Geriatric and Gerontology Advisory Committee

Meeting Minutes

September 19-20, 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
Fayron Epps, Ph.D., RN, FGSA, FAAN, GGAC Member
Jeannie K. Lee, Pharm.D., BCPS, BCGP, FASHP, AGSF, GGAC Member
Carmen Morano, Ph.D., GGAC Member
Joseph Ouslander, M.D., GGAC Member
Barbara Smith, Ph.D., GGAC Member
Julie Stanik-Hutt, Ph.D., ACNP/GNP-BC, CCNS, FAAN, GGAC Member
Roland J. Thorpe, Jr., Ph.D., GGAC Member
Lori Gerhard, ex-officio GGAC Member

VA Staff
Barbra Swann, Health System Specialist, GEC, VACO
Brandy Delong-Casey, VHA
Brenda Rodriguez, Program Analyst, VHA
Byron Bair MD, FACP, MBA, Clinical Director VHA ORH VRHRC SLC
Carolyn Stoesen, Director, Enrollment and Forecasting, VHA
Catherine Kelso, M.D., Deputy Executive Director, GEC, VACO
Chandra Penn, MSHI, BSN RN, Program Manager, Home Based Primary Care (HBPC), VACO
Christopher Bever, M.D., Director, Biomedical Laboratory Research and Development, Office of Research & Development (ORD), VA Central Office (VACO)
Colette Alvarez, Chief, State Home Per Diem Program, VHA
Colleen M Richardson, PsyD, Executive Director Caregiver Support Program, Caregiver Support Program
Daniel Schoeps, Director, Community Care, GEC, VACO
Darlene Davis, National HBPC Manager, VHA
Ernest Moy, Executive Director, Office of Health Equity, VHA
Gay “Lynn” Warren, MSN, RN, CNL, National Program Coordinator, PLTSS, VACO
Gregory Krautner, National GeriPACT/GEM Program Manager, VHA Office of Geriatrics and Extended Care
Jeffrey Moragne, Advisory Committee Management Office
Jennifer McKenzie, MSW, LCSW, National Program Manager, PLTSS Programs, GEC, VACO
Kameshia Harris, Health Systems Specialist, SVH Construction Grant Manager, VHA
Kayla Lalande, VHA
Kendra Madison-Harswell, RN, Community Care, DVA
Kimberly Church, MS, Age-Friendly Health Systems National Lead, Office of Geriatrics and Extended Care
Kristin L Humphrey, Director, Associated Health Education, VHA
Danielle Latimore, Management Analysis, VACO
Lisa J. Moore, Management and Program Analyst, VHA
Roshonda Phillips, VHA

Russ Peal, Director, Workforce Recruitment & Retention (VHA/WMC) Ryan Weller, LCSW, APHSW-C
Scott T. Shreve, DO, National Director of Hospice and Palliative Care, VHA
Scotte Hartronft, M.D., MBA, FACHE, Executive Director, Geriatrics and Extended Care (GEC), VACO
Shane J. Stults, CPRP, National Healthcare Recruitment Consultant, DVA
Shannon Munro, CRNP, VHA
Sharon Sloup, VHA
Sharya Bourdet, Associate Director, Associated Health Education, Office of Academic Affiliations, VHA
Tanisha Mcgriff, National Program Manager-Community Living Centers, VHA
Thomas Edes, MD, Senior Medical Advisor, Council Co-Chair Electronic Health Record Modernization, VHA Office of Geriatrics & Extended Care (GEC).
Marianne Shaughnessy, PhD, AGPCNP-BC, GS-C, FAAN, Designated Federal Officer
Dawn Fuhrer, BA, Designated Federal Officer

Guests:
Roscoe Butler, Paralyzed Veterans of America
Harold Hanson, MPH, CPHQ, Veteran's Healthcare Policy Specialist, Vietnam Veterans of America
Tracy M. Schaner, LNHA, LRCA, SHRM-CP, PHR, President, National Association of State Veterans Homes
Heyward Hillard, National Association of State Veterans Homes
Rose Dunaway, BSN, RN, Kindred at Home
Melissa Jackson, National Association of State Veterans Homes
Peter Dickinson, National Association of State Veterans Homes
Whitney Bell, National Association of State Veterans Homes

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

The Committee first met with Scotte Hartronft, MD, MBA, FACHE, Executive Director, Office of Geriatrics and Extended Care (GEC) who dialed in virtually to the meeting. Dr. Hartronft discussed the Geriatric's and Extended Care's (GEC) Continuum of Care for Veterans of All Ages from independence through end of life. Dr. Hartronft provided a listing of the GEC Programs within Ambulatory Care, Inpatient Care, Home and Community Based Long-Term Services and Supports (LTSS), Facility Based Care, and Hospice Care. Dr. Hartronft reviewed the GEC Strategic Plan for FY2020-FY2024, which was followed by discussion of comparing VHA enrollees to the US general population. Based on the data provided, 47% of VHA enrollees are ages 65 and older versus 17% of the US population that are age 65 and older. In addition, 55% of VHA rural enrollees are age 65 and older versus 20% of US rural population that are age 65 and older. Dr. Hartronft continued by providing VHA demographic projection trends on women enrollees aged 65 and enrollees of both genders ages 85 and older.

Dr. Hartronft explained the key challenges to meeting the VHA's projected demand for long-term care. They included addressing workforce shortages, aligning care geographically, and meeting needs for specialty care. He discussed Aging in Place and the current VA Home Care Expansion initiative. Dr. Hartronft explained what is meant to be Age-Friendly and shared that

118 VA Medical Centers have earned Institute for Healthcare Improvement (IHI) recognition as of September 1, 2023. He also shared that as of September 2023, 67 of the 111 VA Emergency Departments had earned the Geriatric Emergency Department Accreditation recognition and more applications are pending. Dr. Hartronft provided some information on the Nursing Home to Home Pilot, the Redefining Elder Care in America Pilot (RECAP), and VA Employed Home Health Aide in Home Based Primary Care pilots. Dr. Hartronft provided a description of the VA State Veterans Home (SVH) Modernization structure and purpose and provided VA Nursing Home Program information that included VA Nursing Home utilization in FY22, VA costs in FY22, utilization based on Veteran priority levels and general nursing home population differences. Dr. Hartronft described the plan to meet facility-based care needs which included continue increasing Aging in Place utilization to prevent or delay nursing home admissions, continue to collaborate with State Veterans Home partners to expand nursing home sites where needed, and maintain and/or expand community care network contracts where and when necessary. Lastly, Dr. Hartronft shared data on the Rural Health Funding for GEC programs trend from 2021 through 2025.

Ms. Gerhard inquired about the treatment costs presented for Chemotherapy/Radiation, IV Medications, and Dialysis for the VA Nursing Home Program. The data showed that the treatment costs were much higher in the Community Living Center than in the Community Nursing Homes and State Veterans Homes. Ms. Gerhard asked where the costs to SVH and CNH were being charged and if they were included in the per diem. Dr. Hartronft explained that the per diem provided does offset some of the costs of the treatment and that the per diem levels are based on the priority level of the Veteran. Ms. Gerhard also asked if there was a way to get equity on the cost comparisons by extracting out costs that are unique to the different settings. It was suggested to have a representative from VA Accounting and the SVH present additional information on costs and per diem. While Dr. Gifford applauded the VA Nursing Home program, he suggested that the CLC cost data be presented differently in the future. Without additional explanation of the numbers provided, it appears to be misleading and could drive policy change in the wrong direction. Dr. Gifford asked Dr. Hartronft to provide more detailed information regarding the cost disparity between CLC care and that paid for Veterans in CNH and SVH.

Dr. Cohen commented that the biggest crisis facing all the nursing facilities is personnel, both in the VA and in the private sector. He asked where the VA sits in that regard compared to the private sector. Dr. Hartronft responded that staffing levels in our CLCs are already above what will be required by CMS and that VA does not have access to staffing data in SVH and CNH facilities to determine if it will meet the new guidelines. Dr. Gifford informed Dr. Hartronft that all the SVH and contracted CNHs that are either Medicaid or Medicare certified will submit Payroll Based Journal (PBJ) data that can be used to determine how many of them meet the proposed minimum staffing requirements from CMS. He asked that they stay cognizant to the challenge of staffing levels and suggested enlisting the GRECCs to look at some of the data to take the burden off GEC staff.

Dr. Gifford applauded Dr. Hartronft for providing demographic data on Veterans in his presentation. He pointed out that while on GRECC site visits, he has repeatedly noticed that staff are aware of the increasing age of the Veterans and some shifts, but they don't have this data available to use for strategic planning. The data is not filtering down from VACO to the VISN or VA facility level. Dr. Gifford asked if there was a way to provide that data broken out by

VISN and facility and he encouraged Dr. Hartronft to build an infrastructure within the GRECC program to assist with pilot testing in this area.

Dr. Morano asked that given the changing demographics, especially in the 85and older population, what is VHA doing to increase the enrollment of our more diverse populations by gender and race? Dr. Hartronft responded that they are currently in evolution and are starting to look at health equity. He also reminded the committee that Dr. Moy, from the VHA Office of Health Equity, would be speaking to the committee later in the day and would be able to provide further information.

Dr. Cohen commented on the good work going on in the Age-Friendly initiative. He asked that we keep pushing for all aspects of our facilities to be age-friendly and not just the geriatric settings that are already age-friendly. He asked that we keep reiterating that what we are aiming for is an age-friendly health system, which means that all settings in the facility are age-friendly.

Next the committee met with Sarah Bender, MHA, Program Analyst for the VA Office of Enrollment and Forecasting. Ms. Bender discussed enrollment and forecasting, shifting demographics of aging Veterans, and strategic planning. Ms. Bender began by sharing that Enrollment and Forecasting is organizationally aligned within the Chief Strategy Office. The Chief Strategy Office's mission is to integrate strategy, information and insight to enable VHA to provide industry-leading health care to Veterans. Their office provides insightful, timely projection scenarios to support VHA budget formulation, strategic planning and policy analysis. They work with contracted actuaries from Milliman to produce the VA Enrollee Health Care Projection Model (EHCPM), a sophisticated health care demand projection model which projects Veteran enrollment, utilization of VA health care and associated expenditures, as well as other actuarial analyses to support these key VHA functions.

Ms. Bender described what the EHCPM is and how its projections enable VA to plan for the resources needed to meet the projected health care demand. She discussed how projections account for demographics and provided a list of drivers of demand. Ms. Bender indicated that projections are developed for Priorities 1a, 1b, 2, 3, 4, 5, 6, 7, and 8, five -year age bands, male and female enrollees, post-9/11 era combat Veteran enrollees, and VA Direct and Community Care. She also indicated that geographically, projections are developed at the sector, submarket, market level and nationwide. She discussed the enrollee-based model and noted that the EHCPM projects over 150 Health Care Services Categories. Ms. Bender provided a list of Long-Term Services and Supports Health Care Service Categories for Institutional and Non-Institutional VA Direct Care and for Institutional and Non-Institutional Community Care. Ms. Bender provided information on Model Concepts, Model Outputs, and Strengths and Limitations of the EHCPM. Lastly, Ms. Bender provided information specific to the submarket and market that the Bronx VAMC site is located in, recently visited by GGAC members.

Dr. Cohen asked how they define long stay for facility-based care, and it was clarified to be 91 days or more. Following the report on the Bronx Medical Center, Dr. Baker asked why are we seeing a drop in mental health services for aging Veterans. Ms. Bender indicated that she would need to check with the Office of Mental Health. Dr. Shaughnessy asked if it could be that older Veterans are not being referred or that there is a lack of resources. Ms. Bender was asked to find out and report back to Dr. Shaughnessy. Dr. Shaughnessy did report that the Bronx is a unique medical center and includes a small catchment area. There are five hospitals in that general area, including Manhattan VAMC, Brooklyn, VAMC, Hudson Valley VAMC and St.

Albans VAMC in Queens. It could be that patients needing mental health services are being referred to another medical center in the area. Dr. Baker suggested that in the future, they include reference to that in their presentation.

Ms. Gerhard asked how the innovations and evolutions of some of the pilot studies that the VA has been doing on the predictive modeling are getting factored into the actuarial assumptions that will be needed to help address some of the LTSS needs over time in the 85+ populations. Ms. Bender responded that a lot of that is accounted for in their utilization and intensity trends.

Ms. Gerhard commented that they still have some concern about whether we are continuing to make investments in helping people get access to mental health services, assistive technology, and home modifications that help them stay in their homes longer. Ms. Bender responded that when they are working closely with the different program offices, they are talking with them about what they expect them to do. They work that into the model as they are planning for the budget. Ms. Stoesen commented that they do the best that they can to understand what is going on in the system and noted that collaborations with their colleagues are crucial.

Dr. Gifford noted that this is valuable data and the primary audience has been budget forecasting from the Secretary's office. He commented that as we travel around to do site visits, many sites are unaware of the value of this data and are trying to make strategic planning decisions for allocation of resources without this data. Dr. Gifford noted that one recommendation that may come out of this meeting is how to make this data more available to the clinical managers so that it can be used to its fullest.

Next the committee met with Dr. Harvey Cohen, who is the Vice Chair of the GGAC. Dr. Cohen discussed the GRECC Advisory Subcommittees (GAS) report and listed the items sent forth for recommendation for GEC Program Office, VACO or GGAC review. They included 1) a recommendation to make CMS data sets available to VA, 2) a recommendation to accelerate a solution to work on the backlog of HRMACS new hires, and 3) a recommendation for VA IT to keep Zoom.gov. Dr. Shaughnessy clarified VA will be phasing out all telehealth platforms except WEBX and VA Video Connect. She explained that the Gerofit program currently uses Zoom.gov and that the other programs do not offer the same capabilities that Zoom.gov does. A waiver has been submitted to IT to request that the Gerofit program be allowed to continue using Zoom.gov until the other programs can offer the same capabilities.

Dr. Cohen motioned to accept the report. Dr. Beizer seconded the motion to accept the report. All committee members were in favor of accepting the report.

Next the committee met with Colleen Richardson, PsyD, Executive Director, Caregiver Support Program. Dr. Richardson provided a Caregiver Support Program Overview. Dr. Richardson explained that the Caregiver Support program is one program with two components. The first being the Program of General Caregiver Support Services (PGCSS) and the second being the Program of Comprehensive Assistance for Family Caregivers (PCAFC). The mission of the program is to promote the health and well-being of Veterans' caregivers. Dr. Richardson provided an overview of where the program started in 2008 through where the program is headed. Dr. Richardson first discussed the PGCSS program and explained the VA's definition of what a General Caregiver is and indicated that they do not need to be a relative or live with the Veterans. She discussed the four core elements of the program, which are Education and Support, Collaboration and Partnerships, Outreach, and Resources and Referrals and reported that there is no formal application required to enroll in PGCSS. Next, Dr. Richardson discussed

the PCAFC program and provided a list of PCAFC services which included Education and Training, Enhanced Respite Care, Mental Health Counseling, Beneficiary Travel, Monthly Stipend, Access to health care through Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), if eligible, and financial planning and legal resources for Primary Family Caregivers. Dr. Richardson provided the eligibility criteria for PCAFC and reported that there is an application process for this program and an official review and appeal option for Veterans and caregivers who disagree, in whole or in part, with a VA decision under this program. Lastly, Dr. Richardson provided information on education and support for all referrals to the program.

Mr. Combs asked for an age breakdown of the recipients of the caregiver program. Dr. Richardson reported that the recipients range from ages 24 to106 and that close to half of the recipients are over 65.

Mr. Combs also asked for further discussion about eligibility for the caregiver program for Veterans who's only service-connected condition is a mental health disorder. Since these Veterans do not need assistance with ADLs but need supervision or protection of a caregiver, he questioned if this is taken into consideration when determining if a Veteran is eligible for the program. Dr. Richardson reported that they look at multiple things when determining a Veterans potential need for in person personal care services. They must need personal care services for a minimum of 6 continuous months. The other two things that they look at is a need for supervision or protection based on symptoms, or residuals of a neurological or other impairment, or injury. Lastly, they look at the need for regular or extensive instruction or supervision without which the ability of the Veterans function and daily life would be seriously impaired, which is where mental health disorders could be a qualifier. The program takes a holistic approach to the Veterans need for in person personal care services. They do not look at diagnosis as a qualifier for the program. They look at the need for personal care services.

Mr. Combs reported that according to VBA guidelines, when Veterans who are determined to have a 60% or more service-connected disability rating and establish entitlement to a total disability due to individual unemployability, the unemployability rating is considered to be the same as a 100% (total) service-connected disability rating and they receive the associated VBA benefits. He has seen that sometimes these Veterans are denied access to LTSS such as the caregiver support program because they do not have the requisite 70% or above service-connected disability rating. Mr. Combs stated that VHA does not recognize this and therefore Veterans are not getting access to all the VHA benefits that they have earned. Dr. Hartronft confirmed that if a Veteran is completely disabled and unemployable at 60% or greater service-connection, that they are deemed by the VA as 100% disabled. Dr. Richardson also confirmed that for the PCAFC program unemployability based on a single 60% service-connected condition does not meet the criteria for inclusion, which requires a minimum of 70%. It appears to be unclear if everyone at VHA is on the same page with this determination. Dr. Shaughnessy will investigate this issue and report back to the committee.

Dr. Cohen asked for clarification on what resources were offered for the PGCSS program. Dr. Richardson clarified that, in that program, they offer whole health coaching, peer support mentoring, suicide training, Alzheimer's training, spiritual care as well as multiple other training and support needs.

Next the committee met with Byron Bair, MD, Medical Director, Salt Lake City Rural Health Resource Center, VHA Office of Rural Health (ORH). Dr. Bair provided an overview of ORH programs. Dr. Bair began by discussing the four rural health care challenges which included provider shortages, geographic and distance barriers, limited broadband coverage, and social determinants of health. He provided maps displaying the rural prevalence and of the enrolled rural Veterans. Dr. Bair also educated the committee on the public law establishing the Office of Rural Health and its statutory functions and purposes. There are 4.4 million rural Veterans, 24% of all Veterans. There are 2.7M or 61% of enrolled rural Veterans. Of those rural Veterans, 8% are women, 44% earn less than $35,000/year, and 54% are 65 years or older. Dr. Bair discussed the ORH Vision, Mission, and Strategic Goals which include to promote federal and community care solutions for rural Veterans, reduce rural health care workforce disparities, and enrich rural Veteran health research and innovation. Dr. Bair reported that the 2023 portfolio includes 36 national access initiatives adopted at 100 percent of VA Health Systems. Dr. Bair displayed the ORH organizational chart, a map indicating the locations of its Satellite Veterans Rural Health Resource Centers (VRHRC), and a list of its VRHRC partners. Dr. Bair reported that ORH has a $327M total annual budget, that their FY2022 Enterprise-Wide initiatives impacted 1.3M+ Veterans, with 1,975 VHA Sites served. Dr. Bair discussed the concept of ORH Rural Promising Practices and provided a list of ORH Rural Promising Practices that included the Geriatric Scholars Training Program. He also discussed the ORH Enterprise Wide Initiative and provided examples which included Gerofit, Medical Foster Home, Home Based Primary Care, and Telehealth Clinical Resource Hubs. Dr. Bair reported on the FY2021 funding execution and shared the FY2022 and FY2023 Rural Health Initiative budgets. Lastly, Dr. Bair shared ORH successes and Enterprise-Wide initiatives and Rural Promising Practices FY2022 outcomes.

Mr. Browdie asked if ORH defines rural the same way as the US census does? Mr. Bair confirmed that they do. Dr. Cohen asked if the Office of Rural Health funds pilot programs. Dr. Bair responded yes, within the resource centers, and added that they are redefining the application process and making it simpler for staff to apply for funding. Dr. Bair noted that they have talked with Dr. Shaughnessy about the possibility of talking with the GRECC Directors to ensure that they understand the pathway and how to apply for funding.

Dr. Cohen pointed out that he noticed that they listed Geriatric Scholars as one of the programs and asked for confirmation that their budget was being cut. Dr. Bair responded that their budget is being cut due to the results of a recent audit that identified that an average of only 37% of the providers participating were rural. Further evaluation of the program identified ancillary projects that had grown attached to the original Geriatric Scholars program. Dr. Bair noted that staff have been encouraged to submit separate proposals for funding for the ancillary projects.

Dr. Roland asked about the number of rural veterans by race and ethnicity and asked if they look at that against urban veterans by race and ethnicity. Dr. Bair reported that this is one of the things that they are incorporating into their application templates for pilot project submissions. They are looking at ways to improve how the VA collects information on race and ethnicity.

Ms. Gerhard thanked Dr. Bair for the amazing work that they are doing. She pointed out that the partnership piece is essential and that it enables them to increase the number of Veterans who enroll and can access VA Programs and initiatives. She asked how ORH is working in the 5 satellite sites to build out partnership to address social determinants of health? Dr. Bair responded that there are several projects working to do this. He indicated that he would provide

Dr. Shaughnessy with a list. Dr. Bair specifically mentioned the Wellness and Veteran Engagement (WAVE) program that works with individual communities to find out what community projects are available where Veterans can volunteer.

Dr. Baker thanked Dr. Bair for his presentation. Her question was regarding the allocation of funding in the Research category ($.5M). Dr. Baker asked why it was such a small amount for Research compared to the other categories and further asked what is defined under research. Dr. Bair clarified that the pot is larger for research. Portions of funding from other categories support research as well. The funds shown in the research category represent a partnership with the Office of Research and Development.

Dr. Gifford acknowledged that these are very impressive accomplishments in such a short time for this program and applauded their effort to work with Dr. Shaughnessy to include the GRECCs in their program more.

Next the committee met with Shane J. Stults, CPRP, National Recruitment Consultant, Health Professions Trainee (HPT) Placement, Kristin Humphrey, PhD, ABPP, Director, Associated Health Education, Office of Academic Affiliations, and Sharya Bourdet, Associate Director Associated Health Education, Office of Academic Affiliations. Mr. Stults presented on noncompetitive hiring flexibilities and Health Care Professions Trainees (HPT) in VA. He began by reporting that the VA invests $2 billion dollars annually on approximately 113,000 Health Professional Trainees (HPT) and that the VA loses a significant number of HPTs to the private sector. He noted that Congress and the VA have created hiring flexibilities to facilitate the hiring of Title 38 occupations. Mr. Stults discussed the hiring flexibilities for Title 38 and Hybrid Title 38. He also discussed Job Opportunity Announcements (JOA) for HPTs and specified that posting announcements on USA Jobs is not required by law or VA Policy for Title 38 or hybrid Title 38 employees. He provided the requirements for the JOA to ensure that trainees are not screened out and discussed the availability of using contingent job offers. Mr. Stults pointed out that HPT applicants should receive contingent/firm job offers if they are on track to meet grade requirements in the qualification standard at the time of appointment/Entrance on Duty (EOD) and must not be disqualified because qualifications are not met at the time of application/recruitment. He went on to report that facilities should use the Prolonged Start Date Reasons to appropriately document delays in the USA Staffing platform. Mr. Stults provided multiple resources for recruitment and hiring of trainees.

Dr. Gifford asked what the retention rate of trainees is and if they track that by VISN or Medical Center? Mr. Stults responded that they currently do not have an identifier for trainees to follow them throughout their careers. He added that a process to attach some type of identifier to all trainees to enable them to track them throughout the system is currently in development. Dr. Gifford questioned the onboarding process and pointed out that once a trainee has received an offer, the onboarding and clearing process is very onerous and takes time and trainees can't afford to wait so they end of taking jobs in the public sector. Mr. Stults responded that even though there are flexibilities in hiring, the onboarding issues will still exist. Dr. Gifford expressed his appreciation for their passion and energy in trying to solve this problem and applauded them for their efforts in working to change the historical culture of the practice.

Dr. Thorpe asked if there is a flow chart showing the whole process from the time the person is hired through the onboarding process. Mr. Stults responded that there is a flow chart and that he will send that to Dr. Shaughnessy. Dr. Thorpe also asked how they communicate the non-competitive hiring process to the trainees. Mr. Stults responded that they do this by offering

training to residencies and fellowships throughout the year and that every trainee must take a TMS training which includes information on how to apply and how to make sure they can go through the non-competitive hiring process.

Dr. Gifford asked Mr. Stults what are two things that he would change to expedite the process. Mr. Stults responded that he would like to get rid of issues where we have an HPT selected but their degree is not conferred for (i.e.) 2 months. He would highly suggest that VA create a bridge or gap program that would allow us to select a trainee 12 to 18 months out so that they would be able to stay onboard and be immediately converted into their new position. We are currently not able to do that with trainees. He added that there would need to be a budgetary push for funds to be available for the agency contributions towards benefits, etc.

Dr. Lee had a question about compatibility. Dr. Lee is a PharmD who completed her residency at the VA. Dr. Lee did want to stay and work for the VA, but before she completed her program, the VA went into a hiring freeze, so she left to work for another federal agency. The VA did come back to her later and made an offer, but it was not competitive. Dr. Lee questioned the VAs strategy in this situation as well as compatibility. She asked if the VA is conducting compatibility assessments across job sectors in the community and well as at other VA's. Mr. Stults provided some insight on what happens when offers are extended during hiring freezes. He also shared that there has recently been pay increases and salary rate increases across Pharmacy. Mr. Stults also shared that there are retention incentives and scholarship programs that are available and can be offered.

Dr. Cohen asked for a definition of who is included as a trainee. Mr. Stults responded that trainees can be paid or non-paid and that they don't have to be going through a VA program. You can hire residents, trainees, or interns that are going through any program if it is a VA-approved program. Dr. Cohen also asked if trainees are made aware of other VAs that are hiring? Mr. Stults explained that they are currently working on a database and to share this information across VISNs and facilities. Lastly, Dr. Cohen asked Mr. Stults how familiar he thinks the local sites are with the information he shared with us today. Mr. Stults explained that there is a lot of turnover in Human Resources, and they work hard to make sure that everyone is made aware of this information. They will continue to educate both Human Resource (HR) staff and non-HR staff.

Ms. Gerhard asked if there is any way to provide awards or special incentives for Human Resources employees that help to hire trainees. Mr. Stults will bring this suggestion back to his leadership.

Next, the committee met with Russ Peal, CPRP, CMSR, Director, Workforce Recruitment & Retention Service (WRRS). Mr. Peal provided a Human Capital Management update. He provided an update on the WMC Centralization/Office of Research and Development (ORD). The update included that 80% of the 800+ backlogged hiring actions have been processed. There are 404 new actions in the active recruitment phase and 567 employees have been onboarded. Retroactive personnel actions that have been completed include 241 resignations and 154 reassignments. In addition, 4,528 other personnel actions and 713 Not to Exceed extensions have been completed. He shared their Hire Faster and More Competitively plan which includes actions such as Improve VA's staffing effectiveness, commit to hiring proactively, attract, recruit, and retain the best employees, and onboard fast and flexibly as well as the outcomes of these actions and the target completion dates. Mr. Peal shared the FY23 VHA workforce hiring results and reported that the VHA total workforce grew by 6.2% in the first 11 months of FY23, ending August with 403,000 employees onboard. Mr. Peal described several

new programs. The HR Specialist Training & Accelerated Readiness (STAR) program is a one-year Training program for recent graduates, especially those in human resources management. The Onboarding Surge Event Model which is a standardized event focused on the candidate/selectee experience through the onboarding journey by coordinating all required pre-employment actions into a single day event (background check, fingerprinting, license verification, VetPro, etc.). The National Sourcing Office (NSO) provides a centralized strategic operation that will generate large actionable talent pools of health care provider candidates it needs to leverage against VHA practice opportunities. The Contract Buy-Out Program (CBOP) authorizes VHA to buy out service contracts for certain covered health care professionals in exchange for employment at rural or highly rural facilities of the Department of Veterans Affairs for a period of obligated service. Lastly, Mr. Peal discussed the VHA Physician/Provider Recruiter (PPR) Implementation and targeted use of recruitment, relocation, retention (3R) incentives, and permanent change of station (PCS) to help close staffing gaps and provide greater flexibility in the efforts to hire and retain highly qualified employees.

Dr. Cohen asked about recruitment of Geriatricians and how one medical center who needs Geriatricians know about non-paid Geriatrician trainees working at another facility. Mr. Peal responded that those connections are significantly enhanced through the physician recruiters at the facilities. Local Physician Provider Recruiters (PPR) are part of the national PPR Community of Practice-led by the National Recruitment Service, which promotes collaborative sharing of candidate to ensure successful placement. Mr. Peal noted that they could find candidates for any critical hard to fill positions/occupations, physician or non-physician.

Dr. Shaughnessy complimented Mr. Peal on HR STAR program as VA has been struggling with its HR workforce and its downstream effects. Mr. Peal responded that this is a pipeline for building our healthcare patient care workforce and that he is proud VA now has a program that pipelines HR talent.

Dr. Shaughnessy noted that we have a lot of foreign medical graduates that come into trainee programs at the VA who are not eligible for hire because of their non-citizenship status. Mr. Peal did report that they have some of their national recruiters that are focused exclusively on improving the recruitment of non-citizens into our workforce. He also pointed out that many HR professionals in the field are not as familiar with the process of bringing on a non-citizen provider. He advised that we could reach out to the national recruiter's group where there are individuals currently focusing on how we can improve outcomes.

Dr. Cohen thanked Mr. Peal for his presentation and added that it has been very informative and encouraging.

Next the committee met with Ernest Moy, MD, MPH, Executive Director, VHA Office of Health Equity. Dr. Moy began by providing a definition of Health Equity, which he defined as all Veterans getting support that helps them achieve their highest level of health. He reported that VA is doing the following to promote equity 1) work with staff to ensure a diverse and inclusive environment, 2) work with social supports to address social needs, and 3) work with providers to reduce health inequities in care delivery. Dr. Moy also discussed high equity reliability organization fundamentals and indicated that the ultimate outcome is exceptionally safe, consistently high-quality care for all Veterans. Dr. Moy provided the Joint Commission Equity Standards, effective January 1, 2023, specific requirements (abridged) and the Centers for Medicare and Medicaid (CMS) Equity Standards, effective January 1, 2023. Dr. Moy discussed Assessing Circumstances & Offering Resources for Needs (ACORN) and reported that it aims to systematically identify and address unmet social needs among all Veterans to improve health

and advance health equity. Dr. Moy shared data for Veterans screened across pilot sites for social determinants. He talked about the Primary Care Equity Dashboard (PCED) that was developed to engage the VA healthcare workforce in the process of identifying and addressing inequities and enables VA to meet these standards. He reviewed the VISN performance and Disparity Matrix and reviewed additional statistics on disparities in health care.

Dr. Baker asked Dr. Moy to provide more explanation about a figure presented on the slide titled Disparities Standards/PCED, where he indicated that they are comparing whites to these other groups. Dr. Moy indicted that it is meant to be a summary slide and went on to provide further explanation on what each column represented. He indicated that their focus is on the red areas where they think there are opportunities to both improve quality and reduce disparities.

Dr. Baker questioned why the groups are being compared to whites. She explained that it would be more informative if they looked at within group variability, for example focusing specifically on blacks, Hispanics, or Asians. Dr. Baker asked that they be more intentional when presenting this type of data and to make sure that there is a narrative behind why they are making these comparisons, knowing that there is a lot of variability within these different groups. Dr. Moy thanked Dr. Baker for her comment and explained the intent is to identify where there are problems.

Dr. Cohen asked if the VA has a plan to address social determinants of health which are not directly in the purview of the VA to be able to adjust? Dr. Moy responded that they could address some of these social needs for the individual Veteran. He added that there are social services at the VA that can be provided such as having access to education, transportation, GI bill, employment issues for Veterans, and rehabilitation systems for those previously in prison.

Dr. Thorpe asked how will they know that they have achieved health equity? Dr. Moy replied that they will know when every Veteran achieves their optimal health outcome. They want to make sure that all Veterans receive all their care needs and that their social needs are met. He added that health equity will be achieved when everyone gets the best possible care with the best outcomes. Dr. Thorpe also asked how much do they think it costs to achieve health equity based on ethnicity/race? Dr. Moy responded that VA has not costed it out, but they do know that addressing these issues sooner is less expensive than later, when it is more costly. He shared that he has observed that many of the interventions that they develop are very low cost and that they are spending a lot of money on quality improvement and delivering care.

Dr. Gifford pointed out that one of our concerns is that as we travel around the country and do site visits, it's rare to have discussions like this brought up by staff or programs in the field. He asked how do they know it's working? How are they getting this out into the field, and how is it integrating throughout the organization? Dr. Roland reported that at the last GGAC meeting, we were told this was supposed to be cutting across all entities in the VA. Dr. Moy responded that what we are seeing is the product of the 2023 Under Secretaries identified priorities. Their efforts will continue, and he assured us that if they are not talking about it now, they will be soon because unless they do these things our hospitals will not be accredited.

Following Dr. Moy's presentation, the GGAC discussed the topics presented during the day and adjourned at 4:41 pm.

Day 2 September 20, 2023

The Committee re-convened at 8:30am ET on the morning of September 20, 2023.

Dr. Gifford informed the Committee that they may be able to use this same building that we are currently meeting in for the April meeting, if desired by the committee. Dr. Cohen noted that in the past meeting we discussed meeting with congressional staffers. Dr. Gifford responded that it may not be possible for this committee to go to the Hill but that it may be possible to have congressional staffers come to our meeting. This is still being explored for the Spring meeting that will take place April 10-11, 2023.

Dr. Gifford encouraged members that as ideas come up and there are things that they want additional information on or want to hear more about, that they send an email to him, Dr. Cohen, Dr. Shaughnessy and Mrs. Fuhrer so that we can begin to gather the information and line up the appropriate speakers for the next meeting. Also, after each site visit, he asked that they keep a list of items that should be brought back to the meeting for additional discussion.

Next the committee spoke with Christopher Bever, MD, Director, Investigators, Scientific Review and Management (ISRM) Office of Research and Development. Dr. Bever began by discussing the motivations behind the organizational realignment which included to improve efficiency, reduce redundancy, and diminish silos and to better achieve and deliver on their mission to service Veterans. He also discussed the new organizational structure. Dr. Bever reported on the current state of research operations which showed siloed research activities under specific scientific disciplines as compared to the future state which will include broad portfolios and actively managed portfolios. Dr. Bever continued to discuss where they stand in the process, which is currently in the prototyping portfolios phase of the reorganization. He added that the designing and testing process should be complete by April 2024 which is when they should have a clear idea of what the structure will look like. Full transition from services to portfolios is expected in October 2024. Dr. Bever discussed the proposed ISRM structure. The organizational chart showed the reporting relationships as well as the collaborative relationships between the Leadership group, Research Integration Leadership, the Broad Portfolios, the Actively Managed Portfolios, and Support Services. Dr. Bever discussed the broad portfolios scientific review groups and current application review and project management process versus the proposed future application review and project management process. In addition, Dr. Bever discussed the tabletop modeling sessions that addressed standardizing the scoring scheme for portfolios and the operations challenges of tracking them.

Dr. Hartronft asked why the brain, behavioral and mental health broad portfolio was broader than the other broad portfolios? Dr. Bever responded that it is because there is too little integration of advances of neuroscience into mental and behavioral health on both the clinical side and the research side. This brings those areas together.

Dr. Cohen was delighted to see the word aging in the broad portfolio and thanked Dr. Bever for including that. He commented that both at the portfolio and review level, there are areas of overlap and asked how will that be handled? Dr. Bever noted that he is open to additional suggestions on how that might be handled and added that they will have integrated teams to focus on the overlap areas. Dr. Cohen noted that it will be critical for them to ensure that at the review level appropriate expertise is represented on an overlap application and at the portfolio level they should be clear on who is funding what.

Next the committee discussed a written statement received from the public. Dr. Gifford began by informing the committee that according to the FACA rules, these are open meetings and part of that includes the ability for the public to attend, listen, and provide written comments.

He continued by adding that both he and Dr. Shaughnessy have received written correspondence from the National Association of Veteran State Homes that has been provided to all Committee members ahead of the meeting to review. (see attached Appendix A and B) Dr. Gifford noted that the only subcommittees that we currently have are the GRECC Advisory Subcommittees. He added that we can have workgroups, which are smaller with a defined scope and charter. They do not make recommendations but do collect information and provide reports to the larger GGAC. Those reports can then be accepted by the GGAC. Dr. Gifford and Mr. Browdie reported that we did have a workgroup that gathered information pertaining to VHA relationships with the State Veterans Homes. Workgroup meetings are not open to the public.

Dr. Cohen reported that in general, this committee has not accepted membership for a specific advocacy group but rather for areas of expertise. We have had members with expertise in long term care broadly and more specifically expertise in State Veterans Homes, although that was not part of the selection criteria. He further stated the content of the statement reflected a need for more of a NASVH interface with GEC, which should be supported. The Committee supported the idea of continuing and even enhancing the interfaces that GEC has with the State Veterans Homes Leadership. For best ways to handle the long-term care of Veterans they suggested that GEC meets with the stakeholders.

Dr. Beizer complimented the summary provided, noting the overview of the relationships and the potential for provision of home and community-based services. Dr. Gifford suggested that we think about how to provide opportunity beyond written comment to get input from stakeholders. Dr. Cohen suggested that we invite stakeholders to present to the GGAC. He felt it will be a useful topic to learn more about the interface with the State Veterans Homes. Dr. Hartronft commented on type of and number of meetings that will occur between GEC and NAVSH post covid and felt that they are on a good track with communication between the two organizations.

Dr. Lee asked if there were opportunities for national organizations or associations to have a membership on the committee. Dr. Cohen reiterated that they select people with expertise in an area and not because they represent an organization. Dr. Gifford went on to report that we have had members of this committee who have had leadership positions in either professional associations or trade associations, but they must recuse themselves from any discussion for which that affiliation represents a conflict of interest. Dr. Cohen explained that this does not prevent someone from NAVSH from applying if they have the expertise needed on the Committee. Members are selected depending on the needs of the committee at that time. Dr. Cohen also reminded the committee that our main mandate is reviewing the GRECCs, and we must be sure that on the committee membership, we have enough expertise to do that. Dr. Gifford concluded by saying that the Spring agenda will include a period for public comment that can be taken verbally during the meeting.

Ms. Gerhard noted that the letter was very informative and went on to state that the State Veterans Homes as well as the states have a critical role to play and she agrees that the administrative relationship needs to be with GEC and the role of this committee is really around the GRECCs and their work.

A representative from NAVSH that attended today's meeting as a guest requested to speak. The chair denied the request because the Notice of Meeting published in the Federal Register specifically included a statement indicating the Committee could only accept written comment at this meeting. Dr. Cohen reported that we can invite someone from NAVSH to the April meeting to present, allowing them to speak on the topic. In addition, Dr. Gifford indicated that we could put together a workgroup to collect more information and that workgroup would be allowed to reach out to the organization to collect information.

Dr. Smith raised concern about the cost of the CLC's versus the State Veterans Homes and suggested that it would be useful to know more about the contributions of the State Veterans Homes to the big picture in terms of costs of care. Dr. Gifford tasked Mr. Browdie with collecting information, if necessary, to help identify the topic of discussion on the State Veterans Homes for the next meeting.

Next the committee talked to Thomas Edes, MD, Senior Medical Advisor, Council Co-Chair Electronic Health Record Modernization, VHA Office of Geriatrics & Extended Care (GEC). Dr. Edes provided an update on the Electronic Health Record Modernization. Dr. Edes began by discussing the organizational structure of their council. He pointed out that there are four primary workgroups and that they organized their approach to align with the Geriatrics and Extended Care office. The four primary work groups are Hospice and Palliative Care, Facility-based Nursing Home Care, Geriatric Services, and Home and Community Based Care. Dr. Edes discussed how he is hoping that with enterprise-wide engagement, the electronic health record will get some more momentum. He also mentioned that under Home and Community Based Care they have brought in caregiver support into the Geriatrics and Extended Care Council.

Dr. Edes talked about high priority issues. In January, he noted that they had 280 enterprise-wide high priority issues unresolved having to do with patient safety and staff burden that needed to be resolved before going live in a level 1 facility. Geriatrics had 4 issues within the top 50 on the list. They are making progress but still struggling with local flexibility and agility for quality improvement, clinical demonstrations, innovation, and the entities of research that includes GRECC. Dr. Edes notes that they are working to create a cross council governance structure work group. He noted that they are also struggling with medication migration but have gotten approval to set up a cross-council workgroup on that issue as well. Dr. Edes went on to inform the committee that the contract was renewed in May 2023 and that they renegotiated from a 5-year term to 5 one-year terms, have stronger performance metrics, and increased accountability with heavy financial consequences.

Dr. Edes spoke about the EHRM reset, which was a pause on new site implementation put in place until the priority issues have been resolved. He noted that the pause is not time dependent and will be determined by the resolution of priority issue backlog. There is one exception to this which is the North Chicago Federal Health Care Center scheduled to go live in Spring 2024 because this is a combined Department of Veterans Affairs/Department of Defense facility. Dr. Edes emphasized that the readiness to go live is determined by the facility. Next, Dr. Edes discussed the Rapid EHRM Baseline Improvement Initiative and noted that the goals of the initiative included addressing the backlog of the unresolved requests, restoring trust in EHRM with live site staff, and demonstrating to live site users that we have listened, are aware of their issues, are taking action and have capacity to resolve a substantial number of their requests within 2 months.

Dr. Cohen applauded the incredible amount of work that Dr. Edes has invested in this initiative thus far and questioned if any of the five test sites have a GRECC. Dr. Edes responded that none of the sites have a GRECC, but he did mention that they pulled the GRECCs into this 4 years ago to help clarify what their requirements were for the EHR.

Dr. Epps asked for further clarification on the statement made indicating that the sites will let them know when they are ready for implementation. She noted that there will always be sites who are not ready and asked if his team had a checklist to ensure checks and balances against the site's readiness decision. Dr. Edes added that go live also involves his team going to the facility and meeting with them. The Facility Director is the one who decides if they are ready but there are a lot of items that must be in place first.

Dr. Cohen pointed out that at many of the larger sites the real users are the trainees, and he asked if they had gotten input from them. Dr. Edes responded that they do have conversations about the trainee responsibilities and make sure to set up HER training for the trainees, but he felt that they could do a better job bringing in the trainees and will take that request back to his team for further discussion.

Dr. Gifford thanked Dr. Edes for his work. He acknowledged that launching a new enterprise-wide system is a massive undertaking. Dr. Cohen suggested that they train a select group of clinical champions to serve as the people for contacts at each facility. Dr. Edes agreed that this is important and that it is the direction they are moving in.

Next the committee talked to Marianne Shaughnessy, PhD, AGPCNP-BC, GS-C, FAAN, Director, GRECC Programs. Dr. Shaughnessy discussed the status of GRECC Programs and the upcoming GGAC schedule. Dr. Shaughnessy provided committee members with the FY22 GRECC Annual Report prior to the meeting. The report is a composite of all FY22 GRECC annual reports. Dr. Shaughnessy reported that we visited 5 GRECCs this year including Tennessee Valley, Ann Arbor, Baltimore, Bronx, and Eastern Colorado. The reports for each site visit have all been completed. She noted that the reports encourage the GRECCs to take a proactive role in addressing areas identified as needing work. All GRECCs are required to respond back within 60 days of receiving the report. Based on the response, she added that we can then determine if the site needs to keep reporting back every 6 months.

Dr. Shaughnessy pointed out that in FY23 we started collecting information on a new metric: the number of trainees that take VA jobs. Based on the information provided by the GRECCs in FY22, VA hired 51 trainees out of 279. Dr. Shaughnessy reported that she will follow-up with the Office of Academic Affiliations (OAA) and Workforce Management and ask that they come speak with the GRECC Associate Directors for Education and Evaluation (AD/EE) so that they can start to educate staff locally about the WMC authorities we heard about on Day 1 (Stults presentation). Dr. Shaughnessy went on to report that since she came into her role as Director of GRECC Programs, she has made it a point to have regular communication with OAA. Members of that office have been invited to attend the monthly GRECC AD/EE calls so there is now a direct link between OAA and the GRECC AD/EEs. Similarly, Dr. Shaughnessy has linkages with the Office of Research & Development who regularly come to the monthly GRECC Associate Director for Research calls.

Dr. Shaughnessy reported that this year we stood up an Advanced Fellow Coordinating Center. The Advanced Fellowships in Geriatrics are open to any discipline. Currently 18 out of 20 GRECCS were approved to have these fellows. The Advanced Fellowship in Geriatrics

Coordinating Center (AFiG CC) will create a community cohort, establish a standardized curriculum and try to match these fellows with jobs within the VA when they finish their training.

Regarding site visits, Dr. Cohen mentioned that we must be careful about how we couch the recommendations and criticisms that we make. He learned from a recent site visit that the GRECC's administrators' reaction to site visit criticisms was to question the value of the GRECC to the facility. He suggested that we be clearer and balance the advantages with the opportunities for improvement. when we make our reports.

Dr. Gifford pointed out that in the past the GGAC had made a recommendation to the Secretary to add a new GRECC. Has asked if the committee if we should continue to advocate for that. Dr. Shaughnessy recommended that the committee continue to advocate for more GRECCs. She reported that $7M is needed to start a new GRECC as well as buy-in from OAA and ORD, who provide funds for trainees and pilot research projects. Committee members were reminded that after 3 years, GRECCs are expected to be self-sufficient. Dr. Shaughnessy noted that there is currently one VISN who does not have a GRECC. Dr. Gifford asked if Dr. Shaughnessy can pull together past recommendations to the Secretary where there was a recommendation to establish a new GRECC. He also asked if they should recommend a specific focus for the GRECC or let the GRECC determine that on their own. Dr. Shaughnessy reported that in the past, there was discussion about establishing a new GRECC with a focus on long-term care. This information will be reviewed at an upcoming meeting so that the committee can discuss whether to go forward with another recommendation. Dr. Shaughnessy will also pull together a brief analysis of the GRECC Research portfolios. Ms. Gerhard asked that when Dr. Shaughnessy does her analysis that she begins to align the research with the priorities of the administration.

Dr. Shaughnessy informed committee members that site visits scheduled for next year will include Salt Lake City in March, Minneapolis in May, Palo Alto in June, and San Antonio in July. Dr. Shaughnessy asked that each member go on at least one site visit per year. She also noted that either the Chair or Co-chair must be at every site visit.

Dr. Shaughnessy thanked committee members for their commitment to going on the site visits and evaluating the GRECCs by offering helpful, constructive advice on how to improve the strengths of the GRECC programs and the local GEC programs. The new members have been asked to come and observe at least one site visit before they will be asked to participate as a member. Dr. Lee asked, when talking about the successful vs. struggling GRECCs, is there a mentoring program for GRECCs to collaborate with each other so that the more successful GRECCs can mentor the struggling GRECCS? Dr. Shaughnessy responded that she is putting together a mentoring program for new GRECC Leadership. In addition, she reported that we have not done a good job creating a geriatric scientific workforce. She wanted to try to influence by putting together the AFiG CC so that we can keep the fellows that come up through the GRECCs within the VA to eventually become GRECC leaders. Dr. Lee mentioned that the AGS and ASGAP have a leadership aging development program and that it may be an opportunity to collaborate. Dr. Cohen reported that we are also trying to stress with all GRECCs succession planning. Dr. Gifford added that other characteristics distinguishing successful GRECCs besides the ones who have delivered succession planning have been the ones who have figured out how to integrate those within the VA with the academic affiliate. Those that are successful and have leaders that are at both the VA and the affiliate truly understand the

GRECC and see it as an asset. He added that the GRECC is a feeding system to within the broader healthcare system.

Dr. Baker asked if there is any way that we can ask that certain areas of research be integrated into a GRECC by asking them to incorporate at least one pilot study, on certain focus areas of interest, if they have that expertise? If a mentor does not exist within that GRECC, they can look outside of the GRECC or at the affiliate. Dr. Shaughnessy will take this message to the GRECCs.

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

1. The Committee was impressed with the work VACO offices shared at this meeting, but the information regarding available enrollment and forecasting data, Program Office priorities and strategic plans is not reflected by field staff when site visits are conducted, suggesting there may be communication gaps that could aid in GEC program management, quality improvement and planning at the field level. Specifically, the Committee recommends that the Enrollment and Forecasting office put into place a procedure to ensure that VISN and Medical Center leaders have current forecasting data on older Veterans in their catchment areas and the data is presented in an interpretable and useable way.

2. The committee recognizes VA's aim to reduce disparities and improve health equity, but does not see the steps and work being done are producing meaningful results. The Committee does not see high visibility of this issue in the field, therefore the Committee recommends the Office of Health Equity to develop a communications plan for the pilot programs underway, and embed health equity measures into their local and national dashboards to track progress.

3. The Committee applauds the continued hard work and the recent successes of VHA's Workforce Management Consulting Group discussed during this meeting. It has previously recommended that VA examine ways to translate trainees into employees and the recent hiring flexibilities are moving VA closer to that goal. However, there remains a gap that must be addressed between the time that trainees complete their educational programs and pass licensure examinations during which VA loses trainees. The Committee recommends the Secretary pursue authorities to create a bridge program for Title 38 and Title 38-hybrid health care professions trainees to be hired provisionally until full licensure is secured.

Respectfully Submitted:

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

October 25, 2023

Enclosures: SVH Letter to GGAC Chair, Statement of Tracy Schaner-NASVH-GGAC Meeting-Sept 2023

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

"Caring for America's Heroes"

September 11, 2023

David Gifford, M.D, MPH
Chairman, VA GGAC
Chief Medical Officer, AHCA
1201 L Street NW
Washington, DC 20005

Sent Via Electronic Message

Dear Dr. Gifford:

On behalf of the National Association of State Veterans Homes (NASVH), I respectfully request your support to have a representative of NASVH be appointed by VA Secretary McDonough as a full-time member of the Geriatric and Gerontology Advisory Committee (GGAC) in order to provide critical information and insights that will strengthen the work of the Advisory Committee.

As you may know, NASVH is an organization with a history dating back to 1952, with our members being the largest provider of long-term care to our Nation's Veterans with close to 30,000 beds. NASVH members represent all 50 states and the commonwealth of Puerto Rico, and we are comprised of the licensed nursing home administrators and other senior leaders with oversight of State Veteran Homes with hundreds of years of experience operating and managing skilled nursing home programs. The State Veteran Home (SVH) program is a valuable partnership between the federal government and the States that helps meet the long-term care needs of aging and disabled veterans. There are currently 165 SVHs across the Nation, to include 158 skilled nursing care programs, 48 domiciliary care programs, and 3 adult day health care programs. Additionally, these numbers continue to expand with the anticipation that there will be 24 new SVHs seeking VA recognition between now and 2024.

In recent years, NASVH has nominated several highly qualified State Home Administrators for membership on the GGAC however none of them were chosen. Although the GGAC has previously had a SVH Subcommittee, NASVH has never been invited to participate in any of their meetings or discussions. In fact, NASVH was informed that we were unable to observe a workgroup meeting that took place within the past year due to a lack of sufficient space.

As you are aware, the Charter of the GGAC provides that the "Committee will be composed of *approximately* [emphasis added] twelve (12) members…", thereby offering the opportunity for selection and appointment of a NASVH representative at any time without having to wait for the terms of members to expire or to remove any current members.

Dr Gifford, the only way our nation can truly honor the service and sacrifice of our veterans and their families is by all of us – VA, the States, and other stakeholders – working together and maximizing our assets to meet their needs. NASVH as an organization, and as a group of highly qualified members, could offer a wealth of experience and expertise about geriatrics, gerontology, and the full spectrum of services and supports that aging and disabled veterans require. We have been and remain ready, willing, and able to volunteer our time and efforts to strengthen the provision of long-term care services and supports for aging and disabled veterans. However, without a seat at the table as key decisions are being made, we are too often hindered in our efforts to empower America's heroes to live their final years with dignity in the setting of their choosing.

I will be attending the upcoming GGAC on September 19-20th, as member of the public. Since no time can be allocated for receiving oral presentations from the public, I recently submitted the attached written statement to GGAC's Designated Federal Officer, Marianne Shaughnessy, in order for it to be reviewed by the Advisory Committee. This statement provides greater detail and information about the SVH program, and it identifies how NASVH's expertise can assist in ensuring our aging veterans have greater access to a full spectrum of high-quality long-term care options, whether at home or in nursing homes.

For the above reasons, and those found in the attached written statement, we respectfully request your support to have a representative of NASVH appointed to serve on VA's Geriatric and Gerontology Advisory Committee. Should you be available, I would be pleased to meet with you in person during the week of September 18th to discuss this matter further.

Please don't hesitate to reach out should there be any questions.

Respectfully,

Tracy M. Schaner, President
National Association of State Veterans Homes

Attachment
c: NASVH Executive Committee

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

"Caring for America's Heroes"

Statement of
TRACY SCHANER, PRESIDENT
NATIONAL ASSOCIATION OF STATE VETERANS HOMES (NASVH)

To the
GERIATIC AND GERONTOLOGY ADVISORY COMMITTEE

Public Meeting on
SEPTEMBER 19, 2023 – SEPTEMBER 20, 2023

Chairman Gifford and Members of the Committee:

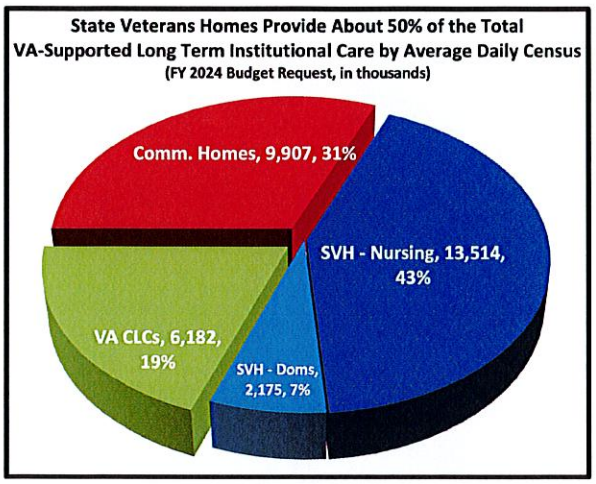
As President of the National Association State Veterans Homes (NASVH), I wanted to take this opportunity to introduce you to NASVH, provide some background and perspective on State Veterans Homes, review the long-term care needs of veterans, and offer some ideas on how NASVH could help your Committee and the Department of Veterans Affairs (VA) in our shared mission of providing quality, compassionate, and innovative care to aging and disabled veterans.

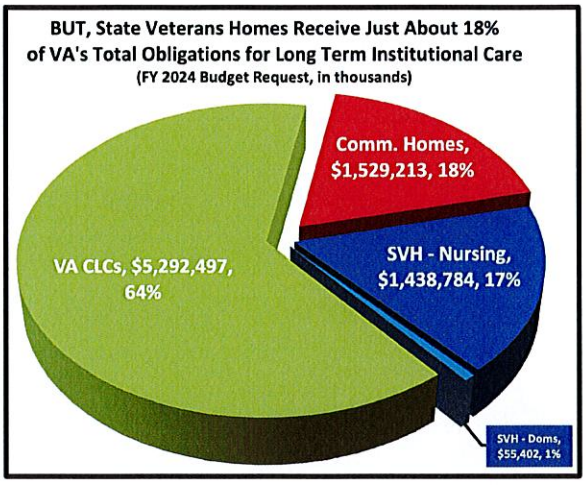
NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our State Veterans Homes through education, networking, and advocacy. All 165 State Veterans Homes are members of NASVH, the only organization that represents their collective interests. In July, I was elected President of NASVH and will serve in that voluntary position over the next year. Professionally, I serve as the Deputy Chief Administrator of the Idaho Division of Veterans Services, which includes oversight of the state's four State Veterans Homes.

Background of State Veterans Homes

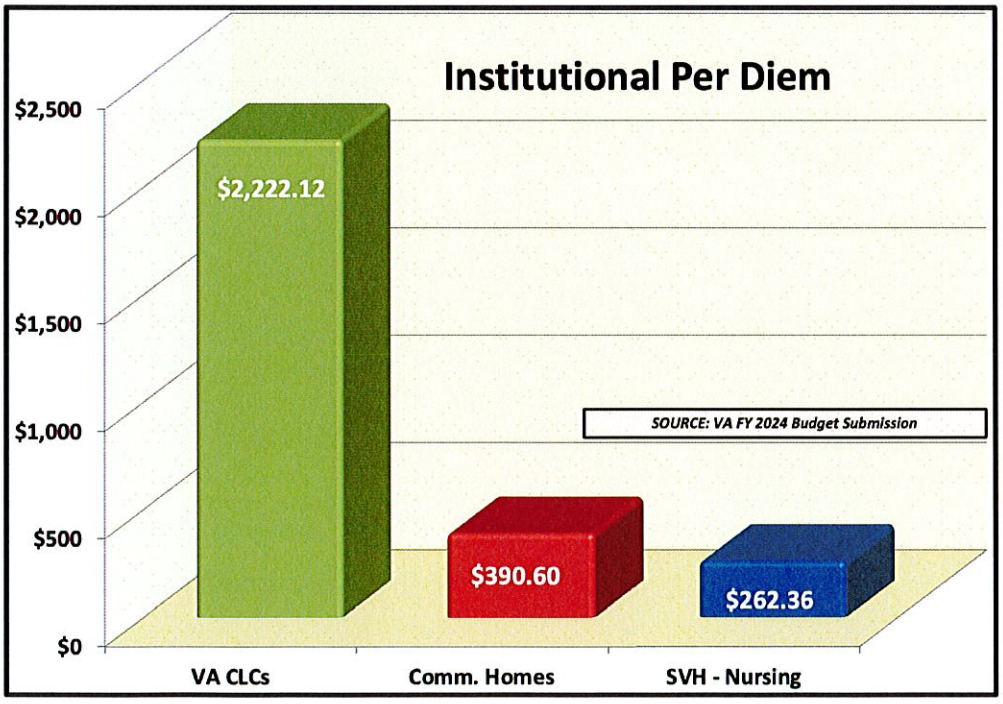
The State Veterans Homes (SVHs) program is a partnership between the federal government and state governments that dates back to the post-Civil War period. Today, there are 165 State Veteran Homes located in all 50 states and Puerto Rico, with close to 30,000 authorized beds providing a mix of skilled nursing care, domiciliary care, and adult day healthcare.

SVHs provide approximately half of all federally supported facility-based long-term care for our nation's veterans according to VA's FY 2024 budget submission. However, State Veterans Homes will consume less than 20% of VA's total FY 2024 obligations for veterans' long-term nursing home care.





According to VA, the institutional per diem for SVH skilled nursing care is about 33% less than private sector community nursing homes and about 88% less than VA's Community Living Centers (CLCs). While there are important differences among the three programs, it's clear that the SVH partnership provides tremendous value for VA and for the veterans it serves.



To help cover the cost of America's veterans who choose to reside in SVHs, VA provides per diem payments at different rates for skilled nursing care, domiciliary care, and adult day healthcare (ADHC). VA also provides State Home Construction Grants to cover up to 65 percent of the cost to build, renovate and maintain SVHs, with states required to provide at least 35 percent in matching funds for those projects.

As a responsibility of providing federal funding, VA certifies and closely monitors the care and treatment of veterans in SVHs. Although VA does not have direct statutory *"...authority over the management or control of any State home."* [38 USC 1742(b)], federal law provides VA the authority to *"...inspect any State home at such times as the Secretary deems necessary"* and to withhold per diem payments if VA determines that the Home fails, *"to meet such standards as the Secretary shall prescribe..."* [38 USC 1742(a)]

Multiple Layers of Oversight of State Veterans Homes

Due to the unique partnership that underlies the State Veterans Home program, there are multiple layers of oversight for all SVHs from governmental entities at the federal, state, and local level. Before a SVH to can be certified to receive federal financial support, VA performs a comprehensive recognition survey to ensure safety and security for the veterans who will reside there. VA then conducts annual inspection surveys of each Home to assure resident safety, high-quality clinical care, and sound financial operations. This inspection survey is typically an unannounced week-long comprehensive review of the Home's facilities, services, clinical care, safety protocols and financial operations.

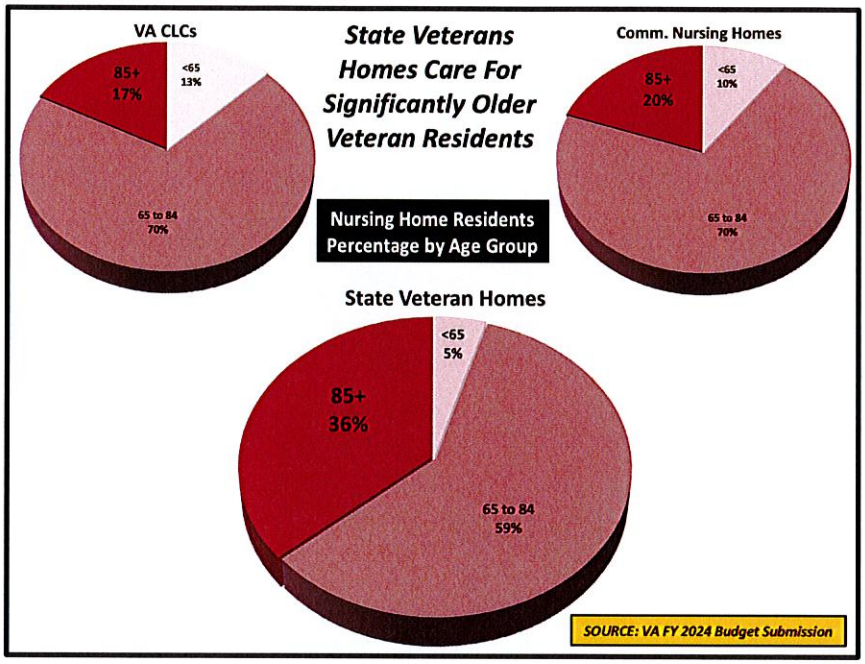
There are extensive regulations that SVHs must comply with that cover every aspect of SVH operations. 38 C.F.R. Part 51, Subpart D, sections 51.60 through 51.210 provide a description of the standards for skilled nursing facilities that every State Veteran Home must comply with to ensure resident rights, quality of life, quality of care, nursing services, dietary services, physician services, specialized rehabilitative services, dental services, pharmacy services, infection control, and the safe physical environment of the Homes. In total, there are more than 200 clinical standards reviewed during VA's annual inspection survey, in addition to dozens of fire and life safety standards, which are outlined in the National Fire Protection Association (NPFA) Life Safety Codes and Standards. Finally, VA conducts a comprehensive financial audit of the Home's financial operations and ensures proper stewardship of residents' personal funds. There are similarly detailed regulations VA uses to oversee domiciliary and adult day healthcare programs run by State Veterans Homes.

About 74 percent of State Veterans Homes are also certified to receive Medicare and Medicaid support for their residents and must undergo annual inspections by the Centers for Medicare and Medicaid Services (CMS) to assure safety and quality care. The CMS inspection survey includes more than 90 percent of the same clinical life and safety sections of the VA inspection survey in a week-long process. All deficiencies identified by the CMS inspection must be corrected by the Home as a condition of continuing to receive CMS financial support.

In addition to the VA and CMS inspections, State Veterans Homes are subject to inspections and audits from VA's Office of Inspector General as well as the Civil Rights Division of the Department of Justice. Furthermore, SVHs usually function within or are overseen by a state's department or division of veterans' affairs, public health, or other accountable agency, and typically operate under the governance and oversight of a board of trustees, a board of visitors, or other similar accountable public body. State Veterans Homes also receive regular and frequent inspections by state and local authorities examining fire safety preparedness, pharmaceutical practices, health and sanitary protocols, food safety practices and other public health and sanitization protocols. As public institutions, SVHs operate with complete transparency.

Veterans Need Home and Community Based Services and Traditional Nursing Home Care

There are an estimated 8.4 million living veterans aged 65 or older, including approximately 2.6 million who are 80 or older, of which about 1.3 million are 85 or older. VA data shows that SVHs care for a significantly older veteran population than either VA CLCs or community (contracted) nursing homes; about twice as high a percentage. State Homes also provide more long-stay care and more end-of-life care, as would be expected for their older veteran population.



In total, the average daily census (ADC) for VA-supported nursing home, both long and short stay, is only about 32,000 veterans; which is less than one-half of 1% of the approximately 8.4 million living veterans 65 or older, and just over 2% of those 85 plus; and these percentages are projected by VA to drop in future years.

Alarmingly, this represents a dramatic decrease in VA-supported nursing home care provided to veterans since the onset of the pandemic. In FY 2019, the total ADC for all VA-supported nursing home care was over 42,000 with a total of more than 115,000 veterans cared for. For FY 2024, VA projects an ADC of less than 32,000 veterans, which is a 23% reduction. The total number of veteran patients for FY 2024 is projected to drop to approximately 80,000, which would be about a 30% reduction compared to FY 2019. For State Veterans Homes, the FY 2024 ADC for nursing home care is projected to be 30% less than prior to the pandemic, dropping from over 20,000 veterans to less than 14,000, while the total number of veteran patients cared for is expected to be 33% less, down from about 30,000 in FY 2019 to about 20,000.

Over the past decade, VA has been placing greater focus and resources on home and community-based services (HCBS) with the stated goal of "rebalancing" between institutional and non-institutional care. NASVH certainly understands and strongly supports the need for expanded HCBS options; however, the amount of nursing home care offered by VA is woefully inadequate

to the overall need, and while it may diminish some, it will never go away. There will always be significant numbers of veterans who lack adequate family support to allow them to age at home. There are also many veterans who will be able to utilize HCBS for some time but will eventually reach an age and stage where traditional nursing home care is required. For these reasons, Congress and VA must continue to make smart investments to sustain and expand traditional bed-based care. NASVH strongly supports expanding home- and community-based care, but it should be in addition to, not a subtraction from facility-based care.

NASVH and our member State Veterans Homes will continue to seek new and innovative ways of delivering long-term services to aging and ill veterans, including supporting veterans who want to age in place; however, it would be a grave mistake to neglect or reduce the existing SVH infrastructure. SVHs understand aging veterans' needs and have expertise in connecting them with their VA benefits and services, as well as helping them with their eligibility. With our clinical expertise and existing infrastructure, State Veterans Homes could potentially serve as hubs in communities across the country, particularly in rural areas, to offer aging veterans a full spectrum of long-term support services, including home-based care.

How the COVID-19 Pandemic Impacted State Veterans Homes

When COVID-19 first emerged in early 2020, State Veterans Homes were among the first institutions to take significant precautions to protect our residents. Battling communicable viruses has always been a regular part of our operations and we have strong infection control regimens which have long been utilized to help prevent and mitigate the spread of influenza and other viruses in our facilities. However, the outbreak and spread of COVID-19, particularly in its early asymptomatic form, made it virtually impossible to prevent it from entering any facility or location in the country. Despite the significant precautions taken – including enhanced use of personal protective equipment (PPE), suspension of visitation and new admissions, screening of staff and residents for symptoms, and strict social distancing – the lack of vaccines, treatments and testing capacity made all nursing homes a prime target of COVID-19.

It is important to note that veterans in State Veterans Homes are primarily older men who have significant disabilities and comorbidities, and that studies have concluded that COVID-19 disproportionately affected older men with underlying health conditions. As noted above, the percentage of veterans residing in SVHs aged 85 or older is about twice as high as VA's CLCs or community nursing homes.

From the onset of the pandemic, State Veterans Homes proactively sought to procure sufficient PPE to protect veterans and staff. However, inadequate national inventory and stockpiles of PPE – particularly N95 masks, isolation gowns and face shields – posed a tremendous problem. Another critical challenge was the inability to quickly and accurately test for COVID-19 and receive timely, valid results for both residents and staff.

As a result, when one resident or staff member tested positive, Homes would often quarantine numerous other staff or residents who might have come in contact with the person who tested positive. This resulted in large numbers of staff in some State Veterans Homes being required to remain at home until they passed a 14-day quarantine period or had one or more negative test results to indicate they did not carry the virus. Consequently, SVHs were forced to dramatically

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At the same time, occupancy levels in most SVHs declined as veteran residents passed away due to COVID and non-COVID causes, and because new admissions were suspended. Today, even with effective vaccines, treatments, and testing now available to mitigate many of the dangers from COVID-19, SVHs still face significant challenges in bringing their occupancy rates back up to normal levels, primarily due to national staffing shortages impacting all health care facilities. As a result, the level of VA per diem support provided each year to State Veterans Homes has declined significantly over the past three years, creating serious financial challenges for Homes to remain solvent at a time when their state budgets are also in crisis.

Working to Develop New Models for Geriatric-Psychiatric Care for Veterans

State Veterans Homes offer the federal government a unique opportunity to explore and test innovative methods of caring for aging veterans, and NASVH has been working with VA and Congress to develop new pilot programs to do just that. For example, NASVH worked with the Senate Committee on Veterans' Affairs to draft and enact legislation that requires VA to create a new geriatric psychiatry pilot program for State Veterans Homes. (Section 163 of Public Law 117-328.) As this Committee is well aware, aging veterans with severe mental health and behavioral issues represent a challenge for both VA and SVHs due to the high level of supervision and intensive care required, particularly for veterans who pose a danger to themselves or others. In support of this legislation, several states indicated a willingness to move forward with implementing geriatric psychiatry programs, including Louisiana, Washington, and West Virginia, in partnership with VA once the legislation was implemented.

Regrettably, VA did not consult with NASVH nor any State Veterans Homes regarding how to implement this provision of law, and instead announced a program to provide virtual geriatric-psychiatric support to a limited number of veterans in State Veterans Homes. While this program will provide some benefits, it falls far short of what could have been accomplished by working together with NASVH to develop new models of care for this challenging population.

Expanding VA's Spectrum of LTC to Include Assisted Living for Veterans

In addition to skilled nursing care, more than 20 states offer domiciliary care in over 50 SVHs, which provide alternative long-term support to about 2,000 veterans every day who would not qualify for skilled nursing care, but who do need shelter and supportive services. The level of care in SVH domiciliary programs varies from state to state, with some providing only basic food and shelter, while others offer more enhanced levels of support that may include social, vocational and

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However, there are millions of aging veterans who can no longer live independently but whose needs fall in between the two levels of VA-supported institutional care in State Veterans Homes. In an effort to offer support to these veterans, NASVH worked with the Senate and House Veterans Affairs' Committees to support legislation – S. 495/H.R. 1815, the *Expanding Veterans' Options for Long Term Care Act* – that would authorize VA to create a three-year pilot program to provide assisted living care for veterans at six sites, including at State Veterans Homes. We are hopeful this legislation will be enacted during the 118th Congress.

Expanding Adult Day Health Care and Exploring New Home-Based Care Solutions

In addition to skilled nursing and domiciliary care programs, SVHs are also authorized to offer Adult Day Health Care (ADHC), which is a non-institutional alternative to a skilled nursing facility for aging veterans who have sufficient family support to remain in their own homes, but who need or will benefit from a day program that promotes wellness, health maintenance, and socialization. Due to VA's limited and restrictive support for this program, there are currently only three State Veterans Homes operating ADHC programs – New York, Minnesota, and Hawaii – although several other states are working on plans that could lead to additional programs in the future.

To encourage more SVHs to open ADHC programs, NASVH has proposed that VA and Congress allow the State Veterans Home Construction Grant program to support the construction, modification, or expansion of SVH facilities to operate ADHC programs. In addition, NASVH has proposed allowing SVHs to establish satellite ADHC programs outside their facilities and campuses in more conveniently located areas where there are high concentrations of veterans who could use the services. Given the small size of these programs, the Construction Grant program could also fund grants for SVHs to reconfigure existing private medical or office space to meet the needs of ADHC programs.

In addition to expanding ADHC programs, NASVH has also been in discussion with Congress and VA to explore ways for SVHs to offer additional home-based care programs, similar to VA's Home-Based Primary Care, Homemaker Home Health Aide Care, Respite Care, Palliative Care and Skilled Home Health Care. During the pandemic, some SVHs found innovative ways to support veterans in their homes, including providing meals, telehealth, and home care visits. Given the flexibility and financial benefits to VA from partnering with State Veterans Homes, there are myriad possibilities for better addressing the changing demographics, needs and preferences of veterans today and in the future. Furthermore, SVHs already offer a number of medical and therapeutic services that could be provided on an outpatient basis for veterans participating in home-based programs.

With our expertise on the needs of aging veterans, State Veterans Homes could develop an array of home-based services to support veterans who want to age in their own homes. When they are no longer able to remain at home, SVHs could ease their transitions to facility-based skilled nursing care. Such an integrated non-institutional program could begin as a pilot program, with different states customizing their programmatic offerings to meet local circumstances. NASVH would

welcome the opportunity to collaborate with the GGAC to explore the feasibility of new arrangements for providing integrated non-institutional care programs through and in partnership with State Veterans Homes, which could offer veterans integrated LTC support from home-based care to skilled nursing care.

Mr. Chairman and members of the Committee, State Veterans Homes can and should play a greater role in meeting aging veterans needs in partnership with VA and other federal agencies. NASVH would welcome any opportunities to work with this Advisory Committee in furtherance of our shared mission to help ensure aging veterans have greater access to a full spectrum of high-quality long-term care options, whether at home or in nursing homes.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

"Caring for America's Heroes"

Statement of
TRACY SCHANER, PRESIDENT
NATIONAL ASSOCIATION OF STATE VETERANS HOMES (NASVH)

To the
GERIATIC AND GERONTOLOGY ADVISORY COMMITTEE

Public Meeting on
SEPTEMBER 19, 2023 – SEPTEMBER 20, 2023

Chairman Gifford and Members of the Committee:

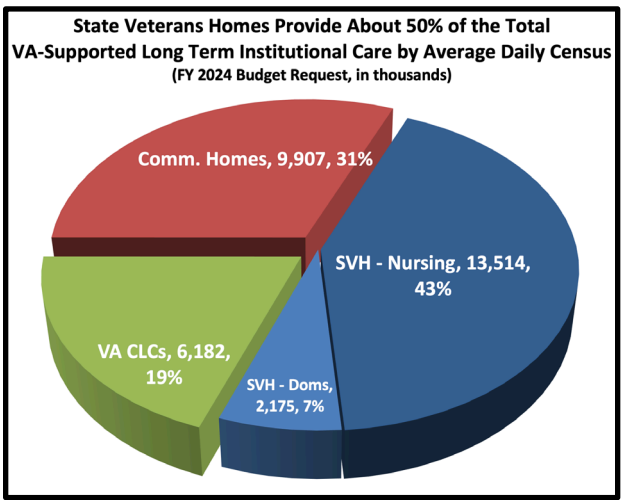
As President of the National Association State Veterans Homes (NASVH), I wanted to take this opportunity to introduce you to NASVH, provide some background and perspective on State Veterans Homes, review the long-term care needs of veterans, and offer some ideas on how NASVH could help your Committee and the Department of Veterans Affairs (VA) in our shared mission of providing quality, compassionate, and innovative care to aging and disabled veterans.

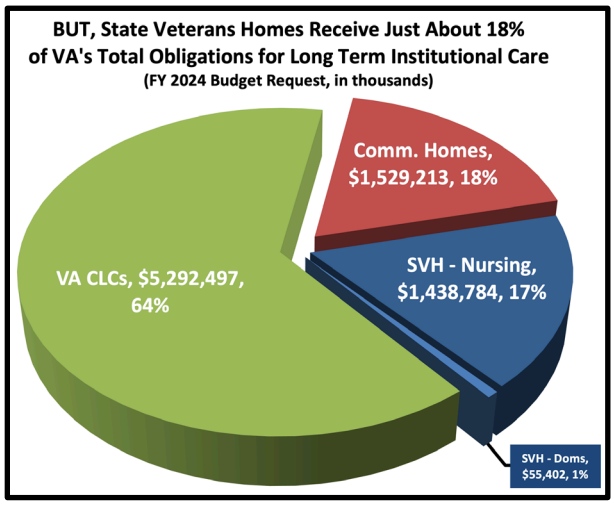
NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our State Veterans Homes through education, networking, and advocacy. All 165 State Veterans Homes are members of NASVH, the only organization that represents their collective interests. In July, I was elected President of NASVH and will serve in that voluntary position over the next year. Professionally, I serve as the Deputy Chief Administrator of the Idaho Division of Veterans Services, which includes oversight of the state's four State Veterans Homes.

Background of State Veterans Homes

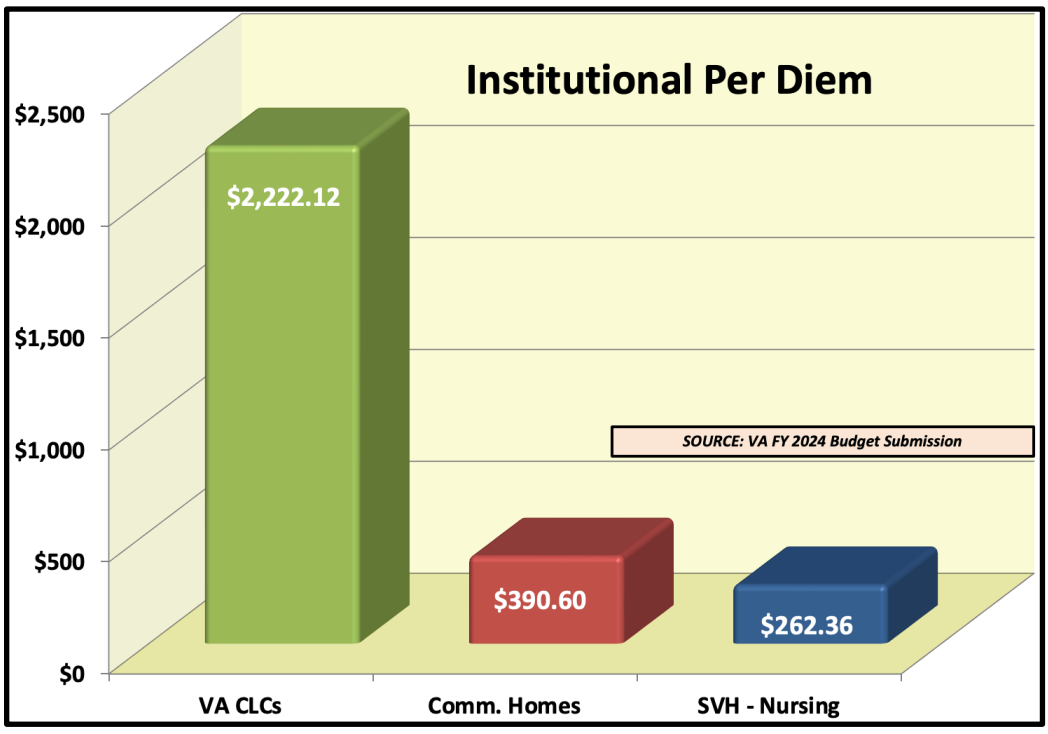
The State Veterans Homes (SVHs) program is a partnership between the federal government and state governments that dates back to the post-Civil War period. Today, there are 165 State Veteran Homes located in all 50 states and Puerto Rico, with close to 30,000 authorized beds providing a mix of skilled nursing care, domiciliary care, and adult day healthcare.

SVHs provide approximately half of all federally supported facility-based long-term care for our nation's veterans according to VA's FY 2024 budget submission. However, State Veterans Homes will consume less than 20% of VA's total FY 2024 obligations for veterans' long-term nursing home care.





According to VA, the institutional per diem for SVH skilled nursing care is about 33% less than private sector community nursing homes and about 88% less than VA's Community Living Centers (CLCs). While there are important differences among the three programs, it's clear that the SVH partnership provides tremendous value for VA and for the veterans it serves.



To help cover the cost of America's veterans who choose to reside in SVHs, VA provides per diem payments at different rates for skilled nursing care, domiciliary care, and adult day healthcare (ADHC). VA also provides State Home Construction Grants to cover up to 65 percent of the cost to build, renovate and maintain SVHs, with states required to provide at least 35 percent in matching funds for those projects.

As a responsibility of providing federal funding, VA certifies and closely monitors the care and treatment of veterans in SVHs. Although VA does not have direct statutory *"…authority over the management or control of any State home.*" [38 USC 1742(b)], federal law provides VA the authority to *"…inspect any State home at such times as the Secretary deems necessary*" and to withhold per diem payments if VA determines that the Home fails, "*to meet such standards as the Secretary shall prescribe…*" [38 USC 1742(a)]

Multiple Layers of Oversight of State Veterans Homes

Due to the unique partnership that underlies the State Veterans Home program, there are multiple layers of oversight for all SVHs from governmental entities at the federal, state, and local level. Before a SVH to can be certified to receive federal financial support, VA performs a comprehensive recognition survey to ensure safety and security for the veterans who will reside there. VA then conducts annual inspection surveys of each Home to assure resident safety, high-quality clinical care, and sound financial operations. This inspection survey is typically an unannounced week-long comprehensive review of the Home's facilities, services, clinical care, safety protocols and financial operations.

There are extensive regulations that SVHs must comply with that cover every aspect of SVH operations. 38 C.F.R. Part 51, Subpart D, sections 51.60 through 51.210 provide a description of the standards for skilled nursing facilities that every State Veteran Home must comply with to ensure resident rights, quality of life, quality of care, nursing services, dietary services, physician services, specialized rehabilitative services, dental services, pharmacy services, infection control, and the safe physical environment of the Homes. In total, there are more than 200 clinical standards reviewed during VA's annual inspection survey, in addition to dozens of fire and life safety standards, which are outlined in the National Fire Protection Association (NPFA) Life Safety Codes and Standards. Finally, VA conducts a comprehensive financial audit of the Home's financial operations and ensures proper stewardship of residents' personal funds. There are similarly detailed regulations VA uses to oversee domiciliary and adult day healthcare programs run by State Veterans Homes.

About 74 percent of State Veterans Homes are also certified to receive Medicare and Medicaid support for their residents and must undergo annual inspections by the Centers for Medicare and Medicaid Services (CMS) to assure safety and quality care. The CMS inspection survey includes more than 90 percent of the same clinical life and safety sections of the VA inspection survey in a week-long process. All deficiencies identified by the CMS inspection must be corrected by the Home as a condition of continuing to receive CMS financial support.

In addition to the VA and CMS inspections, State Veterans Homes are subject to inspections and audits from VA's Office of Inspector General as well as the Civil Rights Division of the Department of Justice. Furthermore, SVHs usually function within or are overseen by a state's department or division of veterans' affairs, public health, or other accountable agency, and typically operate under the governance and oversight of a board of trustees, a board of visitors, or other similar accountable public body. State Veterans Homes also receive regular and frequent inspections by state and local authorities examining fire safety preparedness, pharmaceutical practices, health and sanitary protocols, food safety practices and other public health and sanitization protocols. As public institutions, SVHs operate with complete transparency.

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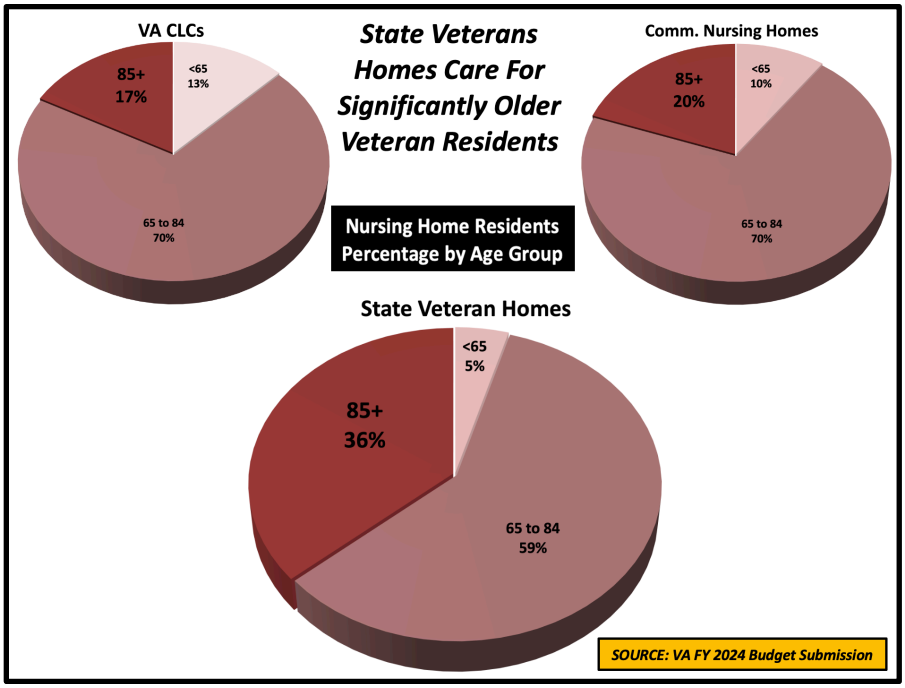

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