolph replied that he would ask who was leading the portfolio and who was reviewing the grants to ensure that there were enough aging

researchers on each of those panels. Dr. Rudolph clarified that COIN grants are reviewed by HSR&D and there is an aging research panel. Dr. Beizer asked what percentage of COIN trainees go on to positions within the VA. Dr. Rudolph replied that they retain 40-50% as VA investigators. Unfortunately, LTSS-COIN doesn't have any Advanced Geriatric Fellowship slots. Dr. Ouslander asked why they don't have any slots and who makes the decisions about slots. Ms. DeLoof clarified that the OAA makes the decision on who gets Advanced Geriatric Fellowship slots. Dr. Morano asked how much the researchers utilize Artificial Intelligence (AI). Dr. Rudolph replied that they collaborate with researchers at the Washington DC VA Medical Center for using AI.

GGAC spoke with Steven Lieberman, M.D., MBA, FACHE, the Deputy Under Secretary of Health (DUSH) for VA, who discussed his priorities. Dr. Lieberman discussed how his office played an important role in helping VA address challenges with aging Veterans and believes that continued collaborations are critical. Dr. Lieberman noted that he is looking forward to serving more Veterans as part of the recent PACT Act, which is the largest expansion of benefits and healthcare seen within VA in a long time and includes serving the aging Veteran population. VA has added 20 new presumptive conditions for which Veterans with these conditions can apply for benefits. VA is here to help the Veterans who have never enrolled in VA. The administration wants Veterans to know that the VA is here to help them apply for medical care and benefits even if they don't use the benefits or services right away.

Dr. Liebermann discussed VA's attempt to hire employees faster and easier. The goal for FY 2023 was to grow staff by 3%. In the first 6 months, they have already grown by 3.1% and he is very pleased with the results. He believes these efforts will lead to recruiting and retaining the best of the best within VA. VA is working with Workforce Management and Consulting (WMC) to help raise employee salaries to be competitive. VA is also working on legislation to be more competitive with salaries for the hardest to recruit positions. Dr. Cohen asked if geriatricians are among those being looked at for salary increases. Dr. Lieberman replied that individual medical centers now have latitude to offer recruitment and retention options for geriatricians.

Dr. Liebermann talked about the VA' s struggle with implementing the EHR. His office has made the decision to place a pause on rollout of the EHR to any new locations until the areas of concern are addressed. A decision has also been made to correct the issues at the existing five sites who have already gone live. Overall, the EHR system is better but still not where it needs to be. Dr. Cohen applauded the efforts to get the EHR right for the five existing facilities before rolling it out elsewhere. He discussed how the existing sites do not have a GRECC or a Mental Illness Research, Education, and Clinical Center (MIRECC) and hopes implementers will seek advice and input from facilities with those programs. Dr. Lieberman remarked that the implementation teams have individuals from the GRECCs and MIRECCs represented on EHR workgroups advising them on their specific needs. He appreciates VA's plan to correct the basics so that they can expand to facilities conducting research.

Dr. Gifford spoke about GGAC site visits to GRECCs and GEC programs. He is impressed with the VA workforce as they are the most dedicated and passionate workforce they encounter. At every site they visit, they hear about the hiring process being an obstacle. In addition, GGAC members learn about the challenges of hiring of administrative support for these programs. Lack of administrative support leads to VA staff limiting care delivery to complete administrative work that must be completed. Dr. Liebermann agreed that VA needs to focus on increasing support staff. Other areas of focus include addressing burnout. VA has formed a workgroup, about 1.5 years ago, to address work-life balance.

Dr. Gifford shared his appreciation for the implementation of Age-Friendly principles across the country. He also remarked that the VA is light years ahead of other health care systems but discussed that there is still more to do. GGAC wants to ensure that VA doesn't slow its efforts and suggested they use a tiered recognition process for greater execution. Dr. Lieberman agreed that they are making great progress with age-friendly initiatives.

Dr. Gifford noted that addressing health disparities is a high priority for the VA and commented that GGAC members heard very little mentioned in the presentations. GGAC is very interested in this topic and wanted to raise this to the Under Secretary for Health's (USH) attention. Dr. Lieberman agreed and remarked that addressing health disparities is one of their top priorities.

Dr. Ouslander discussed Geriatric Emergency Departments (ED) (GED). He discussed how the VA has been very successful in getting its EDs certified as GEDs. However, physicians who complete residencies in Emergency Medicine are not eligible for Geriatric Fellowships. GGAC suggested collaborating with the American Geriatrics Society (AGS), American Board of Internal Medicine (ABIM), and Emergency Medicine organizations to expand the potential pool of physicians trained in Geriatrics who will be instrumental in further development, implementation, evaluation, and maintenance of the GED program. Dr. Lieberman acknowledge the discussion and indicated that he would pass this on to their academic and ED leadership team.

GGAC heard a presentation from Rhonda Toms, DNP, RN, CMGT-BC, GERO-BC, who is the Chief, for the Community Living Centers (CLC), at VACO. Dr. Toms noted that there are over 130 CLCs across the continental United States and in Puerto Rico. She reviewed eligibility criteria for admission to a CLC and provided a description of the services offered. Dr. Toms also discussed the cultural transformation that has occurred in the CLCs which has been a work in progress since 2005. Dr. Cohen noted that the concept of cultural transformation is great; however, when GGAC visits CLCs, the residents and culture don't appear to reflect the transformation. Many CLCs are in hospital buildings where it is difficult to achieve a home-like environment. Many of the longer stay Veterans are in community nursing homes which results in CLC's taking care of those with post-acute care needs. With this type of population, it now seems like they the CLCs are inappropriately named. Many have home-like components but there still is a lot of work to be done. Dr. Toms responded that she appreciated Dr. Cohen's

perspective on the shift in the Veteran population, however, she was not sure that the program would move away from the CLC transformation. Her goal is to maintain the environment to ensure that the Veterans are getting the best care possible. Dr. Hartronft noted that many of the CLC buildings aren't easy to transform. VA does have some CLCs with a more home-like design that is congruent with the small house model.

Dr. Morano asked what is being done to ensure that the voice of the Veteran is included in the transformational change. Dr. Toms replied that the program is working with the Veterans Experience Office (VEO) to develop a resident specific survey for Veterans to provide direct feedback to CLC administration. The new survey is ready to go out to Veterans and Dr. Toms expects to have data by the end of the fiscal year.

Ms. Gerhard asked what the occupancy looks like in the CLCs and asked how it changed from pre-pandemic to post-pandemic. Dr. Toms replied that pre-pandemic the CLCs were averaging about 7,500 Veterans per day. Once COVID hit, the CLCs were averaging 4,000 per day. Ms. Gerhard also asked about the workforce experience pre-and-post COVID. Dr. Toms responded that the CLCs struggle to maintain staffing. They discovered, during COVID, that the community was offering higher pay for nurses. Various efforts were put forth to address the issue. CLC administrators continue to work hard to hire and retain staff.

Dr. Browdie commented on the resident population in the CLC and reported that it was both younger and had higher representation of Mental Health needs compared to broader populations not in nursing homes. He asked if this is still the same or if has it has changed post-pandemic. Dr. Toms replied that treating of behavioral health is more prevalent and resident data confirms that there is a younger population in the CLCs. Dr. Ouslander emphasized the difference between short stay and long stay and expressed his concern that mixing the two is a mistake for several reasons. First, he shared his agreement with Dr. Cohen in that when you visit a CLC and see the staffing model, it is not the way a typical long stay population is staffed or needs to be staffed. Second, Dr. Ouslander participated on a commission about the future of long-term care in VA, it was recommended that VA focus on short stays and Veterans with chronic illnesses. Dr. Hartronft noted that the mix of short stay and long stay residents is dependent on Veteran needs and what the facility can offer. Dr. Ouslander suggested that VA can be a leader in collaborating with non-VA nursing homes for Veterans with behavioral health conditions.

Mr. Combs asked if CLCs were familiar with the Program of Comprehensive Assistance for Family Caregivers (PCAFC) in relationship to the large population of Veterans struggling with mental health issues in the CLC. He has seen many times caregiver requests denied if psychiatric disability is the primary disability or is the only VA connection. Dr. Hartronft recommended that the GGAC ask the Caregiver Program to present at a future meeting.

Dr. Gifford noted that the way the VA recognizes the Veteran population in the CLCs is different than in the private sector. He advised that VA use caution in labeling Veterans

with mental health issues because this is a unique population to take care of. He encouraged VA and GEC Leaders to visit the Chelsea Greenhouse Model, https://chelseajewish.org/communities/leonard-florence-center-for-living/specialty-residences/, where they take care of patients with Amyotrophic Lateral Sclerosis (ALS). They care for unique patients using a different model of care. Dr. Gifford agreed that physical design is challenging and applauds the VA for the direction that they are taking.

GGAC met with Josea Kramer, Ph.D., who is the Associate Director (AD) for Education & Evaluation (AD/EE) at the Greater Los Angeles GRECC. Dr. Kramer provided an overview of the Geriatric Scholars Program. The Geriatric Scholars program provides education and training opportunities for VA primary care providers throughout the VA. The program also provides workforce development for VA clinicians caring for older Veterans. She discussed the origins of the program and how the program has been historically and largely funded by the Office of Rural Health (ORH) with smaller amounts of sporadic funding from GEC. Dr. Kramer was notified this year that ORH will no longer be able to fund the Geriatric Scholars Program at its previous levels. Dr. Kramer shared a map of the VA sites participating in the Geriatric Scholars program and shared the program's long-range goals. Dr. Kramer reported that there have been 1,421 providers who completed the Geriatric Scholars program and 8,977 other VA employees who have participated in the program. Dr. Kramer shared responses from clinicians who have participated in the Geriatric Scholars program indicating how it positively impacted their careers. Lastly, Dr. Kramer discussed the multiple threats to the program which included there being no reimbursement for employee education from Veterans Equitable Resource Allocation (VERA); unstable, temporary year-to-year funding which prevents planning and hiring; and available funds do not cover all the program needs. Dr. Kramer is working with GEC to explore other streams of funding and hope that they will continue to support the program.

Dr. Cohen asked when a primary care provider expresses interest in the program, what the steps are and the length of time it takes to become a Geriatric Scholar. Dr. Kramer responded that, pre-pandemic, the program was a 4-day face-to-face intensive program offered by universities or GRECCs. During the pandemic, the program moved to virtual modalities which lead to a 19% drop-out rate. The Geriatric Scholars Team coached attendees through their Quality Improvement (QI) project and team-based practices. The Geriatric Scholars Team continues to stay in touch with the Scholars and offer new opportunities which are available for all alumnae. Scholars can stay in the program as long as they wish to. The program has been in existence for 15 years. They also have an advanced scholar track for those involved in the program for a long time with the Team finding new ways to keep them active in the program. Geriatric Scholars offers continuous learning, where there really is no end point.

Ms. Gerhard asked Dr. Kramer what she has learned over the last 15 years around dissemination and embedding the program within the VA. Dr. Kramer replied that the Team is working on taking the knowledge gained, curriculum, and adopted changes and disseminating it to the specialty providers. Ms. Gerhard asked if the program has explored other partnerships to help with sustaining the program including CMS or the

Agency for Health Research Quality. Dr. Kramer replied in the negative and commented that she is managing the program on a shoestring budget. Dr. Cohen asked what the current budget is and what that covers. Dr. Kramer responded that the budget is used for travel to attend the courses and tuition. She added that the program receives a lot of in-kind contributions from VA faculty. The overall administration is in-kind and uses one FTE. She estimates needing $11 million to cover the existing program and to expand to its full potential.

GGAC met with Ms. Jessica Bonjorni, MBA, PMP, SPHR, Chief of VHA Human Capital Management for Workforce Management and Consulting (WMC) at VACO.
Ms. Bonjorni presented on WMC and provided updates on previous questions from GGAC. Ms. Bonjorni reported that there have been many new priorities from SEC VA and the USH to improve hiring. She discussed the new legislation for hiring included in the RAISE and PACT Acts which have been implemented. Unfortunately, meeting the timelines are still a challenge based on substantial volume. WMC is currently drafting job aids for onboarding to increase standardization of the hiring process. WMC hopes the job aids and standardization will boost the HR Specialist population with the HR Star program. The eBenefits improvement has been piloted in one VISN and will soon be rolled out nationally. WMC has expanded the applications for childcare, the debt reduction program, and the public loan forgiveness program. Hiring faster and more competitively has improved, which is an USH priority. WMC aims to achieve a 3% increase in total employee onboards by hiring 52,000 employees by October 1, 2023. VA staff retention rates are dropping. WMC will be focusing on critical occupations for critical operation, i.e., nursing assistants, nurses, housekeeping aids, medical support assistants, food service workers, and physicians. Ms. Bonjorni noted that WMC needs to practice a more consistent approach with the use hiring authorities. Her office is identifying ways to apply hiring authorities consistently by occupation. WMC aims to reduce the time-to-fill a position by 20% and find out what is taking too long in the process. VHA has hired over 27,000 employees during the first half of the fiscal year. Ms. Bonjorni described new changes to the Technical Career Field Program and discussed maximizing recruitment, relocation, and retention incentives (3Rs).

Ms. Bonjorni provided the following updates on questions raised by GGAC:

- **Increase the geriatrician salary pay table from Tier 1 to Tier 2.** Ms. Bonjorni shared that the 2020 Physician, Dentist, and Podiatrist Steering Committee recommendations are still in process, awaiting concurrence.
- **How much of the hiring process is standardized across the VHA? What are the variables and what is being done to address hiring challenges?** Dr. Gifford learned within VHA's onboarding process, candidates must interact with multiple departments and platforms, often with very little direction or an understanding of the purpose, the ask, or even how to do something. This ambiguity leads to candidates dropping out of the application process, accepting jobs elsewhere, rejecting final offers, and overall frustration with the onboarding process. Ms. Bonjorni shared that WMC is implementing the Candidate Care

Model to assist VHA hiring managers and HR specialists in providing a consistent outstanding onboarding experience.

- **Will VHA Office of Research and Development (ORD) research hiring be centralized?** Dr. Cohen mentioned the issues surrounding hiring of research staff who are funded on a newly acquired grants through the VA. Ms. Bonjorni noted that the hiring authorities differ, and local HR staff may not be familiar with hiring authorities and how they work. WMC now has a dedicated team who understands how to hire for research staff, and they are working on standardized position descriptions so that they don't have to worry about classification. Ms. Bonjorni also shared that the shift of ORD HR servicing to WMC will provide a variety of human capital needs including the consistency of position descriptions and the hiring of research staff. WMC is in the process of pursing a legislative proposal to streamline the ORD hiring authorities to align hiring practices with grants timelines.
- **Are there standardized position descriptions for the research community?** WMC has been standardizing position descriptions (PD) within VHA Central Office since 2019 and has standardized over 300 PDs to date. Her office is in the process of standardizing numerous PDs, in FY 2023, including ORD positions. WMC is also implementing numerous other classification improvements to expedite the hiring process including the launch of functional statement standardization and validation of implementation with Consolidated Classification Unit (CCU) assistance.

Dr. Gifford explained that on every GRECC site visit conducted by the GGAC, issues with the hiring process is a complaint that they often hear. Dr. Gifford thanked Ms. Bonjorni and noted that he appreciates that WMC is addressing the issues in a thoughtful systematic way with discrete goals. He also acknowledged VA leadership recognizing hiring as a complex issue. Ms. Bonjorni replied in agreement and responded that at one given time, her office was working on 25-30 legislative proposals related to workforce.

Dr. Gifford asked about the recruiting of trainees on H1 visas. He asked how the VA can recruit individuals who are non-citizens. He noted that there appears to be a gap in knowledge on the local level as to how to do this locally. Dr. Gifford also asked if the VA is taking the time and resources to train individuals who are non-citizens why aren't they able to hire them. Ms. Bonjorni replied that they are actively working on addressing this issue.

GGAC deliberated from 3:30-4:00 pm at which time the meeting adjourned.

The GGAC Committee re-convened at 8:30 am EST on the morning of April 27, 2023.

Sherri DeLoof, LMSW, is the Program Manager, GRECC and the DFO for this meeting. Ms. DeLoof reported that a notice for solicitation for new GGAC members was published and will close on May 15, 2023. There will be two members rotating off the committee at the end of September 2023. Ms. DeLoof encouraged GGAC members to contact Marianne Shaughnessy if they know of potential candidates, not VA employees, who might be interested in being on this committee.

Ms. DeLoof went on to discuss the upcoming schedule for GGAC. The fall meeting is scheduled for September 19-20, 2023. The meeting will be face-to-face in Washington, DC. The final location is to be determined. Suggested agenda items for the next meeting include Geriatric Scholars, HR Updates, and diversity, equity, and inclusion (DEI) activities, and the CLC cultural shift. Dates for the 2024 GGAC meetings have been confirmed as April 10-11, 2024, and September 17-18, 2024. Location to be determined later for both meetings.

Ms. DeLoof discussed the upcoming GGAC site visits to GRECCs and GEC Programs. She reported that GRECC site visits remaining for FY 2023 include Ann Arbor, Baltimore, Bronx, and Eastern Colorado. Site visits scheduled for FY 2024 include Minneapolis, Palo Alto, San Antonio, and Salt Lake City.

Ms. DeLoof shared summary information resulting from the GRECC FY 2022 annual report of GRECC activities. Ms. DeLoof reported that they have seen a drop in the number of trainees approved by the Office of Academic Affairs mainly because some professions moved from undergraduate to graduate (postgraduate) positions. In addition, nursing slots were replaced with Nurse Practitioners (NP) positions. Dr. Browdie asked what the rationale for these changes was. Ms. DeLoof shared that OAA focuses on the terminal clinical experience needed to become hired in the VA. As qualification standards shift, OAA shifts its funding focus. Dr. Gifford asked what the retention rate of trainees was and encourages OAA or WMC to track that information.

GRECC staffing and vacancies were presented and noted that there are currently seven vacancies for GRECC Directors. One new Director was appointed this week and three others are in process. The current vacancies for GRECC leadership include one GRECC AD/EE, four vacancies for GRECC AD for Research, five vacancies for GRECC AD for Clinical Innovations, and no vacant Administrative Officer (AO) positions. Dr. Cohen noted the importance of getting GRECC employees thinking about succession planning. Dr. Gifford reported that GGAC does encourage and talk to the GRECC directors during every site visit about succession planning. Dr. Gifford asked how GRECC AOs are meeting, sharing, and supporting each other. Ms. DeLoof responded that she and Dr. Shaughnessy have met with each group to discuss succession planning. In addition, the AOs are participating in an Administrative Officer Boot Camp in May 2023 and new AOs have been assigned a mentor. Lastly, Ms.

DeLoof provided the attendees with examples of some research, education, and clinical multi-GRECC collaborations.

Dr. Thorpe asked what the success metrics are for the GRECCs and what is considered success. Ms. DeLoof shared a couple of performance metrics and results. Dr. Gifford added that GRECCs are self-sustained through VERA funding from the local VAMC. Dr. Hartronft noted that he is not sure if the medical centers know how much GRECCs contribute to the VERA coming into the VISNs and facilities and suggested that GGAC should highlight the impact the GRECCs bring to the local VAs.

Ms. DeLoof provided committee members with an inclusive list of recommendations previously made by this committee. Dr. Gifford reported that the big trends in recommendations are related to hiring challenges, EHR issues, Age-Friendly, and disparities in health care. He also acknowledged the VA's priority for addressing health disparities in its Veteran population, however, a previous recommendation for GEC to address health disparities in older Veterans and include diversity, equity and inclusion in GEC metrics has not been addressed yet. Dr. Beizer noted that one expectation of GRECCs is to provide training for both staff and trainees on geriatric topics but there appears to be no incentive to encourage VA staff to take the training. Dr. Morano also noted that there is no mention of diversity training. Regarding bringing in high school and undergraduates to engage in volunteer experiences within VA, Dr. Cohen suggested that VA include "in diverse underrepresented minority groups" for inclusion in VA experiences.

Dr. Baker asked about two recommendations for GEC to create a subcommittee to focus on disparities in care and to include disparities in GEC metrics. After lengthy discussion, there was concern from the committee that while DEI has been declared a mission of the VA, they did not hear much from presenters to indicate that DEI has diffused throughout the organization. GGAC members suggested that a GGAC subcommittee be formed to look at DEI within VA.

Dr. Browdie asked about telehealth expansion and if VA is investigating barriers to Telehealth expansion, i.e., providing care across state lines. The Office of Connected Care responded that practice across states lines is no longer an issue.

Following discussion and deliberations, the GGAC Committee agreed on the following recommendations:

1. GGAC appreciates the VA's commitment to the aging Veteran population and research and strongly recommends the area of Aging, Geriatrics, and Geroscience be one of the Portfolios in the ORD reorganization. Given its cross-cutting nature, GGAC believes it could be a Broad Portfolio, but if not, at least a Managed Portfolio. In addition, regardless of other aspects of the reorganization there should be consistent aging research expertise presence on the review committees.

2. GGAC recognizes the challenges in bringing on a new EHR and recommends that broad input be sought from programs such as the GRECCs, MIRECCS, COINs, and other VAMCs with strong research programs and special clinical program development as the new EHR structures are considered. The initial pilot VAMCs did not have such programs. Input on the unique clinical and programmatic aspects of geriatric care is critical in providing high quality care to the older Veteran population.

3. GGAC appreciates the efforts from the Geriatric Scholars program in training and developing a geriatric workforce and recommends finding mechanisms to maintain the funding for the program which has by all accounts been quite successful and is under threat of significant constriction because of funding cuts from the Office of Rural Health.

4. GGAC recognizes the VA's priority for addressing health disparities in its Veteran population and recommends Geriatrics and Extended Care integrate disparities in older Veterans and include diversity, equity and inclusion in GEC metrics across all the programs.

Respectfully submitted:

David R. Gifford, M.D., MPH
Chair, VA Geriatric and Gerontology Advisory Committee

July 13, 2023