Veterans Rural Health Advisory Committee Meeting Department of Veterans Affairs
Meeting Summary

Session Objectives:	▪ VRHAC will gain increased understanding of key program office activities. ▪ VRHAC will visit local rural Veteran health care facilities and services. ▪ VRHAC will discuss 2017 goals.
Date & Time:	Tuesday, June 27, 2017, from 8:50 AM to 5:00 PM
Location:	Ioannis A. Lougaris VA Medical Center 975 Kirman Avenue; Tahoe Room – 5th floor Reno, NV 89502
Attendees:	Chair: Margaret Puccinelli Designated Federal Officer: Thomas Klobucar Members: Graham Adams, Angeline Bushy, Dale Gibbs, Francisco Ivarra, Kevin Kelley, Michael McLaughlin, John Mengenhausen, Brenda Moore, Buck Richardson, Ex officio members: Michael Bouchard, Ben Smith Ex officio representatives: Wilbur Woodis Office of Rural Health: Judy Bowie, Meghan Ochal, Emily Oehler Speakers: Listed below with presentation summary
Note Takers:	Meghan Ochal

Part 1: Traditional Blessing

8:50 – 9:00 am

- Speaker: Jason Hill, Prevention Outreach Coordinator, Reno-Sparks Indian
- Colony – Tribal Health Center

Jason Hill, Prevention Outreach Coordinator, Reno-Sparks Indian Colony – Tribal Health Center

- Ms.Cheryl Johnson provided a traditional Native American blessing to start the meeting.

Part 2: Welcome, Introductions and Meeting Overview

9:00 – 9:20 am

- Speaker: Margaret Puccinelli, Chair, Veterans Rural Health Advisory Committee (VRHAC)

Margaret Puccinelli, Chair, VRHAC

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Ms. Puccinelli welcomed the Committee and reviewed highlights from the last Committee meeting. She encouraged Committee members to use and share their personal experiences to inform the work of the Committee but to focus on national issues and solutions.

- Ms. Puccinelli confirmed that notes and follow-up files from this meeting will be shared with all the Committee members.
- Ms. Puccinelli thanked the local VA staff who planned the Committee's visit.

Q&A/Group Discussion

- All members and attendees introduced themselves and described the rural Veteran health care experience they brought to the Committee, such as working for local, state and federal organizations and agencies that serve Veterans; directly providing rural health care, and working in education/academia.
- The group reviewed the agenda for the next three days.
- The group agreed to standing ground rules, including:
    - Using local experience to inform national thinking/decisions
    - Being engaged and present throughout the meeting

Highlights/Key Takeaways/Themes:

- The Committee members' wide variety of experiences contribute to their ability to address rural Veterans' access to care issues.

Part 3: Presentation: Emergency Response Procedures

9:20 – 9:30 am

- Speaker: Brian Passow, Emergency Management Specialist, Ioannis A. Lougaris VA Medical Center

Brian Passow, Emergency Management Specialist, Ioannis A. Lougaris VA Medical Center

- Mr. Passow discussed the emergency management/response activities at the
- Sierra Nevada Health Care System (SNHCS), including the SNHCS' participation in local/regional emergency response coalitions.
- The SNHCS Director has authority to support emergency response in the community, not just for VA and Veterans.
- Mr. Passow described the Dual Use Vehicle (DUV) Program intended for patient/evacuee transport and the vehicles' capacity. The DUV can:
    - Support community needs as well as provide transport for evacuation.
    - Regularly transport Veterans to appointments, recreational therapy, etc. during non-emergency periods.
- Mr. Passow explained the SNHCS' use of Western Shelters Systems, which has the capacity to handle the entire acute care census in three inflatable shelters and two hard frame shelters. The shelters deploy quickly and have their own heating, ventilation and air conditioning (HVAC) and sanitary functions.
- The SNHCS hosted the 6th Annual Rural and Ready Conference last month in collaboration with state and local agencies and groups.
- The SNHCS conducts outreach to Veterans and the larger community so all are aware of these resources in case of emergencies.

Q&A/Group Discussion

- The Committee discussed whether the vehicles/shelters could be used for longer terms (up to 90 days).
- The Committee inquired about staff support. Mr. Passow noted that SNHCS
    - personnel set up the units but are not dedicated to staff them; however, they can deploy as needed. Alternately, the local facility that is using the equipment may staff units. The Continuity of Operations (CoOP) system provides personnel coordination capabilities. Mr. Passow also noted that DUVs transporting patients require two drivers and at least one patient care provider on board.

- The Committee inquired as to how often assets deploy. Mr. Passow responded that they participate frequently in required state and local exercises (at least three functional and one full scale exercises a year as part of The Joint Commission's Accreditation, Health Care Certification process) to ensure interoperability across state and county resources.
- The Committee inquired about reporting on capacity to the state; Mr. Passow highlighted a state-managed reporting program.
- Mr. Passow noted he conducts annual training with partners and DUV driver certification courses.
- The Committee inquired about the cost of the DUVs. Mr. Passow noted the average cost of a DUV is $210,000 with a lifespan of 16-20 years.
- The Committee inquired about decision-making process during emergencies and the order of succession for leadership decisions in the SNHCS. Mr. Passow referenced set policies.

Highlights/Key Takeaways/Themes:

- The SNHCS' emergency response system and equipment is well situated to support rural Veterans and the larger rural community.

Part 4: Presentation: Advisory Committee Management Office

9:30 – 10:15 am

- Speaker: LaTonya Smalls, Program Specialist, Advisory Committee Management Office

LaTonya Smalls, Program Specialist, Advisory Committee Management Office

- Dr. Smalls, on behalf of Secretary Shulkin and the ACMO Director, welcomed the Committee.
- Dr. Smalls discussed the Secretary's Top Five priorities, which are:
    - Greater choice for Veterans, including reauthorization of Veterans Access, Choice and Accountability Act of 2014 to ensure continued community care.
    - Modernizing VA, which entails developing better integration and a market-focused approach based on the specific Veteran population, needs and capacity in VA and a community. Pilots will inform VA's
    - approach to change national infrastructure.
    - Focus resources, including integrating foundational services and partnerships that support the health and well-being of Veterans and promoting operational efficiencies.
    - Improving timeliness, specifically by delivering high-quality and timely care.
    - Suicide prevention. Given that an average of 20 Veterans die by suicide each day and only 6 of those 20 received VA health care in the current/previous year, this is a critical focus area, and VA is working to reduce Veteran suicide to zero.
- Dr. Smalls provided the following updates on the VA Secretary's additional advisory committees:
    - VA has 27 advisory committees, all of which are a key component of VA strategies to engage stakeholders/public to better serve Veterans and families.
    - VA increased advisory committees from 27 to 29 this year, adding the discretionary Veterans Family, Caregiver and Survivor Committee and the statutory West Los Angeles Veterans and Community Oversight and Engagement Board.
    - In the next few months, two new committees will be formed: the Combat Fraud, Waste and Abuse Committee and the Creating Options for Veterans Expedited Recovery Commission.
    - Secretary McDonald hosted an advisory committee chairperson meeting during his

tenure; ACMO is planning a similar meeting in the fall with chairpersons and Designated Federal Officers.
    - Dr. Smalls stressed the importance of cross-committee collaboration to generate more robust cross-committee recommendations.

Q&A/Group Discussion

- The Committee agreed that timeliness/wait times are a critical area for rural Veterans and noted that the topic has been brought up to all Secretaries but significant progress is still needed.
- The Committee agreed that rural health improvement requires the support of other VA committees and offices, especially the Office of Community Care, and that it will be important for VRHAC to coordinate with VA committees focused on community care.
- The Committee inquired if 20 Veterans a day dying from suicide includes active duty military. It was confirmed that this figure only includes Veterans, and that DoD separately monitors/addresses active duty suicide and collaborates with VA to address suicide overall.
- The Committee noted that one of the Department of Health and Human
- Services (HHS) priorities is addressing the opioid crisis and asked where this falls within the Secretary's five priorities. Dr. Smalls offered to research this.
- The Committee discussed how potential cuts to HHS and other health care programs could impact Veterans and asked if there has been any analysis, especially related to impact on rural Veterans. Dr. Klobucar noted that the Assistant Deputy Under Secretary for Health for Policy and Planning is analyzing how changes to health care generally will impact Veterans/VA but acknowledged that proposals/legislation are constantly changing and it is a moving target.
- The Committee asked what Veteran Service Organizations can do to demonstrate impact of new health care laws on rural Veterans.

Highlights/Key Takeaways/Themes:

- The Secretary's five priorities support improved care for rural Veterans.
- The Committee will review how to increase collaboration with other VA advisory committees.
- The Committee will consider how their recommendations align with the Secretary's priorities.

Part 5: VISN 21 Sierra Nevada Health Care System

10:30 – 11:15 am

- Speaker: Lisa Howard, Director, VISN 21 Sierra Nevada Health Care System

Lisa Howard, Director, VISN 21 Sierra Nevada Health Care System (SNHCS)

- Ms. Howard provided an overview of the SNHCS' service area and facilities. In addition to the VAMC, the SNHCS has five Community Based Outpatient Clinics (CBOC). Given the growth in the overall area's population and in local Veterans, the SNHCS opened a new CBOC a few years ago and is opening a new clinic in north Reno next year. Projected continued growth of the area's Veteran population means the SNHCS is actively planning for additional facility capacity in the near future.
- Ms. Howard reviewed the SNHCS' clinical care areas; the SNHCS provides 1C level facility services but relies on the community or other VA facilities for neurosurgery and cardiac surgery.
- Ms. Howard discussed workforce and recruitment issues. The SNHCS has 1,500 employees, one-third of which are Veterans. The SNHCS is working on expanding its graduate medical

education (GME) program with the University of Nevada-Reno (UNR) to take advantage of available Veterans Access, Choice and Accountability Act (VACAA) funds. The GME expansion is focused on rural health and the SNHCS will be a critical part of the GME training because UNR does not have own hospital. The HCS also has robust nurse, social work and pharmacy training programs. There is constant recruitment for vacancies.

- Ms. Howard highlighted the low average wait time for appointments in the SNHCS; the medical center was one of the first facilities to offer same day access last year.
- Ms. Howard demonstrated data showing the steady growth in Veterans treated over the last few years and noted that patients/encounters will continue to grow given Reno's overall growth in local businesses, housing, etc. While the medical center has been able to accommodate Veterans' needs, they anticipate the demand and pace will increase.
- Additional information on the Veteran population provided by Ms. Howard included:
    - The percent insured rate of enrolled Veterans has not changed; most Veterans seem to want to receive care at VA.
    - Average age of patient is 47-48, which has been decreasing due to deaths and younger Veterans enrolling.
    - Approximately half of enrollees are rural.
- Ms. Howard provided an overview of ORH funding at the SNHCS and noted that there has been a 19 percent increase in unique patients utilizing telehealth services between 2015 and 2016.

Q&A/Group Discussion:

- The Committee asked which era of Veterans is contributing to the growth, and Ms. Howard clarified it is the younger generation of Veterans who served in Iraq and Afghanistan. Ms. Howard noted that even if Veterans have private health insurance (e.g., through jobs at Tesla plant) the SNHCS' percent insured has not changed.
- Ms. Howard and the Committee discussed how the SNHCS is focusing on more enrollment of native Veterans. The SNHCS currently has 430 American Indian/Alaska Native (AI/AN) enrolled Veterans, has an MOU with a local tribal facility and has a unique partnership with the Reno-Sparks Indian Colony – Tribal Health Center. The Committee recommended increasing Tribal Veterans Representative (TVR) education/training to get more AI/AN Veterans enrolled.
- Ms. Howard noted that the SNHCS is aiming to hire navigators for outreach to special populations within the next year.
- The Committee inquired about provider recruitment and retention in very rural areas. Ms. Howard noted that the SNHCS has a number or programs focused on employee satisfaction, such as:
    - VOICES program adapted from Alaska VA Health Care System, a two- day experience that focuses on relationships and connections to build employee commitment.
    - 6 of 17 innovation projects focused on improving employee satisfaction.
    - SNHCS clinical leaders' personal and direct involvement and developing strong relationships with potential applicants early on in recruitment process.
    - Supporting residents during rural health rotations.
    - Employing telemedicine in very remote areas.
- The group discussed barriers to recruitment and retention, including that time from application to hire ranges anywhere from 45-60 days to an even longer time for difficult to recruit positions, and that there are key salary differences in rural areas. The SNHCS has been able to grant exceptions based on cost of living (per VA approval).

- The Committee requested the ethnic/racial/gender breakdown of patients/enrollees as well as employees. Ms. Howard will provide this data.
- The Committee asked about limits to telehealth, especially in very remote areas.
- Ms. Howard noted that major challenges in telehealth/health information exchange (HIE) include connecting to community care/Veterans Choice
- Program providers, information security across agencies limiting the ability to expand telehealth to non-VA facilities, and licensing across states at community facilities (pending VA legislation to address this; some local/state models have come up with solutions). Ms. Howard noted that most mental health providers are within the SNHCS and see patients at CBOCs directly or via telehealth. The SNHCS is currently recruiting for two mental health positions.
- The Committee asked about growth in female Veterans. The SNHCS has seen slow growth in younger women and is trying to better support women Veterans (e.g., hosting baby showers quarterly with 17-18 current pregnancies). The new Women's Health Coordinator is implementing new initiatives.
- Upon request, Ms. Howard further explained VA wait time measures/indicators
- (based on clinical or patient preference).
- The Committee inquired how highly rural Veterans access care. Ms. Howard noted that patients cross different catchment areas depending on geography, regardless of parent facility. The SNHCS leverages the Veteran transportation network and Veteran Service Organization support to get Veterans to appointments. The SNHCS partners with the nonprofit Guest House to provide housing for patients that need to travel far distances to the medical center.
- The group discussed outreach activities and how the SNHCS identifies whether a Veteran is eligible for VA services. The SNHCS encourages anyone who served to apply for health care benefits and employs eligibility workers to help the Veterans navigate the benefits process. Even if a Veteran is not eligible for health care, it is helpful to have the Veteran's information in case the SNHCS has the ability to offer care in the future.
- The Committee discussed how VA interacts with other insurance providers. Ms. Howard clarified VA does not bill Medicare but can bill third parties (including Tricare) for non-service-connected care.
- The group discussed how care coordination is a critical area for VA. Ms. Howard noted that the SNHCS has a Women Veterans Coordinator and Minority Veterans Coordinator, and is looking to expand navigators and enhance Patient Aligned Care Teams (PACT) by adding social workers. The SNHCS also is starting a new program with a nurse/pharmacist to support triaging of tertiary care patients back to PACT.
- The group discussed hospice/palliative care options. The SNHCS spent the last few years building up outpatient and inpatient/Community Living Center programs; other VA medical centers are copying the program to honor Veterans when they pass away.
- The SNHCS accommodates requests for traditional healing and religious ceremonies.

Highlights/Key Takeaways/Themes:

- The SNHCS provides a wide variety of services to a growing population of Veterans, with a focus on rural counties.
- To respond to growing demand for services, recruitment and retention of workforce and care coordination are critical focus areas for the SNHCS, especially in its rural areas, now and in the future.

Part 6: Presentation: Nevada Department of Veterans Services

11:15 am – 12:00 pm

- Speaker: Katherine Miller, Director, Nevada Department of Veterans Services

Katherine Miller, Director, Nevada Department of Veterans Services

- Mr. Cesar Melgarejo explained his role as a coordinator of Veterans issues between the Governor's office, State Veterans Services Office, National Guard and VA.
- He provided an overview of challenges in Nevada: finding/communicating with rural Veterans, transient populations due to industry/tourism, connecting to services, educating service providers and collaboration challenges.
- Mr. Melgarejo described how many programs the Veteran license plate options fund.
- Mr. Melgarejo described key rural Veteran programs, including the Telehealth and
- Veteran Experience Office, Rural Transportation Grants, Improving Virtual Connection, Community Clergy, and advocate/outreach programs. He noted the state is working to improve information systems and social media on NvVetNet and generally expanding broadband/wireless/IT options in rural areas. They are also sharing data with the Department of Defense and VA and integrating a state Veterans information system (going live at the end of the year).
- Mr. Melgarejo highlighted several other Veteran-serving programs:
    - Nevada Veterans Advocate Program – through 28 classes they have 238 certified (43 rural) advocates and 564 in training. Advocates are paired with Veteran Service Organizations, partners with casinos, etc.
    - The ROVER program – an outreach program which travels to rural areas to disseminate information using local video teleconferencing (through community college network).
    - Veterans in Care (almost a year old) – 400 thanking ceremonies in care facilities and for homebound Veterans; trains medical staff on military culture.

Q&A/Group Discussion:

- The Committee inquired how the state connects to Veterans:
    - Mr. Melgarejo noted that Nevada has the option for Veterans to note their status as a Veteran on their driver's license and whether they want to be contacted by state offices regarding benefits. Nevada is able to use that data to direct outreach.
    - All state departments that gather any Veteran data forward it to the Nevada Department of Veterans Services.
    - Nevada is attempting a more data-driven approach to outreach.
    - The group discussed how other states collect data from licenses and how this is a great method for targeting Veterans, especially those who are not enrolled for VA care.
- The Committee inquired about homeless Veterans initiatives:
    - Mr. Melgarejo responded that Reno and Sparks have highly transient populations and the Governor's interagency council on homelessness works with the Veterans office and directly with cities/counties to address homelessness.
    - In addition, the state provides grants to local Veterans organizations to address homelessness.
- Mr. Melgarejo noted there are 25 Veteran Service Organizations throughout Nevada
- In response to a question about the number of state Veterans' homes in Nevada,
- Mr. Malgarejo responded one currently exists, and the state is breaking ground next month on an additional home with 194 beds.

- The ORH Acting Executive Director highlighted the similarity of state grants to the VA's Highly Rural Transportation Grants to counties and tribal entities.

Highlights/Key Takeaways/Themes:

- The state of Nevada has a collaborative approach to serving the growing population of Veterans, and has multiple programs that target rural Veterans.

Part 7: Presentation: Suicide Prevention

1:00 – 1:45 pm

- Speaker: Marlyn Scholl, Suicide Behavior Specialist, Ioannis A. Lougaris VA
- Medical Center

Marlyn Scholl, Suicide Behavior Specialist, Ioannis A. Lougaris VA Medical Center

- Ms. Scholl recounted an example of a Veteran she worked with who illustrated the highest risk profile (not enrolled in VA care and did not think he was eligible, had legal issues, tenuous income, etc.).
- Ms. Scholl provided key statistics on Veteran suicide and highlighted the overrepresentation of Veterans in overall suicides:
    - Twenty Veterans take their life each day - six of which receive VA Health Care
    - Veterans are 8.5 percent of the population, but 18 percent of all suicides are Veterans
    - Firearms account for 67 percent of all Veteran's suicides
- Ms. Scholl provided the Veteran Crisis Line (VCL) background and statistics and explained the organization of the suicide prevention coordinator/team at VA Medical Centers.
- The suicide prevention team offers an enhanced care package to prevent Veterans from falling through cracks, such as regular follow up, ensuring they get to appointments and helping guide treatment options.
- To provide suicide prevention support and information to unenrolled Veterans, the team attends Veterans events and targets high risk groups (American Indian; lesbian, gay, bisexual, transgender; etc.) through outreach.
- The team conducts behavioral autopsies (including a thorough review of clinical records, family outreach, etc.) after a suicide to learn how to improve services locally and nationally. The autopsy findings resulted in the REACH VET program – a predictive statistical model to identify and reach out to highest risk Veterans which analyzes more than 380 variables from physical and mental health, life events and economics.
- The team coordinates multiple family and non-enrollee activities. For example, Change the Conversation trains family and friends to recognize symptoms, start conversations and help refer Veterans.
- Ms. Scholl explained the recent VA policy change to provide mental health services to Veterans with Less Than Honorable Discharge. VA can provide services for 90 days to stabilize the Veteran and up to 90 additional days if needed.
- Ms. Scholl discussed Nevada's suicide rate and noted the Veteran suicide rate is much higher than non-Veterans in Nevada: 50 percent of 25-34 year old Nevada Veterans died from suicide from 2010-2014. However, data may be underreported given the stigma of suicide, especially in rural areas, and the ease of overlooking a Veteran status notation on death certificates.
- Ms. Scholl presented information on Nevada's geography, history and the rural Nevada Veteran profile.
- Ms. Scholl discussed Thomas Joiner's research on suicide prevention (three elements leading to suicide: ideation + sense of burdensomeness + capacity) and how rural Veterans

are more likely to experience these elements that contribute to higher rates of suicide. Ms. Scholl noted that if these three elements exist, access to lethal objects or substances also increases risk; Ms. Scholl noted that firearm ownership is greater in rural areas.

- Nevada has steadily dropped in state rankings of suicide – contributed to by the Nevada Crisis Call Center (since 1966), strong community partnerships (state office, state coalitions and small groups in rural areas), suicide support groups, training and advocacy. The Nevada Office of Suicide Prevention supports an interdisciplinary team reviewing suicides.
- Ms. Scholl revisited the original example of the Veteran she served and noted how they were able to enroll the Veteran in VHA care, including connecting him to a mental health provider and a rehabilitation program. He has been 130 days sober for alcohol abuse, received a reduced sentence for driving under the influence and is in regular contact with VA staff.

Q&A/Group Discussion:

- The group discussed how national and VA data analysis includes demographic factors like gender, race, ethnicity, etc.
- The group inquired about and Ms. Scholl explained the free gun lock distribution program, which was a result of behavioral autopsy data analysis.
- The Committee asked how sexual assault, including Military Sexual Trauma (MST), affects suicide and discussed how every VA medical center has an MST coordinator. Statistically, MST does not play a large role in deaths by suicide although MST does increase the chronic risk for suicide. The group discussed issues with coordinating MST support between the U.S. Department of Defense (DoD) and VA. It was noted that the recent VA decision to start using the same electronic health record system as DoD should facilitate sharing data on military mental health issues.
- The group discussed how to address the root causes of suicide (e.g., able to financially support oneself) and the need for more than mental health support.
- The group highlighted the recent improvement of having VA medical centers automatically route Veterans to the Veteran Crisis Line versus telling callers to hang up and call a new number.
- The Committee asked if there is collaboration between the Veterans Benefits Administration (VBA) and the Veterans Health Administration on Veterans at risk for suicide. Ms. Scholl noted they train VBA staff on making referrals and ensure the VBA staff know the suicide prevention team. Ms. Scholl also noted there will be additional momentum given the policy allowing less than honorably discharged Veterans to receive care.

Highlights/Key Takeaways/Themes:

- VA has made progress in addressing Veteran suicide but much work remains to be done.
- Rural Veterans have unique factors that may increase the risk of suicide.

Part 8: Successful VA and Community Care Coordination

1:45 – 2:30 pm

- Speaker: Robin Silvaroli, Chief, Non-VA Care Program, Ioannis A. Lougaris VA Medical Center

Robin Silvaroli, Chief, Non-VA Care Program, Ioannis A. Lougaris VA Medical Center

- Ms. Silvaroli provided an overview of the evolution of community care and the Veterans Program. She noted that the April 2017 legislative extension of the Veterans Choice Program made VA the primary coordinator of benefits.

- Ms. Silvaroli provided the Reno VA medical center's Veterans Choice Program data highlights, including nearly 8,400 episodes of care to date in fiscal year 2017.
- Ms. Silvaroli explained how VA is transitioning to a more coordinated model of patient care by encouraging VA nurses to communicate directly with community providers rather than via a third party.

Q&A/Group Discussion:

- The Committee discussed barriers for community providers to participate in the Veterans Choice Program (e.g., time required to sign up, credentialing, etc.).
- Ms. Silvaroli noted the VA medical center meets regularly with the Nevada Hospital Association and provides technical assistance/education to members.
- The group discussed the current and future coordination nurse caseload issues, which may vary by facility, but noted in-progress pilots should inform how to avoid/address issues. Ms. Silvaroli noted 18 facilities are currently generating positive results from pilot programs. Access to data and using the Patient Care Alignment Team model help facilitate coordination. The group emphasized the importance of having a sophisticated care coordination training/model/staff, and the criticality of involving nurses with care coordination backgrounds.

Highlights/Key Takeaways/Themes:

- Community care continues to evolve with updates to the Veterans Choice Program.
- Community care requires care coordination between providers.
- Provider shortages exist with both rural VA and community provider facilities.

Part 9: Presentation: Rural Enterprise-Wide Initiative – Increasing Access to Clinical Pharmacy Specialist Providers for Rural Veterans

2:45 – 3:30 pm

- Speakers: Scott Mambourg, Associate Chief Pharmacy Services, Ioannis A. Lougaris VA Medical Center; Beth Foster, Chief of Pharmacy Service, Ioannis A. Lougaris VA Medical Center

Scott Mambourg, Associate Chief Pharmacy Services, Ioannis A. Lougaris VA Medical Center

- With 25 years in VA, Dr. Mambourg thanked ORH for the opportunity to implement the Enterprise-Wide Initiative (EWI), which is a huge opportunity for
- clinical pharmacies nationwide.
- Dr. Mambourg explained the national variation in pharmacists who have advanced practice scope (ability to prescribe, highly qualified) known as Clinical Pharmacy
- Specialists (CPS) and noted trends in VA showing increases in CPS staff and encounters.
- Reno has a high number (85 percent) of CPS and 10 residents currently, which is the largest class to date. Reno recently finished hiring the last of five full time employees as part of the EWI.
- The Pharmacy Team is currently establishing appropriate clinic/stop codes to maximize workload capture of CPS, who spend at least 75 percent of their time in
- direct patient care, and to demonstrate clinical outcomes.
- To fulfill the EWI goal of serving rural patients, the EWI employs rural patient
- prioritization through clinical care agreements, dashboards to identify actionable patients and added filters to identify rurality.
- Patient referral methods include provider/specialist, self, population based management, and CPS to CPS referrals.

- The EWI is funding three areas: Patient Aligned Care Team, mental health and pain – each with corresponding VISN metrics and a VISN level task force.
- Dr. Mambourg demonstrated the process for audits and dashboard sampling (external peer review), the interactive dashboard that allows drilldown/direct
- patient outreach and lead/lag measures. This reporting and transparency help the CPS to focus on areas of expertise and fulfill the goal of ORH funding.
- Dr. Mambourg also highlighted the Reno VA medical center CPS residency program (supported through the VA Office of Academic Affiliations) and the residents' year-long projects.

Q&A/Group Discussion:

- The Committee asked about the day to day responsibilities/role of CPS. Dr. Mambourg clarified CPS responsibilities include conducting rounds with providers for inpatient care and participating in scheduled patient appointments (including via telephone, face-to-face, or other modes based on patient needs) for outpatient care. Clinical pharmacy specialists also perform some administrative work (education, medication review, etc.).
- Dr. Mambourg clarified that clinical pharmacists (not advanced scope/CPS) typically conduct dispensing in outpatient settings.
- He discussed initiatives to reduce medication dependence, especially with pain management:
    - Shifting pharmacist focus to de-prescribing.
    - Educating patients directly on medication risks to empower shared decision making. This initiative has been very well received.
    - Developing pain menus to look at different options, including non- medication options (e.g., acupuncture, yoga).
    - Making sure goals on pain are realistic.
    - Using clinical decision support tools.
    - VHA is examining the concept of integrated care at a national level.
- The group discussed how telehealth modalities for pharmacists have increased over the last few years.
- Dr. Mambourg discussed Naloxone education and how VA provides kits to Veterans and their circle of caregivers – VA realizes it is not just patients who need education. VA also provides kits to the community.
- The group discussed the need to holistically care for patients and address cultural needs. Dr. Mambourg emphasized that shared decision making helps accommodate patients' needs and beliefs and noted that the My Life, My Story program helps inform providers on how best to honor patients' beliefs.
- The group discussed how impressed it is with the available data. Dr. Mambourg acknowledged the data warehouse has enabled advanced analysis and user friendly dashboards, as well as an enhanced ability to extract key patient factors from records rather than individual chart reviews. Teams are also learning together and sharing data across providers.
- The Committee asked if there are cost savings data on reduced or improved medication use. Dr. Mambourg noted his team is evaluating and will eventually publish findings on this topic.
- The Committee asked about the increase in female Veterans and how pharmacy is impacted. Dr. Mambourg noted his team is examining how to provide access to the right care, including working with community providers.
- The committed asked if there are any barriers to prescription monitoring across state borders. Dr. Mambourg noted that all VA facilities participate in state programs and the

SNHCS has access to California and Nevada data and systems. He also noted that nationally the state boards of pharmacy are working to connect all monitoring programs and databases, and that VA has collaborated with states on 21st Century Cures Act funding.

- The Committee asked how mail order pharmacy coordination works. Dr. Mambourg responded that most prescriptions go out through this program, which has a very good tracking system. The majority are for refills since initial prescriptions are from direct consultations with providers.

Highlights/Key Takeaways/Themes:

- The ORH Clinical Pharmacy Specialist EWI has successfully increased access for rural patients to critical pharmacy staff and services and increased primary care availability in the process.

Part 10: Presentation: Office of Rural Health Update

3:30 – 4:00 pm

- Speaker: Dr. Thomas Klobucar, Acting Executive Director, Office of Rural Health

Dr. Thomas Klobucar, Acting Executive Director, Office of Rural Health

- Dr. Klobucar noted there have been many changes to VA since the last VRHAC meeting, including his new position as Acting Executive Director. Dr. Klobucar also noted there will be some major reorganization in the next 3-4 months for VA central office and the overall health care system in the next 1-2 years.
- ORH contributes to all five of the Secretary's priorities through its Enterprise- Wide Initiatives (EWI) program.
- Dr. Klobucar highlighted key statistics about rural Veterans, including rural Veterans' dependency on VA care and increases in Veterans accessing the internet from home.
- Dr. Klobucar provided background on ORH's creation, discussed the evolution of the Veterans Rural Health Resource Centers' (VRHRC) structure, and highlighted ORH's mission and goals.
- Dr. Klobucar highlighted key ORH initiatives:
    - EWI model that includes Rural Promising Practices
    - Public-facing Rural Veteran Health Atlas
    - The Rural Veteran Coordination Pilot which completes in September
    - VHA-Indian Health Service MOU
    - Various communications efforts
    - Improved partnerships/coordination with VA Center for Innovation and VHA Diffusion Council.
- Dr. Klobucar reviewed the fiscal 2016 VRHAC recommendations and provided updates on each recommendation.
- Dr. Klobucar informed the Committee that the new VRHAC Chairperson and new member nominees will be announced following Secretary approval.
- Dr. Klobucar asked the Committee to consider establishing a VRHAC nomination workgroup, transition to a three-year planning model for VRHAC rural site visit meetings and examine the formation of workgroups to facilitate recommendation finalization.

Q&A/Group Discussion:

- The Committee discussed the challenges of outdated equipment and point-to-point connectivity issues for telehealth. Dr. Klobucar noted the new VA Video Connect will be an improvement, ORH is partnering with the VA Office of Connected Care to re-equip Community Based Outpatient Clinics with current equipment ("telehealth modernization")

and ORH is planning to do more with Indian Health Service facilities to revitalize partnerships.
- The Committee requested data by state of which facilities are participating in EWIs.
- The Committee discussed the degree to which its 2016 recommendations have been implemented. The Committee agreed it is important to continue to highlight workforce-related recommendations and to tie recommendations back to the Secretary's priorities going forward.
- Ms. Puccinelli requested the Committee review the 2016 recommendations to prepare for in-depth discussion Thursday.

Highlights/Key Takeaways/Themes:
- ORH is implementing multiple initiatives that not only serve rural Veterans but also support the VA Secretary's priorities.
- The Committee greatly informs the work of ORH and VA broadly through its recommendations.

Part 11: Presentation: Veterans Rural Health Resource Centers

4:00 – 4:30 pm
- Speaker: Byron Bair, MD; Clinical Director, Veterans Rural Health Resource Center—Salt Lake City

Byron Bair, MD; Clinical Director, Veterans Rural Health Resource Center – Salt Lake City
- Dr. Bair noted that by advocating for rural Veterans, ORH and the Committee help all Veterans, since rural solutions are often transferable to urban areas.
- Dr. Bair provided a history of ORH and Veteran Rural Health Resource Centers (VRHRCs) within the context of key VA milestones, noting that VRHRCs were originally intended to be five-year programs but demonstrated such value that they became a permanent component of how ORH does its work.
- VRHRCs innovate in clinical, research, collaborative, creative and entrepreneurial areas. They focus more on implementation science to minimize the time it takes to prove models and integrate methodologies for real time clinical improvements. When coupled with an innovation network, ORH can provide feedback to further grow new programs.
- Dr. Bair explained the development of Rural Promising Practices and how "promising" demonstrates ongoing improvements – but are still in review prior to being established as a "best practice." ORH set six criteria to identify rural promising practices (increased access, strong partnerships, clinical impact, return on investment, operational feasibility and customer satisfaction) and currently has six with mentored implementation funding and eight for direct implementation.
- Dr. Bair presented key data highlighting VRHRC impact since 2009, including:
    - 342 studies and innovations
    - 7 disseminations
    - 595 manuscripts, briefs and reports
    - More than 140 VA program office and 230 community entities
    - More than 300 Tribal partners
- Dr. Bair noted that VA can support communities without funding by offering partnerships which often simplify community relationships.

Q&A/Group Discussion:
- The Committee noted that ORH and VRHRCs are well situated to help explore more collaborative opportunities given their role in VA health care and across federal agencies.

ORH is a major player in breaking down silos.

- The Committee noted that the areas ORH is focusing on align with the locations of tribes and IHS facilities.
- The Committee discussed how VRHRCs evolved from a regional focus to having the capacity to impact care nation-wide .

Highlights/Key Takeaways/Themes:

- VRHRCs are a key component of ORH's legislative mandate and help drive continuous innovation and improvements in care provided to rural Veterans.

Part 12: Discussion: Recap Day 1

4:30 – 5:00 pm

- Speaker: Margaret Puccinelli, Chair, VRHAC

Q&A/Group Discussion:

- The Committee reviewed areas of interest that stemmed from presentations and discussions.

Highlights/Key Takeaways/Themes:

- The Committee will incorporate key topics into the recommendations discussion on Thursday.

Veterans Rural Health Advisory Committee Meeting Department of Veterans Affairs

Meeting Summary

Session Objectives:	• VRHAC will gain increased understanding of key program office activities. • VRHAC will visit local rural Veteran health care facilities and services. • VRHAC will discuss 2017 goals.
Date & Time:	Wednesday, June 28, 2017, from 8:30 AM to 5:00 PM
Location:	Multiple locations
Attendees:	Chair: Margaret Puccinelli Designated Federal Officer: Thomas Klobucar Members: Graham Adams, Angeline Bushy, Dale Gibbs, Francisco Ivarra, Kevin Kelley, Michael McLaughlin, John Mengenhausen, Brenda Moore, Buck Richardson Ex officio members: Michael Bouchard, Ben Smith Ex officio representatives: Wilbur Woodis Office of Rural Health: Judy Bowie, Meghan Ochal, Emily Oehler Speakers: Listed below with presentation summary
Note Takers:	Meghan Ochal

Part 1: Visit: Sierra Nevada Health Care System Patient Education Resource Center (PERC)

8:30 – 9:15 am

- Speakers:
  - Jana Patterson, Veteran Engagement Team Supervisor, Sierra Nevada Health Care System PERC
  - Jeff Holmes, My HealtheVet Coordinator, Sierra Nevada Health Care System PERC

Jana Patterson, Veteran Engagement Team Supervisor, Sierra Nevada Health Care System PERC

- The Committee spoke with key staff and toured the PERC facility, which seeks to engage rural Veterans while they are at the VA medical center/in between appointments. Ms. Patterson provided the Committee an overview of the work and demonstration of key activities that Veterans engage in at the PERC, such as support with online applications/enrollment and a wide variety of classes.
- The new Advance Care Planning enterprise-wide initiative (EWI) coordinator introduced her program to the Committee.

Jeff Holmes, My Health*e*Vet Coordinator, Sierra Nevada Health Care System PERC

- Mr. Holmes discussed resources available to Veterans in the resource center, including on-site computers to access MyHealth*e*Vet accounts, community recreational activities and on-site VA health and wellness trainings.

Q&A/Group Discussion

- N/A

Highlights/Key Takeaways/Themes:

- The VA medical center focuses on integrating support services into the Veteran health care experience to support their over-all well-being.

Part 2: Visit: Veterans Outreach Center

9:30 – 10:15 am

- Speaker: Elizabeth Pope, Supervisor Health Care for Homeless Veterans **(**HCHV) Outreach, Veterans Outreach Center

Elizabeth Pope, Supervisor HCHV Outreach, Veterans Outreach Center

- Ms. Pope gave the Committee a tour of the facility and provided an overview of the services staff offer through the Outreach Center, including details on the HCHV outreach as well as the U.S. Department of Housing and Urban Development's Veterans Affairs Supportive Housing (HUD-VASH) program.
- Ms. Pope noted that community collaborations have been a benefit to helping Veterans find permanent housing.

Q&A/Group Discussion

- The Committee discussed barriers to housing, including long waits, availability of vouchers, eligibility for vouchers and housing costs.
- The Committee discussed with Ms. Pope how the Outreach Center works with formerly incarcerated felons to help them find housing.

Highlights/Key Takeaways/Themes:

- The Veterans Outreach Center provides critical services to help Veterans stabilize and find permanent housing.

Part 3: Visit: Banner Community Hospital

1:00 – 1:30 pm

- Speakers: Rob Carnahan, Chief Executive Officer (CEO), and Betsy MacDarmid, Banner Community Hospital

Rob Carnahan, CEO, and Betsy MacDarmid, Case Manager, Banner Community Hospital

- Mr. Carnahan provided an overview of the hospital, including key services, history of becoming a Critical Access Hospital and general patient and stay data.
- Mr. Carnahan and Ms. MacDarmid discussed how the hospital coordinates directly with the local VA community-based outpatient clinic on transfers, transportation and homeless outreach, as well as how they collaborate with other health care providers.
- Mr. Carnahan and Ms. MacDarmid identified key staffing shortage issues, but noted they have strong employee retention initiatives and partner with University of Nevada-Reno to train students and residents.
- Mr. Carnahan and Ms. MacDarmid discussed how patients can receive care via telehealth services and how they are able to serve very remote areas by partnering with CareFlight.

Q&A/Group Discussion

- The Committee discussed some limitations and confusion around the Veterans Choice Program participation, including drive time eligibility and availability/flexibility of services.

Highlights/Key Takeaways/Themes:

- Banner Community Hospital is a key provider of health care to the rural community, and partners with VA regularly to increase care to rural Veterans.

Part 4: Visit: Lahontan Valley Outpatient Clinic

1:45 – 2:20 pm

- Speaker: Leslie Quinley, Nurse Manager, Lahontan Valley Outpatient Clinic

Leslie Quinley, Nurse Manager, Lahontan Valley Outpatient Clinic

- Ms. Quinley provided a tour of the clinic and an overview of the services offered, including telehealth services.
- Ms. Quinley also discussed the services offered at the outreach clinic in Winemucca and limitations of providing care in a remote area.
- The clinic hosts many well-received social worker-led support groups.

Highlights/Key Takeaways/Themes:

- The Lahontan Valley Outpatient Clinic provides critical services to rural Veterans closer to their homes, but challenges remain in providing access to care at the clinic versus the VA medical center more than 60 miles away.

Part 5: Rural Veteran Panel at American Legion Post 16

2:30 – 4:00 pm

- Host: John Ezzell, Commander, American Legion Post 16
- John Ezzell, American Legion Post 16 Commander
- Commander Ezzell welcomed the Committee and Veterans.
- Margaret Puccinelli VRHAC Committee Chairwoman
- Ms. Puccinelli thanked the American Legion for hosting the rural panel and welcomed the rural Veterans and their caregivers.
- The panelists and Committee discussed:
    - The need for the Committee to recognize and support the great work and deep patient knowledge of VA staff. Rural staff especially need an incentive to stay to minimize turnover and improve experience for staff as well as Veterans.
    - Veteran patient reliance on VA for care and how often Veterans travel to the VA medical center versus securing care locally at the Community Based Outpatient Clinic (CBOC) or other local providers
    - The success of the support groups offered at the CBOC
    - Interest in expanding telehealth options
    - Difficulties in administrative issues and paperwork, including resolving Veterans Choice Program referrals and billing challenges
    - Wait times and finding a balance with working with community providers
    - DoD/TriCare and VA disconnects
    - Positive experiences with and local support for the Caregiver program, but difficulties in other VA staff understanding the Caregiver role
    - The lack of communication regarding new policies and administrative changes and resulting confusion among Veterans

Q&A/Group Discussion

- The Committee acknowledged they have heard about Veterans Choice Program issues

everywhere and work to address them.

- The group discussed how some groups of Veterans are dependent on individual staff initiative rather that a systematic solution and agreed to explore the issue for possible inclusion in recommendations.

Highlights/Key Takeaways/Themes:

- The panelists highlighted access challenges and provided specific end-user input which will inform the Committee's work and recommendations to VA.

Part 6: Discussion: Recap Day 2

4:30 – 5:00 pm

- Speaker: Margaret Puccinelli, Chair, VRHAC

Margaret Puccinelli, Chair, VRHAC

- The Committee reviewed areas of interest that stemmed from site visits and rural Veteran discussions.

Highlights/Key Takeaways/Themes:

- The Committee will incorporate key topics into the recommendations discussion on Thursday.

Veterans Rural Health Advisory Committee Meeting Department of Veterans Affairs

Meeting Summary

Session Objectives:	• VRHAC will gain increased understanding of key program office activities. • VRHAC will visit local rural Veteran health care facilities and services. • VRHAC will discuss 2017 goals.
Date & Time:	Thursday, June 29, 2017, from 8:30 AM to 5:00 PM
Location:	Ioannis A. Lougaris VA Medical Center 975 Kirman Avenue; Tahoe Room – 5th floor Reno, NV 89502
Attendees:	Chair: Margaret Puccinelli Designated Federal Officer: Thomas Klobucar Members: Graham Adams, Angeline Bushy, Dale Gibbs, Francisco Ivarra, Kevin Kelley, Michael McLaughlin, John Mengenhausen, Brenda Moore, Buck Richardson Ex officio members: Michael Bouchard, Ben Smith Ex officio representatives: Wilbur Woodis Office of Rural Health: Judy Bowie, Meghan Ochal, Emily Oehler Speakers: Listed below with presentation summary
Note Takers:	Meghan Ochal

Part 1: Visit: Reno-Sparks Indian Colony – Tribal Health Center

8:30 – 9:30 am

- Speaker: Andrea Johnson Harper, Executive Director, Reno-Sparks Indian Colony– Tribal Health Center

Andrea Johnson Harper, Executive Director, Reno-Sparks Indian Colony – Tribal Health Center

- Mr. Arlan Melendez provided background on the tribe and its history.
- Ms. Johnson Harper provided an overview/history of the facility and how they coordinate with Indian Health Service (IHS) as a self-governed facility. Ms. Johnson Harper also gave the Committee a tour of the facility.
- Ms. Johnson Harper discussed how they have been able to retain support staff and nurses but there are difficulties in retaining providers. The clinic has two Public Health Service providers through an MOU with IHS.
- Ms. Johnson Harper discussed the major health care issues of the clinic's patients, including hypertension, diabetes and behavioral health.

Q&A/Group Discussion

- The Committee discussed issues and costs associated with electronic health record systems as well as coordination of payment for Veteran patients between IHS and VA.
- The Committee discussed opportunities for native healing options at the clinic.

Highlights/Key Takeaways/Themes:

- The Committee gained an understanding of how the clinic works with the IHS, VA and the community, and the potential for improving coordinated services for tribal Veterans.
    - Mr. Bouchard highlighted an example of a DoD-VA jointly funded/governed facility where both patient types are treated with the same priority.
- Mr. Bouchard reviewed the sections of the NDAA, including consolidation of services and enhancing partnerships, including with VA (e.g., piloting Veterans Choice collaboration at DoD facilities).

Q&A/Group Discussion

- The Committee asked about the pilot program under which DoD treats civilians. Mr. Bouchard clarified that a pilot at the San Antonio military treatment facility sees civilians through the emergency room and bills their insurance providers or Medicare/Medicaid. This supports the community and ensures providers reach training quotas to maintain standards.
- The Committee discussed the pros and cons of the joint governance facility.
- The Committee noted the importance of having a DoD ex officio representative on the Committee to continue improving the DoD-VA relationship and coordination, especially in rural areas.

Highlights/Key Takeaways/Themes:

- Under the NDAA, DHA has the potential to greatly streamline services.
- The results of current and planned pilots will inform how DoD can best work with VA to improve services not only to active duty military but also Veterans.

Part 4: Presentation: Veterans Justice Programs

11:15 am – 12:15 pm

- Speaker: Mary Ann Moss, Veterans Outreach Coordinator – Health Care for Homeless Veterans, Ioannis A. Lougaris VA Medical Center

Mary Ann Moss, Veterans Outreach Coordinator – Health Care for Homeless Veterans, Ioannis A. Lougaris VA Medical Center

- Ms. Moss showed a video clip from *A Matter of Duty*.
- Ms. Moss reviewed key data on Veterans' involvement with the justice system and mental health concerns:
    - One in five returning Veterans suffer from mental health concerns or cognitive impairment
    - One in six returning Operation Enduring Freedom/Operation Iraqi Freedom Veterans abuse substances
    - Veterans make up 8 percent of the United States' justice system, not including the military justice system
    - 82 percent of Veterans found in the criminal justice system might be eligible for VA health care, but they must be identified
- Ms. Moss described the two key programs under the Veterans Justice Program – the Health Care for Reentry Veterans (HCRV) and Veterans Justice Outreach (VJO). In both programs, VA works with community partners to prevent
- incarceration and/or to provide Veterans access to key services (e.g., eligibility/linkages to VHA, Vet Centers and VBA) as well as community care and related programs.
- Under HCRV, Ms. Moss explained the "no wrong door" policy and Sequential Intercept

Model, which the program utilizes in its work with partners to identify and enroll Veterans into the program at any phase of the judicial/corrections process.

- Ms. Moss reviewed program results, including a high percentage of Veterans
- who receive HCRV services also enrolling in VHA health care and receiving needed mental health treatment.
- VJO is part of the intact treatment team with Veterans with specialty courts, but not case managers. Especially in rural communities, VJO works to educate judicial system staff, attorneys, etc. on the needs and options for Veterans. Ms. Moss has developed a referral sheet/process for rural counties to check with VJO for individual Veteran eligibility.
- Ms. Moss provided an overview of the more than 350 Veterans Treatment Courts (VTC) and cited 2013 findings that demonstrated participating Veterans experienced improvements in health and social outcomes; peer volunteer mentoring (which currently involves 3,000 volunteers) was particularly effective. The Veteran focus of VTCs allows the court to address the overall Veteran experience and not just one area as is the case in mental health or drug courts.
- The Veterans Justice Program partners include legal clinics for Veterans.
- A national medical/legal clinic pilot provided legal support in conjunction with medical care (e.g., family law, housing needs, debt relief, estate planning).

Q&A/Group Discussion

- The group discussed the coordination process with local resources and the limitations if a community is unaware the patient is a Veteran. The group noted care coordination issues between VA and the community.
- The Committee inquired about types of offenses common among Veterans. Ms. Moss noted many are related to substance abuse, domestic violence and weapons charges.
- The Committee discussed variations when working with tribal entities and their courts.
- The Committee discussed how much mental health screening and support could occur before, during and immediately after active duty instead of waiting for a Veteran to get into the VA system. The Committee agreed this requires further discussion with the Department of Defense.
- Ms. Moss confirmed to the Committee that the release of information consent is built into the VJO process.
- The Committee discussed limits on assisting felons. Ms. Moss noted the program can't assist with felony charges but can assist felons with misdemeanor charges.

Highlights/Key Takeaways/Themes:

- The Veterans Justice Program coordinates with key VA and community partners to support Veterans in navigating the legal system and connecting to other needed VA services.
-

Part 5: Lunch Group Discussion

12:30 – 1:30 pm

Q&A/Group Discussion

- Dr. Klobucar provided the Committee with updated/detailed data on racial breakdown of enrolled Veterans.
- Dr. Klobucar clarified the VA facility classification system and its evolution.
- Members met various local medical center staff who support rural Veteran care.

Part 6: Working Session

1:30 – 4:00 pm

- VRHAC Committee

Technical Updates/Discussion:

- The Committee approved a nominations subcommittee to provide recommendations of applicants to the Designated Federal Officer.
    - Interested Committee members will email Ms. Puccinelli, and the new chair will make final decision of subcommittee members.
    - ORH will share a federal register notice for member nominations once public.
- The Committee prioritized site visit location preferences
- The Committee recommended meeting dates for fiscal year 2018

Q&A/Group Discussion:

- The Committee discussed the Secretary's charge to be bold and think big.
- The Committee discussed how to focus attention on key issues through more concise, targeted recommendations.
- The Committee agreed two key themes from this meeting included:
    - Collaboration, including education and communication
    - Access, including workforce recruitment and retention as well as leveraging technology and ensuring equitable access for minorities
- The Committee noted that focusing on collaboration could have a larger impact, as in the rural context, collaboration is often the only option. Great opportunity exists to make connections to improve utilization of existing resources in the key areas of finance, workforce, technology and facilities.
- The Committee discussed how to take proven practices at rural facilities and standardize them across all facilities.
- The Committee emphasized the importance of rural workforce recruitment and retention and the lack of wide-reaching solutions in rural areas. Key workforce solutions/issues discussed included:
    - Partnering with other health care providers and companies for economic opportunities and jobs to keep health care providers in the local community
    - Leveraging other federal programs – National Health Service Corps and Commissioned Corps – for placement at VA
    - Offering incentives to care coordination workers
    - Establishing designated care coordinators that help Veterans in a certain area – even if the community doesn't have a Community Based Outpatient Clinic and the person is remote
    - Reducing turnover in rural providers, as local Veterans indicated a preference for consistency to build trust and understand the complexity of their case
    - Addressing pay parity, which is a key barrier to retention
    - Relying on and supporting nurse practitioners
    - Addressing the limited use of Title 38 authority in rural areas
    - Examining the ability of VA medical centers to offer bonuses and the limits of authorization
    - Expanding academic medical centers to train more providers; VA funding more slots in medical schools

  - Increasing incentives for social workers and require staying in rural areas
  - Targeting early funding and support for education of local students ("grow your own")
- VHA Office of Rural Health (ORH) will provide data on VA workforce and students who receive VA training.
- The Committee discussed VA's scope of authority now for incentivizing
- providers to come to VA and stay in rural areas.
- The Committee discussed which national level organizations VA should partner with on workforce, including:
  - Role of legislators and increasing and/or committing resources to medical education and workforce
  - Coordination with other VA advisory committees that focus on medical education and workforce
  - Collaboration with VA human resources, Health Resources and Service Admiration's Bureau of Health Workforce, Indian Health Service and VA Office of Nursing
- ORH and VA's Advisory Committee Management Office will provide a list of other advisory committees.
- The Committee discussed how to develop and frame recommendations, including making sure they are actionable and specific/concrete, setting targets/metrics to help achieve strategy and tying recommendations to the Secretary's priorities.
- The Committee also explored eligibility to make enrollment and payment simpler for Veterans.
- Ms. Puccinelli noted she would like to review additional data and background information and have draft recommendation(s) by September.

Highlights/Key Takeaways/Themes:
- The Committee's experience at this meeting will inform its recommendations.
- Workforce recruitment and retention is a top issue for rural Veteran health care.

Part 6: Public Comment Period

4:30 – 5:00 pm
- Speaker: Margaret Puccinelli, Chair, VRHAC
- No attendees.