Department of Veterans Affairs
Advisory Committee on Prosthetics and Special-Disabilities Programs
April 18-19, 2023
Hybrid Meeting (In-Person and WebEx)
Minutes

Tuesday, April 18

Committee Members Present:

Brig. Gen. Arthur "Chip" Diehl III (Retired), Chair
Isaac Alston (virtual)
Felecia Banks, Ph.D.
Shaun Castle
Charles Ellis Jr, Ph.D.
Steven Gard, M.D. (virtual)
Marlis Gonzalez-Fernandez, M.D., Ph.D.
Russell Gore, M.D.
David Gorman
Flora Hammond, M.D.
Linda Hood, Ph.D.
William Morgan, D.C.

Committee Members Absent:

Andrew Contreras, DPT

Department of Veterans Affairs Staff Present:

David Dunning, Medical Center Director, James A. Haley Veterans Hospital
Kolina Ford, Lead Medical Support Assistant, Physical Medicine and Rehabilitation Service, James A. Haley Veterans Hospital
Barry Goldstein, M.D., Deputy Executive Director, National Spinal Cord Injury and Disorders Program
Mark Havran, DPT, VHA National Physical Therapy Program Office Lead
Rachel McArdle, Ph.D., Deputy Executive Director, VHA Office of Rehabilitation & Prosthetic Services
Bonita McClenny, Ph.D., Alternate Designated Federal Officer (virtual)
Jeffrey A. Moragne, Director, Advisory Committee Management Office
Ajit Pai, M.D., Executive Director, VHA Office of Rehabilitation and Prosthetic
Frederica O'Donnell, VHA National Occupational Therapy Program Office Lead

Lauren S. Racoosin, AuD, Designated Federal Officer (DFO)
Judy D. Schafer, Ph.D., Alternate Designated Federal Officer (ADFO)
Steven Scott, D.O., Chief, Physical Medicine & Rehabilitation, James A. Haley Veterans Hospital
Sonya Skinker, Committee Support

Public Attendees:

Stuart Cohen
Sidath Viranga Panangala

Tuesday, April 18, 2023

The Advisory Committee held a hybrid meeting and site visit via video teleconference. The Committee met in-person at the Spinal Cord Injury (SCI) Building, Middle Dining Room, James A. Haley Veterans Hospital, Tampa, Florida, and simultaneously via WebEx video teleconferencing. The meeting began at 8:30 am EDT, Brigadier General (Retired) Arthur F. "Chip" Diehl III, Committee Chair, presiding.

Opening Remarks

General Diehl welcomed and introduced David Dunning, Medical Center Executive Director, James A. Haley Veterans Hospital. Mr. Dunning gave opening remarks.

Mr. Dunning welcomed the Committee and expressed his pleasure at the opportunity to showcase all the amazing things the Tampa VA is doing with Prosthetics, Traumatic Brain Injury (TBI), and the many other rehabilitation specialty programs. Mr. Dunning shared a little of his background. He is a 30-year Army career, just started 7 years as a Director in VA, with a total of 10 or 11 years as a CEO across the Federal Government.

Mr. Dunning acknowledged appreciation for the VA's new mission statement which is more inclusive of our women Veterans and more reflective of the current times.

Dr. Steven Scott, Chief, Physical Medicine & Rehabilitation, James A. Haley Veterans Hospital, asked Mr. Dunning to share where Rehabilitation fits in the pyramid of the Medical Center's strategic plan. Mr. Dunning described the pyramid with the base representing people-Veterans and staff. Above that base are five focus areas, of which the Polytrauma Center (and rehab) is one area. First is primary care. Primary care is how we get our Veterans in to take care of them, Specialty care is the second area, and the third area is mental health. Mental health is critically important. They have plans to open up a new consolidated mental health facility 3 miles away. This facility will have most specialties, a main cluster of mental health services and two domiciliaries. One domiciliary will be for PTSD and one for substance abuse. They are also looking to buy

another existing substance abuse center. Fourth area is building physical capacity which includes building a new bed tower. Fifth is the world-renowned polytrauma center. The pinnacle is High Reliability Organization (HROO). While each one of those 5 areas has an Executive Leadership Team (ELT) member that's responsible for leading and championing that area, they all work together.

General Diehl next introduced Dr. Ajit Pai, Executive Director, VHA Office of Rehabilitation and Prosthetic Services. Since January 2023, Dr. Pai has held the position formerly held by Dr. Lucille Beck until her retirement.

Dr. Pai provided introductory remarks. He thanked the Tampa team for their hospitality. Dr. Pai shared his background; he is a physiatrist and has been in the VA for 13 years, all of his career. He began at the Richmond VA through polytrauma; he completed a fellowship in spinal cord medicine and then with the brain injury program. As Chief of Physical Medicine and Rehabilitation (PM&R) Dr. Pai had a service of over 200 employees with all the different rehabilitation specialties. Dr. Pai has worked on VA's Electronic Health Record Modernization project (EHRM) with many different rehabilitation groups. Dr. Pai also worked in Northern California and the Pacific Northwest, managing rehabilitation and geriatrics.

Dr. Pai believes VA healthcare is the gold standard and that we are beholden to the taxpayer and to the Veteran. We are able to do so much for the Veteran because without challenges from insurance companies and other stakeholders, we can prioritize the Veteran and do what is in the best interest of the Veteran.

Dr. Scott stated, "each of you represent yourselves, your profession, your agency, and our country. I take this our mission very seriously because this is the fabric of our country The Committee and the uniqueness and its mission to try to improve the lives of our Veterans, to protect our country and to maintain its freedom and principles". He expressed a welcome and appreciation for the Committee and its importance.

Dr. Racoosin formally called the roll call. She reviewed the Rules of Engagement, reminded the Committee that the meeting is being recorded, transcribed and captioned for the record. She asked that all speakers identify themselves for the record and address their questions to the Chair, General Diehl. She encouraged questions and discussion. She announced that no questions had been received from the public in advance. Dr. Racoosin reviewed the VA Secretary's Strategic Goals and Priorities and the VHA Under Secretary for Health's Principles & Priorities.

Dr. Racoosin turned the meeting over to General Diehl who introduced the first speaker, Mr. Jeff Moragne, Director, Advisory Committee Management Office.

Presentation:

Federal Advisory Committee Act 101

Jeffrey Moragne
Director, Advisory Committee Management Office

Mr. Moragne shared his office's charge which by the Federal Advisory Committee Act is to oversee all of the Federal Advisory Committees in VA's portfolio, including health, research, benefits and underserved Veteran groups. He shared the establishment of new committees, the Advisory Committee on Tribal and Indian Affairs and the Freely Associated States Advisory Committee which will have representatives from all US territories and freely associated states (e.g., Samoa, Palau, Micronesia).

Mr. Moragne presented the required annual Federal Advisory Committee Act 101 training. His presentation included a review of the following:

- Definition of Federal Advisory Act (FACA)
- When FACA applies
- Requirements for Federal Advisory Committee (FAC)
- Elements of a Federal Advisory Committee meeting
- Elements of a Closed meeting
- Other, non-public meetings of the FAC
- Administrative Calls
- Permissible and Non-Permissible testimony from FAC members
- Federal Advisory Committee Best Practices

Mr. Moragne noted that the FAC member handbook was in the process of being updated and that it is an important document for members to read.
Mr. Moragne talked about cross-committee collaboration and again mentioned the two new Committees and suggested Committees meet and work together.
He thanked the Committee for their service and entertained questions related to FACA.
General Diehl expressed interest in the Committees coming together every year or two with the Secretary or other Official. Mr. Moragne reported that they previously held a summit with Chairs and DFOs, however, the onset of COVID19 pandemic ended that practice. He reported that they would like to return to those meetings.

General Diehl asked about the possibility of going to one of the Veterans Games or Special-Events. Mr. Moragne suggested scheduling a meeting that pairs with an event.

Mr. Castle noted that the wheelchair games will be in New Orleans in 2024, from July 25-30, and that New Orleans has a good facility; it may be good to see a different facility that's experienced challenges (rebuild post-Katrina), as well as an opportunity to see a lot of athletes. It would be a great opportunity for the Committee to meet with Veterans,

and providers from across the country as participants come from all the SCI centers as well as all the Polytrauma Centers. There would be opportunity to interact with those who put games on from the VA, VSOs, as well as athletes. Mr. Castle noted there would be touch points for a lot of men and women who served the country, who now benefit from the work of the Committee.

General Diehl asked if Committees meet more than twice a year. Mr. Moragne responded that the meeting requirement is captured in the charter. Dr. Racoosin noted that our Charter calls for at least two meetings annually.

Dr. Gore asked to review the recommendations from last meeting and the Secretary's response, if any.

Dr. Racoosin noted that the Recommendations from the October meeting are currently at the level of the Secretary. Dr. Racoosin then reviewed the Recommendations which included:

- Integrating Sensory Health into Whole Health
- Workforce Management and Consulting to develop a plan to recruit and retain non-physician rehabilitation specialists
- VHA Communications to develop a plan and a toolkit to better inform the public about VA Rehabilitation and Prosthetic Services (RPS) programs.

In addition, updates from the two Recommendations from our May 2022 meeting will be provided during the meeting presentations. One, from Dr. Highsmith regarding realigning Clinical Orthotics and Pedorthics Services (O&P). O&P is a clinical service and should be aligned as such. Dr. Webster will update on the Recommendations for Amputation System of Care.

Dr. Racoosin noted that she would re-circulate via email, recommendations from the past meetings.

Dr. Gore also noted that what stood out to him from Mr. Moragne's presentation was that subcommittee can discuss drafting recommendations. He suggested creating subcommittees of subject matter experts interested in discussing and drafting.

Mr. Moragne discussed the process for establishing subcommittees. Draft recommendations are presented to the parent committee. Need to notify the Secretary if subcommittees are formed.

Mr. Moragne discussed the 12 Neurology subcommittees which are field based at local VA Centers of Excellence.

General Diehl adjourned the formal meeting at 9:52 a.m. so that the Committee could visit the site and tour the Polytrauma Center facility.

The site visit included touring the following areas: aquatic therapy center; polytrauma patient areas; recreation therapy; physical therapy; occupational therapy; assistive technology; vision rehabilitation and vestibular testing; TBI optometry; driver rehabilitation; vocational rehabilitation; creative arts therapy, PREP area; robotics lab (exoskeleton); spinal cord injury units; rehab gym; independent living apartment; amputation system of care and prosthetic fabrication lab.

The formal meeting resumed at 2:56 p.m.
Dr. Racoosin acknowledged that all Committee members had returned to the room and those in virtual attendance were present. With a quorum, the meeting continued.

General Diehl introduced the first speaker, Dr. Frederica O'Donnell, VHA National Occupational Therapy Program Lead.

Presentations:

VHA National Occupational Therapy Program

Frederica O'Donnell, OTD
National Program Lead, VHA Occupational Therapy Program

Dr. O'Donnell shared Occupational Therapy (OT) Programs' unique healthcare lens with the Veteran always in the center. Occupation Therapy looks at:

- the physical, cognitive, mental and psycho-social factors that impact Veterans
- home and community environments; social, economic, and cultural systems
- how Veterans are doing with their activities of daily living; not limited to bathing, dressing, and rooming, but in roles as parents, grandparents, and employees
- how Veterans take care of themselves and others; promote and maintain health and wellness; participate in meaningful occupations
- translating skills, routines and habits into the community and into the home

Dr. O'Donnell noted it is the ethical duty of Occupational Therapists to prevent occupational deprivation. Veterans need to sustain participation in occupations.

Dr. O'Donnell reviewed the current VA staff demographics:

- 1980 Occupational Therapists (OT) and Occupational Therapy Assistants (OTA)
- the number of OTs has been increasing gradually; was 1605 in 2019
- OTs and OTAs work in a variety of areas including Physical Medicine and Rehabilitation Services, Mental Health, the Homeless Program, and the Caregiver Support Program.

The number of encounters and unique visits dipped in 2020 but is gradually increasing, for FY2023 with expectations to exceed 2019 numbers this year.
*Due to the pandemic, 2019 is the last full year for benchmark comparisons.

Current access is 18.8 days for an OT evaluation.
Seven percent of all OT encounters in FY2023 have been virtual.

Fellowship Programs:

- OT is proud of its Fellowship program expansion
- Fellowship programs are optional postgraduate specialization areas for OT
- In Academic Year 2021-22 there were five Fellowship programs
- Currently 16 programs, with projections for 19 in the next Academic Year
- VA is the largest sponsor of American Occupational Therapy Association (AOTA) Fellowships
- Fellowship programs assist in hiring staff faster and more competitively and promote best practices in OT

Fellowship areas include:

- Mental Health
- Assistive Technology
- Hand Therapy
- Neurorehabilitation
- Lymphedema
- Gerontology
- Physical Rehabilitation

Reviewed FY2023 Initiatives:

- Prevent Veteran Suicide
    - OT's complete suicide screens (Columbia Suicide Screen)
    - Provide OT mental health services for high-risk Veterans
- Decrease Veteran Homelessness
    - Office of Rural Health grant (VISN19) to provide OT services earlier
    - Expand use of OTs on HUD-VASH teams
    - Finding the need for earlier intervention
    - Focus on rural areas, working with Native American tribes
- Drive equity for LGBTQ+ Veterans
    - OT and Prosthetics to provide gender affirming prosthetic devices
- Increase accessibility for Veterans
    - Streamlining virtual home evaluations with Veterans Benefits
- Support Active-Duty Service Members transitioning to Veteran status
    - Assisting with transition from military-losing mission, camaraderie

- TBI as a chronic condition
    - Use of Lifestyle Redesign for Veterans with TBI

Challenges, Opportunities, and the Way Forward

- Increase Veteran access to all OT services
- Complete expansion of OT Fellowship programs
- Expand the role of OT in mental health care for high-risk Veterans
- Educate VHA on the unique healthcare lens of OT

Dr. O'Donnell shared that April is Occupational Therapy Month. She expressed appreciation to Drs. Pai and McArdle of RPS for their support of the OT program

Questions/Discussion:

General Diehl introduced our next speaker, Dr. Mark Havran, VHA National Physical Therapy Program Lead.

VHA National Physical Therapy Program

Mark Havran, DPT
National Program Lead, VHA Physical Therapy Program

Dr. Havran reported on the current state of physical therapy services, accomplishments and challenges. He reviewed the demographics of the VHA Physical Therapy (PT) Programs. PT is organizationally aligned at VA Medical Centers (VAMC). PT is also positioned in patient-aligned care teams within primary care, geriatrics, women's health or home care. Approximately 11 sites have PT in education or emergency departments as well as spinal cord injury clinics.

Physical Therapy services are delivered at medical centers, community living centers and community-based outpatient clinics (CBOC). Services may be part of patient aligned care teams such as primary care and geriatrics, women's health, home care, emergency and spinal cord injury. Services are also delivered through virtual care; PTs are embedded within clinical resource hubs that provide tele-consultation and treatment. Two clinical contact centers and a referral coordination program assist the care in the community process, when needed.

Demographics, at the end of first Quarter FY2023:

- 2944 Physical Therapists (PT) and 636 Physical Therapy Assistants (PTA)
- most (68%) work under Physical Medicine and Rehabilitation (PM&R)
- 17% work under geriatrics and extended care
- 4% in Spinal Cord Injury (SCI), 3% in Primary Care (PC), and <1% in research

Unique/encounters: In FY2022 roughly 1.9 million patient visits, more are anticipated in FY2023. Keeping more services in house.

VHA PT is proud of their initiatives and accomplishments:

- Embedding PT into Primary Care Patient Aligned Care Teams (PACT)
    - Working with office of healthcare Innovation and Learning
    - Goal: to implement PT in PACT in at least one location (VAMC or CBOC) in every VA health care system by 4/1/2025
    - To date, have successfully implemented PT in PACT in 61 facilities; FY2023 goal is 80 additional facilities
- Enhancing Pelvic Health Across the Continuum and Care Access
    - Increase training and education in this specialty area
    - Collaboration with Women's Health to embed PT in clinics
    - Gathering data to identify gaps in coverage
- Center for Payment Innovation
    - Virtual Reality Pilot working with 5 sites to come up with PT specific assessments to collect and track activities.
    - Hoping this will allow for improved and safer evaluation techniques in rehabilitation facilities
- Biopsychosocial PT Pain Mentorship
    - Mentors training rural sites in this model of care to tackle chronic pain
    - Work with pain office; embed PT and psychologists into pain programs
- Expansion of PT Residency Programs (accredited)
    - Currently 35, anticipate expansion to 54 by Academic Year (AY) 2025
    - Primary care will be a brand-new residency
    - Expanding geriatrics, orthopedics and women's health
    - Currently 42 residents/year, plan to have 86/year at end of AY2025
    - Important recruitment tool: last year 84% resident graduates stayed in VA

Challenges and the Way Forward:

- Supply and Demand: health care projection model
    - Anticipate 86% increase in utilization FY2021 to FY2025
    - By 2025, only 37% PT will be in-house

How to meet Supply & Demand? Working on how to improve, ensure coverage is met.

- Recruitment and Retention
    - Pay challenges
    - Qualification standard revision or Title 38 consideration
    - Healthcare scholarship program for rural area equity and access

How to improve Recruitment and Retention? Look at pay challenges, qualification standard revisions, healthcare scholarship program for rural areas.

- Limited Residency Programs to meet future demand
    - Need for Women's Health, Pain (a year from accreditation), Primary Care

    - How to Expand with Office of Academic Affiliations
    - Consider opportunities to collaborate with Department of Defense (DoD) and other Federal Agencies such as Indian Health Services.
- Expanding Clinical care outside of VAMCs
    - Increased use of virtual care
    - Connect with Veterans no matter where they are
    - Community Based Outpatient Clinics

Dr. Havran asked for questions and/ or comments.

Dr. Pai noted that there is an outstanding Recommendation with Workforce Management Consulting (WMC) relating to recruitment and retention for many of our rehab specialty areas and we may want to hear from WMC at a future meeting.

Dr. Gonzalez-Fernandez was pleased to hear there are efforts to advance pelvic floor PT and asked if the services would be provided outside of gynecology or women's health clinics, as men could potentially benefit as well.

Dr. Havran agreed and shared that the interest in women's health also came from the SCI-trained therapists knowing of the multitude of pelvic health issues Veterans experience. They will be tracking gender. Rural Health Project still has about 75% men compared with 25% females; collaboration with Whole Health is currently 100% female.

General Diehl introduced our next speaker, Dr. Barry Goldstein, Deputy Executive Director, National Spinal Cord Injury and Disorders Program.

VHA National Spinal Cord Injury and Disorders Program

Barry Goldstein, MD, PhD
Deputy Executive Director, VHA National Spinal Cord Injury and Disorders Program

Dr. Goldstein presented an overview of the VA Spinal Cord Injury and Disorders (SCI/D) System of Care from a national level and program office perspective.

- SCI/D is well-balanced and distributed from coast-to-coast
- Provide care both locally as well as in 25 specialized centers
- Each center is affiliated with facilities that provide primary care (hubs/spokes)

Looking at where Veterans are living. Currently:

- 95% of Veterans live within 100 miles of a hub or spoke
- 50% of Veterans live within 100 miles of an SCI Center

Lifelong Services, Resources and Care

- Rehabilitation is necessary, but small part of SCI/D

- Focus on lifetime integrated care from injury throughout Veterans' VA care or life
- Care for traumatic and non-traumatic etiologies of SCI

SCI/D Registry

- Evolved over many years; now fully functional
- Provides reports for frontline clinicians, those who are more focused on national functions of the program, and researchers.
- Captures live Veterans in a very accurate way
- Approximately 23,000 Veterans across diagnoses (including MS, spinal cord involvement, motor neuron disorders
- Registry provides automated updates each night; integrated with health record
- Use registry to identify Veterans with SCI/D who are at high risk

Dr. Goldstein shared an example of the Registry identifying Veterans which led to an action plan to assist them during a weather emergency.

Breast Cancer Screening

- New legislation passed last year
- Looking at accessibility of mammography for women Veterans with SCI/D
- Also looking at amputees
- Collaborative efforts involving SCI/D, diagnostics, specialty radiology, women's health services, rehabilitation and prosthetics, neurology, and community care

Initiatives for FY 2023

- Expansion of SCI/D in home care
    - Expanding the multi or interdisciplinary team that go into Veteran's home
    - Evaluate Veterans in their home circumstances
    - Evaluate certain diagnoses that don't require or benefit from SCI/D Center or spoke stay
    - Combining with virtual care will expand services for Veterans
- Implementation of age friendly health systems
    - Majority of patients are over 50
    - Geriatrics and Extended Care (GEC) and VHA moving toward VA being largest health care system to be recognized as age friendly

Bowel and Bladder Program

- Important for Veterans with SCI/D to maintain health and independence in community
- Requires assistance through family member or independent caregiver
- Process now standardized for payment, alleviating previous issues

Challenges and the Way Forward:

- Demographic shift to older Veterans with more co-morbid conditions
- Limited non-institutional and institutional long term care options
- Absence of equivalent system of care in the private sector
- Limitations on high quality improvement and research studies
- Modeling, resources, priorities
- Unique populations, rules and restrictions
- VA System of Care
- Collaborate with other Systems of Care: Cross-Diagnoses

Dr. Goldstein asked for questions from the Committee.

Mr. Castle asked Dr. Goldstein to elaborate on the long-term challenges VA is currently facing and the challenges of where the locations are for the long-term facilities and, what it looks like if we don't address these types of issues.

Dr. Goldstein noted the following challenges:

- Having educated providers to provide care needed (need staffing appropriate to the needs of highly complex cases with a number of comorbidities).
- Veterans preferring to be close to their family, so they are in a community long term facility but not SCI specific
    - SCI home care teams visit at least 4 times per year
- SCI bed expansion planned for in early 200s is still not realized
- Have 6 facilities with SCI/D long-term care dedicated beds and not enough
- Plans to continue to identify and open SCI/D long-term care, but need to meet needs now
    - Looking at repurposing open beds in SCI/D centers, allowing 20 additional facilities
    - Regionally could more carefully address needs of those Veterans

Mr. Castle asked Dr. Goldstein if he knew the timeframe at which we're going to hit max capacity for long-term care facilities versus what the number of needs might be currently, compared to what we expect in the next 10-15 years.

Dr. Goldstein noted that we hit capacity a long time ago. As new SCI/D centers open, beds are filled immediately.

Mr. Castle asked if a Veteran can't find an SCI/D bed inside the VA and there isn't a local facility geared toward taking care of them, what are the options?

Dr. Goldstein noted that patients end up in acute care beds. He notes the challenges of having limited number of nurses, of beds with patients who can't be discharged into the community due to the complexity of their cases.
General Diehl about our younger Veterans with needs. As Veterans age is there long-term care across the enterprise for that?

Dr. Goldstein noted that the GEC looks at that carefully. Have learned that those with complex physical and/or intellectual disability are a different group of people to take care of than general geriatrics population. Have been working on that now, can't wait for the future to start planning.

Note: Dr. Goldstein included in his presentation remarks that the AIR Commission Recommendations included the closure of an SCI/D Center.
For the record, Mr. Moragne reported that the AIR Commission never met, nor did they issue any recommendations. He noted that Dr. Goldstein was referring to a market assessment which looked at VA facilities and capabilities for the next 10-20 years. The market assessment was supposed to be delivered to the AIR Commission for assessment, concurrence, or non-concurrence, however that never happened

It was suggested that the Committee take a group photo prior to recessing.

The transcriptionist went off record at 4:13pm.
General Diehl and Dr. Racoosin adjourned the meeting at 4:25pm ET, after the photos were taken.

The Federal Advisory Committee meeting recessed for the day at 4:25pm.

Wednesday, April 19, 2023

Committee Members Present:

Brig. Gen. Arthur "Chip" Diehl III (Retired), Chair
Isaac Alston (virtual)
Felecia Banks, Ph.D.
Shaun Castle
Charles Ellis Jr, Ph.D.
Steven Gard, M.D. (virtual)
Marlis Gonzalez-Fernandez, M.D., Ph.D.
Russell Gore, M.D.
David Gorman
Flora Hammond, M.D.
Linda Hood, Ph.D.
William Morgan, D.C.

Committee Members Absent:

Andrew Contreras, DPT

Department of Veterans Affairs Staff Present:

David Dunning, Medical Center Director, James A. Haley Veterans Hospital
Kolina Ford, Lead Medical Support Assistant, Physical Medicine and Rehabilitation Service, James A. Haley Veterans Hospital
Bonita McClenny, Ph.D., Alternate Designated Federal Officer (virtual)
Jeffrey A. Moragne, Director, Advisory Committee Management Office
Ajit Pai, M.D., Executive Director, VHA Office of Rehabilitation and Prosthetic

Lauren S. Racoosin, AuD, Designated Federal Officer (DFO)
Judy D. Schafer, Ph.D., Alternate Designated Federal Officer (ADFO)
Steven Scott, D.O., Chief, Physical Medicine & Rehabilitation, James A. Haley Veterans Hospital
Sonya Skinker, Committee Support

Public Attendees:

Stuart Cohen
Sidath Viranga Panangala

Opening Remarks

General Diehl opened the meeting at 8:17 a.m. He addressed the Committee and thanked Mr. James Vale and Dr. Jeffrey Rosenbluth for their service and significant contributions to the work of the Committee. Both Mr. Vale and Dr. Rosenbluth have concluded their committee membership positions.

General Diehl also acknowledged Dr. Beck and her many contributions to VA and wished her well in her retirement.

Dr. Racoosin called the roll. Mr. Alston and Dr. Gard were online, all in-person attendees were present. Dr. Racoosin acknowledged the meeting had a quorum and could begin.

Presentations:

General Diehl introduced the first speaker, Dr. Joseph Webster, VHA National Medical Director, Amputation System of Care (ASoC).

VHA National Amputation System of Care

Joseph Webster, MD
National Medical Director, VHA Amputation System of Care

Dr. Webster reported on VA Amputation System of Care (ASoC). He began by recognizing Patty Young, ASoC National Program Manager. He also acknowledged Dr. Heckman and other members of the Tampa amputation clinic team with whom we met yesterday.

Dr. Webster highlighted the systems-based approach to longitudinal care. The VA ASoC's mission is to enhance the quality and consistency of amputation care through providing specialized expertise, incorporating the latest practices in medical rehabilitation, therapy services and prosthetic technology.

He noted that the Tampa facility, which we toured yesterday, is one of the seven Regional Amputation Centers (RAC) and it is a top-tier facility with excellent leadership and staff; it is an outstanding example of amputation services.

ASoC is organized into seven (7) Regional Amputation Centers (RAC); eighteen (18) Polytrauma Network Sites (PANS); one hundred and one (101) amputation clinic teams, fifteen (15) virtual amputation clinic team sites, and ten (10) amputation points of contact. Program has continued to grow and evolve, expanding the number of VA facilities that have amputation clinic services, either in person or virtually.

As far as overall population served, no significant changes since last year's presentation. Still have a fairly large number of new amputation procedures being performed each year.

The Veteran amputation population includes the following demographics:

- 97095 Veterans with amputation seen in FY2022
- 9000-10000 new amputations yearly (9448 in FY2022)
- Majority related to disease (diabetes/vascular)
- 1743 post-911 Veterans with conflict-related amputation
- More amputations performed below the knee compared to above the knee (tend to have better outcomes)

Trends:

- Continued growth in amputation specialty clinic visits over time, significant between 2021 and 2022
- 1.8 million Veterans currently at risk for amputation
- Cohorts with conflict-related amputation are aging
- Continued work on prevention programs.

Accomplishments and Activities:

- Commission on Accreditation of Rehabilitation Facilities (CARF) Amputation Specialty Accreditation maintained by all 25 Regional Amputation Centers and Polytrauma Amputation Network Sties
- Robust Education and Training Program an important focus
- Clinical Practice Guidelines (CPG) – joint VA and DoD effort
    - Upper limb CPG released in April 2022
    - Lower Limb CPG update planned
- Collaboration with Amputee Coalition-national advocacy group for people with limb loss and limb difference; help provide peer support services for Veterans undergoing amputation.
- Working on new resources related to sex and intimacy following limb loss
- Electronic Health Record updates –to meet needs and services
- Virtual Care and New Service Delivery Models
- OPRA Osteointegration Program

Measure performance through Veteran feedback. Work with Veteran Experience Office (VSignals) to monitor and make improvements. Majority of negative comments were related to issues that were occurring prior to the actual visit. Most of positive comments came from experience during the actual clinic visit. Feedback was used to develop a process improvement project to inform patients and provide them information about what to expect during the clinic visit. Will continue to monitor over time and potentially develop additional process improvement initiatives.

Satisfaction, overall confidence and trust with the visit remains high in FY2023 but will continue to look at data and develop future projects.

FY2023 ASoC Strategic Planning Priorities

- Directive 1172.03 Amputation System of Care (anticipated publication 8/2023)
    - Establishes policy and procedures for ASoC
- Mid-Atlantic and Northeast Regional Training Conference (scheduled for 8/2023)
    - Return to in-person training
    - Collaborative training with Prosthetics and Sensory Aid Services (PSAS) and Orthotic Prosthetic and Pedorthic Clinical Service (OPPCS)
- FLOW3 adoption and reporting; focus on prosthesis checkout
    - Application that helps us to track artificial limbs from the time they are prescribed by a VA provider until they are delivered to the Veteran and then checked out by our amputation clinic teams
    - Checkout process: verify items are received and meet needs and satisfaction of the Veteran

Status of 2022 Recommendations for ASoC were discussed.

One Recommendation was to develop a plan to enhance education resources for Veterans with amputation, related to the context of whole health and providing opportunities to explore both supervised as well as self-managed wellness programs, exercise and nutrition.

ASoC developed several resource documents based on this recommendation.

- Whole Health patient education materials developed in FY23:
    - Preventing Hypoglycemia During Exercise After Amputation
        - Related to both exercise and nutrition
    - Adaptive Sports and Activities Resource Guide
        - Consolidates activities available through National Veterans Sports Programs and Special Events, as well as others
    - Get Moving: Adding Physical Activity into Your Routine

One Recommendation was to proactively prepare for capacity and capability to meet demands of the aging amputation population.

- Future Workforce and Training Needs Assessment
    - Formal Needs Assessment completed
    - Trends over past 10-20 years analyzed
    - Projections for future workload, workforce and training needs completed
    - Key strategies for enabling future success identified
        - Continued refinement of tiered approach to care, more specialized centers of excellence
        - Continued expansion of amputation care expertise across VA
        - Development of focused, specialized training, available on-demand
        - Enhance capabilities for utilization of virtual care platforms
        - Explore opportunities for enhanced care coordination services

    Another recommendation was to ensure training for the successful integration of advanced rehabilitation and prosthetic technology, such as osseointegration.

    OPRA Osteointegration Program
    - Candidacy screenings ongoing
    - Surgical referral for qualified candidates
    - San Francisco-surgical procedure site, Portland VAMC anticipated surgical site within the next 6 months, Palo Alto is a candidacy, rehabilitation and care coordination site
    - Care coordination requirements; referral to community providers and DoD
    - Two new sites interested in becoming OPRA Implant location

Summary and the Way Forward:

Focus remains on enhancing quality and consistency of amputation care while evolving to meet changing needs and new developments.

- Anticipate continued growth in need for services and specialized clinicians
- Advanced technologies and complexity of care for this population demand specialization and training
- Advances in care (prosthetic technology and surgical techniques) will impact future care, requiring specialized clinicians
- VHA priority for providing world-class healthcare into the future
- Enhance service delivery and access through new virtual platforms
- Improved care coordination
- Enhanced delivery methods for provider training

General Diehl asked if there was anything that the Committee could do to assist. Dr. Webster stated that the recommendations from the Committee last year were very beneficial and helped ASoC focus on some key areas.

Dr. Webster stressed the importance of educating and training providers as technology changes, to address needs of aging Veterans.

They are working on virtual care-VA Images: Veteran can capture a picture or a video and send to VA provider. Veteran can send a picture or video that can enhance care. (e.g., skin breakdown, walking with prosthesis)

An unidentified member of the Committee asked where the guidelines are published. Dr. Webster responded that the guidelines are publicly available on the website, healthquality.va.gov or search VA/DoD clinical practice guidelines.

Dr. Scott asked if the research shows health inequalities; if there are any in amputation care where certain segments of the population have different outcomes based socioeconomic or other factors.

Dr. Webster noted studies have looked at that for Veteran population as well as more broadly in the general population. Unfortunately, race plays a factor in whether or not people receive an amputation or not, as well as the level of the amputation. Focus is on growing female Veteran population, making sure ASoC is meeting the needs of that population. In the past, prosthetic technology has been focused on males.

General Diehl introduced Dr. Scholten, National Director, Physical Medicine and Rehabilitation Services as well as Polytrauma Program. General Diehl noted that prior to his current position, Dr. Scholten worked alongside his mentor, Dr. Scott, for ten

years at James A. Haley Veterans Hospital, where he was the Medical Director for Brain Injury Rehabilitation Programs.

VHA National PMR

Joel Scholten, MD
National Director, VHA Physical Medicine and Rehabilitation Services

Dr. Scholten expressed appreciation for the James A. Haley Veterans Hospital team and for the care which focuses on doing what's best for the individual Veteran and developing an individualized treatment for everyone undergoing rehabilitation services.

Dr. Scholten reported on general Physical Medicine and Rehabilitation (PM&R) with primary focus on three areas for FY2023:

Modernize Workforce-meet needs of Veterans
    - All rehabilitation disciplines have proposed National Standards of Practice
    - Rehabilitation providers will implement virtual care when appropriate
    - Train providers on new/emerging technology and practices
- Promote Early Rehabilitation
    - Embed physical therapy in Primary Care
    - Early mobility programs to prevent deconditioning
- Promote access and care delivery with virtual care
    - Employ both synchronous and asynchronous virtual care
    - Share resources throughout enterprise, Clinical Resource Hubs
    - Ensure resources and expertise is disseminated across VA system

Dr. Scholten reviewed the PM&R demographics:

- Workforce
    - 732 physicians; numbers have stabilized
    - 279 funded PM&R Residency Program positions
    - 283 Kinesiotherapists (KT), decreasing due to loss of training programs (PT and OT covered in other presentations)
- Access
    - New patient evaluation (by Physiatrist) wait time approximately 27 days
    - 94% outpatient Physiatrists deliver virtual care; every clinician should have virtual care as part of their toolkit
    - New patient evaluation (by KT) wait time is 8.5 days
    - 87% outpatient KTs deliver telehealth
- Modernize Practice
    - KT role in best practice areas of driver rehabilitation training programs, within whole health, wheeled mobility clinics, within programs for cardiopulmonary rehabilitation; match skillset for best utilization
    - VA Driver rehab Program Instructor trainers are field based KTs

Challenges:

- Salary rates for pain interventionalists, higher in the community, challenge to adequately compensate them in VA
- Equitable access to specialty systems of care
- Leadership training for Service Chiefs
- Effective communication and representation on Rehabilitation and Extended Care Integrated Clinical Communities REC ICC, help move information up and down through the system

Wheeled Mobility Clinics

- FY22 saw 54,199 unique Veterans
- Clinics staffed by PT, OT, KT and MD depending on site needs
- Average wait for new patients 19.6 days
- 8% of encounters are virtual
- Working to develop synchronous and asynchronous virtual care protocol to modernize practice
- Continued efforts to educate and train providers on emerging technology

Wheelchair and driver rehab technology is expanding; challenge to keep workforce up to date.

Driver Rehabilitation Program

- Provided at 48 sites across VA
- Credentialed specialty for Driver Rehabilitation: ADED certification
- Services provided by KT, OT, PT
- Training for Driver Rehabilitation Specialist consists of 2-week course, didactic and behind the wheel training.
- In-house training to ensure a level of quality and competency to ensure Veterans receive the best possible care

Dr. Scholten shared a Veteran success story. The Veteran, with paraplegia due to gunshot wounds sustained in combat, received driver rehabilitation services and now gives back by helping to train others to deliver the services.

Dr. Scholten shared Quality Improvement measures for Rehabilitation Services in VHA:

- Outpatient Rehab programming Patient Reported Outcomes Measurement Information System (PROMIS) measures available for quality measures, available in Electronic Health Records, both in VistA and in Cerner
- Random sampling of satisfaction through V Signals shows showed 90.78% satisfaction with outpatient services across the country

- Inpatient rehabilitation-VA uses Functional Independence Measure (FIM) for outcome comparison. Transitioning to Inpatient Rehab Facility Patient Assessment Instrument (IRF-PAI) which is now the community standard
- Working with other offices to take data, make it usable for sites so they can analyze quality of care and compare to other VAs and private sector
- All inpatient rehab facilities have CARF accreditation

Dr. Scholten asked for any questions before moving to cover Polytrauma.

Dr. Morgan, President of Parker University, asked about the minimum standard for a Kinesiology therapist (KT).

Dr. Scholten replied that they are master's level trained and hold accreditation with their national accrediting body, COPSKT. They are not licensed. KT is one of the first professions that went forward for comment in the Federal Register with respect to VA National Standards of Practice (NSP) project. Once published, NSP will provide some standardization across VA.

Dr. Morgan asked if they are trained clinically in their master's programs.
Dr. Scholten acknowledged that yes, they do rotations at different sites, many at VAs.

Dr. Banks, Chair Occupational Therapy, Howard University, asked if KTs receive training in their clinical practice to provide Driver Rehab services.

Dr. Scholten noted that they do not receive that training, VA trains in house. Outside training exists but VA developed a 2-week training program to ensure adequate competency in knowledge and skills to ensure that we are safe when we take Veterans on the road for driver training. Need to be aware of all technology and options available to maintain independence.

Dr. Banks noted that the OT curriculum has a standard specifically that requires the discipline to be driver rehab prepared. They are not certified but they do get training in the curriculum as well as in assistive technology. She suggested OT might fill that role as numbers of KT are reducing.

Dr. Gore noted that in October 2021 one of the recommendations related to outcome measures for telerehabilitation and needed some extra time. He was curious about telemedicine delivery in terms of services, interested in what sort of progress has been made in terms of assessing outcomes for virtual versus in-person care across VA.

Dr. Scholten noted the need for continued study, as we don't have a good comparison yet and some limitations exist due to our EHR. The ability to include in clinical notes exists but it is hard to mandate incorporation of outcome measure in each visit.

Challenges exist in the current environment; resources directed toward programming and additional data collection were divided; need to continue to work on it.

Dr. Gore noted that in his experience they found that percentage of telemedicine care in an IOP model of care for mild TBI among Veterans does not influence outcomes. He noted they are a tiny program compared to VA. An opportunity VA could leverage to benefit all.

Dr. Pai commented on challenges with our data collection and noted that within our national office we have individuals that are splitting their time between National Program Office outcome measures and supporting the field with regards to data, as well as challenges with new EHR. Suggested having Data Analytics Office present on where they are with supporting specific program offices, challenges they may be having with supporting new EHR, as well as where the draw of manpower goes. Information may help us with recommendations in the future.

Dr. Scholten agreed and noted we need their support to measure outcomes and put findings together in a manner that can support front line clinicians.

VHA National Polytrauma Program

Joel Scholten, MD
National Director, VHA Polytrauma Program

Dr. Scholten reported on the Polytrauma Program. He began with an overview of the integrated system of care and specialized rehabilitation sites.

The system has 5 Regional Polytrauma Rehabilitation Centers (PRC) located in Palo Alto, Tampa, San Antonio, Richmond, and Minneapolis. He acknowledged the Tampa PRC which we toured yesterday as one of the five premier regional polytrauma centers with all the resources needed to cover care for Veterans with TBI or Polytrauma.

He explained that the VA is divided into different regions or Veterans Integrated Service Networks (VISN). There are 23 Polytrauma Network Sites, an additional 86 Polytrauma Support Clinic Teams which focus on providing outpatient TBI polytrauma care and doing comprehensive TBI evaluations after positive screens, as well as providing ongoing care for Veterans with TBI. Every site that doesn't have a fully staffed team has a point of contact that connects them with the higher level of care they may need. There are 39 Polytrauma Points of Contact and most have significant rehab assets on site and most are doing TBI evaluations. They either refer to community for additional services or connect within VA to provide care in-person or virtual. The hallmark of care is that following TBI diagnosis, an individualized treatment plan is developed.

All Polytrauma Rehabilitation Centers are considered Centers of Excellence and are subject to a five-year review and evaluation. Review shows 99-96% overall satisfaction with care over the five years. There are over 700 annual admissions. Consistently 62% and, last year, 70% of admissions at the 5 PRCs are from outside catchment area. We are meeting needs of Veterans across system, not only those living in one of the 5 locations. All PRCs are CARF accredited under Brain Injury standards.

In addition to the high-quality clinical work there's a huge amount of work in education, training and research at the PRCs.

- Training remains a key mission; 279 slots last year covering residents, fellows and trainees at the 5 PRCs.
- Consistent growth in research grants and projects with 93 grants and projects awarded in FY2022 at the 5 sites.

Dr. Scholten reviewed the history of the Polytrauma System of Care beginning in 1992 when we first established four brain injury centers within VA with a Memorandum of Understanding (MoU) between VA and DoD. There are a number of highlights throughout the years, but it has taken 30 years to develop these amazing sites.

Dr. Scholten discussed the development of the Intensive Evaluation and Treatment Program (IETP) used today throughout VA. (called PREP at Tampa)

Dr. Merritt, at James A. Haley Veterans Hospital, started a two-week comprehensive evaluation for service members and Veterans with TBI ongoing needs, mostly mild TBI, complex pain, sleep, and mental health issues. This is a valued program for VA and for our DoD partners, Special Forces in particular. Following a comprehensive review in 2018-2019 it was decided that the program should be spread through the other PRCs, building expertise and capacity across the system.

Dr. Scholten's slides included photos of the Tampa facility and elements of the program such as the climbing wall.

Intensive Evaluation and Treatment Program (IETP):

- Provides comprehensive, inpatient individualized evaluation and treatments for combat -related physical, cognitive and mental health symptoms
- High demand from active-duty special forces personnel
- Defined assessment, treatment and outcome protocols for:
    - Sleep
    - Mental Health
    - Cognition
    - Musculoskeletal Pain
    - Vestibular

- Funding for expansion FY2022-24 to cover construction and hiring
- Knowledge Translation Specialists identify best practices, improve efficiencies

Assistive Technology (AT) Programs enhance the ability of Veterans and Active-Duty Service Members with disabilities to maximize functional independence with assistive technology in the following areas:

- Alternative and augmentative communication
- Electronic cognitive aides
- Electronic aids of daily living
- Adaptive sports
- Complex wheeled mobility
- Computer/driving
- Mounting and alternative access

AT Programs have expanded and matured since start in 2009

- Staffing rehab engineers
- Strategic planning
- Education and training opportunities
    - Communication aids
    - Smart home technology
    - Mobility devices
    - 3D printing
    - Concussion Coach App has anticipated update release in 2023, aligns with DoD clinical practice guidelines for Mild TBI

Outpatient TBI/Polytrauma Care

- Develop individualized interdisciplinary plan of care for each Veteran
    - Electronic templated plan of care notes help teams develop individualized plan of care
    - Measure Outcomes with Mayo Portland Adaptability Inventory Participation subscale
    - Integration of virtual care (last year 54% of all Veterans seen in polytrauma clinics had at least one virtual care encounter)
- Proactive Case Management
    - Review high risk Veterans on the Chronic Disability List (CDL) identify Veterans most likely to need ongoing services
    - Follow up visits

*FY2021 recommendation was to look more at who was getting services, who was on the list and how plans of care can be better integrated. Continues to be our focus.

One challenge is that the data is a year behind due to how it is pulled. It lists all Veterans seen in VA with a code consistent with severe TBI or a Mayo Portland

Community Participation score of 50 or greater, indicating they would have poor community integration or participation.

We look at the percentage that have a follow up in a polytrauma clinic the following year and an updated plan of care. In FY2021, 46% had a follow up and now that number is up to 52%; we continue to educate and train providers on best practices to increase this number. Will never get to 100% due to flaws in the data and in clinician coding.

Dr. Scholten again acknowledged the Tampa VA, the beautiful facilities and the amazing teams. He highlighted the work we all do is truly about and for the Veteran.

General Diehl acknowledged the benefit of the field visit bringing to life the PowerPoints that we see in presentations. It has been a privilege to see and appreciate the impact of the quality of care here at Tampa and across the enterprise.

General Diehl asked for questions from the Committee.

Dr. Gore echoed appreciation for coming to Tampa, seeing Polytrauma management and spending time with Dr. Scott.

Dr. Gore asked about the Concussion Coach App noting the 5-year cycle for clinical practice guidelines. He noted the Amsterdam sports concussion meeting which occurred in the fall, with productivity from that meeting expected any day. There are substantial changes in concussion management being recommended, at least for athletes in terms of activity management and treatment definition of time from injury. He asked how long ago that review was done as he would hate for App to be updated and then find it's not aligned with latest recommendation.

Dr. Scholten reported that clinical practice guidelines were updated in 2021. He plans to look at the results of the Amsterdam work and if needed, will update based on those recommendations. Felt we could not wait any longer because the current content was out of date and the infrastructure was no longer serviceable by the current iOS platform.

Dr. Gore noted that there was a lot of DoD representation at the meeting, but he did not remember anyone from VA. Suggested it might be good to align those efforts.

Dr. Gore asked if the other centers had implemented the IETP programs.
Dr. Scholten reported that all 5 PRCs have implemented and are up to full capacity. Richmond is at 10 beds, San Antonio at 6 beds and Palo Alto at 8. Minneapolis is starting slow because they are also renovating their existing transitional residential programs and having to consolidate beds during the construction phase.

Dr. Gore noted that the program here is at 80% active duty and 20% Veterans and asked if that was consistent across programs.

Dr. Scholten replied that sounded correct, however Minneapolis, based on geography of not being as close to large military bases, is just serving Veterans.

Dr. Gore did some quick calculations based on newest VA data that show 450,000 TBIs, 80% of which are mild. Noting capacity to take care of these Veterans due to number of spots and length of stay, it would take time to get through needs. Would like to continue the dialogue and make sure we are focused on needs of Veterans with these injuries to make sure we are meeting that need.

Dr. Scholten agreed and noted that not every Veteran with symptoms is going to need an inpatient 4-week program. There is a need to work to update our existing outpatient programming and meet needs on outpatient basis, if appropriate. One challenge is Veterans are working and don't want to take time off for a 3–4-week program. We need to think creatively to make sure we have a menu of potential services that could be individualized to meet each Veteran's unique needs.

The Committee paused for a quick break at 9:49am and resumed at 10:02 am. General Diehl acknowledged the quorum returning to the room. He introduced Dr. Highsmith, National Director VHA Orthotic Prosthetic and Pedorthic Clinical Services (OPPCS) also referred to as Clinical O&P. He acknowledged Dr. Highsmith's current work and positions and also congratulated Dr. Highsmith on his promotion to Major this weekend. Dr. Highsmith serves in the Army Reserves.

VHA OPPCS

M. Jason Highsmith, PhD, DPT
National Director, VHA Orthotic Prosthetic and Pedorthic Clinical Services

Dr. Highsmith acknowledged a new team member Dr. Michael Carroll, former Clinical O&P Chief at the Orlando VA, who will help in areas of program management, education and procurement.

Last year talked about 3 topic areas: HR, pedorthics and therapeutic footwear, and realignment to a clinical service. Senior leaders have taken removed HR and we will continue to keep working to make improvements. We will focus on the other two areas.

Dr. Highsmith reviewed the role of the OPPCS in VA and the roles the VA Orthotist and/or Prosthetist plays in patient assessment, formation and implementation of treatment plan, rehab, follow-up and practice management. It is important to note the patient element because of the ongoing professional struggle to separate orthotics and

prosthetics from durable medical equipment (DME) provision and into recognition as a clinical professional service.

Clinical O&P works closely with PSAS, contracting office. procurement and logistics—who do the buying. Clinical O&P (OPPCS) is a clinical program office, focused on policy development and guidance.

Dr. Highsmith reviewed the OPPCS expenditures and compared to the cost per distinct Veteran. The largest expenditure (prostheses) serves the smallest number of Veterans.

Expenditures are divided roughly in thirds: artificial limbs ((prosthetic), therapeutic footwear (in-shoe orthotic), orthoses (includes a wide range of items). All need education and training to the Veteran and customization. Looking at how many Veterans use services; artificial limb is small but high cost at 1/3 of the expense. Orthotic is roughly half. Orthotic and therapeutic footwear have high volume, high demand, high numbers of Veterans but much lower cost point.

OPPCS is working with ASoC to have our clinicians as part of that team.
Overall staff size across enterprise consists of 506 O&P staff. Includes clinicians as well as technical staff like fitters, pedorthists. Numbers are up from 350 in 2017 with staffing at 120 of the 140 VA facilities up from 85 facilities in 2017. VA is a good place to work.

Priorities for OPPCS in FY23

- Pedorthic Care (therapeutic footwear and inserts)
    - Manage supply and demand; manage increase in demand for services
    - OPPCS staff not available at every VA and CBOC; Veterans often have to travel to main Medical Center for services
    - Modernize workforce to meet pedorthic needs; allow for more complex custom devices and artificial limbs.
- Realignment to a Clinical Service (Recommendation FY22)
    - Currently most OPPCS staff are managed by an administrative service; at the field level there's a subordinate relationship with PSAS the prevailing organizational structure overseeing O&P
    - National OPPCS Program Offices partnering to realign OPPCS staff at facility level

Opportunities and the Way Forward

- Pedorthic Care
    - Improve hiring; Qualification Standards are in field concurrence, needed to help take a person from training or community practice and bring into VA
    - Currently have under 30 pedorthists to manage enormous patient load, results in orthotists doing that work instead of more custom lower extremity or spinal or cranial orthotic care provision

    - Education and training for VA stakeholders (OPPCS staff, prescribing physicians and PSAS staff); no consistent private sector pathway for education and training, mostly short courses; will need to develop our own VA model around education and training; US academia not interested in educating pedorthists
    - Improve access to qualified providers within VA and private sector
    - Need to get creative with community partnerships
    - Increase access to pedorthic services; work with field staff to identify needs
- Realignment of OPPCS
    - In the past year 8 VA facilities have moved OPPCS under clinical service
    - Gathered feedback from sites that transitioned; lessons learned, which led to the development of a Realignment Memorandum of Understanding (MoU) and toolkit to help sites realign
    - Conducted national office hours reviewing MoU and realignment plan
    - Plan to further socialize plan with Executive Leadership groups
    - Support efforts for realignment at VISN level
    - Considering broader strategies such as Directives to standardize organizational structure

Dr. Highsmith's takeaways

- Promote/support realignment of OPPCS to a clinical service
- Promote/support development of novel approaches, bridge gaps in access to Pedorthic Care (therapeutic footwear and inserts); support a rigorous analysis of therapeutic footwear to understand how to best meet patient's needs in the most efficient way
- Focus on staffing and training to provide highest level of care to Veterans
- Focus on provision and procurement options for pedorthic care

Dr. Morgan, President of Parker University, asked why the academic programs have turned away from training pedorthists; their university is always looking at certification programs. What is the need and what's the training required in certification?

Dr. Highsmith noted a couple of factors - there is an enormous job market and demand. Salary is disproportionate to what people are being expected to do, and it is not the most glamorous work working with feet all day. Pedorthists need a passion for the work, ultimately academic programs couldn't fill the seats.

Dr. Morgan suggested a solution with online education, have training in the field, get certification, bridge to associate degree then bridge to bachelor's degree.

Dr. Highsmith noted they are working on VA educational modules on general foot anatomy and disease process, taking the training piece in house.

Dr. Gore noted that anyone with military experience knows that foot care is the quickest way to disable a fight for strength. Very important.

Dr Gore noted that a recommendation last year was for a plan to pursue realignment for O&P at all VAMC across the enterprise, and we are supporting that currently. He asked for elaboration on the biggest barrier.

Dr. Pai noted that he and Dr. Highsmith have been working on this since before he took his new position. The National Program office is the policy driver, but the operational implementation comes down at the field level. VA is aligned with 18 regions or VISNs, each led by a CEO and then within those regions, multiple healthcare centers, each led by a CEO. Each VISN has a slightly different look with regards to how clinicians are structured within their facilities.

Treadling lightly not to just create a blanket policy that will cause chaos at the facility level and not trying to step on the toes of the CEOs because they are inevitably our partners for programs we want to expand. Began with having crucial conversations with each of those CEOs. Out of those conversations we've had some give us their approval and desire to move to this clinical model. Met with DC region, with Northern California. Four sites in the past month and a half have said they want to move over to realignment. Once we get a threshold number of VISNs on board, we will go to our national governance board and show the need from a clinical and patient safety standpoint. Readiness as an enterprise to take next step takes some maneuvering. Dr. Highsmith shared a case in California where once realigned they were able to use resources more appropriately and obtain more resources, better serving Veterans.

General Diehl introduced Dr. Anthony Lis, National Director VHA Chiropractic Program.

National Chiropractic Program
Anthony Lisi, DC
National Director, VHA Chiropractic Program

Dr. Lisi provided an update on the Chiropractic Program. VA Chiropractic Program delivers evidence based, patient centered care. It is in high demand by Veterans and by referring physicians in VA. Program strives for excellence in care provided to Veterans.

- Continuing to increase service delivery, have a way to go.
- Ongoing initiatives aim to improve access and quality and try to reduce some of the variation and delivery in the field.
- Continued assessment, optimization and strategic expansion of program will provide best care and customer service for Veterans.

Current On-Station Delivery of Chiropractic Services in VA

- trend shows more VISNs are increasing overall population of VAMC delivering chiropractic care; nationwide we're at about 78% with some variation between and within each VISN
- some will use more community care

VHA Chiropractic Use by Delivery Mechanisms:

- Encouraging VISN leaders to think of some threshold of on station care that might be a reasonable target to optimize balance (between community and on station care)
- Majority of chiropractic clinics are in PM&R, but also a sizeable percentage in pain medicine, primary care and other departments

Annual Chiropractic Use Rate in VHA and externally:

Dr. Lisi discussed the trend in chiropractic care among 3 populations of Veterans: those who receive care only in the community, those who receive on station care only, and those who have had one visit by each.

- Majority of care is through the community and accelerated rapidly from 2016-19
- Acceleration of community care has slightly attenuated
- From 2019-22 the use of on station care has been increasing
- In house care is perceived as better quality, with better coordination and bett4er collaboration between the team of providers managing the Veteran

Ongoing Initiatives:

- Patient care
    - Optimizing care delivery with respect to both quality and timeliness
- Systems
    - Improving Electronic Health Record functions to capture data and clinical decision support
- Policy
    - Four items currently
    - Federal Regulation codifying VA's chiropractic care as a medical service and a preventive service (modeled as tertiary or quaternary prevention)
    - National Directive up for revision and in concurrence
    - Qualification Standards originally drafted in 2002 and in process of revising with WMC partners
    - National Standards of Practice in development
- Discovery
    - Assessing prevention/service offset of the impact of delivering chiropractic care to a population of Veterans and partnering with a VA Center of Excellence (CoE) that has expertise to extract and analyze VA data

- Working with Office of Academic Affiliations (OAA) for residency training innovation, expansion in training programs

Dr. Lisi reviewed the challenges, opportunities and the way forward:

- For facilities predominantly or exclusively using community care, there is a high variation in quality and significant limitations in care coordination. An opportunity to encourage a VAMC to provide some on-station chiropractic care.
- Service delivery needs to be right sized overall as Veteran access to care is variable. An opportunity to develop chiropractic service delivery models that are commensurate with the Veteran population. Allows facilities to balance delivery of care between in-house and community
- Workforce, recruitment and development: for the last 15 years VA was a leader in terms of US hospital systems that brought on chiropractors. Only other model was DoD which started about 10 years before VA. Last 5 years or so, private hospitals have included chiropractic care in-house resulting in increased private sector competition. For staff we do have, need continuing education opportunities to avoid challenges in the realm of workforce development. An opportunity to include chiropractors in VA employee compensation and education initiatives.

Dr. Lisi paused for questions.

Dr. Morgan, President of Parker University, concurred that there is competition for graduates (chiropractors). Currently two positions for each graduate with tighter market anticipated. Agrees with recommendation for increasing compensation and educational incentives. He asked about the increased standardization of care in the field for VA and whether it helped when they are going into the economy (community care).

Dr. Lisi noted that it doesn't necessarily standardize the care delivered by community chiropractors but helps provide the facility with some who could be engaged in utilization review process when Veteran is sent to a community provider. In house chiropractor helps assess need for ongoing care, enables the facility to feel they've got better control of the area being delivered in community.

Dr. Morgan followed with a question about referring physicians and their ability to help control the care in the community.

Dr. Lisi noted the challenges with managing quality of community care in multiple disciplines. They hear from Primary Care colleagues or Physiatry once they have an in-house chiropractic team, that MDs are more confident in the choice they make with patients on when to refer and what to expect.

Dr. Gore stated he was interested in the value proposition looking at chiropractic care in-house versus in the community, with respect to cost. As similar data focused on PT and shows that with PT were less likely to move to opiates and less likely to end up with surgical care; findings have been reiterated over and over in the last decade with most common orthopedic procedures.

He noted that we currently have a Recommendation for WMC focused on trying to attract more PTs would be interested if trying to increase access to PT and increase salaries, how would that compare to expanding chiropractic care.

Dr. Lisi noted that they do not need PT to be retracted for Chiropractic care to be expanded. There are about 350 chiropractors in VA and 3000 physical therapists.

On limited type of economic analysis, for past 5 fiscal years, a case sent out to community care will cost $1000 where a case in-house by VA chiropractor would cost about $430. Rudimentary analysis but believe cost is lower if delivered in-house.

Dr. Lisi noted that there are a number of providers a patient may be driven to, there are really no strong indicators of which is best or what treatment is best. This is something we need to figure out in and out of VA. (PT, physiatry, chiropractic care, OT, neurology, pain medicine, etc.)

General Diehl thanked Dr. Lisi and asked Mr. Dunning to make any final remarks, leading with how we can bottle up all we have seen at Haley and spread it around.

Mr. Dunning spoke about innovation, replication and scaling. He talked about a program across the country called Uber Health. He noted two barriers: number one reason patients don't get to their appointments is lack of transportation. If they do arrange for transportation, they have to pay for it first and then get reimbursed. Now working with Uber Health in 60 VAMCs to provide transportation back and forth.

Mr. Dunning talked about bringing together those within his VISN to showcase programs, disseminate information, share with everyone in one place at same time.

General Diehl noted that he always likes coming to Haley because they are forward leaning, always looking to the future, bringing tomorrows' technologies to care for Veterans today. He asked Mr. Dunning to share his view of the future and what he saw coming, specifically with Artificial Intelligence (AI).

Mr. Dunning noted they are a preeminent center for AI, led by Dr. Mastorides at Tampa they are looking at using AI in relation to radiology, disease progression, things that may be missed by providers. He noted that VA is investing in AI.

Dr. Pai thanked the Tampa team for their hospitality and for the opportunity for the Committee to see operations across the spectrum of what we do in RPS for our Veterans. He noted that it was so meaningful to have Mr. Dunning and other Executive Leaders come and talk to the Committee about programs. He stressed the importance of how we can use and leverage the knowledge and experiences that are at Tampa and other Centers of Excellence, how we can spread that knowledge using innovation.

Mr. Dunning reported that they are building a new Community Living Center and moving to a neighborhood concept instead of institutionalized room after room, He first saw it at Lovell and then sent staff to go see it; enabled the team to plan and develop in Tampa. Again, stressing the importance of learning from one another.

Mr. Dunning mentioned an Inspector General visit at Tampa today. He appreciates when they come as they bring pieces that teach and show different perspectives. Visits are stressful and also helpful.

Mr. Dunning thanked the Committee as the visit provides an opportunity for him to learn.

General Diehl posed questions to the Committee:

- what's the vision for the future?
- how will we take care of the aging population?
- how do we assess our resources across the continuum of care?
- how do we distribute the information?

Dr. Hood noted that what is happening in Tampa should be shared with other facilities. Need formal dissemination of this level of innovative care across VA. Suggested that innovation has to be drilled into training programs for the next generation of clinicians. May need to bypass other health systems and go directly to universities because health systems can be resistant to novel approaches that don't align with their philosophies.

Dr. Banks also commented on the need to expand and duplicate. She noted we don't have enough workforce to keep up with the innovation. She noted that every presentation expressed a need for staff, for training opportunities. Need to make sure we have the capacity, for the new generation in training and academic programs, so that expansion is not ahead of what we an provide in terms of workforce to implement.

Dr. Gore noted we have a number of current Recommendations related to WMC across all therapy disciplines. Supports the idea of better understanding resource allocation within VA, at least for our recommendations to figure out where that fits into our scope.

Dr. Gore addressed Mr. Castle's previous comment about long term care across rehabilitation. Suggested an information gathering of information to better understand long term plan to meet the needs of this population. Need to consider if there are

opportunities in the short term to meet needs because we have learned it takes 10 years to build a building. May want to look at other ways leveraging affiliates, community, or offering military-relevant neurotrauma training so we can use existing beds in long term care facilities to provide care,

Dr. Pai noted that he had been taking notes regarding potential presentations for fall and that we may be interested in hearing from geriatric and extended care. They are looking at aging of Veterans with a robust system of care that seems ever-expanding. One of their themes is aging in place. Perhaps we can have them discuss with Committee what they are doing and how we can partner with them. May help with future recommendations.

Mr. Moragne reminded the Committee that the charter requires meeting at least twice a year; but can meet more. ACMO does not expect anyone to come back with completed recommendations. Suggested using subcommittees to draft recommendations, polish up to a high level and then come back when the parent committee meets. Then present the draft to be deliberated on and voted on and incorporated into a report.
He cautioned against group writing of recommendations as that exercise is frustrating. Committee is not required to report each meeting, report when ready. Great recommendations come out of committee because they waited until ready, as long as it is going to make a difference to Veterans

Mr. Gorman noted that our committee is unique in the way that we're dealing with prosthetics and special disabilities, not average healthcare. Most in private sector don't look at disabled Veterans, they look at generalized healthcare. Would like to hear how other people see our committee. Are we going to be a long-term survivor that VA takes care of? Would like to hear from senior leadership (Secretary, Under Secretary for Health), or someone from the Hill that looks at us and the segment of Veterans we're talking about and how they see that cohort in the future.

Mr. Moragne noted that there are plenty of senior advisors who can give an overview of the VA Secretary's plan and vision.

General Diehl suggested preparing a 3-4 slide presentation about the aging population, our view, as a read ahead. Perhaps the subcommittee can think about it and then maybe put together a presentation to accompany an ask.

Mr. Castle expressed interest in hearing from senior leaders about what they feel the future of specialized care is inside VA, because there seems to be a movement towards putting many into the community to be seen faster. He noted that specialized care is unique inside VA and a Veteran can only receive that style and level of care inside VA. Would like to hear from senior level about how they see future of specialized care. Is it a

priority? Is there a movement to keep inside VA or move outside? He expressed that his personal involvement with SCI and specialized care inside VA is second to none.

Dr. Gore noted that we need to be focusing on providing care within VA and what the trajectory looks like, want to know plan for special populations. He was thinking about general suggestions for subcommittee names: disability services, polytrauma, sensory services, sensory-focused. He was trying to figure out how to encompass the breadth of what we do. Perhaps members could gravitate toward serving on one of those subcommittees so we could put our possible draft recommendations into those areas.

Mr. Moragne suggested meeting for half an hour virtually and throw ideas around to talk about the structure, or via email chain. Or, have an administrative meeting with subcommittees as the topic.

General Diehl suggested setting up a virtual administrative meeting in about a month, after giving some thought to our discussions.

Dr. Pai thanked General Diehl for his leadership. He noted that he is here to help provide guidance so recommendations we put out in the future and over time are valuable and VA can rise to meet them

General Diehl thanked the Committee and everyone who attended and participated in the Meeting.

Dr. Racoosin expressed her appreciation to the committee for attending and for adhering to the administrative requirements throughout the year. She asked those who need to return Letters of Agreement to submit them so that they could receive the honorarium.

Dr. Racoosin thanked Kolina Ford, Lead Medical Support Assistant, Physical Medicine and Rehabilitation Service at James A. Haley Veterans Hospital, who helped with every element of the program. She thanked the Haley team for their hospitality and shared that they had provided lunch again and invited the Committee to stay and enjoy or take a sandwich on the way out.

General Diehl inquired about travel receipts to which Dr. Racoosin reminded the Committee to forward receipts for hotel and transportation costs to Sonya Skinker, Committee Support.

The meeting was adjourned at 11:59 a.m.

Lauren S Racoosin 108514 Digitally signed by Lauren S Racoosin 108514 Date: 2023.05.15 14:54:21 -04'00'

Lauren S. Racoosin, DFO

Date

Arthur F. Diehl III, Chair

18 MAY 2023

Date