



Meeting Summary

Veterans Rural Health Advisory Committee Meeting Department of Veterans Affairs

Session Objectives:	<ul style="list-style-type: none"> • VRHAC will gain increased understanding on key program office activities. • VRHAC will build knowledge of national rural Veteran health initiatives. • VRHAC will review status of 2016 recommendations, and begin discussion on 2017 goals.
Date & Time:	Tuesday, November 15, 2016, from 8:30 AM to 5:00 PM
Location:	U.S. Department of Veterans Affairs 1800 G Street, NW Room 870 Washington, DC 20006 VANTS: 1-800-767-1750, code: 03907#
Attendees:	<u>Chair:</u> Margaret Puccinelli <u>Designated Federal Officer:</u> Gina Capra <u>Members:</u> Graham Adams, Verdie Bowen, Angeline Bushy, Dale Gibbs, Kevin Kelley, John Mengenhause, Michael McLaughlin, Brenda Moore, Randy Reeves, Buck Richardson <u>Ex officio members:</u> Tom Morris, Benjamin Smith <u>Ex officio representatives:</u> Wakina Scott, Wilbur Woodis <u>Office of Rural Health:</u> Zavian Cooper, Maichi Halley, Richard Huang, Meghan Ochal, Emily Oehler <u>Non-speaker Attendees:</u> Laura Ahmed, Christopher Clark, Jacob Gadd, Jenny Kim, Joy Ilem, Kenneth Jones, Ellen Milhiser, James Moss, Kristy Park, John Peters, LaTonya Small <u>Speakers:</u> Listed below with presentation summary
Note Takers:	Meghan Ochal, Richard Huang, Emily Oehler

1	Part 1: Welcome, Introductions and Meeting Overview 8:45 – 9:15 am <ul style="list-style-type: none"> ▪ Speakers: <ul style="list-style-type: none"> ○ Margaret Puccinelli, Chair, VRHAC ○ Kathleen Klink, MD, Chief, Health Professions Education, Office of Academic Affiliations, U.S. Department of Veterans Affairs (VA) ○ Gina Capra, Director, VA Office of Rural Health (ORH)
	Margaret Puccinelli, Chair, VRHAC <ul style="list-style-type: none"> • Ms. Puccinelli welcomed the Committee and thanked the Office of Academic Affiliations (OAA) for hosting today’s meeting. • Ms. Puccinelli welcomed the Committee’s newest members – Graham Adams, Michael McLaughlin, Brenda Moore, Francisco Navarra, and Angeline Bushy.



- Members introduced themselves and shared rural Veteran health connection.
- The Committee observed a moment of silence for an active duty service member recently killed in combat.
- The Committee reviewed and agreed upon standing committee ground rules.
- Ms. Puccinelli encouraged the Committee members to draw upon their personal perspectives, but to focus on how the VRHAC can have a national impact.
- The Committee reviewed the agenda for the meeting.

Kathleen Klink, MD, Chief, Health Professions Education, Office of Academic Affiliations (OAA)

- Dr. Klink provided an overview of OAA and its work, including:
 - OAA is celebrating its 70th anniversary of the creation of the original memorandum that created a partnership between VA and medical schools.
 - The VA is the second largest funder of graduate medical education (GME), supports over 40 training programs, and has the statutory authority to train health professionals for the VA as well as nation.
 - OAA estimates that 70 percent of all physicians in the U.S. have received/are receiving training from VA
 - With passage of the Choice Act in 2014, OAA was authorized and funded to increase GME positions by 1,500 over five years, with a focus on primary care and mental health (psychiatry) providers in communities that are rural, underserved and/or high concentration Veteran communities. This translates into one third of all residents in the U.S. coming through VA at some point.
 - OAA has awarded less than 600 positions after three years so is aiming to extend amount of time allotted in order to fill all 1,500.
 - The Centers for Medicare and Medicaid Services (CMS) GME program generally doesn't focus on the type of provider, so VA has authority to emphasize primary care and mental health positions.
- Dr. Klink noted that OAA is supporting the development of infrastructure (staff, space, faculty development/capacity) in rural areas but welcomes ideas from the Committee on how to improve OAA's GME and infrastructure efforts.

Gina Capra, Director, VA Office of Rural Health

- Ms. Capra welcomed the Committee.
- Ms. Capra noted that ORH is working with various VA partners to compile responses to the Committee's 2016 recommendations and that all the subject matter experts will meet with the Committee tomorrow.

Highlights/Key Takeaways/Themes:

- The meeting will provide members with access to national rural Veteran health experts to inform current and future recommendations.
- OAA welcomed input from the Committee to inform its work on expanding GME to rural areas.



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Part 2: Presentation: Emergency Response Procedures

9:15 – 9:30 am

- Speaker: Rosie Jones, Management Analyst, Veterans Health Administration (VHA) Office of Academic Affiliations

Rosie Jones, Management Analyst, VHA Office of Academic Affiliations

- Ms. Jones explained the emergency procedures and how to exit the building during an emergency.
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Part 3: Discussion: Review Fiscal Year 2016 Recommendations

9:30 – 10:15 am

- Speaker: Margaret Puccinelli, Chair, VRHAC

Committee Members

- Ms. Puccinelli reviewed the Committee’s August 2016 letter to the Secretary, highlighting the four recommendations and relevant updates. Recommendations addressed were: 1) response time to proposed recommendations, 2) models of rural care delivery, 3) workforce, and 4) telehealth. Fiscal year recommendations are located online at <http://www.ruralhealth.va.gov/aboutus/vrhac.asp>.

Q&A/Group Discussion

- Recommendation 2 – models of rural care delivery: In reality, many rural Veterans couldn’t access Choice because Third Party Administrators (TPAs) were not conducting outreach to rural providers, who therefore weren’t participating in the program. Payer of last resort should be the Veteran. The Committee raised examples of barriers, including:
 - Providers are not properly billing VA because providers weren’t trained on what to do.
 - Patient needs to keep track of own Veteran Choice Program numbers for the providers.
 - Patient lacks awareness in advance of what care is covered.
 - Patients are sent to VA farther away when community providers are much closer.
 - Recommendation 3 – workforce: There is the potential for the Committee to review Title 38, Chapter 4, which allows exemption from Title 5 salary guidelines so Federal agency can offer market pay for salary rates, including incentive of adjusted accrued annual leave hours. If this authority is being utilized, would want to look at why disparity in pay still exists. The Committee would like to understand whether salary disparity in rural and urban areas is still true and due to cost of living and commuting, and how does this balance in importance with meeting the needs of Veterans. Rural workforce is an issue larger than the VA – the question is how can VA, Indian Health Services (IHS) and the private sector collaborate to address provider shortages in rural areas? Providers are more likely to settle where they train, so ensuring student and training programs in rural areas is key. Some institutions are not accredited at the level the VA requires (e.g., community college nursing programs).
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- Recommendation 4 – telehealth: the Committee would like to understand more about how costs and allocation decisions occur at Veterans Integrated Service Network (VISN) level for telehealth services. There may be lessons learned across VISNs. There are currently issues with how VISN to VISN reimbursement works with telehealth, which is complicated further by adding community providers.

Highlights/Key Takeaways/Themes:

- The Committee continues to support all fiscal year 2016 recommendations, and indicated the issues around community care (Veterans Choice Program), workforce and telehealth continue.
- Many rural Veteran health issues are not unique to VA, but are systemic of rural health issues at large.

Part 4: Presentation: Office of Rural Health Update and Discussion

10:30 – 11:00 am

- Speaker: Gina Capra, Director, Office of Rural Health

Gina Capra, Director, Office of Rural Health

- Ms. Capra presented information on rural Veterans and the work of the Office of Rural Health (ORH), which included:
 - Rural Veterans demographic data, including: that a higher proportion of rural Veterans enroll in VA health care (compared to urban Veterans), which implies rural Veterans rely more on VA as a safety net; 33 percent of enrolled rural Veterans live in rural communities; 54 percent earn an annual household income of less than \$36,000 ; women are the fastest growing rural Veteran segment; 36 percent do not access the Internet possible due to affordability, lack of desire, and lack of access
 - ORH’s four strategic goals (http://www.ruralhealth.va.gov/docs/ORH_2015-2019Strategic_Plan_508compliant_FINAL.pdf).
 - The Undersecretary for Health’s five priorities, highlighting the strong focus to increase access to care for current patients; and the strong focus on sharing best practices and bringing those to scale to improve consistency across the VA.
 - ORH’s enterprise-wide initiatives (EWI), which include: 1) Collaborative Rural Access Solutions, which expand national program office access efforts to sites serving rural Veterans – such as the EWI with the Office of Social Work for including social workers in Patient Aligned Care Teams, which has been lacking in rural areas, and 2) Rural Promising Practices, which are field-tested, innovative projects that meet ORH criteria demonstrating improved access to care for rural Veterans. It was noted that ORH applied criteria to local pilots to identify which could be brought to scale – identified six in fiscal year 2016 for mentored implementation.

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- Data projections for EWI fiscal year 2017 investments, which showed a bigger spread/reach this year compared to past years.
- Fiscal year 2017 projected outcomes of funded enterprise-wide initiatives
 - 570,000 rural Veterans served
 - \$219 million distributed
 - 40+ initiatives
 - 400+ sites of care
 - 75 percent of all VA medical centers
- Note that ancillary services investment is so large because of transportation investments which are critical to access many other interventions.
- In support of the 2015-2019 ORH strategic plan, ORH focused on sharing rural Veteran health information with partners and the general public to demonstrate the VA’s commitment to deliver quality care regardless of a Veterans location. Over the past 2.5 years, ORH reached more nearly 168 million Americans through a variety of communication channels, such as social media, video, newspapers, radio, brochures, fact sheets, issue briefs and a new website. All outreach materials are available on website for download and distribution by VRHAC members (<http://www.ruralhealth.va.gov/newsroom/background.asp>).

Q&A/Group Discussion

- The Committee asked about ORH’s work on access to pharmacy services. Ms. Capra discussed the new EWI for clinical pharmacist support and how it is “beaming in” clinical pharmacists to spend time with patients/providers at community based outpatient clinics (CBOC) to be more engaged in patient care. It was noted that the Maine Health Care System has been leader in VA in this effort. Ms. Capra noted there is the opportunity to grow this EWI once ORH evaluates results of fiscal year 2017 investments.

Highlights/Key Takeaways/Themes:

- ORH activities are centered on achieving four strategic goals that work together to increase rural Veterans’ access to care.
- The new approach of EWIs will enable VA to deliver consistent, quality care to rural Veterans across the Unites States.

Part 5: Panel: Veterans Service Organizations

11:00 am – 12:00 pm

- Speakers:
 - Roscoe Butler, Deputy Director for Healthcare, The American Legion
 - Joy J. Ilem, National Legislative Director, Disabled American Veterans (DAV)
 - James Moss, Assistant Director, Veterans of Foreign Wars (VFW)
 - Tom Porter, Legislative Director, Iraq and Afghanistan Veterans of America (IAVA)

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- Christin Zito, Senior Associate Director of Health Policy, Paralyzed Veterans of America (PVA)
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Panel Questions

What do your rural members say are the top health care challenges?

- DAV: Rural Veterans are priority issue, and DAV often has a member on VRHAC although not currently. The membership passes resolutions – including two longstanding issues related to rural health. Key concerns for the membership are transportation, access, recruitment/retention, and Choice, including changes to existing VA-community partnerships that previously worked well but don't now. They want to ensure a high standard of care by community providers, including oversight by the VA, and emphasized that one size care doesn't fit all.
- VFW: Key issues are mental health awareness in communities and suicide prevention. The VFW has partnered to support the President's Suicide Prevention initiative. Members have brought up their concerns with provider shortages and reluctance of community providers to deal with VA red tape in order to partner.
- The American Legion: Focusing on female and American Indian/American Native (AI/AN) Veterans and unique needs. Members have difficulty in figuring out IHS- versus VA-funded services.
- IAVA: Is a Veteran empowerment organization. Issues they hear about include transportation and access (especially for tribal areas); mental health treatment and infrastructure – had recommended the elevation of the suicide prevention office to direct report to USH; accountability of the VA – including wait time issues, employee issues and how to incentivize recruitment and retention of high quality employees.
- PVA: Transportation is the number one issue. Other issues include staffing and specialty care; including the VA hiring process, which is too long and lacks incentives.

What do you hear is working well in rural communities that should be replicated nationwide?

- VA's treatment of patients.
- VA specialized care (e.g., combat-injury care like amputation, PTSD) is done really well but need to figure out how to ensure it's available to all Veterans

What legislative, policy and/or program actions are you working on that support rural Veterans?

- VFW developed a suicide prevention card that highlights five signs to look for and how to provide help.
 - American Legion has the "System Worth Saving" program in which they host town halls for Veterans and meet with VA to connect and make recommendations.
 - Multiple VSOs noted that resolutions exist for supporting mid-level providers for rural areas to support basic standard of care.
 - Veteran Service Organizations (VSO) have done a lot with directly supporting access through transportation, filing claims, etc.
 - At local level, there are many opportunities to partner directly to support rural health care.
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What issues should the Committee think about?

- American Legion requested the Committee review their 2012 rural Veterans report “System Worth Saving.”
- VA pilot program on training service member medics needs to be re-evaluated and restored nationwide.

Q&A/Group Discussion:

- Trust, respect and cultural competency is the core to Native American care, and IHS and VA agreement does not seamlessly allow Veterans to move between agencies. There is a lack of education/training on both the IHS and VHA sides regarding ability of AI/AN Veterans to be treated by both agencies.
 - The VA should look at opportunities for health aide professionals if high level providers aren’t accessible – these professionals are still able to take care of needs and bridge gaps. With rural care, it’s not just about providers – it’s about getting patient to the right care or the care to the patient. Cited example of 1,500 providers shortage in Alaska – rely on Physician Assistant and Nurse Practitioners, and now health aids.
 - The VA can have a workforce plan but expectations may be too high; need to focus on what is needed to sustain basic quality of life (e.g. using mid- and low-level providers as foundation for basic care). The VA should build upon the military medic model, which informed nurse practitioner programs.
 - Internet access issues in remote areas prevent ability to provide services via telehealth.
 - What are VSOs doing to recruit young Veterans who say they don’t have time or interest?
 - American Legion challenged its members to recruit and come up with better ways to bring in younger members. VSOs and members need to explain the benefits of membership - tangible benefits as well as being able to serve fellow Veterans that have worked hard to secure those benefits (e.g., GI Bill).
 - IAVA has a younger membership (average age is 30); some are members of other VSOs but expressed interest in doing more. Younger members want to be involved in outdoor and athletic activities local government, and active on social media. Members are empowered to support advocacy efforts (e.g., IAVA brings members to testify to Congress).
 - DAV has done more to connect younger members to community such as 5K runs and social media engagement. It’s important to adjust VSO activities to the needs of membership.
 - How do VSOs and younger members get involved in rural health?
 - VA needs to ask and actively include members, make them feel welcome, and empower members to participate.
 - American Legion may be able to put topic of how to support rural health care on their agenda for upcoming national conference.
 - Younger Veterans don’t register with the VA because they don’t want to deal with the bureaucracy, which is an opportunity for VA and VSOs to educate Veterans. Bureaucracy is part of issue, especially because VA’s
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- benefit and health care administrations aren't always integrated.
- VA did do pronounced outreach to OIF/OEF Veterans that resulted in successful enrollment rates for service connected Veterans.
- Soldier for Life, Transition Assistance Program (TAP), and demobilization efforts offer touch points for VA to engage with rural Veterans; options to support easier enrollment across transitioning groups from active duty to Veteran status.
- Now, there is a smaller population of service members who are serving longer – so have fewer Veterans to join VSOs. It would make sense to focus on community level connections (e.g., Community Based Outpatient Clinic working directly with local VSO representatives).
- VA and VSOs need to think about differences in promoting generational awareness and can tailor outreach to these Veterans.
- How does VA's work interface with broader health care environment? (e.g., value based care) VSOs are staying in touch with Veterans to ensure their needs are met and benefits are maintained. This will be a major discussion in the near future.
- Do changes to broader health care systems change Veterans expectations for care from VA? How does VA accommodate those expectations? VSOs have partnered with VA on programs that emphasize positive Veteran experience in the way Veterans want to be engaged such as MyVA.

Highlights/Key Takeaways/Themes:

- VSOs and members believe the VA provides quality care but transportation and lack of providers are top challenges for rural Veterans trying to access care, along with continuity of care between VA and community providers
- VSOs empower and encourage their Veterans to speak out and be involved in their communities.

Part 6: Presentation: Enrollee Healthcare Projection Model

12:00 – 12:30 pm

Speaker: Russell Armstead, Policy Analyst, Veterans Health Administration (VHA) Policy Analysis and Forecasting

Russell Armstead, Policy Analyst, VHA Policy Analysis and Forecasting

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- Mr. Armstead reviewed his Enrollee Healthcare Projection Model (EHPM) presentation slides. Highlights included:
 - An overview of the EHPM , which projects 20 years into the future utilizing actuarial method and informs 90 percent of the VHA budget.
 - Rural enrollee projections include no major demographic differences from urban enrollees and confirmation that rural enrollee population is growing (including higher than proportionate growth of female Veterans)
 - Nationally, Vietnam-era Veterans are the largest group and are approaching Medicare eligibility; the EHPM projects the number of 85 year olds to double by 2035, which has a significant impact on need for long-term care services.



- Number of enrollees with service-connected disability will continue to grow (Mr. Armstead clarified VA's health care priority groups - https://www.va.gov/healthbenefits/resources/priority_groups.asp).
- There is similar probability of movement to a different geographic area among rural and urban groups by age, although rural veterans are more likely to stay in/move to another rural area.
- Utilization of VA-paid services is similar among rural and urban enrollees, with the following exceptions: lower rural enrollee utilization of mental health services, homeless programs, and emergency room; higher rural enrollee pharmacy use.
- Mr. Armstead reviewed projected changes in enrollment in rural areas using two national maps showing changes from 2005-2015 and 2015-2025, respectively. The maps account for geographic movement, new enrollment, and death; the impact of these three drivers varies greatly by locality.

Q&A/Group Discussion:

- The group discussed potential differences in demographics and health care utilization between Veterans and non-Veterans in rural areas; it is likely that Veterans and non-Veterans have similar trajectories but ORH and Mr. Armstead can evaluate data further with U.S. Department of Health and Human Services' Federal Office of Rural Health Policy.
- Do Veterans work to get disability rating in order to obtain VA health care? Yes.
- The group discussed retirement preferences in terms of geographic locations. Is there a correlation for where rural Veterans retire or re-locate based on availability of VA facilities? ORH to coordinate with VA program offices on request and provide follow-up information at a later date.
- Many questions remain on long term care needs projections and what VA care could be available in future.
- Is Medicare enrollment and a decrease in accessing VA care different among urban and rural enrollees? Could these data serve as a proxy for understanding access? Mr. Armstead noted that VA has some data but it might not be sufficient to serve as a proxy.
- The group requested that Mr. Armstead provide data on enrollees' first use of VA care over age of 65 to be able to inform long term care needs and VA capacity. ORH to coordinate with VA program offices on request and provide follow-up information at a later date.
- What are key trends over the next few years?
 - Not a lot of difference between rural and non-rural enrollees
 - Not a lot of difference in usage patterns of services between rural and non-rural enrollees
 - Growth in service-connected disability
 - Lower income for rural enrollees
- Mr. Armstead confirmed that the VA definition of "rural" uses Rural-Urban Community Areas (RUCA) tiers from the Departments of Agriculture and Health and Human Services, which are mapped to the VA master enrollment file.
- The group discussed potential reasons for differences in service utilization between

urban and rural enrollees (e.g., lack of homeless services in rural areas, increased distance to ER in rural areas).

- If overall budget is informed by these projections, why are VA disability claims not automatically routed to enrollment in VA health care? VA’s recent strategic planning process is looking at ways to address this concern, as well as establish better integration with Department of Defense (DoD) systems.
- Mr. Armstead clarified that the projection maps legend had large spread due to one rural county showing a 100 percent decrease in enrollees (Emporia County).

Highlights/Key Takeaways/Themes:

- The projected growth and utilization in services by Veteran enrollees is similar across urban and rural Veterans.
- Overall, the number of older enrollees is growing and it is important for VA to plan for long term care needs and how to partner to best provide services for aging enrollees.

Part 7: Discussion: MyVA

1:00-2:00 pm

Speaker: Bob McDonald, Secretary of Veterans Affairs

Bob McDonald, Secretary of Veterans Affairs

- Secretary McDonald expressed appreciation to the members for serving on the Committee and noted that he finds tremendous value in all advisory groups as they bring expertise and voice of the Veteran to the VA.
- Secretary McDonald acknowledged that he had read the Committee’s fiscal year 2016 recommendations and that all are on target, including:
 - The response time for recommendations is too long, and VA is focused on a 90 day response time.
 - Improving the Veteran Choice Act is necessary.
 - Telehealth and recruitment are critically important to the future of VA.
- Secretary McDonald then reviewed his presentation slides and discussed the progress of the MyVA initiative, including:
 - A department-wide focus on mission and values, plus training VA staff every year so that staff consistently understand and demonstrate values.
 - The vision that VA will be the best customer service agency in the government; are already there in some areas (e.g., mail order pharmacy and National Cemetery Administration).
 - Clarified five strategies to achieve vision - 1) Veteran Experience (e.g., journey map), 2) Employee Experience (e.g., Leaders Developing Leaders, VA 101, values-based culture instead of a rules-based culture), 3) Internal Support Services (shared services and minimized duplication such as IT improvements and replacing outdated systems), 4) Continuous Improvement (e.g., human centered design, Lean Six Sigma), 5) Strategic Partnerships (e.g., partners are force multipliers, partners fulfill an ethical need to serve Veterans who may not be eligible for VA services directly).
 - Reviewed 12 breakthrough priorities for 2016 and several key examples.

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- Highlighted Veteran survey findings and service provision data, noting that there is still confusion around and differences across community care and is working with Congress to pass legislation to consolidate the programs; wait lists are growing but this is because VA is scheduling next appointment six months in advance (which allows urgent appointments to be prioritized sooner); Million Veteran Program has 560,000 DNA samples.
- Noted importance of community boards.
- Mentioned 13 priorities for 2017 – many of which are continuations of ongoing work.

Q&A/Group Discussion:

- What is your perception on rural?
 - Almost half of Veterans today are settling in rural areas and the VA has to continue to be leader in telehealth. The VA needs to take a total system approach to address the lack of providers – some current approaches include working with current medical schools and setting up new medical schools (in Idaho, New Mexico, Nevada, and Montana) to be pipeline to the VA; forming a unique program with Tufts to send doctors to train in Maine; working more with Doctors of Osteopathy (DO) who are more likely to settle in rural community; getting more spots set aside for VA positions at the Uniformed Services University of Health Sciences; looking to increase ability to reimburse provider student loans above current \$120,000 limit.
- VA is experiencing health care issues before the rest of the country – and there is an imminent health care crisis.
- As transportation is a major barrier to care, the Committee asked how the VA can work better with local providers to create synergy:
 - The issue is that the Veterans Choice Act has constraints on due to Veteran eligibility (e.g., distance, appointment time, geographic barrier) – the Chief Business Office estimates that if the Veterans Choice Program were open to every Veteran it would cost \$50-150 billion. If Veterans Choice Program eligibility were opened, VA would need to be cautious and ensure it could pay for it. The VA is partnering with other federal agencies to minimize redundancy and leverage existing infrastructure, and trying to recruit more providers to Veterans Choice Program.
 - The two main issues with the Veterans Choice Act are: 1) it was imperfect when written so VA has provided list of improvement to benefit Veterans (part of Veterans First Act), including taking back customer service aspect within VA and making VA primary payer and 2) there is a three year time limit that expires August 6, 2017. So there is a hole in 2017 budget. For example, if a Veterans Choice Program provider is providing prenatal care earlier in 2017, what does the Veteran do after August 2017?
- The Committee brought up examples of community providers' lack of understanding of and training on billing within the Veterans Choice Program, Third Party Administrator's Physician Assistants' lack of understanding of



geographic reality, and trying to send Veterans hundreds of miles away over geographic barriers when community providers are closer.

- The Secretary requested the Committee inform him about every single issue they hear about with the Choice program.
 - The committee discussed an example of a Federally Qualified Health Center directly working with a VA facility on a new individual provider agreement where VA is the primary payer (in order to do this, parameters must be met including the TPA not meeting certain criteria).
 - A Committee member raised an example of a visit to CBOC where they met a primary care physician who loves his job but hates the electronic health record processes and paperwork. What can the VA do about this and how can the VA provide additional staff support?
 - The Secretary responded that the VA wants all providers to practice at top of licenses and noted the Advance Practitioner Registered Nurse rule currently out for comment. VA started its electronic health records (EHR) early on but now that more options are available, the question is “does VA want to be software company?” The VA does not want a new version of VistA and discussions with EHR experts made it clear that VA couldn’t choose to go with one commercial record in future. How can VA create the capability to read any medical record on the cloud? VA is working with GA Tech on pilot program to do just this: access other records but VA providers would see in their own interface.
 - Committee members noted that IHS wants to partner more with VA, especially on workforce, but it is difficult with having to operate under different authorities; the goal is to not let bureaucracy get in way of Veterans getting seamless care. How could agreements extend to tribes? One urgent challenge is reimbursement agreements that are set to expire.
 - The Secretary confirmed the reimbursement agreements need to be extended.
 - Committee members asked the Secretary how the VA can increase the value that VA employees see in Veteran Choice Program and partnering—and decrease reluctance to partner?
 - The Secretary welcomes individual examples and names because the assumption of reluctance is limiting when it might only be a few staff. This is why the third party administrator (TPA) was included in the Veteran Choice Act. Right now many new VA Medical Center directors are focused on improving Veteran experience and partnering with community providers is part of that. Cited Alaska pilot of having VA team coordinate appointments with TPA processing payments in background, which is showing success. The VA needs to find balance of VA, community, and TPA roles and responsibilities.
 - The Committee and Secretary highlighted the importance of cultural competency among providers and partners. Understanding rural needs and issues isn’t as prominent and VA needs to think about how to do better in cultural competency around rural Veterans.
 - Members introduced themselves and shared backgrounds with the Secretary, and
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highlighted their key takeaways from the discussion.

Highlights/Key Takeaways/Themes:

- The Secretary agrees with VRHAC’s recommendations and many VA activities in progress support the recommendations.
- The Secretary highlighted 2016 successes and ongoing priorities that ultimately focus on improving the Veterans’ experience.
- The VA is looking to leverage all resources across VA, community providers, and other partners to ensure the best care and experience for Veterans.

Part 8: Presentation: General Updates

2:30-3:00 pm

Speaker: Jennifer Lee, MD, VHA Deputy Under Secretary for Health for Policy and Services

Jennifer Lee, MD, VHA Deputy Under Secretary for Health for Policy and Services

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- Dr. Lee provided an overview of some offices under her purview.
- Dr. Lee has been in this position for seven months and provided the Committee with information on her background, including experience as White House fellow, state government and as an emergency medicine physician. Her work as an emergency physician and with Medicaid expansion efforts in Virginia informed her greatly about rural needs.
- Dr. Lee highlighted her experience volunteering with the Remote Area Medical Clinic in rural Virginia, which emphasized the need for basic health care and dental care in rural areas.
- Dr. Lee discussed current VA efforts focused on rural areas: telehealth (700,000 Veterans seen for two million appointments in 2016, with high satisfaction); doing more with staffing, including creative ways to staff with more mid-level providers; DoD partnerships (tribal care coordination example); SCAN ECHO.
- Dr. Lee also discussed the VA’s focus on suicide prevention and referenced the VA August 2016 “Suicide Among Veterans and Other Americans 2001–2014” report (http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwjhI_KlcZQAhXLwlQKHcYYD-wQFgggMAA&url=http%3A%2F%2Fwww.mentalhealth.va.gov%2Fdocs%2F2016suicidedatareport.pdf&usg=AFQjCNFEKL0D6mcpXZ3eaDhJSlfdyN7KcQ) and noted the VA is continuing to drill down and understand differences in Veterans. Of 20 Veterans who commit suicide per day, only six are connected to VA care, so increasing connection to care can help. The VA is rolling out a predictive analytics approach to support Veterans most likely to consider suicide.

Q&A/Group Discussion:

- The Committee asked if Registered Nurses in VA are working at top of license.
 - Dr. Lee noted that it’s hard to know what is happening across the entire

VA, but that the new Chief Nursing Officer will focus on this area.

- The Committee recommended the VA install more X-ray machines in community based outpatient clinics (CBOC), which would greatly reduce barriers for Veterans access.
 - Dr. Lee agreed this would be good and noted VA is also looking at point of care ultra sound expansion.
- The Committee discussed how the change in administration may affect Medicaid expansion and how not having basic access to care impacts socioeconomic wellbeing.
- Dr. Lee explained more about VA’s work around EHRs and Health Information Exchanges. The VA is focused on an “Enterprise Health Management Platform (EHMP),” which is a user interface that sits on top of VistA to allow providers to see other records and supports team based care (similar to Joint Legacy Viewer but more data are available). An early version is available but VA is working on rolling out 2.0. VA is also working with Georgia Tech on making VistA more efficient (e.g., fewer clicks) but they need to balance policy and technical improvements (some “policy” assumptions are not true – e.g., were able to eliminate consent requirement for Hepatitis B testing). Overall this work is a challenge given competing IT priorities in VA.
- A Committee member raised an example of a contract clause that prohibits a community provider from entering VistA data into the provider’s own EHR. Could be related into “opt-in” process for Veterans regarding sharing information; Dr. Lee will investigate this barrier.
- The Committee discussed how weak Health Information Exchange (HIE) systems limit opportunities – in many cases they are built to require separate consent from Veteran to send data as well as to get it back, which is burdensome.
- It was noted that the Vet Connect Act (passed by House) loosens restrictions on data sharing and could have positive impacts on VHA overall and Choice
- Dr. Lee discussed the benefits of SCAN ECHO, a training and mentoring program for primary care providers to deliver specialized services with support of peer networks. It minimizes barriers to care for patients as well as increases provider and patient satisfaction. It was started in New Mexico with Hepatitis C patients but VA has used model for last five to six years in 40 areas including hepatitis, diabetes, and cardiovascular disease.

Highlights/Key Takeaways/Themes:

- VA is working to improve care delivery and access in rural areas through community care integration, health information exchange, more training for providers.



Part 9: Presentation: Healthcare Policy Update

3:00-4:00 pm

Speaker: Terrence Stinson, Director, Policy Analysis, Veterans Health Administration (VHA) Office of the Assistant Deputy Under Secretary for Health for Policy and Planning

Terrence Stinson, Director, Policy Analysis, VHA Office of the Assistant Deputy Under Secretary for Health for Policy and Planning

- Mr. Stinson provided his view on how the incoming Administration may impact VA health care and rural health, noting that the new Administration's agenda is still being clarified:
 - There will be party alignment in executive and legislative branches, which may make it easier to pass legislation; this is an opportunity as Veteran advocates in new landscape to get Veteran-focused legislation passed. Health care, immigration and economy appear to be the new Administration's key priorities.
 - There are components of the Affordable Care Act (ACA) that the incoming Administration will likely disassemble early on – namely the individual and employer mandates and equipment taxes (which are all seen as penalties). Will want to keep provisions to allow young people to remain insured until 26 and the pre-existing condition requirement.
 - It is expected the new Administration will move quickly due to single party alignment between House, Senate and White House, and Veteran advocates should be prepared to address health care policy immediately.
- For rural Veterans, ACA helped to cover Veterans' families plus self if person can't get to VA. If ACA changes, the VA can focus on this group to support this transition and figure out how the Veteran Choice Program fits (noting pending expiration in August). The method of addressing these legislative changes could vary – is it a line item, is it its own bill, or is it some other form?
- The VA's view is that it wants community care consolidated in order to have the same funding pool, and more flexibility and authority to implement provider agreements.
- The new Administration is an opportunity for VA and the Committee to think its approach to how to engage on behalf of rural Veterans such as working with a more business-centered perspective, preferences of the possibly new Secretary, looking at the whole care landscape and uniting services such as with DoD, pending legislation to make VA an independent non-profit like Amtrak, implications if ACA ends, or long-term planning for the ever-increasing aging population.
- There is an official request from the new Administration to not move forward on regulatory changes (including Advanced Practitioner Registered Nurse rule pending with OMB).

Q&A/Group Discussion

- The Committee discussed the pending expiration of the Veteran Choice Program, and what happens from August to October (budget gap) since money isn't set aside right now for that period. Determined there is a need to figure out how to
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best advocate continuing Veteran Choice Program. If whole healthcare landscape is changing, can VA become more involved elsewhere (e.g., better coordination with Medicare)?

- How many Veterans are currently enrolled in Medicaid? ORH to coordinate with VA program offices on request and provide follow-up information at a later date.
- The Committee discussed how it can inform Congress about impacts of potential ACA changes and impacts if Veteran Choice Program is not continued? The Committee requested that Mr. Stinson's office share data for each state. ORH to coordinate with VA program offices on request and provide follow-up information at a later date.
- The Committee discussed how it could leverage partner voices and coordinate with other national health groups that support Veteran Choice Program and support VA's efforts to continue Veteran Choice Program.
- The Committee also discussed how the VA can work with the Federal Communications Commission to increase broadband funding to fiber optics – which is necessary to increase efficiency of healthcare providers for telehealth.

Highlights/Key Takeaways/Themes:

- The change in Administration is an opportunity for VA to rethink priorities and proposals to ensure that Veterans benefit from legislation passed early on in new administration.
- The Committee's role is to advocate for rural Veterans and be able to inform decision makers about potential impacts of legislative decisions going forward.



Meeting Summary

Veterans Rural Health Advisory Committee Meeting Department of Veterans Affairs

Session Objectives:	<ul style="list-style-type: none"> • VRHAC will gain increased understanding on key program office activities. • VRHAC will build knowledge of national rural Veteran health initiatives. • VRHAC will review status of 2016 recommendations, and begin discussion on 2017 goals.
Date & Time:	Wednesday, November 16, 2016, from 8:30 AM to 5:00 PM
Location:	Location host: Vietnam Veterans of America 8719 Colesville Road Silver Spring, MD 20910 VANTS: 1-800-767-1750, code: 03907#
Attendees:	<u>Chair:</u> Margaret Puccinelli <u>Designated Federal Officer:</u> Gina Capra <u>Members:</u> Graham Adams, Verdie Bowen, Angeline Bushy, Dale Gibbs, Kevin Kelley, John Mengenhausen, Michael McLaughlin, Brenda Moore, Randy Reeves, Buck Richardson, <u>Ex officio members:</u> Benjamin Smith <u>Ex officio representatives:</u> Wakina Scott, Wilbur Woodis <u>Office of Rural Health:</u> Zavian Cooper, Richard Huang, Meghan Ochal, Emily Oehler <u>Non-speaker Attendees:</u> Beverly Cotton, Ellen Milhiser, Kristy Park <u>Speakers:</u> Listed below with presentation summary
Note Takers:	Meghan Ochal, Richard Huang, Emily Oehler

Part 1: Welcome, Agenda Review and Day 1 Recap

8:30 – 9:15 am

- Speaker: Margaret Puccinelli, Chair, VRHAC

Margaret Puccinelli, Chair, VRHAC

- Ms. Puccinelli asked the group for the key point that they took away from yesterday's discussions.

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Q&A/Group Discussion

- Committee highlights centered on ongoing challenges such as lack of dental care, transportation, distance to care; need to integrated services such as VA/IHS, VA/DoD and VA/community provider; need for electronic health information exchange between VA and non-VA Departments, administrations, and providers. Additionally the Committee called attention to VA's combat-related care, Veterans Choice Program, and the aging rural Veteran population.



Highlights/Key Takeaways/Themes:

- More seamless integration is essential in order to effectively and efficiently increase rural Veterans' access to care – connecting providers, systems, Departments and VA administrations.
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Part 2: Presentation: VA Center for Minority Veterans & Advisory Committee

9:15 – 10:30 am

- Speaker: Barbara Ward, Director, VA Center for Minority Veterans (CMV) & Advisory Committee
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Barbara Ward, Director, VA Center for Minority Veterans & Advisory Committee

- Ms. Ward noted that the Advisory Committee on Minority Veterans (ACMV) meets December 6-8 in D.C. and anyone is welcome to attend.
- Ms. Ward reviewed slides on the CMV and ACMV, including:
 - Background, organization, purpose and activities, active duty and Veteran demographics (current and projected), minority Veterans challenges – similar for all Veterans but often compounded for minority Veterans (e.g., Hep C among Hispanic Veterans).
 - CMV's role to conduct outreach and serve as liaisons with internal and external partners including Minority Veterans Program Coordinators (270+ VA employees based in VA Medical Centers (VAMC), claims offices, etc.) and Veterans Services Organizations (VSO), host virtual town hall meetings, and participate in special emphasis month events. Annually, CMV participates in more than 22,500 events that reach more than 1 million Veterans.
 - ACMV conducts two meetings a year – fall in DC and spring as a site visit to facilities serving a high number of minority Veterans.
- Ms. Ward highlighted the ACMV annual report with recommendations – 2016 included request to publish report on utilization and disability compensation by race, ethnicity, and gender by end of FY 2017; it is important to have data to back up any anecdotal complaints. VBA does not collect race or ethnicity data.

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Q&A/Group Discussion

- The Committee discussed the cost of the Hepatitis C cure compared to long term care. ORH to coordinate with VA program offices on request and provide follow-up information at a later date.
 - The Committee asked whether it can ask for geographic data for minority Veterans. Yes.
 - The Committee asked Ms. Ward what the top concerns raised by minority Veterans are beyond disability claims rating discrimination:
 - CMV is working with researchers to 1) improve communication and training between VHA mental health providers given likelihood of minority Veterans starting but not continuing with services and linkage to lack of cultural competence and 2) evaluate pain management
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assessment differences among providers for minority patients (as proven by previous research).

- Have heard complaints from native Veterans that the VA is not providing care and instead trying to send them to IHS. In these cases, CMV will coordinate back with appropriate VA contacts to correct issues or provide additional information.
- Regarding the recommended utilization and disability compensation report, the Committee noted that although VA's benefits does not have race or ethnicity data, but VA's health care does for many Veterans so it should be possible to create. Ms. Ward acknowledged there are many factors that affect disability ratings – e.g., Veterans own perseverance, differences in test results, demographic characteristics.
- The Committee asked if there are data on suicide by race? Yes, it will be included in an upcoming VA's report.
- The Committee asked about the ACMV's recommendation process. Ms. Ward noted that recommendations go to appropriate VA senior leader and then a report is finalized and provided to Congress (as ACMV is a statutory committee). It takes senior leaders about 3-4 months to respond with action plans.
- Ms. Ward clarified that CMV does not manage cultural competence programs and training for the VA, but does collaborate with offices that do and is supporting research for improvement of those trainings.
- The Committee asked how much of the CMV's work, education and materials are available for VRHAC to review to see how it can assist in work for rural Veterans? ORH and CMV share a collaborative relationship and may pursue shared trainings in the future.
- The Committee asked whether there are CMV efforts to collaborate with Supportive Services for Veteran Families (SSVF) program. VHA's Homeless Office does coordinate with all other VA components and homeless liaisons in field coordinate at the local level. There has been a lot of focus on urban homelessness lately; as such, there is the potential for VRHAC to address rural homelessness. The Homeless Office has been gathering research on rural homelessness. The Committee noted that the VA definition of "homeless" doesn't correlate to family structures on reservations and other rural communities with strong family culture/ties.
- A Committee member noted there is a requirement for mental health providers utilizing with telemental health to take training with the Tribal Veterans Representatives.
- Ms. Ward noted that the CMV works with the Minority Veterans Program Coordinators in the field – an updated list is on CMV's website.

Highlights/Key Takeaways/Themes:

- The number of minority Veterans will increase in the future.
- The CMV provides important services to support minority Veterans on an individual and national level, including a focus on building cultural competency.
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Part 3: Working Session: FY 2016 Recommendations

10:30 – 12:00 pm

- Speakers: U.S. Department of Veterans Affairs
 - Recommendation Process: Jeffrey “Boomer” Moragne, Director Advisory Committee Management Office
 - Rural Models of Care Lead: Kristin Cunningham, Executive Officer to the Assistant Deputy Under Secretary for Health for Community Care; Dr. Kameron Matthews, Deputy Executive Director, Provider Relations and Services, Office of Community Care.
 - Workforce: Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services
 - Telehealth: John Peters, Acting Deputy for Telehealth Services, Office of Connected Care

Jeffrey "Boomer" Moragne, Director, Advisory Committee Management Office

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- Mr. Moragne provided an overview of the Advisory Committee Management Office (ACMO) which follows the Federal Advisory Committee Act (FACA).
 - Today, 1,050 advisory committees involving 50,000 U.S. citizens provide independent advice to Secretaries.
 - The VA ACMO mission is to provide oversight of VA’s 26 federal advisory committees; they do not oversee local advisory committees.
 - ACMO maintains the Committee Reports written procedures provided to VRHAC beforehand.
- Mr. Moragne reviewed the process for advisory committee reports and noted that going through the Department can often take significant time depending on how many offices provide input on the Committee’s recommendations.
- ACMO submitted a memo to the VA Chief of Staff to clarify leadership responsibilities and enforce a faster timeframe for responses to Committee recommendations (90 days). Confirmation on 90-day recommendation may be on hold until the administration transition occurs.
- Mr. Moragne recommended that VRHAC should continue to follow best practices when drafting recommendations:
 - All recommendations are Specific, Measurable, Achievable, Realistic, and Time-framed (SMART), which facilitates quick review/processing. ACMO can provide a template for VRHAC.
 - Prioritize recommendations.
 - Prior to finalizing its report, consult with other VA advisory committees to see if VRHAC can leverage or align with their recommendations. Alignment across committees will greatly increase likelihood of resources being devoted to aligned recommendation.
 - Continuous committee member and chair outreach to Designated Federal Official to check on status.
- In response to the Committee’s question to the Secretary on becoming a statutory committee, Mr. Moragne provided an overview of statutory and discretionary committees. Both types of committees can be terminated, and statutory committees have additional oversight and reporting requirements. He



noted that regardless of type, a committee's mission and the value of its input is critical to a committee's continuance.

Kristin Cunningham, Executive Officer to the Assistant Deputy Under Secretary for Health (ADUSH) for Community Care and Dr. Kameron Matthews, Deputy Executive Director, Provider Relations and Services, Office of Community Care

- Ms. Cunningham mentioned that the VRHAC recommendations around community care are basically in sync with the work of the ADUSH for Community Care, with a few nuanced exceptions.
- Ms. Cunningham and Dr. Matthews provided background on the work of the ADUSH for Community Care and the Veterans Choice Act:
 - Encompasses seven to eight non-VA care programs, each with different eligibility requirements, payment and claim structures, which is very disjointed.
 - Last year, VA submitted a plan to Congress on how to consolidate non-VA care based on input from a variety of partners and with the goal to make community care easier to understand for all (referenced link to report in slides).
 - Many parts of the plan are aligned with the VRHAC recommendations but require new legislation, including making VA the primary payer with community providers and establishing a standard set of Veteran eligibility criteria with VHA providers allowed to exercise some flexibility.
 - When the Veterans Choice Act was passed, the VA had only 90 days to implement so the existing PC3 contract was leveraged. However, PC3 didn't have the network capacity as it was still being built. Since PC3 is in its third year, VHA is about to release new request for proposal (RFP) to take over network coordination. With new contract, VHA will keep care coordination and scheduling with Veteran among VHA staff, which is proving successful with pilots in Alaska and Fargo. The RFP will go out in next month and be implemented later in 2017, with pilots in a few sites prior to nationwide rollout.
 - Other improvements already made to Veterans Choice Program include allowing the contractor to directly call Veterans to make appointments and prompter payment to providers prior to medical records return – although note that VA is still working on clarifying clinically appropriate timeframe for medical records overall. Community Care will look into examples raised by Committee of issues with contractor methods of record transfer (e.g., not accepting fax) and is working to clarifying the credentialing process and requirements.
 - To facilitate records exchange, Community Care is working on getting community providers to sign up for Health Information Exchange (HIE) and is testing Joint Legacy Viewer options.
- Ms. Cunningham encouraged VRHAC members to review her slide deck for greater details.



Paula Molloy, Assistant Deputy Under Secretary (ADUSH) for Health for Workforce Services

- Dr. Malloy is new to this role but has extensive previous experience with Department of Health and Human Services (HHS) workforce efforts and VA.
- Dr. Malloy addressed the committee's recommendations and highlighted how they relate to two key areas of the ADUSH for Workforce Services – recruitment and retention:
 - Work with VA's recruitment service to target physicians that will be more likely to come to VA rural facilities (based on physician background, ties, and experience); so far has had 24 percent success rate for rural and highly rural areas, and are continuously reviewing improvements to targeted marketing.
 - VA and IHS are competing with private sector in terms of compensation. The VA's approach is to maximize all flexibilities under Title 38 and Title 5 – including relocation and retention incentives. While authorities allow compensation based on market rates, they are still limited by statutory caps.
 - Retention barriers include salaries, feeling of geographic isolation and limited opportunities for housing, spousal occupations, and children's education. Opportunities in rural areas may be more attractive to younger providers who have not started families and older providers.
 - The VA is looking at leveraging other resources, such as DoD trainee obligations and building pipeline in rural communities with younger students (to prepare for 20-25 years from now).
- Appreciate VRHAC's thoughts on how to ensure this effort targets rural areas.
- Highlighted issue of movement within VA as a retention issue as well as the drastic differences in urban to rural salaries.

John Peters, Acting Deputy for Telehealth Services, Office of Connected Care

- Mr. Peters provided an overview of telehealth at the VA, including:
 - There has been tremendous growth in telehealth services: in FY 2016, 702,000 Veterans participated in telehealth (12 percent of all Veterans – 45 percent of those were rural). This included 2.17 million encounters in 50+ specialties.
 - 970 VA sites were access points for telehealth, and the VA is shifting to connect to care beyond VA sites – serving Veterans where they are with encrypted videoconferencing.
 - Three types of telehealth: 150,600 Veterans with home telehealth (often for chronic conditions), 307,900 Veterans interact via video telehealth (8,200 from home, school, or work); and 304,700 Veterans utilize store and forward telehealth (image capture and review).
 - VA is working to assess connectivity capacity and providing devices to Veterans to ensure they can receive care via telehealth (2,000 distributed so far), while recognizing this method can't help with all cases. Right now Verizon 4G is the sole option. Some devices have peripheral care additions.



- The Federal Communications Commission Connect 2 Health Map is helping to inform broadband distribution and where VA could target telehealth services and collaborate with rural broadband providers to expand.
- Via ORH enterprise-wide initiatives (EWIs), Connected Care is rolling out hub-spoke models for: mental health (4 hubs), primary care (6 hubs plus once a quarter provider travels to spokes), stroke care, Intensive Care Units, State Veterans Homes and several others. These EWIs accommodate workforce preferences and allow ORH funding to support staff salaries across VISNs.
- Connected Care is working with congressional affairs on cross-state licensing issues for VA to community care sites (doesn't matter for internal VA to VA connections). Two bills are currently in committee to clarify Veterans anywhere can access care, through VA telehealth any VA provider anywhere, regardless of States (this is currently allowed with DoD); however, this is likely not a top Congressional priority.
- VA is working with First Responder Network Authority (FirstNet) to expand.
- There has been some piecemeal work to address cross-state telehealth care provision via Office of General Counsel memos and interim agreements.
- Connected Care is collaborating with broadband providers to provide IT support, utilize broadband facilities to further support VA telehealth care, etc.
- Connected Care agrees with all four VRHAC recommendations; submitted responses to ORH.

Q&A/Group Discussion

- The Committee noted that VA should be partnering with other health care organizations to improve health education information dissemination and not duplicating efforts.
- The knowledge of community providers at local VAs is not always sufficient or consistent. The VA Maine Health Care System is an example of a place that does this well; recommend using as a model to replicate as new community care contract is implemented and VA takes on full care coordination. May want to reach out to other partners that represent community providers in each state to facilitate success (e.g., primary care association, rural health association, hospital association). This type of proactive network development could be more effective than one-on-one coordination among providers. The Office of Community Care is working on this and identifying and enforcing best practices for care coordination in future.
- Current community care contracts had issues and VA had no mechanism to receive and address concerns/issues (no one monitoring contracts). VA learned lessons and will build in oversight – including a quality plan and requirement for network adequacy that monitors capacity and demand.
- Some local solutions to workforce include communities creating scholarships to keep future providers in community and online programs that allow students to stay closer to home. Nurses tend to have fewer degree requirements and may be more available in rural areas. But educating potential providers on how the VA



	<p>works (and how it is unique compared to other health care providers) is not there for interested students. The VA should look to literature that already exists on rural retention.</p> <ul style="list-style-type: none"> • The Committee discussed how the major issue with rural workforce is it is competitive within VA, IHS, National Health Service Corps, DoD, etc. How can these entities collaborate and share full time employees within rural communities? This collaboration will also allow leveraging of Veterans Choice Program connections and facility capacities (telehealth, etc.), application processes, etc. • Committee members recommended VA build upon existing authorities. For example, IHS-tribal-VA collaboration has unique components different from other federal contracts and the VA could tap into momentum from the work of the White House Council on Tribal Affairs • The Committee noted that it is important to think about how all these changes need to be clearly communicated to Veterans. <p>Highlights/Key Takeaways/Themes:</p> <ul style="list-style-type: none"> • The VA offices that are impacted by the Committee’s recommendations basically agree with all the fiscal year 2016 recommendations and are providing more detailed responses in the report to the Secretary.
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<p style="font-size: 2em; font-weight: bold;">4</p>	<p>Part 4: Presentation: Advisory Committee Ethics Training 1:00 – 2:00 pm</p> <ul style="list-style-type: none"> ▪ Speaker: Carol L. Borden, Staff Attorney, Office of General Counsel <p>Carol L. Borden, Staff Attorney, Office of General Counsel</p> <ul style="list-style-type: none"> • The “Ethics Training for Special Government Employees” presentation occurred.
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<p style="font-size: 2em; font-weight: bold;">5</p>	<p>Part 5: Working Session: New Information, Recommendations & Next Steps 2:15 – 4:30 pm</p> <p>Q&A/Group Discussion</p> <ul style="list-style-type: none"> • The Committee discussed how expert’s new information impacted fiscal year 2016 recommendations, what new issues emerged, and how to educate the new Administration on rural Veteran health care challenges. • The Committee outlined key information necessary to inform new VA leadership and key Administration staff on rural Veterans’ needs, to include information on ORH; rural Veteran demographics, needs and challenges; VA rural health care successes, and current recommendations on rural models of care with a focus on Veterans Choice Program, workforce and telehealth. • The Committee identified need to increase understanding on existing or pending legislation that could further impact or support rural Veteran care, such as workforce flexibilities.
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- The Committee expressed belief that reimbursement agreements will become an issue because agreements (tribal/IHS specifically) are expiring and most entities will not want the Veterans Choice Program/Medicare rate, and specialty care referrals are not currently included in agreements.
- The Committee agreed it needed to continue to work across VA in coordination with appropriate advisory committees and possibly with other agencies and organizations like the National Advisory Committee on Rural Health & Human Services or the National Rural Health Association.
- The Committee confirmed Veterans Choice Program and community care issues are a priority given expiration of Veterans Choice Program in August 2017.
 - Needs to focus on how Choice can work and that it is ultimately part of one integrated care network that VHA is working toward.
 - One way to look at rural care is to look at equality – why does a Veteran who lives further away from facility not have the same access to care that is supposedly guaranteed to them? Look at all vehicles that allow VA to highlight inequality. IHS has been succeeding at this by empowering community to help make decisions (e.g., community level decisions to use telemedicine, dental aide therapists, community health aides). While this process focused on rural, could also benefit urban communities.
- The Committee also discussed possible updates to its telehealth and workforce recommendations:
 - Telehealth:
 - Link telehealth and related issues: pending legislation; saving money on transportation costs; benefit for mental health/suicide prevention; infrastructure/connectivity issues; importance of HIE, Health Information Technology (HIT) and background technology to support services and providers.
 - The Federal Office of Rural Health Policy representative noted that it supports broadband adoption generally; but up to their individual grantees to educate.
 - Discussed FirstNet, which is a government program for expanding existing cell phone towers and adding new towers where areas don't have broadband to support 911/first responders where capacity to communicate is low.
 - Look at the success of various pilots re: telehealth, HIT, etc. already in place.
 - Workforce:
 - Strategic recruitment, more sharing of rural providers across federal and local agencies, leveraging various levels of providers/trainings of non-providers to support the local community where gaps exist.
 - Main barriers are lack of students and ability to really “grow your own” in rural areas as well as congressional limitations on incentives (the Secretary would need more flexibility).
 - Preliminary findings about rural and urban CBOC panels. Rural panels tend to be smaller. Recent example of IHS asking to pay



for some of provider's free time – caused major issues with legislative, budgetary, etc. limits.

- Lower level certifications – haven't worked out well due to state authority/regulations.
- Need to monitor any changes to immigration policies and potential impact on future provider workforce.
- Loan repayment issues occur when students don't stay on beyond the minimum commitment because they never make connection to the rural community.
- Look at rural-urban compensation reversal to favor rural providers and increase likelihood of staying in community.
- Ultimately is about what a community can collectively support across similar populations/needs. Shared FTEs, including focus on mid-level providers.
- Broader federal legislation to force more primary care residency slots. Are losing many students to hospitalist programs with better pay/hours.
- Rural Health Clinics have to have Nurse Practitioner or Physician Assistant working at least 50 percent to receive reimbursement.

The Committee then discussed the ongoing work of VRHAC:

- The Committee discussed the elements for inclusion the three-day spring meeting at a rural site, to include demonstration of successful VA and community care coordination, VA-IHS integration, VA-DoD integration, Veteran courts, and rural Veteran panel – as well as a possible joint session with U.S. Department of Health and Human Service's rural advisory board.
- Committee members to put hold on calendars for weeks of May 21-26 or June 5-9, 2017.
- Dr. Adams, Mr. Bowen, Ms. Puccinelli and Mr. Richardson volunteered to assist with planning and coordination of the spring 2017 meeting.
- Committee members provided feedback on the meeting and completed an evaluation.

Highlights/Key Takeaways/Themes:

- The Committee plans to educate the new Administration on the needs and challenges of rural Veterans, and VA's role in addressing them to ensure all Veterans receive the care they need regardless of their location.

Part 6: Public Comment Period

4:30 – 5:00 pm

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- Speaker: Margaret Puccinelli, Chair, VRHAC
- No public comments offered.



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Part 7: Chairman's Adjournment

5:00 pm

- Speaker: Margaret Puccinelli, Chair, VRHAC

Margaret Puccinelli, Chair, VRHAC

- Chair adjourned the meeting.
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