

Veterans' Rural Health Advisory Committee

Terry Schow, Chairman



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The Honorable Robert A. McDonald
Secretary
US Department of Veteran Affairs
810 Vermont Ave, NW
Washington, DC 20420

March 31, 2015

Dear Secretary McDonald:

The Veterans Rural Health Advisory Committee respectfully submits for your consideration the following three recommendations resulting from our Fiscal Year 2014 efforts to advise you on issues most relevant to the health of our rural Veterans.

Recommendation #1: That within both rural and highly rural geographic areas, the VA should identify all local and regional health care organizations (Ambulatory Care Centers, Physician practice groups, Ambulatory Care Agencies, etc.) that have achieved select national accreditation status and consistently demonstrated favorable patient outcome metrics. Once identified, the Department of Veterans Affairs (VA) should actively pursue partnership arrangements with these entities rather than passively waiting for them to respond to contracting requests. The VA should offer these select health care entities the opportunity to expedite a collaborative partnership and assign a VA rural outreach health care coordinator to help navigate this process.

The Department of Veterans Affairs (VA) is statutorily required to provide VA enrolled Veterans with access to timely and quality medical care (38 U.S.C. §7301). Although those receiving care in the VA health care system report high scores in both inpatient and outpatient care customer satisfaction indexes, access to this care falls short, especially for Veterans living in rural/highly rural areas. Contracting with local, non-VA health care providers and agencies has been one approach to expanding the capacity of services (and thereby access) for rural/highly rural Veterans, however the approach and requirements associated with this contracting process can be discouraging, complicated, and excessive.

The VA should offer these select health care entities the opportunity to expedite a collaborative partnership.

- a. Acknowledge the similarities versus differences in the quality of care delivered by regionally and nationally accredited health care entities.

- b. Revamp the current contracting process by eliminating all duplicative and unnecessary requests imbedded in the current contracting process which have been met via achievement of regional and national accreditation.
- c. Assign a VA health care “navigator” to assist local, non-VA health care providers and health care agencies to understand and successfully complete the revamped contract requirement process in a timely, manner.
- d. Reduce approval turnaround time for revamped contract process to less than 90 days.

Once contracting approval has been achieved, assign a VA rural outreach health care coordinator to:

- a. Support the contracting providers/agencies to ensure that their experience in providing care to rural/highly rural veterans remains positive.
- b. Monitor rural/highly rural veterans’ customer satisfaction index and quality of care delivered.
- c. Assess the ongoing, at times unique, health care needs of rural/highly rural Veterans and look for opportunities with contracting agencies to improve upon both access to and delivery of health care.

Recommendation #2: The Committee recommends the Secretary remove onerous health information technology (IT) requirements for contracts with rural providers that result in having to maintain duplicative electronic health records (EHRs) and allow for the use of Blue Button as an alternative.

As the VA increases Access for Veterans through contractual arrangements with private providers, it will be important to avoid burdensome contractual requirements on rural providers. For example, in current contractual service arrangements the private provider must use the Veterans Health Information Systems and Technology Architecture (VistA) EHR and its own EHR. This requirement causes duplicative systems to be used and may be a disincentive for entering into contractual service agreements with the VA. Health IT can and should be a tool to improve care coordination for rural Veterans.

Other issues hinder current rural providers and/or prevent contractual agreements with private providers and can be addressed by the following:

- a. Access and efficiencies via IT
 - Increase Health Information Exchange (i.e. between DoD/VHA) efforts
 - Broadband issues need to be addressed
 - Increase contracting options
 - Ensure timelines are on track for HIE between DoD & VHA
 - Avoid duplications between various federal healthcare facilities
 - Harmonize IT security standards with partners for more seamless care coordination

- b. Increase public and private partnerships
- c. Coordinate IT systems between federal organizations and community providers
- d. Increase contracting options, to reduce duplicative efforts between organizations because of inefficient systems
- e. Develop model contract language so that the community providers can better understand VHA systems

Private providers across the country are leveraging health IT, including adoption of EHR, and expanded use of telehealth. VA Telehealth Services uses health informatics, disease management and telehealth technologies to target care and case management to improve access to care, improving the health of Veterans. Telehealth allows for changes to the location where health care services are routinely provided. Further, telehealth refers to any remote telecommunications healthcare providers use to interact with and manage patients. It can range from teleconferencing between patient and provider (or provider to provider) to advanced high-quality online voice and video interactions, enabling healthcare providers and patients to interact with each other remotely. Properly implemented, telehealth can expand access and reduce costs of healthcare. In this regard, the private community is following the VA in moving towards a connected environment.

For clarification of the VA about VistA and Blue Button the following information is provided:

- The Veterans Health Information Systems and Technology Architecture (VistA) - is an enterprise wide information system used in the VA. The Computerized Patient Record System or "CPRS" is the VistA user interface which serves as the Electronic Medical Record for the VA. CPRS enables medical staff to enter, review, and continuously update patient medical information. With CPRS, medical staff can order lab tests, medications, diets, radiology tests and procedures, record a patient's allergies, and enter discharge summaries. CPRS supports clinical decision-making and enables medical staff to review and analyze patient data.
- My HealthVet - My HealthVet is VA's online personal health record. Patients can update personal information, communicate with their health care team, and access personal health care information recorded in the patient's medical record. The Blue Button feature allows patients the ability to view, print, download, and/or save their health information.
- My HealthVet Blue Button - The Blue Button feature in My HealthVet provides an easy way for My HealthVet users to download their personal health information. The Blue Button makes it possible for Veterans to view, print, download, and/or save their personal health information. Blue Button also allows Veterans to create a Continuity of Care Document (CCD). The CCD contains health information directly from the VA medical record that Veterans can share with their non-VA providers.

Rural providers are moving toward meeting Meaningful Use requirements for EHRs but may lag behind some urban providers. In an ideal situation, all of the IT systems would be meeting all Health Information Exchange (HIE) requirements. In the interim, private providers should not have to maintain multiple EHR systems. Instead, many rural providers who could serve as service contractors to the VA could use the VA's established Blue Button technology.

The Committee sees the use of Blue Button as a temporary way to share VA patient information with the ultimate goal of fully integrated health information exchange. As rural providers contracting with the VA make progress toward meeting full HIE they can eventually move from Blue Button to full HIE standards and requirements. In addition, rural providers with telehealth systems may have the potential to link to the VA to expand access to services for rural Veterans. The VA could provide additional guidance regarding how rural community providers can better link to the VA through telehealth.

The VA's expansion of contracting has the potential to increase access points for isolated rural Veterans served by rural clinics and small rural hospitals. It will be important that the VA remove IT requirements that would be burdensome for qualified rural providers while still maintaining integrity of information and processes.

Recommendation #3: The Committee recommends establishing locally-tailored solutions to increase collaboration and service delivery at the community level by way of the specifically recommended model of Local Veterans Services Councils through the direct engagement of the Secretary and staff with government advocacy bodies (i.e. the National Association of Counties, the National League of Cities and Municipalities, National Congress of American Indians, National Association of State Directors of Veterans Affairs).

Currently, tremendous state, local, tribal, and federal services exist, to the degree that the Pentagon has referred to it as a "Sea of Goodwill." While this provides incredible opportunities for existing and transitioning veterans, it has also created a system of services that are difficult to navigate. The Department of Defense has been attempting to address the challenges and opportunities associated with the "Sea of Goodwill" through Inter-Service Family Assistance Committee /Joining Community Forces initiatives, which recognize that the real work of service delivery must be done collaboratively and locally. However, these programs are exclusive to service members and their families and future funding is also in question. In order to maintain the existing "Sea of Goodwill," to improve upon it, and to preserve it into the future, local communities across the country should develop coordinating councils based on the ISFAC/JCF model as well as successful models in California, Nevada, and on tribal reservations around the country.

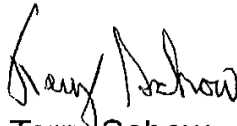
Cities and Counties across the country have various advisory boards and commissions, covering topics from senior services to airport noise abatement, however few have advisory or collaboration committees for veteran's services. Department of Defense funded Joining Community Forces initiatives are currently working to build collaboration and increase coordination of local services, benefits, and opportunities for service members and their families; however these services often do not extend to the veteran community. Local

communities should be encouraged to establish similar advisory boards to provide for enduring and inclusive coordinating committees going forward.

The central issue is that services, primary and ancillary, currently exist. However, there is a lack of local leadership to coordinate and deliver these services. Some coordination is occurring through various entities; however, funding to continue these services may not endure. This model proposes to establish an enduring effort.

Our Committee has worked with the VHA Office of Rural Health and has analyzed these recommendations and determined there is thematic alignment with the Veterans Access, Choice and Accountability Act legislative priorities and the Blueprint for Excellence. I respectfully ask for your concurrence, on behalf of the Veterans Rural Health Advisory Council.

Sincerely,

A handwritten signature in black ink that reads "Terry Schow". The signature is written in a cursive style with a large initial 'T'.

Terry Schow
Chairman

Veterans Rural Health Advisory Committee

CC: Gina L. Capra, Director
VHA, Office of Rural Health