

VA Geriatrics and Gerontology Advisory Committee
810 Vermont Avenue, NW
Washington, D.C.
April 4-5, 2017

Committee members:

Rear Admiral W. Clyde Marsh (USN ret.) (Geriatrics and Gerontology Advisory Committee [GGAC] Chair)
Judith Beizer, PharmD
Harvey Cohen, MD
David Gifford, MD
Jennie Chen-Hansen, MSN (by phone)
Bruce Leff, MD
Shurhonda Love
Nora O'Brien-Suric, PhD (by phone)
Barbara Smith, PhD, MPH
Kathleen Welsh-Bohmer, PhD
Marie Bernard, MD (ex-officio)
Lori Gerhard, NHA (ex-officio)

Presenters:

Richard Allman, MD, Chief Consultant for Geriatrics and Extended Care (GEC), GEC Policy
Carolyn Clancy, MD Deputy Under Secretary of Health for Organizational Excellence
Susan Cooley, PhD, Chief, Dementia Initiatives and Geriatric Research
Tom Edes, MD, Executive Director, GEC Operations
Brenda Faas, Designated Federal Officer (DFO), Strategic Medical Advisory Group (SMAG)
Jennifer Lee, MD, Deputy Under Secretary of Health for Policy and Services
Paula Molloy, PhD, Assistant Deputy Under Secretary for Health for Workforce Services
Marianne Shaughnessy, PhD, ARNP, Director, VHA Community Living Centers (CLC) Policy and Services
Laurie Zephyrin, MD, Acting Assistant Deputy Under Secretary of Health for Community Care (DUSH)

Staff:

Sherri DeLoof, LMSW, Program Analyst, GEC Policy
Alejandra Paulovich, Program Analyst, GEC Policy
Kenneth Shay, DDS, MS, Director, Geriatric Programs and GGAC DFO

Guests:

Latonya Small, EdD, Program Specialist, VA Advisory Committee Management Office
Susan Flanagan, PhD, MPH, Principal, Westchester Consulting Group
Kevin Foley, BA, National Program Manager, Home and Community Based Services
Nicole Katikos, MHA, VHA Workforce Services
Kim Kelley, MA, MSW, LCSW, National Director, Home and Community Based Services

Recommendations for SecVA:

1. GGAAC recommends VA and VHA resume, complete, and act upon the initial efforts of the Intergovernmental LTSS Task Force (Page 5).
2. GGAC recommends that VA develop and implement incentives for geriatricians to work for VA (Page 6).
3. GGAC recommends that means be taken by GEC and 10N to compel compliance with GRECC primary core staffing recommendations in VHA Handbook 1140.08 (Page 9).
4. GGAC recommends the Offices of GEC and Community Care establish a tangible means for setting and tracking clinical programs with which both are involved, in order to ensure the Veteran-centered character of the programs remains intact and Veterans choices are addressed (Page 11).

Action Items:

1. GEC Staff will share GGAC annual report and GGAC minutes with the Strategic Medical Advisory Committee (page 7).
2. Each GRECC site visit report needs to go to the relevant congressional delegation (Page 10).
3. GEC Staff in collaboration with GGAC members will develop a scoring guide to assist in the comparison and communication of site visitors' assessment during GRECC site visits (Page 10).
4. Key recommendations in the GGAC annual report need to be brought to the attention of Congressional offices prior to the report being sent. (Page 11)
5. Staff and GGAC members need to invite representatives of one or more Congressional offices to attend future GGAC meetings (Page 10).

Meeting called to order by Rear Admiral W. Clyde Marsh, 8:45am, April 4, 2017: Admiral Marsh welcomed the group and thanked them for their participation. He also welcomed the new members: Dr. Harvey Cohen, Dr. David Gifford, and Shurhonda Love, each of whom provided brief comments on their backgrounds and current positions.

Review of the agenda: Admiral Marsh reviewed the proposed agenda and provided updates related to speakers and presentation times. Dr. Shay pointed out that Dr. Jennifer Lee would be attending the meeting on 4/5/17 and that this would be an excellent opportunity for GGAC members to ask questions regarding the Intergovernmental Task Force and VHA plans for addressing impending needs of elderly Veterans.

Richard Allman, MD (Chief Consultant, GEC Policy) and Tom Edes, MD (Chief Consultant, GEC Operations): Dr. Allman thanked the group for attending the meeting and reminded them that the goal of GEC is to help VA empower Veterans and the nation to rise above the challenges of aging, disability, and serious illness. He provided justification for the larger than usual number of Deputy Under Secretaries participating in the meeting: the intention was to take a different approach to addressing the recommendation GGAC has made to SecVA year after year. By raising awareness of the underlying issues and recommendations stemming from them, the hope is that VHA leaders from a variety of levels within the organization will advocate on behalf of the desired changes. For example, he encouraged the group to raise issues such as the number and support of GRECCs with Dr. Lee; trainees, recruitment and retention and geriatric competencies with Dr. Malloy; and purchased non-institutional services (NIC) with the representative from Community Care. For Dr. Clancy (Deputy Under Secretary for Organizational Excellence), suggested topics included caregivers, complex patients, multi-generational patient population, and ongoing Human resources challenges.

Dr. Allman he reviewed the GEC Continuum of Care (see figure 1), discussed the priorities, and shared the demographic challenges in the present and projected into the future (see figure 2). He discussed the need to work with other VHA program offices, e.g., Community Care, to facilitate coordination of care and work toward common goals. The GEC Data Analysis Center (GEC DAC) in Canandaigua, NY has become integral to both the GEC Policy and Operations offices. Their analyses have shown that the 6% of VA enrollees constitutes thirty percent of VHA costs. This group of Veterans, the “GEC Cohort”, with significant access issues, is a high utilization group who needs assistance through coordinated inpatient, outpatient, and extended care services (see figure 3).

Figure 1: GEC Continuum of Care

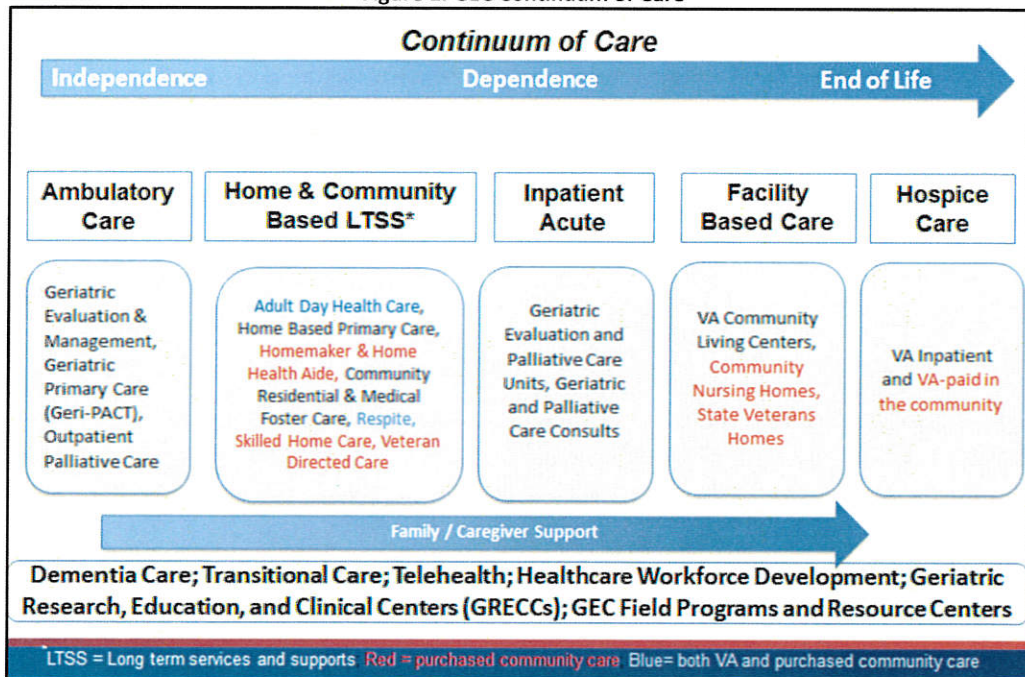
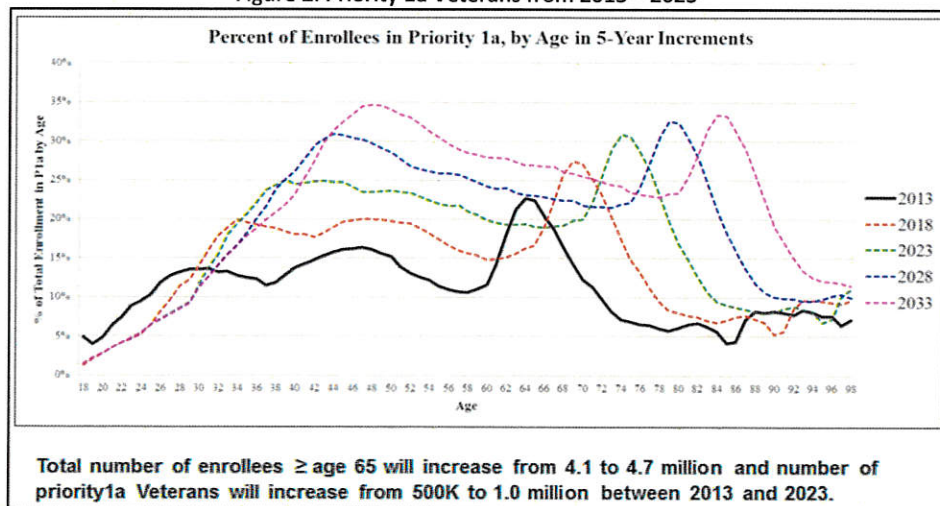


Figure 2: Priority 1a Veterans from 2013 – 2023



Dr. Allman shared that the largest GEC institutional care program is the State Veterans Home (SVH) program, with enrolled Veterans supported by approximately one billion dollar budget annually (see

figure 4). VA contributes to this program by paying a half of the per diem for most SVH Veterans (those who are Priority 1a—70% of more service-connected, or requiring nursing home care for a service-connected

Figure 3: Number of Veterans Receiving GEC Non-Institutional Care

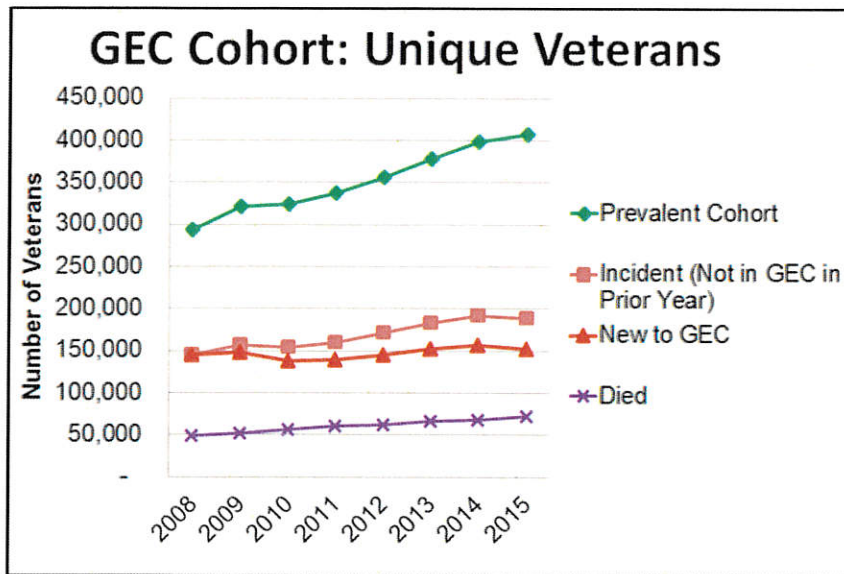


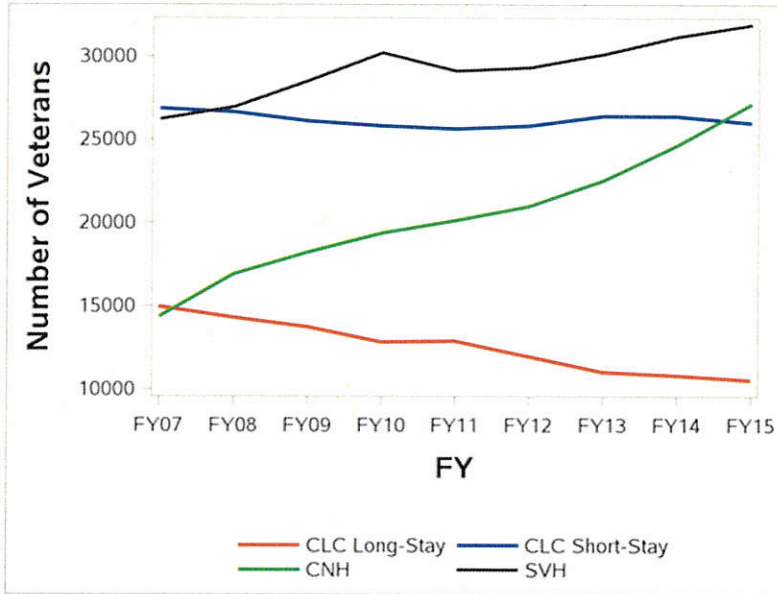
Figure 4: CLC, CNH, and SVH Costs

72% of VA GEC Services budget spent on nursing home care; 12% on personal care services; 18% on HBPC or Other HCBS

Program	Obligations	Enrollment
Facility-Based Care		
Community Living Centers	\$3.38 Billion	33,383
Community Nursing Homes	\$0.86 Billion	27,630
State Veterans Homes	\$1.00 Billion	31,972
Subtotal Facility-based Care	\$ 5.24 Billion	92,985
Home and Community Based Services (HCBS)		
Personal Care Services (HHHA, Community ADHC, Respite)	\$0.88 Billion	128,837
HBPC	\$0.75 Billion	82,064
Other (Purchased Skilled, Hospice, VA ADHC, SCI Home Care, Home Telehealth, CRC, MFH)	\$0.43 Billion	102,636
Subtotal Home and Community Based Care	\$2.06 Billion	313,537
Total VA Provided Geriatrics & Extended Care Services	\$7.30 Billion	406,522
Cost per Veteran – \$56,353 for nursing home care vs \$6,570 for HCBS – 8x greater		

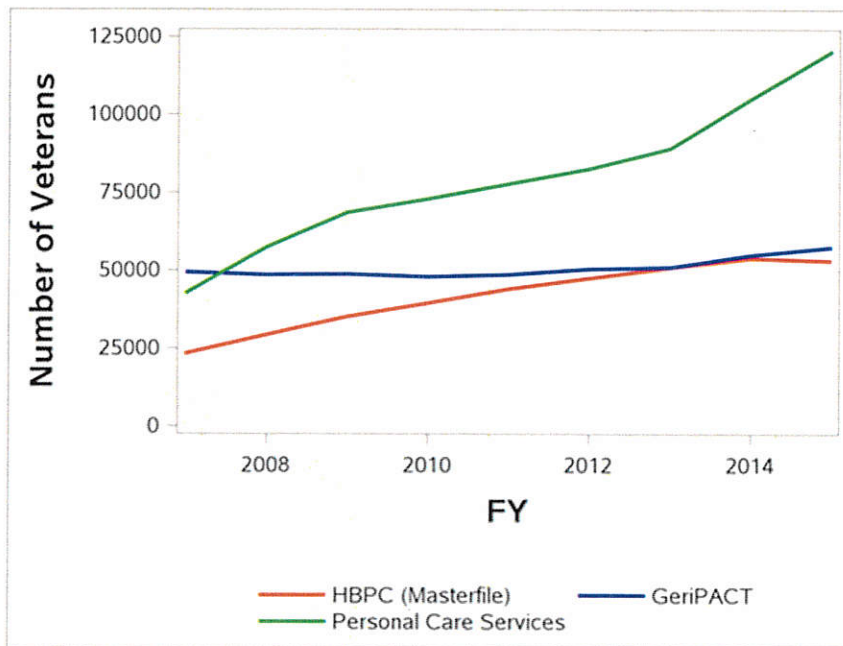
connected condition). VA also pays up to 65% of building costs for new SVH construction. Dr. Allman predicted an upward trend in resources spent on community nursing home and a downward trend for VA nursing homes (see figure 5).

Figure 5: CLC, CNH, and SVH Balance



Non-Institutional Care (NIC) Programs include Adult Day Health Care (ADHC—both purchased and VA-provided), Veteran Directed Health Care (VDHC), Homemaker/Home Health Aide (H/HHA), Respite (both purchased and VA-provided), Home-Based Primary Care, Medical Foster Home, and Community Residential Care (see figure 6). These programs allow Veterans to remain in their homes and communities for longer periods of time while avoiding costly nursing home care.

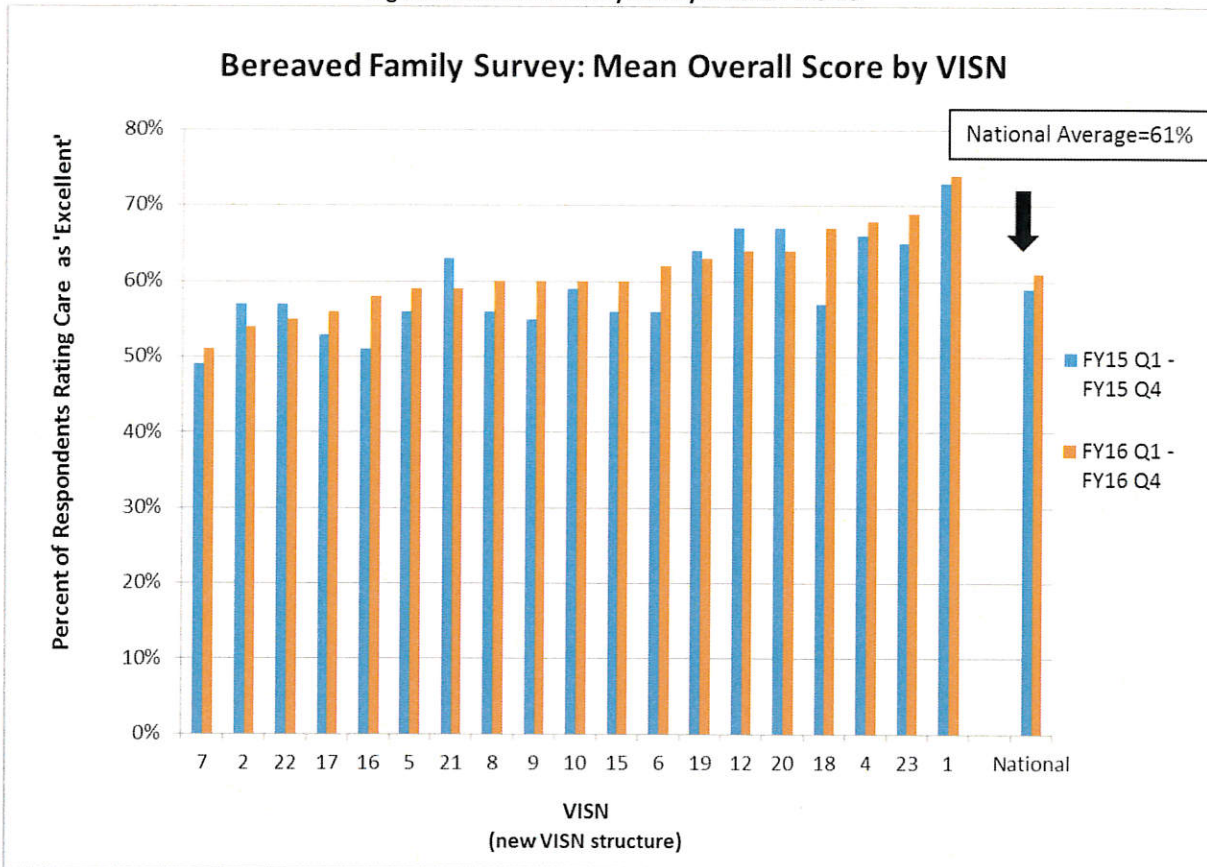
Figure 6: Number of Veterans receiving GEC Non-Institutional Care



Hospice and Palliative Care is another program in the GEC continuum on which VA prides itself. One of every four Americans who died this past year was a Veteran and the number of Veteran deaths will remain over 500,000 per year for the next decade. Currently, the VHA Bereaved Family Survey, endorsed by The

Quality Forum, is a validated instrument that measures patient and family satisfaction with the end of life care the Veteran has received from VA. Results reflect high satisfaction from family members (see figure 7). While the results are good, there is more work to be done to improve the hospice and palliative care services offered.

Figure 7: Bereaved Family Survey Results FY15-16



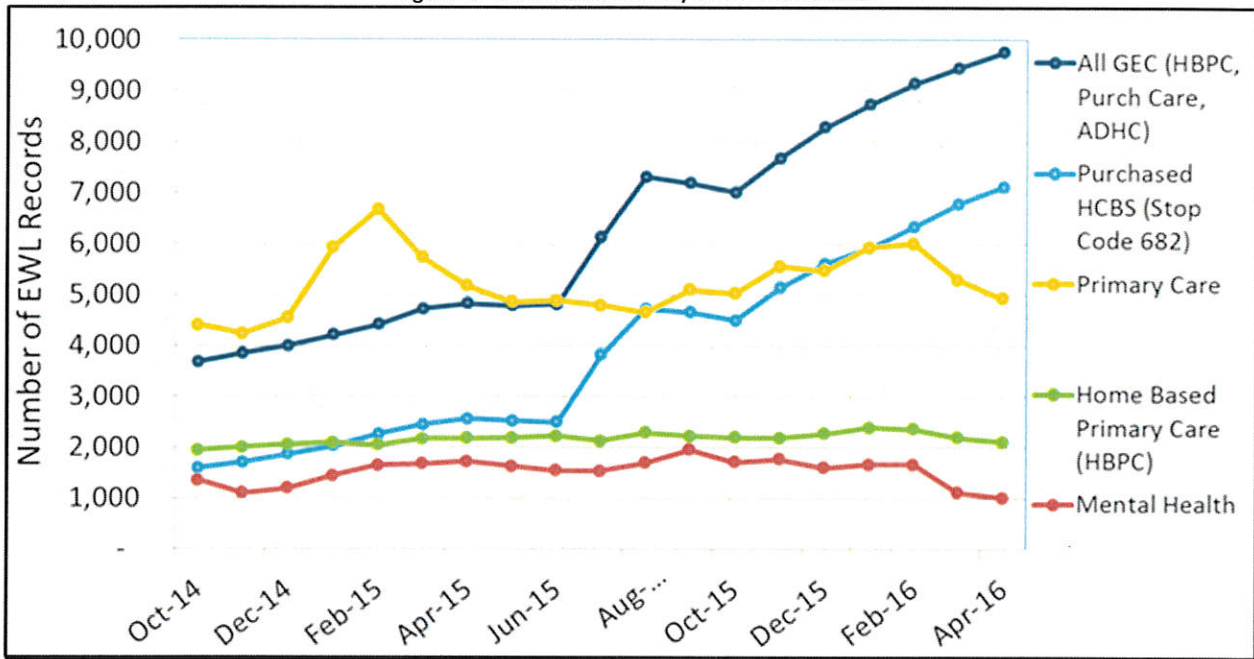
Dr. Allman proudly described a strong partnership with the We Honor Veterans Program, which fosters VA partnering with community agencies to optimize and facilitate Veterans’ access to available VA and community resources. This is another example of helping Veterans remain in their homes and their community, as they choose.

Dr. Edes discussed that VHA cares for Veterans who have the greatest need and receive most frequent episodes of care yet face the steepest challenges accessing that care. He shared that VHA needs to raise awareness of the rising prevalence of Veterans with multiple serious chronic diseases and disabling conditions. He shared that GeriPACT, a program started in the late 1980’s as geriatric primary care, has been implemented at 78 facilities across VHA --but that only constitutes about half of VA medical centers and no community-based outpatient clinics. This shows a missed opportunity for identifying those Veterans with the greatest need early, in time to reduce the decline.

Challenges include the lack of legislative authority to purchase important GEC services not yet covered under the Veterans Choice Program authority; GEC not included in the development of the Office of Community Care, inconsistent alignment of GEC services under a single leader at each VISN and each medical center; and budget constraints disproportionately impacting GEC and social support services.

Dr. Edes suggested that there is a need to raise awareness that, in the context of the unsustainable rise in health care costs, the spectrum of GEC services is integral to the solution. He stated that VHA needs to increase access (see figure 8), improve quality, and where feasible, lower the total cost of care. There needs to be continued focus on the role and priority of nursing home care and of personal support services, reminding stakeholders that VHA continues to follow a traditional medical model yet much of geriatrics and chronic disease management is dependent on a social model for care delivery. The Veteran must remain at the center of any solution.

Figure 8: Electronic Wait List/Access 2014-2016



Addressing these concerns will be dependent on SECVA, HVAC, SVAC, and VSOs taking greater interest in GEC services and thereby reducing avoidable and unwanted emergency room visits, hospitalizations, and nursing home stays. Dr. Edes stated that VHA needs to identify less costly social solutions to foresee and avoid expensive medical problems. He suggests involving intergovernmental dialog, e.g., with Medicare and Medicaid, to address the aging population as a whole. Lastly, VHA needs to collaborate with other VHA Program Offices for resources and support.

Admiral Marsh-Long Term Care Support Services Task Force:

On December 14, 2016, SECVA convened an intergovernmental “Long Term Services and Supports” Task Force (LTSSTF) to develop a strategic approach for addressing the increasing number of aging Veterans and the growing cost to serve them over the next 10 years. The diverse group membership was intended to assist with addressing this issue globally. A one day brainstorming round table session took place discussing the issues, framing the problem, and offering solutions. In its original conception, the hope was that LTSSTF would develop preliminary recommendations that GGAC would review, but the proposed procedure would have been in violation of the Federal Advisory Committee Act so any GGAC involvement will be on a member-per member basis with participants serving as subject matter experts.

The members included:

- Principal Deputy Under Secretary for Health (co-chair)
- Commissioner, Alabama Dept. of Veteran Affairs/Natl. Assoc. of State Directors of Veteran Affairs (co-chair)

- Assistant VA Secretary for Office of Policy and Planning
- Deputy Under Secretary for Health for Policy and Services
- Assistant Deputy Under Secretary for Health for Clinical Operations and Management
- Deputy Assistant Secretary for Intergovernmental Affairs
- Chief Consultant, GEC Policy
- Executive Director, GEC Operations
- National Director, Caregiver Support Program
- Deputy Director Office of Intergovernmental Affairs
- Deputy Director, Pension & Fiduciary Services
- Deputy Outreach Program Manger & Intergovernmental Affairs Liaison
- Deputy Chief Patient Care Services Officer
- Geriatric Evaluation and Management Unit Physician, VA Maryland Health Care System
- Deputy Under Secretary for Food Safety, US Dept. of Agriculture
- Deputy Chief Medical Officer, Centers for Medicare and Medicaid Services
- Director Division of Community System Transformation, Centers for Medicare and Medicaid Services
- Director of Program Evaluation Division of Policy, Development & Research, US Dept. of Housing and Urban Development
- Director, Office of Consumer Access and Self-Determination, US Admin. for Community Living
- Senior Advisor/Intergovernmental Affairs, Dept. of Health and Human Services
- Associate Legislative Director for Health, Natl. Association of Counties
- Principal Housing Associate, Natl. League of Cities
- Vice-President and Legislative Chair, Natl. Association of County Veteran Services Organizations
- Public Assistance Reporting Information System (PARIS) Program Manager, Washington Healthcare Authority
- Assistant National Legislative Director, Disabled American Veterans

The key takeaways from the forum were that this is an urgent and challenging situation and will require a comprehensive and flexible continuum of care that needs to have an intergovernmental approach from federal, state, and local levels. Solutions will need to include engagement and commitment for medical and social models, as well as VA leadership support with a top down focus.

Nationally, State Veteran Homes currently have a Memorandum of Understanding (MOU) with the VA and are strong partners. Action items from the forum will be forwarded to SECVA. Initial recommendations identified included needs for:

1. domiciliary regulations for SVH;
2. addressing legal conflicts impeding access to geriatrics and long term care services;
3. expansion of Cover to Cover and Home and Community Based Services (HCBS); and
4. expanded support for SVH.

(Ms. Gerhard clarified for the group that Cover to Cover has been an Office of Rural Health (ORH)-funded collaboration between the Salt Lake City VA and the Utah Aging and Disability Resources Center, in which VHA and VBA representatives educate staff of Area Agencies on Aging about Veterans eligibility and application procedures—potentially even qualifying some of the AAA personnel to qualify as benefits counselors.)

LTSSTF was put on hold during the VA's leadership change. A White Paper was developed that includes the need for VA leadership presence. The White Paper was submitted to VA for review; its current status is unknown. The White Paper was shared with GGAC for later comment, and **GGAC recommended the processes be resumed, completed, and resulting recommendations implemented.**

Dr. Cohen questioned the likelihood for meaningful change if there is no money to address the rising costs of health for the aging population; he wondered what could be done to specify a line item in the budget? Dr. Allman clarified that, in essence, purchased care is a line item—but the LTC component within it is not specified. Dr. Edes noted the need for adjusting funding streams to better fit the needs of the population. Further discussion clarified that VA benefits are discretionary with a fixed budget. Dr. Gifford suggested that strategic planning would be critical for this type of pendulum shift: with a fixed budget, growing one area (like LTC) requires scaling back in another.

Paula Malloy, PhD-Assistant DUSH for Workforce Services:

Dr. Malloy, Deputy Under Secretary for Health for Workforce Services, described her role in workforce development and discussed the under her: the National Center for Organizational Development (NCOD); Workforce Management and Consulting (essentially Human Resources); Employee Education System (EES); Office of Academic Affiliations (OAA); and Health Care Leadership Talent Service. The office's priority is to address national staffing shortages, with a strong emphasis on physicians and nurses. Dr. Malloy suggested steps for addressing geriatric workforce concerns, including obtaining accurate data on GEC workforce; improved and better-targeted All Employee Survey data; providing geriatric training; targeting geriatric hires; reviewing and developing retention strategies and issues; reviewing pay tables; developing mid-career transition opportunities; improving training opportunities leading to enhanced geriatric competencies; and education debt reduction. Dr. Cohen suggested starting with a review of the pay because other strategies will be dependent on participants having a tangible benefit waiting for them upon completion. Dr. Gifford countered that the work environment is also critically important: high leadership turnover in VHA was cited by many as a factor, in a survey of sites reporting geriatrician recruitment difficulty recently undertaken by Sherri DeLoof from the GEC office. **GGAC recommended that incentives be developed and implemented to foster more effective geriatrician hiring in VHA.**

Dr. Malloy solicited input from GGAC members, and heard:

- A little money can go a long way because the numbers needed are low and the main competition to VA for geriatricians is academia;
- Training experiences need to be multidisciplinary because that is the nature of geriatrics;
- Need for mid-career training to incorporate salary maintenance (not limited to medicine; examples include Medical Director certification by American Medical Directors Association; STAR-VA for nurse behavioral management; REACH for social workers working with dementia);
- Mini-residencies incentivized by cash or a commitment by the agency to new responsibilities (e.g., training certification programs for CLC Directors with financial incentives);
- Explore collaboration with Health Services Resource Administration programs and their efforts to employ people in shortage areas;
- Improve team structure and stability—performance metrics need to reflect team function or it will always be regarded as less important than the metrics that reflect individuals' performance;
- Leveraging the existing GRECC GeriScholars Program and OAA associated health trainee programs to assist in recruitment and placement;
- Enticing medical students into geriatric rotations;
- Geriatricians don't qualify for bonuses because their caseloads are lower than the primary care threshold and the metrics related to medical improvement are unobtainable related to aging and

chronic disease populations;

- Lesson learned in geriatrics can benefit all of health care—teams, integration with community, Veteran-Centric, shared decision-making, etc.; and
- Current generation of health trainees more focused on social good, life style, and job satisfaction—factors that favor a turn toward geriatrics.

Brenda Faas-Designated Federal Officer for the Strategic Medical Advisory Group:

Brenda Faas is the Designated Federal Officer for the Strategic Medical Advisory Group (SMAG). The SMAG was established in 1945 and is charged with advising on the care and treatment of disabled Veterans, education, workforce, and emergency management. The current chair is Jonathan Perlin, MD, former Under Secretary for Health. There are currently 14 members, with representation from podiatry, optometry, medicine nursing, and Veterans Services Organizations and non-VA healthcare (patient satisfaction, quality management, and accountable care. Dr. Perlin's guidance to SMAG is

- Challenge leadership (learn priorities and see what is and is not being done to achieve them):
- Be a megaphone (VHA is not strong at telling its own story adequately); and
- Fight the ground fight (provide comparisons from non-VA world, so VA can benefit).

The group meets later in April and will focus on suicide prevention, community care, and a new public-facing website that will offer access, quality, and CMS comparison information.

Admiral Marsh provided information on GGAC and its charter responsibilities; and speculated that perhaps one or more representatives from SMAG might be brought into the LTSSTF process. Dr. Shay shared that the possible cross cutting topics between GGAC and SMAG might include: low pay scale for geriatricians; lack of recognition of geriatric providers; and the need for geriatric training and increased competencies. Drs. Cohen and Beizer added the importance of multidisciplinary care; Dr. Gifford observed that the leading group at risk for suicide is elderly males—certainly that is a concern shared by both groups. He also noted the general issues attending healthcare transitions and handoffs—Ms. Faas agreed this was a shared concern, citing SMAG's recent interest in promoting eHealth Exchange. Dr. Cohen identified community care as another shared concern. Ms. Faas cited an example of the healthcare kiosk, a real-time recorder of patient feedback. But only those who come into the VA facility can provide input, which excludes many caregivers and Veterans in home care and those living in long term care facilities—this should be a shared concern.

Ms. Faas asked that the GGAC annual report be sent to SMAG. SMAG will see if any GGAC recommendations can be adopted by their committee. Ms. Faas recommended that a representative of GGAC attend the next SMAG meeting if possible. When meeting with SMAG, Dr. Cohen recommended considering the SECVA priorities along with geriatrics as they may not fit with current priorities and younger Veterans. Ms. Gerhard suggested focusing on shifting from facility/provider-centric care to patient-centric care.

Marianne Shaughnessy, PhD, ARNP: VHA Community Living Center (CLC):

The number of Priority 1A Veterans will increase from 500K to 1 million between 2013 and 2023 and they are entitled to VA paid nursing home care in either a CLC or a contracted community nursing home (CNH). In FY15, there were 17,521 Priority 1A Veterans in CNH, 14,666 in CLCs, and 4,732 in State Veteran Homes (SVH). CNHs may not be available in the future related to lack of provider agreement authority, laborious contract processes, and wage issues. VHA is currently losing approximately 50 contracted nursing homes per month due to the challenges listed above. An additional concern includes private CNH's refusing to take complex Veterans with behavioral disturbances. SVHs are experiencing difficulties with

the same issue and have asked for assistance in training staff in effective management skills. Some SVHs have also begun to decline admission to Veterans with behavioral problems. GEC is working with the Education Chair of the National Association of SVH (NASVH) to provide such training.

Strategic Analytics and Improvement Learning (SAIL) Report: The SAIL Report is a VA nursing home quality report built based on the CMS “Nursing Home Compare” quality measures, which was rolled out May of 2016. Data are pulled from the Minimum Data Set/Resident Assessment Instrument (MDS/RAI) but MDS Coordinators have limited training and high turnover. Medical Center directors are concerned that these challenges may skew the data. CLC Operating Beds range anywhere from 7-300 beds per facility, making the CLC SAIL metrics difficult to compare. In the second quarter of 2016, SAIL metrics showed that only in three out of 11 quality categories (Falls, Restraints, and New decubitus user) did VA CLCs score better than CMS nursing homes (see figure 9).

Figure 9: SAIL Report 2013-2016

	2013	2014	FY15Q1	FY15Q2	FY15Q3	FY15Q4	FY16Q1	FY16Q2	FY16Q3	FY16Q4
Quality Star Rating	★★★★★	★★★★	★★★★	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★
Performance Summary										
Quality Quintile Performance	2	3	2	2	2	2	1	1	1	1
Survey Quintile Performance	2	4	4	2	2	2	2	3	3	3
Quality Measures										
Percent of residents whose need for help with activities of daily living has increased (LS)	3	3	2	3	2	2	1	1	2	2
Percent of residents who self-report moderate to severe pain (LS)	1	1	1	1	1	1	1	1	1	1
Percent of high-risk residents with pressure ulcers (LS)	4	1	2	3	2	2	1	2	3	3
Percent of residents who have had a catheter inserted and left in their bladder (LS)	3	3	3	4	4	3	3	4	4	4
Percent of residents with a urinary tract infection (LS)	3	3	3	3	3	4	4	4	4	4
Percent of residents who were physically restrained (LS)	1	1	1	1	1	1	1	1	1	1
Percent of residents experiencing one or more falls with major injury (LS)	3	5	4	4	4	3	3	2	2	2
Percent of residents who received an antipsychotic medication (LS)	3	3	3	3	3	3	3	3	3	3
Percent of residents who self-report moderate to severe pain (SS)	4	4	3	3	2	2	2	2	2	2
Percent of residents with pressure ulcers that are new or worsened (SS)	1	1	1	1	1	1	1	1	2	1
Percent of residents who newly received an antipsychotic medication (SS)	3	4	4	5	4	4	4	4	3	3

Red - 5th Quintile - Orange - 4th - Yellow - 3rd - Green - 2nd - Blue - 1st Quintile

As of FY17, CLCs in VHA will no longer be surveyed by the Joint Commission, which is focused on an organization’s processes and policies. Going forward, CLCs will be subject only to unannounced onsite visits by the Long Term Care Institute, which tracks individual cases and how they unfold. GEC will perform site visits with the Office of Quality, Safety, and Value. In collaboration with the Office of Nursing Services, GEC plans to develop teams to visit CLCs where the quality is good, to learn best practices; the teams will then be able to share those lessons learned with sites with poor performance.

GEC plans to revamp staff and organizational structures within CLCs to include leadership skills, education, competencies, standardization and policies, and help with reporting lines. Future planning also includes a CLC Nurse Manager and MDS Coordinator training in August of 2017.

Susan Cooley, PhD, Chief of Dementia Initiatives and Chief of Geriatric Research:

Dr. Cooley shared that there are 774,000 Veterans with dementia. There are about 400,000 enrollees and 271,000 Veteran patients with these diseases. By 2033, the number of Veteran patients affected by dementia is predicted to increase to 335,000. The Dementia Steering Committee (DSC) is an interdisciplinary and interagency workgroup convened by VACO Patient Care Services in 2006 with the stated goal to develop clinical guidelines for diagnosis and treatment of Veterans with dementia across

VHA. These goals included standardizing evaluation, diagnosis, and treatment of dementia; identifying, diagnosing, and treating cognitive disorders; emphasizing an interdisciplinary team approach in the management of patients with dementia; and drawing attention to dementia caregiver stress and its management.

In 2016, DSC recommendations were developed. They are not policy or mandated but it is expected that the recommendations will form the foundation for the new policy document, “VHA Dementia System of Care”. The 67 recommendations are posted on VA internal and external websites. The DSC recommendations address dementia recognition, diagnosis, and treatment at different stages; care coordination; administrative matters; resources; and education. Thirty-seven of the recommendations are for VHA clinicians and 30 are for VHACO leaders, VISN leaders, and/or VA medical facility leaders. The recommendations support the VA USH priorities and GEC strategic priorities. The implementation plan is to disseminate the recommendations via the VISN and facility Dementia Committees to be incorporated in strategic planning processes. Another strategy is to communicate recommendations along with the Complex Patient Task Force implementation plans. Internal dissemination plans include announcements to VACO and field groups via email, monthly calls, and newsletters. External dissemination includes presentation at Department of Health and Human Services (DHHS) Alzheimer’s’ Advisory Council (which took place in February 2017) and now GGAC. Lori Gerhard asked to hear the top five dementia priorities and Dr. Cooley responded with the following:

1. dementia warning signs-recognition and diagnosis;
2. dementia care coordination;
3. dementia hospice/palliative care (including Advance Care Planning; person-centered care; and involvement of Veterans with dementia in their own care to the greatest extent possible);
4. dementia caregiver support; and
5. dementia staff education and training.

Kenneth Shay, DDS, MS-Director of Geriatric Programs:

Dr. Shay reviewed the 2016 GRECC performance metrics. He shared that GRECC Primary Core staffing vacancies are raising. For each of the twenty GRECCs, there is a minimum requirement of 12 Core FTE. There has been a gradual decrease in GRECC staffing since 2013 (see figure 10). One of the GRECCs could be at risk for losing its Center of Excellence designation due to persistent unfilled vacancies.

Figure 10: GRECC Staffing 1999-2016



Centers of Excellence: The General Accountability Office (GAO) audited the Department of Defense and the Department of Veterans Affairs on their Centers of Excellence (COE). They reviewed the definition(s) of COE, whether it was met or not, whether COEs maintained their adherence to standards, and how agencies made corrections, if adherence was not maintained. VA did not have a standardized definition of COE and GAO recommended that there needed to be one. A workgroup was pulled together to address GAO concerns. GEC, Primary Care, Research, OAA, OMHS, and Neurology all had COEs within VHA. The workgroup developed a COE directive largely modeled after the framework of GRECC. The directive specified that COEs' "excellence" be judged in relation to internal and external standards. The directive addressed the means for assessing adherence to standards and, if not met, provided a timeframe for meeting them. GAO directed VA to develop a procedure for addressing COEs that fail to comply with standards. The new Directive, issued February 14, 2017, specifies that a COE that has not come into compliance with the standards within one year of notification for doing so, the situation is referred to the Deputy Under Secretary for review and consideration. The Deputy Under Secretary can allow one more year for improvement or can remove the COE designation. **GGAC recommends that GEC and 10N undertake an approach to foster enhanced compliance with GRECC staffing standards.**

GRECC Trainees:

New for FY17, Associated Health Trainee education allocations are tracked by the Office of Academic Affiliations (OAA). There is a Veteran Equitable Resource Allocation (VERA) "Education Allocation" that is awarded each site in proportion to its activity in OAA-supported education. The allocation was formerly based only on the numbers of medical-surgical residents (with the assumption that associated health trainee activity would be proportional to the distribution of medical-surgical trainee activity), but with greater accuracy in associated health numbers, this group's impact on the allocations can now be tracked directly. As such, we can now assert that about \$3-4 million per year in VERA comes to the sites that host GRECCS.

GRECC Updates: Dr. Shay shared the list of 2017 GRECC site visits. In addition to the site visits, Eastern Colorado GRECC is in its third year, during which time GGAC is required by statute (38 US Code 7315) to visit the site to determine whether or not the program is fulfilling the plan under which it received its initial three years' funding. Dr. Welsh-Bohmer asked whether the group would consider a standardized site visit tool, such as NIH scoring, to assist in communicating the findings of these visits. Dr. Leff concurred that a scoring system or checklist would be a useful way to evaluate and communicate findings with GGAC and the GRECCs. Dr. Cohen suggested that scoring be built on the GRECC Handbook topics: i.e. what is required? Dr. Gifford cautioned that there are still inter-rater reliability issues and the perception of how the results are interpreted, which should be taken into account in the use and sharing of any such scoring approach. Admiral Marsh cautioned that GGAC is not an accountability organization but rather an oversight group. Dr. Gifford asked whether site visits are devoted to ascertaining whether or not the minimum standard is met; or assisting in continuous improvement. Dr. Shay clarified that the purpose of site visits is both of these. **Dr. Shay will come up with a checklist and criteria and refine it with assistance volunteered by Drs. Welsh-Bohmer and Gifford.**

Ms. Chin-Hansen asked whether GRECC site visit reports go to the state congressional delegation. This has not been done but **the committee concurred that it should be**. Ms. Love recommended building relationships with congressional delegations, and the group agreed that **key recommendations in the GGAC annual report should be brought to the attention of Congressional offices prior to the report being sent. Admiral Marsh recommended and GGAC endorsed the suggestion that congressional**

representatives be invited to the next GGAC meeting. Dr. Welsh-Bohmer suggested that GGAC go to Capitol Hill every four years to foster those relationships.

GRECC issues:

- Minneapolis GRECC has not had a director for three years but instead has two acting co-directors. The search committee has been actively recruiting without success. The updated GRECC Handbook allows for clinical doctoral level non-MDs to apply for director positions. The relationship between the Minneapolis VAMC and the University of Minnesota is part of the issue, with a geographic distance between the school and the VA; outdated anti-VA biases persisting at the University; and geriatrics at the University residing in Family Medicine, which has no presence at the VA. Another concern is that the GRECC's focus is so strongly on Alzheimer's Disease that the geriatrics efforts seem secondary and inadequate. Dr. Shay suggested a call be scheduled with the search committee chair, Admiral Marsh, and Drs. Allman and Veith (former GGAC chair) to see whether or an off-cycle site visit might be indicated. [Subsequent to this discussion, Dr. Shay learned that the site is in negotiation with a promising candidate.]
- Greater LA GRECC: Staff vacancies at the Greater LA GRECC are not being filled and this situation has persisted at least since 2007. They currently have a ceiling of 29 FTE with only 19 staff in place as of 2/1/17. Hospital leadership turnover, hospital staffing and budget issues are felt to be contributing factors. Facility leadership has been virtually non-responsive to GGAC recommendations. Dr. Cohen asked whether this GRECC should lower its FTE ceiling. If staff levels are not addressed at Greater LA, the lack of program compliance will need to be reported to the Deputy Under Secretary, placing the COE designation at risk.

Laurie Zephyrin, MD-Acting ADUSH for Community Care:

Dr. Zephyrin provided an overview of the Office of Community Care. She shared that the Veterans Choice Program (VCP) spends \$15 billion/year on care outside of the VA. VCP authority expires 8/20/2017 and Community Care has requested improved program consistency and additional funding. Non-VA care funds for Purchased Skilled Care, Adult Day Health Care (ADHC), and Homemaker/Home Health are separate from VCP and cannot be used to obtain other forms of care. With the financial resources available through VCP, facilities redirected many of their patients to VCP, to free up funding for other forms of Non-VA Care.

Dr. Zephyrin shared the background and history of VCP, which dates back to 1945. In 2011, Congress passed Project ARCH, (Access Received Closer to Home) for rural Veterans and in 2013, the VA contracted with Patient-Centered-Community-CARE (PC3) to work with Health Net and Tri-West for managing purchased care in the community. Dr. Zephyrin shared that a brand new Request for Proposal (RFP) will soon be issued, seeking new vendors. In 2014, Congress passed the Veterans Access, Choice, and Accountability Act ("CHOICE") to increase access to care for Veterans. The Act allows for patients who have to wait more than 30 days for an appointment, live more than 40 miles away from a VA, or experience excessive travel burden in receiving VA care, to receive care in the community from non-VA providers, at VA expense. Primary insurance must be billed prior to tapping CHOICE funds. With VCP in place, appointments funded in this manner increased 61% in 2.5 years.

Questions arose from GGAC about the definition of "community care" and how it aligns with Long Term Services and Supports (LTSS). It was pointed out that GEC's vision of "community care" means "services that keep the Veteran in the community" (i.e., non-institutional extended care options). In contrast, "Community Care" as described by Dr. Zephyr in seems to connote community-based (i.e., non-VA) sources of care that VA would otherwise provide—but that VA purchases in the community rather than providing. But lumping GEC's "community care" with the Office of Community Care's version has the potential for reducing VA's provision of non-institutional extended care for the simple reason that VA was already

under-providing non-institutional extended care before VCP—and if VCP represents purchasing an equivalent suite of services in the community, it is possible the purchased services will also be deficient in the services that were deficient when they were supposed to be provided by VA, unless deliberate efforts are undertaken to prevent that from occurring.

Other questions were asked about Community Care management of the health information exchange with non-VA community providers. Dr. Zephyrin shared her office's plan for the future by having a "Chief for OIT infrastructure and Care Coordination" at each Medical Center for VCP users. Dr. Allman noted that care management goes far beyond sharing medical records. Dr. Zephyrin acknowledged that while VA has set up fairly straightforward means for sharing medical records; the reverse (sharing of non-VA information with VA) is far less functional. Cohen was concerned that "Community Care" is set up to recapitulate the suite of services VHA provides in its CBOCs and VAMCs: primary and acute care. But extended care seems to not be part of the plan. And Ms. Gerhard expressed concern that VA seems to be building a system of access that is redundant to one that is already present, through Area Agencies on Aging, Aging and Disability Resource Centers, and Centers for Independent Living.

GGAC recommended that means be taken to ensure meaningful coordination between Community Care and GEC stakeholders to ensure the Veteran-centric character of programs remains intact.

GGAC asked how Medicare and Medicaid apply to the Veterans Choice Program and VA. Dr. Zephyrin shared that Medicare, not VA, is the first payer. CHOICE has requested to be the primary payer but this will require legislative action. VCP has also requested authority to bill Medicare. These two issues remain unsettled. Ms. Gerhard recommended that VA needs to keep the Veteran at the center of the care.

Carolyn Clancy, MD, Deputy Under Secretary for Health for Organizational Health

Dr. Clancy shared that society is unprepared for end of life related to its focus on quality, safety, and (value) integrity. VHA needs to take a deeper dive into fraud, waste and abuse and how it impacts GEC services. VA leadership lacks the knowledge of insurance and how it works. Her office is concerned with healthcare analytics, innovations, and Health Equity.

Dr. Clancy asked GGAC, how do we make things better? How do we make sure the staff's providing the care is making it better? VHA needs to honor the commitment to our Veterans by providing capacity and access. VHA should be soliciting anonymous feedback from its stakeholders. The focus needs to continue on quality. VHA has a new website showcasing access. <http://www.accesstocare.va.gov/> There is also the new SAIL Report on CLC data which is internal only; latest progress in SAIL is identifying antecedents to low performers, to keep quality from dropping off. VHA needs to start comparing VA data with community data, although the VA data are more current. Both systems have to constantly ask themselves whether or not the right questions are being asked; the right metrics are being tracked.

Innovative ideas that are currently in circulation include group visits for end of life care and Shark Tank innovations. Hospital in Home is a best practice. VA struggles with how to spread these best practices. My Life My VA is another new initiative: interviewing patients and then placing their personal stories in the medical record.

Dr. Clancy shared her concerns related to leadership turnover and employee satisfaction. She stated exasperation with VA repeatedly generating ideas but being unreliable at following through: her advice is for the agency to "connect the dots; we need to finish what we start". She invited GGAC to provide her office feedback on how it can be helpful around quality, safety, and value.

Admiral Marsh asked Dr. Clancy for suggestions on increasing the number of VA geriatricians: through pay

scales, recognition, incentives, training and education? It seems that HR delays doom many recruitments. Dr. Clancy stated that geriatric providers need to be capable of doing their jobs but the VA has too limited a focus on human capital—something that is far broader than just in geriatrics. But she also said that it is frustrating for people who trained to take care of extended care needs and chronic disease, when they practice in a system set up for acute and ambulatory care. She pointed out that the Quality Scholars program is available for geriatric providers, as is the Chief residents for Quality and Safety program. Dr. Clancy will talk with Dr. Allman about earmarking slots for geriatric positions. She also suggested academic detailing, which involves first understanding a physician's perceived educational needs and then addressing them (rather than imposing a course of study without regard to a person's background or desires).

Jennifer Lee, MD-Under Secretary for Health and Services

Dr. Lee, Deputy Under Secretary for Policy and Services, joined the meeting. Dr. Lee was attending at the request of the SECVA, who asked that she address access and the prioritization of urgent needs. Future thinking needs to include economic implications of the aging population in a new/bold/fresh way. She noted that her office is over Patient Care Services, Specialty Medicine, Telehealth, research, women's health, Health Information Technology, and DOD collaborations. The final two include re-visioning the electronic health record (EHR), a new version of which is slated for unveiling in July 2017.

GGAC needs to ask for support from the White House and congressional staff to leverage that opportunity, and this led to the call for the LTSSTF. She shared that her office would like to continue this work, because SECVA is looking for successes that can be realized quickly. She shared that VHA needs to help Veterans stay at home now, e.g., Medical Foster Home and/or possibly scaling up some existing programs. Dr. Allman shared Gerofit as an excellent program for helping to keep Veterans fit and in the community. Dr. Leff shared the promising practice of the Hospital in Home (HIH), which transitions patients from emergency rooms and inpatient beds back to home. There are currently 8 HIH programs in place in VA. Dr. Lee stated that she liked this idea and noted that she has been looking into the possibility for VA to consider hiring Veterans who were combat medics, to provide some home care services. Dr. Gifford asked for clarification on allocation of resources and how to improve geriatric competencies of the workforce. Dr. Lee stressed relationships with affiliates and community partners, and invited GGAC to suggest programs that were scalable and ready for VHA-wide spread.

Ms. Gerhard pointed out that Home-Community-Based Services (HCBS) and enhancing Veteran Directed Home Care (VDHC) allows Veterans choice on how they want to receive LTSS. Dr. Lee stated that the Veteran Choice Program aligns well with ensuring veteran centered care, but Dr. Cohen noted that, if the Veteran Choice Program does not include GEC Services, then how does this program offer Veteran-centric care for Veterans who needs those services? Dr. Beizer shared the observation discussed earlier in the meeting, that GEC terminology is different from that of the Community Care office, making it difficult to navigate for outside users and Veterans. Dr. Lee agreed and shared that the Office of Community Care office is working to consolidate programs to make it easier for Veterans to navigate. Dr. Baligh Yehia, Deputy Under Secretary for Community Care, is interviewing Veterans on patient satisfaction related to the Veterans Choice Program.

Dr. Lee asked for GGAC's thoughts on caregivers and suggestions to improve the caregiver program. Ms. Chin-Hansen shared that AARP has a three year caregiver initiative, with educational videos that builds a capacity of care via training for caregivers in the community. Ms. Chin-Hansen asked whether there would be consideration for expanding VA's involvement with Program of All-Inclusive Care for the Elderly (PACE). Veterans want to be able to function at their highest capacity. The World Health Organization's current focus is on function. The goal is to help Veterans stay at a stable state in their homes for as long as possible. Dr. Leff suggested that VHA needs to focus on the social model versus the medical model. Only

20% of the health care needs are clinical, which suggests the need for a redistribution of medical resources. Dr. Gifford asked about metrics that would hold everyone accountable, e.g., number of days in the community versus number of days in an institution. Dr. Lee shared that the VERA model should be allocating resources to match the needs of the current Veterans. Dr. Allman pointed out that VERA rewards hospitalization rather than time spent in the community. Dr. Lee asked for GGAC's input on EHR and its functions. Dr. Leff suggested that any update of the EHR must ensure that patients' functional status be included. Admiral Marsh mentioned Cover to Cover Program, now integrated into Veteran Community Partnerships, that offers in-depth benefits and application skills to staff working in Area Agencies on Aging, State Veterans Services Offices, and Centers for Independent Living.

Closing Discussion: setting dates for next GGAC meeting

Dr. Shay polled members for their availability for a two-day face to face in September. After a tentative decision for September 6 and 7, he and Ms. DeLoof agreed to contact members via e-mail to settle the date with everyone's input.

Adjournment

Meeting adjourned on April 5, 2017 at 12:00 noon.

The undersigned certifies the preceding minutes as complete and accurate.



Rear Admiral W. Clyde Marsh (USN, ret.)

5/15/17

Date