



Meeting Summary – Day 1

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 understand local access successes and challenges from the local Veterans, provider and administrator perspectives. ✓ VRHAC will draft fiscal year 2016 recommendations in previously identified priority areas.
Date & Time:	Tuesday, May 3-4, 2016; 8:30 am-5:00 pm
Location:	Mann-Grandstaff VA Medical Center Building 40 Room 225 4815 N. Assembly St Spokane, WA 99205
Attendees:	Members: Verdie Bowen Sr.; Janice Casillas; Dale Gibbs; Kevin Kelley; Syreeta Long; John Mengershausen; Margaret Puccinelli; Randy Reeves; W.J. “Buck” Richardson; Don Samuels Ex Officios: Rich Davis, U.S. Department of Agriculture (USDA), Wakina Scott, Health Resources and Services Administration (HRSA); Wilbur Woodis, Indian Health Services (IHS) Office of Rural Health: Gina Capra; Elmer Clark; Janice Garland; Thomas Klobucar Invited Guests: Pat Justis; John Lee; Brenda Powers; Edgar Rivera; Donald Lachman; Lily Haken; Kimberly Waller; Lourdes E. Alvarado-Ramos
Note Takers:	Janice Garland and Emily Oehler



1	<p>Part 1: Welcome, Introductions and Meeting Overview 8:30 – 8:50 am Speaker: Margaret Puccinelli, Chairwoman, Veterans Rural Health Advisory Committee</p> <ul style="list-style-type: none">• The chairwoman convened the meeting, and announced membership changes: Debra American Horse-Wilson (resigned) and Dr. Angie Bushy (newly appointed).• Meeting attendees provided introductions.• The chair reviewed norms, meeting objectives and agenda. <p>Key Themes:</p> <ul style="list-style-type: none">✓ Committee to actively share personal and professional information to address national rural Veteran health issues.
2	<p>Part 2: Local Room/Emergency Response Procedures 8:50 – 9:00 am Speaker: Chuck Meyer, Emergency Manager, Mann–Grandstaff VA Medical Center</p> <ul style="list-style-type: none">• Emergency management protocol reviewed. <p>Key Themes:</p> <ul style="list-style-type: none">✓ Visitors are to follow VA Medical Center (VAMC) safety protocol.
3	<p>Part 3: ORH Director’s Update and Discussion 9:00 – 9:15 am and Noon-1:00 pm Speakers: Gina Capra, Director and Thomas Klobucar, Deputy, Office of Rural Health</p> <ul style="list-style-type: none">• National environment continues to change with two major factors: (1) Commission on Care report (created by the Veterans Access, Choice and Accountability Act) with a strawman released that suggested significant revision to the U.S. Department of Veterans Affairs (VA), and (2) pending appropriation omnibus legislation. The VA is waiting to see if Congress will accept VA’s request to consolidate its community care programs.• ORH continues to focus its annual appropriation to increase access to care for rural Veterans with concentrated efforts on enterprise-wide programs.• Reviewed four strategic goals:<ul style="list-style-type: none">○ Promote health and well-being in the rural Veteran population.○ Generate and diffuse knowledge regarding rural Veteran health.○ Strengthen community health care infrastructure where rural Veterans reside.○ Inform health care policy that impacts rural Veterans and rural health care delivery.• Explained Under Secretary for Health’s (USH) five priorities:<ul style="list-style-type: none">○ Access to care.○ Improve employee engagement.○ Consistency in best practices and quality.



- High-performing network.
 - Restore trust and confidence.
- USH is focused on inter-agency and intra-agency coordination to deliver quality care and services to Veterans.
- *MyVA* Access is the largest transformation in the history of the Veteran Health Administration (VHA) to transform VA into a world-class, Veteran-centered service organization. The *MyVA* Access Declaration launched in Denver in April 2015. ORH participated in the launch with VISN representatives and select subject matter experts. The purpose was to connect system redesign engineers from Veterans Engineering Resource Center (VERC) with VA Medical Center (VAMC) leadership, and provide subject matter experts with a platform to share best practices for adoption. ORH supported the VERC's evaluations of rural VAMCs and provided enterprise-wide program information (Rural Promising Practices and Collaborative Rural Access Solutions) to event participants for possible adoption.
- ORH continues to concentrate on a three component model: Study. Innovate. Spread.
- ORH's enterprise-wide programs focus integrates ideas across the entire VA system through two avenues: ORH Rural Promising Practices (proven innovative models of care shared through mentored implementation) and Collaborative Rural Access Solutions (VA program office partnerships to spread proven programs and services to rural communities).
- ORH is actively engaged on VHA's Diffusion Council that identifies and disseminates best practices, and supported efforts to ensure the Council's focus on rural communities. Of the 13 gold status best practices, more than half generated from rural VAMCs, and many are also now being adopted by urban VAMCs.
- ORH is active in expanding telehealth into rural communities, acknowledging that telehealth is moving beyond a VA clinic and into a Veteran patient's home. VA Connect will allow patients and VA providers to access to a secure virtual waiting room to conduct a medical appointment. .
- ORH works with the Office of Connected Care to put more than 5,000 tablets that feature 4G cards and data plans in Veteran's home specifically for health encounters, which offers a solution to provide Internet access to rural Veterans who may have limited Internet access.
- Universal Service Administrative Company realized their funding continues to be underutilized and is working with ORH to increase awareness and use of this funding supplement to support telecom services into rural residences.
- ORH program spotlight on Rural Promising Practices:
 - Six criteria: improved access, evidence of clinical impact, customer satisfaction/patient experience, return on investment, operational feasibility and strong partnerships/working relationships.
 - Five-part process: pilot, nominate, evaluate, select (mentored implementation or dissemination) and adopt.
 - Reviewed Home-based Cardiac Rehabilitation Rural Promising Practice.



- Limitation to mentored implementation is ORH and Veteran Rural Health Resource Center staff size in terms of ability to support start-up of program at VAMCs across the country.

Key Themes:

- ✓ ORH shifted its funding model to enterprise-wide programs that deliver proven solutions nationally and across the VA healthcare system.
- ✓ Telehealth continues to grow as a driving force to increase rural Veterans' access to care and deliver care closer to home.

Part 4: Veterans Choice Program & Rural Implications

9:15 – 10:15 am

Speakers: Rob Van Bommel, Chief Business Office Purchased Care (CBOPC) Regional Officer; Kara Hawthorne CBOPC Manager of Provider Management; and Joe Duran, CBOPC Deputy Director of Program Administration

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- Community care is confusing due to the existence of multiple VA programs. To address these issues and offer immediate improvements, VA proposed a plan to Congress.
- There are several goals to make improvements:
 - Immediate short-term goals: implement contract modification, reduce unnecessary steps in the process and improve communications.
 - Long-term goals: develop detailed implementation plan, execute make/buy decisions and implement integrated solutions.
- VA is focused on five key areas to improve Veterans' journey: referral and authorizations; care coordination; community care network; provider payment; and eligibility.
- A national team is engaged to support the transformation and their efforts include interviews, site visits and data gathering.
- Rapid change to community care is underway, as growth in community care appointments increased by approximately 20 percent (from 17.7 to 21.3 million) from fiscal year 2014 to fiscal year 2015. The majority of care VA is buying is through the Veterans Choice Program.
- Five priorities to establish a joint team:
 - Improve customer service
 - Simplify referral and authorization process
 - Decreased returned authorizations
 - Match Veterans with right providers
 - Better visibility into the network
- Short-term accomplishments: delivered care faster and closer to home; expanded provider network; lessened administrative burden for providers; improved provider payment; and improved customer service.
- Adverse Credit Reporting was created to address the issue of inappropriate Veteran payments because provider did not receive payment from VA.
- Processing more claims – a 21 percent increase from fiscal year 2014; and in last six months 78 percent of claims were processed within 30 days.



- Regarding provider agreement authority, VA must adhere to federal regulations to avoid creating a competing network.
- Future state:
 - Going through deliberate steps to create an industry-standard system and be an easy partner with whom to work
 - The new system must meet needs of Veterans, providers and VA staff
 - Five-part community network draft request for proposal: community care network, Veterans we serve, access to community care, care coordination and provider payment
 - Provider Networks will include health care services, and complementary and integrative health services (Native American healing, Tai Chi, hypnotherapy, etc.)
 - Additional features include revised benefits package, a Network Adequacy Plan to ensure the right providers are in the right places, improved direct communication with Veterans and providers, and timely and accurate provider payments
 - The new system will use data to improve outcomes and experience (i.e., access and utilization; payments and costs; quality and safety), have improved IT capabilities, and expand health information exchange
 - In fiscal year 2016, the portion of claims received electronically increased from 12 percent the previous year to 48 percent
 - Immediate legislative relieve is needed to resolve Veteran Choice Program challenges:
 - Contracts create unnecessary administrative burden for community providers
 - Inconsistency of VA as primary or secondary payer creates confusion
 - Obligating funding at the time of authorization leads to inaccurate accounting
 - Unnecessary funding constraints

Key Themes:

- ✓ Current state of Community Care is too complicated and VA is working with Congress to create a better system that meets the needs of Veteran, providers and VA staff.
- ✓ VA's Community Care must meet industry standards.
- ✓ Better communications is needed around Community Care programs for Veterans, community providers and VA staff.



Part 5: Mann–Grandstaff VA Medical Center Tour

10:30 – 11:30 am

Speaker: Timothy Patterson, DO and Dr. Quinn Bastian, Chief of Behavioral Health Service

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- The tele-mental health program is available at four clinics with 600+ patients.
- While the physician is remote, there is an onsite nurses during sessions to check for physical issues such as alcohol on breath, smell of drugs or need for better hygiene.
- Only a handful of patients per year are not suitable for video tele-mental care due to specific case needs, which is the same in private practice.
- This program’s average patient is on 12 medications with eight systemic problems – they are complex cases.
- Physician uses dual monitors, one to access to instant Messenger/email with staff in the VA system and one to access the Internet for supplemental services to support patient care.
- There are good collaborations between tribal nations and VA.
- Spokane worked to drive access with Rural Health Clinics but challenges arose due to technology and staff. We have seamlessness in Community Based Outpatient Clinics (CBOC) but not with other access points due to stringent IT securities and firewalls. Education is needed between VA and private sector to understand technology and security measures.
- Five tribal lands are served by the Mann-Grandstaff VAMC. Nearly 500,000 Veterans enrolled in this VAMC with 158,700 rural and 16,500 highly rural patients.
- An ORH 2009 grant enabled Mann-Grandstaff VAMC to contract with five primary care rural health clinics to increase rural Veterans’ care access.
 - Challenges: staffing, adherence to contractual requirements, PIV cards, limited clinic space, dual practices (VA/private) and Veteran Choice Program (capacity wasn’t available prior to Veteran Choice Program, so it wasn’t available after implementation)
 - Rural services include primary care, diagnostic testing, social work, pharmacy and telehealth
- Staffing is a challenge; if a provider leaves, this can impact a clinic. Clinic closures: Two clinics closed because of staffing issues.
- VA expects a lot from healthcare. VA is exceeding standards of care compared to private practices.
- Implementing the Veterans Choice Program did not increase capacity.
- In addition to initial five grants, ORH awarded more that included support for social work, mental health and mobile medical units.

Key Themes:

- ✓ Tele-mental health care creates access, but it doesn’t create capacity.
 - ✓ Tele-mental health care requires concentrated efforts by VAMC staff to establish a successful program that yields patient and staff satisfaction.
 - ✓ Veterans Choice Program does not address provider shortages in local community.
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Part 6: Working Session

Noon – 1:00 pm

Speakers: Gina Capra, Director and Thomas Klobucar, Deputy, Office of Rural Health

- Morning session continued; discussion reflected in Part 3 summary.

Key Themes:

- ✓ N/A
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Part 7: Washington State’s Rural Veterans

1:00 – 1:45 pm

Speakers: Lourdes E. Alvarado-Ramos (Alfie), Director, Washington State Department of Veterans Affairs

- Washington Veteran statistics:
 - State has more than 600,000 Veterans.
 - 13,000 new Veterans and their families call Washington home annually.
 - 51 percent of Veterans live in rural areas, and more Veterans are migrating to rural areas due to depletion of urban housing.
 - While Washington Veteran population is decreasing, the complexity of Veteran’s conditions is increasing.
 - Currently the state Veteran program include:
 - Rural homeless grant.
 - HHS mobile community services offices.
 - Yearly County Veterans Service Providers Conference to share best practices.
 - Technical assistance and professional development of County Veteran Service Officers.
 - Behavioral health conference.
 - Rural focus by Governor’s Veterans Affairs Advisory Committee.
 - Rural transportation grants.
 - Focus on Tribes.
 - Veterans Estate Management Program fiduciary services to 150 rural Veterans.
 - Bureau of Justice grant for incarcerated Veterans.
 - Homeless prevention program.
 - Expansion of Veterans Employment Resource Group to hire Veterans (hired more than 1,500 Veterans).
 - Military Culture Awareness training (available in state training system for supervisors).
 - YES VETS employer engagement campaign.
 - Six Veteran courts.
 - VetCorps in 20 colleges located in rural Washington.
 - Veterans in Farming program.
 - Military Transition Council to reach active duty service members approximately 18 months prior to transition.
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- Rural Veteran Coordination Pilot (ORH program) to support transitioning Veterans.
- Future state programs focus on Veterans Courts expansion, increase County Veterans Service Officers, rural outposts or micro centers with the proliferation of telemedicine, and an increase suicide prevention awareness.
- Current Veteran challenges include transportation, incarceration, homelessness, recruitment and retention of qualified providers, Veteran Choice Program and Third Party Administrators' lack of ICARE alignment, and Medicare-based reimbursements in competition with Affordable Health Care Act portability.
- The state Veterans office is primarily focused on heightening the value of those who served, and increasing the ability to identify and mitigate Veterans challenges.

Key Themes:

- ✓ Washington offers a comprehensive array of programs and services to support Veterans throughout all aspects of their life.
- ✓ Current Veteran challenges include transportation, homelessness, and Community Care providers (recruiting, retention, payment and alignment to ICARE values).

Part 8: Voice of the Veteran Panel

2:00 – 3:00 pm

Speakers: Vietnam-era Veteran, Female Veteran, Operation Enduring Freedom/Operation Iraqi Freedom Veteran

- Panelists discussed:
 - The long-term care and services provided to them by VA to address diabetes, military sexual trauma, homelessness, post-traumatic stress disorder and general health care.
 - Challenges of receiving health care in a rural community such as driving up to 145 miles for one appointment, but also noted the strong local customer service and interagency coordination for example with a United States Department of Housing and Urban Development Veterans Affairs Supportive Housing (VASH) housing voucher.
 - While panelists think of themselves as healthy, they admit to each having several ongoing combat-related health issues that require ongoing medical attention.
 - Each panelist admitted to mixed success receiving timely primary and specialty care within both the VA and community ranging from two weeks to access a Patient Aligned Care Team (PACT) to three months for a community specialist or VA. Being able to access primary care support through secured messaging prior to an appointment was a benefit of VA care. Need for improved interpersonal communication by medical staff was discussed, as well as need for increased understanding of military culture.
 - The Veteran Choice Program caused each Veteran significant frustration such as months to obtain an appointment, bad/lack of

information, and incorrect billing/sent to collection, but it was noted, "...it's a great program. The problem is poor execution. People are driving the program in the wrong direction. Education and communication are a team effort between the VA and the Veteran. If you've already set bad precedent, it's going to take a complete re-launch to get it right. Veterans have to have communication where they feel respected and feel that they are treated fairly." Panelists stated if the program is improved, "we are your best advertisement, word of mouth spreads like wildfire," and more Veterans will use it.

- Panelists praised the ability to receive care closer to home through a Rural Health Clinic in their local community.
- Panelists noted that more needs to be done regarding:
 - Sensitivity to and planning for women's care (especially regarding military sexual trauma care)
 - Transportation services and/or reimbursement
 - Customer service by support staff
 - Clarity of communication

Key Themes:

- ✓ Veterans praised their VA care, but timeliness of access both within and beyond VA continues to be an issue.
- ✓ Veterans Choice Program is frustrating due to lack of information, inconsistencies and inability to offer increased access to care or timely care.
- ✓ Rural Veterans prefer local care at a CBOC or Rural Health Clinic as transportation is a challenge due to time, resources and expense.

Part 9: Program Spotlight - ORH Rural Veteran Coordination Pilot (RVCP)

2:00 – 3:00 pm

Speakers: Janice Garland, Program Analyst, Office of Rural Health; John Lee, Sr. Vice President Northwest Region, WestCare Foundation; Donald Lachman, Washington Department of Veterans Affairs; Brenda Powers, Research Assistant; WestCare Washington; and Edgar Rivera, Home Base Navigator, WestCare Washington

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- RVCP focuses on supporting transitioning rural Veterans and their families, from accessing benefits to support services.
- WestCare is a nonprofit in 17 states and four territories; WestCare RVCP program covers two states.
- The program stated that the ORH partnership allowed them to learn and expand services through local navigators who establish and maintain working relationships with local organizations to create a network of support for Veterans and their families.
- Veterans are the only people who bring resources with them to a community (e.g. housing, education and health care funds).
- Reviewed Home Base RVCP goals and results.
 - Reached more than 132,000 Veterans.
 - Outreach at more than 14 rural venues.

- Direct assistance to 640 unduplicated Veterans, 113 primary family members and 20 secondary families.
- Program representatives stressed that Veterans quickly share negative experiences, and communications is key to prevent and address word-of-mouth concerns.
- Reviewed action areas:
 - Reduce homelessness in rural communities (VA Supportive Housing team support).
 - Increase access to health care (Veterans Choice Program).
 - Establishment of Tillamook County first responder Veterans Support Team (24/7 access through Lines for Life).
 - Veterans' component to Washington's Benton/Franklin Domestic Violence Demonstration Project.
 - Increase wellness and mobility for Veterans in rural communities (facilitate initial Vet Bikes rural cycle hubs).
 - Promote preventative home safety and livability programs serving elderly rural Veterans.
- Home Base delivers exceptional customer service:
 - 99 percent of consumers felt welcomes by staff.
 - 99 percent believed staff treated them with dignity and respect.
 - 98 percent felt their experience with Home Base and WestCare has been a positive one.
- Will submit a regional proposal to ORH based on lessons learned, and will expand partnerships with federal agencies like Department of Agriculture and state Veteran office with a focus on access to health care (telehealth), housing and incarceration.

Key Themes:

- ✓ A regional approach is possible with inter-state coordination
- ✓ Housing, justice, access to care and transportation are the four areas that WestCare will focus on for rural Veterans using a regional approach.

Part 10: Recap, Day Two Preview and Recognitions

2:00 – 3:00 pm

Speakers: Committee

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- Committee members cited several key points from the day:
 - VA is losing the battle on communications; and word-of-mouth is powerful – with both good and bad news.
 - VA should review structure of co-ed facilities for female patients.
 - Continued need for transportation support, Veteran Choice Program clarification, and benefits of local care in Community Based Outpatient Clinics (CBOC) and Rural Health Clinics, as spotlighted by the Veteran panel.
 - The lack of ORH's budget increase in nearly 10 years.
 - Better approach is needed for integration of Veteran care.
 - Community care is pulling from the same limited rural provider pool:



Veterans Choice Program and P3.

- Need for increased Veterans Choice Program marketing to Veterans and Third Party Administrators.
- Pockets of excellence with tele-mental care, great local VAMC care.
- Committee identified key points for three breakout session on day two:
 - Workforce: principals not rules; recruitment delays, funding and strategy; employee engagement; proper payments; and collaboration with state offices of rural health.
 - Telemedicine: challenges connecting outside of VA; multi-agency cooperation is needed; need to maximize existing technology; loan repayment; does not increase capacity; and reimbursement payments.
 - Models of care: licensing; integrated model; local providers; primary payer; and need to simplify the process.

Key Themes:

- ✓ Community care will continue to be a challenge due to lack of communications, delayed reimbursement and lack of providers.
 - ✓ Telemedicine offers increased points of access for rural Veterans, but does not increase VA's capacity of care.
 - ✓ Transportation continues to be a barrier to rural Veterans accessing care.
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Meeting Summary – Day 2

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 understand local access successes and challenges from the local Veterans, provider and administrator perspectives. • VRHAC will draft fiscal year 2016 recommendations in previously identified priority areas.
Date & Time:	Wednesday, May 4, 2016; 8:30 am-5:00 pm
Location:	Mann-Grandstaff VA Medical Center Building 40 Room 225 4815 N. Assembly St Spokane, WA 99205
Attendees:	<p>Members: Verdie Bowen Sr.; Janice Casillas; Dale Gibbs; Kevin Kelley; Syreeta Long; John Mengershausen; Margaret Puccinelli; Randy Reeves; W.J. “Buck” Richardson; Don Samuels</p> <p>Ex Officios: Rich Davis, Wakina Scott; Wilbur Woodis</p> <p>Office of Rural Health: Gina Capra; Elmer Clark; Janice Garland; Thomas Klobucar</p> <p>Guests: Lily Haken Kimberly Waller</p>
Note Takers:	Janice Garland and Emily Oehler

1	<p>Part 1: Welcome, Agenda Review and Updates</p> <p>8:00 – 8:15 am</p> <p>Speaker: Margaret Puccinelli, Chairwoman, Veterans Rural Health Advisory Committee</p>
	<ul style="list-style-type: none"> • The chairwoman reviewed the agenda and key logistics of the field visit to Idaho. <p>Key Themes: ✓ N/A</p>



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Part 2: Site Visit to North Idaho Community Based Outpatient Clinic (CBOC)

9:15 – 10:15 am

Speaker: Brenda Baker, RN, CBOC Manager

- Committee toured the CBOC that included telemedicine, mental health and rehabilitation services.
- The CBOC does not offer several services such as imaging, vision and audiology.
- The CBOC continues to intake new patients, and will soon reach capacity.
- Many staff like providing care in their local community, and Veterans enjoy more convenient access to care.

Key Themes:

- ✓ Clinic has high patient satisfaction, but is reaching maximum capacity.
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Part 3: Idaho's Rural Veterans

9:15 – 10:30 am

Speaker: David E. Brasuell, Administrator, Idaho Division of Veterans' Service's

- Idaho has 135,000 Veterans, 37 percent of whom are Vietnam Veterans.
- The office has 360 staff who mostly work in the Veteran homes; 25 work at headquarters.
- Idaho has three state Veterans homes:
 - Boise home is 50 years old.
 - 25-30,000 Veterans moved into the Coeur d'Alene area.
 - Considering building a fourth Veteran home.
- Considering another Veteran cemetery; 80 internments last year (very high).
- The state office is like a mini-VA offering healthcare, benefits, cemetery and GI Bill.
- Challenges:
 - The freeway system runs east/west, but nothing comes to the panhandle and it's very rugged and hard to get around the state.
 - Twin Falls CBOC is small but Veterans Choice Program causes concern of if a larger facility would be utilized with Veterans moving or using community care.
 - Telehealth is key solution for accessing care, especially specialists
 - Rural providers accepting Tricare.
 - Indian Health Services billing concerns.

Key Themes:

- ✓ The primary "access to care" issues for rural Veterans in Idaho are transportation, availability of providers and tribal relations.
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4	<p>Part 4: Lunch at American Legion Post 143 1:15 – 3:00 pm Speaker: Gary Mallon, First Vice-Commander and Chuck Buttz, Adjutant, American Legion Post 143</p> <ul style="list-style-type: none"> • There are 632 Post members; about 132 are “snow birds” and 325 are on email. • Post 143 is open to all Veteran groups at no charge, and it hosts Alcoholics Anonymous every day. • Post 143 plans to build a museum on the property. • Two newsletters are distributed monthly. • Would like to expand services to Veterans and to the community. <p>Key Themes: ✓ Post 143 focuses on supporting their Veteran and local community.</p>
5	<p>Part 5: Working Session Breakout Groups 1:15 – 3:00 pm Speaker: Committee</p> <ul style="list-style-type: none"> • The committee dispersed into their three work groups to discuss research, presentations and prioritization of top issues: workforce, telemedicine and models of care. <p>Key Themes: ✓ N/A</p>
6	<p>Part 6: Working Session Recap 3:15 – 4:30 pm Speaker: Committee</p> <ul style="list-style-type: none"> • Work groups presented top three issues: <ul style="list-style-type: none"> ○ Workforce: difficulty identifying the most critical staffing needs in rural areas; need to streamline VA’s hiring process; retention of current health care professions. ○ Telemedicine: preference to call it “Tele-Veteran Access;” lack of Internet access as it supports entire rural lifestyle (health, education, career, entertainment, etc.); connectivity between systems and through firewalls. ○ Models of Care: Veteran Choice Program routinely impedes rural Veterans access to care; Lack of equitable care for rural Veterans regardless of the provider (VA or community care); community care does not address rural community’s lack of providers. • To prepare for a final recommendation to the Secretary: <ul style="list-style-type: none"> ○ Each workgroup to submit a one-page draft by July 15, 2016 to the VRHAC chairwoman. ○ The final recommendation paper will be submitted by Committee by end of the fiscal year.



- The committee discussed potential topics for the next meeting that is tentatively scheduled for March 14-17, 2017 in Washington, D.C.
 - VA Connect.
 - Under Secretary of Health.
 - Ex officio members.
 - Veterans Choice Program.
 - Appeals process
 - VA advisory committee updates from Homeless, Minority Veterans, Geriatrics and Gerontology, and Women Veterans
 - “Age in place” program.
- Additional updates:
 - Last week Secretary of Veterans Affairs signed off on the revised charter, approved the revisions provided by the committee; the Charter is for two years.
 - 35 applications are in review for the VHRAC vacancies.
 - A new member orientation guide is in development.
 - The Secretary has not yet formally responded to the Committee recommendations submitted by the Chair in fiscal year 2015.
 - Chair requested interest from VRHAC members who could provide additional leadership support for fiscal year 2017 to support the transition process as current chair has one more year of service.
 - The Community Engagement Board list was provided to members with a charge to elevate rural Veteran needs to the boards as appropriate.
- The committee provided feedback on the two-day meeting
 - Successes: Veteran panel, working sessions, local site visits, seeing emerging technology in action, ability to talk to front-line staff, participation of state Veteran director and committee dinner.
 - Recommendation: increase length of meeting to three days to foster deeper discussion and learning on presentations.

Key Themes:

- ✓ Workgroups provided top three concerns based on current research.
- ✓ Access to front line staff, technology and rural Veterans was beneficial to VRHAC members.

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Part 7: Public Comment Period

4:30 – 5:00 pm

Speaker: Margaret Puccinelli, Chair, Veterans Rural Health Advisory Committee

- No attendees.

Key Themes:

- ✓ N/A