Unidentified Female: In this episode, Part 2 of a wide-ranging conversation with VA geriatrician and palliative care physician Jim Rudolph. In this episode, Dr. Rudolph discusses his current work evaluating VA's response to providing vaccines to Veterans in community living centers. He also touches on what it means to be a geriatrician in VA and to provide compassionate, supportive, and effective care for Veterans as they enter their final phase of life.

James Rudolph: We have been very fortunate to have partnered with the Office of Geriatrics and Extended Care, and they had early indications because they do such close monitoring of not only COVID cases, but of their vaccine rollout, that they were able to, or they wanted us to, help get some of the word out on what we've seen. So, in VA CLCs, the first vaccine was approved on December 10th. The second vaccine was approved on December 17th. By December 20th, we had over 50% of our CLC population vaccinated. So, that's a remarkable rollout strategy.  
  
The second phenomenon we saw is because we do standardized COVID testing, or sweep testing in the nursing facilities, we were able to monitor how the virus infectivity dropped. And so, within four weeks, we saw a 75% drop in the amount of COVID we had. That's continued to come down, and that's true across non-VA nursing homes as well. COVID has just plummeted as we have vaccinated people. So, those are really very encouraging signs from this.  
  
The other part that we can't officially say, but we saw evidence of, is herd immunity. So, in those CLC residents who chose not to be vaccinated, COVID has actually come down in them too. But we have over 90% vaccination in the VA CLCs. So, we're probably above that herd immunity threshold. And I think that those are really exciting findings. It shows the value of an integrated health system. It shows the priority that VA put on vaccinating nursing home residents. As well as, even in the community nursing homes, there was a lot of priority put towards nursing home residents and vaccination.

Interviewer: There's some work being done by some of your colleagues on vaccine hesitancy and resistance. Is there anything that you noticed or saw about that, or anything that kind of struck you, or it wasn't really something that came up?

James Rudolph: I have read some of the reports coming out of the community nursing homes where vaccine hesitancy is surprisingly high amongst nursing home workers who have seen the brunt of this virus. And I don't exactly understand the full spectrum of why people are hesitant around the vaccine. Understanding this vaccine hesitancy, because it's such a personal decision, is going to take more time to develop.

Interviewer: I think you did cover kind of what you might do differently in the future with regard to good health stewardship for infectious diseases regarding, you know, flu or pneumonia or norovirus. Is there anything else about that question that you want to cover?

James Rudolph: VA came through COVID, and VA CLCs in particular, came through COVID for some very discreet reasons. The first is they acted boldly at a time when guidance was not necessarily lacking to implement tight infections control or infection control procedures. And that includes the isolation we were talking about, but it also includes some rigorous staffing controls as well. So that was very bold. It was aggressive. It was absolutely the right decision to make, both at the time and in hindsight. But it was a complete reversal of culture.  
  
The second part is that VA has always had access to adequate PPE. While we could argue that everyone should get a new mask for every resident, we were not washing our masks after two weeks of use. We always had PPE available when we needed. And that's a huge VA benefit. And probably someone will do some study along the way to show that our access to PPE had an impact on veterans.  
  
The third is we had infection control expertise. And that impacted the policy I talked about. It probably impacted our PPE availability. But a community nursing home is run by usually an administrator and a nurse, and then everyone else comes in and visits. They don't have infection control people or expertise on staff, and VAs do. And that's a really strong benefit for us. And I would say the final part was a lot of the access to testing and the actions we took based on testing.  
  
Because, again, this is a VA infrastructure piece, but because we had labs, fully functioning labs in most of our medical centers, we were able to test people in the CLCs for COVID. And knowing that a portion is asymptomatic, doesn't have temperature spikes, doesn't have any symptoms, we were able to isolate those people with more rigorous infection control. And that makes a difference, too.  
  
Remember, a private sector nursing home sends out all their labs to another place. Even when Health and Human Services sent them a COVID testing machine, they often had to convert their break room to become the new, quote, lab where they were going to run all these tests. They aren't set up to be hospitals. They're set up to be homes. And VA has had some strong infrastructure opportunities that helped us get through COVID.

Interviewer: So this is another example of how an integrated system can really be quite beneficial and be nimble. And I think that that's one of the other things that you've pointed out that people fail to take into consideration. They look at a large integrated healthcare system that's run by the federal government and say it's like turning the Titanic on a dime. When in reality, what you've pointed out was there were 30 or 40 years’ worth of progressive forward change that literally turned on a dime to address, effectively, this pandemic. How did you come to VA? And when you were doing your medical training and education, why did you choose to go into geriatrics and palliative care?

James Rudolph: I've always been a VA employee. And in fact, if you look, my medical school was situated on the campus of a VA facility and the VA was our primary training grounds. And so our VA rotations were always part of our training. And I knew from very early on in my career that I connected well with older veterans.  
  
I've always had a VA appointment since medical school and really chose the VA to build my career because of the population, their sacrifices, and my belief that I could have the best impact within the VA system. So the question of why geriatrics, I think if you look at any geriatrician, you will always have a grandparent story. And mine is just really positive aging role models early in my life that I knew as they aged and I watched their functional struggles develop that often come with age, I knew that I could have impact in that domain.  
  
Going into geriatrics, going into palliative care, we don't cure a lot of people. I haven't found Ponce de Leone's fountain of youth. And if someone sells you a magic pill about aging, they're wrong. When you look at an older person and you see this complex milieu of things that are influencing their lives, I'm not going to make someone 20 and I'm not going to make someone 50, but often little things that we do have tremendous impact in people's lives. Just being able to manage someone's medications or pare down their medication list eliminates some adverse effects of those medications, which all of a sudden make people a little bit more functional. And that's really the beauty of this specialty is guiding people through those final phases of life.  
  
The other part is it's very intimate. We're in there talking about what they do on a daily basis and trying to maximize that function that they have. And you really develop a great understanding of how resilient people are and how their life has influenced them to that point. In the end, it's great stories that drew me to geriatrics.

Interviewer: What are some of the issues with regard to older veterans that differentiate their late life health concerns versus the general population, someone who may not be a veteran?

James Rudolph: We're in a shifting demographic right now. VA has led the country in terms of aging populations for decades, largely because of our World War II and Korean vets. And now we're in the process of aging in our Vietnam vets into the, quote, older, end quote, category. And so VA has always brought a concentration of some really unique people and a really unique group of veteran related challenges. So the first part is we train people in the military to do things that you and I may not be willing to necessarily do on our own.  
  
And that training is absolutely necessary for their time and service, but it carries with them throughout life. So veterans tend to be a little bit more disciplined than your average 80 year old. And I would say that with the time and service, particularly during times of conflict, veterans, as a cohort, will accumulate more mental health illnesses related to their time and service. Post-traumatic stress disorder, traumatic brain injury, some mental health challenges as well.  
  
Then we try and reintegrate them back into society. And in general, most people reintegrate well. Some people don't reintegrate well and use alcohol and tobacco and other drugs, potentially compensate for either some of their mental health challenges or their integration challenges.  
  
And so when all of those life exposures come to the 80 year old sitting in front of me, it's a culmination of factors. It isn't that they were an alcoholic for 20 years. It might be that they had post-traumatic stress disorder and were treating the post-traumatic stress disorder with their alcohol. And they didn't get on a stable medication regimen until they were 45 or 60 years old.  
  
But during that time they alienated their family. And so now we have to compensate. Everyone's a unique story at the end of the day. And it really takes a lot of clinical skill and a lot of community engagement to really wrap around that veteran and guide them through that final phase of life.

Interviewer: Is there something that VA does with regard to care for older veterans or veterans at end of life that you would love to see leave VA and be a model for the private sector?

James Rudolph: VA has always been engaged in delivering home and community-based services to veterans. Since the Millennium Act in 1999, VA has been mandated to develop these home and community-based services. And the idea is that delivering care to a veteran in the home and community is preferred by the veteran. It prevents nursing home utilization. And ultimately, that combination is better for the veteran and cheaper for the VA.  
  
The focus on those has been ramped up with recent legislation, particularly the Mission Act because Mission Act has something called the Caregiver Support Program in it. And it recently opened up to Vietnam and earlier era veterans. So there's a strong focus. There's always been a strong focus on VA on delivering home and community-based services. I think geriatrics and extended care and VA in general really looks at this as a management of our population in the environment that's preferred. It's a win-win when we can keep someone out of a nursing home and in their own home.

Unidentified Female: The views and opinions expressed in the preceding podcast are concerned with the scope of recently concluded or ongoing VA HSR&D funded research and do not necessarily reflect current or to-be-implemented VA policy. To learn more about this research, visit the VA HSR&D website at www.hsrd.research.va.gov.