MEETING MINUTES

March 3 - 4, 2009

The Veterans Rural Health Advisory Committee (VRHAC) convened its second meeting on March 3, 2009 at the Squaw Peak Hilton Hotel in Phoenix, Arizona.

Committee members present:
James Ahrens, *Chairperson*
Charles (Abe) Abramson
Bruce Behringer
Michael Dobmeier
James Floyd
Ronald Franks, M.D.
Rachel Gonzales-Hanson
Susan Karol, M.D.*
Tom Morris*
Robert Moser, M.D.
Tom Ricketts, Ph.D.
Terry Schow

Committee members participating remotely for all or part of the meeting:
Cynthia Barrigan
Hilda Heady
Major General John W. Libby

Committee members absent:
Robert Gibbs, Ph.D.*

**Ex-officio members*

Other Presenters:
Byron Bair, *Director, Veterans Rural Health Resource Center – Western Region*
Richard Hartman, *Director, Policy Analysis and Forecasting, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, Veterans Health Administration*
Kara Hawthorne, *Director, Office of Rural Health, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, Veterans Health Administration*
Alana Knudson, *Associate Director for Studies and Analysis, Policy and Planning Group, Office of Rural Health; Former Deputy Director, Veterans Rural Health Resource Center – Central Region*
Ryan Lilly, *Acting Director, Veterans Rural Health Resource Center – Eastern Region*
Patricia Vandenberg, *Assistant Deputy Under Secretary for Health for Policy and Planning, Veterans Health Administration*
Alan West, *Deputy Director, Veterans Rural Health Resource Center – Eastern Region*

March 3, 2009

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

Welcome and ORH Updates

Committee Chairperson James Ahrens opened the meeting with welcoming remarks and Committee member self-introductions. Mr. Ahrens discussed the changes that had occurred within the Office of Rural Health (ORH) since the September 2008 meeting, the role of the Advisory Committee in advising the Secretary and the importance of helping Veterans in rural areas.

Kara Hawthorne briefly discussed ORH two-year, $250 million appropriation for rural health initiatives within VISNs and program offices. This funding will be overseen and distributed by ORH. The funds are intended to improve access and quality of health care for rural Veterans. Ms. Hawthorne also discussed her testimony before the U.S. Senate Committee on Veterans' Affairs and the interest of ORH in making headway in the congressionally mandated focus areas: increasing mobile clinics; establishing new outpatient clinics; expanding fee-based care in areas not served by Department of Veterans Affairs (VA) facilities; exploring collaboration with other Federal/community providers; accelerating deployment of telelmedicine; and funding innovative pilot and demonstration programs.

Other issues discussed during the welcome included member interest in mental health and collaboration with Vet Centers; the need for emphasis on suicide prevention and collaborations with the Department of Defense; mobile health clinics; integration of medical, dental, and mental health services; IHS services and potential partnerships with IHS; and the provision of care and/or outreach to Veterans' families.

Approval of September 16, 2008 VRHAC Meeting Minutes

The meeting minutes from the September 16, 2008 VRHAC meeting were unanimously approved.

VRHAC Working Group Report and Discussion

Cynthia Barrigan, member of the VRHAC Working Group, gave a presentation on the VRHAC Working Group.

The Working Group serves as a steering body for the Advisory Committee, and works on behalf of the full Advisory Committee by representing member interests and views.

- The Working Group is comprised of four (4) Advisory Committee members, appointed by the Chairman, who serve up to two one-year terms: Cynthia Barrigan; Hilda Heady; Michael Dobmeier; and Ronald Franks.

- Core functions of the Working Group include clarifying issues before the Committee, formulating strategies, developing work products, and maintaining an active working relationship with ORH staff in pursuit of Advisory Committee goals and objectives.
- The Working Group's process helps develop Committee goals and objectives, sets work plans with milestones, and meets monthly to plan and coordinate activities.
- Activities to date include three teleconferences in which focus areas were identified for recommendation to the full Committee; current rural health needs were discussed; the Phoenix meeting agenda was developed; discussions were held with stakeholders to identify needs and resources; and members engaged with ORH staff to bring new information forward.
- The Working Group recommended two focus areas to the full Committee:
    - Year 1: Collaboration with community partners, both Federal and non-Federal, to leverage existing rural health care infrastructure to better serve rural Veterans.
    - Year 2: Increase health information technology (health IT) deployment in support of rural health needs. Specifically, recommend strategies for enhancing electronic medical record (EMR)/telehealth capabilities in rural areas.

The Advisory Committee welcomed the input of the Working Group, and after a detailed discussion, accepted the Working Group recommendation that community collaboration be examined prior to taking up the question of developing and deploying health IT in rural communities.

The following observations/recommendations were offered by the Committee:

- Examine the factors that promote and impede collaboration.
- Examine continuity of care in rural areas.
- Place appropriate emphasis on the question of the sustainability of collaborations.
- Collaborate with IHS to develop telehealth and other initiatives that leverage the capabilities of information technology platforms.
- Avoid duplication of services by understanding the current landscape of health IT services before more are implemented or rolled out.
- Seek to better understand the human element of information technology; IT functions need to be taught and learned.
- Pursue interoperability between the EMR systems of the VA, DOD, and the private sector.
- Avoid the mistake of addressing the needs of rural Veterans as though they are uniform (i.e., older and younger Veterans utilize different services); consider whether it is necessary to sub-divide rural and highly rural veterans into more specific groupings and whether such groupings require attention with different priorities.

Veterans Rural Health Resource Center (VRHRC) Overview, Project Presentations, and Discussion

Kara Hawthorne provided an overview of VRHRCs to the Committee. Each VRHRC gave a presentation of their focus areas, current projects, and potential areas for collaboration.

- Four primary functions of VRHRCs: conduct policy oriented studies and analyses; function as field-based clinical laboratories for policy relevant pilot projects and concomitant evaluations; serve as regional rural; health experts organizing and sharing information within and across

VISN boundaries; and serve as an educational repository and academic and clinical information clearing house.
- VRHRCs engage with VA medical centers (VAMC) in the region; build relationships and engage VISNs; and develop proposals for collaboration with other agencies, departments, and organizations.
- VRHRCs use the VA-defined rural definitions, which are based on definitions from the U.S. Census Bureau. VRHRCs have been working to develop a crosswalk between geocoded VA data and ZIP codes, so that research can be better disseminated and understood.

Central Region

Alana Knudson, Former Deputy Director

- Key partners include four VAMCs (Iowa City, Minneapolis, Fargo, and Omaha), the University of North Dakota – Center for Rural Health, University of Nebraska – RUPRI Center for Rural Health Policy Analysis, and University of Minnesota – Rural Health Research Center.
    - Because the original application was submitted by VISN 23, partners are clustered in the northern end of the VISN. Central Region is in the process of expanding partners, which is a central component of Year 2 plans.
    - Future projects and goals will focus on regional differences within the VISN.
    - Potential to partner with state Veteran offices, the second largest deliverer of health care services to Veterans.
- Project Portfolio
    - Pilot project on innovative care delivery.
    - Focus on access with a project on the Patient-centered medical home.
    - Dual-utilization is a key topic for all projects, particularly for older Veterans.
- Final products include how-to manuals (i.e., how to develop a telehealth project; reports, issue briefs, fact sheets, and journal articles), presentations at national VA and non-VA conferences, such as the NRHA meeting, and dissemination efforts.
    - Center for Rural Health hosts the Rural Assistance Center (RAC), an information portal for rural health and rural services, funded by the Office of Rural Health Policy.
    - Engagement with VISN rural health consultants, who share expertise with Resource Centers and broadly within the VISN, region, and collaborations with Western and Eastern Regions.
    - Expertise in data management, data collection tools, capacity for program evaluation and policy evaluation—how does policy impact care and delivery of a program?

Eastern Region

Ryan Lilly, Acting Director

- Key partners include two VAMCs (Togus and White River Junction), North Florida/South Georgia Veterans Health System, Upstate New York Healthcare System, Dartmouth Medical School, University of Southern Maine Muskie School of Government.
- Project Portfolio
    - Has evolved from an initial focus on research to incorporate demonstration projects and pilot projects.
    - Focus areas include access, innovative care delivery, quality, and education and information repository.

  - A recommendation to look to Vet Centers as potential partners for the mobile clinics; such a partnership may assist in identifying actual vehicles to be used for the mobile clinics.
  - Challenges and lessons learned have primarily revolved around logistics and staff and recruitment. Specifically, the mobile clinics project has seen issues with deployment, functionality of buses/vans, and interfaces with the local community,
- Final Products include policy reports, issue briefs, and journal articles, phone based telehealth intervention, program evaluation toolkits, web access to rural health literature. Dissemination Strategies used by the Eastern region include internal report to ORH, utilization and leverage of current dissemination partners, and presentations to VA and non-VA medical providers, administrators and other stake holders.

Western Region
Byron Bair, Director

- Key partners include two VAMCs (Salt Lake City and Eastern Colorado VA Health Care System), University of Utah, and Brigham Young University. These community partnerships must be strengthened to better understand the landscape of Veteran health in rural areas.
- Project Portfolio
  - A key goal is baseline communities that face challenges in obtaining access and care as a paradigm for providing health care services to other populations. This involves looking at the individual Veteran, and determining his/her perspective on care desired. Projects revolve around determining what is unknown about Veterans, as well as projects based on what is already known.
  - Developing a scholarly approach for physicians to determine the needs of Veterans in rural areas.
  - Areas of focus include:
    - Technology—technology is a tool, not an intervention. It is important in terms of reach individuals with difficult access to health services.
    - Access—need to discover the perceived needs of Veterans, and gain an understanding of what makes rural Veterans rural, i.e. determining the dimensionality of rurality.
  - Collaboration—cornerstone for building the other areas of focus. Particular concern in this region with Native Americans, Alaska, and the insular islands.
- Final Products include program manuals to disseminate lessons learned on the collaborative process, networking maps between VA and community partners, and an interactive Web site for interested customers. Dissemination Strategies include Web-based sharing (e.g., Web sites, webinars), utilizing and leveraging community partners, targeting specific conference presentations, journal publication, and VISN and facility-level strategic planning groups.

The Alaska Federal Health Care Partnership: An Example of VA Collaboration with Community Partners

Mr. Alex Spector, Director of the Alaska VA Health Care System, presented an overview of the Alaska Federal Health Care Partnership. The partnership is voluntary and shares talents, resources, and experiences in order to improve patient care throughout the state of Alaska.

- The partnership was developed on a need basis and is not externally funded.
- Costs of running the partnership are low; resources are pulled in from other agencies as needed.
- The partnership has resulted in financial gain for those involved, as well as improvement of services, continuity of care, and quality of services provided.
- The underlying philosophy of the partnership includes: long term relationships; health care as close to home as possible; respect individual cultures; business/patient centered; evolving process; and inclusive but not exclusive.
- In summary: relationships are everything, communication is a major key to success, and success also relies on the need/want within the community.

Advisory Committee discussion of the presentation centered on the administrative costs of running the partnership, and the improvement of services and quality of care due to the partnership. The Committee commended the Partnership's philosophy and the principles that guide the relationships that are formed. These philosophies will be kept in mind as the Committee develops recommendations for the Secretary.

Presentation: The Indian Health Service and Rural Veterans

Mr. Don Davis, Director of the Phoenix Area Indian Health Service (IHS), presented an overview of the Indian Health System. IHS provides a comprehensive health service delivery system for approximately 1.9 million of 3.3 million American Indians and Alaska Natives.

Highlights of the presentation included:

- There are 161 service units in 12 areas, located in 35 states throughout the U.S. IHS facilities are federally operated or overseen by tribes, who have the option of purchasing and operating them independently.
- IHS facilities include hospitals, health centers, Alaska Village Clinics, and health stations.
    - Health centers provide tertiary services, health stations provide basic care, and hospitals provide acute and patient care.
- All IHS hospitals are accredited by The Joint Commission or certified by CMS.
- Historic barriers to collaboration.
    - One of the keys to collaborating between VA and IHS may be reaching out to those who receive care, and discussing benefits of VA services and needs. Cultural sensitivity is necessary for reaching out to tribes.

The Future of VA Collaboration with Community Partners: Framing the Issue

Dr. Richard Hartman discussed collaboration between the VA and community partners. He provided a high-level overview of the development of ORH's focus areas, and the specific emphasis on collaborations, highlighting the fact that rural Veterans face different challenges than urban Veterans with health-related issues, such as, technology use; distribution of pharmaceutical providers; collaborations dealing with partners other than just facilities or providers; recruitment and retention of providers in rural areas.

He also made the group aware of P.L. 110-387, Section 403 which mandated VA provide contracted care across several VISNs in a national pilot project. This legislation encourages the VA to explore the contracting process with more non-VA providers, both Federal and non-Federal, to provide care access to rural Veterans

The Future of VA Collaboration with Community Partners: Discussion

Chairperson James Ahrens and Cynthia Barrigan moderated a discussion that framed the issue of VA community collaboration. The VA engages in a number of collaborative partnerships with Federal and non-Federal partners. The Working Group would like to focus on the following questions:

- What lessons have been learned from these collaborative efforts?
- What additional opportunities are there to expand collaborative relationships to improve access and quality of care for rural Veterans?
- What are the barriers and concerns—structural, cultural, and otherwise—to successful VA collaboration with community partners? How can those barriers be overcome?
- What are the critical success factors for creating, sustaining, and growing collaborative partnerships?
- What are the best means to share knowledge about lessons learned and best practices on collaborative strategies?
- What are this Committee's recommendations for maximizing the potential of existing rural health infrastructure and capacity to better serve rural Veterans?

The Advisory Committee continued a discussion regarding future steps and potential focus areas:

- A statement should be made recognizing that all Veterans do not have the same needs. For example, some Veterans have multiple sources of care. The signature wounds also differ depending on the Veteran subgroup which affects the different healthcare services required for care including chronic disease, pain, mental health issues—PTSD and depression, and substance abuse.
- There are four potential areas for collaboration:
    - Provision of primary care services;
    - Training non-VA physicians to address needs of Veterans and recognize issues relevant for Veteran health care;
    - Quality of care, and developing protocols for non-VA partners to follow that may help ensure continuity of care;
    - Coordinated follow-up care in the home.
- Regional differences in health care for Veterans.
- Educational programs for physicians.
- Specific barriers that are faced in rural areas include:
    - Economies of scale and contracting to provide care and form collaborative relationships.
    - Veteran culture and acknowledgement that Veterans have a different value set for health care.
    - EMR adoption and use of VistA among contractors and/or collaborators.
    - VA standards of care and reporting systems and a willingness and/or ability of contractors to meet standards.

    - Developing long-lasting relationships to support Veteran culture and community.
- Understanding that Veterans' health is a community issue with multiple stakeholders. What are the ways to drive this at both the national and local level? The projects of the VRHRCs will be able to provide data and aid this understanding for the Committee and VA.

The VRHAC will develop a framework in the form of an outline or white paper for the Secretary that will detail plans for collaboration and recommendations for ORH focus areas.

VRHAC members confirmed their availability to have the next meeting September 2-3, 2009, in Washington, DC. In the interim, email and teleconference will be used to communicate and develop a working draft of the deliverable for the Secretary.

At the conclusion of the meeting, a video created by the Utah Department of Veterans Affairs was shown. The video was produced for law enforcement and focused on Veterans' mental health and suicide crisis interventions.

The meeting adjourned at 5:15 p.m.

March 4, 2009
Day 2 of the VRHAC opened at 7:30 a.m.

Site Visit: Phoenix VA Health Care System (Closed to the Public)

In a closed portion of the VRHAC meeting, Committee members participated in a site visit to the Phoenix VA Health Care System (PVAHCS). Dr. James Robbins, Interim Director of the PVAHCS, welcomed the group and delivered an overview of the PVAHCS. A presentation from Mr. Rick Bard, Chief of Health Administration Service and American Indian Service Coordinator of PVAHCS was given and focused on the Native American culture, providing VHA services to Native Americans on reservations, and other important considerations for Native American rural Veterans. He emphasized the need to develop a greater cultural understanding of Native Americans in order to provide care on reservations and open the potential for partnerships with IHS. In addition, Dr. Mervin Myrvik gave a visual demonstration of the functionalities of VistA and CPRS (Computerized Patient Record System), the electronic health record used by VHA. Committee members were interested in the IT functionalities of the system, particularly its interoperability with other EMRs and tracking compliance for the patient.

VRHAC Discussion and Wrap-Up

The meeting was reopened to the public. VRHAC members reconvened to wrap-up the meeting and develop a plan for moving forward with recommendations. The following topics were discussed.

- The EMR system used by VHA is a powerful tool that can be used to encourage collaborations with non-Federal partners.
- The ORH is open to the ideas of Committee members, and will consider all recommendations put forward by the Advisory Committee.

In the following weeks, committee members will consider ideas for ORH's development and strategies to overcome the barriers faced by Veterans in rural communities, develop a working report through email communication, convene via teleconference after a working report is developed, meet again in-person next September, and continue revising and vetting the recommendations to the Secretary as needed.

Public Comment
Public comment was presented to the Committee from Alison Hughes, *Director, Arizona Rural Hospital Flexibility Program and Former Director of the Arizona Rural Health Office.*


Public Comments.doc

The meeting adjourned at approximately 11:15 a.m.

Respectfully submitted,

_____
Kara Hawthorne
Designated Federal Officer
Veterans Rural Health Advisory Committee

I hereby certify that, to the best of my knowledge, the foregoing minutes from the March 3 – 4, 2009, meeting of the Veterans Rural Health Advisory Committee are true and correct.

_____
James Ahrens
Chairperson
Veterans Rural Health Advisory Committee

These minutes will be formally considered by the Committee at its next meeting, and any corrections or notations will be incorporated in the minutes of that meeting.