U.S. DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Office of Rural Health

VETERANS' RURAL HEALTH ADVISORY COMMITTEE

October 24, 2024
Meeting Minutes

Attendees:

Committee Members:

Marcus Cox, Chair
David L. Albright (Virtual)
Thomas M. Driskill Jr
Pavithra Ellison
Vanessa E. Meade
Angela Renae Mund
Marcus Pigman
Rodney Hummer
David (Clay) Ward

Ex-Officio Members:

Wilbur Woodis (For Ben Smith)
Kellie Kubena
Kristin Martinsen

VHA Office of Rural Health:

Paul Boucher, Committee Manager Peter Kaboli
Robin Islam
Phillip Welch
Kristen Wing
Justin Heesakker
Karyn Johnstone
Kelly Lora Lewis
Micheal Lindner
Kim Mainville
Christina Aciego
Jina Fritz
Amy Kunce Patrice Luneski Nikki
Sanchez Ryan
Sharpe Maura
Timm Travis
Lovejoy Sarah Ono
Byron Bair
Carolyn Turvey Samantha Solimeo Keith Myers
(Virtual) Sergio Romero
Vince Watts
Mathew Vincenti (Virtual) Bret Hicken
Richard Lee Kimber
Parry Kristin Pettey
Rachel Wall Shannon Boyles

Other VHA Offices and Programs:

Dr. Christopher Saslo
Shreya Kangovi
Bertha Fertil
Christine Kolehmainen
Daniel Buckland
Davila Heather
Don DePhilippis Ellen Milhiser
Mary Good
Harold Hanson Sally Haskell Jessica
Sanders Jennifer
Childers Jackson
Haney Joseph Liberto
Colleen Mcquown
Michelle Mengeling
Jeydith Gutierrez Michael Ohl
Ben Williams
Kathleen Metzger
Jessica Weiss Lesly Roose
Kathy Marchant-Miros

Advisory Committee Management Office

LaTonya Small (Virtual)

Public:
Marion Fera
Melissa Harcrow
Rebecca Cox
Shabbir Bharmal

Meeting Objectives:

1. VRHAC will gain an increased understanding of the U.S. Department of Veterans Affairs' (VA) strategic and community partnerships that increase access to health care for rural veterans.
2. VRHAC will gain an increased understanding of the Office of Rural Health's current programs and research initiatives.
3. VRHAC will develop recommendations for the VA Secretary.

Thursday 24, 2024

VRHAC Meeting Welcome and Opening

Dr. Peter Kaboli, Executive Director, ORH; Dr. Marcus Cox, Chair, VRHAC

- The U.S. Department of Veterans Affairs (VA) Office of Rural Health (ORH) Executive Director opened the meeting, took Committee Member roll, and covered meeting Rules of Engagement.
- VRHC Committee Manager provided a reminder regarding travel arrangements for the in-person VRHAC meeting to be held in April 2025 in Portland, OR.
- Committee Chair welcomed attendees to the meeting and thanked them for their participation.
- ORH Executive Director reminded Committee Members the meeting purpose was to prepare for developing recommendations for the Secretary of VA, and established meeting format of 45-minute presentations followed by a 30-minute question-and-answer session.

Presentation: COMMUNITY PARTNERSHIPS: Perspective Across 4 Collaborative Venues

Presenters:

The role of Rural Health Coordinators in VA- American Indian Community Partnerships Northern Arizona VA Healthcare System (NAVAHCS): Dr. Steven Sample, *Facility Director*, Andrew Taylor, *Rural Health Coordinator*, Joshua Wear, *Rural Health Coordinator*, and Priscilla Gibbs, *Rural Native Veteran Health Care Navigator*

VA Collaborations with FQHCs, Critical Access Hospitals, and Rural Health Clinics: Dr. Carolyn Turvey, Clinical Director, Veterans Rural Health Resource Center-Iowa, City, Project Lead, Jeydith Gutierrez, MD; Project Lead Tele-Hospital Medicine, Bryant Howren, PhD; Project Lead Pilot Implementation, Michael Ohl, MD, Project Lead Tele-Hospitalist

Community Veteran Organization Collaborations: Dr. Lillian Dindo

Community Home Health, Rehab, and Extended Care Collaborations: Dr. Heather Davila, Dr. Mary Good, Dr. Michelle Mengeling

- One project links VA care with federally qualified health centers (FQHCs) and other safety net hospitals. A pilot project links VA providers with community providers to optimize post- treatment cancer care management for Veterans in Southeastern Iowa. The project works to streamline and fast-track Veterans' access to the VA for oncology care and other services that may be in shortage in rural communities.it also links VA providers with community providers for tele-consultations.
- In FY25, the demonstration pilot will collect data on the clinical, administrative, and technical issues associated with VA-community clinical provider collaborations of this nature.
    - The tele-hospital medicine program (Tele-HM) allows multiple facilities to share hospitalist services. It allows for VA hospitalists to consult, via telemedicine, with critical access hospitals (CAHs) where Veterans are admitted. The goal is to help these Veterans gain faster access to VA care and services.
- Rural health coordinators forge partnerships between the VA and American Indian communities in northern Arizona. The pilot created a VA clinic closer to where Native American Veterans live using a mobile medical clinic.
    - The VA personnel also did a lot of outreach to inform those Veterans about what the Department has to offer, including 26 events focused on the PACT Act.
- The representatives noted the difficulty in setting up things like the dedicated Starlink connection for internet access. Community partnership navigators were crucial in setting up and maintaining those initiatives.
- BRAVE workshops are one-day workshops for Veterans and their partners and hosted by rural community organizations. They focus on managing relationship difficulties and including acceptance and commitment therapy and integrative behavioral couple's therapy.
    - Researchers also spoke about the importance of providing care in the home of aging rural Veterans. Over half of rural Veterans are age 65 or older, and many have service-connected disabilities. Providing care in the home enables them to age in place and reduces the VA's dependence upon community nursing facilities.
        - The home care workforce is shrinking. From FY21 to FY23, there has been a more than 50% decrease in the VA's use of skilled home care. Rural Veterans are 20% less likely to use these services than their urban counterparts.
- Veterans, their families, and VA clinicians were not always aware of the range of services available or how to access them and community agencies have limited knowledge of what the VA can provide, such as walkers or grab bars.
    - VA staff had found creative ways to work around these barriers. They approached education and outreach on multiple levels, including going to

community events to meet with people.
- Another challenge is a mismatch between what the community provider offers and the Veteran's needs, especially when it comes to mental health issues. Some VA sites have reached out to educate home health agency staff about things like post-traumatic stress disorder (PTSD) and other Veteran-specific issues.

Discussion

The PACT Act is definitely sending more Veterans to VA facilities for care. VA providers are encouraging all Veterans to enroll and to file a claim, rather than guess for themselves whether they would qualify. The representative from Iowa City said they are screening Veterans for toxic exposures and enrolling them if they are positive. Rather than have the Veteran try to figure out if the exposure is from military service or being a farmer, she believes the Veteran should file a claim and let the VA make that determination.

Many rural providers view the VA as a bureaucratic behemoth that condescends about local facilities. This does need to be repaired. The local representative said this can only be fixed through personal relationship building in rural areas, but it can be done.
Committee members asked if the people from Iowa have identified any best practices that could be applicable across the country, or if each region is too different to generalize. The representatives said each of the initiatives presented demonstrate the importance of meeting in person with community representatives, understanding what they need from the VA, educating them on what the VA can offer, and creating relationships to maximize opportunities. "It's not earth shattering," one said, but is a place to start.

It is important to identify when a Veteran receives care in the community. One potential solution would be to have rural facilities' electronic health records (EHR) pose the question, and not allow providers to continue until that question is answered. This underlines the importance of ensuring community providers understand why it is so important to identify when they are seeing Veterans.

The community wants to establish best practices and make the building of these community relationships more systematic.

A committee member noted that natural disasters, which are happening more frequently and with greater intensity, tend to impact rural areas more than urban ones. This makes it even more important for the VA to have partnerships in place, in order to more quickly and effectively provide assistance in the wake of such disasters.

Presentation: Community Health Workers/Intermediate Care Techs
Presenters:
COMMUNITY HEALTH WORKERS (CHW)/INTERMEDIATE CARE TECHS (ICT): Shreya Kangovi, MD, MS, Chief Executive Officer, Individualized Management for Patient-Center Targets (IMPaCT) Care, Colleen McQuown, MD, FACEP, Emergency Medicine Physician, SCOUTS Medical Director, VA Office of Primary Care

- IMPaCT Care's research was funded by PCORI, NIH, and other institutions. They have created an evidence-based program for using CHWs to expand access to health care.
    - Disproportionately higher problems with social determinants of health (SDOH), chronic diseases, and suicide risk faced by rural Veterans. Traditional clinical models, to address social drivers of health, medical care only drives about 15% of health outcomes. "It is dwarfed" by the impact of things such as relationships, loneliness, trauma, violence, and other social drivers.
    - CHWs are individuals who share either geographic or sociocultural experiences with their clients. They must have inherent traits such as empathy, not being judgmental, being able to listen, and reliability.
    - When a CHW meets with a client and truly gets to know them and establish a relationship. This allows the CHW to better understand what the Veteran wants and is willing to accept with progress being measured in increments.
        - IMPaCT is the most evidence-based and widely used CHW model in the country. It has demonstrated the ability to move the needle on some critical outcomes, including engagement, quality experience, and utilization. They have also demonstrated a net annual savings of $2,500 per person.
- The IMPaCT program is standardized across the country. While they are building the initial blueprint, some tailoring occurs to meet local needs. However, the program is not scalable if every community gets to reinvent the wheel.
- The ICTs program was developed in 2012 to employ combat medics when they leave the military. They can perform some minor procedures, interventions, treatments, and standardized screens. ICTs work under the clinical oversight and delegated authority of a licensed independent practitioner.
    - The mission of the ICT program is to take all the training these former combat medics have received and continue using it. They can also continue developing their skills and education and go on to pursue other employment opportunities. The program also enables many service members in the reserve components to maintain their combat medic skills in a job while waiting to be deployed.
    - When they come to the VA, there's some transition that needs to occur." The VA has created several training courses focused on certain care areas, such as geriatric emergency medicine, and some advanced procedures that are more likely to be seen in a clinical setting than in the battlefield.
        - In 2016, ICTs were used in the Cleveland VA to perform additional screens and care coordination for older adults as part of geriatric emergency medicine. They were able to significantly decrease hospital admissions and emergency department (ED) re-visit rates and increase Veterans' connections with coordinated care.
- SCOUTS (Supporting Community, Outpatient, Urgent Care and Telehealth Services) sends ICTs to the home of older and medically complex Veterans identified as high risk for functional decline during an acute care encounter. The

ICT completes the home visit and acts as an assistant with a provider on a telehealth connection. Since its start in 2021, over 600 rural Veterans have been served. Analysis shows a statistically significant decrease in hospital admissions in both the VA and community, and increased follow-up with VA services, especially social work, and physical therapy.
    - ICTs have also provided podiatric care in rural areas without a podiatrist. The ICT performs basic foot care and eye screenings, after which a video visit is performed with a remote podiatrist.
- The ICT program is also looking to connect with combat medics entering the SkillBridge program as they transition out of the military. The VA can employ them, provide them with additional training, and provide scholarships for them to continue their education.

Discussion

The biggest barrier right now is having sufficient manpower to run this program at more facilities.

The VA has created a program to provide former military medics with certification for working in the VHA. Only Virginia has changed its state legislation to allow former military medics to work as unlicensed assistant personnel. Even that is limited to one year of employment before they have to enroll in a professional school that will provide them with an official license. Every state would need to pass its own legislation in this area. McQuown said ICTs in EDs tend to be very task specific. Unlike nurses, they do not tend to follow a patient through the entire ED visit. Thus, ICTs turnover their patients faster than nurses.

Civilian EDs do not have a direct correlation to ICTs. She said some facilities use paramedics to perform many of the procedures that ICTs do in the VHA, though, when they receive additional training.

Right now, the VHA is scrutinizing its hiring of new people. McQuown said they are up to 16 sites, but further expansion is constrained by the hiring complications.

As the committee started considering potential recommendations, McQuown asked for additional hiring to be a priority. She said that Veterans value their independence and enabling them to age in place supports that. Expanding the ICT program would facilitate that, as well.

The committee wants the VA to look at the workforce. They want to make it easier for combat medics to enter the VHA as ICTs and then move into other areas of the healthcare workforce as certified and licensed practitioners. They stressed the importance of creating seamless transitions to enable people to get higher levels of education. Staff cautioned they may not yet know enough about this to write an actual recommendation.

Another committee member suggested that they simply recommend an expansion of the

ICT program, especially in rural settings.

The committee members are also interested in using the IMPaCT program to serve rural Veteran communities.

Presentation: Women Veterans Health

Presenters:
WOMEN VETERANS HEALTH: Sally Haskell, MD, MS, Acting Chief and Deputy Chief Office for Clinical Operations, Office of Women Veterans, Department of Veterans Affairs (VA), Aimee Sanders, MD, MPH, Physician Educator, Office of Women Veterans, VA, Michelle Magellan, PhD Investigator, Center of Access and Delivery Research and Evaluation, Iowa City

- Rapid growth in the number of women Veterans using the VHA in the last 20 years. With over 900,000 women are enrolled for care, with 655,000 being active users. With large group between ages 45 and 65 years old with the majority of women veterans live in urban areas, with only 28% in rural areas,
    - Mental health conditions and substance use disorders (SUDs) are very common. Almost 56% of women have musculoskeletal (MSK) conditions, compared to 47% of men.
- The VHA Office of Women's Health directs the implementation and operationalization of women Veterans' health care. Their mission is to serve as a trusted resource for the field and to ensure that women Veterans experience timely, high quality, comprehensive care in a sensitive and safe environment for all types of care including fertility, maternity, and newborn care is provided in the community, and the VA pays for it.
    - Designated Women's Health Primary Care Provider (WH-PCP) is a primary care provided trained and experienced in women's health. Women generally have to see both a primary care provider and a gynecologist. Patient satisfaction ratings are higher among women Veterans who have an WH-PCP and tend to stay more engaged in VA care.
- Small rural community-based outpatient clinics (CBOC) are more likely than urban facilities to not have a provider trained in women's health care services. Overall, over 80% of VA healthcare systems have gynecologists on site.
    - Almost 83% of women Veterans get screened for breast cancer. This is much higher than what is seen in Medicaid, Medicare, and commercial health insurers.
- Although prenatal, delivery, and post-natal care is delivered in the community, the VA has a national maternity care coordination program in place. These coordinators meet with women Veterans at least eight times during their pregnancies. This has recently been expanded to cover the 12 months after delivery.
    - The Women's Health Innovation and Staffing Enhancement (WHISE) provides funds to VA medical centers to enhance women's health programs through the hiring of new staff and purchasing equipment. This has supported the hiring of over 1,100 people in a variety of positions and

programs, including lactation support.
    - The VA in its culture change to eliminate sexual harassment and assault, and to support inclusion of women and LGBTQ Veterans. Recent surveys indicate that 10% of women experience some form of harassment in VA facilities, which is down from the 25% of a few years ago.
- The Office of Women Veterans support the VA's women's health workforce. They provide ongoing education, including hands-on training and mini residencies. Trainings target different professional groups, including primary care and emergency care. Bringing mini residencies to their facilities helps them access training.
    - Through a partnership with the Office of Rural Health, the Rural Women's Health Mini-Residency goal is to increase the number of women's health primary care providers and nurses in rural areas who serve women Veterans. Data showing that providers who participate in these kinds of mini residencies tend to stay in the VHA longer.
- The Office of Women's Health is also focused on expanding its programs to sites where they have not yet been present, such as Alaska, the Pacific Islands, and Puerto Rico.

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Discussion

Haskell told the committee members she would like to see outreach efforts strengthened. The VA offers services and benefits women Veterans will not receive in the private sector. These women should be made aware of this. Sanders agreed.

Sanders also stressed the importance of ongoing training for VHA staff.

Haskell did not have information on differences between urban and rural areas for things like breast and cervical cancer screening. She noted that previous gender gaps for a variety of screening types, such as hypertension management and diabetes, and vaccination, have pretty much disappeared.

The committee members were interested in having the VA support doula training and provision of this kind of care. They also want more care coordination for women Veterans in rural areas.

Presentation: Substance Use Disorders

Presenters:
SUBSTANCE USE DISORDERS (SUD): Joseph Liberto, MD, National Mental Health Director for Substance Use Disorders, Office of Mental Health and Suicide Prevention, VA, Jessica Wyse, PhD, Investigator, Center to Improve Veteran Involvement in Care (CIVIC), VA Portland Health Care System, VHA, VA

- VA's "no wrong door" approach to ensuring patients with SUD can be treated in

their preferred setting of care. They have several initiatives aimed at narrowing gaps in care available, which mostly address hiring problems.
    - Expanding peer support services. have enhanced engagement and retention in evidence-based treatments across various settings.
- Funding from the Office of Rural Health has been used to fund and expand SUD care in rural settings and for rural Veterans. They are increasing their use of telehealth, including for group therapy.
    - There are 33 VA opioid treatment programs certified by the Substance Abuse Mental Health and Services Administration (SAMHSA). Most are in urban areas, and the VA is looking to increase its footprint in rural areas.
- Expanding access to medications for opioid use disorder (OUD) in rural primary care settings. there is a pretty significant gap between rural and urban patients when it comes to access to any form of medication. Rural patients are more likely to receive buprenorphine then methadone. Patients who are using fentanyl likely need this stronger medication.
    - The Modernizing Opioid Treatment Access Bill in Congress would allow board- certified addiction specialists to prescribe methadone in office-based settings and allow for it to be dispensed from community pharmacies.
        - There are existing programs (CRVA MH-REACHES) that enable community pharmacists to connect rural Veterans with buprenorphine.
- Explore creating “bridge clinics.” This would play a role when a patient comes into a hospital and needs to be connected to care in another setting. High-touch treatment approaches, which require in-person medication initiation and frequent in-person visit requirements,

Discussion

Wyse said primary care providers already have a lot of responsibilities. Many views new requirements for them to provide SUD care and medication as a burden. However, she said, the VA views care as a team-based effort. It works better when there are personnel and resources dedicated to this care. “It’s a bit of a cultural shift,” she said. The VA will need to take steps to ensure that primary care providers are not overburdened.

Liberto explained that methadone can be harmful if diverted to non-patients. Thus, the Food and Drug Administration (FDA) strictly regulates and oversees who can dispense it to patients. It is used to treat patients with OUD who have high levels of tolerance for buprenorphine. There are some states with no methadone programs. The VA has 33 of them.

Liberto said that, among Veterans, alcohol is the most common abused substance. The VA treats about 565,000 Veterans with SUD, and over 400,000 have problems with alcohol. Many have problems with more than one substance.

The VA is now seeing a rise in the prevalence of cannabis use problems.

The VA is aiming to launch a new mobile app with information about different types of SUDs to educate Veterans and their families. That should launch in November or December.

The VA is also developing a mobile app that could work as an adjunct to ongoing SUD treatment. It would support evidence-based treatment (such as cognitive behavioral interventions). It could also help measure and monitor how patients are doing over time to help guide clinicians in treatment decisions. They hope to connect this app to VA EHRs. Liberto does not expect this to be ready for another couple years.

The VA has developed an anti-stigma language guide. It includes both suggested languages to use and language to avoid as clinicians and others speak with Veterans about their SUD issues.

Some advanced practice nurses and physician assistants have a Drug Enforcement Administration (DEA) certificate allowing them to prescribe schedule 3 agents, such as buprenorphine. The VA encourages its providers to take advantage of this if they hold such a certificate.

The speakers acknowledged that there is not nearly enough access to methadone for rural Veterans. Liberto said this is a problem for all of rural America, not just for Veterans.

The VA is looking to pilot mobile methadone units yoked to the 33 programs that can prescribe methadone. This might expand those programs' radius to include more rural Veterans. The VA is also looking to contract with community care programs to treat Veterans, to further expand access to methadone.

Wyse noted that methadone is treated in other countries much more like buprenorphine. The American approach to this medication is based more on historical precedent than on the science.

Generally, a primary care provider sees any given patient once or twice a year. When this provider oversees providing SUD or OUD care, the number of visits increases, the amount of oversight required increases, and the consequence of making a mistake increases. At the same time, primary care providers' caseload may not be decreased to consider the greater severity of this group of patients. This is part of why so many primary care providers are nervous about expanding into this area.

A committee member suggested making a general statement encouraging more inter-agency collaboration to expand the availability of care rather than more specific recommendations.

Another committee member would like to see the VA's tele-consultation service made more widely accessible.

Committee members also expressed interest in having the VA accept traditional healing

methods for Native Americans. Medicare recently approved coverage of these care methodologies.

RECOMMENDATIONS & NEXT YEAR

Based on the day's presentations, the committee laid out their ideas concerning recommendations to the Secretary.

They want to build out on VA's use of community partnerships, and to better publicize those.

They want to have the Office of Rural Health work with the Office of Women Veterans to start a pilot program to provide doula care.

There should be specific, concentrated outreach to women Veterans in rural areas.

For SUD, they want to expand the program allowing pharmacists in rural areas to prescribe buprenorphine. They also want to expand the current consultation service program in mental health to provide more SUD care.

Staff will draft the recommendations. Committee members will have opportunities to revise and approve them via email.

Committee members are very interested in further expanding the ICT program, as well.

Committee members were given a chance to make suggestions for issues they will cover in the coming year. They expressed interest in the expanded caregiver support program, and VA's roles and plans to help in natural disasters.

A committee member brought up emerging research on using psychedelic drugs to treat PTSD.

Committee Discussion Session
Facilitator: Dr. Marcus Cox, Chair

Additional topics for consideration:

- Community care (delays, workforce shortages)
- Transportation
- formal partnership between VHA and HRSA to implement the ORH program VETCOOR.
- Broadband/Hot Spots
- Expansion of SCOUTS to Tribal Communities and Colleges
- Continue to build on the Cleland Dole Act
- Social Determinants (Drivers) of Health ACORN
- Community Health Workers
- Telehealth
- State-by-state availability of medications for the treatment of opioid use.

Wrap Up and Closing

- The VRHAC Chair and ORH Executive Director thanked Committee members for their work and closed the meeting.

Public Comment Period

Dr. Peter Kaboli, Executive Director, ORH; Dr. Marcus Cox, Chair, VRHAC

- 1 Public Call from Callie Cox who read a letter concerning CRNA's Expanded Privileges.

/s/ Marcus Cox
Chair, Veterans Rural Health Advisory Committee
November 19, 2024

/s/ Paul Boucher
Designated Federal Officer