U.S. Department of Veterans Affairs (VA)
Special Medical Advisory Group (SMAG)
Meeting Minutes
September 25-26, 2024
Palo Alto VA Medical Center, 3801 Miranda Ave., Palo Alto, CA 94304

ATTENDEES:

Committee Members Present:
Dr. Gregg Meyer (Chairperson)
Dr. Terry Fulmer (Vice Chairperson)
Dr. Francis Crosson
Dr. Arthur Kellermann (Virtual)
Dr. Kameron Matthews (Virtual)
Dr. Michael Mittelman (Virtual)
Dr. John Prescott (Virtual)
Dr. Carolina Reyes (Virtual)
Dr. Phillip Sandefur (Virtual)
Dr. Lewis Sandy
Dr. Ross Taubman (Virtual)
Dr. Mary Wakefield
Dr. Misty Wilkie
Dr. Robert Winn (Virtual)

Committee Members Absent:
Dr. Jeffrey Akman
Dr. Robyn Begley
Dr. Bijiibaa' Garrison
Mr. Chanin Nuntavong
Dr. M. Christopher Saslo

U.S. Department of Veterans Affairs Staff and Presenters:
Dr. Shereef Elnahal, VA Under Secretary for Health (USH)
Dr. Ryung Suh, Veterans Health Administration (VHA) Chief of Staff (CoS) (Virtual)
Mr. Jeffrey Moragne, Director, Advisory Committee Management Office (ACMO)
Ms. Nadia Smith, VHA Acting Chief Digital Health Officer (Virtual)
Ms. Latriece Prince-Wheeler, VHA Acting Deputy Chief Digital Health Officer (Virtual)
Ms. Hillary Peabody, VHA Acting Asst. USH of Integrated Veteran Care (IVC) (Virtual)
Dr. Neil Patel, Acting Dep. Exec. Director, VHA National Emergency Medicine (Virtual)
Ms. Donna Hill, VA Dep. Ops Director, Nat'l. Artificial Intelligence Institute (AI) (Virtual)
Dr. Michael Charness, Chief of Staff, VA Boston Healthcare System (Virtual)
Dr. Carolyn Clancy, VA Asst. USH, Discovery, Education and Affiliate Networks
Dr. Jennifer Strawn, Executive Director and Deputy Chief Nurse, VHA Office of Nursing
Ms. JoAnn Seppelt, VA Act. Senior Advisor, AUSH, Patient Care Services/CNO (Virtual)
Dr. David Au, Executive Director, VHA Center for Care and Payment Innovation
Dr. Ilana Seidel, Veteran Service Integrated Network (VISN) 21 Clinical Resource Hub Long COVID Section Chief
Ms. Marian Adly, Deputy CoS, National AI Institute, VA Office of Research and Development (Virtual)
Dr. Ralph Schapira, Chairperson, VHA Institutional Review Board (Virtual)
Dr. Neil Evans, Acting Executive Director, VA Electronic Health Record Modernization Integration Office (EHRM IO) (Virtual)
Dr. David Massaro, Senior Medical Advisor, Functional Champion, EHRM IO (Virtual)

Dr. Paul Veregge, Staff Physician, VA EHRM IO (Virtual)
Ms. Jean Gurga, Exec. Medical Director, VA Palo Alto Health Care System (PAHCS)
Ms. Megan O'Connor, Interim Deputy Executive Director, VA PAHCS
Ms. Kristan Murray, Interim Deputy Executive Director, VA PAHCS
Dr. Michael Kozal, Chief of Staff, VA PAHCS
Dr. Rina Shah, Deputy Chief of Staff, VA PAHCS (Virtual)
Dr. Peter Lee, Associate Chief of Chief, VA PAHCS (Virtual)
Dr. Kiran Rai, Associate Director for Patient Care Service, VA PAHCS
Mr. Charles Hume, VHA Chief Informatics Officer (Virtual)
Ms. RimaAnn Nelson, VA Assistant USH for Operations (Virtual)
Mr. Alan Cleaver, Executive Assistant to the VHA Chief of Staff (Virtual)
Mr. Fernando Rivera, Director, VA Southeast Louisiana Health Care System (Virtual)
Dr. Christina Cellura, Director, VA Southern Oregon Health Care System (Virtual)
Mr. Josh Geiger, Director of Operations, VHA National Emergency Medicine (Virtual)
Ms. Purvi Desi, Director, VHA Digital Health Experience and Product Delivery (Virtual)
Mr. Adrian Sims, Director, 10B Admin Ops (Virtual)
Mr. Brian McCullers, Administrative Officer, 10B Admin Ops (Virtual)
Ms. Mariah Skylr, White House Fellow
Dr. Elizabeth Bast, Staff Physician, Miami VA Medical Center (Virtual)
Dr. Pandora L. Wander, Staff Physician, VA Puget Sound Health Care System (Virtual)
Dr. Megan Miller, Clinical Psychologist, VA Puget Sound Health Care System (Virtual)
Dr. Calvin Yang, Staff Physician, VA Greater Los Angeles Health Care System (Virtual)
Dr. Jacqueline Neal, Staff Physician, VA Chicago Medical Center (Virtual)
Ms. Theresa Johnson, Staff Physician Assistant, VA Atlanta Medical Center (Virtual)
Dr. Lixmar Pereira, Health Science Specialist, National AI Institute (Virtual)
Dr. Sushant Govindan, Acting Exec. Director, AI and Emerging Technology, VHA Digital Health Office (Virtual)
Dr. Benjamin Baum, Staff Resident Physician, VA Central Texas Health Care System (Virtual)

Other General Public Attendees:
Ms. Johnna Kuykendall, Assigned Transcriptionist, Jamison Professional Svcs. (Virtual)
Ms. Tracie Ellis, Division Manager-Transcriptionist, Jamison Professional Svcs. (Virtual)
Mr. Sidath Panangala, Congressional Research Service (Virtual)
Ms. Ellen Milhiser, Editor, Synopsis (Virtual)
Ms. Cheryl Scheidt, Exec. Director, VA Business Development, Mantech Int'l (Virtual)
Mr. Geoff Howard, Vice President, Federal Healthcare, Mantech Int'l (Virtual)
Dr. Samir Benosman, Accenture Federal Services (Virtual)
Mr. Alan Petrazzi, Accenture Federal Services (Virtual)
Ms. Stacie Rivera, Accenture Federal Services (Virtual)
Ms. Corey Siebers, Program Manager, Maxim Healthcare Services (Virtual)
Mr. Drake Martin-Greene, Maxim Healthcare Services (Virtual)
Ms. Kristy Park, Principal for Park Government Relations, LLC (Virtual)
Ms. Karen Rose Dunaway, Gentiva Personal Care (Virtual)
Ms. Annita Ferencz, Gray and Associates, L.C. (Virtual)

SMAG Support Staff:
Mr. Brian Schoenhofer, Designated Federal Officer (DFO)
Ms. Aimee Corcoran, Health System Specialist (Virtual)
Ms. Jeannie Ferrell, Health System Specialist
Ms. Yvonne Johnson, Program Analyst (Virtual)
Mr. Dennis Lahl, Management Analyst
Ms. Berenice Perez-Ruiz, Program Analyst (Virtual)
Ms. Stephanie Seeley, Staff Assistant (Virtual)
Mr. Kyle Sommer, Legislative Program Specialist
Ms. Melissa Spady, Assistant DFO
Mr. James Wilson, Assistant DFO

September 25, 2024 - Meeting Commencement: 8:30 A.M. PT

SMAG DAY 1 OPENING REMARKS

Summary of Opening Remarks by Mr. Brian Schoenhofer, VA DFO for SMAG

- Per Federal Register Notice, a half-hour session is designated for the general public to offer feedback to the SMAG and the VA.
- A subcommittee of the SMAG will meet with local VA medical center leadership for a facility and campus tour, as well as briefing on proprietary information. The meeting on day two will pause from approx. 9:15 a.m. PT until 1:15 p.m. PT.

Summary of Opening Remarks by Dr. Shereef Elnahal, VA USH

- The Sergeant First Class Heath Robinson Promise to Address Comprehensive Toxics (PACT) Act of 2022 remains the most important health care initiative. To date, VA has granted over one million Veteran claims.
- The PACT Act has afforded Veterans travel benefits to get to and from medical appointments, long-term care, service-connection benefits, and specialized care at external medical facilities.
- VHA faces rising demand for healthcare services. Despite these challenges the VA has maintained the momentum by increasing the access to care.
- The success of the telehealth and community care programs has helped VHA to reach the pre-pandemic enrollment levels.
- Community care represents approximately 40% of VA care.
- Tele-emergency care is now in use in three VISN's, which helps to increase patient encounters and decreases the cost of patients being outsourced.

Key Takeaways from SMAG Members

- The SMAG Chair thanked the VA for being “extraordinarily helpful” during the last few months to support displaced and disproportionate Veterans impacted by a major regional hospital closure in the Massachusetts catchment area due to financial bankruptcy. Lauded efforts by VA included the Boston VAMC led by Mr. Vincent Ng and Dr. Michael Charness.

Key Recommendations

- VHA is a complex enterprise and works through physician shortages and strategic challenges. VHA’s partnership with the Department of Health and Human Services enables hires for skilled physicians to fill vacant positions.

VHA STRATEGIC REVIEW

Summary of Presentation by Dr. Ryung Suh, VHA Chief of Staff

- The VHA Strategic Review report discussed the rising number of Veterans who receive VHA care and services and their impact on VHA capacity.
- Increased reliance on VHA due to:
    - Increased life expectancy of Veterans requiring more services.
    - Increased number of Veterans moving to a higher priority group.
    - Expanded eligibility from the PACT Act.
- The report notes VHA capacity is not only being impacted by the increase of Veteran demand, but also by the increased cost of health care, primary care provider shortages and VHA critical occupations shortage.
- The report notes VHA is experiencing localized inpatient and outpatient capacity constraints and aging infrastructure.
- The report states there is an increase in community care costs, almost double the amount in the past five years.
- Despite all this, the report states VHA has made significant progress in enhancing care quality, patient experience and trust amongst Veterans that receive care. In addition, VHA has improved workforce capacity to address staffing shortages and productivity.
- VHA is committed to continue implementing strategies already in place to combat these challenges and alleviate risks to Veterans.

Key Takeaways from SMAG Members

- Return to VHA mission to develop a strategic plan and VHA health care priorities.
- Decide on top health care priorities that give VHA “the most bang for the buck.”
- Consider partnering with the Department of Defense to help with capacity challenges.

Key Recommendations Shared

- Optimally mange the balance of care between VHA direct care and community care systems.
- The communication piece will be very important as calibrating services regionally.
- VHA should analyze Medicaid programs around the country as it relates to long term support.
- VA SMAG Committee would like to discuss the topic of aging infrastructure with VHA in the future.

FOLLOW-UP: DIGITAL HEALTH OVERVIEW

Summary of Presentation by Ms. Nadia Smith, Acting Chief Digital Health Officer and Ms. Latriece Prince-Wheeler, Acting Deputy Chief Digital Health Officer

- The Digital Health Office (DHO) applies modern, innovative technologies and data solutions to deliver world class healthcare experiences to Veterans and their care team. Capabilities include categories such as mobile health, health information technology, health data management, artificial intelligence, immersive technology, wearable devices, telehealth and telemedicine, personalized medicine, and advanced care delivery products for Veterans.
- Focused collaborations on experience, and not process, associate the Veteran and care team experience among EHRM-IO, Office of Information and Technology, and Veterans Experience Office.
- Several goals including the continued integration for digital health solutions and ways of working to simply, standardize, and automate (e.g., process automation to allow care teams to work at the top of their license, self-service tools for patients, portfolio rationalization to reduce redundancies and focus resources on highest impact priorities).
- DHO measures how well products are meeting the needs of humans across their end-to-end journey. This includes observing behaviors, measuring outcomes, and taking actions based on these data.
- DHO's "journey area approach" encapsulates what the journeys are and defining areas large enough to be valuable and noticeable, but small enough to be transformed.
- Priority next steps focus on building upon existing human centered research and discovery across these potential journeys to identify pilots to move into a new collaborative digital operating model.

Key Takeaways from SMAG Members

- DHO has accomplished a significant amount of strategic planning.
- SMAG applauds the DHO's shifting to a broader journey mapping umbrella approach; a necessary transition that also deals critically with maintaining our workforce and balancing both capacity and burnout.

- Incorporating concepts around change management as VHA moves into these new technologies, particularly the AI space, for your care teams while being cognizant for pushback for workforce replacement by technologies.
- Discussed metrics of evaluation effectiveness including prior metrics dashboards of past, and its relative access and leveraging by both staff members and Veterans in order to gain more quantitative feedback.

Key Recommendations Shared

- Continue leveraging collaborative working relationships and personas with the Veteran Experience Office.
- Leverage the country's many other health systems and digital health officers working on their digital health work, to include the Health and Human Services Office, for their varied experiences that accelerate everybody including the VA.
    - By example, KLAS Research's digital health evaluation tools and broader sets of evaluation beyond standard dashboard metrics.
- Consider Veterans having to interact with all these different technology pieces and how best to pull it all together between these to make it much easier and clearer for Veterans to get them excited about these products.

FOLLOW-UP: COMMUNITY CARE GROWTH AND SOONEST AND BEST CARE ACTIONS

Summary of Presentation by Ms. Hillary Peabody, VA Acting Assistant Under Secretary for Health for IVC

- Veteran community care is slowing in the weight of growth; measured in volume of referrals not dollars.
    - Growth rate is at 14.5% for the fiscal year (FY).
    - Growth rate is slowing in emergency and oncology services including the recent addition of the "Close to Me" initiative.
    - Slowing in Mental Health albeit significant growth is noted.
    - Purposeful growth in Veteran directed care is a driving component in Medical Center performance plans.
- Referral Coordination Initiative
    - Targeted areas are Cardiology, Gastroenterology, and Oncology services.
    - VISNs and facility leaders had the autonomy to select additional specialties.
    - Goals for continued improvement include documented consult toolbox, additional telehealth, interfacility consults within Networks, resource huddles, and e-consults.
- VA Health Connect had a successful roll-out to several VISNs with the health chat feature and tracking tool.
- Utilization Management (UM) continues to be a major focus in VHA with Community Care Network (CCN) contracts. As regulatory guidance changes,

subject matter experts continue to examine the best method for determining UM and to what degree in inclusion in CCN contracts.

- External Provider Scheduling, a technology platform, occasioned 1,300 providers to utilize the tool in the initial roll out phase. It is worth noting that a major benefit of the tool's application enables a scheduler to "schedule" a Veteran within six minutes. Inception of the tool, though highly successful, continues to remain a challenge in getting more providers to buy into this tool.

Key Takeaways from SMAG Members

- Community care growth remains an existential threat.
- Community care growth rate is slowing due to a huge staffing effort to increase workplace capacity; however, the increase is faster than the VA's ability to augment.
- There is need for more holistic approaches to direct care and community care; the magnitude of opportunities is not enough to affect spending in community care.
- UM provides an array of tools, i.e., payment policy, and network configuration.
- A model for UM could encompass medication management, necessity, and determination.
- Provider adoption of direct scheduling is not a technology issue, rather a laxity in the delivery system and not understanding capacity. Overall, scheduling in healthcare has become worse, not better.
- Provider adoption of tools continues to be a good technology issue - if the technology is better, then provider productivity will rise; however, there continues to be provider hesitancy. Until there is a better solution, providers will continue to struggle with the adoption of technology tools.
- Per the Mission Act, contracts with third-party administrators (TPA) are written into law to pay the provider then request reimbursement.

Key Recommendations Shared

- Consider the future state and invest heavily in modeling analytics nationally.
- In addition to UM, consider different payment methodologies (i.e., standard episode(s) of care).
- Recommend providers adopt direct scheduling with the possibility of adding on a small payment as a return on investment or the cost of referral care management.
- Recommend community care consider analytic capacity and forecasting, more actuary and less budget.
- Recommend consideration of care delivery partners relating to provider direct scheduling, ask TPA, then nail down capacity before incorporating technology.

FOLLOW-UP: TELE-URGENT CARE/EMERGENT CARE

Summary of Presentation by Dr. Neil Patel, Acting Executive Director, VA National Emergency Medicine Office

- Revisited tele-emergency (Tele-EC) care and Veterans calling the VA's Clinical Contact Center (VA Health Connect) with a symptomatic complaint(s) followed by registered nurse triaging and less than two hours follow-up care referral to an emergency department or tele-emergency care setting in the current state that affords the Veteran immediate virtual care triaging if they prefer.
- Greater asynchronous care support is given to include telephone advice, setting up orders for labs or imaging at their closest VA clinic, and follow-up care access.
- Highlighted virtual care visits successfully resolving near 60% acute concerns.
- Over 50,000 Veteran encounters completed during FY 2024. The coming FY 2025 will target increasing the ease of referrals into Tele-EC, as well as increasing Tele-EC capability to better accommodate Veterans.
- Most calls between Monday through Friday, 8:00am to 4:00pm, and affords the VA opportunities to explore additional value and care options after hours and on weekends outside of a community or a VA emergency department.
- From a value proposition lens, the VA's greatest return on investment has been towards utilizing tele-emergency care for acute Veteran patients being informed to visit an emergency department right away.
- Revisited prior enterprise plan to launch Tele-EM care across all 18 regional networks, which has come to fruition and in concert with VA Health Connect that optimizes "powerful business intelligence" at the enterprise level.
- Three VISNs have been online with Tele-EC care for nearly a year, and contrasting cost analysis for Veteran patient population triaging zero to two in a particular VISN divvied into two buckets and costs: Veterans who had a tele-EC encounter versus triage to same category with no Tele-EC care encounter and overall community emergency care costs within seven days.
    - Data shows substantial cost avoidance by an average $432 per encounter, revealing successful resolution for Veterans' concerns and deterrence against low value community emergency care spending.
    - The delta between cost avoidance figures is significant between the VISN's that affords the VA further analysis in effective VISN approaches.
    - Personnel time to do this care averages between $120 and $150 per encounter based upon physician labor and Tele-EC nursing, which from a physical capital infrastructure perspective is a VA strength, but the enterprise needs more computers and electrons.
- Highlighted the importance for ensuring Veterans' trust and confidence in the VA Tele-EC experiences, which efforts are spearheaded by an inter-office Patient Experience Office leveraging survey tools specific to virtual emergency care.

Key Takeaways from SMAG Members

- Consideration of aggressively marketing of Tele-Health Emergent Care to Veterans on how to access services.
- Is there other marketing other than the physician and nurses?

- Additionally, is there data to support the rural and urban areas usage of Tele-Health/Emergent Care?
- Has there been a developed system of care for with “under-triage” of Tele-Health Emergent calls as well as “E-911” scenario for triage nurses?
- Is there a role for local Emergency (911 Centers) in communication with Tele-Health Emergent Care if they have a Veteran based “911” emergency?
- Consideration of a “pre-triage” for a more concise handoff within the marketing outreach
- What is the average cost per phone call for services provided?
- As Tele-Health /Emergent Care grows what is the return of investment via the preventative care and the provided care?
- Consider collaborating with a community partner such as Kaiser Permanente and ChenMedical to compare how they currently handle “emergent calls”?

Key Recommendations Shared

- Is there a marketing for Native American Indians due to the distance of VA and reservations?
- Directly speak to the Indian health regional services to bridge the gap to meet the needs for Native American Indians access the Tele-health/Emergent Cares services.

FOLLOW-UP: ARTIFICIAL INTELLIGENCE (AI) TECH SPRINTS

Summary of Presentation by Ms. Donna Hill, VHA Deputy Director of Operations, Office of Research and Development

- Two AI Tech Sprints (competitive engagement where vendors created AI-enabled tools) were completed. The first track is Ambient scribing, and the second track is Community Care records.
- The Ambient scribing AI-enabled tool can extract transcripts and key details from ambient recordings of patient encounters and generate standard medical documentation for the encounter. Will be piloted in five sites.
- The Community Care records AI-based system can generate a searchable, quality transcript that summarizes events from episodes of care. Will also be piloted in five sites.
- Data collected from the pilot sites will be used to:
    - Create an implementation roadmap.
    - Document any hurdles in the process.
    - Document accuracy and quality or transcription.
    - Access feasibility of VA systems integration.
    - Evaluate capability preferences.
    - Analyze sustainment and economics.
    - Analyze burnout impact.
    - Record Veteran and clinician satisfaction.

- Goal is to develop an implementation toolkit to support an enterprise roll out and a pilot passive surveillance system for ongoing assurance of trustworthiness.

Key Takeaways from SMAG Members

- SMAG members interested to find out which vendors VA selected for the AI pilots.
- VA needs to be careful with how scribe works in a Mental Health and Emergency Department setting.
- Keep in mind Veterans will be a big selling point for AI transcription.
- It would be beneficial for AI to summarize only a year's worth of historically information, it is unlikely for providers to utilize older information unless it is for a colonoscopy.
- Be mindful of variations between provider types and how they use this technology.

Key Recommendations Shared

- Collect data as early as possible with the additional set of functionalities during these pilots.
- Explore the value of AI beyond provider burnout, should also address quality, cost, or access.
- Consider a national publication or commentary of this competition to communicate to congress and taxpayers process of selecting vendors.

FOLLOW-UP: VA EFFORTS TO REDUCE ADMIN BURDEN FOR PROVIDERS (ACCESS SPRINTS)

Summary of Presentation by Dr. Michael Charness, Chief of Staff, VA Boston Healthcare System

- There remains relation between trying to increase productivity and access, and simultaneously increasing burnout and retention problems.
- VA access is good per Suffolk University Boston Globe poll looking at access in Massachusetts, and looking at what may be the best universal measure of access (satisfaction or dissatisfaction with the time available to be seen). In the private sector in Massachusetts, dissatisfaction with primary care access was 33%, and with specialty care, 37%, versus the VA in general at under 10% (Boston VAMC is closer to 5%).
- Trying to balance influx of patients through the PACT Act, and hopeful shift of Veterans selecting care inhouse versus community care, and ultimately requiring new resources and increased productivity while reducing burdens and finding ways to increase productivity.
- VA's productivity versus the private sector hovers in all specialties somewhere around 80% academic median.

    - Veteran population is older, sicker, more rural, has a higher prevalence of mental health conditions, and other risk factors for adverse outcomes.
    - Private sector are largely fee for service including specialty care support staffing and incentivizes higher coding and clinical decisions that favor higher RVUs.
    - VA's capitated and provider-salaried system incentives for making decisions to give Veterans more care than they require are different (beneficial). However, the incentives for selecting higher coding are also not as prominent, leaving dollars on the table when VA does its coding (non-beneficial).
- One study shows Veterans older than 65 making up 46% in private sector versus 18% for the VA. Younger Veterans who are generally healthy make up almost half of the private sector, versus up to 16% in the VA.
    - 37% of Veterans live in rural areas, versus just under 19% in the private sector.
    - For Veterans, a much higher rate of disability, higher rate of risk factors for adverse health outcomes, more chronic pain, more post-traumatic stress disorder (PTSD), more alcohol use disorder, drug use disorder, and schizophrenia.
- Almost a threefold difference in support for physicians in gastrointestinal (GI), cardiology, and neurology in the private sector compared to the VA, where numbers are close to one in terms of support staff per physician.
- VA needs to incentivize capture of workload performed.
- Currently piloting a project that connects referring providers in specialty scarce rural areas to specialists in metro areas across state lines, taking advantage of MISSION Act authorities allowing VA to practice medicine, telemedicine across state lines.
    - Primary care providers in rural arenas are heavily burdened with lack of specialists nearby.
- Piloting at the Boston VAMC analyzes and incentivizes testing terms of billing using 2021 CMS time-based encounter codes that allow VA clinicians to get credit not only for the time spent in the visit, but also the time before the visit and after the visit (looking up the patient's information and documenting, ordering tests, and putting in consults).
    - Allows clinicians to write much shorter notes, which increases productivity and reduces the burden.
    - Residents also encouraged to use time-based billing templates.
- Further Boston VAMC piloting in collaboration with the VA's Office of Connected Care is studying the vision to build a nationwide network of specialists to serve rural Veterans and to support primary care and other referring providers real-time (e.g., 25 national hubs supporting 38% of rural arena Veterans).
    - Developed Salesforce software akin to rideshare software, that projects and connects the closest referring provider in a rural area with specialty providers nearest.
        - "Overwhelming" increased confidence by referring providers studied and additional sites have been launched (Bedford, Central

Western Massachusetts, as well as rural Louisiana and Texas arenas). Alexandria in rural Louisiana represents one of the arenas with significant lack of specialists.

- Regarding specialty staffing, an analysis by the Houston Health Services Research Group shows that by going from 1.3 VA support per physician to just 2.0; still not at the private sector's 3.1 capacity, there's an opportunity to increase by 11% new encounters, by 11% new patient appointments, and to reduce by 6% Community Care referrals due to wait times.
- Field engagement remains strong in soliciting feedback followed by recommendations and best practices sharing presented on weekly Chief of Staff calls, with an established SharePoint Site hub to complement.
    - Evolving recommendations include simplification of commonly used consults reducing clicks, cognitive load, views alerting and teed up medication renewals.
    - Ongoing reductions in mandatory training burdens via redesign of EHR workflows, IT collaboration, and transport consult modeling.
- VA's Clinical Teams and Efficiencies Group, which reported to SMAG last annual meeting, has continued its work:
    - Halved the amount of work necessary for transport consults,
    - Reduced the effort for primary care providers to provide essentially scribe services for community providers for ordering medications and tests,
    - Reduced the number of contacts for mental health clinics for Veterans who are not at high risk,
    - Reduced view alerts, especially for clinics when not the ordering provider, to be notified (e.g., pathology results),
    - Simplifying processes for universal suicide screen to ensure credit given for screening that's done at other facilities, which is not currently the case.
- Challenges moving forward include available budget (e.g., AI ambient dictation licensing is expensive) and software facilitation for results, patient communication, and further specialty support staff.

Key Takeaways from SMAG Members

- SMAG acknowledges the complexities and challenges associated with addressing admin burdens on providers particularly when a "really complicated" EHR is involved.
    - "Irreducible heterogeneity of 139 medical centers attempting to standardize; a really tricky balancing act."
- Discussed the Agency for Healthcare Research and Quality's related project associated with "minimum error and maximum outcome", which centered on reducing workload while maintaining value in team-based institutions.
- Reflected on SMAG member's prior Department of Defense (DoD) Uniformed Services experience with similar goals associated with care for military retirees for direct care versus purchased care, which indicated direct care as the most appropriate and patient-centered care, in contract to lesser purchased care outcomes that presented more productively on the surface.

- Discussed maintaining and/or further developing ongoing focus communication groups designed to also help build confidence for accountability.
- Reflected on Intermountain's Dr. Brent James philosophy for provider autonomy that leveraged standardizing all key workflows while tailoring only to meet specific, unique patient characteristics; not the clinician's personalities or preferences.

Key Recommendations Shared

- Leveraging the Chiefs of Staff community, ensure greater attention paid to human-centered design techniques and optimizing provider workload with appropriate oversight and assurances around addressing moving forward as new procedures come to place.
- SMAG strongly advised that the VA/VHA consider alternatives to using relative value unit (RVUs) and Medical Group Management Association (MGMA) productivity benchmarking. However, RVU and MGMA productivity benchmarking may help supplement added resource monitoring and objectives such as additional specialty support staff.
    - Consider RVU approach as "really dangerous" to Veteran care.
    - Leverage available VA/VHA research funding and resources to help assess and determine necessary return on investment.
- Continue team-building initiatives.
- Narrow the scope of private sector health systems that the VA/VHA continues to compare & contrast its enterprise services against.
- Continue balancing cost versus benefits without allowing productivity to suffer. For example, the "three big things":
    - Identify alternate staff to do the work for providers (scribes, etc.),
    - Bridge greater connectedness via information dissemination framework, solicited feedback, and other anecdotes that doesn't contribute to unintended burnout,
    - Enhance staff engagement and maximize licensure capabilities, while finding an approach to autonomy that is favored by VA clinicians.
- Integrate simpler specialty consultation for primary care doctors to attain and regionalize or nationalize in scale. Consider Intermountain Health System's management for all diabetes care enterprise-wide with only four total endocrinologists that could support all primary care providers.

VHA NURSING INFRASTRUCTURE

Summary of Presentation by Dr. Jennifer Strawn, Executive Director and Deputy Chief Nurse for VHA Office of Nursing

- Overview of Veterans Health Administration (VHA) mission and vision were provided.

- The strategic plan was created “by nurses for nurses” utilizing the governance model. The plan cross-walked a matrix consisting of the six priorities, VHA long range plan framework; VA strategic plan and all recruitment/retention initiatives. Of note, the strategic plan is a 10-year plan that took two years to put into place utilizing a strong, competent nurse workforce.
- Model is supported by four pillars:
  - Pillar 1 – Optimizing and Informing Nursing Practice
    - Office of Nursing Service (ONS) and Care management and Social Work (CMSW) collaboration
    - Covers basic, moderate, and complex needs
    - 48,000 Veterans have an assigned coordinator
    - Decrease in 30-day readmission rate and increase in patient trust
    - $60 million in cost avoidance over the past year
  - Pillar 2 – Strengthening the Nursing Workforce
    - Modernization of Nursing
    - Every VISN has a Chief Nursing Officer
    - Emphasis placed on qualifications standards
    - Assignment codes have been established
    - Reduce Employee Burnout and Optimize Organizational Thriving (REBOOT)
    - Focuses on resiliency, reducing burnout, whole health, and retention
    - VHA Nursing Education and Scholarship Programs
    - Residency programs equates to a 95% retention rate
  - Pillar 3: Reimagining Lifelong Learning and Career Development
    - Simulation learning based on Medical/Surgical design guide
    - Enterprise standardization
    - Nurses are the largest users of the electronic healthcare record
    - 96% are using the tool and real-time reports
    - Nursing research
    - Nursing practice impacts positive patient outcome
    - State of the art (SOTA) event and development of learning collaborations
  - Pillar 4: Inspiring an Industry Leading Culture
    - Focuses on drawing nurses in, working at the top of the licensure with full practice authority
    - Certified Registered Nurse Practitioner (CRNP)
    - Clinical Nurse Specialist (CNS)
    - Certified Nurse Midwife (CNW)
    - Certified Registered Nurse Anesthetist (CRNA) practice in team-based care
    - Employer of choice with 13 designated sites
- Strategic Sustainment Efforts are demonstrated in the following manner:
  - Utilization of SharePoint, Guidebooks, Community of Practice Calls, and the Project Management Office
  - Adoption of “How to prevent pressure injuries in darker skin tones?” in addition to use of skin bundles
    - Guidebooks on governance
    - Publication
    - Workforce blueprint

- The ability to recruit is attributed to decreasing nurse loss rates; three years ago, the nurse workforce was 112,000, today it is 120,000.

Key Takeaways from SMAG Members

- Clear focus on research at the National and Network levels; time spent on targeted research agenda.
- The nursing agenda is considered hand in glove.
- Structure is based on a research agenda:
  - VA nurses and clinical front-line nurses.
  - Veterans are part of the research process.
  - VA policies and procedures can be impacted by the research.
  - High impact research celebrates contributions followed by dissemination and application of research findings.

Key Recommendations Shared

- Recommend research data pathways sharing with Centers for Medicare and Medicaid Services (CMS) and Health and Human Services (HHS).
- Build the data for nursing research; Electronic Health Records Management (EHRM) should be data matching for nursing research.
- In patient care outcomes, focus on the problems that are trying to be solved and understand the difference that it can make to the people being served.
- Recommend flexibility in reimbursements and compensation with full practice authority.

FOLLOW-UP: VA'S EHRM PROGRESS, INCLUDING PLANS TO RESTART FEDERAL EHR DEPLOYMENTS

Summary of Presentation by Dr. Neil Evans, Acting Executive Director, EHRM-IO

- Both the EHRM Mission and Vision have been revisited and updated, along with a new name of Federal EHR.
- In the last year and a half have paused to work on:
  - Achieving Reset Goals
    - Address concerns of the live sites.
    - Invest in future foundational work.
    - Completed deployment at Lovell Federal Health Care Center (FHCC) in March 2024.
  - Measuring Progress
    - Better EHR stability and reliability.
    - Better EHR experience.
    - Improved health system operations.
  - Meeting Congress' Intent
    - Quality care and services.

        - Increased productivity, efficiency, satisfaction of employees.
        - Improve patient experience.
        - Increase medical collections.
- Plans to restart deployment in FY 2025, as having two health information technology systems introduces risk and are seeing “good enough” progress.

Key Takeaways from SMAG Members

- In considering restarting deployment:
    - View as a cultural transformation instead of a technology project.
    - Goal is to provide better care.
    - Continued comparison with VistA is not helpful.
    - Incorporate user voices and their anecdotes.
    - Define a list of items that would make the VA use the pause button to prevent deviation.
    - Analyze anxiety management, marketing, and branding strategies.

Key Recommendations Shared

- Reach out to the DoD to analyze their lessons learned on deployment of the electronic health record.
- Utilize AI for help desk chatbots to help with new tickets.
- Present this as a new product as you begin to deploy again instead of the old product with modifications. Portray the future will be different than the past.
- Include in marketing as a selling point the fact that Joint Longitudinal Viewer (JLV) will no longer be needed to integrate information.

EFFECTS OF LONG-COVID (LESSONS LEARNED), AREAS OF NEEDED IMPROVEMENT, DESIRED PARTNERSHIPS, AND RESOURCES

Summary of Presentation by Dr. Ilana Seidel, VISN-21 Clinical Resource Hub Long COVID Section Chief, and Ms. Marian Adly, Deputy Chief of Staff, National AI Institute, VA Office of Research and Development

- The VA remains a key partner in the “Whole-of-Government” strategic effort via National COVID-19 Preparedness Plan, which coordinates efforts to provide support to staff and families, as well as support the administration’s proposals for new investments in health care and health care workers’ well-being.
- Overviewed the National Academies of Sciences, Engineering and Medicine’s Long COVID definition, “*Any "continuous, relapsing and remitting, or progressive disease state that affects one or more organ systems", is present for three months, and occurs after a SARS-CoV-2 infection.*”
- Discussed the VHA’s Long COVID priorities:
    - Customizing a Whole Health System
    - Long COVID Patient-Aligned Care Team/Primary Care

    - Specialty Care and Evidence-Informed Clinical Guidelines
    - Models of Care (e.g., Long COVID Hub-and-Spoke/s)

- Reviewed VHA's integrated agency-wide approach comprising Integrated Project Teams, Joint Incentive Funds, Communities of Practice, and Practice Based Research Networks.
- Discussed innovative mechanisms for capturing Veteran feedback:
    - Veteran Interviewing (National Strategic),
    - Digital Screening (Local/Regional),
    - VSignals Surveying (Clinicians)
- Considered forward-moving digital transformation initiatives targeted towards delivering operational value towards:
    - Increasing Veteran visibility,
    - Providing clinical support,
    - Engaging Veterans,
    - Aligning and adopting operationally.
- Four digital transformation pilot sites active:
    - San Francisco, California, and VISN-21 (Clinical Resource Hub)
    - Bronx, New York
    - South Texas and VISN-17 (Nationally Designated Telehealth Hub)
    - Miami, Florida

Key Takeaways from SMAG Members

- Considering having a more precise explanation of how the effects of Long COVID directly affected the Veterans population and VA overall care management?
- What are the results of the chronic fatigue from effects Long COVID?
- Create a feedback loop to provide critical information to the appropriate VA staff?

Key Recommendations Shared

- How can you assist Veterans in rural areas that affected by effects of Long COVID and Native Americans?
- Consideration of the Broadband for users that would require it?
- Focus on the 5% of "Frequent Callers "Super Users" to support the marketing?
- What is the value of using Tele-Urgent/ Emergent – Care, is it a "Super Pass" to bypass the Emergency Room wait?
- Specified waiting area for Tele-Health /Emergent Care callers?

OPEN PUBLIC COMMENTARY SESSION

- No comments were shared by the public during this open session.

SMAG DAY 1 CLOSING REMARKS

Summary of Closing Remarks by Mr. Brian Schoenhofer, VA DFO for SMAG, and Dr. Gregg Meyer, Chairperson for VA SMAG Committee

- The SMAG thanked all attendees, presenters, and particularly the VA USH, for accommodating the Day 1 meeting and discussions.
- The USH reinforced the enterprise's appreciation for all contributing efforts towards strategic solutions that will aid the VA's mission efforts moving forward.

September 25, 2024 - Meeting Adjournment: 4:30 P.M. PT

September 26, 2024 - Meeting Commencement: 9:02 A.M. PT

SMAG DAY 2 OPENING REMARKS

Summary of Day 2 Opening Remarks by Mr. Brian Schoenhofer, VA DFO for SMAG, and Dr. Gregg Meyer, Chairperson for VA SMAG Committee

- The SMAG, as well as all other attendees including VA leadership and the general public were welcomed back for the Day 2 planned agenda.
- As part of an adjusted agenda to incorporate several operational components, the SMAG parent committee meeting paused from approximately 9:15 a.m. PT until 1:15 p.m. PT to accommodate its Subcommittee engagement with local VA medical center leadership for a facility and campus tour, as well as briefing on proprietary information.

SMAG SUBCOMMITTEE LOCAL FACILITY AND CAMPUS TOUR

- The subcommittee component of on-site SMAG members briefly engaged a local facility and campus tour, as well as proprietary information session, hosted by Palo Alto VAMC leaders.
- The subcommittee completed its tour with local VA officials and rejoined the SMAG parent committee environment to reopen the scheduled annual meeting.

CARE AND PAYMENT INNOVATIONS

Summary of Presentation by Dr. David Au, Executive Director, VHA Center for Care and Payment Innovation

- The Center for Care and Payment Innovation (CCPI) is charged by MISSION Act 2018 mandate to test innovative payment and care delivery models.

- CCPI has emerging pilots that require wavers for financial incentives such as Tobacco Cessation, Patient Travel and Tiered Provider Networks.
- The Tobacco Cessation pilot is designed to improve the rates of long-term abstinence and improve the patient's quality of life.
- Transportation incentives for patient care helps to decrease the no-show rates for patient appointments.
- VA transportation helps to improve the quality of care and reduces costs and patient care outsourcing.
- The tiered provider network tests the impact of eliminating Veteran's copays and is funded via Congressional appropriations.

Key Takeaways from SMAG Members

- *Revisited current and future piloting projects, including potential current "blockbuster" pilots that may not be suiting the VA's most optimal care and financial needs, and copays innovation support for Veterans by way of the program's $50 million budget that remains appropriated via request.*
    - *The budget covers not only piloting, but all programmatic attributes including Dr. Au's office workforce staffing/time, which further cuts into available monies out in the field to support pilots.*
- *Reinforced that the ongoing challenges associated with community care is continuing to erode the VHA's capability in providing the most optimal comprehensive health care to Veterans. The SMAG was reminded that MISSION Act "really kind of set the structure to embrace Community Care".*
    - *Leveraging, when most valuable to the Veteran, high-value based payment methodologies and models such as "tiered provider networks" while bringing more care in-house.*
    - *Approximately 1% increase in community care totals out to $2.6 billion that the VA absorbs.*
- *Many internal pilots sourced from shared conversations with preventative and operational leaders including the Office of Payer Services, which are trying to identify problem areas for the VA/VHA.*
    - *Internal committee review platform in place to grade all proposed piloting projects. The committee considers availability to scale, resource needs, conceivable feasibility, staffing, etc.*
- *Current field pilots span eight respective VISN's and their respective regional facility that have cultivated organizational improvement planning piloting around priority projects for improved outcomes.*
    - *While generalizable in concept, probably all different processes and leadership interventions, finance stipulations, staffing and molecular processes including actual systematic care delivery modeling.*
- *Revisited potential CMS partnership and payment opportunities including employer shared responsibility provisions and payment waivers. Dr. Au clarified pilots using a waiver must still go through VA internal committee review and public review via Federal Register prior to Congressional joint resolution vote.*

- *There exists an apparent "huge gap" between Dr. Au's Office mission and the available amount of resources to accomplish the mission. By example, the SMAG and Dr. Au noted the "cost of the Medicare program is larger than the cost of the VA."*
- *SMAG invited Dr. Au and his office to revisit strategic piloting at a future annual meeting, particularly with the several absent SMAG members who were not able to join today and who will contribute greatly to brainstorming the proposed SMAG subcommittee that may be devoted to this focus area.*
    - *The VA Advisory Committee Management Office Director, Mr. Moragne, reminded that any subcommittee(s) report directly to the parent committee. Thus, ensuring that any SMAG subcommittee(s) NOT report to any specific VA program office even if collaborating closely.*

Key Recommendations Shared

- To look within the community to identify where the need for the pilot initiatives will be most served. Reflect on prior annual meeting's VHA community care summary highlighting inappropriate and unmanaged care costs.
- Seek collaboration opportunities and tools from experts such as Elizabeth Fowler, Ph.D., Centers for Medicare & Medicaid Services. In addition, transportation piloting opportunities and strategies from prior Barnard research conducted.
    - Prior models assessed and funded.
    - Methods to measure impact.
    - Discrete parts of pilot(s) that have had an impact on particular populations.
- Reassess piloting for money specialties such as cardiac care, kidney care, orthopedics, oncology due to majority inappropriate utilization spending and "big cost drivers" most likely.
- Determine feasibility and risk stratification for bundled payment and cost capitation models to include diversifying risk profiles based upon populations.
    - For example, piloting provider incentives and beneficiary incentives in alignment to one another.
    - Continue exploring transportation modeling such as air modalities that enable the VA to cover a plane ticket(s) and lodging accommodations including for Veteran's spouse.
- Continue innovating in the "payer" mindset with goals to improve quality, reduce costs, and improve value. Overvalue pilots associated with lots of cost variation and lots of inappropriate care.
- Consider a pilot on-line that provides patients with second opinions from VA providers to assist with direct care, which may save significant dollars, ensure VA providers are getting the volume that they need, and help boost Veteran trust and interest for VA care.
    - Virginia Mason may have adopted similar secondary evaluation/consultation for back surgery patients.

    - Research the VA's apparent "VIP" evaluation program that ensures a whole health systems approach to prevention and whether it can be generalized.
- Reassess potential partnership strategies with CMS including waiver component(s) and employer shared responsibility provisions.
- Solicit greater enterprise nimbleness with respect to respond and adapt to change.
- Plan to regroup with the SMAG during a future annual meeting to revisit current state and future pilots on track.

SMAG DAY 2 CLOSING REMARKS

Closing Remarks by Mr. Brian Schoenhofer, VA SMAG DFO, and SMAG Committee

- The SMAG thanked all attendees for their engagement to include VA leadership, scheduled enterprise presenters, and other key stakeholder officials to include the Veteran and Veteran caregiver community.
- **Dr. Wakefield:** Follow-up sessions were extremely helpful. The purpose should be for members to provide recommendations. Query the presenters in advance and ask are the members valuable to you? Anything else the members should be doing to assist?
    - Local site visit component is helpful and valuable.
        - **Recommendation:** A five-minute window to ask questions for the site visit speakers after each location.
- **Dr. Fulmer**: Liked the robust agenda with follow-up briefings and local site visit and the opportunity to see the organization.
        - **Recommendation:** Go to a location with fewer resources or rural for the next meeting.
- **Dr. Crosson**: Enjoyed the site visit, it was very enriching; feels very proud of the expertise of the facility.
    - Follow up presentations were very useful, provides continuity from one meeting to another.
        - **Recommendation:** Would like to see feedback on recommendations, committee members do not always received feedback on what recommendations were implemented.
- **Dr. Wilkie:** Really enjoyed the facility tour (seeing what folks are doing, contributions to Veterans and healthcare in general).
    - Appreciates how the meetings are set up with presenters and key responders providing an opportunity for discussion and feedback.
        - **Recommendations:** Lack of services with American Indian services. How can we get American Indians access to use VA?
        - Mr. Moragne recommended to invite the Advisory Committee on Tribal Affairs to present on how they are engaging American Indians for access to care i.e., Chair to Chair interaction.

        - Mr. Moragne also suggested that the SMAG submit formal recommendations in writing, to better ensure enterprise feedback from the Secretary down.
- **Dr. Sandy:** Liked the VHA strategic plan review and follow-up topics.
    - Liked the facility site visit.
        - **Recommendations:** Have an overall meeting goal. What is the goal of the meeting i.e., to inform or to get a recommendation?
        - Guidance for presenters: What are you most excited about and what do you most need assistance with?
- **Dr. Kellerman:** Thanked the staff for all the work and effort; presentations were excellent.
        - **Recommendations:** The SMAG can be more listening and advising, i.e., what ideas does the committee to save money.
        - The presentations are useful, be more specific and directed, push 20-25% of the meeting and put heads together on the most 3-4 topics they want presented.
        - The members be more proactive and place issues on the table and staff take back to consider.
- **Dr. Matthews:** Grateful to the staff; enjoyed presentations and conversations, enjoyed follow-up presentations.
    - Liked the nursing component.
        - **Recommendations:** Does not have a sense where their recommendations hit. Were the member recommendations helpful?
        - Have more formal recommendations and have an opportunity for formal feedback.
        - Would love to hear more from the field i.e., Network Director, Network Chief Medical Officer. Thoughts around how the Networks are performing or shortcomings. What are their concerns and how are their Networks moving against other Networks?
- **Dr. Sandefur:** Thanks to Mr. Sommer for the great virtual experience and for making it easy to navigate.
    - Appreciated Dr. Suh's presentation and believes VA has a great foundational presentation. His presentation was one of the best high-level briefings which highlighted VA's challenges in balancing good things occurring; it was very rich.
        - **Recommendations:** EHRM discussion very good, would like Dr. Evans to come back to SMAG.
        - Would like a follow-up and to hear more on the 50 million group.
- **Dr. Meyer:** Follow-ups on previous presentation; loves the site visits; VA does not lack amazing facilities.
        - **Recommendations:** Wants to go to a less well resourced site.
        - Emphasize to the speakers that the members will have read materials in advance, and they can skip through the slides.
        - Struggled with acronym use. Remind speakers to articulate in their slides or provide a glossary in advance of the presentations.

- **Mr. Moragne**: Appreciated attending this SMAG meeting, it was the first field meeting that he attended.
    - **Recommendations:** Participation - FACA wise – all members to focus on dates and locations to maximize participation. Shoot for 70-80% of members able to attend in person.
    - Need help with recruitment. Who would provide level of participation and thoughtful leadership to this body? Can't do it alone, please assist VA.
    - Subcommittees report to the parent committee.
    - Send recommendations up – concur, nonconcur, or concur in principle.
- **Mr. Schoenhofer:** Dates for Spring 2025: April 30 - May 1, 2025, in Washington, D.C.
    - Dates for Fall 2025: September 17-18, 2025, would be a remote site.
        - **Recommendations:** Digital Binders: Members believe it was great!
        - Future Sites: Find the goal of the meeting and match it with the site i.e., EHRM or lower CMS star.
        - Select a site based on SMAG's goals; hearing from local staff – what issues are you having?

September 26, 2024 - Meeting Adjournment: 2:59 P.M. PT

Meeting Minutes approved by:

/s/ Gregg S. Meyer, M.D., MSc
Chairman, VA Special Medical Advisory Group

/s/ Brian Schoenhofer
Designated Federal Officer