Meeting Summary

Veterans Rural Health Advisory Committee Meeting
Department of Veterans Affairs

Session Objectives:	• Veterans Rural Health Advisory Committee (VRHAC) will gain increased understanding on key program office activities. • VRHAC will understand how to apply the ethics requirements per training for advisory members. • VRHAC will identify priorities for fiscal year 2016 recommendations. • VRHAC will determine spring 2016 meeting parameters.
Date & Time:	Tuesday, November 17, 2015, from 8:30 AM to 5:00 PM
Location:	Grant Thornton 333 John Carlyle Street; Alexandria, VA 22314 Registration: 5th floor VANTS: 1-800-767-1750, code: 23087#
Attendees:	Chair: Margaret Puccinelli Designated Federal Officer: Gina Capra Members: Verdie Bowen, Janice Casillas, Dale Gibbs, Kevin Kelley, John Mengenhausen, Randy Reeves, Buck Richardson, Debra American-Horse Wilson Ex officio members: Richard Davis, Tom Morris, Wakina Scott, Colonel Seferino Silva, Wilbur Woodis Ex officio representatives: Wakina Scott, Wilbur Woodis Office of Rural Health: Elmer Clark, Thomas Klobucar Speakers: Listed below with presentation summary
Note Takers:	Krista Holyak, David McCloud, Emily Oehler

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Part 1: Welcome, Introductions and Meeting Materials Review

8:30 – 9:15 am

- Speakers: Margaret Puccinelli, Chair, VRHAC
- Gina Capra, Director, U.S. Department of Veterans Affairs (VA) Office of Rural Health (ORH)

Margaret Puccinelli, Chair, VRAHC

- Ms. Puccinelli welcomed the Committee and recognized former Chair, Terry Schow's leadership. Committee members introduced themselves with a focus on connection to Veterans, importance of rural health, their role at work and desired meeting outcome(s).
- Ms. Puccinelli reviewed meeting objectives, past recommendations, fiscal year 2016 recommendation schedule, and agenda in which the selected speakers tied to the three fiscal year 2015 recommendations. She explained that, by end of meeting, the Committee would explore areas of interest for the VRHAC spring 2016 meeting.
- Facility logistics, emergency meeting site and meeting package were reviewed.

- The Committee established meeting ground rules.

Gina Capra, Director, VA Office of Rural Health

- Ms. Capra welcomed the Committee and reviewed member status changes and absentee members.

Highlights/Key Takeaways/Themes:

- VRHAC is a discretionary Committee that must stay abreast of the VA Secretary's national efforts, and relevancy to and impact on rural Veterans.

Part 2: Presentation: Affordable Care Act, Veterans Choice Act and Future State of Community Care

9:15 – 10:15 am

- Speakers: Duane Flemming, Director, Policy Analysis and Forecasting Veterans Health Administration (VHA) Office of the Assistant Deputy Under Secretary for Health for Policy and Planning
- Terrence Stinson, Director, Policy Analysis, VHA Office of the Assistant Deputy Undersecretary for Health for Policy and Planning

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

- Mr. Stinson reminded the Committee that "policy begins with each of us," "policy codifies an idea in to law" and encouraged members to provide policy feedback through the Office of Rural Health.
- Veterans Choice Act information was provided, along with legislative updates:
    - The Veterans Choice Act was implemented in November 2014 and the Choice Improvement Act was signed into law on July 31, 2015, to highlight improvements to the Veterans Choice Act.
    - Reviewed Choice Improvement Act provisions that included VA-requested key changes:
        - Waiver of the enrollment date.
        - Authority to expand provider base (Choice Network).
        - Allowance for appointments inside of 30 days where clinically indicated.
        - Immediate option for Choice benefit when no full-time physician is present.
        - Expansion of the 60-day episode of referral care
        - Final provisions are scheduled to be implemented December 1.
    - Once implementation is finalized, the public can submit comments through email during a 120-day public comment period; VA reviews and considers comments before taking action.
    - Shared that Veterans newly eligible under the Choice Improvement Act will receive written notification.
    - Stressed that with new Community Care model, patient care coordination between VA and community providers will be essential.

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Duane Flemming, Director, VHA Office of the Assistant Deputy Under Secretary for Health for Policy and Planning

- Mr. Flemming discussed VA's efforts to consolidate community care to deliver "best-in-class" care for Veterans through core competencies and a network for non-core services:
    - Focus is on personalized, proactive, patient-centered care; a high-performing network; metrics to drive improvements; research and education; use of innovative technologies and care models; and investment in and growth of VA's core health care competencies.
    - Shared impact to Veterans (e.g., access to private sector's best practices; coordinated care across the system; personalized tools).
    - Reviewed key considerations for community care consolidation (e.g., provide a simplified program, improve Veteran experience, make it easier for community providers to work with VA, apply leading practices from industry and federal partners).
    - Shared focus on how the community care consolidation plan joins programs through a three-phase program: develop plan, implement systems and process changes, and deploy and make data-driven improvements.

Q&A/Group Discussion

- VRHAC members provided feedback on both presentations:
    - Comments on engagement of State Directors of Veterans Affairs for policy development.
    - Concern on complexity of physician enrollment and reimbursement rate.
    - Recommendation to make Veteran care a more attractive patient proposition as solvency is an ongoing physician challenge.
    - Concern that administrative burden is on Veteran patient and community provider.
    - Concern on primary care physician workforce shortage and suggestion that government fund more residency slots with loan repayment.
    - Concern on how changes will be communicated, so VA gives one uniformed answer to all Veterans and community providers.
    - Concerns on Native American Veterans, Indian Health Service (IHS) and Veterans Choice Program integration.
    - Questions on reimbursement for telehealth services (Medicare) and possibility of oral health inclusion in the Veterans Choice Program.
    - Questions on third party administrator contract status.
    - Questions what "core" providers and network means: Federally Qualified Health Center providers, establishment of preferred network and expanded additional providers.
    - Questions on how VA addresses cultural preferences when providing care options such as Western or traditional medicine.
    - Questions on how PC3 would work with new model of care and VA's plan to consolidate it seamlessly from the Veterans perspective.
    - Discussion on whether patient education is needed on expertise of each

type of care provider.

Highlights/Key Takeaways/Themes:

- Current confusion on Veterans Choice Program and added confusion expected with changes in Choice Improvement Act.
- Need for unified communication to Veterans, VA providers and community providers on new Choice Improvement Act for uniformed understanding.

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Part 3: Presentation: *My*VA Communities

10:30 – 12:00 pm

- Speaker: Laura O'Shea, Deputy Director, Interagency Care and Benefits Coordination Office, Veteran Experience Team

Laura O'Shea, Deputy Director, Interagency Care and Benefits Coordination Office, Veteran Experience Team

- Ms. O'Shea explained that the *My*VA Communities model is about unification of a "sea of goodwill" that focuses on the Veteran experience, is community driven, and not a VA initiative.
    - Example: the Alaska Forget Me Not Coalition added *My*VA Communities nuances to its Charter. Participants signed three-year commitments to expand the model.
- VA Secretary's expectation is that senior local leaders (VA medical center director, regional office director, etc.) are engaged with community groups so that decision makers are at the table for active engagement.
- All *My*VA initiatives focus on the Veteran experience, and not how VA operates.
- Explained that tribal relations are part of the *My*VA Communities model.
- Each community has the flexibility to define its local objectives based on local concerns (e.g., age-related, socioeconomic).
- Toolkits on how to set up a Community are available at www.va.gov/icbc/myVA.asp.
- Members were encouraged to visit new www.vets.gov website (beta version launched November 11, 2015) and www.explore.va.gov.

Q&A/Group Discussion

- Questions on how to use *My*VA Communities in rural areas. Contact myvacommunities@va.gov with opportunity.

Highlights/Key Takeaways/Themes:

- VA is focused on building synergy and interaction with existing local Veteran support programs, not building a new program.

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Part 4: Health Information Exchange/Virtual Lifetime Electronic Record

1:00 – 2:00 pm

Speakers: Theresa Hancock, Director, Veterans and Consumers Health Informatics

Office, Connected Health

- Glen Crandell, Direct Program Manager, VHA, Virtual Lifetime Electronic Record (VLER) Health

Theresa Hancock, Director of Communications & Member Services, Mississippi Health Care Association

- Ms. Hancock discussed My Health***e***Vet and Blue Button:
  - My Health***e***Vet is a comprehensive personal health record and patient portal; Veteran-trusted since it is behind the VA firewall; it is not just for Veterans, but also VA employees, non-enrolled Veterans and families.
  - My Health***e***Vet allows for transactions (e.g., prescription refills), secure messaging (e.g., provider shares lab results with patient, saving trip to hospital), VA-physician developed health education, appointment reminders and more.
  - Patient portal with 3.4 million unique users and 1.4 million unique VA Blue Button users with a focus on user-friendly, personalized care through relationship development.
  - Population is 64 and older; more than 2,000 users are older than 90.
  - Veterans are protective of their personal health information and like that MyHealth***e***Vet is behind a firewall and customizable for their personal needs.
  - Vets.gov will be the face of VA, a one stop resource; it will pull from My Health***e***Vet.
  - The Robert Wood Johnson Foundation created the Blue Button (access to patient data–health, education, etc.); 100 million people have access to Blue Button.

Glen Crandell, Direct Program Manager, Veterans Health Information Exchange (formerly VLER)

- Mr. Crandell explained the Health Information Exchange between VA and community partners:
  - 75 percent of Veterans seek and/or use community health care.
  - Two key tools provided to users for health information exchange between VA and community partners:
    - Veterans Health Information Exchange (VHIE)–query and retrieve partner information (57 community partners):
      - Two ways a doctor can pull information to send to community provider: VistAWeb and Joint Legacy Viewer.
    - VHIE Direct–converse/back and forth via secure email; does not currently upload into personal health record but plans to in the future; can be imported and uploaded through VistA imaging as part of the patient record.
    - VA and IHS are working together to use VHIE Direct.
  - ORH funded 56 rural health community coordinators at 56 of the most rural VA medical centers (VAMC) across the U.S. to provide on-site training for Veterans and VAMC clinicians on the benefits of using VLER health exchange, direct secure messaging, and Blue Button.

- Walgreens offers Veterans free flu shots, and a nightly batch updates their VA health record. Sixty percent of Veterans traveled five miles or less to Walgreens to get a flu shot, which saved 2M+ miles during the 2014-2015 flu season.

Q&A/Group Discussion

- VRHAC members provided feedback on the presentation and VA health information exchange.
    - Questions on if/how patients can hide selected medical data, such as data related to behavioral health; Veteran must sign waiver to release information to a community provider.

Highlights/Key Takeaways/Themes:

- Data security and information sharing capabilities are key to provide personalized care to Veterans.
- Health technology must be built from Veteran perspective and delivered by an intuitive structure.

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Part 5: Rural Health and Workforce

2:00 – 3:00 pm

- Speakers: Russ Peal, Associate Director, Healthcare Recruitment Office of Workforce Management & Consulting
- Ryan Lilly, Director, Maine VA Medical Center at Togus, Maine

Russ Peal, Associate Director, Healthcare Recruitment Office of Workforce Management & Consulting

- Mr. Peal discussed national VHA health care recruitment efforts, with a focus on rural communities to recruit "mission-critical health care providers:"
    - VHA recruits 30,000 medical professionals (e.g., physicians, nurses) each year.
    - The national attrition rate is seven percent; this is consistent with or better than similar large scale health systems.
    - Hard to recruit and compete with higher, private industry salaries.
    - National provider recruiting efforts are complimented by local and regional marketing efforts to attract high-demand professionals; in addition to traditional postings on USAjobs, take a proactive focus to find medical providers where they are through media buys, VA careers call center, recruitment conferences, public service announcements, public relations and community outreach, and social media.
    - Recruitment was expanded to have one recruiter within each VISN to recruit for the most difficult-to-find providers for that area.
    - Since 2011, VA partners with the national rural recruitment and retention network (3RNet) to connect with providers interested in rural opportunities.
    - "Take a Closer Look at VA" is standardized national outreach strategy to attract VHA health profession trainees to permanent positions.

- Twenty-five percent of recruiting is in rural facilities.
- Recruited rural providers come from all over the United States; those who want to serve in rural areas, or those who trained there or have family there.

Q&A/Group Discussion:

- VRHAC members provided feedback on the presentation and VA recruiting
  - Suggested using native languages in materials to recruit at tribal colleges.
  - Suggested a program that would allow health care students to shadow a VA provider.
  - Requested information on recruiting incentives, how a VA facility identifies a need for a provider and local human resources integration with national recruiting.
  - Questioned how many providers are hired and lost each year in rural areas.
  - Questioned why providers leave VA.

Ryan Lilly, Director, Maine VA Medical Center at Togus, Maine

- Mr. Lilly shared a local perspective on recruitment and staffing at rural clinics.
  - Rural challenges to local recruiting:
    - Sparseness of specialists in rural areas—VA's strategy is to increase specialty care provided through Community Based Outpatient Clinics to reduce travel time to VA medical centers.
    - Recruitment incentives are locally funded (recruitment/retention spending is separate line item in budget; 25 percent per year of annual salary is max bonus for position).
    - Confines to the VHA salary structure such as pay cap and that no one can make more than the President ($400,000)–which is non-competitive with industry (e.g., neuroscientists typically make one million annually).
    - Federal recruitment process limitations restrict VA on how to attract candidates (e.g., only flying out candidate and not spouse during an interview, host meal). This is a less competitive approach compared to private sector.
  - Rural training programs are essential to rural recruiting because where individuals spend their residency years is generally where their career starts; however, there are not a lot of medical schools in rural areas.
  - Use of telemedicine is a solution to access specialists, especially if there is low demand.

Q&A/Group Discussion:

- VRHAC members provided feedback on the presentation and VA recruiting.
  - Question on VA's ability to use temporary providers; must use a contract, comes out of general operating budget.
  - Question on salary cap; providers leaving VA for IHS or Department of Defense (DoD) for salary increase.

- Question on hiring process; position has to be posted 14 days internally before VA can consider external candidates.
- Question on why medical providers leave VA; increased administrative burden reduces clinical time.
- Question on how administrative burden affects interaction with patient:
  - Patient complaints of physician focus on computer screen, not person.
  - Less than half of allocated appointment time is designated for the patient, and the remaining time is for administrative actions.
  - Reduction of administrative burden would create better patient experience.
  - VA is better than private sector for not double or triple booking.
  - VA has longer appointment times and more face-to-face time with patients than private sector.
- Question on how to address administrative burden; improve ratio of support staff to provider, fix space issue, be smarter about how VA uses staff (e.g., nurses can call in prescriptions to save physician time) or hire a scribe to type information in while provider provides eye-to-eye contact.

Highlights/Key Takeaways/Themes:

- Discrepancies between public and private sectors provide increased challenges to rural health care professional recruitment and retention.
- Administrative burden impacts physician/provider retention and patient experience.
- Knowledge of rural vacancies (location/specialty) will help support targeted recruitment efforts.

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Part 6: Working Session Part 1: Recap and Observations

3:15 – 5:00 pm

- Chair led members in discussion on key findings of the day.
  - Committee expressed concern on multi-faceted issues surrounding access to and retention of rural medical providers, and stressed need for new business model.
    - Adjust health care salaries to be competitive in the market and relook at monetary incentives.
    - Review use of locum tenens to shift money to pay more competitive salaries:
      - Explore shared staffing as possibility for rural areas, especially for care coordination.
  - Discussion on use of and payment for telehealth through the Veteran Choice Program.
  - Discussion that U.S. simply does not have enough physicians at large (even beyond rural), and VA must look for staffing solutions not centered on a primary care physician and explore how to expand patient's understanding

of physician extenders (e.g., nurse practitioner, physician assistant).
    - Discussion occurred on physician job satisfaction, and the impact it has on patient care (i.e., administrative burdens, provider/support staff ratio, and increased patient time).
    - Discussion on how to educate and empower Veterans to drive their care and pull in VA for support, with a shift to Veteran-centric approach that does not create continual dependency on the VA system.
    - Discussion on the Transition Assistance Program, how it works for rural Veterans and adding Veteran Choice Program topic to the training.
    - Discussion on need for proactive awareness to increase input on developing policies.
    - Discussion on VA's work to establish one community care group within VHA.
    - Discussion on need to streamline contracts so providers can focus more on health care delivery and patient care.

Highlights/Key Takeaways/Themes:

- Concern on multi-faceted issues surrounding access to and retention of rural medical providers, and stressed need for new business model for both VA care delivery and community providers.

7 Part 7: Chairman's Adjournment

5:00 pm

- Chair reviewed agenda for day two and adjourned the meeting.

Meeting Summary

Veterans Rural Health Advisory Committee Meeting
Department of Veterans Affairs

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Date & Time:	Wednesday, November 18, 2015, from 8:30 AM to 5:00 PM
Location:	Grant Thornton 333 John Carlyle Street; Alexandria, VA 22314 Registration: 5th floor VANTS: 1-800-767-1750, code: 23087#
Attendees:	Chair: Margaret Puccinelli Designated Federal Officer: Gina Capra Members: Verdie Bowen, Janice Casillas, Dale Gibbs, Kevin Kelley, John Mengenhausen, Randy Reeves, Buck Richardson, Debra American-Horse Wilson Ex officio members: Richard Davis, Wakina Scott, Colonel Seferino Silva, Wilbur Woodis Ex officio representatives: Wakina Scott, Wilbur Woodis Office of Rural Health: Elmer Clark, Speakers: Listed below with presentation summary
Note Takers:	Krista Holyak, David McCloud, Emily Oehler

1	**Part 1: Welcome and Agenda Review** 8:30 – 9:00 am ▪ Speaker: Margaret Puccinelli, Chair, VRHAC

Margaret Puccinelli, Chair, VRAHC

- Ms. Puccinelli reviewed agenda items and key Committee findings from previous day.

Highlights/Key Takeaways/Themes:

- Main topics from day one were found to be enterprise-wide–meaning they are not exclusive to just one local facility, but could affect rural health delivery as a whole.

2	**Part 2: ORH Strategic Communications Update** 9:00 – 9:30 am ▪ Speaker: Emily Oehler, Manager, Grant Thornton

Emily Oehler, Manager, Grant Thornton

- Ms. Oehler reviewed the communications philosophy (i.e., explore, evaluate, explain and empower) that informed 30 million Americans in one year and earned ORH three national communication awards.
- Fiscal year 2015 strategic communications highlights included:
    - Video that reached more than 300,000 VA employees and received more than 6,400 views on YouTube.
    - Public affairs efforts reached more than 10 million Americans through six interviews for news outlets such as *San Antonio Express*, *San Francisco Chronical*, *Task and Purpose*, and *Signal*.
    - National Rural Health Association (NRHA) e-newsletter and quarterly magazine articles reached more than 21,000 members with each distribution.
    - ORH's quarterly newsletter, "The Rural Connection," reached nearly 13,000 subscribers, of which 17 percent are VA employees, and had an 87 percent increase in subscribers in one year.
- New ORH communications materials in fiscal year 2016 will include the 2015 annual report, info sheets, Rural Promising Practices, core deck, videos and webinars. Also, ORH will launch a new website, coordinate the NRHA Veteran journal supplement and prepare for ORH's tenth anniversary in 2017.

Q&A/Group Discussion

- Discussed criteria for Rural Promising Practices and how white papers will be distributed and used.

Highlights/Key Takeaways/Themes:

- Targeted ORH communications efforts reached key audiences and empowered partners to advocate on behalf of rural Veterans.

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Part 3: Ex-Officio Reactor Panel: Veterans Care in the Community

9:30 – 10:15 am

- Speakers: VRHAC ex officio members
- Rich Davis, Deputy Administrator Community Programs Rural Development, U.S. Department of Agriculture
- Wakina Scott, as designee for Tom Morris, Director, Federal Office of Rural Health Policy (FORHP), U.S. Department of Health and Human Services
- Colonel Seferino Silva, Department of Defense, Reserve Medical Forces Advisor to Air Force Surgeon General
- Wilbur Woodis, as designee for Captain Susan Karol, U.S. Public Health Service, Chief Medical Officer, Indian Health Service, U.S. Department of Health and Human Services IHS

- Panelists provided agency insights on: (1) major efforts that support rural Veterans' health, (2) Veteran Choice Program initiatives, and (3) future collaborative opportunities on rural Veteran care. Discussions included:
    - Access to medical records to support disability claims process.

- Electronic health records.
- Recruitment efforts for nurse practitioners, physician assistants and primary care physicians.
- Financial support is available for rural infrastructure (e.g., grants or flex programs to build rural hospitals).
- Housing challenges on reservations to support rural Veterans.
- Need for new models of care, such as shared providers.
- Concern on Veteran Choice Program bureaucracy and payment challenges experienced by community providers.
- Veteran Choice Program eligibility.
- Need for ongoing outreach on Veteran Choice Program to community providers and tribal governments and leadership.
- Increased need for telehealth.
- Inter-agency collaboration to increase access to broadband in rural communities.

Highlights/Key Takeaways/Themes:

- Veteran Choice Program continues to have implementation challenges for Veterans and community providers.
- Technology (broadband and telehealth) is an essential component of rural Veteran care.
- Overall community infrastructure and services impact health and well-being of rural Veterans.

Part 4: Presentation: Advisory Committee Management Office Update and *My*VA Advisory Committee Report Out

10:30 – 11:30 am

- Speaker: Jeff "Boomer" Moragne, Director, Advisory Committee Management Office, U.S. Department of Veterans Affairs

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

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- Mr. Moragne presented appointment certificates to Dale Gibbs, Randy Reeves and Margaret Puccinelli.
- Reviewed key Federal Advisory Committee Act (FACA) elements:
  - Reduced number of committees across the federal government, enacted standards and established transparency.
  - Two types of federal advisory committees–statutory (indefinite charter) and discretionary (short or long term to solve an issue).
  - Formal meetings with quorum must appear in the public record and have the Designated Federal Officer or alternate in attendance.
  - Private, "preparatory" meetings possible such as for research, to share proprietary information, administrative in nature or sub-committee work.
  - Advisory members can testify to Congress as a private citizen, and may not speak on behalf of VRHAC or VA; similarly, written correspondences must disclose membership, and state that opinion is personal and does not represent the Committee.

- Committee member employee handbook published for 2015.
- VA currently has 26 advisory committees, with two recently created:
  - *My*VA Advisory (first VA discretionary committee in nine years).
  - Commission on Care (first VA statutory committee in 11 years).
- VA Secretary is focused on fresh perspectives with a maximum commitment of two terms per person per advisory committee.
- The newly created *My*VA Advisory Committee focuses on VA's transformation to a Veteran-centric agency, and is comprised of 14 members from diverse public and private sector organizations (e.g., Veterans, academic professionals, medical professionals, military officers, CEOs).
- Every *My*VA Advisory Committee begins with a status discussion on its' five focus areas:
  - Improve Veteran experience.
  - Improve employee experience.
  - Service support.
  - Continuous improvement (from public and private sector).
  - Strategic partnerships.
- Committee advises on implementation, appropriate levels of support, long- and short-term support and periodic progress reviews.

Q&A/Group Discussion

- VRHAC discussion on employee satisfaction, culture change with leadership focus and better management of the unexpected.

Highlights/Key Takeaways/Themes:

- Committee must adhere to FACA and be fully transparent to the general public.
- New *My*VA Advisory Committee focused on VA's transformation to a Veteran-centric agency.
- Advisory committees are encouraged to coordinate with other committees for integrated recommendations.

Part 5: Presentation: ORH Director's Update

12:30 – 1:30 pm

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

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Gina Capra, Director, VA Office of Rural Health

- Ms. Capra reviewed ORH's vision, mission and five-year strategic goals; more than 100 representatives from federal agencies, national stakeholder groups and partners from across the VA helped the four strategic goals over the course of a year.
- Discussed current enrolled rural Veteran data and demographics, and rural health care access challenges, such as 25 percent of rural Veterans live below the poverty line.
- Explained definition of rural with rural-urban commuting area codes.
- VHA funding shortfall in fiscal year 2016 resulted in preliminary reallocation of

ORH funds to urgent agency needs and possible budget reduction. Approximately 600 ORH pilot projects were under sustainment or new award review in fiscal year 2015, and approximately 200 were not able to be funded.

- ORH is focused on enterprise-wide rural health solutions.
- ORH Rural Promising Practices are part of enterprise-wide solutions to nationally disseminate proven models of care that meet six criteria. Participant sites can receive peer-mentoring opportunities to increase rural Veterans access to care through adoption of vetted ORH Rural Promising Practices.
- ORH will complete the first national rural Veterans needs assessment over the course of fiscal years 2016-2017, which will inform funding, policy and recommendations.

Q&A/Group Discussion

- Telehealth enables providers who relocate to maintain patient care and relationships.
- Lack of broadband needs to be addressed with innovative ideas (example: broadband access through cell phones for first responders during a disaster).

Highlights/Key Takeaways/Themes:

- To increase rural Veterans access to care, ORH focuses on enterprise-wide level programs with a focus on studies, innovations and spread of key findings.

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Part 6: Presentation: Ethics Briefing

1:30 – 2:30 pm

- Speaker: Purnima Boominathan, Staff Attorney, Office of General Counsel

Purnima Boominathan, Staff Attorney, Office of General Counsel

- An "Ethics Training for Special Government Employees" presentation occurred.

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Part 7: Working Session Part 2: VRHAC Operations

- **Membership**
- **Charter**

2:30 – 3:00 pm

- Members reviewed Committee vacancy and acknowledged the Federal Register Notice soliciting candidate nominations for consideration by the Secretary of the VA.
- Members conducted a charter review and proposed minor revisions to the Designated Federal Officer for processing.
    - Committee clarified Charter statement to note that ex officio members are non-voting members.

Part 8: Working Session Part 3: Fiscal Year 2016 Recommendations

3:15 – 4:30 pm

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- Committee members discussed potential alignment of key issues (and eventual recommendations) to the five *My*VA focus areas.
- The Committee established working groups on the topics of telehealth, workforce and models of care:
    - The telehealth working group will discuss challenges such as telehealth payment challenges exclusive to Veterans Choice Program and state reimbursement; expansion of telehealth beyond VA into community; broadband connectivity; and updating technology to incentivize providers. Members selected were John Mengenhausen, Dale Gibbs, Debra Wilson, William "Buck" Richardson; ORH representative Thomas Klobucar; and ex officio member Rich Davis.
    - The workforce working group will explore challenges that impact rural Veteran care such as workforce employee experience and satisfaction, role of mid-level medical providers, and contracts and related administrative burdens (e.g., Veterans Choice Program provider contracts). Members selected were Janice Casillas, Kevin Kelley, Syreeta Long and Don Samuels; and ex officio member Tom Morris.
    - The rural models of care working group will explore how to bring services to rural Veterans through various models of care (e.g., mobile, telehealth, Veteran Choice Program) and shared facilities with IHS. Members selected were Chair, Margaret Puccinelli; members Randy Reeves and Verdie Bowen; ex officio member Colonel Seferino Silva and ex officio representative Wilbur Woodis.
    - Committee established way forward for working groups with actions and timeline leading up to next VRHAC meeting in spring 2016.
- Committee members provided guidance to Designated Federal Officer for spring meeting planning that included timeframe, rural locality criteria, "best in class" rural programs, and preferred speakers and topics. Members recommended new travel and hotel approach for spring meeting. Member Verdie Bowen was selected to lead event planning.
- The Committee selected Chair Margaret Puccinelli, member Kevin Kelley and ex officio member Colonel Silva to support new ORH communication efforts.

Highlights/Key Takeaways/Themes:

- VRHAC will explore telehealth, workforce and models of care for fiscal year 2016 recommendations through three working groups.

9	**Part 9: Public Comment Period** 4:30 – 5:00 pm • No public comments offered.

10	**Part 10: Chairman's Adjournment** 5:00 pm • Chair adjourned the meeting.