

**OFFICE OF RURAL HEALTH
VETERANS' RURAL HEALTH ADVISORY COMMITTEE**

**MEETING MINUTES
October 13-14, 2011**

The Veterans' Rural Health Advisory Committee (VRHAC) convened its meeting on October 13-14, 2011, at the Wyndham Portland Airport Hotel, in Portland, ME.

Committee members present:

Charles Abramson
James Ahrens, *Chairman*
Bruce Behringer
Michael Dobmeier
Hilda Heady
Major General John Libby
Terry Schow

Committee members absent:

Rachel Gonzales-Hanson
Cynthia Barrigan
James Floyd

Agency representative participating on behalf of member:

*Ex-officio members

Richard Church, Pharm D.* (Representing Dr. Susan Karol)
Tom Morris

Presenters and Other Participants:

Brian Stiller, Center Director, VA Maine Healthcare System
Michael J. Labbe, MyHealthVet Coordinator, VA Maine Healthcare System
Dr. Mary Beth Skupien, Director, Office of Rural Health
Judy Bowie, DFO, MA, Management Analyst, Office of Rural Health
Dr. Peter Kaboli, Director, Veterans Rural Health Resource Center (VRHRC) – Central Region
Paul Hoffman, M.D., Director, Veterans Rural Health Resource Center (VRHRC) – Eastern Region
Ryan Lilly, Associate Director, VA Maine Healthcare System
Adrienne Kinne, Veterans Rural Health Resource Center (VRHRC) – Eastern Region
Phil Welch, Veterans Rural Health Resource Center (VRHRC) – Eastern Region
Kristen Wing, Veterans Rural Health Resource Center (VRHRC) – Eastern Region
Christopher Woodford
Nancy Nally
Kate Callahan
Peter Ogden, Maine Veterans Services
Steven J. Henry, American Legion
Gary Lawyerson, MVCC, MOPH, and Maine Veterans Coordinating Committee
Jerry DeWitt
Gary York, 1st Jr. Vice Commander, DAV
Cynthia Swaney, Maine Women Veterans Commission
Scott Lewis
Bobby Reynolds
Richard O'Leary, Jr. Vice-Commander, VFW

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Thursday, October 13, 2011

Day 1 of the VRHAC meeting opened at 8:00 a.m.

Welcome

Chairman James Ahrens opened the meeting with welcome remarks, and Committee members gave brief self-introductions. The agenda and approval of the spring conference call minutes were accepted.

VA Leadership Remarks

Brian Stiller, Director, VA Maine Healthcare System, Togus VAMC

Mr. Stiller shared the history of the VA Maine Healthcare System. The System currently serves 40,000 Veterans in 12 locations throughout Maine – out of about 150,000 eligible Veterans currently residing in the state. As a very large, very rural state, Maine continues to undertake a variety of means to ensure Veterans have access to health care benefits, even in the state's more remote regions.

Mr. Stiller discussed various outreach and health care clinic models of collaboration with local hospitals and health care centers to create access points throughout the state. These models included the nation's first rural community-based outpatient clinic (CBOC) in Caribou, ME. This collaboration started with a municipal hospital and a mobile health care clinic that provided access in the heart of Maine as part of a pilot study. For the time being, the mobile medical unit will be stationed in Bingham, ME, to ensure that Veterans in that area maintain their access point. The center is currently discussing opportunities with providers in Bingham, ME. The mobile clinic in Bingham is open 2 days a week and serves 500-540 Veterans. However, some of the challenges have been related to staffing the clinic, and providing health care in a cost effective manner.

Mr. Stiller discussed what community health care providers bring to VA that would prompt VA to pursue a relationship with them. Difficulty is that the computerized medical record system that VA uses does not line up with billing as it is clinically based. In addition, because we are outcomes driven, there are many clinical reminders that pop up in the computerized patient records system (CPRS), which ties into billing and creates a problem for use by community providers. To improve collaboration between VA and community providers, we would benefit by using one computerized medical record system.

Mr. Stiller expressed they are currently looking at having extended hours, but they are looking at volume and whether the facilities have the patient flow to justify costs of having staff on for extended hours.

Project ARCH Overview – Access Received Closer to Home

Collette Alvarez – Project ARCH Project Manager and Ryan Lilly, VA Maine Healthcare System, Associate Director.

Mrs. Alvarez discussed the background of Project ARCH. This is a contract care pilot program. VISNs 6 and 15 chose to use the program to expand primary care services. VISNs 1, 18, and 19 chose to provide specialty, acute, and care services (refer to slide deck information presented). Veterans need to have been enrolled in VA at the time Project ARCH was implemented (the only exception being current era Veterans – Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn (OEF/OIF/OND)). This project was not viewed as being an avenue to increase enrollment, but rather to

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ease travel burden for previously enrolled Veterans. One barrier to overcome is the sharing of VA computerized medical records. Providers enrolled in Project ARCH may not have access to CPRS. Mrs. Alvarez said that the Project ARCH case managers through Humana do have limited access to CPRS and the project is moving in the direction of increasing access over time. MyHealthVet was offered as one avenue of ensuring that Veterans can share their records with their community providers. The committee discussed the benefits and limitations of MyHealthVet in meeting this gap in communication between VA providers and community providers.

Mr. Lilly provided an overview of the acute care hospitalization process under Project ARCH. The Veteran is identified as needing acute care services by the VA or other non-VA provider (e.g. an emergency department (ED) provider). The Veteran consents and a Project ARCH request is generated for inpatient hospitalization. A Veteran hospitalized at a contract site is followed by an RN Case Manager who participates in discharge planning. Records are sent to VA by secure means and scanned into the medical record. Veterans admitted through the ER for life threatening conditions will have a consult and consent process done after admission and start of therapy. Weekend, evenings and night (WEN) coverage for approval is arranged by the Patient Care Coordinator at Togus. Discharge medications will be provided through VA pharmacy services including VA contract pharmacies.

My HealthVet

Michael J. L'Abbe, My HealthVet Coordinator, VA Maine Healthcare System

Mr. L'Abbe discussed the new features that have been added to MyHealthVet. Highlights included secure messaging with providers from the patient's home. This system is particularly helpful for Veterans who are hearing impaired and have difficulty with basic communication via the telephone as a result. Mr. L'Abbe discussed the objectives of MyHealthVet and how it complements rural health initiatives to increase effective communication with rural stakeholders, such as healthcare providers. MyHealthVet is a portal that capitalizes on federal investments to ensure that Veterans have access to portions of their CPRS medical record, Pharmacy, Secure messaging, a medical encyclopedia, Vista appointments, and the Master Patient Index (which protects user's identity). This system engages Veterans in his or her healthcare.

The committee asked Mr. L'Abbe to go into a little more detail about the verification process. Mr. L'Abbe explained that anyone could access the basic MyHealthVet site. Any Veteran can enroll in MyHealthVet and gain basic access. However, to access specific healthcare information, such as prescriptions names, appointments, secure messaging, basic medical records and reminders, a Veteran must be authenticated in-person. Appointment reminders are available two weeks and two days prior to an appointment via email, which is helping to decrease no show rates. Secure messaging also helps eliminate phone tag and spending time waiting on the phone or being transferred from provider to provider; now a Veteran asks a question via secure messaging and it is recorded and responded to as appropriate without requiring someone to be waiting on the phone.

Mr. L'Abbe reviewed the benefits to the health care team, which included patient satisfaction, and patient involvement, reminders, instructions, and attachments can be shared. The system also benefits rural Maine by saving trips and cuts down on unnecessary driving, expands options in bad weather and expands hours. Additionally, it can be used as a research and tracking tool and has social and economic value. MyHealthVet is used by younger and older Veterans alike.

ORH Update

Dr. Mary Beth Skupien, Director, Office of Rural Health

Dr. Skupien provided an overview of the VHA mission and goals. ORH Areas of focus include six (6) goals that have been updated given recent guidance from Office of Inspector General (OIG) and through discussions and collaborations with the Committee.

- Improve access and quality of care through measurement, evaluation, & documenting impact of best practices in rural health.
- Optimize use of available and emerging health information technologies.
- Maximize use of existing and emerging studies and analyses to improve care delivered to rural Veterans.
- Improve availability of education and training for VA and non-VA providers by increasing distance learning and developing new education resources for health care professionals.
- Enhance existing and implement new strategies to improve and begin new collaborations and increase service options for rural Veterans.
- Develop innovative methods to identify, recruit, and retain health care professionals and expertise in rural communities.

ORH organizational structure has been updated and the national office has expanded from three (3) staff people to fifteen (15). All positions are currently filled except one media position. ORH now has a newsletter and updated website and blog that have enabled ORH to get its story out and let Veterans know what our goals are and how we are working to improve Veterans' care and access in rural areas as we strive to meet our goals.

There was a question regarding whether or not entities outside of the VA can submit a proposal for funding through ORH. The response was that the only way an outside entity could participate would be through VA collaboration. Anyone in the VA can apply, but it must be through the VISN.

Dr. Skupien also reviewed the ORH funding breakdown for FY 2011 and 2012, sustainment projects.

Mobile Medical Unit Services

Ryan Lilly, VA Medical Center Associate Director, Togus

Mr. Lilly discussed the history of mobile health clinics, which began, with the funding of six mobile clinics in 1988. Four factors were examined for these six sites: access, quality, staff satisfaction, and costs. 56% of patients seen were new enrollees and 23% had no other access to health care, this was a success in terms of access to care. This was true across sites for bringing in new users. They had a health benefits advisor on the bus that could enroll them on the spot. Quality indicators were roughly equivalent to the fixed sites. Problems: logistics and mechanics. It was difficult to keep the bus on the road – engine trouble was frequent and continuity of care was a challenge. Labs and x-rays were difficult to communicate. It was difficult to recruit and retain staff. Costs were two to three times that of fixed sites. Most sites ended by 2005, though one site was maintained through 2010. Fixed site CBOCs (which were not as prevalent when the mobile clinics started) are more numerous today.

In 2010, four new sites were selected as new trial sites for the mobile medical unit model, one being in Maine. Veterans were still able to enroll on the bus. There was more collaboration with local medical care facilities. Satellite hook-up was the chosen means of connecting to CPRS from the mobile clinics;

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however, in the most rural areas even satellite connection was spotty at best and that was never able to be resolved in terms of gaining reliable access to CPRS. The clinics were evaluated at the end of FY2010; recommendations were incorporated into FY2011; and the clinics were again evaluated in FY2011.

The mobile clinics did not survey the patients; however, anecdotally, Veterans were very positive. Staff satisfaction was high; however, there was seventy-five percent staff turnover. Over the course of the mobile health clinics duration of providing care costs: \$425.00 per visit, whereas the national average at a fixed site is around \$223.00 per visit.

Challenges: mechanical breakdowns, weather challenges, transportation, changed from four days a week to two days a week. ORH agreed to fund it for an additional year due to the lag time in getting the program up and running. At its peak, we had slightly over 500 enrollees and at the fixed site, there are still over 300 Veterans enrolled.

Ms. Heady shared with the committee there are sites that have worked and there are mobile health clinics in West Virginia among other places that have demonstrated success with different models offering various services (e.g. mammography, radiology, dentistry). These models have demonstrated success.

The committee raised discussion regarding Beneficiary Travel. Now that the benefit has increased substantially per mile, Veterans are increasingly taking the time to apply for Beneficiary Travel for their visits and that has been a burden on limited staff. Mr. Lilly responded Maine is piloting a card swipe machine that would allow Veterans to swipe their cards at the facility after their appointment and have money transferred electronically to a debit card that will give them immediate access to their travel funds.

Maine Medical Rural Alliance is one avenue to incorporate rural Veterans perspective into the training of medical providers through an alliance with Tufts. The committee raised discussions regarding work force development. Mr. Lilly reported, that there are ad campaigns in the works, both toward employment and in terms of health care services available (especially directed towards OEF/OIF/OND Veterans).

Ethics Training for Special Government Employees (SGE)

Elizabeth Anne Kopely, Office of General Counsel, Department of Veterans Affairs

Mrs. Kopely provided the Committee with an overview of the Ethics Training for Special Government Employees (SGE). She highlighted ethics rules and regulations as they apply specifically to Advisory Committee members appointed to serve not more than 130 days during any 365-day period (with or without compensation).

Additionally, Ms. Kopely discussed the importance of seeking, taking, and complying with advice to protect SGE from criminal prosecution or other administrative actions.

Eastern Resource Center Update - Dr. Paul Hoffman & Staff

Dr. Hoffman highlighted some of the projects that have been completed and ongoing in the Eastern Region. One of the successes to come out of the Eastern Region was piloting a model for concept paper review that has been further developed into a process that allows for soliciting ideas from the field and assisting in the development of projects based on our expertise in project development and evaluation.

VRHRC-ER FY 2011 Completed Projects**Access and Quality**

- Evaluation of Veteran-Centered Medical Home Implementation in Rural Community Based Outpatient Clinics
- Houlton VA Outreach Clinic Evaluation
- Survey of Veterans' Healthcare and Informational Needs
- Maine General Surgery Assessment
- VRHRC-ER Geospatial Outcomes Division - National Geographic Access Assessment
- Transportation needs assessment and the effect of increased travel reimbursement rates on health care utilization in the VA

Education and Training

- Suicide among Rural Veterans: Prevalence, Prevention, and Promoting Best Practices
- Rural Health Training Program for Medical, Nursing and Associated Health Professions Students
- Public Psychiatry Fellowship Program
- Telepharmacy – Brown Bag Clinics for Rural Maine CBOCs

Technology and Telehealth

- Clinical Video Telehealth (CVT)-Neurology for Follow-Up Care of Veterans with Progressive MS Living in Rural Areas
- CVT-Rehab (Physical Therapy/Recreation Therapy) for long term stabilization/ improvement in function for Multiple Sclerosis (MS)
- CVT-Caregiver Assistance Program
- Delivery of Primary Care to Veterans with Spinal Cord Injuries/Disorders by CVT to home or CBOC: Expanding Telehealth Services to SCI Rural Veterans
- Rural Telehealth Veteran Independence Initiative

Dr. Hoffman discussed work in Technology and Telehealth, particularly in the area of Clinical Video Telehealth Neurology consultation for follow-up MS care, which began as a pilot study and has recently expanded to ten sites through collaboration with the MS Centers of Excellence.

Question regarding the prevalence of MS among Veterans if there is a presumption of service-connection. Dr. Hoffman responded, Amyotrophic Lateral Sclerosis (ALS) is presumed connected and MS is presumed connected if diagnosed within seven years of discharge. There are about 40,000 Veterans with MS, and Rural Veterans comprise about 35% of this population and this is a concern particularly for rural areas.

There was a question regarding whether this was related to the discussion the group had in Helena and the model for the Center for Excellence. Dr. Hoffman responded that it is not directly related; however, it may become a pilot for further developing along that model.

Discussion about how to reach out to PharmD students and graduates to recruit to a rural area, which is often times difficult particularly in rural areas where the earnings will not enable the graduate to pay off his or her student loans.

The committee adjourned for the evening and prepared for the local Town Hall Meeting that was held on location. Approximately 12 Veterans participated in this Town Hall meeting.

Friday, October 14, 2011

Day 2 of the VRHAC meeting opened at 8:00 a.m.

Opening Remarks and Review of Veteran Forum Activities

Chairman Ahrens provided an overview of the first day of the meeting. The committee discussed the need to engage the community, and raise awareness when pilot programs are being rolled out. The committee expressed a desire to engage more interest from Veterans on new pilot programs, in an effort to sustain them.

The committee discussed the following issues: Why does VA need approval to survey more than nine Veterans and those Veterans who are among special populations? OMB approval is required to survey over nine Veterans. There was discussion about whether we can get that regulation changed so that it is easier for the VA to survey Veterans in a systematic manner.

There are some limitations involved with surveying National Guard units. They do represent a segment of OEF/OIF/OND population, and perhaps we should more fully explore surveying this group of Veterans.

VRHAC – Annual Report Development Workgroups

(This was a closed session; the committee developed their working strategy and approach to writing the 2011 committee report to the Secretary.)

Discussion: Spring 2012 VRHAC Meeting

Dr. Skupien informed the committee that Rachel Gonzales-Hanson would like to host the meeting in Uvalde, Texas for the semi-annual spring meeting. The proposed date is the week of March 29-30, 2012. Dr. Skupien thanked the Committee for their hard work and for a highly productive meeting. Further, appreciation was given to Judy Bowie and ORH staff for their hard work and support to the Committee.

Public Comment

No public comments were submitted for the record.

Follow-up Action Item

The committee agreed to receive the draft annual report from Ms. Heady by November 10, 2011, for ORH review and concurrence.

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Adjournment

Day 2 of the meeting adjourned on October 14, 2011 at 11:00 a.m.

Respectfully submitted,

JUDY BOWIE

Judy Bowie
Designated Federal Officer
Veterans' Rural Health Advisory Committee

I hereby certify that, to the best of my knowledge, the foregoing minutes from the October 13-14, 2011 meeting of the Veterans' Rural Health Advisory Committee are true and correct.

James F. Ahrens

James Ahrens
Chairman
Veterans' Rural Health Advisory Committee

The Committee at its next meeting will formally consider these minutes, and any corrections or notations will be incorporated in the minutes prior to that meeting.