

Minutes of the Meeting of the
VHA Geriatrics and Gerontology Advisory Committee (GGAC)
April 11, 12, 2012; VA Central Office, Room 530

Participants:

Adrian Atizado (GGAC Member)
Marie Bernard, MD (*ex officio* GGAC member)
Robert C. Carbonneau (GGAC Member)
Richard Della Penna, MD (GGAC Member)
Teresa A. Dolan, DDS, MPH (GGAC Member)
Jeffrey Halter, MD (GGAC Member)
Mary Jane Koren, MD (GGAC Member)
Richard Veith, MD (GGAC Chair)
Janette Warsaw, RN, MSN (GGAC Member)

Guests:

Madhu Agarwal, MD (VHA Deputy Under Secretary for Policy and Services)
Deborah Amdur, LCSW, ACSW (Chief Consultant, Care Management and Social Work)
James F. Burris, MD (Chief Consultant, Geriatrics and Extended Care)
Susan Cooley, PhD (Chief, Dementia Initiatives and Chief, Geriatric Research—*by phone*)
Thomas Edes, MD (Director, GEC Operations—*by phone*)
Stacy Garrett-Ray, MD, MHA, MBA: Acting Initiative Lead for New Models of Care, Office of Healthcare Transformation
Stuart Gilman, MD (Director for Advanced Fellowships, Office of Academic Affiliations—*by phone*)
Rajiv Jain, MD (Chief Officer, Patient Care Services)
Lawrence Lemos, CNS, Chair, GEC Field Advisory Council, Office of Nursing Services (*by phone*)
Thomas O'Toole, MD (Director, Homeless Patient-Aligned Care Teams initiative)
Karen Ott, MSN (Clinical Executive, Office of Nursing Services)
Scott Shreve, DO (Chief, Hospice and Palliative Care—*by phone*)
Gwynn Sullivan, ARNP (Director of Quality and Program Planning, National Hospice/Palliative Care Organization—*observer*)
Suzanne Thorne-Odem, MSN, Clinical Nurse Advisor, Office of Nursing Services (*by phone*)

Staff:

Kenneth Shay, DDS, MS (Director, Geriatric Programs; Designated Federal Official for GGAC)

Summary of Recommendations and Action Items stemming from this meeting:

- 1. Formal Vote/Recommendation: Withdraw GRECC designation from St. Louis VAMC**
2. Recommend Evidence Synthesis Report on impact of geriatricians be peer-reviewed and published.
3. Need to clarify process and performance regarding getting GGAC reports to UnderSec, Sec, Congress
4. GGAC Chair to meet with USH to emphasize/discuss (2) and (3) discussion of (3) to include potential downstream repercussions/alternative approaches to GRECC FTEE assignment.
5. GGAC to communicate with New England GRECC—want a target date for new Director
6. GGAC concerned about succession plan/support for VACO support of GGAC in GEC Policy Office
7. GGAC will communicate to the Chief Officer for Nursing Services how much they appreciated the quality of the presentation and how impressed they were with the exciting developments described.
8. GGAC encourages integration of non-VA support possibilities within VA Caregiver Support materials, information, applications, website, etc.

9. GGAC would like Dr. Stuart Gilman to return in September to continue discussion of Advanced Fellowships/change agents.
10. GGAC supports PCS Chief's recommendation that GRECCs and Ofc of Health Promotion/Disease Prevention develop a partnership.
11. GGAC would appreciate improvements in travel reimbursement/support procedures.

Meeting called to order by Richard C. Veith, 8 AM, April 11, 2012

Dr. Veith welcomed participants; asked all members to introduce themselves for those on the phone.

Review of minutes of September GGAC meeting

Dr. Veith ascertained that the minutes had been previously reviewed electronically and all corrections incorporated. Dr. Shay briefly reviewed the action items specified in the minutes and affirmed that all either had been or were in the process of being addressed.

James F. Burris, MD (Chief, Consultant, GEC) and Thomas Edes, MD (Director, GEC Operations)

Dr. Burris began by briefly describing some program highlights, including:

- Veteran-Directed Home and Community-Based Services—partnership with Administration on Aging, based on that agency's "Cash and Counseling" program that provides VA resources and fiduciary support to Veterans in need of home and community-based services, so that the most appropriate amount and character of services can be obtained. Presently offered to a limited extent in 50% of VISNs.
- Comprehensive End of Life Initiative--multi-year, multi-phasic effort that will be described in greater by Dr. Shreve later, to incorporate hospice and palliative care throughout the fabric of VHA care with suitable consultative and care services, caregiver support, staff education, integration of VA and community services, and customer-focused continuous improvement.
- Cultural Transformation in VA CLCs—complete restructuring and re-imagining of institutional long term care through evidence-based changes in staffing, organization, infrastructure, expectations, and outcomes. Strong focus on patient-centricity with progress tracked by Medicare "Artifacts" instrument.
- National Alzheimer's Project Act (P.L. 111-375, Jan. 2011): Directs the U.S. Department of Health and Human Services (HHS) to develop a national plan to address Alzheimer's disease and related dementias. Also establishes an Advisory Council on Alzheimer's Research, Care, and Services. VA is a designated member of the Advisory Council, and Dr. Burris is VA's representative. VHA Offices of GEC Policy, Care Management & Social Work, and Research & Development participated with other Federal agencies in identifying a current inventory of Federal dementia programs and research. The first U.S. National Plan to Address Alzheimer's Disease and Related Dementias is expected to be released to the public by HHS in mid-May, 2012. VA will participate in ongoing implementation activities.
- New Models of Non-Institutional Alternatives for Extended Care: 80 programs underway in nearly all VISNs that blend demonstrated, successful approaches to care with local capabilities and needs, in rural home care, transition care, delirium prevention, adult day care, GeriatricPACT, hospital at home, dementia case management. 55 are about to transition to self-sustainability; 25 are in first year of funding. FY13 funds will offer support for second year of the 25; broader dissemination of successful models with emphasis on GeriPACT as a cornerstone

program for building/coordinating additional local geriatrics visibility and growth; and support for expansion of “GeriScholars” mini fellowships in geriatrics for PACT teamlet members.

- “HWAVE”—Healthcare Workforce for Aging Veterans Executive Taskforce: recommendations of taskforce have been briefed repeatedly to Under Secretary; have been discussed on several occasions with Healthcare Delivery Committee of National Leadership Council, who seems unclear on the evidence basis of the recommendations and has requested an evidence synthesis of the professional literature be undertaken for refining the recommendations. This has slowed but not terminated progress on two of the three basic recommendations: focus existing Recruitment/Retention Strategies on preferentially retaining and targeting those with enhanced geriatrics expertise; and enhance education of future and existing staff through a variety of coordinated modalities. The third recommendation concerns adding outpatient and inpatient, geriatric-focused models of care to both manage the most complex of Veterans in these settings and to support the non-specialist care teams in those settings who still are responsible for the majority of care of aging Veterans. Major issues are present stem from staffing ceilings and absence of dedicated funding.
- Adaptation of the “Assessing Care of Vulnerable Elders” quality indicators to initially assess, and then begin to enhance, the quality of care provided to Veterans over age 75 in outpatient and inpatient settings. Falls and functional assessment data have been collected for several years and the metrics, assisted by educational programming and CPRS-based clinical reminders and note templates, have advanced along the trajectory that will likely lead to instruction of true performance metrics concerning this large, complex, and problem-prone cohort. Other metrics, involving end of life care, continuity of care, transitions in care, delirium risk assessment, medication reconciliation, and incontinence, are also embarking on this path.

Dr. Della Penna: what outcomes are monitored? *Ans.: depends on the program. Workload, census, delays in filling positions, GRECC productivity (grants, publications, lectures delivered), quality measures within CLCs, etc.*

Dr. Bernard: no funding to drive the Workforce initiative? What will be necessary to incent VAMCs to undertake the recommended clinical models? *Ans.: This is still under discussion. The hope is that the Evidence Synthesis may offer some cost-benefit arguments that would drive compliance. The FY13 funding of the New Models project is also going to provide some fund infusions for those willing to undertake the approaches.*

Dr. Halter: why is the evidence synthesis focusing on geriatrics? Is a similar effort underway for gastroenterology? Rheumatology? *Ans.: Those subspecialties are not asking for a focused workforce supplementation, but geriatrics is. Increasingly NLC is insisting on evidence-based arguments beyond “it’s overdue” or “it’s a good idea”.*

Dr. Bernard: but didn’t the Institute of Medicine do this? The GEC Strategic Plan? *Ans.: not this methodically; and the evidence synthesis report is using the IOM report as one of its resources for identifying suitable studies to consider.*

Mr. Carbonneau: do we know how big a problem dementia is in VA? *Ans.: One way is to count the number of Veterans with a dementia diagnostic code in their medical record. That requires choosing which diagnostic codes to include as “dementia.” VHA Office of GEC Policy maintains a list of dementia diagnostic codes for official VA reporting purposes. GEC Policy has recently updated the list of codes and is working with VA Allocation Resource Center to update the estimated number of VA patients with dementia, based on dementia diagnoses in the medical record. One caveat is that the number based on diagnostic codes in the medical record is likely low because dementia may be under-recognized or may*

not be listed in the medical record if it is not the focus of a visit. Another way to count is to apply to VA population projections actuarial projections based on observed dementia prevalence rates in the general community. VA Office of Policy and Planning has such projections out to 2022, and they are currently working with GEC Policy to update those actuarial projections to account for newer data.

Dr. Bernard: if this is more in depth than the IOM effort, it should be strongly recommended that the final report be then submitted for peer review and published in the professional literature—it will clearly be an important document to guide future actions, and not only in VHA.

Dr. Dolan: is there a standardized set of geriatric services that all VAs are required to provide? Ans: yes, but compliance varies geographically. One of your materials is the latest draft of a “Geriatric Universal Services Handbook” that the GEC Office is currently walking through VACO to document just such guidance, with the intention it will enhance compliance both reminding sites of their obligations and providing them guidance on how to fulfill them.

Thomas Edes, MD, Director of GEC Operations

Dr. Edes began his presentation by describing his new office’s vision and priorities—which included foci on enhanced access, non-institutional care, identifying and addressing unmet need, coordinating with telehealth and PACT, and optimizing quality for cost.

He described one important trend as the shift of resources to non-institutional approaches. He offered several forms of compelling data demonstrating that growth in the very elderly is a bigger challenge to VA than to society as a whole, but that VA has largely held the line on costs in a range of settings even as Medicare costs have steadily climbed. He acknowledged that there is a small group of very costly patients, on which efforts should be focused to conserve resources to benefits the remaining patients. Much of these costs are directed toward managing chronic disabling diseases.

The Congressional Budget Office has observed that VA is quite effective at holding costs down in the management of such patients, which they attribute as being assisted by the Electronic Health Record (which reduces redundancy and errors), VHA’s quality management approach, and VHA’s inclusion of support services for chronic disease management. He pointed out the dramatic increases in numbers of patients served in a number of VHA programs between 2000-2005, including hospice (up 400%), inpatient hospice (up 2500%), medical foster home (up 200%), Home-Based Primary Care (tripled—yet still not available at 700 or VA’s 900 CBOCs).

He noted that HBPC has been able to document true utilization and other outcome decreases (not just cost shifting to Medicare) by decreasing hospital admissions by 25%, decreasing inpatient days by 36%, and decreasing costs of care (VA and Medicare) by 13%. Passage of the Independence at Home Act in March 2010 demonstrates Congressional recognition of the merits of the HBPC approach, by setting out terms for instituting that approach outside of VA. Dr. Edes expects saving outside of VA, from HBPC, to be even greater than within VA, because individual physicians in the private sector are more likely to dictate actual changes in patient utilization in that setting.

Upcoming important foci are transitions in care and the development of a “Data Analysis Center” for GEC that can tackle complex challenges in trending outcomes to enhance future care delivery.

Dr. Halter: You speak of reduced cost but aren’t you really talking about “reduced cost per Veteran?” Chronic disease is expensive to treat and since you have a growing population of those with advanced chronic disease, you can’t expect to treat the population at reduced cost, can you? Ans.: absolutely not. The important message is that we must remain attentive to unit costs.

Dr. Halter: You speak of “shifting costs” to institutional care—meaning shifting from institutional care? Are you proposing decreasing infrastructure? *Ans.: the shift would be in the length of time a dependent person would spend, on balance, within a nursing home versus in home care. We need to diminish the first.*

Dr. Della Penna: you showed that overall costs are on the rise. What is VA doing to shift spending on high-cost approaches to lower-cost ones? *Ans.: it is disappointing that non-institutional growth has not kept up, despite all the efforts since the Mill Act. That is why doing so is one of the stated priorities of GEC Operations.*

Dr. Bernard: you showed that VA has held its cost down even as Medicare has not. Yet VA has a cost cap (its annual budget) but Medicare does not. Are these comparisons for comparable services, or do they just reflect that there is more unmet need in VA? *Ans.: uncertain of the terms of the comparison—will check.*

Dr. Veith: impressive growth in numbers in non-institutional services 2000-2005. But that sounds like 7-year old information. How has growth progressed since then? *Ans.: Hospice has plateaued. But of greater concern is that inequality in access persists. For example, a VAMC with 6,000 patients within a 30-mile radius and one with 20,000 in a similar area have HBPC censuses that are identical.*

Dr. Della Penna: when you do more for less, who gets the savings? Can you recycle them back into your more-efficient program, to cyclically support more growth? *Ans.: that is the plan with the non-VA incentives to emulate HBPC in the private sector. But in VA it just goes back into general operating costs. The hope is that managers recognize the merits of sustaining or even growing such a program, but there is not automatic redirection of recouped funds.*

Kenneth Shay, DDS, MS, Director of Geriatric Programs: GRECCs and other matters

Dr. Shay updated the group on the St. Louis GRECC. He reminded the group that:

- The GGAC site visit in early 2010 had identified a need for a number of vacancies to be filled, and to redirect a number of GRECC staffs’ efforts away from direct clinical care and into GRECC programs.
- The site agreed to this at the exit interview and in their 60-day response to the GGAC report.
- At a 6-month follow-up, however, they reported that they were unable to undertake the recruitments or reassign the clinicians owing to severe budgetary challenges.
- From early until mid 2011 the GEC office and the St. Louis/VISN 15 leadership were in discussions, trying to come up with an interim plan that would be acceptable to GGAC.
- The director of the GRECC retired in June in response to the site abruptly reassigning the administrative officer; the Associate Director for Education was appointed acting Director by the Deputy Chief of Staff; and a plan for restoring the GRECC promised to GGAC by September 2011.
- This plan was presented to GGAC at their Fall 2011 meeting and was judged inadequate.
- GEC involved the Assistant Deputy Under Secretary (ADUSH) for Operations and Management who suggested an external assessment; two GRECC Directors, assisted by Shay, provided him their recommendations at the beginning of 2012.
- The major recommendation was that Washington University, which is an affiliate of the VAMC but to date relatively uninvolved with the GRECC, should be part of plans for restoring the GRECC.
- At about the same time as the ADUSH was briefed on the site visit, the acting Director was relieved of that responsibility and the acting Associate Chief of Staff for Research, a psychologist with no background in geriatrics, was appointed to that role.
- On February 2 the remaining GRECC staff was all reassigned to other services. Subsequent discussions with the acting Director, the acting VISN Director, and the ADUSH made clear that

the site and the VISN were undertaking development of a plan to reconstitute a GRECC—yet without a director or any staff, it was hard to regard the GRECC as anything but closed.

- GGAC convened a phone conference and developed a letter to the Under Secretary, expressing their recommendation that the St. Louis GRECC should be regarded as closed; and that an RFP be issued to award a GRECC designation to the health system submitting the most meritorious application.

Dr. Shay reported that he had recently briefed the Deputy Under Secretary for Policy and Services on the situation and she had agreed a re-competition was the way to go. She did not believe the Under Secretary would support awarding of new FTEE with a GRECC designation, however.

Mr. Atizado: is the reassignment a matter of public knowledge? Nothing has been heard from the Congressional delegation. *Ans.: yes, it is an established fact and needn't be regarded as privileged information.*

Dr. Veith: it does highlight a contributory factor: we are getting indications that GGAC's reports and recommendations have not been transmitted to Congress, as is specified in 38 USC 7315. This is definitely a matter that needs to be investigated and resolved.

Dr. Dolan: I am concerned about the precedent. GGAC has always been able to assert that GRECC FTE were inviolable. If a site can simply reassign people without consequence, doesn't that seriously erode that assertion?

Ms. Warsaw: although VISN receive their operating budgets thru VERA, it seems one could ascribe a value to 12.0 FTE and then remove that amount from their allocation.

Dr. Bernard: if USH will not agree to transferring or awarding FTEE, what is the alternative?

Dr. Halter: When I came to Ann Arbor, there was no plan for additional GRECCs, but I sold the Regional Director on the merits of underwriting the development of one. He pledged a measure of support and subsequent to that, VACO issued an RFP for new GRECCs. Clearly it would cast a wider net if FTEE were attached to an RFA, but if a site wants one badly enough, they should be able to pull together the necessary attributes to make a credible proposal. I also believe GGAC should take a formal action to recommend that the St. Louis GRECC lose its GRECC designation, in order to initiate the set of steps necessary for moving forward with the designation of a new GRECC.

Dr. Della Penna: So moved. Ms. Warsaw: Second the motion. Vote: Passed unanimously.

Dr. Shay then updated the group on other recent GGAC site visits.

- New England was site-visited in May. There were significant concerns that the GRECC Director was essentially disregarding the part of the program located at the Bedford VAMC, ever since he accepted the position of Chief of Neurology at Boston and relocated his research operation there. That site was experiencing substantial staff turnover, inadequate infrastructure, excessive clinical obligations—yet the GRECC Director was playing no role in addressing any of this. A recommendation that he step down and that a new Director be recruited was stated explicitly in front of the GRECC Director, VISN 1 representatives, and the Chief of Staff at the exit interview. The response from the site arrived one month late—and had completely bypassed both the VISN and the input of the Bedford GRECC and VAMC. With the assistance of the VISN 1 acting Chief Medical Officer, Boston was compelled to collaborate with Bedford on a response, which was received near the end of the calendar year. A factor slowing definitive action toward a new Director is an impending integration of the Bedford site into the Boston VA healthcare System, which will require a reassessment of the present 24-FTE, 2-site arrangement. Yet that could conceivably take years to resolve and in the meantime there is a leadership dearth than must be addressed. GGAC instructed

Dr. Shay to communicate back to the GRECC that some measure of progress toward recruitment of a new Director was overdue.

- Madison was site-visited in late August. The major suggestion was that programmatic growth at the VAMC suggested that it was time to have a Division of Geriatrics in the Department of Medicine. The response is overdue—it apparently went forward in a timely manner but was never sent to VACO by VISN 12.
- Miami was site-visited in early February—and for the second time, GGAC devoted one-half day to assessing the clinical GEC programs. The GRECC was found to be on a strong footing although the GRECC Director currently has a poor working relationship with his Chair. He has identified a potential successor but GGAC encouraged a search be conducted. The clinical programs are strong, multifaceted, well-staffed, well-regarded, and both integrated with yet independent of the GRECC.
- Cleveland was site-visited April 3-4. The GRECC has regained its stride under the new Director, Dr. Robert Bonomo. There were two major concerns identified. One is that Dr. Bonomo, in addition to directing a very productive and well-regarded basic scientific operation (currently supported by 3 NIH program projects and one VA merit grant) is now the Chief of the Medicine Service. His Memorandum of Understanding with the VA and the affiliate (Case Western Reserve University) reflects 40 hr/wk VA, 40 hr/wk University, which several on GGAC regarded as surprising. The site visit team also felt strongly that his effort as Chief of Medicine should not be supported by GRECC eighths. Although Dr. Bonomo is presently able to fulfill the obligations he has accepted, both in his estimation and in everyone interviewed, there are concerns about what will be left for back-filling his responsibilities following his inevitable (if not imminent) departure. The other concern is that the affiliate continues to play a nearly invisible role with the GRECC. These will be discussed in a phone interview with the Chief of Staff, who could not be present at the time of the site visit.
- Dr. Shay had been asked to approach the Bronx GRECC with the possibility that some of his local challenges might be better addressed by a 2012 site visit—he declined the offer.
- Puget Sound GRECC and the GEC programs will be site visited May 30 and 31. Dr. Fulmer will Chair the site visit, supported by Dr. Shay; Drs. Dolan and Della Pena, and Ms. Warsaw will participate.
- Little Rock GRECC and the GEC programs will be site visited on July 24-25. The team will be led by Dr. Veith and supported by Dr. Shay; other team members will be Ms. Warsaw and Mr. Carbonneau.

Madhu Agarwal, MD, Deputy Under Secretary for Health, for Policy and Operations

Dr. Agarwal greeted the committee on behalf of Dr. Robert Petzel, who would have liked to meet with the group but was called to represent VHA at the “Joining Forces” kickoff in Philadelphia with the First Lady, Michelle Obama. This program will focus on offering job opportunities to Veterans, building programs for families of Veterans, and training community groups and providers on issues of military-related mental health and traumatic brain injuries. She noted that Dr. Petzel has been a sustained and strong supporter of geriatrics—in fact, had co-chaired (with Dr. Shay) the Steering Committee that developed the 2009 GEC Strategic Plan.

Dr. Agarwal also recognizes the importance of geriatrics in VA. She was the Chief Officer of Patient Care Services for 7 years prior to her current position, and observed in that role Dr. Burris and his programs—which span the full continuum of care—with avid interest; and in that role helped the current focus on Primary Care and PACT come to fruition. Prior to that she was Chief of Ambulatory Care at the Washington DC VAMC. And now in her current role her responsibilities include Ethics, Research and Development, Public Health, Planning, and Information/Analytics—in addition to Patient Care Services. She sees her new group of responsibilities as the logical link point between the areas overseen by Mr. Schoenhard—heading up Operations and Management—and Dr. Jesse, who is charged with Quality,

Safety, Value, and Oversight. But she also stressed that the new organization in VHA is less about “boxes” and more about relationships.

Dr Veith: GGAC has been strongly focused on GRECCs for decades—but in the past couple years, have expended to fulfill its charge to be familiar with, and make recommendations concerning, all VHA programs on behalf of aging Veterans. Yet currently there is a great deal of GRECC concern—regarding St. Louis. GGAC admires the site’s commitment to resurrect their program, but they also have an historic pattern of falling short in delivering on their promises.

Mr. Carbonneau: we have been made aware of problems at St. Louis for years but our recommendations were ignored—leading to the current situation. It seems like a challenge to the influence of VACO that a site could go its own way and not be held accountable, in some manner, for failing to follow recommendations from a group that reports to the Secretary. We’ve been told that there will be a re-competition—that’s great—but without the “carrot” of new FTE, what is the incentive for worthy sites to pursue the opportunity—and without those resources being withdrawn when the site has regarded them irresponsibly, what is to prohibit other sites to similarly devalue their GRECCs when they encounter difficulties?

Dr. Della Penna: In my time on GGAC, I’ve been very impressed that this government agency—the VA—has increasingly taken a business approach to arrive at its decisions. But it doesn’t seem to me that this is being regarded as a business decision: you have a unit that had a very special resource, and it didn’t take care of it. In the private sector, those resources would be pulled and reassigned at the very least—not even necessarily as a punitive measure, but out of regard for the value of the resource, and the expectation if the resource isn’t being used to good advantage at one site, it should be reassigned where it can be.

Dr. Veith: Particularly in times when there are restrictions in filling vacancies—like now—GRECCs have had to rely on special status of their FTE to ensure staffing. If a site is permitted to absorb GRECC FTE it sends a very concerning message system-wide.

Dr. Dolan: Like everyone on GGAC, I am here out of a sense of commitment to VHA and its mission. I was there on the 2010 site visit and was concerned at how the site was falling short. The recommendations were ignored and now the program has failed. If that occurs without some sort of consequence, it really undermines the potential worth of GGAC recommendations.

Dr. Della Penna: the outcome of this one decision could be a turning point for GRECCs in VA. Top VHA management should consider what geriatrics in VA and in the US in general might be like had there never been GRECCs—and keep that in mind before finalizing the decision.

Dr. Agarwal stated her awareness that there have been broader challenges at St. Louis than just the GRECC—and those problems, and admittedly some of the measures that have had to be introduced to address them—have likely contributed to the current situation with the GRECC. She noted that she had been kept informed by Dr. Shay of the ongoing accomplishments of GRECCs and recognized that it had to be an ongoing campaign to keep Chiefs of Staff and Directors aware of the value of the programs. She mentioned the Herpes Zoster vaccine and the Minimum Data Set as two very visible, very far-reaching GRECC contributions. But she also knows that the VERA mechanism for resource allocation really has no provision for reassigning FTE. The system is 25 years old and is likely due for an overhaul—but that isn’t going to occur in the timeframe that is going to help the current situation. She stated she was not in a position to make this particular decision, but would carry forth the concerns to Mr.

Schoenhard and Dr. Petzel—and agreed with a suggestion from Dr. Veith that he, as much in his role as the first new chair in two decades as well as the major advocate on this issue, should schedule some time shortly with Dr. Petzel to discuss GGAC’s concerns.

Dr. Halter: I would like to take our remaining time to bring another matter to your attention. GGAC has felt that the Office of Research and Development has been inaccessible to discussions undertaken by GGAC as part of its charge. With that group now part of your responsibilities, we are optimistic there can be some progress in that area.

Dr. Veith: We are devoted to sharing our expertise in the service of continuous improvement in VHA. We want to be advocates, but not adversarial—yet feel our input has been regarded by ORD unfavorably. We believe what we bring is done with the best of intentions and is at least worthy of a fair hearing.

Mr. Carbonneau: I have served on this group for 8-9 years and want to comment Dr. Shay's efforts on behalf of GGAC. He has provided information and guidance and a corporate memory to the group that will be difficult to recreate after he is no longer in this position. Yet his staff support (and that of others) has eroded rather than grown as a direct result of the reorganization: we have concerns that, without some sort of protégé to both assist him and be groomed for the role, GGAC will be substantially compromised in its efforts on behalf of VHA when he is no longer here. **We really strongly advocate for a focused effort to be undertaken to provide him with staff assistance without further delay.**

Dr. Agarwal noted her awareness of the concerns about ORD and their resistance to input, and assured GGAC she considered that a matter that was not going to be overlooked. She also agreed with the importance of planning for the future and thanked GGAC for their efforts, accomplishments, and candor.

Scott Shreve, DO: Chief, Hospice and Palliative Care

Dr. Shreve noted that ten years ago, about 1/3 of VAMCs had no provision for consultative support at end of life. Now 100% of VAMCs have not only a consultative team but HPC leadership and a range of programs and services across the continuum of care. In 2008, about 30% of inpatient deaths were in a hospice bed—now the figure is over 44%. The vision that has driven this growth has been “reliable access to quality end of life care”. A convincing outcome measure is patient and family satisfaction: currently 65% of sites rate HPC services as “Excellent”—the overall score is 58% rated as Excellent. Currently all VAMCs report >60% of inpatient deaths have been preceded by a Palliative Care consultation. By comparison, ICUs have much higher variability, ranging from 21-84% “excellent”.

A potent factor driving this system-wide growth is that Hospice is not a discretionary service—it is part of the Veterans Benefits Package. Even when purchased in the community, VA is required to underwrite its costs. Because these are processed through the Fee office, some in VHA continue to regard it as an optional service, but it is not. Fee is important—about 4% of Veterans who die in a given year do so in VA—the remainder (642,000) do so outside VA. Because of this, VHA has partnered with the National Hospice Palliative Care Organization (NHPCO) to offer the “We Honor Veterans” program to serve Veterans whether they are in VA or not. 1,300 of the 4,500 hospice organizations/providers nationally are part of this program—which won the “Global Vision Award” from NHPCO in 2011.

Much of the progress in the VHA HPC program is due to leveraging existing resources rather than creating them anew. VHA has partnered with Northwestern University to adapt their EPEC (Education for Physicians in End of Life Care) and with the City of Hope to adapt their ELNEC (Education and Leadership in Nursing for End of Life Care) for Veterans and VA providers. These programs are now in the public domain where they can be shared broadly—they are also in VHA's Talent Management System, which is our internal tracking mechanism for staff education.

The “Coordinated End of Life Campaign” that Dr. Burris mentioned has fostered development and support of several critical centers, including

- “PROMISE” at the Philadelphia VA, where the Bereaved Family Survey (BRS) was developed, refined, validated, and is now tracked;
- “Implementation Center” directed by Dr. Carol Luhrs at the NY Harbor VA, where findings from the BRS are implemented to continuously improve care; and
- “QIRC” on the West Coast, where tools and templates are developed for dissemination.

The Bereaved Family Survey is being broadly used: 53% of families of recently deceased Veterans participate. Findings from the survey were selected as a performance measure targeted for improvement in FY11 by 3 Network Directors; and by 7 in FY12—Scott hopes to be able to require it for all VISNs in FY13. Satisfaction is quite site-dependent—about 46% of those receiving end of life care on acute wards report the care as Excellent—whereas 66% on Inpt. Hospices do. The Promise Center has allowed detailed drill downs, correlating enhanced satisfaction with different program characteristics to a surprising level of granularity. Impact of individual influences can be demonstrated to account for small satisfaction enhancements—but something like a hospice unit, which represents a “culture change” in care, is far more impactful.

Despite all these impressive gains, the program continues to strive to greater heights. An RFP was recently released that offers up to \$30K per site to implement improvements consistent with the Under Secretary’s “I-CARE” priorities, such as Respect, Caring, and Listening. Many analyses of data have been able to demonstrate lower costs associated with palliative care—for example, VISN 16 went from 4% “Excellent” ratings to over 40% and could demonstrate cost savings of \$2,000/d as a result—yet these really are “cost avoidance” figures because staffing has not changed.

Dr. Halter: a comment was made that “funding was going away?” Does that mean all these gains will be lost? *Ans.: For the past few years, all this growth has been supported through Special Purposes Funding, and yes, that will end soon. But we believe that VISNs and VAMCs will perceive the enhancements in satisfaction (patient, family, staff) as well as the cost avoidance data as compelling reasons to maintain the programs.*

Dr. Della Penna: where do most consults come from? *Ans.: It varies by site. Used to be predominantly from Oncology but now from all over. QIRC has developed thresholds and triggers to reduce barriers regardless of the source. Some are registry-like triggers (“Does the patient have metastatic CA? Does the patient spend >50% time in bed?”) to assist clinicians in learning when to request a consults. Not all such approaches are successes: “Would you be surprised if this patient died in the next 12 months” would open floodgates. Some automatic triggers went on a test-basis into the electronic record—but they had very low positive predictive value.*

Dr. Della Pena: Are there lessons from the BFS that you could conceivably put to use in other (e.g., non-HPC) programs? Dr. Shay: For example, are there any correlations between BFS and overall Hospital Experience (“SHEP”) scores? *Ans.: There is, but there is also a tendency for negative correlation. In other words, for the most part there is a strong positive correlation—but there are also concentrations of outliers of hi BFS/low SHEP and hi SHEP/low BFS—still don’t know what that means.*

Karen Ott, MSN, Clinical Executive, Office of Nursing Services (ONS)

Ms. Ott stated that she would organize her comments on new developments in ONS around the recent Institute of Medicine report on the future of nursing. The report had 8 recommendations and these aligned very closely with ongoing and emerging priorities within ONS in VHA.

Nursing is the single largest professional group within VHA employees, numbering about 80,000 in a workforce of about 300,000—when looking just at health professionals, this is about 1/3 of the total. But there are great concerns—a huge number are eligible, or soon to be eligible, for retirement—a number that fortunately is not growing although it isn't shrinking either.

- “Remove Barriers to Scope of Practice:” Although state licensure rules don't apply to VHA physicians and dentists, traditionally they have applied to nurses—and particularly to nurse practitioners, who experience a state-specific range of levels of independence. This is an historic practice but with a new Handbook under development, it will be addressed. There are some union partner issues that remain, but the change will come
- “Prepare Nurses to Lead”. A common career path is for outstanding nurse clinicians to be promoted to administrative roles, yet they seldom receive preparation for these. And the administrative roles may actually benefit from certain kinds of clinical background (e.g., Associate Chief Nurse for Extended Care) without that being a requirement for the position. In conjunction with the VA Engineering Process Centers, ONS has introduced “Clinical Nurse Leaders”—to diminish the gap between nurse management and nursing clinical excellence. CNL may have up to 25 nurses for whom they are responsible—oversee cares, focus on outcomes, collect data, optimize processes.
- “Implement a Nursing residency Program”. Most RNs go straight from their baccalaureate program into a clinical position. A pilot of a 12 month residency program was very well received—100% retention—and is now going to be introduced system-wide for all recent graduates.
- “Increase proportion of bachelors-prepared nurses to 80%”. Currently VA is at about 67% (the private sector is lower)—but there is literature demonstrating that quality of care is improved when nurses have bachelor-level training. The VA Nursing Academy, a unique partnership between schools of nursing the VHA Office of Academic Affiliations, has helped to drive this.
- “Increase the number of RNs with a doctorate by 2020.” Currently there are 636 doctoral nurses in VHA—177 have advanced nursing degrees; 459 have non-nursing doctorates (e.g., PhD). As with all non-MDs on academic tracks, there is no cost-sharing of salaries with RNs, making dual appointments less appealing for the professional school than they are for a medical school.
- “Enhance adoption of Evidence-Based Nursing.” To improve nursing practice the focus must be increasingly on lifelong learning. There is a growing number of opportunities for advanced certifications in nursing—e.g., Gerontology, Minimum Data Set, etc.
- Promote Nursing research.” Ms. Ott cited some impressive examples of nurse researchers who were playing strongly academic roles—Mary Anne Dellefield in San Diego, Ellie McConnell (at the Durham GRECC), Connie Uphold (at the Gainesville GRECC), Kathy Horvath (at the Bedford division of the New England GRECC; and Charlene Weir at the Salt Lake City GRECC.
- “Undertake Nursing Workforce Management.” This effort is being led by Cathy Rick, Chief Nursing Service Officer. VHA has introduced a proactive nurse staffing methodology that is evidence-based. It is based on the maximum workload over a span of time, and assists nurse managers in their distribution of staff resources.

Dr. Veith: How is it that state statutes applied to nurses but not other professionals? *Ans.: unknown, but becoming a growing problem when VA nurses transfer—and even more when a CBOC is in a different state than the parent facility, resulting in different scopes of practice for two nurse practitioners working for the same health care system.*

Dr. Shay: your description of the growth of baccalaureate nurse made it sound as if VHA nurses have had an opportunity to enhance curricular requirements for schools of nursing. GGAC has heard in the past from the Office of Academic Affiliations that they do not see their role in medical education as including influence on curriculum for medical students or medical residents (this is response to suggestions that VA, as a strong partner in medical education, should be promoting geriatrics enhancement in the curriculum, both for its own needs and in reflection of demographic trends across the US). *Ans.: VHA nursing has historically enjoyed a strong impact on national nursing education.*

Dr. Veith: Is nursing an identifiable priority within the Office of Research and Development? *Ans.: no*
Ms. Warsaw: *do people throughout VHA know of these transformative changes? Ans.: Nursing leadership certainly does. Whether it is actively or effectively communicated down the hierarchy is another question.*

Ms. Warsaw: GGAC should communicate to Ms. Rick how excellent and appreciatively received Ms. Ott's information was!

Thomas O'Toole, MD, Director, Homeless Patient-Aligned Care team (PACT)

Dr. Shay reminder GGAC that the Secretary's stated interest on Homeless Veterans had led to their expressing interest in learning more about aging Veterans and their homelessness status. Dr. O'Toole was kind enough to address the group. He is a general internist who has worked for much of career in primary care, including leading a service. He noted that 9.2% of homeless Veterans are age 62 years and above; whereas the comparable figure for all homeless Americans is only 3.5%. The age of 62 as a geriatric cutoff point reflects the observation that "the homeless 50 year old is the housed 75 year old." Approximately 250,000 Americans are homeless and as they age, the challenges nationally will only escalate.

When Secretary Shinseki declared his intention to end Homelessness among Veterans in 5 years, there were about 150,000-190,000 homeless Veterans; now there are about 69,000. Dr. O'Toole was quick to point out that much of the decrease is owing to non-medical interventions—most is due to HUD programs and use of VHA Domiciliaries—and that many of the predisposing factors that accounted for the individuals' homeless situation were still extant—yet they at least now have housing. Women Veteran homeless are still relatively uncommon—maybe about 5%—but this is expected change. And with the change come new challenges owing to the different health needs encountered. Mental health issues, histories of sexual trauma and sexual abuse are more prevalent. Four states (California, Arizona, Florida, and New York) account for about 50% of all homeless Veterans.

NHANES and other studies have demonstrated high rates of mental illness, functional incapacity, chronic diseases. About 40% are HepC-positive; about 20% have diabetes; 30-40% have hypertension. 30% have persistent, serious mental illness, particularly depression. Schizophrenia/bipolar disorder is actually more commonly encountered than PTSD. Their age-adjusted mortality is about three times the level of age-match but non-homeless individuals. Mean life expectancy is generally 20 years less than for the non-homeless. Post-TBI is regarded as a concern waiting to happen. In Canada currently about 20% of homeless have a history of TBI—when combined with PTSD and malnutrition it is a setup for homelessness.

In counts of homeless individuals, including Veterans, those “doubling up”—living with someone else—are not counted. Those in homeless shelters and living in abandoned buildings, cars, etc are counted. And even when more stable housing is secured, most of the health issues persist if not recognized—such as malnutrition, leading to pernicious anemia, B12 insufficiency, malabsorption syndrome. Recurring obesity is exacerbated by use of atypical antipsychotic agents.

Factors leading to homelessness in the elderly are eviction/foreclosure and release from incarceration. The latter is particularly difficult if the imprisonment was for a sexual offense, which will make them ineligible for many HUD-approved housing supports. Social security is often not a safety net for those with life-long mental illness, who may have never been employed long enough to earn social security benefits. An exacerbating factor is often the past loss of anything resembling a social support network—often a homeless person’s only social contacts are the various health and services providers.

Homeless PACT—seemingly an oxymoron when one realizes PACT used to be termed Medical Home—represents a program of one-stop shopping, offering transportation, scheduling support, case management, expedited referrals, and meals. The homeless life is often strongly dictated by a daily search for food and shelter—and seeking healthcare only comes once those are addressed. It is necessary to identify and then to impart unique skills and sensitivities to providers who would care for the homeless—a combination of motivational interviewing and harm-reduction/avoidance strategies. Currently about 1,000 Veterans are enrolled nationally—it is a constant challenge. Yet among those who are followed, there is a 40% reduction in ER use, 30% reduction in hospitalizations.

The Secretary’s 8-point plan strongly emphasizes prevention of the antecedents of homelessness—it is far less costly to pay up front—for instance, supporting rent, utilities. There are VERA incentives for participation in the homeless PACT—“vesting” (enrolling only) a Veteran is worth about \$600, but enrolling someone in homeless PACT is \$32,000. There is presently no separate allocation for building homeless PACT so they have to be formed out of existing PACTs. To the extent these programs have adopted truly Veteran-centric approaches, team function, etc. will largely determine their success with these most challenging cases.

Mr. Atizado--how are the healthcare needs of dependent children of the Veterans addressed? *Ans.: currently VA has little to no pediatric services, so customarily is handled—as is prenatal care in the case of an expectant mother—through vouchers, in order to attempt to keep families intact.*

Dr. Della Penna—has VA had much success with mobile vans? *Ans.: A donor has provided 7-8 vans and these can be helpful—often the final barrier between making an appointment or not is getting to the site of care. We try to work closely with community agencies, who are glad to have the Veteran clients off their rolls if we can take them. Some of the challenges with community agencies--that not all Veterans are eligible for VA care (e.g., because of dishonorable discharge, less than 2 yr service)—don’t apply for the homeless program, which targets all Veterans.*

Deborah Amdur, LCSW, ACSW, Chief Consultant for Care Management and Social Work

Ms. Amdur stated her plan to provide GGAC with an update on the Caregiver programs that she had discussed one year ago, on the eve of the beginning of the Caregiver Support Stipend roll-out. Many exciting developments have occurred.

There is a menu of supports for Caregiver—many of these (e.g., respite, education, support groups) predate the May 2010 legislation. But the most visible are those that have started in the past year. In combination with the pre-existing services, these have led a shift in attitudes caregivers have about

themselves and their roles: they feel acknowledged, validated, spoken to. The most visible benefit is the stipend, which goes to the caregiver (unlike Aid and Attendance, which goes to the Veteran). It is not intended to be a living wage although it is indexed to the hourly local rate for a home health aide. It varies from \$600-\$2,300/month.

Caregivers are identified by PACT, polytrauma programs, Spinal Cord injury programs. The post 9-11 cohort, in addition to eligibility for stipend support, can get VHA health services if they don't have CHAMPVA—and even if they have CHAMPVA, they can get mental health services above that (CHAMPVA has these services, but with a 25% co-pay). Since the service opened about 11 months ago, there have been about 6,000 applications—currently 3,800 are receiving a stipend. Most of these get the highest stipend and the program is currently costing about \$130M annualized. The program is budgeted for a total of about \$160M. If an application is denied there is an appeals process. About 20% of applications are clearly inappropriate—wrong era, not line of duty injuries. Out of 6,000, there have been about 70 appeals to VACO—an appeals board has been established with representatives from SCI, PolyTrauma, SW, etc.

The process has been carefully orchestrated so it does not vary by locale. The criteria are clearly spelled out. Following application, there is a baseline psychosocial assessment of the caregiver, based on Katz ADL, FIM, and the Neuropsychiatric Inventory. The caregiver must participate in a core curriculum developed by Easter Seals. A home visit by the VA is conducted (122 sites undertake these). Once the application is approved, payment goes back to the original application date. The process has been reviewed and revised according to recommendations—for example, the review group suggested development of a detailed guidance tool to foster standardization. Information on the appeals process is another addition that was recommended by this group. Application can actually begin while the Veteran is still active duty—about 80 cases have been approved in this way, with stipends going to Caregivers even as the Veterans is still active duty.

The Caregiver Support Line started operations early in 2011—have fielded over 34,000 calls. The call center is staffed by 8-10 licensed social workers who assist over the phone, make referrals to local Caregiver Support Coordinators. They do callbacks, track outcomes. They are located in Canandaigua, NY. The service is not limited to post-911 Veterans, in fact the majority of calls are for other eras.

There several other growing components to the full caregiver initiative. One is the dissemination of evidence-based approaches—for example REACH-VA, based on an NIH-supported model for Alzheimer's caregivers, now modified for SCI and TBI. This has been shown to reduce ED visits and BDOC. There is also a telephone support program, based on an Army program to support spouses. Another is a contract to Stanford University: “building better caregivers”—which trains VA staff to foster enhanced caregiving skills. There is a partnership with the National Center for PTSD to prepare a webinar on PTSD management that includes a link to an online support group. Social Work just launched a Peer Mentoring program, linking experiencing caregivers with those identified by case workers as potentially benefitting from support of this nature. The program plans to have 25 mentor/trainee dyads by the end of 2012.

Dr. Halter: might there be any use for the Caregiver Assessment tool outside of the 911 population? For example, to establish the degree of need among other cohorts of Veterans? *Ans.: presently there are no plans, but that is a good idea. IN one year VHA has to report back to Congress on the feasibility of expanding these benefits to Veterans of other eras. Having that information in hand would be a useful part of such a report.*

Dr. Della Penna: how are tracking your Return on Investment? What outcomes do you follow? *Ans.: Zarit Caregiver Burden Scale, BDOC, ED visits.*

Dr. Dolan—if a Caregiver receives Social Security, is the stipend diminished? *Ans.: no. For example, many of the Veterans are already getting Aid and Attendance—that also doesn't impact the stipend.*

Mr. Atizado: but the stipend is not taxable—which means it also will not confer Social Security eligibility, correct? *Ans.: yes, that is the tradeoff.*

Dr. Veith: have there been instances of Veterans dying while the application process moves forward? *Ans.: yes—about 15 instances. Out of 6,000 applications that is pretty low.*

Dr. Koren: are there any programs specifically for the children? *Ans.: no, but that is a great idea. We do have some educational modules on discussing dependency and feelings with children.*

Dr. Della Penna: if a Veteran's status changes (e.g., is institutionalized for a time), how quickly do the benefits change? *Ans.: the stipend is easily and quickly changed—although oftentimes the caregiver is still at the bedside daily. Aid and Attendance stops very quickly in such situations. More difficult is changes to health insurance—we work with the family and insurers to have a smooth transition and identify the resources needed to support it. In general the goal is to err on the side of family support whenever possible.*

Stacy Garrett-Ray, MD, MHA, MBA: Acting Initiative Lead for New Models of Care, Office of Healthcare Transformation

Dr. Garrett-Ray reported she had assumed this responsibility two days ago and apologized in advance for whatever shortcomings she might demonstrate in her familiarity with her material. She came to this role from the Office of Women's Health, where she was Deputy Director of Women's Comprehensive Health Care. She is a family practitioner and faculty at the University of Maryland; she still has clinical obligations at the Loch Raven CBOC of the VA Maryland Health Care System in Baltimore. She stated that she perceived GGAC would not need to receive background in patient-centered care because geriatrics is one of the original embodiments of that concept.

She noted that there were originally—in the fall of 2009-- 6 “New Models of Care” under the Transformational Initiative: PACT, Non-Institutional Care, Preventive Health, My Health-E-Vet, Telehealth, and Specialty Care. The following year Women's Health and Mobile Applications were added; most recently (a manner of weeks ago), Patient-Centered Care was added.

She expanded on characteristics of the health system in conjunction with PACT by walking thru several clinical scenarios. Between her scenarios and GGAC questions, the following points were shared:

- PACT has a core “teamlet” of 3 support staff to one provider; other team members (e.g., Pharm, SW) may be shared with other teamlets. Teamlets “huddle” at the beginning of the day or clinic session to clarify roles, identify expected issues, necessary pre-appt. labs/studies, etc.
- A PACT teamlet is expected to be available to communicate with a Veteran within 24 hours of being contacted. This includes a face to face visit, secure messaging (e.g., e-mail that becomes part of the Electronic Health Record) or a phone visit.
- Phone triage is generally a role delegated to the RN care manager of the team. Same with secure messaging.
- Rollout of PACT has been an 18-month process that is still underway, and has progressed/been adopted to differing degrees at different sites.
- There are “Special Population PACTS”—for example SCI, Homeless, Geriatrics, HBPC—that have core characteristics in common with PACT but also have distinct features consistent with their target populations.

- Progress on the journey toward becoming a “PACT” is largely reflected in process outcomes—panel size, team make-up/size, adoption of non-face to face visits, delays in seeing Veterans, use of “huddles”, etc. Clinical outcomes will follow soon—already there are some data on diminished hospitalization rates and emergency room visits. Provider and patient satisfaction will be among these as well.
- An ongoing challenge is the coordination between VA and non-VA care provided. One advance is the “Blue button” that allows the Veteran to download information from the VHA record, to share with non-VHA provider.
- PACT is now working on integrating better with telehealth. Currently telehealth is run by a service separate from Primary Care—this necessitates a handoff of information and instructions.

Stuart Gilman, MD (Director for Advanced Fellowships, Office of Academic Affiliations-OAA)

Dr. Shay introduced Dr. Gilman, and introduced Gilman’s comments by reminding the group that the Advanced Fellowships programs of the GRECCs began when the original geriatric fellowships, pre-accreditation, were 2 years long. When ABIM decided to limit minimal training for the specialty of geriatrics to a single year, VA folded the training programs into the Residency (PGY series) slots. Some GRECC leaders recognized that a single year was inadequate for training a cadre of faculty leaders and were successful in getting the Office of Academic Affiliations to reinstate the 2-year (unaccredited) program as research/faculty preparation, and limited the program to GRECCs. Six GRECCs were awarded these. The first 5 years of the program found spotty success in recruitment—whereupon the program was opened to non-physicians (e.g., nurses, psychologists, physical therapists, occupational therapists) and to non-geriatrician medical subspecialists with research interests in geriatrics) and a second phase of applications was accepted. Currently all but two GRECCs offer these, and the fill rate is greatly improved. Recently one of the two GRECCs without one of these programs asked if it could make application, and Dr. Gilman described a shift in focus that the Office of Academic Affiliations was contemplating. Dr. Shay invited Dr. Gilman to discuss this with GGAC.

Dr. Gilman began by introducing himself—he is a general internist with primary care responsibilities at the Long Beach VAMC. He used to work for the Regional Educational Medical Education (RMEC) System, and then the Employee Education System (EES) before coming to OAA. He clarified the divisions within OAA: there is Advanced Fellowships, Nursing, Associated Health, and Medical/Dental.

Only Advanced Fellowships stresses interdisciplinary education. His is the smallest division in OAA—he oversees about 300 positions (versus 11,000 position/33,000 individuals in Med/Dent) in 18 different programs. Because the programs are, by definition, not accredited, there is a great deal of flexibility in administration and curriculum. Advanced Geriatrics Fellowships is one of his largest, currently supporting 27 trainees. He regards this program as successful—a high matriculation rate, many retained by VA and contributing to the field academically after completion. He does not sense a need to “fix” or change anything in the existing programs—but when faced with possibly opening a new one, he wants to think strategically.

Specifically, his leadership wants him to regard the Advanced Fellowships as the source for system improvement and system change—because these are NOT areas that are well developed within the academic partners. To that end, VA has developed the RWJ Clinical Scholars, VA Quality Scholars, Patient Safety Fellowships, and Medical Informatics Fellows. This are focused very differently from the clinical foci of Advanced Geriatrics, Geriatric Neurology, SCI.

The current thinking is to develop a cohesive core curriculum that would connect fellows and faculty for overall strengthening of professional identity; and then augment that core with local strengths/interests to improve systems of care, enhanced patient safety theory.

Dr. Veith: **We really want to continue this discussion and hope you, Dr. Gilman, can return to talk more in the Fall.** I feel, and I am sure others in the room would agree, that the GRECC model, while not focusing explicitly in the way you are describing, has addressed much of what you envision in the course of advancing geriatric care: collaborative care, team care, telehealth—these are all system changes. Dr. Halter: In Ann Arbor, we have transformed care thru GRECC efforts: the introduction of quality and assessment in the full range of extended care programs, national quality Metrics like ACOVE from the Greater LA GRECC. Medicare’s Accountable Care initiative is led by a former GRECC faculty member.

Rajiv Jain, MD, Chief Patient Care Services Officer

Dr. Jain thanked GGAC for the opportunity to share with them a small glimpse of all that is going on within Patient Care Services—and then stated his hope to open a dialog with them on matters they regard as important.

He noted that next week will find him working with the Network Directors on a 5-year Strategic Plan—one that will integrate VA and VHA priorities. Dialog and shared perspectives during such times often result in new ways of seeing the challenges facing the system. For example, a few weeks ago the 10P (Policy and Services) office convened a retreat—and Dr. Jain was struck by the alarming, increasing rates of obesity, depression, dementia, ischemic heart disease, hypertension. This despite all the sophistication in diagnostics and therapeutics. Obesity has increased 20-25% in the past 10 years. End stage renal disease—largely a result of under-treated or untreated diabetes and hypertension, continues to grow. Recently a large vendor of dialysis services suggested to VHA that they wanted to be paid at above the Medicare rate—a very costly possibility. Yet for VHA to begin delivering dialysis internally, to a greater extent than it does presently, would cost \$300-400M—and yet demand would not abate, it would only continue to increase.

There is growing evidence that identification of those with renal disease before they require dialysis, and institution of treatment with familiar modalities—ACE inhibitors, controlled blood pressure, limited antibiotic exposure—could start to drop that curse. We should be able to do this with PACT. Can we do the same with obesity? Address potentially increasing costs by earlier identification and intervention? With dementia? If we diminish chronic disease across the board by 5%, we can save 1\$1/7B/yr. IF we could diminish it by 15-20%—the savings would be huge. What would it take? Bicycle paths to promote weight loss and cardiovascular fitness. “Healthy Kitchens”—education targeted to the food preparer of the family, train them to read a label, to understand basic principles of good nutrition.

To turn these ideas into action, everyone has to be on the same page. Dr. Jain has recently met with each of the Chief of Consultants and directed them to identify tangible outcomes for the coming year—they will be held accountable for those. He will monitor progress monthly and if shortcomings are noted, remediation will be initiated while there is still time to bring performance around.

Dr. Halter: We know we can do what you’ve described for diabetes—we can identify those in the over-60 age group at elevated risk and count on an 80% success rate in limiting their disease. And diabetes doubles risk for cognitive disorders and ESRD. *Ans.: absolutely, and with those with depression and dementia as well—institute behavioral strategies that slow or even stop or reverse decline BEFORE the decline is so significant that participation in the needed activities is no longer possible.*

Dr. Della Penna: we discussed earlier with Dr. Edes how much less costly social supports are than health care. By instituting measures that promote healthier lifestyles—really putting resources behind them so they stick—we could have huge downstream savings. *Ans.: yes. In Mexico City, they close off parts of downtown just to promote bicycling—and in that way re-establish interpersonal contacts, neighborhood awareness, safety, etc. It absolutely takes a paradigm shift—and often more than just the health care system—to transform behaviors.*

Dr. Koren: in Cooperstown, NY, there is a partnership between a healthcare system's dieticians and the grocery chains—the dieticians are in the stores and assist shoppers. David Kessler's book on the pernicious marketing by the food industry: physicians need to education their patients on being more judicious about the information they are exposed to. *Ans.: yes—some are swayed, others are immune to the misinformation; some have will power, others don't. An important consideration is to identify who will most likely to benefit as well as who needs to.*

Dr. Dolan: fostering change is challenging; there are often historical and environmental factors that are out of reach. For example, dental disease is very strongly associated with poor education and low socioeconomic status.

Dr. Halter: How can GGAC help in this transformation? *Ans.: perhaps foster partnerships between, for example, Health Promotion/Disease Prevention and the GRECCs.*

Dr. Halter: We are challenged by following the distribution of responsibilities post-reorganization. We recognize there are two groups charged with GEC—are the distinctions between them clear to them? To the organization? *Ans.: they should be clear. I was part of the discussion of these matters when I was the Chief Consultant for Medical and Surgical Specialties. The heart and soul—the face—of GEC resides in Patient Care Services, and the Chief Consultant is it spokesperson. Operations is the cache, the checkbook, the operationalization of the concepts and approaches that Policy and Services develops. Policy is the subject matter expertise, new program development—the forward-thinking division. Operations is pragmatic and focused on delivery.*

Dr. Halter: yet it seems very clear that Dr. Edes is becoming the de facto spokesperson for GEC—both in terms of existing programming and anticipated directions. Does that fit into his role in Operations? *Ans.: a good team is one in which every member can clearly articulate the team's point of view.*

Dr. Veith: we have strong concerns that the point of view that is being articulated doesn't derive from the appropriate origin, or represent a consolidated vision of the subject matter experts as described. *Ans.: that sounds like a reasonable topic for a sidebar discussion. Geriatrics is important—represents a large number of patients and there are not enough new professionals entering the field. I have challenged the current leadership to become more engaged and involved—we have to give this a chance.*

Dr. Veith noted that many members of GGAC have expressed frustration over the latest set of procedures they have to tackle to arrange and be reimbursed for their travel to these meetings—he hopes that something can be done to address that.

Meeting is adjourned at 12:00 noon on April 12.