Meeting Summary
Veterans Rural Health Advisory Committee Meeting
Department of Veterans Affairs (VRHAC)

Session Objectives:	• VRHAC will gain increased understanding of VA's workforce program offices' key rural initiatives. • VRHAC will gain increased understanding of the Office of Rural Health's fiscal year initiatives. • VRHAC will discuss 2018 committee recommendations.
Date & Time:	Wednesday, November 1, 2017, from 9:00 AM to 5:00 PM
Location:	Grant Thornton 333 John Carlyle St. 4th floor reception for event in 2nd floor training room Alexandria, VA 22314
Attendees:	Chair: Dale Gibbs Designated Federal Officer: Thomas Klobucar Members: Graham Adams, Andrew Behrman, Stephanie Birdwell, Angeline Bushy, Deanna Lamb, Michael McLaughlin, Brenda Moore, Keith Mueller, Joe Parsetich, Randy Reeves, Lonnie Wangen Ex officio representatives: Ben Smith, Thomas Morris, Wakina Scott, and Wilbur Woodis Office of Rural Health: Judy Bowie, Vicki Brienza, Stephen Miles, Emily Oehler, Blaine Reynolds Speakers: Listed below with presentation summary
Note Takers:	Meghan Ochal, Zavian Cooper

	Part 1: VA Modernization 9:00 – 9:30 am **Speaker: Gina Farrisee, Deputy Chief of Staff, U.S. Department of Veterans Affairs**

1	• Ms. Farrisee greeted VRHAC and briefly reviewed her background, noting her four years in service at VA.
	• Ms. Farrisee discussed the Secretary's five priorities and how they are the vehicles for implementing improvements in the VA:
	  ○ Greater choice for Veterans (e.g., proposal to Congress includes redesigning the 40 miles and/or 30 day rule for accessing private providers; public website shows VA facility wait times)
	  ○ Modernize systems (e.g., improve Electronic Health Records (EHR) by using the same EHR system as the U.S. Department of Defense (DoD) and continue efforts to coordinate care, VA's IT infrastructure, a new logistics supply service management

system, and a new finance system)
    - Focus resources more efficiently (e.g., human resources system)
    - Improve timeliness of services (e.g., leverage the use of telehealth, decision-ready claims process started in September)
    - Suicide Prevention (e.g., improve continuity of care with DoD with pre-registration and pre-authorization of transitioning service members who use mental health services
- Ms. Farrisee underscored that rather than solely recognize Veterans Day, VA will celebrate November as Veterans Month with daily events around the country such as open houses at VA Medical Centers (VAMC).
- Ms. Farrisee noted that VRHAC's recommendations are critical to the Secretary and how VA moves forward; committees are incredibly important to the Secretary as VA recently went from 28 to 30 advisory committees.
- Related to VRHAC's prior recommendations, Ms. Farrissee discussed telehealth and workforce developments that were pertinent to the committee's prior recommendations:
    - She noted the gains in telehealth in the last year, and encouraged VRHAC members to learn about emerging technologies during upcoming site visits so that they can provide feedback to the Secretary on what does or does not work
    - She noted human resources (HR) improvements (e.g., more direct hire authority in certain occupations, hiring more mental health providers, HR function consolidation) that VRHAC can review and report on in the future

Q&A/Group Discussion:

- VRHAC discussed the assistance Veteran Service Organizations (VSO) can provide in navigating claims systems, and specifically VSO's role in the new decision-ready claims process.
- VRHAC noted that non-VA (community) facilities also try to hire medical professionals in rural areas and asked if VA considered partnering with community facilities in rural areas to share primary care, mid-level and mental health providers. Ms. Farrisee noted this was an excellent idea that she would explore with the Secretary. She also acknowledged that the overall shortage of providers in rural areas may benefit greatly from more telehealth solutions.
- VRHAC discussed that a major barrier to implementing telehealth in rural areas is lack of broadband access. Ms. Farrissee stated the Secretary supports the increase of broadband access. Partnering with more community sites to create telehealth connections to VA could increase the ability of Veterans who cannot access telehealth from home to connect to VA providers from community sites.
- Ms. Farrisee highlighted the difficulty in identifying "true" vacancies in VA's health administration. Upon completion and full adoption of the

	new HR*Smart System, of the data review, the system will be able to clearly identify actual vacancies based on factors such as budgets and authorizations and allow more strategic hiring. • The VHRAC encouraged VA to do more to eliminate the stigma attached to mental health in order to prevent suicide. Transitioning service members are not getting the proper "deprogramming" to help them psychologically deal with what they experienced. Ms. Farrisee noted that the new DoD partnership on pre-registration should benefit newly transitioned Veterans who might not have otherwise come to VA for support.. • In response to a question about recruiting and hiring foreign-born medical providers, Ms. Farrisee noted that applicants must adhere to VA's verification processes. **Highlights/Key Takeaways/Themes:** • Of the Secretary's five priorities, access to care and suicide prevention are of significant concern for rural Veterans' health and well-being. • New partnerships with DoD will better integrate systems and health care to increase rural Veterans access to care. • Enhancements to HR technology and processes should aid rural hiring efforts.

2	**Part 2: Welcome, Introductions and Meeting Overview** 9:45 – 10:15 am **Speaker: Dale Gibbs, Chairman, Veterans Rural Health Advisory Committee** • Mr. Gibbs welcomed VRHAC and noted that since the Spring 2017 VRHAC meeting workforce emerged as a critical focus area that continues to impact rural Veterans ability to access timely, high-quality health care, therefore it's the focus for this meeting. • Members introduced themselves and acknowledged affiliations with federal agencies, academia and research, VSOs, state offices of rural health, community health care systems, and advocacy organizations. **Q&A/Group Discussion:** • N/A **Highlights/Key Takeaways/Themes:** • VRHAC is charged to think in terms of national solutions and bold ideas, informed by local experiences that increase rural Veterans' access to quality and timely care where they live.

3	**Part 3: Presentation: National Health Service Corps**
	10:30 – 11:00 am
	Speaker: Israil Ali, Director, Division of National Health Service Corps (NHSC), Health Resources and Services Administration, U.S. Department of Health and Human Services
	• Mr. Ali explained the structure and background of the NHSC and its focus on underserved communities; the NHSC has grown from 1,800 providers in 1972 to over 10,000 providers today:
	  ○ NHSC provides care to 11 million patients
	  ○ 61 percent of NHSC personnel serve in Federally Qualified Health Centers (FQHCs)
	  ○ 34 percent of NHSC clinicians serve in rural areas – 1,400 primary care, 481 dental, and 1,200 behavioral health
	  ○ 88 percent remain in their underserved communities after loan repayment
	• Mr. Ali reviewed the four different NHSC programs:
	  ○ Loan repayment program: Participants receive up to $50,000 for two years for full time service in approved area (tax-free); optional one year extension; must be US citizen with unpaid student debt; licensed in state; have job offer from eligible site.
	  ○ Scholarship Program: Supports five disciplines; must demonstrate commitment to stay in underserved area after scholarship; receive tax-free tuition, educational fees and taxable living expenses.
	  ○ The newer Students to Service Program is a hybrid of scholarship and loan repayment programs in which students receive scholarships for a three-year, full-time or six-year, part-time commitment after complete schooling.
	  ○ State Loan Repayment Program is a federally-funded grant program to states and territories that provides cost-sharing grants to assist them in operating their own state educational loan repayment programs for primary care providers working in Health Professional Shortage Areas (HPSAs) within their state. The cost-sharing grants are currently provided to 37 state participants; some states encounter matching requirement challenges; and the next competition will launch in February 2018.
	• Mr. Ali explained requirements for becoming an NHSC-approved site, eligibility for which is determined by the site's Health Professions Shortage Areas (HPSA) score. Eligible sites provide outpatient primary care, dental or behavioral health in rural, urban or tribal communities. To become approved, sites go through the application process and then have access to NHSC tools such as the Health Workforce Connector (https://connector.hrsa.gov/), a web platform that brings clinicians and sites together.

Q&A/Group Discussion:

- Mental health providers require at least a Masters level education to qualify for NHSC programs.
- Mr. Ali clarified that the NHSC is comprised primarily of civilians (reservists may participate), but that the NHSC is often confused with the Commissioned Corps. He noted that active military cannot participate in NHSC given the legal requirement that NHSC providers cannot have another service obligation.
- VRHAC inquired as to if any NHSC sites are VA facilities. Mr. Ali responded that VA facilities are currently not eligible since the NHSC legislation requires NHSC sites to provide care to the entire community, and VA only serves Veterans.
- VRHAC discussed if and how HPSA scoring could take into account a site's service to Veterans and participation in the Veteran Choice Program, in order to incentivize care to Veterans. Mr. Ali noted that HPSA calculations focus on provider ratios and those FQHCs receive an auto-HPSA designation, but that the calculation process is set by legislation. Adding a Veteran variable to the calculation could be something for VRHAC to explore.
- VRHAC asked how to increase participation in rural areas. Mr. Ali stated that U.S. Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) noticed fewer applications from rural areas and so HRSA partnered more with rural organizations to try to increase rural applicants.
- VRHAC discussed the opportunity to recruit for both Veterans Choice Program and NHSC participation as a joint effort.
- Mr. Ali asked how Veterans care is tracked. VRHAC members noted that some individual community providers track Veterans in their health records and FQHCs do report Veteran patients to HRSA's data system. Other providers such as Rural Health Clinics may not collect and report data on Veterans as consistently. Dr. Klobucar noted that VA tracks all enrolled Veterans whether they receive authorized care at a VA or community setting.

Highlights/Key Takeaways/Themes:

- More than 10,200 clinicians serve in the NHSC, of which 88 percent remain in underserved community after their commitment ends.

  One-third of the NHSC provide mental and behavioral care in rural areas.

4	**Part 4: Presentation: Public Health Service Corps – Commissioned Corps** 11:00 – 11:30 am **Speaker: Rear Admiral (RADM) Joan Hunter, Director, Division of Commissioned Corps Personnel & Readiness**

- RADM Hunter explained the Commission Corps (also known as the U.S. Public Health Service [PHS]) and VA are increasing their collaboration; Secretaries Shulkin and Price signed a Memorandum of Agreement (MOA) about six months ago so that Commissioned Corps Officers can serve in VA facilities with provider shortages.
- RADM Hunter provided an overview of the Commissioned Corps:
  - Existed since 1789 and became Uniformed Service in 1889
  - Includes eleven professional categories (all officers)
  - Requires ten-year commitment
  - Has 6,500 officers in 600 locations worldwide
    - Majority of officers are in HHS (e.g., Center for Disease Control and Prevention [CDC], Food and Drug Administration [FDA])
    - Unlike NHSC, PHS officers do not have to serve entire community
    - Has MOUs with other agencies – VA is the most recent partner
    - Requests to increase officers across all agencies continue
- RADM Hunter's division has a new liaison officer coming in January to oversee the partnership with VA. RADM highlighted additional recent initiatives with VA:
  - A Senator's recent proposal to send 500 officers to VA would be heavy lift because Corps does not currently have capacity; new officers go through a lengthy review process and that would require more resources
  - Corps is working with VA to see if officers can volunteer time in VA facility. This proposal is currently undergoing legal review
  - VA is exploring a program similar to Indian Health Services (IHS), where VA can ~~in~~ sponsor students to go to the Uniformed Services University of the Health Sciences in exchange for commitment to VA service
- The Corps' application process is very rigorous but there is a lot of interest.

Q&A/Group Discussion:

- VRHAC asked if there is a PHS officer opportunity for Service members transitioning out of the military. RADM Hunter noted that in order to qualify for the Commissioned Corps, the Service member must have eight years or less in military given retirement and benefits factors. DoD does have an inter-service transfer option with the Corps.

	• VRHAC acknowledged that partnering with different agencies including VA is beneficial, but how can the Corps address competition from the same agencies to fill similar needs especially in rural areas – for example, through more collaboration across all agencies? The PHS realizes this and does not want to create competition, and therefore is starting slowly with VA to figure out how to best collaborate. The partners would need to work through laws and regulations first. RADM Hunter encouraged VRHAC to think about local areas where this type of coordination could work. • The VHRAC discussed potential issues with sharing PHS officers across VA and Indian Health Services (IHS); may be able to review and build upon current VA-IHS agreements in place to share facilities to serve tribal Veterans. • VRHAC discussed how tribal preference for hiring sometimes may inhibit filling critical positions, but that often PHS officers can fill those positions temporarily. • The Commissioned Corps is supporting new legislation to resurrect the Ready Reserve (was discontinued due to a legislative error) to allow for deployment for quicker response. **Highlights/Key Takeaways/Themes:** • Rural VA facilities may be ideal locations for Commissioned Corps officer placement but PHS and VA are pursuing partnership methodically based on data to ensure they deploy limited resources most effectively. • In future, there may be potential for greater collaboration across federal agencies with how Commissioned Corps officers are placed.

5	**Part 7: Discussion: VRHAC Business**
	11:30 – Noon
	Q&A/Group Discussion:
	• Spring meeting will be at the Gulf Coast Health Care System in Biloxi, MS. Identified tentative potential dates 21-25 May.
	• At the last meeting, VRHAC discussed having a nominations workgroup. Looking for ~three members to join Chairperson. Graham Adams, Michael McLaughlin, Angeline Bushy, and Deanna Lamb volunteered.
	• VRHAC discussed what ORH could provide members to help recruit new members, and shared potential organizations to contact:
	  ○ National Rural Health Association (NRHA)
	  ○ Substance Abuse and Mental Health Services Administration (SAMHSA)
	  ○ National Association of State Directors of Veterans Affairs
	  ○ HHS Federal Office of Rural Health Policy
	  ○ HRSA
	• Committee discussed types of new member expertise to consider: opioids, SAMHSA employee, suicide prevention, Vet Center provider,

	rural community physician, telehealth, Universal Service Administrative Company (USAC) and/or Federal Communications Commission (FCC), and ex-officio from other allied advisory committees. **Highlights/Key Takeaways/Themes:** • Committee members will support new member recruitment of experts with diverse expertise on key rural Veteran health challenges.

6	**Part 6: Office of Rural Health Update and Staff Introductions**
	1:00 – 2:00 pm
	Speaker: Thomas Klobucar, Acting Executive Director, Office of Rural Health (ORH)
	• Dr. Klobucar noted that ORH's budget of $250 million (annually since 2006) enables ORH to fulfill its mission to increase rural Veterans access to care, and in fiscal year 2018, ORH disseminated all $250 million in early October.
	• Dr. Klobucar introduced ORH staff and contractors, highlighting each person's background and roles.
	• Dr. Klobucar provided background on the office and key rural Veteran demographic data:
	  ○ 56 percent of rural Veterans are enrolled in VA compared to 38 percent of all Veterans, which could speak to lack of available care in rural areas or lower income of rural residents
	  ○ Women Veterans are disproportionately urban, which makes it even more challenging to provide care to rural women Veterans
	• Dr. Klobucar outlined ORH's four strategic goals for 2015-2019 and explained ORH's structure, highlighting the role of the Veterans Rural Health Resource Centers (VRHRC), which are formalized through legislation. VRHRCs conduct ORH's rural research, and create and maintain Rural Promising Practices.
	• ORH funds nearly 50 Enterprise-Wide Initiatives (EWI) at 90 percent of the VAMCs nationwide. There is great demand for implementing EWIs in the field, as applicants requested $350 million in fiscal year 2018 and ORH expects future requests to increase. From fiscal year 2017 to fiscal year 2018:
	  ○ Primary care EWI increased 22 percent
	  ○ Mental health focused EWI increased 82 percent
	  ○ Specialty care centered EWI increased 30 percent
	  ○ Workforce training and education EWI increased 27 percent
	• Current ORH funding aligns to the Secretary's five priorities with a focus on "foundational services." ORH anticipates serving 1.2 million rural Veterans through its 48 EWI in fiscal year 2018.
	• 90 percent of VAMCs participate in EWI, meaning that a lot of rural patient care is delivered by urban VAMCs; ORH provides proportional

funding based on percent of rural Veterans treated by a facility.

- Dr. Klobucar discussed the current role of telehealth in the VA:
  - Clinical Video Telehealth (CVT) among rural Veterans grew 352 percent between fiscal years 2009 and 2016, with 55 percent of encounters being with rural Veterans
  - 151 percent growth in rural home telehealth (home remote monitoring) between fiscal years 2009 and 2015
  - 44 percent growth in rural use of Store and Forward telehealth
  - Telemental health grew 514 percent from fiscal year 2009 to 2016
  - Video-to-home telehealth for rural Veterans grew 523 percent from fiscal year 2009 to 2015
  - There are significant issues with data and broadband access and inconsistencies in rural areas, including coverage and affordability
  - VA Video Connect addresses a major barrier of strict VA security rules; The system lets providers and patients talk through any platform on a secure connection via a “Virtual Medical Room”
  - Tele-Intensive Care Unit (TeleICU) is a major ORH investment; The program provides 24/7 ICU coverage from Minneapolis and Cincinnati to smaller VAMCs
- Dr. Klobucar noted some key workforce issues:
  - 93 percent of rural counties do not have a single licensed psychologist
  - Shortage of providers with geriatrics focus, especially as rural Veterans are older that urban Veterans
  - VA does educate and train 120,000 providers and students annually, having more than 1,800 unique academic affiliations
  - Results of a recent medical resident survey shows high demand for primary care providers
  - Recruiting in rural areas is key to have providers stay in rural areas
  - ORH recently hosted five national rural workforce webinars and will continue to focus on workforce throughout the year
- Dr. Klobucar covered VRHAC management items:
  - Confirmed new Chairperson, Mr. Dale Gibbs
  - Confirmed six new members from 18 nominations
  - Establishment of a nomination workgroup
  - Transition to three year planning for VRHAC site visits
  - Utilization of the Advisory Committee Management Office (ACMO) SMART template for VRHAC recommendations that are Specific, Measurable, Actionable, Realistic and Timed

Q&A/Group Discussion:

- VRHAC discussed current and potential opportunities for telehealth services:
  - Broadband expansion must be linked with telehealth growth
  - South Carolina project for putting iPads in home shows not having Wi-Fi in home is a barrier
  - Confirmed Veterans Choice Program providers can provide care via telehealth but VA to community care facility is not as simple
  - Need to leverage the opportunity for better coordination between VA and other federal telehealth investments; there are lots of programs that can be connected
  - ORH-funded TeleICU program supports small and mid-size receiving sites
  - Data encryption is built into the VA Video Connect software
- VRHAC discussed current and potential opportunities for workforce recruitment and retention:
  - Salaries are lower in rural areas but it's more expensive than people think to live in rural areas; Other barriers include adequate housing, schools, jobs for partners, and infrastructure
  - Opportunity to do "early release" for transitioning Servicemembers with medical background to have them enroll in targeted VA training and commit to working at VA (similar to early release for education)
  - Targeting medical school slots and funding for rural students; There are some schools with rural tracks
- It was clarified that VRHAC member appointments are staggered multi-year terms with an option for one reappointment.

Highlights/Key Takeaways/Themes:

- Through the $250 million President's Rural Health Initiative budget line item, ORH funds nearly 50 Enterprise-Wide Initiatives (EWI) at 90 percent of the VA medical centers nationwide.
- A focus on expanding telehealth solutions, as well as workforce recruitment – particularly increasing the rural pipeline – may have a huge impact on rural Veterans' access to care.

7	**Part 5: Presentation: Ethics** 2:00 pm – 2:45 pm **Speaker: Carol Borden, Staff Attorney/Deputy Ethics Official, Office of General Counsel** • Ms. Borden provided annual ethics training. **Q&A/Group Discussion:** • N/A **Highlights/Key Takeaways/Themes:** • N/A

8	**Part 8: Modernizing VA Health Care**
	3:00 – 3:30 pm
	Speaker: Regan Crump, Assistant Deputy Under Secretary for Health for Policy and Planning
	• Dr. Crump provided his background of 33 years in the U.S. Department of Health and Human Services (HHS) and the past eight years at VA.
	• Dr. Crump reviewed the VHA mission and vision and how the notion of exceptional health care and being a high-performing network is imperative.
	• Dr. Crump highlighted the Secretary's five priorities and discussed the changing paradigm for planning in the VA, emphasizing the high rate of change occurring in the VA:
	  ○ Moving from facility-based to market-based planning
	  ○ Updated guidance for operational plans as opposed to strategic plans
	  ○ All operational plans will be integrated and progress will be tracked using measurable outcomes
	• Dr. Crump reviewed the Veterans Health Administration's draft operational goals:
	  ○ Goal 1: Veterans choose VA with a focus on easy access, greater choice and clear information to make informed decisions
	  ○ Goal 2: Veterans receive timely and integrated care and support that emphasizes their well-being and independence throughout their life journey
	  ○ Goal 3: Veterans trust VA to be consistently accountable and transparent
	  ○ Goal 4: VA will modernize systems and focus resources more efficiently in order to be competitive and to provide "best-in-class" services to Veterans
	• Dr. Crump discussed the fiscal year 2018-2019 VHA operational and modernization plan:
	  ○ Priority 1: Greater choice for Veterans
	  ▪ Coordinated Access and Rewarding Experiences (CARE)

is proposed legislation to promote easier navigation, informed care decisions, clearer responsibilities and guidelines for market area health systems, and accessible/single data system

- Priority 2: Modernize systems
  - Capital infrastructure (e.g., eliminating unused space), Information Technology/Electronic Health Record (IT/her) and organizational structure improvements (including VHA central office streamlining and strengthening Veterans Integrated Service Networks [VISN])
- Priority 3: Focus resources more effectively
  - Align resources under the five priorities and to foundational services, finding areas of waste and correcting, determine appropriate and efficient use of services and ensure care coordination across all settings
- Priority 4: Improve timeliness of services
  - Expand virtual care and all possible solutions to optimize access (e.g., process improvements, additional care locations)
  - Same-day access for primary care and mental health initiative looks at ways to add other services or community providers to same -day access initiative
- Priority 5: Suicide prevention
  - Improve active duty transition, partner across communities (including key suicide prevention national and regional partners), , improve access to all service that can reduce suicide
  - Noted recent integration of mental health offices for greater centralized focus on solutions

- Market assessment and planning methodology focuses on demand and future supply, and how to match supply to demand.
- Dr. Crump asked VRHAC to think about how these market assessments and plans can best support rural Veterans.

Q&A/Group Discussion:

- VRHAC discussed better collaboration with DoD:
  - EHR integration should be smoother given VA's move to use same EHR system as DoD
  - Is there a plan for mandatory counseling when transitioning from active duty and auto enrollment in VA if certain criteria? There has been authorization for VA to provide certain care if a service member was receiving treatment in DoD, but it isn't mandatory
  - Auto-registration is trying to focus early to provide access to mental health services to Veterans upon discharge; VA is using a predictive analytics tool to look at a wide variety of risk factors to

identify vulnerable Veterans who may not self-identify given military culture of not talking about mental health; The VA will proactively contact those on the “at risk” list

- VRHAC requested data on demographics (e.g., age groups, time since on active duty, rural and women) on suicides among Veteran populations.
- HHS’ Federal Office of Rural Health Policy (FORHP) representative noted that the HHS Rural Advisory Committee will write a brief on suicide prevention as well as revising the Rural Health Clinic Program to support more mental health care positions in rural areas; VA is using a variety of providers to deliver mental health care (e.g., marriage and family therapists, chaplains); ORH connect the Suicide Prevention team at VA with FORHP on this brief.
- As part of the market assessments, VRHAC encouraged VA to look at hot spots where Veterans are less healthy (chronic disease) to better focus resources
- VRHAC encouraged the VA to share the market assessment evidence with others in order to support community and partner involvement.
- VRHAC inquired as to how the VA develops quality measures; VA is shifting from VA-created measures to commercial measures (e.g., National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), Hospital Compare); many VA measures are similar and can easily be aligned.
- VRHAC discussed how to change perceptions so that VA facilities do not see community providers as competitors; The VA recognizes this perception and is slowly shifting the paradigm for VA providers to view community providers as partners; One issue is that the VA views primary care as a foundational service, so the ideal collaboration will be where a community provider such as an FQHC will provide specialty services the VA isn’t providing, or provides more care where there is no VA facility in area; VA’s goal is to see how FQHCs can complement VA care; Proposed new legislation and new contracts should address some of this perceived competition and other barriers.

Highlights/Key Takeaways/Themes:

- VA will have one strategic plan, and each administration and associated program office will have an operational plan that aligns to support the singular plan in order to reach modernization goals.
- Modernization will focus on building a high-performing network that delivers care regardless of where a Veteran resides.
- Increased DoD collaboration should improve transition into VA services and better address mental health care needs of Veterans.

9	**Part 9: Coordinated Access and Rewarding Experiences (CARE) Act**
	3:30 – 4:30 pm
	Speaker: Terry Stinson, Director, Policy Analysis, VHA Office of the Assistant Deputy Under Secretary for Health for Policy and Planning
	• Mr. Stinson noted that health care policy changes every day then provided a high level overview of the current healthcare environment:
	  ○ VHA has advanced appropriation but all other partners and the rest of VA could be impacted; Community Health Centers and Children's Health Insurance Program funding is also not final (legislative goal is to fast track two programs together by December)
	  ○ Various budget resolution activities on health care and tax reform; tax reform can have big impacts on healthcare; health care reform will affect Medicaid and Medicare that could impact the 800,000 enrolled in Medicaid but not in VA
	  ○ Congress focused on Affordable Care Act (ACA); Focus is on individual state implementation and waivers; Some states implemented Veteran counseling programs for enrollment in VA or other insurance options
	• Mr. Stinson highlighted legislation and activities specific to VA:
	  ○ VA proposed CARE bill; The Secretary discussed the VA version compared to the House version during committee hearing on October 24, 2017; A key component of the VA version is community care being based on a VA clinical decision; VHA is still analyzing the Senate version
	  ○ During the hearing, the Secretary reported VA has $1.1 billion of Veterans Choice Program funds to get through end of 2017; encouraged Congress to act and make CARE permanent
	  ○ CARE vote is expected in Committee in November; to the floor for a vote in December
	  ○ Telehealth supremacy bills in Senate and House; VA wants to cover VA employees in "any point" to "any point" telemedicine
	Q&A/Group Discussion:
	• VRHAC discussed that at this point in time, Congress and the public recognize the importance of a permanent community care program
	• VRHAC inquired if there was legislation stating IHS was part of a high-performing network and the impact on tribes; Right now reimbursement between VA, IHS and tribes is occurring but unclear of future management model; Had discussions on how to better incorporate partners into single high-performing
	• Dr. Klobucar noted a telehealth roundtable made up of VA and Congressional representatives convened last month; while the telehealth supremacy bill is still in Committee, appears to have wide support

	Highlights/Key Takeaways/Themes: • The health care policy landscape is constantly changing and in ways that could impact rural Veterans access to care. • The proposed CARE legislation has the potential to greatly streamline and improve how Veterans receive care in rural communities.

10	**Part 10: Discussion: Recap Day 1** 4:30 – 5:00 pm **Speaker: Dale Gibbs, Chair, VRHAC**
	Q&A/Group Discussion: • VRHAC discussed areas of interest from the presentations that included increased federal and community provider partnerships, integration of telehealth technology between VA and community providers, and focus on health professional recruitment and retention. **Highlights/Key Takeaways/Themes:** • N/A

Meeting Summary
Veterans Rural Health Advisory Committee Meeting

Department of Veterans Affairs Session Objectives:	• VRHAC will gain increased understanding of VA's workforce program offices' key rural initiatives. • VRHAC will gain increased understanding of the Office of Rural Health's fiscal year initiatives. • VRHAC will discuss 2018 committee recommendations.	
Date & Time:	Thursday, November 2, 2017, from 9:00 AM to 5:00 PM	
Location:	Grant Thornton 333 John Carlyle St. 4th floor reception for event in 2nd floor training room Alexandria, VA 22314	
Attendees:	Chair: Dale Gibbs Designated Federal Officer: Thomas Klobucar Members: Graham Adams, Andrew Behrman, Stephanie Birdwell, Angeline Bushy, Deanna Lamb, Michael McLaughlin, Brenda Moore, Keith Mueller, Joe Parsetich, Randy Reeves, Lonnie Wangen Ex officio representatives: Ben Smith, Thomas Morris, Wakina Scott, and Wilbur Woodis Office of Rural Health: Judy Bowie, Vicki Brienza, Stephen Miles, Emily Oehler, Blaine Reynolds Speakers: Listed below with presentation summary	
Note Takers:	Meghan Ochal, Zavian Cooper	

1	**Part 1: Welcome** 9:00 – 9:15 am **Speaker: Dale Gibbs, Chairman, VRHAC** • Mr. Gibbs welcomed and reconvened committee. **Q&A/Group Discussion:** • N/A **Highlights/Key Takeaways/Themes:** • N/A

	Part 2: Panel Presentations: Rural Workforce Recruiting and Retention 9:15 am – 12:00 pm ▪ Panelists from U.S. Department of Veterans Affairs: **Jessica Bonjorni,** Acting Chief, Workforce Management **Kathleen Klink, M.D**., Chief of Health Professions Education, Office of Academic Affiliations **Christine Engstrom, PhD**, Research Advisor, Office of Nursing Services
2	**Ms. Bonjorni** • Ms. Bonjorni acknowledged that HR current structure is very complex but VA is pursuing a modernized, streamlined hybrid model with regional HR operations and centralized enterprise HR strategy and governance (e.g., retirement consolidation). • HR's major barrier to address workforce shortages is high internal staff turnover (14 percent vacancy rate) which results in a lack of staff with the proper expertise or working knowledge to support VA hiring (e.g., technical expertise to calculate special salary survey rates). • A key recruitment barrier is that each VISN has only one physician recruiter compared to private sector where would be many more at a local level, and there are only three national nurse recruiters to support nurse recruiters at VA Medical Centers. • Ms. Bonjorni reviewed average VHA workforce statistics: o Average 10,000 position net increase and overall increase of 3.5 percent annually o Hiring freeze in 2017 had negative growth impact – closer to 2 percent growth in 2017 o Average 9 percent vacancy rate which is reasonable compared to private sector healthcare turnover, although vacancy rates vary by occupation in VHA: ▪ Nurse – 7.60 percent vacant ▪ Physician – 10.91 percent vacant ▪ Medical Support Assistant/Schedulers – 8.55 percent vacant ▪ Practical nurse – 8.75 percent vacant ▪ Nursing assistant – 8.59 percent vacant • VA is starting to do more marketing such as national job announcements and the new goal to hire 1,000 suicide prevention and mental health professionals. • Ms. Bonjorni discussed turnover and vacancy rates by geography, noting that they depend on position type, environment, and competition from private sector; VHA recruitment, retention and relocation allocation is capped and was reduced by 40 percent, and 81 percent of funds are used in urban locations;. There is a slightly higher voluntary quit rate in rural 5.2 percent vs. 5.1 percent for non-rural facilities, possibly due to lifestyle differences, low salaries, cultural isolation, poor quality schools, housing, and lack of spousal job opportunities.

- Another barrier is bureaucratic process (e.g.,, silos, shortages in HR staff) that create longer onboarding times and negative experience for candidates.
- One solution for rural facilities may be legislation that dedicates funds for education debt reduction (similar to Department of Education's Public Service Load Forgiveness Program), additional pay flexibilities (not just market rates), the use of critical position pay for rural areas, and special residency programs where providers are sponsored to go to rural facilities.
- Ms. Bonjorni highlighted the new Memo of Understanding (MOU) with the Commissioned Corps, noting that the first five VA locations are identified but implementation will be slow.

Dr. Klink

- Dr. Klink explained that the VHA Office of Academic Affiliations (OAA) helps fulfill one of VA's four missions—to provide health professions education for VA and the nation; OAA supports more than 40 professions and 125,000 trainees annually and is affiliated with almost all medical schools in the United States.
- OAA has 7,200 agreements with 1,800 institutions across country, from major medical schools to small community hospitals.
- 25,000 medical students rotate annually through VA for training, as well as 40,000 in graduate medical education (GME) training and 25,000 associated health professionals (e.g., physical therapy, occupational therapy, psychology, licensed clinical social work, pharmacy).
- In the student model, VA doesn't pay but provides trainers, space, etc.
- In the training model, VA provides funding to facility and facility pays the trainees. Combined, trainees account for about 10,500 full-time employees (FTE), but trainees often have shorter-term rotations.
- Transportation and housing are barriers for training at rural facilities.
- OAA also supports professional staff development, such as staff faculty appointments at academic affiliates; This development improves staff recruitment and retention but often distances to affiliates in rural areas is a barrier.
- Dr. Klink reviewed OAA's innovative programs:
    - Post-Baccalaureate Registered Nurse (RN) Program: Recent graduates assigned a staff nurse mentor and placed for up to one year in a residency program; OAA plans to work with Office of Nursing Services (ONS) to create more of these positions; Many private sector facilities don't support this type of program
    - Nurse Practitioner Program: Paid one-year residency under mentorship
    - Similar programs with Physician Assistants and Physical Therapists
- OAA's programs provide professional experience with "whole health" that includes technical, patient support, and integrated care expertise to encourage trainees to commit to VA employment.

- Dr. Klink discussed rural challenges to recruitment: According to a Merritt Hawkins survey, 92 percent of medical students prefer communities with greater than 50,000 populations; in rural areas, disincentives to recruitment include long hours with little backup and specialist support, lack of community infrastructure (e.g., housing, schools, spousal employment), and lack of accessible academic affiliations.
- Dr. Klink shared that nurse retention is low in VA compared to private sector, but there are pockets in VA, often rural, where this is not the case.
- Dr. Klink highlighted that success in securing a rural workforce is more likely if VA can recruit from rural communities as those individuals are more likely to want to live and work in rural areas; focus also should be on recruiting earlier in the education pipeline.
- Dr. Klink explained key OAA initiatives to address workforce shortages:
    - GME expansion under the Veteran Access, Choice, and Accountability Act to add 1,500 primary care and psychiatry positions in high Veteran concentration communities and Health Professional Shortage Areas, which are typically rural
        - Noted that the Centers for Medicare and Medical Services GME positions have been capped since 1997 so anything above the cap has been paid for by institutions – institutions will pay for high-need/high-return specialist (e.g., anesthesiology) but less likely to pay for lower paying positions like family practice, pediatrics, and psychiatry.
        - Over the last four years, went from 22 low-complexity rural VAMCs with no GME to only four with no GME; VHA is halfway through 1,500 positions but received extension for ten years to place all

Dr. Engstrom

- ONS reports directly to the Undersecretary for Health and focuses on four work streams: workforce, policy, education and legislation, clinical practice, research, and analytics.
- Currently there are nearly 100,000 unique nursing personnel in VA, including approximately 65,000 Registered Nurses (RN) and 6,000 Advanced Practice Registered Nurses.
- Many nurses stay with VA for a significant career, but there is pivotal moment between years one and five when they are more likely to leave; VA needs to foster connection and commitment to VA.
- The VA Post-Baccalaureate RN Program (note: American Academy of Nursing accredits these residences) is a good recruitment tool; Nurse Practitioner (NP) residencies are also very important to help build up experience.
- Dr. Engstrom highlighted issues around care coordination experienced by both VA and community providers.
    - VA would like to have care coordination staff at every VISN and

every facility, and more than one for larger facilities
    - The ORH EWI transitions nurse program trains nurses in care coordination to help Veterans discharged from VA Medical Centers get to first primary care appointment; The EWI is in its third year and at approximately one dozen participating facilities; Findings showed decreased re-admission rates and ER visits, increased medication reconciliation, and related cost savings
    - Intermediate Care Technician (ICT) program recruits military medics and corpsmen who are transitioning from military and who are located in many rural states (currently are pilots in Poplar Bluff and Wilkes-Barre); coordinated with some debt reduction, VA Learning Opportunities Residency and scholarship programs
- The VA nursing research advisory group has been trying to increase rural health nursing research (Denver Center of Innovation and White River Junction).
- Three major areas to consider for rural VA nursing are nursing residency programs (RN/NP), remove cap on pay for nurses, and care coordination.

Q&A/Group Discussion:

- Q: Are there opportunities for part-time positions?
  A: There are some nursing part-time FTEs and job sharing (two people in one position), but scholarships and loans are generally targeted to full time trainees; VA uses part-time staff less than the private sector.
- Q: VRHAC discussed the logic of creating a type of fast track like the ICT program; are there other examples in the VA of this type of fast track?
  A: HR is embarking on more partnerships with DoD, including expanding ICT and creating more infrastructures; National funding for ICT is gone so now it's up to facility to fund, but VA could try to provide more underlying structure; Another program is VA's Warrior Training Advancement Course (WARTAC) where a service member receives Veterans Service Representative training while still on active duty; WARTAC has converted 95 percent of trainees to full time VA employees non-competitively; VA is trying to expand to Veterans Health Administration (VHA) but there are some barriers—one is that VHA cannot acquire a list of DoD service members from DoD who will transition in the next six months.
- Q: Could VA directly train and credential transitioning service members and/or provide accommodations such as credits for military service, fast tracking the educational program application process, streamlining the VA application and hiring process, etc.? How could VA eliminate some of the bureaucratic processes for transitioning service members to not lose their interest in working for the VA?
- A: VA does all its training at VA facilities but VA leaves credentialing to the academic affiliate; Given credentialing requirements, it would be difficult to not have an academic partner and not sure how it could be

operationalized in the VA. There is the potential for VA to provide some incentives to local schools to address local barriers, but it would be too difficult to try to impose national requirements; There could be a way to encourage giving transitioning service member priority in school application process (similar to federal hiring preferences for Veterans). Programs that provide education and pay for school could encounter issues similar to scholarship programs that require commitments farther out, so historically VA has looked more at loan repayment to target commitment; Scholarships still important for higher-need students.

- Q: What are the differences in training of combat medics compared to nurses?
  A: While there are transferable skills, there is different training and more focused skills within a limited population with medics and there is not a license for medics; There could be some potential resources VA can provide to academic affiliates to better support placing transitioning members into the right pipeline based on skills and interests.
- VRHAC and panelists discussed additional ideas for transitioning service members into VA staff, such as: timing VA's outreach well in advance of discharge; analyzing how certain military positions, skills, training can count for some basic courses and prerequisites for clinical education programs; piloting ideas to work out barriers, lessons, etc.; National Guard and Reserves opportunities for recruiting in rural areas for some transition program pilots; U.S. Department of Labor funding for two year training programs within states – hasn't had historical healthcare focus but VA could collaborate with states on helping Veterans get fast tracked into programs.
- Q: Does VA have the ability to establish some requirements for their residency programs?
  A: There are national standards for accredited residency programs, but VA does require additional training for VA specific needs (e.g., military cultural competency, Veteran specific exposures).
- Q: Is it difficult for VA to find training sites and partners?
  A: CMS pays direct and indirect funds to the sponsor (university or hospital); VA pays direct (salary and benefits) but indirect funds stay at the VA facility (does not get passed on to sponsor); So there is some pushback from sponsors who do not get same funding as they get from CMS; Overall affiliates are glad to partner with the VA.
- Q: Are there programs to prepare health professionals in private sector on how to work with Veterans?
  A: There are some but should be more; Some schools have received grants to develop Veteran-centric training for health professionals. VA recently developed courses with continuing education credit on military competencies, PTSD, Traumatic Brain Injury (TBI) for community providers which are hosted on VA's Training Finder Real-time Affiliate Integrated Network (TRAIN); Joining Forces has web content is still available; ORH promoted current training to National Rural Health Association (NRHA); For physicians, several questions on military and Veterans have been added to national board exams.

- In some cases, it isn't practical for a community provider to try to provide clinical programs unique to VA (e.g., inpatient PTSD, domiciliary); this is why VA is focused on ensuring it can directly provide foundational services.
- Q: What happened to proposed legislation for states without medical schools to have residents train in tribal facilities and areas of high need?
  A: Don't believe the legislation has gotten traction; VA can't pay for residents at community settings; there has been talk of introducing bills to allow VA to do that but not any movement.
- Q: For students receiving training at VA, what is HR doing to convince them to come back to VA for their career?
  A: This is a known gap at VA as there is no central database to track trainees that enables HR to have a coordinated approach to recruitment; VA Office of Information and Technology (OI&T) has committed to creating a data base but this project does not have capacity at moment; VA is not currently using Title 38 U.S.C Section 1151 - authority with trainees completing their training.
- Q: Should VA focus more on retention instead of recruitment given cost savings of retention?
  A: Retention data is sparse; VA tried to survey why nurse scholars were leaving – but there is no central place that this data is gathered; Exit interviews and surveys are not mandatory nationally; "Stay interviews" would be ideal; Common findings for leaving are "lack of respect" and "lack of advancement opportunities."
- Q: Has VA used Intergovernmental Personnel Act Mobility Program - provides for the temporary assignment of personnel between the Federal Government and state and local governments, colleges and universities, Indian tribal governments, federally funded research and development centers, and other eligible organizations.
  A: Sometimes, OI&T uses this authority but it is a very tedious administrative process.
- VRHAC noted that HR may need to be more top-down with some national policies and requirements.
- Does VA have spousal hiring preferences?
- A: Certain offices and facilities have effectively worked to help connect spouses to jobs, but not a national program
- Q: Does VA's practice environment play a role in recruitment and retention (e.g., Patient Aligned Care Team [PACT], team-based environment, and fully integrated system with EHR, not having financial concerns get in way of treatment plan – such as leveraging telehealth technology)?
  A: Yes, these benefits are highlighted in the "Twenty Reasons to Work for the VA" publications; The PACT team isn't always an incentive for nurses given complexity and high-volume workload for nurse care managers.

	• Q: Fifteen other federal agencies conduct medical professional training and hiring – could federal agencies pool resources in training, hiring and providing services in certain geographic areas? A: VA's recent collaborations with DoD continue to highlight a lot of barriers in federal coordination; Broader coordination would probably require legislation to eliminate some of these barriers across agencies, especially in sharing funding. • The panelists stated the following priorities for VRHAC consideration: o OAA: Creating a better workforce pipeline; link training programs to ongoing VA recruitment o ONS: Expansion of care coordination staff, especially in rural settings; expansion of nurse residency programs for RN and NPs o HR: Increase collaboration with DoD on training transitioning service members for future VA careers (including sharing list of service members with VA); earmarking rural incentives through legislative action– OAA is in discussion with House Committee on Veterans Affairs (HVAC) on higher loan repayment rates for high need occupations and geographies **Highlights/Key Takeaways/Themes:** • Rural recruitment and retention are a challenge for VA. • Increased inter-agency coordination is necessary as various federal agencies seek to address similar rural workforce shortage recruitment and retention issues.

3	**Part 3: Discussion: 2018 Recommendations** 1:00 – 4:00 pm **Q&A/Group Discussion:** • Dr. Klobucar reviewed process for developing recommendations based on ACMO guidance, as well as what constitutes a foundational service. • Dr. Klobucar explained the role of VISN Rural Consultants (VRC) and how the public can access their contact information online at www.ruralhealth.va.gov. • VRHAC broke into work sessions on recruitment, retention, and delivery of care, and presented prioritized issues to the full committee. <u>Recruitment highlights</u> • Decrease barriers between federal and community care for staff sharing with federally funded positions (e.g., across VA and DoD facilities, FQHCs, IHS). • Establish VA University with academic affiliate residency—VA could operate the brick & mortar facility, but also offer online education that could feature a discharged military track and open application, integration with DoD Health Services School; rural quota with service obligation, integrate rural content, and telehealth track. • Recommend legislative action to remove caps and increase incentives in rural areas.

	Delivery of Care highlights • Enhance public-private partnerships to increase rural Veteran access to telehealth care such as: incentivizing major cellular companies to build towers and lower monthly costs for Veterans; maximize USAC internet lifeline programs. • Use telehealth technology to full potential for quality patient care, along with recruitment and retention of providers; Increase data/telehealth connections between VA and community providers; Recruitment and retention efforts should include education opportunities, collaboration and networking with community providers, and e-consults. Retention highlights • Modernize systems to give VISNs authority to seek out partnerships in high-need rural areas that share clinical staff with community providers. • Enable VISNs to create alternative work schedules in rural areas—a pool of support providers that can rotate with a primary provider at a rural site. • Create a rural retention innovation challenge for VISNs to improve retention in high-need rural areas to target existing resources to support rural clinicians and their families (e.g., address spousal careers, schools, welcome wagon, joint hiring initiatives across VA and community) **Highlights/Key Takeaways/Themes:** • VRHAC identified (1) decreased barriers between community, federal and VA providers for staff sharing, (2) legislative flexibility for rural hiring and (3) rural retention challenge/strategies as priority areas for continued research.

4	**Part 4: Discussion: Recap and Evaluation** 4:00 – 4:30 pm **Speaker: Dale Gibbs, Chairman, VRHAC** • Mr. Gibbs expressed appreciation for the targeted focus on the rural workforce challenges. • VRHAC provided feedback on the meeting's content and logistics. • The committee reviewed next steps to draft recommendations. **Q&A/Group Discussion::** • N/A **Highlights/Key Takeaways/Themes:** • VRHAC will continue to work on fiscal year 2018 recommendations, and will reconvene in Biloxi, Mississippi in the spring.

5	**Part 5: Discussion: Public Forum** 4:30 – 5:00 pm **Speaker: Dale Gibbs, Chairman, VRHAC** • N/A **Q&A/Group Discussion::** • N/A **Highlights/Key Takeaways/Themes:** • N/A