Department of Veterans Affairs
Special Medical Advisory Group

April 6, 2022
Washington, DC
9:08 a.m.-3:29 p.m.

MINUTES

Committee Members Present:

Gregg S. Meyer, M.D., MSc, (Chair) President of community division and EVP for Value Based Care, Mass General Brigham (Present)

Jeffrey Akman, M.D., Former Vice President of Health Affairs, W.A. Bloedorn Professor of Admin. Medicine and the Dean of the School of Medicine and Health Sciences at the George Washington University (In person)

Robyn Begley, DNP, RN, NEA-BC, FAAN, American Organization for Nursing Leadership Chief Executive Officer (Virtual)

Francis J. Crosson, M.D., Senior Lecturer in Health Systems Science at the Bernard J. Tyson Kaiser Permanente School of Medicine (Present)

Terry Fulmer, Ph.D., RN, FAAN, President, The John A. Hartford Foundation (Virtual)

Trent Haywood, M.D., JD, Chief Medical Officer of Zing Health (Virtual)

Arthur L. Kellermann, M.D., MPH, FACEP, Senior VP, Virginia Commonwealth University (VCU) Health Sciences; Chief Executive Officer, VCU Health (In person)

Kameron Matthews, M.D., Chief Health Officer for CityBlock Health, Former Assistant Under Secretary for Health for Clinical Services, Veterans Health Administration (Present)

Michael Mittelman, O.D., MPH, MBA, FAAO, FACHE, Rear Admiral, USN (Ret.) President of Salus University (established by the Pennsylvania College of Optometry) (Present)

Chanin Nuntavong, National Director, Veterans Affairs and Rehabilitation, The American Legion Headquarters (Present)

Jonathan B. Perlin, M.D., Ph.D., MSHA, MACP, FACMI, President, Clinical Services and Chief Medical Officer, Hospital Corporation of America (HCA) (Present)

Richard Pollack, President and Chief Executive Officer, American Hospital Association (Virtual)

John E. Prescott, M.D., Retired Chief Academic Officer, Association of American Medical Colleges (Virtual)

Phillip R. Sandefur, D.D.S., Associate Director of Dental Laboratory Operations, VHA Central Office, Office of Dentistry (Virtual)

Lewis Sandy, M.D., FACP, Executive Vice President, Clinical Advancement, UnitedHealth Group (Virtual)

Ross Taubman, D.P.M., President and Chief Medical Officer, Podiatry Insurance Company of America (Virtual)

Beth Taylor, D.H.A., RN, Assistant Under Secretary for Health for Patient Care Services and Chief Nursing Officer, Veterans Health Administration (Present)

Mary Wakefield, Ph.D., RN, Visiting professor at Georgetown University and the University of Texas at Austin (Present)

Robert Winn, M.D., Virginia Commonwealth University Massey Cancer Center Director (Virtual)

Committee Members Absent: None

Department of Veterans Affairs Staff and Presenters:
Steven Lieberman, M.D., Deputy Under Secretary for Health, Performing the delegable duties of the Under Secretary for Health, Veterans Health Administration (Present)
Carolyn Clancy, M.D., Assistant Under Secretary for Health for Discovery, Education and Affiliate Networks (Present)
Mark Upton, M.D., FACP, Acting Deputy to the Deputy Under Secretary of Health (Virtual)
Erica Scavella, M.D., Assistant Under Secretary for Health for Clinical Services, Veterans Health Administration (Present)
Miguel LaPuz, M.D., Acting Deputy Under Secretary for Health (Present)
Jeffrey Moragne, Ed.D, Director, VA Advisory Committee Management Office, Office of the Secretary (Present)
Roshni Ghosh, M.D., MPH, Executive Director, Center for Care and Payment Innovation (Present)
David Carroll, M.D., Office of Mental Health & Suicide Prevention Director, Veterans Heath Administration (Virtual)
Rachel Ramoni, D.M.D., Sc.D, Chief Research and Development Officer for VA (Present)
Marjorie Bowman, M.D., Chief Academic Affiliations Officer, Veterans Health Administration (Present)
Gerard Cox, M.D., M.H.A., Assistant Undersecretary for Health for Quality and Patient Safety (Present)
Joseph Francis, M.D., Executive Director, Office of Analytics and Performance Integration, Office of Quality and Patient Safety, Veterans Health Administration (Virtual)
Reena Duseja, M.D., Senior Advisor, Office of Quality and Patient Safety, Veterans Health Administration (Present
Ernest Moy, M.D., Executive Director, Office of Health Equity, Veterans Health Administration (Present)

Other Attendees:
Sidath Panangala, Analyst in Veterans Policy, Congressional Research Service, Library of Congress (Virtual)
Randolph Harrison, COL, Army War College Fellow (Virtual)
Sandra Cotton (Virtual)
Lisa Pape Senior Advisor(Virtual)
Donna Stratford Director of Communications, Undersecretary for Health for Quality and Patient Safety (Virtual)
Toby Schonfeld (Virtual)
Katheryn Pierce (Virtual)

SMAG Administrative Team:
Selina Meiners, Designated Federal Officer (Present)
William Judy, Alternate Designated Federal Officer (Present)
Dennis Lahl, Committee Manager (Present)
Kyle Sommer, Committee Manager (Present)
Katie French, Committee Administration (Present)
Sara Lyon-White, Committee Administration (Present)
Faustine Huynh Arzadon, Committee Administration (Virtual)

Call to Order: The meeting to order at 9:08 a.m., April 6, 2022.

Ms. Meiners:·Welcome to today's Special Medical Advisory Group spring meeting, April 6. I am the Designated Federal Officer and I'm going to officially call this meeting to order. Just a few notes before we begin.

This is an official Federal Advisory Committee meeting and it's open to the public. A reminder to the public that you are in listening mode only. If we find that someone has an open microphone and not able to remain muted, we will remove you from the meeting. There is no time allotted for public comment today. We have not received any public comments prior to the meeting.

I am going to turn things over to Dr. Jeff Moragne. He is the Director of the Advisory Committee Management Office and he's going to conduct some mandatory FACA (Federal Advisory Committee Act) training.

Mandatory FACA Training:

Dr. Moragne: Good morning, Members of the Committee, Dr. Lieberman, Dr. Clancy. I am Jeff Moragne, the Director of the Advisory Committee Management Office. Our Office oversees the VA portfolio of federal advisory committees, which we have 27. We also have 120-plus subcommittees, about 1400 parent committee and subcommittee members and 125 Designated Federal Officers (DFO). The purpose of my briefing today is to give you a booster shot in the FACA boundaries so that the body of your work remains viable, remains legal, for the Secretary to concur, not concur or concur in principle.

Before I get started, I wanted to take one minute to thank the outgoing Chair, Dr. John Perlin. Your leadership, your vision, your guidance, your services has been unparalleled and superb. Thank you, Sir, for setting the gold standard. I have many conversations with other Chairs who are nervous about being in the chair, and I tell them, "Just call Dr. Perlin. He'll give you the way ahead, he'll settle your bones, he'll focus your vision, he will get you where you need to be. You weren't selected because you were bottom of the barrel, you're the top of the barrel, but the tippy-tippy-top has always been Dr. Perlin."

Dr. Perlin: Thank you, very much. Please note this was an extraordinary privilege and an honor not only to work with all of you; the VA Leaders and staff, colleagues on the SMAG, but I think you know it's a labor of love and an important mission, so thank you, very much.

Dr. Moragne: I normally start off this briefing by giving you a little bit of history. FACA came into being in 1972; 50 years later it still exists. It's 10 pages and it establishes the standard on how you establish a committee, manage a committee, and terminate a committee. FACA is all about two principles - transparency and accountability, and it has done it very well. The final rule for FACA was vetted for four years and came into being in 2001, so it's been in place for 21 years. One of the things I really want you to walk away with and realize is, anytime you meet, the Federal Advisory Committee Act applies.

Whether you meet as a parent committee or a subcommittee, a DFO must be present. We want the body of your work to make it legally to the Secretary to concur, not concur or concur in principle. Now, a footnote for you, but a very important one, is that this Committee, over the last 10 years, under Dr. Perlin's leadership, under your participation

as Committee Members, has had 90% of its recommendations concurred on and fully implemented by VA. That is not the gold standard, that's the platinum standard.

Part of what's embedded in this briefing is to ensure that you maintain that 90% standard, if not increase it. So many elements of what you need to be legal are: you must have a Designated Federal Officer, you must have a signed charter, a new charter is signed every two years. That's a check-and-balance system to say that this statutory committee, our oldest committee in our portfolio, from 1945, is viable. Every two years that check and balance occurs, the Secretary signs off on and we move along. Your meetings are announced in the public Federal Register 15 days prior; if we ever fall short, then we move the meeting. We don't fudge the date, that's very important.

You have a balanced plan. That's because your Committee was designed to reflect a certain Veteran constituency. Your skillsets and your experience, which obviously fill out the mission and the scope of the work that you do, but also the demographics of your committee reflect that Veteran constituency, and we have been working diligently to make sure that your balanced plan and your committee demographics do exactly that.

Finally, for the public, for those listening out there in the virtual space, we keep records. We don't require you to Freedom of Information Act request those records. Put it on the back of a napkin, hit us in the hallway, see us walking to McDonald's, whatever, we give it to you. Records of the meeting, that's the Minutes reports, other things like that. Those are also online, more officially, at our VA.gov/advisory site or at the General Service Administration FACA database. It has all the records that you may want to use and, obviously, all the VA and the 1,000 Committees in the government. Footnote: When FACA came into being, 8,000 committees went down to 1,000 committees. Fifty years later, the federal government still has 1,000 federal Advisory Committees. When I said FACA is doing the job, it really is doing the job, they eliminated nepotism, favoritism.

To do business, you must have a quorum - 50 percent of your membership, plus one; it's very important. Anything less than that, you'll be considered an ad hoc subcommittee and that agenda can go through; however, that ad hoc subcommittee needs to brief a parent committee quorum for it to be official. That's very important that you continually work together as a Committee to deconflict your personal and professional schedules against this commitment so that you have that quorum.

From time to time, you can close your meetings, but it is a very deliberative process to close a meeting. Statistically, 99.5% of your meetings will be open to the public; that 0.5% is because we went through this deliberative process where you, as Members, and the Chair discuss why you want to close the meeting to the DFO, the DFO makes that argument to me, I confer with the Office of General Counsel (OGC), and then we reflect that in the Federal Register. Some of the reasons why you may want to do that is if you were touring a facility. We don't want to drag the public along with that because you'll be exposed to sensitive information, personal stories, HIPAA; we can legally keep the public out of that. If someone were presenting you with their personal story, providing data and information behind that story, then that's something that the public doesn't have a right to hear. If you were hearing proprietary information - an app, a service, a program, a capability that someone's sweat equity has been put into it, but you know it will benefit Veterans, we would close the meeting to hear that proprietary information. The big

footnote is it's a very deliberative process. You cannot make an audible during a meeting and say, "We're going to close the meeting." Unless the building is on fire or someone is being disruptive, then that agenda is going to continue as an open meeting.

Can you meet privately? Yes, you can meet privately for two general broad categories. You can meet privately as a parent committee or subcommittee because you're doing preparatory work. If you're dividing up research, if you're looking at different areas to perhaps explore, a field visit, that kind of stuff, you can meet privately and chat about that. If you are doing administrative work - filling out travel voucher, talking about travel to a field visit, and so forth, FACA allows you to do that. You can do that either physically or virtually or you can do an administrative call. The big, red line in the sand is, if you meet privately, do not discuss past, present or future recommendations. To do so would invalidate any future recommendations. You would literally have to start from the beginning in an open forum and reform that recommendation. So don't talk about recommendations if you're meeting privately. Your DFO and the committee management support staff will help guide you when you meet privately so that you don't cross that red line.

Based off the character of people and your backgrounds and your experience and your skillsets, that from time to time you'll be invited to provide testimony to a united legislative body: state, federal, local. You can do that, but you do that as a private citizen. “I believe this,” “I believe that” “I think this”; not “the SMAG thinks this,” “the SMAG thinks that.” If you were to say those things, you're representing yourself as the SMAG, and you cannot do that. If offered an opportunity to talk to staffers or congressional bodies or things like that, please give us a call. Five minutes, we'll get you straight. We'll at least inform you of what I just said, put it into context into the forum that you're going into. We want you to be in the green [permissible], as we would say, not in the red [misconduct]. If you're ever in the red, I'm just going to say thank you, very much, for your service, and that will be that.

Seeing that you are already at 90% and you desire to go higher, I'm sure that you're going to embrace many of these best practices. Master your calendar today. Please take the opportunity to talk about the next meeting and the next meeting after that. Get a year's worth of meetings, in general, penciled on the calendar, again, to deconflict your personal and private commitments. That is the biggest return on investment as committee members, is to master that calendar so that we have that quorum, and we can press forward. The next biggest return on investment is you need to, annually, read the Charter and our revised VA Committee Members Handbook, September 2021. Please read the Charter and please read the VA Committee Members Handbook because it really sets those ethical boundaries, tells you about all the other committees in our portfolio that you want to reach out to. It sets the stage for what those boundaries are, crystallizes the mission and scope.

Subcommittees: You're already organizing subcommittees, so continue to do that. Subcommittees draft recommendations, do the heavy lifting. Subcommittees can meet privately. They don't have to have a DFO at all, they don't have to do a Federal Register. Subcommittees have flexibility.

Meeting mechanics: Design a meeting so that you have time to think and deliberate about what you just heard, not just presentation after presentation after presentation because the

introvert and extrovert will come out of us, and you really won't get that rich deliberation and recommendation if you don't design those gaps in meetings. You all do that very well.

Cross-committee collaboration: We have a new Committee in our portfolio. I strongly recommend that, as a subcommittee or a work group, you reach out to the Advisory Committee on Tribal and Indian Affairs. They had their first meeting in January. They have 15 members. I know there is something in what you have done, as a Committee, over the last 8-10 years, that they can benefit from. They are just now organizing in subcommittee, they're embracing these best practices, but an outreach from the Chair to their Chair, saying, “Hey, look, this is what we do, we would love to come and chat with you either privately, administratively, or publicly during one of your meetings because we think we have something we could offer you as you look at your constituency group, which is Native American Veterans.” Please consider that.

SMART template: I'm not going to tell a bunch of doctors how to write. I am going to tell you don't write like Ernest Hemingway, because if you do, it won't make it through the institution to the Secretary. Your goal, in writing, is to write SMART: Specific, Measurable, Action, Realistic, Time-based, because you have an action officer who is going to triage that and figure out where the equities are, what's already started, in terms of missions and program, what can be started. The DFO and the Committee management staff are going to pull that back together and then they're going to send the response up to the Secretary to be considered. Concur, not concur, concur in principle for every one of your recommendations. If you write like Ernest Hemingway, who wrote one recommendation that went on for four-and-a-half pages, that's not going to fly, and changes were made. They now write SMART recommendations.

We do have a library service. They will do research for you. All you must do is pose the question to the DFO and she will reach out to them, and they will compile it for you. You all have a rolodex of subject-matter experts (SMEs). I encourage you to have them either pose questions or come testify in front of the Committee because that, again, enriches the deliberations and recommendations that you have. But that won't happen unless you reach out to your fellow subject-matter experts.

I've already seeded the ground for annual field visits, so I'll reiterate what I've said to many folks: please go out to the field. Our stakeholders desire the opportunity to see you at a field location and engage with you, whether they're Veterans, family members, caregivers, Veteran Service Organizations. They can't do that unless you go to where they are. Virtual environment is kind of morphing into a hybrid where we have some folks in a room, some folks virtually, but that doesn't preclude you, the next visit, or a future visit, going to some VA function. There's a lot to learn, there's a lot that can be learned and incorporated in the deliberations and recommendations.

Finally, I don't expect you to be a FACA or an ethics expert, especially when you file Form 450, Financial Disclosures. When you have those questions, reach out to the DFO, they'll reach to me, I'll reach to OGC. We’ll get you an answer quicker, faster, better. FACA questions go to your DFO. Subject to your questions, that's all I have.

USH Opening Remarks:

Dr. Lieberman: Thanks everybody, for coming here today, both in person and virtually, those of you on the line. I want to thank Dr. Perlin for his chairmanship. Your guidance has been invaluable to us. Also, Dr. Gregg Meyer will be starting as our new Chair. I would welcome our five new members: Dr. Mary Wakefield, Dr. Robert Winn, Dr. Trent Haywood, Dr. Robyn Begley, and Dr. Kameron Matthews, so welcome.

It's been a busy six months for us in VA, as it is everywhere in healthcare. Most recently, I'm sure you all heard about the nomination of Dr. Shereef Elnahal for the Under Secretary for Health in the Veterans Health Administration, and certainly all of us here have offered our congratulations to him. If you don't know of him, he certainly has extensive experience in healthcare administration in the public and private sector. As many of you are aware, we all know him from working as the Assistant Deputy Under Secretary for Health Quality, Safety, and Value from 2016-2018. Also, he came back as a volunteer working as a senior advisor for COVID to the Secretary during the first year of the current administration. If he is confirmed, we will work with him to ensure a smooth transition.

The Electronic Health Record Modernization: We launched a second site on March 26, in Walla Walla. We worked hard to prepare. A lot of lessons were learned from our first go-live in Spokane. A lot of improvements were made to the system by Cerner. We really appreciate the challenges that they faced and, overall, it really went well at Walla Walla. We are currently looking at our rollout schedule and determining whether, in the long run, maybe, there can be ways to smooth out the rollout. In the meantime, we're very happy with how things are going. The next go-live is April 30 at Columbus. And they were already supposed to have gone live, but their training was delayed because of the most recent surge in COVID, but they are anxious to get started.

COVID-19: Just like everyone, we are in a much better place than we were just a few months ago.

Vaccinations: We have vaccinated over 4.7 million individuals, of which about 4.1 million are Veterans. The rest are staff and other individuals that we have been able to help. We're working to develop what is the new norm. Hopefully, we are in or entering the endemic phase. Time shall tell, but we have a group of our leaders who are planning how do we respond if the numbers go up again, when do we have testing of employees, when do we increase our precautions, how do we handle a large surge again, how do we assess for and then offer options and therapies to our patients with long COVID symptoms. VA is one of the leaders in research in this area and we already have clinics set up at almost 20 VAs across the country. We're looking at how do we broaden this to offer this to all Veterans across the country. We have a team working on that and Dr. Clancy is one of our leaders helping with that. We really appreciate Dr. Anah Ali, at the VA in St. Louis, who's done a lot of great research, as have others, in this area. We finally received our first shipment of single-dose testing materials this week. As the numbers continue to increase, we'll be providing single-testing materials to Veterans. They can still get it the same way that the nation gets it, but we'll also be providing it at the VA facilities. We're also focusing on vulnerable populations, such as homeless, those that are homebound, and bringing the testing materials to them.

We continued to deliver care despite the pandemic. Last fiscal year, we broke our record for the most appointments ever at 78.8 million total outpatient health care visits; that was

both in person and virtual. We also, by far, broke our record for virtual care in FY21 and did 10 million visits. To show you our growth in Telehealth - and I know we're not alone, but the VA always was one of the leaders, before the pandemic - we used to do about 2,500 video visits to Veterans at home or at the place of their choosing. Back then, we thought 2,500 was a relatively good number but we knew we wanted to grow. Now we deliver over 40,000 such visits a day in VA. That has continued, despite the ebb and flow that we're seeing because of the pandemic. We continue to look at how we're going to grow that. We still would like to grow more in specialty care.

We also have implemented what are called digital divide consults, so we are looking at those Veterans who, either because of where they live or because of financial reasons, are unable to receive virtual care. We now have at VAs across the country, a consult that can be requested. The Veteran will meet with a social worker who will look at where they live, what options are available, and how, at a reduced cost or through other means, whether we can offer them Wi-Fi or offer them a tablet or other options to try to help them to get wired so that, if they want to have virtual care, they can have that available to them. That will continue to grow in the coming months.

I'm sure you heard about the AIR Commission (Asset and Infrastructure Review Commission), and we've discussed that before at the Senior Medical Advisory Group meetings. The Secretary released his recommendations for the AIR Commission. We had delayed that because we wanted to make sure that we had time to inform our staff and others of what the recommendations would be before we went live. We didn't think it made sense to do it during the peak of the surge in January, so we delayed for six weeks, but then released our recommendations for 96 individual markets around the country. Clearly, an important part of that was clinical care and how we were going to grow and improve clinical care across the country. While we did propose some closures at VA inpatient facilities across the country, it really was more about what we were going to grow and new opportunities for care around the country. It also had a heavy focus on education and research. As you know, VA is a leader in both of those areas and part of our strategic plan for the AIR Commission was, at a minimum, we would not see a decrement in education or research but, ideally, we would see increases. So, working with Dr. Clancy and her team, we came up with plans of how to envision the future and then, as these changes occur, how we could modernize training, even in the setting of a VA facility closing and the same thing - how could we enhance our research as that moved forward.

We are very active participants in the Moonshot (improving survival from cancer care in the coming years) with the White House and all the federal agencies. The VA already has 13 projects on the books and, likely, that number will increase. I'm a representative for VA on that Committee, it’s exciting work. Also, there is a White House task force dealing with mental health issues of active military Veterans with a heavy focus on reducing suicide, which remains our top clinical priority in the VA and something that we had presented here intermittently before. I am also the Co-Chair for that, along with DoD (Department of Defense) and a representative from Health and Human Services. I'm looking forward to seeing the progress that we'll be making there, which will benefit not just active military and Veterans, but, certainly, also the American public.

New Member Welcome/Photos

New Chair Welcome/Photos

Departing Chair Recognition/Photos

Dr. Lieberman: I just want to say a few words, and I'm fine if we keep saying words all day about Dr. Perlin. It's just been such an honor and a privilege to have you serve as a member of SMAG since 2013. You've been Chair since 2015. And, of course, you were the Under Secretary before that. You were away for a while, but we were so glad to get you back to continue to benefit from your knowledge, your advice, your advocacy, your innovative approach to things that really have led to so many indelible improvements in VA for patient care, quality, and Veteran trust. We are forever indebted to you for that. So, thank you, so much.

I also just want to share a story which I shared at SMAG a few years ago, but I just want to share it again, just from a personal experience. There was this up-and-coming physician leader almost 20 years ago who was in the National Veterans Health Administration leadership training program, who was graduating the next day and the keynote speaker was Dr. Perlin, and that individual was lucky to spend about 20 minutes with Dr. Perlin the night before an event. Dr. Perlin offered a lot of wisdom, experience, and was very encouraging about that individual's career. That individual was me. He told me to shoot for the stars. I did. Thank you, Dr. Perlin, for that, too.

Dr. Meyer: Before John steals the floor, I just wanted to reflect on three things that I've really appreciated from Dr. Perlin over the years. John and I started out in government at the same time. I was at Arkin and John was here in the VA. One of the things I think that I would characterize his career as demonstrating, as you heard earlier, is just one of service in everything that he does. The second, which may not be as visible to all of you, is courage. I had the opportunity of seeing John lead what a very controversial decision at the time was, believe it or not, that was mandated flu vaccines. When there was extraordinary opposition and he went forward leading one of the largest health systems in the country and said, "we are going to do this because it is the right thing, and it is the right thing for patients." I think one of the things that's going to characterize John is he's always, always focusing in on patients. And the third one, I would say, is the one that probably made me the most intimidated. It is that John has this amazing ability to take what are very complex and somewhat convoluted conversations around this table and the one preceding it and summarizing it in just a few salient points. I have to say I've benefited from two other people who I've been close to and have served as mentors to me who shared that with him. One was Dr. John Eisenberg, who was just incredible at doing that, and the second one was Dr. David Blumenthal. Both have been lifelong mentors and friends. We lost John. David is still going strong. I would say that, you know, Jonathan Perlin's ability is right up there with theirs. It is really masterful. So, thank you, John.

Dr. Perlin: Those were such kind words and generous words, Gregg, that I'm intimidated following that. I'm sure the Committee will quickly realize that you have traded up. Gregg Meyer is just an extraordinary individual and leader. Any of the things that you recounted, just none of them were done alone. They were done with great colleagues like Gregg, great colleagues like Carolyn Clancy, Steve Lieberman, and, over the years, all of you.

This is a very special Committee to me. It may not be obvious to those who are new members, but when you think about VA, who is the Board, who's the Board you turn to for

the strategic advice, for the constructive conversation in a manner that is both open, but is what you would want from any extraordinary Board, the ability to discuss complex topics, gain insights, constructively dissent, and move forward? And that's this organization.

When I had the privilege of serving as Under Secretary, even though this committee has been in existence for 45 years, it hadn't reached its potential and many individuals, Gregg and Carolyn, came over from Arkin, you know Bob Burke at the height of OIF and OEF, and Dwayne Lerner from RAC. And it really is an extraordinary group - the Surgeon General colleagues from Kaiser and elsewhere, it took to really run ideas by.

My greatest hope is that this group will continue, because I know it will with Gregg operating even more effectively in helping to serve the mission of the VA, caring for those who've borne the battle. For me, that simple motto is so focusing. And, you know, while we work hard as Members of the Committee, I know that, obviously, Veterans have served with willingness to pay the ultimate price in support of our country, and I think that makes it easier. I also know that there are colleagues at VA that work harder than anyone knows to meet that specific mission.

So, my thanks to all the Membership, Dr. Lieberman, and senior leadership. Please know how much those kind words and recognitions mean more than you'll ever know. To Gregg, Selina, Dennis, and all the staff who make this happen, my thanks. Members of the Committee, Commission, I know that you'll do great things going forward. I will miss you, but you never really leave, as you've heard, so I'm in the community. Thank you, very much, for this recognition.

Center for Care and Payment Innovation (CCPI):

Dr. Clancy: I just wanted to note that, for people who have been on the SMAG for a couple of years and have heard about the Center for Care and Payment Innovation, or the Veteran Innovation Center, as we were calling it before, this comes out of the MISSION Act (Maintaining Internal Systems and Strengthening Outside Networks Act), which was passed in 2018; it started being implemented in 2019. There's a very specific section authorizing, based on the many Centers for Medicare & Medicaid Innovation. Not with the same budget. It might also be a micro or nano version of that. That was originally in the Secretary's office. I know that some of you have heard about that Center when it was first launched. Over the past year and a half or so, that was moved from the Secretary's office where it benefited from internal visibility, which was great, but also made it one step removed from the operation folks in the context in which innovations would be deployed. It is now in the Veterans Health Administration as part of my group with the academic missions and so forth.

We're very lucky to have recruited Dr. Ghosh to lead this, and she had been working as sort of a contractor in the original Center. I think it's much better positioned right now.

Dr. Ghosh: As Dr. Clancy mentioned, that we were set up through the MISSION Act in Section 152, our mission really has been to drive the VA towards high-value care. We're looking at ways to obviously improve outcome, maintain costs, but it's a collaboration with program offices, other federal partners, and private sectors. We're trying to figure out what the promising practices are that we can customize and then test in the VA and then, hopefully, scale. We have a unique authority that is important towards payment

innovations. We have a waiver authority, which allows us to change law, with congressional and Secretary approval, aligned to a pilot that runs for five years to justify the need for that change in law. That will be important down the road as we look at how payment models are being rolled out and how things are paid for. Right now, we are focused on multiple pilots, which I'll go through. Our ask from Congress is to run about five to ten pilots per year.

We have looked at a couple principles to drive our work. First is value, that would include outcomes and reducing costs. Equity: enhancing access and reducing disparities. Innovative: to take innovation piece in a way where a lot of things that are happening on the private sector is innovative but then applying that to the VA. It's also innovative, but we must be kind of mindful about how far we want to take the innovation. We want to test things, make sure it works. Then scalable, that's why it's very important for us to engage with program offices and other partners so that, once we have tested the pilot, we can either hand it off or get it built out with the program office. And measurable, that's the underlying tenant to everything that we do. It needs to be evidence-based, measurable so we can show the impact, we can help the other groups if we're going to scale and how to measure, and so we have a separate kind of effort in this group to look at the data side and build the infrastructure so we can bring in all types of data, not just VA data, to really be able to measure the equity, see how we're having an impact.

One of the main things is we're integrating with Governance. We have an Innovation Steering Subcommittee, which is chartered under the Subcommittee of the Strategic Directions Committee under the Healthcare Operations Council. It's really a diverse group of leaders that are helping guide our pilots, helping provide input. We have a lot of discussion around what it is that we're trying to accomplish, what the impact is going to be. It also helps us learn about all the different initiatives that are happening at the VA so we're not repeating anything. We are very set on not creating new processes. If processes exist, we want to build on that. We're not trying to be in a silo. We really want to work with everyone, understand what's already happened and if it potentially provides more structure or data or find a gap that we can build a pilot around.

Some of the priorities that we've had is looking to go to value-based models, focusing on complex care conditions. There's a lot of space there for different approaches to care management as well as payment innovation. Then how do we put social determinants or measurements of equity through our pilot. Maybe not focus on it but how do we integrate it, how do we measure it? Then just to focus on women Veterans and preventing Veteran suicide, which is a big issue for the VA, we're looking to see what we can do around that. There's a lot of great work that's happening, but that is still one of our strategic priorities.

When we look at pilots, we have a very standardized process because we want to be able to really look at everything, holistically, from all angles. We look at attractiveness; is it aligning to our principles? Is there a strategic fit? There are some pilots that come to us that may work a year from now or two years from now or there's some dependency with that that we don't have any control over, so we look at strategic fit. Feasibility: something that might work in private sector may not work that well in the VA. How do we either customize it, is it a principle or an idea that we want to work on? We'll look through that before we figure out if it's feasible for the VA. Then risk: there's always risk putting in new pilots. There's a lot of relationships, there's a lot of different ways the care is delivered.

Those are the four areas that we look at for every pilot, and that's what we present to the Governance Board and our leadership.

In our CCPI Pilot Lifecycle, we have a pre-explore phase where we have ideas that have been brought to us, we come up with ideas, we identify gaps and needs, look at data. We work with program offices, we talk to VISN (Veteran Integrated Service Network) Directors that may have been impacted, we're looking at specialty care groups. A lot of thinking goes into the pre-explore phase. Then we land on a concept, and with that concept, we say that's an explore. That's where we take it to the Governance Board and ask for funding or let them know this is something that we're looking to evaluate further and have either an approval or an informational session around it. Then it goes into design where the bulk of the work is, to figure out how we're going to measure the pilot, who's going to be impacted, where it's going to be rolled out, the size, the scale, scope, all of that. Then implementation, monitor, evaluate, learn, and diffuse are all kind of bundled together. When the pilot is being run, those are all the different pieces that are wrapping around the pilot. But the monitor and evaluate, all that work is done also phase to phase, so we try to figure out what data sets we need, what data is available, how are we going to measure it, talk to other leading experts who have worked on this. Then the decision to scale or close. We try to run all pilots as a short-term pilot to make sure that we're not wasting resources if it's not going to work. Then if it can scale, then we want to make sure that we set it up in a way that can be scalable. For the pilots that do have a waiver, though, those are five years, and we do report to Congress officially every six months, but currently we've also been reporting to them every three months all our activities.

We have a lot of pilots, and I will go through them, high level. The first pilot is VETSmile. This is a pilot that is aligned to a waiver, that allows the VA to connect Veterans to dental care partners in the community for pro bono or discounted care but to not be responsible for the services. It's a mouthful but all those words are important for this pilot. What we're basically creating is a network for Veterans to be able to get access to dental care. This is an incredibly important pilot for us because, as we try to drive towards value-based care, with 85% of Veterans who have health benefits, not having access to dental care in the VA, that's a key component of health care, in general, right? We're really using this pilot to connect oral care to health care, especially if we're looking at chronic conditions. Our focus has been on the 1.3 million Veterans that don't have an ability to pay, so our model has been to work with universities who serve kind of as a foundational element, and then federally qualified health centers. We started in New York and New Jersey, and we've seen about 1,200 unique Veterans, and have a plan to scale to nine more states this year and to be nationwide over five years. Alongside of that, we are also partnered with ADA (American Dental Association) and ADEA (American Dental Education Association) and the Office of VA Dentistry to figure out how we can start looking at the data, because one of the requirements of the waiver is for the encounter to come back to the VA and be put into the record in some form, but we can at least know that the Veteran has had dental care.

RECAP is a pilot that we're measuring and evaluating. It is really focused on helping the Veteran figure out where they want to get care, so if they want to remain in the home. On this pilot, we've been focused on helping the data around supporting the pilot effort.

Our new pilot that we're hoping to launch soon is a bundle payment around breast cancer. We are looking at the prevention, diagnosis, and treatment arm, but the treatment arm being more the surgical side. We picked one with the focus on women, but it's also very well-defined and there's a lot of evidence in support of the different steps. And it allows us to see kind of where are the pipes that we need to be figuring out, like what the data is and how it's going to work. So that's our first work towards a payment innovation.

The second one we're looking at is innovating PT (physical therapy) care pathways. Physical therapy is a high-cost area for the VA. We've been working with the physical therapy group and other offices. What we're looking to do is provide greater access to the Veteran population by co-leasing space and putting in physical therapy options closer to primary care, closer to emergency rooms, primarily targeted towards the rural areas where access is an issue. Then the way to align that is with virtual reality; there's lot of evidence around how virtual reality can help with PT.

Diabetes and end-stage renal failure. Diabetes is a problem everywhere. We've spent a lot of time looking at the care pathway for diabetes. Where we've kind of landed for this pilot is looking at different interventions, at how the care pathway is, at how to re-stratify the patients to really take the models that already exist in the VA and potentially direct them in a more, I won't say efficient manner, but if there's some way we could stratify the patients where someone has only one chronic condition, maybe they don't need six follow-up visits, but then someone who has multiple chronic conditions would probably need six to eight follow-up visits. How do we take the care pathway that's already there and align it a little better based on the patient? Then we're also looking at different kind of cognitive behavioral modalities that we can incorporate through that pathway. There's a lot of technology out there that we can leverage, but we want to make sure that it's been tried and tested before and that we have the option to try different things, based on that patient population.

Joint replacement is one that we're exploring. There's been a lot of bundles and a lot of work done, so we will just see what would work best. That's a very large effort so we're taking some time to figure out how to design it. We have a separate effort going to looking at payment model innovation that's really focused on dual eligibles, so either with TRICARE or with Medicare. We want to make sure that we can understand how dual eligibles are getting care if there is a potential to figure out a payment model there. There's a lot of research that's already been done so we look forward to trying to bring in some experts to help us dig through what are some of the options, especially with the TRICARE connection, given that there's a direct linkage there.

In terms of community care, we are leveraging some of the technologies that are out there to really understand how community care is being delivered, some of the costs around it, things like that. So that's the effort there. We're going to focus the first effort around Telehealth and how Telehealth is being delivered.

Aligned to having all these pilots is portfolio strategy. Then you have your program management effort for the group, but then with all the pilots, we spend a lot of time talking to CMS (Centers for Medicare & Medicaid Services) and trying to understand lessons learned and I think that portfolio management is important so it's all consolidated and coordinated and we're leveraging all the kind of same tools. We're measuring the pilot,

itself. The pilot will have its own outcomes, but then also just how the pilot is being run, what are some of the things that we need to be considering, how do we kind of look at the full portfolio, where the gaps are. Alongside of that, how do you prepare the sites for a pilot to be deployed? There's a lot of change management training readiness that we need to look at, having kind of a repeatable, standardized model that we can use for all pilots is that portfolio strategy piece.

And then street medicine. We're moving to call it Mobile Pathways for Homeless Veterans. This is a focus in LA County, and we are working with a nonprofit who has developed a model to provide street medicine, care where the homeless individual is; they've developed a network. It's a care coordination team to really bring them off the streets and connect them with California services, but what we're doing is aligning it to the Veteran services. There are homeless Veteran services, but it's hard to identify the Veteran, it's hard to bring them in, those resources are kind of tied up. There's a need for more resources. This is a model that we are going to test with 25 Veterans. Those that are eligible for health benefits are in the system. Hopefully, we can link them back in and bring them back into the fold, so they get into a primary care model and then if they need mental health services, if they need to find shelter. There's a lot of lanes that they can be directed to. That's an effort to help, at least, tap into a solution to address the problem in LA County, and then we'll look to see if we can scale it. There's a lot of other areas that have need too, so once we figure out the model, we'll see if we can scale it to other areas. This is very much aligned to connecting the Veteran with existing services, but also making sure that they receive the health care that they need at the VA.

Then there's Hospital at Home. It's been tested for a couple of years and there's a lot of initiatives happening around it, so we're doing a market scan of what's happening in the VA around Hospital at Home. We want to learn and see if there's a standardized model that we should be trying to drive towards, learning from what has been happening, how does the technology fit in. There's a lot of work to be done here but we are looking to see how this can be incorporated. Given the population, I think it's helpful to have this option that Veterans can receive care in their home.

Alternatives to institutional long-term care. How do we ensure that the Veteran is receiving other ways of getting care and not just being put into an institution? We're still kind of in the pre-explore phase on that because I think that's a large topic. We are starting to work with some experts around how to think through that.

Telehealth. Due to COVID, obviously, there's been a massive uptick in Telehealth, and I think there's an opportunity to really leverage that, that's incorporated in the care pathways. We are first looking at how it's being used, how it's being paid for, how it's being used in the community, and then we will start thinking through what the pilot should be. It might be an add-on to pilots that we're doing because it's a capability that could augment some of the work that we're doing, or we might look at it from payment innovation within VA.

And then there's the Suicide Prevention Grand Challenge that is being run out of the Office of Mental Health, but we will hope to run a challenge under it once the challenge has launched around suicide prevention.

Just a little bit more detail around VETSmile. This launched in July of last year. It's really been a great effort with a lot of partnerships. We're really kind of diving into how we provide training to the dentists around how to treat Veterans and what are some of the things to consider. Then down the road, my hope is that there's a way to probably integrate something like public relations, where PTSD and things like that, prevent Veterans from wanting to go see a dentist because the environment is not pleasant; there are a lot of triggers there. We're looking at other types of innovation that we could potentially try to inject into this pilot. There are some great academic universities that want to do research with us. Our focus right now is to get it rolled out to as many states as possible, but then we also have an effort to look at how do we build the core of a strategy around the data that we're identifying and the partnerships and the work that's already being done. We have Florida, Texas, and California on our list for growth in the next year and then we'll continue to expand. One of the things that VETSmile, is helping us learn about is the rural areas, how do we provide care, and what are the challenges there, and how do we align to that for other pilots? It's giving us an opportunity to connect with VA Medical Center (VAMC), as the model is either to get a referral from a VA Medical Center from the medical side or to do a cohort model. We are starting to engage with the VA Medical Centers, and then in the rural areas, there's a lot of Veteran service organizations and nonprofits that are providing services, so you almost serve as a point of coordination for some of those areas, too.

We have a slide which gives you an overview of what we're really trying to accomplish within breast cancer; what our goals are, how we're going to approach it, what the initiatives are, and then how we're going to measure it. This snapshot is something that, is our guiding kind of framework and then we'll obviously update it every six months to a year as needed.

[Questions for Discussion from slide:
When designing innovative payment models, what have you seen as critical success factors?
What have you seen as key failure points?
What contractual considerations should be included as we design innovative models?]

Dr. Sandefur: I'd like to take this opportunity, as a dentist, to spotlight the VETSmile pilot for a moment and give some context as to why this excellent Veteran-focused project is so important and how the CCPI guiding principles are so valuable in its success. I think medical and dental providers can agree that Veterans cannot be healthy without good oral health. From a context point of view, let me just give you a little bit of information here.

Veteran dental eligibility for VA dental services and the scope of the care is defined by concurrent Congressional statutes under Title 38. There are nine different categories of dental eligibility to provide the Veteran with comprehensive dental care, and the other five categories have time and/or service limitations, in terms of their eligibility. Unfortunately, the criteria can be very complicated and is frequently misunderstood by providers and Veterans alike. There are 9.1 million Veterans enrolled in VHA (Veterans Health Administration) healthcare in general, and so only 1.4 million meet the eligibility criteria contained in these Title 38 statutes. That is 15% of the total VHA Veteran population and, of that only 35% of these Veterans take advantage of their eligibility.

The VA has 236 dental clinics and approximately 1,000 dentists. Veterans and medical providers often perceive these eligibility limitations as barriers to holistic models to improve total health. While this may be true, these laws very much predate whole-health concept implementation. It is also worth noting that in 2016, the VA Dental Insurance Act was signed into law and the VA selected Delta Dental of California and MetLife to offer private insurance to all Veterans. Monthly premiums for MetLife in the state of Texas are $28 for the standard plan and the high-plan premium is $59 a month. As of September 2021, there are only 133,000 enrolled Veterans in this dental insurance program. All this kind of creates a complex condition for case management, which is one of the guiding goals to tackle with the CCPI program.

I think, in this context, we can all agree that the VA Center for Care and Payment Innovations' VETSmile pilot project is an outstanding initiative and leverages the goodwill of multiple dental community assets to provide pro bono and discount dental care. This project also advocates the oral and systemic connection to chronic disease management and provides a much-needed health care and medical care delivery option to many Veterans who are otherwise ineligible for VHA dental service. I also think that the CPI guiding principles of value and equity innovation, scalability, and measurement are well represented in this VETSmile pilot project. It is truly an innovative payment model and benchmark, I think, for successful contractual considerations and it's a critical component to this program. Future success will, I think, be a VHA's health care provider and Veteran’s awareness of these resources as this moves on and goes to a national level. I think the good news out of all this is their plans would increase this initiative across the United States would certainly meet the dental needs of thousands and thousands of Veterans.

Dr. Crosson: Dr. Ghosh, let me just congratulate you on this work. I can think of very few things that are more important than dental. I've got a few comments, a few things to think about that I suspect you've already thought about. Some of it's derived from having watched CMMI (Capture Maturity Model Integration) over the years, particularly the issue of accountable care organizations, which derived from some work we did early on at MedPAC (Medicare Payment Advisory Commission) when I was a commissioner on the committee.

First, I think the issue of bundled payments is a tricky one, for several reasons. I think you've picked, with respect to breast cancer, one of the smartest things to pick. The reason is that one of the problems with bundled payments is that, while it can save money within the episode of care, sometimes, if it's particularly profitable, it can drive more episodes of care, certainly, schematically; joint procedures and the like, whereas in breast cancer, that opportunity, thankfully, is somewhat limited. One of the other problems, parenthetically, is, and this is derived from the observations in the CMMI strategic refresh, which I suspect you've also looked at, and I would recommend it because it's a good self-reflection on the part of Liz Fowler and the others at CMMI on what's worked and what's not worked over the last 10 years, that it can conflict with global payments, of course.

In terms of some things to think about in designing your models, and I'm a reductionist here, but I'm focusing a lot of the issue of value-based payments or value-based care as one of the drivers of this work. I've always believed in the development of higher-quality and less cost. There's the issue of risk and how are you going to determine the balance between upside risk and downside risk. With respect to the ACO (Accountable Care

Organizations) work and CMMI, this has been one of the stumbling blocks, too little risk and they run the risk of the process costing more; too much risk and organizations and physicians and others drop out.

Then there's the issue of consistency. I think one of the problems that the strategic refresh identified for CMMI was from the point of view of the recipients that there was a lack of consistency over time. The rules of the game, the projects, the name of them, how they were organized, how it was a bundled, changed a lot and it made it difficult for entities to understand what was going to happen next year at the organizational level to convince people. We're talking about voluntary engagements to continue that work.

The issue of benchmarks and how you develop those and where they are perceived as fair, both to the Federal Treasury, as well as to the entities they're engaged for, and particularly how they're updated. One of the complaints, I think, in the ACO environment over the last four or five years has been that organizations that achieve savings and improve quality then have the benchmark set higher or lower the next year and there is a point of diminishing returns in the delivery of healthcare services.

There's also the issue of the potential for adverse selection. Organizations, individual physicians, and I'll expand that beyond, sign up or don't sign up, depending upon whether they think they can be successful. The problem with that is, it complicates the examination success of the project and whether it's scalable, which then brings up the question of voluntary versus mandatory participation. Again, there's a balance to be struck there. Having watched this for the last 10 years or so, I'm starting to lean towards the notion of mandatory, at least in areas of the country that I think that solves at least some of the problems that are identified.

And the last point I'll make is how many things you can do well. I understood your mandate is five to ten a year. I think I would tend to think about that lower number, because I think, the reflection at CMMI was that it was simply too many projects to manage and focus and you can do that by starting things and then cutting them off if they're not working but ending up with a list that is both important, but also manageable. I think the issue you brought up about portfolio management is very important because it's very easy to assume that the entities that you're involving or giving a grant to or whatever know what they're doing. Many times, they will pretend that's the case, but I think to the extent that you try to analyze and support them, you're likely to get a better result.

My last question has to do with how physicians and other providers are paid. I don't know, but to what degree are physicians on salary? How many are on payment systems that have rewards based in? How many are purely fee for service? And how do you think about, particularly physician payment, in designing these models?

Dr. Ghosh: That's a very large question. My understanding, and I'm still learning, but on the VA side, it's primarily salary. I think the incentive side is a little bit, I think it varies by facility how it's done. Then on the Committee side, they're negotiated rates. As we're looking into this, in the past my work has primarily been really focused on how does the provider deal with technology and how do they leverage it and how is it impacting their workflow day-to-day? We have created a field advisory board, to make sure that we're

talking to the physicians, the providers, and the frontline staff for every pilot to get information like how the care is being delivered? Then how it's going to impact them.

I think that with any model that we bring in, there's going to have to be a lot of discussion around payment, paying physicians on both sides and how do we incentivize them? There's a lot to learn about how you incentivize them, because you have self-selection and other behavioral things to manage. In terms of numbers, I don't know, but I know that would be kind of how I would divide how the providers are paid for those who are delivering care to Veterans.

Dr. Haywood: By way of background, I worked at CMS when I oversaw the quality that ended up being linked to payments and had the honor of being able to work on the PCORI (Patient-Centered Outcomes Research Institute) Board. I will end my comments that's more related to the portfolio management component because I had been pushing for both to do that and I spend much of my time now working with venture capital (VC) firms and private equity companies; that's what they do is manage their portfolio companies.

On contractual considerations, I do think you're going to have to be able to do the legal components that allows for modifications as you're learning to be able to move forward. We can talk about that in some detail because I know a lot of issues come up with those contractual considerations, to be able to allow flexibility and more to your contracts. Same thing with intellectual property issues that arise. The unit of analysis is where a lot of them have run into issues about how you're being able to look at failure points. Obviously, the data exchange and the timing of the data exchange has continued be a problem, whether you're a commercial payer in a Medicare Advantage space and the like. We can follow up on some of that offline.

On the portfolio management, it depends on how you're planning on doing that, and I know Liz Fowler and Cheri Rice and others at CMS are looking at these issues, to be able to see if they can be able to show some return on the investment or the value of the supplemental medical benefits. In my day to day world, it varies according to whether those VCs are private equity companies, looking at their investment hypothesis and I think it's important to be able to be clear about that on the front end, about how you're thinking about the investment hypothesis because it impacts the way that you evaluate your portfolio, the timeframe by which you're evaluating your portfolio, whether or not you're looking for certain multiples for that investment that you're being able to see. I know we're not just talking about financial impact, but we're more importantly probably talking about health outcome benefits and being able to see the timing by which you're being able to look at that. What we specifically spend a lot of time on is understanding what's the risk mitigation strategies within your portfolio management model. A lot of that comes down to a technical risk or a market-based risk and you stage your investment according to milestones to be able to de-risk your investment. Venture capital firms do that well, which is why you have early C stage and then you have C, and then you have A and B and C routes because you're stripping away those risk components to be able to be more successful over the management of your portfolio.

If you really are going to do portfolio management and not just use kind of the term of art, I think it's important to take the time. I was pushing PCORI early on, saying, "You need to be able to do management of this portfolio short-term, midterm, and longer-term."

Depending upon how your evaluators are thinking about your success, you modify your portfolio to be able to make certain that you're being able to demonstrate some outcome short-term, midterm, and long-term. That's all consistent with your investment hypothesis.

Those are my comments and suggestions to you, Dr. Ghosh. I would love to spend more time to get into the details of each of the pilots that you're doing. I congratulate the Veterans Health Administration for taking this leadership role.

Dr. Winn: I did want to focus on what really got me excited with the street medicine; I had two quick questions around that. The first is about its connectedness with other programs. I remember there was a program about ending homelessness for Veterans, the Zero Homelessness Veterans Program, that I believe, under Michelle Obama, had a challenge or something like that. I remember there were places, like in Rockford, Illinois, where Mayor Lawrence Morrissey was successful at that. The question for me is, how are those programs still in existence and how are you going to partner up the street medicine, or is there any plans to partner up the activities of the street medicines with those prior activities around ending homelessness? That's question one.

Question two was as we're doing about street medicine, understanding that oral health is primary care, is there a bundle package? When we talk about street medicine, what's coming to our homeless Vets? So those are the two questions. I did want to really kind of hone in on the street medicine program because I am intrigued by that, but wanting to know how is that being aligned with prior programs to address homelessness and Vets?

Dr. Ghosh: We're working with a nonprofit that's aligned to a relatively large health plan. I think in terms of external programs that are focused on helping homeless individuals and then homeless Veterans will have a natural connection point; they're just testing the model.

We're also working very closely with the homeless program office within the VA to understand what some of the initiatives are because we don't want to repeat any kind of initiatives or anything in place. From our conversations, it's been either one or the other, maybe provide the health care or bring them in. What we're trying to do is combine both and then we'll leverage what has already been done, in terms of what we can learn. With this model, it's unique, the way they've set up the cost for it. They do provide the Veteran with a cell phone 24/7 so we don't lose touch with them. There's a care coordination team that's going on around them, and they're very involved within LA. We are very mindful of the fact; I think there's even a White House initiative around this. I really wanted to make sure that the model works and we're starting with 25 Veterans, let's see if this is something that can connect within the VA and make it something that's scalable.

I think the big difference is that they've been separate, in terms of the health care side, and then they try to move from shelter to shelter. On the dentistry side, that's how we came about this idea because, with the street medicine side, they're focused on medicine, not dental care. So VETSmile provides them with that avenue to get dental care. We will most probably be the dental arm for the street medicine program. We've made that a priority and have a partnership with two or three universities there.

Dr. Perlin: Is there ever a situation where you partner differently with CMMI and use VA as the exclusive platform for a CMMI initiative to really help to drive the coordination? The

third option is really an extension of coordination care. In the list of Telehealth initiatives, you mentioned something called the common operating platform. So much of the magic of VA care is just the coordination. Is that useful for other purposes as you partner in the community, in terms of brokering necessary clinical information, electronic health record information, to be able to really integrate care?

Dr. Ghosh: You're asking how would we find the right partner?

Dr. Perlin: Best providers, basically.

Dr. Ghosh: We are doing a lot of analysis around where the need is and then we will engage with the partners that are probably within the community already and partnered with the VA, and kind of present this model to them. Part of our effort for every pilot is we are bringing in groups that have already done this work and that have engaged at the state level and have developed these partnerships. For every pilot, we're very specific, in terms of who we want to align to, to be able to bring in that expertise. There is a change management buy-in piece to it, too, and some of that will help your work in Veteran service organizations, especially if there is a priority. For breast cancer, how do we nationally get individuals involved? I think that there is an opportunity to work with associations. ADA has been incredibly helpful with messaging and then being able to bring on providers. The ADA calls an association or Delta Dental says, "Hey, we're really supporting this program." It really makes it easier for them to sign up with us. That's why the partnerships, externally and internally, are important before we have selected a region, and that's part of our design process.

Partnership with CMI or the dual eligibles. We are starting to have conversations with DoD, and I had conversations with CMS with the prior Administration and there is a lot of interest in trying to do something together. The data is the challenge, and then the types of models, too. From the way that our care is delivered right now, there's not a model that we fit into, so we would have to devise something that is unique to the population, but I think there's a lot of value in doing that. I think that, as we start kind of getting some of these pilots out, getting some of the data that we need or identifying the data that we need and figuring out the linkages to that, we can go in that direction.

Then with the Telehealth side, the care coordination piece is very important. Telehealth is widely used in the VA, and they've done a really good job with it.

Dr. Perlin: Just the specific point on that was the common operating platform. Can you elaborate on what that allows, in terms of interchange? Because if that's a way to exchange information, that increases your degrees of freedom, in terms of community coordination.

Dr. Ghosh: That's what we're trying to drive towards, is a common operating platform. Like, with having a consistent EHR (electronic health record) and then having other tools that are not custom-made but they're all commercial products. I think that's what you're trying to drive towards. In Telehealth, I think there's multiple modalities out there but they all stem from a common operating model. They're all trying to ingest data; they're trying to use similar capabilities. We're trying to drive towards that more with the VA. I think, as the rollout happens, we can integrate with the medical record.

Dr. Wakefield: What an exciting area to be working in and to hear about. Is it possible to get an org chart (organizational chart) that would provide a little bit more of an understanding of where it fits? I heard the narrative about this being a subcommittee of the Healthcare Operations Committee, but I would just like to see where this sits to try to better understand visibility.

One question about your decision-making process. When I looked at the strategic priority and then I'm thinking about cross-walking those strategic priorities with the many pilots that you have underway, and I come back in behind Dr. Crosson's comment about sometimes less is better, and I'm thinking about the strategic priorities and how you're using that to cross-walk your initiatives because I can envision that there would be a fair amount of pressure on staff to really move in a lot of different directions. There's so much that can be done.

As I looked at your strategic priorities, I was thinking you could probably put just about anything in there, given the focus. You don't want it to be so constricting, but on the other hand, you want it to be meaningful. It's probably more of an observation than anything else, other than I was sort of wondering what that decision-making process really looks like. I was excited because I had it as a question on how you're engaging frontline input into that process, it sounded like prioritizing areas of focus, as well as the structure, because obviously, that would be important to have that kind of ongoing sustained input, because that's where you're going to be rolling these out. That is going to be very important if it's structured in a meaningful way, to obtain that input.

On the pilot lifecycle, it is mentioned with the pre-explore actions, you're connected with VHA specialty care groups. Does that include primary care? Do you think of primary care as a specialty area? *(Dr. Ghosh nods)* Then, regarding CMMI, obviously, they've got great history that you're learning from and they're obviously probably right now already starting to learn from you in your engagement, but they're also doing a major refresh, as you know, in their strategic directions.

I was wondering if you've got a sustained engagement with them or is it just sort of an ad hoc engagement, because it does seem they'll benefit a lot from you and your work. It doesn't matter that you're smaller as you're being strategic in your investments. They'll learn from you and then vice versa. I was thinking, wouldn't it be interesting to see, at some point, a co-developed manuscript, paper, commentary, something for the broader organizations that are stakeholders and are interested to see how you fit together, what is that alignment, what are those next directions. That would be bring visibility to your operation and VHA's interest in driving innovation for the population they serve, but then also partnering with CMMI.

It's more a question of, are you sustaining or can you work to make those relationships a little bit tighter, even if it's at the staff level, particularly because there are shared overarching priorities, like equity. How does one bake equity into every single one of these pilots? For example, not necessarily the priority, sort of the lead point, but are you widening the aperture on every one of those pilots to ensure that that's there, even as they are doing similar kinds of things. There's just a lot of ability, but it's also easy to sort of miss those opportunities because there isn't that set opportunity for engagement.

Dr. Ghosh: I agree that there's a lot that can come to us for prioritization. We spent a lot of time with all of this. We met with all the VISN leaders; we spoke to different groups to really figure out what the topic areas were of interest. We started with looking at these very broad areas, and then I think our focus is to narrow it down, based on those principles. For example, within breast cancer, what are we going to do, within diabetes management. I think that the way that we've been picking the work is to have strategic sessions with external priorities that have already developed work and we try to get the lessons learned, see what would fit, what can we kind of bite off, what is the data that's needed. If we don't have the data right now, we're not going to be able to really move forward on it. Is there a way to get the data externally that we can then eventually kind of bring into the VA? Connecting the record with the external information. Right now, it's still very difficult. What are some of the processes that we can use to be able to measure? Then there are certain priorities that the VA has, so we'll kind of drive an initiative based on those priorities.

I'm very much of the mindset that we are not going to take on more than we can handle. We have a lot of topic areas, but we will stop them in design if they don't make sense. And where that kind of real thinking is going to come in is in the design area. Then a lot of the asks that do come in are portions of pilots, honestly. Is there a technology that you want to test, is there a care pathway that you've created that would work? We are ingesting all of that. As we design, we can layer that into a pilot. I think that's the unique ability that we have because it's almost like an incubator in that sense. If we're going to do diabetes care management, can we go look at behavioral therapies that are potentially modifications that are working or is there remote modern technology that we can incorporate into it. It's not set up around the technology, but that technology could augment it. That's the thinking.

We have been doing this now for a year, so it's been kind of a year of thinking and presenting and there is a lot of back and forth. Even with the program offices, is this something that can be scaled, do you even have the resources and the ability to scale, or do we have to think about how that's going to happen? Then understanding kind of the payment model as it is now. Can this work or is this going to be a waiver? If this is a waiver, what are we driving towards and what do we have to show, in terms of data, to be able to drive that waiver? It's a lot of different components for each one.

In terms of the CMS, I'm absolutely with you, regarding engagement. We don't have any formal or continued engagement. We've been very lucky, given the work done in the past, to be able to learn kind of firsthand from lessons learned and best practices. I think we wanted to make sure that we were established before we continued some of those conversations. I would love to engage; I think that we have a lot to learn there, too.

Dr. Matthews: I love that I'm finally able to think about your space more from where I am now that I've separated. Being in this new value-based sort of model that I'm in, the one thing that jumps out to me that crosses all the pilots, and that I think VA could really think of differently, is really the streamlining and pulling together of all the necessary data sources that you have. Just thinking about VA, you have your own VA HIE (health information exchange). We're now got two different Cerner HIEs. You have VA actual data, we've got the agreement with CMS for, I think it was more population data, but I remember we were on the edge of looking at individualized Veteran-level data. You've got TPA (third party annotation) data, you've got claims data. and then you could think about, maybe we need to start going out to broader kind of commercial third-party payers for claims data.

But nowhere is any of that data being brought into a single place so that you can look at value across these pilots, you've got it very separated.

What I would probably argue, now that you have Francine Sandrow in a leadership role, as far as in VHA, you're really thinking about a data strategy. I would really look to think about how you're going to fill in the gaps from a data standpoint so you can make some impact on, or at least measure some of the impact of these pilots because, particularly when we're thinking about payment innovation, even on a bundle standpoint, you need to have the full picture. That's one of the issues, unfortunately, that VA hasn't been able to address, because of the plenty of third-party care that we know the Veterans are getting. So how are we going to fill in the gaps so that we have the information?

There are 30,000 health systems that you can access data, through those two Cerner HIEs, but we need to be using that more readily. And of course, the CMS relationship. The other thing that I wanted to point out from a care delivery standpoint. I'm so glad Hospital at Home is on here. I would make sure we're not restricting that to just looking at the Hospital at Home concept but that we're thinking of general urgent care. We're going to start doing MAT (medication assisted treatment), substance use disorder and long acting injectables in homes. We're going to start doing a lot of what is more ambulatory services in the home, and we're going to start doing a hybrid model where we're not sending the providers, we're sending EMTs (emergency medical technician) and MAs (medical assistants) and they're on an iPad with the provider back at home. So, you have a broader face that you can reach by the actual prescriber.

There are ways to be innovative, but at the same time, if I remember correctly, this waiver only allows you to waive VA authorities, it doesn't allow you to waive any other pieces. I remember when we talked about sending staff into homes, there were driving restrictions, which is more of an OPM (Office of Personnel Management) issue, as opposed to VA issue. The innovation that we can do, unfortunately, is restricted to VA authorities, but the more you explore different ways that we can still provide VA services in the home, I think it's critical.

Dr. Ghosh: The way that we're structured is we have a program management arm and a data elements arm. We check the data arm, and that group is focused on creating a cloud database, investment data, working with volunteers, working with all the different potential ways to get data. Then just given the pilot, we're also working with OIT (Office of Information Technology) to figure out, are there certain things that we could do within a pilot to test and collect data and not connect it to the record but bring in some of the equity data.

We've also engaged with some groups outside that have been collecting data for a long time, and we're building partnerships with them where we can at least look at the need. Social determinants is a great term but there's a lot in there, right? So, we're looking at, distance and groceries and all the pieces that would prevent a Veteran from getting care. Other people have already kind of developed those data sets and can help us, we don't have to reinvent the wheel.

The incubator model would really push for the data side where it's all protected, can we just test and see if this works and then we can go to the broader group and say, we need

to do this. I think that Peltier has an opportunity for us to test ingesting a lot of data. We're integrated into that and trying to figure out is there a centralized way to do this, and the external datasets are incredibly important, and I think state HIEs are important, depending on where they go, and how do we get permissions, for that. There's a whole effort from that side.

Dr. Scavella: I currently serve as the Assistant Under Secretary for Health and Clinical Services. Prior to that, I was the Associate Deputy Under Secretary for Health. Most of the offices that Dr. Ghosh is partnering with are aligned under the Chief Medical Officer for VA. I just wanted to thank you for your willingness to partner with us. There is a lot of work in this space, and it includes dental and homeless, as well as primary care and all the specialties.

I just wanted to address Dr. Wakefield's concern about where this all aligns. I think you all have positioned yourselves well to partner with clinical services to make sure that we have what we need and that you have what you need and then, hopefully, we'll have some of the data that can show how we can drive and scale.

Dr. Clancy: I think this discussion was wonderful. Dr. Wakefield, we will get you a diagram. I think our governance is a work in progress; it's so much better than a couple of years ago, but we're still working to perfect it. The contrast here for me is that, when this was in the Secretary's office, it was kind of a free-floating thing. There was some advisory group and people were never sure if they needed to go and what kind of stake they had in it.

Dr. Crosson, your comments about consistency were hugely helpful to me. If there's one thing I've learned, having the pleasure of co-chairing our internal steering committees, we have a vocabulary problem in a big way. We talk about Telehealth, virtual care, whatever, fill in the blank, and everyone's got a clear idea. And by the way, everyone in VHA is doing it in some fashion.

We had an extraordinarily lively conversation recently about Hospital at Home. This is exactly the kind of feedback you want from the Advisory Group. But I think it is a problem that extends well beyond the VA healthcare system. For example, even when we come up with a Hospital at Home pilot that would make people happy, it works very well in the design phase and then there we go. But people may say I'm going to drop out. I think it could be an evaluation nightmare. Dr. Lieberman will be coming to tell us, you know, what potential incentives do we need in legislation and that kind of thing. But it will be intensely interesting.

Dr. Meyer: When designing the payment models, I think my colleagues captured most of this incredibly well. Things that are just so important are data, alignment of incentives, really identifying that coalition of the willing. As failure points, I think you talked a little bit about changing goal posts, the consistency of the program and the challenges with overlapping populations. Then, finally, contractual considerations. Again, that alignment of incentives and thinking about how you measure to make sure that you're successful and build that into the contracts.

Reflecting just on the comments that were made, in general here, a few things I'd share. First, this is incredibly exciting. The notion that the VA is going to participate in the volume-to-value transition is incredibly helpful and that is a truly wonderful thing.

I think the second thing that we heard from folks is just the real opportunity to learn from and partner with your colleagues at CMMI and CMMS. I would say looking at the new strategic review, I think it's very helpful, and steal shamelessly and share graciously with them because I think that there's a great opportunity there.

One of the other things that I think were touched on with this whole notion of portfolio management, trying to really look and make sure that you have a balanced portfolio. As I think about this, really what that comes down to is just a series of conflicts and tensions that you must manage. One of them is that how much risk do you put versus not enough risk. Choosing a population to focus on. Using something like bundles versus having problems with overlap with global payment models is something that we've confronted numerous times. That notion of finding that coalition of the willing to do this versus your desire to scale this into the future is something to manage in a portfolio. Voluntary versus mandatory. In a target rich environment, there is so much to improve. Like Dr. Crosson, I looked at that list and said, “Wow, that's a lot to bite off.” Just focusing in on a few to manage that portfolio. Then reflecting on what Dr. Clancy said, that notion of really trying to attract new people to these models, but also respecting the fact that some people have been doing this for long period of time in their niche area, they figured it out and it's working well, and you want to tap into their expertise, too, and not alienate them in the process.

Finally, we heard about the importance of data sources, and can't agree more fully, and it's not just having data sources, but sharing them with those participating in any programs with you and doing it on a timely basis. That makes a huge difference. With that, I would say this is a terrific program, great portfolio, and hopefully the advice this morning is helpful.

Dr. Ghosh: I would love to connect with each one of you separately, but this is very helpful as we build this out. I hear everything that you're saying, and I think when we get into design, our portfolio will narrow because we'll see that some of these risks are not something that we want to take on right now, or there are just blockades that we can't fix with a waiver, or we can't get the data. I think what this gives us is almost like a five-year plan of where we want to focus and how we can start rolling things out. We can build on what we're learning, too. The breast cancer pilot will show us a lot about data and data sources and actuarial and measurement and partnerships and contracting at a smaller scale, and then hopefully we can learn from that and drive forward. This has all been incredibly helpful, so thank you.

Dr. Meyer: So, I'll take the risk and speak for all my colleagues around the table here. We would all be happy to have you reach out to us in any way. We're happy to help where we can.

Additional remarks from the chat window:
Dr. Prescott: *Regarding scalability and contractual considerations: Academic medical centers can be great partners. Key will be knowing who has the local authority*

(departmental) and who has hospital/system authority. Once proof of concept has been established for any of these programs, the VA may want to reach out to organizations such as the AAMC's (Association of American Medical Colleges) Group on Business Affairs (GBA) to allow the program to be highlighted and to ease adoption on a national level. GBA has most of the PBO's (projected benefit obligation) of AMCs involved.

Dr. Sandy: *On the breast cancer bundled payments pilot (and other bundled payment models) agree with Jay Crosson's thoughtful comments. There are many technical challenges in designing and implementing bundled payment models. There also is a commonly stepped over issue…what I call the "theory of the bundle." Which is: what do you think will get better if the payment for the condition is bundled? Why do you think so?*

Break for lunch 11:29-12:20

<u>Update on H.R. 2797 National Green Alert Act of 2021</u>:
Dr. Carroll: I'm very happy to talk with you about HR-2797, the Green Alert Act of 2021. This is proposed legislation and the item for discussion today is to review the proposed legislation with you and get your feedback for the Secretary, to help inform his recommendation and next steps. Hopefully you've had a chance to look at the materials ahead of time and I will just review them briefly with you here before we move into the discussion.

This bill would establish the Green Alert System Advisory and Support Committee. It is somewhat unlike other proposed legislation that may state you need to do a particular thing in the field within the VA system, within the healthcare system. The overarching goal of this proposed legislation is to establish this Advisory and Support Committee, which would then develop best practices to provide technical assistance for state governments for the implementation of a Green Alert system, which would be activated when a Veteran, with a history of mental health issues goes missing.

As you can see, just in that very first paragraph, there are a lot of conditions that need to be defined and clarified and that would be the work of the Committee, but they are important distinctions that need to be addressed and we'll talk about those in just a moment. The ask is to assess the current state or any existing local Green Alert systems and the practices, with an examination of the outcomes that includes both the benefits prior to development, as well as the risks, and to have a recommendation to the Secretary regarding the next steps for the Department on this proposed legislation.

The risks and consideration for Green Alert systems: Green Alert systems are like Silver Alert or Amber Alert systems. They are intended to be systems that would create a public notice when someone who is at risk's whereabouts are unknown and they feel they could be at risk. Certainly, I think everyone on the Medical Advisory Group understands how those function in our communities. The Silver Alerts, the Amber Alerts, when there is an older person or a child, who cannot care for themselves or may be medically compromised, and their whereabouts are unknown, there is an alert, perhaps on a smart phone or electric billboards along the roadways with any identifying information. This would be for Veterans who are considered at risk regarding their own safety, their status, looking at suicide risk, particularly for Veterans with known mental health issues. The challenges here are that, to date, there is minimal evidence to support the effectiveness of these

systems, partly because there aren't many. There was a description of one in the NPR article that was attached regarding some work that's being done in the state of Wisconsin.

The risks are definitional, in terms of who should be considered at risk for a mental health condition. Then the privacy concerns are quite significant as were well described, I thought, in the NPR article. The lingering concern is their risk of increasing the stigmatization of Veterans with mental health issues, in that someone would be publicly identified as having a mental health issue, and that is a concern regarding these systems.

Privacy concerns: The identification of someone with a mental health condition, under what circumstances. I would also add a temporal dimension - if someone had a mental health condition, sought treatment and treatment was effective and they had moved on with their life and it is now 5, 10, 15 years later. If someday something happened at home and they decided just to take off and clear their head for a while, is that someone who should be identified through a public Green Alert system as being missing and potentially at risk? I mean, the permutations, and I'm giving some very rough examples here, if you'll pardon me, are legion, but I think they're all things that would need to be thought through.

We can move into a discussion, here are questions for your consideration.

[Questions for Discussion from slide:
Should further investigation be conducted while thresholds for triggering Green Alert Systems while complying with Federal and State laws for protected health information?
Should the legislation define "missing" or under what circumstances and alert would be enacted?
Should the law consider existing federal and state policies that govern imminent risk and involuntary treatment?]

We would welcome your feedback. I know we have a discussant who is ready to share some views. We are certainly open to this moving in whatever direction. Leadership, the Secretary, this Group, certainly our congressional partners want to take on this, but I think we need to have clarity around some of those definitional issues.

The primary question is, should we further investigate thresholds for establishing Green Alert systems while also respecting patient privacy or protected health information? Would we want legislation?

Would we recommend to the Secretary that legislation define what is meant by "missing" or define the circumstances? Who would get to authorize that? Should it be a family member? Should it be a mental health provider?

Finally, what laws or policies should be in place to cover the risks and the concerns about privacy, about minimizing stigmatization of Veterans with mental health issues going forward?

Mr. Nuntavong: I guess I would start with what is the true number of Veterans that go missing? My concern is that this bill may demonstrate capability in the face of a need that may not need to be fulfilled. Veterans have issues with seeking mental health care to begin with. If one of the goals is to reduce Veteran suicide, I think we need to look at how those Veterans are seeking the care that they need.

Many Veterans are very private about their struggles with mental health, despite the years of work that we all put into getting the care that they need. There's still a stigma around those who seek mental healthcare services, and we need to make sure that our Veterans are safe but exposing a Veteran's medical background due to them being missing can have catastrophic events.

The statistic is already out there that 14 of the 20 [suicides] per day aren't seeking care at VA. We know that VA mental health care is valuable. We need to destigmatize that. This Green Alert system, I think, has a lot of holes, a lot more questions than answers.

Dr. Schonfeld: I'm the Executive Director of the National Center for Ethics and Healthcare at the VA and I appreciate the opportunity to offer some additional thoughts here. We would be happy to work with folks, either in enhancing the language of the bill and/or an implementation, should the Secretary decide to go in this direction. One of the ideas here that we have to keep in mind is that, even when there are laudable goals, as there are here, to try to do all that we can for our Veterans, especially our at-risk Veterans, those goals must still have a favorable risk-benefit calculus when we go to implement the activities, and it's unclear whether or not this proposal has a favorable risk-benefit calculus.

We share the temporal concerns that Dr. Carroll mentioned about, what if you had a suicidal crisis 20 years ago, does that pose you at risk here? There are problems with the way the bill is currently worded. We are equally concerned about unintended consequences of stigmatization. We also thought the NPR article did a nice job of giving a real-life picture of what that might look like, but one of the things that demonstrates is that simply following privacy laws is not enough, and that's what the bill currently says, that issues of privacy are much more complicated and robust than is described, or perhaps originally considered. One of the possible consequences is failure to seek care, whether that's at VA or elsewhere, and there is no question that that would not enhance the care that we provide to Veterans; that would not be in their best interest.

We are also worried about possible re-traumatization, depending on who responds to a potential Green Alert. I saw a comment in the chat on this issue. We know that it can be problematic when it is law enforcement who responds when individuals are having a mental health crisis, and so we worry about that, in particular, in relationship to equity concerns. I consider our Veterans who have histories of military sexual trauma or other vulnerabilities that might be further harmed by this practice.

We have a principle or a doctrine in ethics that refers to really looking at the least restrictive alternative. What we're doing there is trying to balance Veterans, all individuals' right to self-determination, with society's interest in protecting them. How do we do that? How do we use the least restrictive alternative? One thing we can do is essentially a step-by-step interventional ladder that we currently have. In Dr. Carroll's pre-reads, you saw the variety of activities that are already going on to try to address Veterans who are in crisis, who are approaching crisis. Release of private and protected health information must be restricted. We might say an at-risk Veteran is missing without saying anything about specific diagnostic information, although, again, the NPR story demonstrates the risk of even doing that. At the very least, what you would have to do is show a picture of that person because the idea is to have people looking for that person. That's enough when you're in a small town, and you're in a diner, for somebody to say, “Hey, you're that Green

guy, right," and all the sudden, that person's privacy can never be restored. We are also concerned about transparency. How will Veterans be informed that this is a potential consequence of seeking VA mental health and substance abuse treatment and what are the possible impacts of that notification?

Finally, we want to think about how we respect Veteran goals and preferences. One of the ironies of this, and I think Dr. Carroll referenced this and I wanted to emphasize it, is that, by instituting something like this, it might remove a common coping mechanism for those with mental health issues. Many of us during COVID just took off in campers or went out into nature to restore our balance. Sometimes we did that by not being connected and, in fact, that was a recommendation we gave as part of mental health care – disconnect; connect with nature, don't connect with the electronics, and that sort of thing. This would remove the ability to just be, to have that sort of positive preference.

These Veterans certainly may be vulnerable, but that vulnerability is qualitatively different than what we see in the elderly with dementia or in minors, so for the other examples of Silver Alerts and Amber Alerts. These are individuals, in many cases, who can make their own decisions. The key is how are we going to be able to distinguish this. Finally, and we could go on ad infinitum, which is why Dr. Carroll said some of the issues here are legion, is that what if this person took off because they're escaping an abuser? The way we have this set up is that that abuser, then, activates whatever the processes are for the Green Alert and then the person is found and brought back to the abuser.

There are numerous challenges with the bill as it currently is worded, and if we do move forward with it, there are lots of implementation specifics that we're going to need to think through very carefully if we want to achieve the goal, which is really assisting our Veterans in whatever way we can.

Dr. Akman: Thanks for these terrific presentations and bringing this to our attention. This is feel-good legislation that was not well thought out and as a psychiatrist, it's worrisome to me. I appreciate the previous comments about the false equivalency between the Amber Alerts, the Silver Alerts, and now this Green Alert, and the nature of the issues that these individuals are dealing with and the potential assessments that ultimately trigger these alerts. I don't have to go through all that was just gone through that I think were all valid comments, but I think, in terms of the Secretary, I'm really pleased that we started with Mr. Nuntavong because I think the voices of the Veterans and the nation advocacy groups are the most important voices, not the families, quite frankly. I think of the voices of the Vets who have the potential to really be harmed by this legislation.

Until there is data to back up legislation, I don't think that we should be posting individuals' faces and names on highways who have mental health or mental problems or mental illness. I think about, at the emergency room where you have a physician assessing imminence of harm to self or others. In Washington, if a psychiatrist makes that assessment, to hold a patient involuntarily, it requires a second physician to then make that assessment. Frequently, they're not consistent, they don't agree, so right off the bat, you've got two psychiatrists who don't agree on that assessment of imminence of risk or threat to self or others.

I could certainly understand a family member who is particularly worried about their loved one with either depression or some mental health problem, wanting to raise the alarm, and that seems extremely reasonable to me, but to post this publicly then could potentially be a very, very serious violation. I just think without any data, there are going to be more false positives than accurate, where a person is imminently suicidal and needs to be brought into treatment immediately. I think the risk for false positives is the real harm here, as well as the tremendous violation of privacy. So many of the mental health laws across the United States, at the core, are based on privacy rights and the ability of the individual to be able to communicate that information and I share almost all the same thoughts, and the notion of just broad-based mental health problems, that's a total nonstarter. That should be a total nonstarter.

So how you want to zero in on what could potentially trigger the alert, you're still going to get a lot of false positives ultimately. The idea of seeing this play out state by state becomes even a greater nightmare. How it's going to be implemented differently from state to state? I hope this doesn't see the light of day.

Dr. Fulmer: This is exactly the conversation we should be having. I agree with everything Dr. Akman said, and I would add the following, which I input in the chat. I'm a nurse. I've worked a lot in emergency rooms. I'm a geriatric expert. The difference between serious, persistent mental illness is worlds away from individuals who can function and have depression.

I live in New York City, I'm in the subways a lot, I can't identify a Veteran from a different person, but I've never seen anything quite like it, post COVID and watching the numbers of serious tragedies take place. For the VA to take this on, maybe without any alerts, but to take it on in some sort of consensus way so that we can have a path forward for program research would be a gift to the nation.

Dr. Crosson: I have grave reservations about this, but I don't have anything to add that has not already been said.

Dr. Kellermann: I think this is feel-good legislation, that doesn't feel good, and for all the reasons that were said. I was only going to suggest that, if there isn't a SMAG member who feels we should endorse this, this might be one of those case where you could say the Committee has grave reservations. That might give the Secretary significant cover if, in fact, the VA leadership chooses to -- no one wants one Veteran to commit suicide, but we also want to help encourage people to seek access in.

Dr. Meyer: I guess I would just put the question to the Committee: Is there anyone here who wants to speak in favor of moving forward or supporting the implementation of this legislation? *[No response.]* Hearing none. Do we have a motion?

Dr. Perlin: The Special Medical Advisory Group, composed of healthcare experts, policy experts, and many Veterans appreciates the intent of H.R. 2797 and those that put it forward, but has great reservations about this legislation.

We agree with the intent of preventing suicide, support access to mental health care for Veterans in all manners possible, but specifically identify privacy concerns that would lead to misidentification of Veterans not in distress, as well as identification of Veterans in ways

that may be harmful to them personally, their mental health, and their current and future employability.

Dr. Meyer: Second that? *[Multiple Seconds]* Dr. Carroll, any other comments before we move to a vote?

Dr. Carroll: I appreciate the discussion very much. I think we are all for doing all that is good for Veterans and getting them engaged in care and supporting them and making sure their committees recognize the strengths and skills that Veterans bring to the communities and enrich all our lives, in addition to their service, but there are multiple concerns, in my opinion, with this proposed legislation. I appreciate the discussion by the Committee and the comments from the other discussants, as well. Thank you.

Dr. Meyer: I think one of you has raised that notion of being data-driven and I do think that, over time, there will probably be some review of the experience in Wisconsin, in addition to that perhaps more fulsome review of the number of Veterans who do commit suicide, who go missing prior to that, to help understand whether this was ever a worthy target.

The second thing I would note is I think that this is emblematic of the need that we all must work on the stigma of mental and behavioral health. I just think it's another signal of how much further we must go.

With that, I'm going to ask just for a vote of acclamation here. For all those who agree with the motion that was seconded, respond by "I." *[Response in unison.]* Any nays? [*No response.]* Any dissensions? *[No response.]*

For the record: The Special Medical Advisory Group unanimously expresses great reservations about H.R. 2797. We appreciate the intent of the legislation and those that put it forward, with the intent of preventing suicide, support access to mental health care for Veterans in all manners possible, but specifically identify privacy concerns that would lead to misidentification of Veterans not in distress, as well as identification of Veterans in ways that may be harmful to them personally, their mental health, and their current and future employability.

Additional remarks from the chat window:
Dr. Fulmer: *Does mental health include persistent mental illness along with other less severe syndromes? Does it include those with substance issues? BIG category. My concern is that police get to these people first- not healthcare.*

Dr. Carroll: *"Mental health conditions" is a broad term that includes serious persistent mental illness, short term conditions which may or may not be episodic, and substance use conditions.*

Dr. Matthews: *Do we have a sense as to what the Bill Sponsors were trying to address?*

Dr. Prescott: *I agree with Mr. Nuntavong and Dr. Akman - they hit the nail on the head. "Feel good legislation" that will definitely have negative consequences.*

Dr. Mittelman: *As a Veteran and provider, I had a visceral reaction when I read about this last night. I echo all the comments that were made - respecting Veteran's privacy is an*

extreme step to take prior to understanding all the unintended consequences of such legislation. You mentioned training at military facilities, but the MHS (Military Health System) is also seriously considering downsizing which will necessitate military GME (Graduate Medical Education) looking to VA and other health care entities for GME opportunities.

Dr. Kellermann: *This is "feel good" legislation that doesn't feel good I suggest you ask the SMAG if anyone supports or endorses this bill. If not, that's a powerful statement to share with the VA Secretary and Legislative affairs.*

Dr. Sandefur: *This legislation will drive Veterans away from mental health services.*

Redevelopment of VA Facilities:
Dr. Clancy: You've heard of the AIR Commission, or the Asset and Infrastructure Review (AIR) Commission. This has been a huge amount of work, although I pointed out to several of my colleagues that large systems do this a lot. The only difference is they don't broadcast it to the world and then wait a couple of years to get moving on it. In fact, sometimes impacted communities find out a week or two ahead of time, or at least that's how the press makes it sound.

Timing-wise, could not have been worse, vis-a-vis, the pandemic. A lot of very, very hard work; looking at the markets in which our facilities are located, looking at general trends in health care delivery, which is a lot about moving care out of hospitals to ambulatory settings. Sometimes I look back at the kinds of problems in patients we admitted when I was training, and it is a total new day. That has been going on for decades. You can see every single year the number of hospitals discharges has dropped, 4%, 3%, 5%.

Then we get hit with this unprecedented pandemic, at least in the past hundred years which created all kinds of interesting dilemmas. Early on, there was a lot of focus on keeping these conversations within VA. Very worried and, by the way, with very good reason, that some members of Congress advocating for the Veterans in their district might do things like insert report language into appropriations bills and things like that. “Good luck with all that work on this Commission but, by the way, don't touch this multispecialty clinic over here.” Mostly, that did not happen, or people were persuaded to hold their fire, but we still had a very, very close hold. We weren't in a position for quite a while to consult with our partners, which might have been one way of doing business. Then the Administration changes and Secretary McDonough wants to make this as transparent as possible.

I'm going to tell you, if you've ever looked at microdata (if you like data, this a lot of fun; how many hospital beds are there, what's the occupancy rate), and we had a practice run at this in the state of New Hampshire when they were looking at what should the future of Veterans health care, look in New Hampshire, circa 2015-16. Even there our colleagues were nervous because this was clearly foreshadowing the work we were going to be doing. I finally said, “All this data is public, all we're doing is framing it for them so that they can see the data behind different options for moving forward or not.” Their move-forward motion was that we need something like a Mayo Clinic in the state of New Hampshire, which, given the population, probably wouldn't make a lot of sense. We were able to point out how many excess beds the state had and what were the other opportunities.

The Secretary comes in and he wants to make this all transparent. Of course, there's a couple of initial conversations that go something like this: No one says, “You just don't understand,” but that's what they're saying, right? And he says, “No, I get it, but just because someone is going to be upset doesn't mean we're not going to be transparent, we're going to be very, very transparent,” and he was very insistent that these recommendations, going forward, at a minimum, that they're academic missions and even better, training.

Now here, too, as in changes in care delivery, the academic enterprise in education and training terms has got to change. It has been in baby steps, right? I learned from Dr. Wakefield's husband that the students usually played the taped lectures at one-and-a-half speed, and I thought, “That's great, I wonder if you can do that with streaming WebEx,” but I haven't figured out how to do it yet. But that’s a bit reactive, right? The idea of moving a lot of the clinical training out of the mother house, from hospitals to outpatient settings and beginning to think about that as the center of the universe is a very, very different idea. As well as how can we be more focused, particularly emerging from the pandemic, whether that's endemic or heard immunity or whatever, what do we do about virtual care? It's hard to imagine we're walking all that back. Well, that's going to have to be part of training, as well.

I also think that we have not been terribly strategic about the use of simulation. Now I have learned recently that there's several Embraer jets that one can be licensed to fly without ever putting your foot in that jet. We do it all in the sim lab. I had stopped using that example quite as often because some people have said, I don't want to be in a jet, that they've never been in. But they're for a pilot, it was licensed that way. The point is I think that there is a very big opportunity for VA to help lead because we are not hemmed in by the same reimbursement structures in terms of outpatient education. “Great idea. Who's going to pay for that?” That's just not part of the equation for us. Some of the considerations for you are what changes should we be anticipating in academic medical centers in the near and longer terms and how can we, at VHA, most effectively assure the sustained success of our academic partnerships? Frankly, this is my aspiration, lead requisite changes in education and training. This also applies to research.

When he was here, Secretary McDonough asked me who our best affiliates were. I started rattling off a few that I knew very, very well and were strong in health services research because I know that field, right? So, Duke, Penn, Boston and so forth. I think we need to think about this because I don't think we have a definition of that, I'm not altogether sure what that means. Several of us had an e-mail conversation very late on a Friday night about things and just trying to kick around how we might begin to define that. I'm still not sure we have the right definition. We do know that geographic proximity feels like it matters. Duke and Durham are very closely co-located now, but Duke is also expanding. They're building new facilities as they, like many others, become the hubs of larger extended systems.

You're going to hear first from Dr. Marjorie Bowman, our Chief Academics Officer, who leads the Office of Academic Affiliations (OAA). It is far more than physicians: it's nurses, pharmacists, psychologists, occupational therapists, the list goes on and on. In fact, we've been conspiring, and I mean that in a very positive way, with Dr. Taylor about how we can

think about other opportunities, even the challenges everywhere, in terms of recruiting and building a pipeline for nurses.

Then, you'll hear from Dr. Ramoni, who approached this in the most joyous kind of fashion. She had a great challenge for these incredible opportunities. So, Dr. Bowman, you first and then hand it off to Rachel.

[Questions for Discussion from slide:
What changes are anticipated in academic medical centers in the near and longer terms?
How can VHA most effectively assure the sustained success of academic partnerships – and lead requisite changes in education and training?]

Dr. Bowman: I have been OAA since 2018, after having been at various universities, some of which you are associated with, and always, of course, been associated with the VA. That's the norm. That's what we expect. It's what we're used to, and it provides great value for education in the U.S. and for our healthcare workforce.

We have a lot of trainings. During the pandemic we trained 113,000 Health Professions Trainees. We were higher than that before and I suspect we'll be higher than that again. We have 60 different disciplines (physician, nurse, nurse practitioner, physician assistant, multiple mental health disciplines, physical/occupational therapy, dental, blind rehabilitation, pharmacy), it is the largest training program in the country by far. It involves 150 healthcare facilities and many ambulatory sites that aren't directly the inpatient units that you're familiar with. We are quite involved in health care inside of VHA and for the country. It provides us great workforce in the future, it's how we get the people who work in the VA; they come and experience it and love it and they stay.

We also have programs to help to encourage them to stay, loan repayment programs and things of that nature. We also know that because of our widespread training programs, most of these professions listed, podiatrists, psychologists, optometrists, physicians, and others, worked in the VA before they came to the VA. It is a major recruitment tool for VHA. Our satisfaction for the trainings is also quite high. Since I've been here, it has been 91, 91½, 92%; it's always quite high. The trainees love their experience. They learn a lot from the Veterans; the Veterans tend to like them. Most U.S. medical schools (99%) are affiliated with VA, so this is going to clearly affect them; 15,000 trainees are with minority serving institutions and we are trying to increase that. We're using geomapping to find where our VHAs are located, in minority-serving institutions, to create more outreach.

As part of MAHSO (Market Area Health Systems Optimization), we were given data and I also served on a committee that looked at how MAHSO is working over time. We evaluated 154 facilities and the data that was presented. Of course, by the time it's with us, it's with a couple of years old, but it was still quite recent, and for us, with the trainees, the problem is more for the inpatient units. We looked to where inpatient units were going to be removed or requested to be slated for closure through the AIR Commission, and we looked at those where there wasn't going to be a replacement nearby (with some of these, the recommendation is building a hospital right next to the current location or very close). We only looked at those where the VA inpatient facilities were going to disappear, and then we looked at how many trainees were there. We looked particularly at physicians, nurses, and mental health. I think there might be obvious reasons for that, because with 60

disciplines, we couldn't consider all of them, and anywhere they're sufficient to have much GME (graduate medical education) is when you have more other types of training programs. If we looked at GME and look if there were substantial risks there, that helped to know that we were hitting on the most difficult ones. We also looked at where they were, what's near them, what are the possibilities, what can be done, and in that review, we finally came down to a reasonable conclusion that our training mission will be able to be sustained.

Now there are going to be individual problems in certain areas; that is not a surprise. Mostly, it can be handled, and they're in areas where there are going to be less Veterans. That's something that's going to be hard to recall, but in areas that are more rural, where there are few Veterans and getting to be fewer, there won't be, in the future, enough educational milieu in which to train. For those, we are going to say that there may be impact, but what are the alternatives? We also looked at where may be problematic because something is being closed. The Secretary was very helpful with this because we did talk to him about the most potentially difficult sites, for more than one of which, he had some extremely good answers. I've been very impressed with his support of the training mission and how we went through the MAHSO process.

It took a lot of people spending a lot of time looking through a huge volume of data, but our conclusion was we'll be able to manage. Now that means some trainees will not go where the trainees from that same institution currently go. For some, it means more travel. We're talking mostly not, though, but for some, there will be more travel. We also have sites that have facilities to house residents or other trainees if they're coming from a distance. That's something that we hope that is considered in any kind of new facility development; how will trainees be able to be housed if they go to those facilities that's further away from their institutions. More and more of our VA facilities have more and more trainees from around the country; I remember it was always just the people from next door. Now many more institutions, mostly in the associated health professions, are sending trainees further away. That creates issues for how you house them and how they get there.

I would say that we talk to VISN directors, they always have answers for those kinds of questions. The VISN directors are the regional directors who know their areas very well. We called several of them and we got down to a few that we just didn't know what could happen, and one of them said, oh, it's not a problem, they had answers in basically every location. We had one we were left with that's going to be quite difficult, but there will be almost no Veterans there, so it will mean more travel for the trainees that are currently going there.

Another item to note is that it's not always easy for our trainees to be able to work at military facilities. We require a certain amount of security clearance to be able to get into VA, and as some of you may be familiar, that's not always smooth or exactly quick. You must expect some time before they can just come into a VAMC and get into a medical record; the military has additional layers. The problem that presents is in timing. If it takes six months for this trainee and a year and a half for that, it becomes very difficult to count on the military facilities to be where our trainees could be housed. Yet, we would like to have more of that, so if those other issues could be resolved, one of the options for more of the trainings could be to have them at the military facilities.

Dr. Ramoni: It's wonderful to be in the Office of Academic Affiliations, which was created, in fact, by the SMAG. It was recommended by the SMAG to have an academic unit within VA. It's an affirmation of your value of the academic mission of VA that we're here in front of you today. I'll say that I feel like I'm somewhere between Hippocrates and maybe Arnold Schwarzenegger with, "first, do no harm" versus "no pain, no gain," and that is the sort of middle ground that we're trying to walk here.

We're fortunate to get $882 million from Congress. We also bring in funds from NIH (National Institutes of Health) and other sources, and that brings us to about a $2 billion enterprise. We have about 18,000 active projects and we're nearing 7,000 principal investigators, most of whom are also clinicians in VA. Come for the education, stay for the research; we found that is a great retention component within VA.

We vary a great deal in size, from $13,000 to over $70 million, and because of these close links with our academic affiliates, the strength of the academic affiliate really is a predictor of the strength of the research program at the VA. Not all the successive research depends just on research: we need to operate within buildings, have protected time for clinicians, have the necessary IT infrastructure, and some of our research, in fact, we take advantage of our academic affiliate relationships by conducting that research off-site so we can also access resources that are at those sites, either through leased space or if they loan us the space to do the VA research. There is a range of facilities that will be impacted by some of the recommendations; they range from our site in Decatur, that is the Atlanta VA, at about $26 million annually, down to St. Cloud, Minnesota, at $33,000. If you look at the high end, they have some large numbers, so this will impact a large proportion of our portfolio and many Veterans.

How do we prepare for success? We don't focus just on those facilities that are going to be replaced. We must maximize opportunities across the entire VA because the idea that you're going to move a VA and not see any impacts there is overly optimistic, but can we prepare the rest of the VA to gear up research so that, as an enterprise, we maintain our strength? I think we can, while we wait for those sites to recover from the change and then, I think, over time (this is the no-pain, no-gain), we can see some longer-term benefits, even at those sites.

Some of the recommendations we had, both for that VAMC in particular: retention bonuses, maintaining proximity for the research components where possible, including a robust research footprint when you move the VA. Often space is at a premium in the academic affiliate. If you can give them great research space at the new facility, that will be an attractor, and include a clinical research unit there for our clinical trials. Across the two-step, we highlight research as important to the entire system by having a quality measure for all VISNs, in terms of conducting research so that it's something that we value and track across the system. That we have consistent policies for protected time for clinician researchers, and that's something that our executive committee are working together to see if we can formalize some of those recommendations together. We can actively recruit as an enterprise high-priority researchers into the VA through, for instance, what would be equivalent of start-up packages to achieve our diversity goals. I've talked to some of the HBCUs (Historically Black Colleges and Universities), and they love the idea of working together to recruit more people.

We would need fast turnaround leases for research space because when these places move, we need a place for those labs to go, and sometimes that process can take a while. Some of our teams, as Dr. Clancy mentioned, can be virtual; if you're conducting data analysis, you can be off-site. I think we can retain some good researchers that way, too, who want some more flexibility. Finally, there are some high potential VA medical centers that have strong academic affiliates but small VA research programs. Let's focus on strengthening those because those have a lot of potential to grow.

Dr. Clancy: The thing that was mentioned that I wanted to just emphasize in both presentations is, and for those of you who have been at VA, please try not to roll your eyes, in general, there is a very elaborate and many-year, small planning process for building new facilities, the Strategic Capital Improvement Projects (SCIP) list. It's an acquired taste. I think it is fair to say that anticipating the needs of the academic mission is not part of the conversation. Coming out of the AIR Commission recommendations, whatever the President and then the Congress decide to do, I think an absolute requirement to live up to the Secretary's interests would be that research and education are there at the table as part of this planning. You can't say to a new facility, “Where are the labs?” “Oh, we didn't build any.” “How about the conference rooms or whatever for some interactive sessions and so forth?” “Oh, we didn't do that, either.” That would be a new order of business for us, whether it's facilities that we're building from the ground up or leasing, but I think there are a lot of opportunity is there.

To say that this AIR Commission is a groundbreaking endeavor, I think, states the obvious. Again, the Secretary has a very, very strong interest in this. Some of the considerations that I would be thrilled to hear from you about, is what changes should we be anticipating in academic medical centers as more are becoming hubs of systems? It's not always all that easy to find out in a minute how much is there for any system. Now I think that has evolved over time and many of these systems are a work in progress. How can we effectively assure the sustained success of academic partnerships? It frankly needs some requisite changes in education and training. I give kudos to both of my colleagues in terms of what OAA did for approving remote supervision. This is a very big deal. I'm not actually sure where ACGME (Accreditation Council for Graduate Medical Education) and CMS stand on this, in terms of getting reimbursed. I'm going to guess at the moment they haven't been too thrilled, at least, before the pandemic, we'll see how that changes. I think you'll also see how many curricula for teaching are going to be changing, as well, and how can we most effectively assure this sustains in this changing world on so many fronts. Here after COVID, academic centers themselves changing, VHA. Presumably, we should be, at least, anticipating changes, even though it's not clear how this all shakes out at the end of a couple of years.

When he was Under Secretary, you may have heard Dr. Shulkin and the Surgeon General, Dr. Murthy, had a big press release saying that VA was going to have 10 slots at the Uniform Services University (USUHS) for people who would pay their time back. These were extra slots allotted by the Affordable Care Act. HHS (US Department of Health and Human Services), for a variety of reasons, think that their other mechanisms for supporting health professionals were more effective than slots that USUHS, so the idea was we would give HHS the money, these people would be termed members of the public health services (you must be part of a uniformed service to be at the USUHS), and this was wonderful

news. There was only one problem; legally, we couldn't do it, the issue relates to a somewhat arcane piece of law called the Economy Act, which relates to how federal departments may or may not give each other money.

This year, finally, we broke the logjam internal to the Administration so it's now part of our fiscal year 2023 budget request. I have no doubt that our committees will love this. We could see 10 students per year and possibly more. The Uniformed Services University people are very excited about that.

Dr. Ramoni: One of the ways that will work is because the public health service commissioned officers have been participating in uniformed services. Also, commissioned officers and public health service also serve in VA. It seems complicated, but basically, we're taking advantage of that to make this work.

Dr. Clancy: One other issue I would just highlight for your attention: in all the analysis, the rural question is a problem. Hopefully, we don't do worse, but I don't think U.S. healthcare has really faced up to recruiting more people from rural areas, over this past several decades, basically no change at all, and trying to think about how we could create those experiences is part of the training.

Dr. Kellermann: I just want to make sure I hear that right. If this Economy Act hurdle is crossed, does this mean there will be students at USUHS or sprinkled around the country? *[Dr. Clancy confirms at USUHS]* I would just add to the Committee, because they're public health service officers, that means a minimum 10-year obligation to the VA, after which they might stay in the public health service at the VA or retire and go to work for the VA. In contrast, all the GME money that sort of goes to wherever the resident goes, these will be folks who will be deployable, movable, wherever you need them. It's a huge win for both the institution and, very importantly, for the Veterans Administration.

Dr. Perlin: It's such an important, timely presentation; important in some right by virtue the impact of VA's substantial role in training health professionals across our nation, but also timely because it's hard to think of an issue that will be more defining of the immediate decade ahead than the issue of workforce. The great resignation has affected health care substantially. If one does simple math and you say that X percent have left the workforce, but the simple math would be wrong because it's disproportionate in that more senior leaders, according to most recent statistics in medicine, have left. There is no substitute for the learned, lived experience of being on-site. Which is to say that I think our country needs to make some investment in VA being a continuing source of the provision of health care.

I make that in the context of three other points. First, is that the locus of training is changing substantially, not only terms of academic health systems becoming a nucleus of a larger health system that's geographically dispersed, but then, for any number of reasons, the private sector has gone big. In medical education, for example, a nurse in training, in part, by virtue of being able to create that workforce. My alma mater will be training 7,000 health officers a year by 2025: it's up to approximately 6,000 a year now.

The second, is that the means of training is changing rapidly. It's hard to believe that with the economic pressures on health care, that every university will be creating its own

unique individual curriculum that is taught once and revised. Galen Nursing School provides nursing education for nontraditional individuals on an eight-quarter basis. What's interesting is that all eight quarters are taught every quarter and the exact same curriculum is taught at 11 sites simultaneously. So, you just think about the scaling of education in a different way, and it may cause us to think differently about who VA's potential competitors are, who are VA's potential collaborators.

And a final point is that this sort of set of shifts is going to put different emphasis, because the interest of nonacademic educational environment is on workforce, not necessarily on research. I think, as a matter of both national security and the economy, it's in our interest to be able to build a capacity for biomedical research, certainly with respect to the immediate mission of VA, biomedical research, and education, in the interest of Veterans. There are three mega changeups in the context of a defining issue, workforce: The locus of training is changing; the means of training is changing, and thus, the focus of training is changing.

Dr. Bowman: I've not managed to be as excellent as you are in stating what the future is; we don't know for sure. We know there's going to be more virtual training. There's going to be more training that's based on various kinds of models. I think it's interesting to look at what happened during the pandemic, in terms of training, and what could have happened during the pandemic, and what's happened as we're getting out of it. The trainees are coming back in droves, there were a lot that were pulled immediately. Most of the associated health trainees and undergraduate nurses were pulled immediately when the pandemic hit, but almost all of that has come back. Even though we're not quite through the pandemic and the hospitals may not be quite as easy to deal with trainees, most of the trainees are back that we had previously. Even though we increased the virtual, we allowed more virtual supervision, even in mental health, and we are conducting studies with an internal group called QUERI (Quality Enhancement Research Initiative) to try and look at what we have figured out from here.

Mental health is doing more continued virtual than the other fields. This may not be a surprise, and it's not just because we say there's virtual supervision available, it's because more mental health is being done by Telehealth than it used to be. I think that the simulations are another area that we would like to see more of, that we know are rich enough, extend enough that people feel comfortable when they're done, but it's only taken off some. We're not to where it feels like it could be. That will also influence how training is done in the future: how much requires an inpatient hospital environment, how much requires an ambulatory environment? I think that we can and should retain VHA's role in training, what the future of training is and offering as much forward-looking training as we can.

Dr. Prescott: First, I want to say thank you, to my colleagues Drs. Clancy, Bowman and Ramoni. They have been just wonderful to work with and I can't think of folks who are more dedicated, insightful, trusted. I was trying to hear Dr. Clancy's comments regarding the Secretary and looking forward to the new facilities that could be built and when they would be built, but I was also struck by something I read in the Minutes from our last meeting. It had to do with electronic health record, in which we clearly knew that there were things that we had to do during implementation, and we failed to do them. That was brought out in the commentary that we had with the entire group. I just hope that, again, as

these facilities, thinking about the future and where we move things, the simple things (conference rooms, educational efforts, research efforts) are not forgotten because that's critical in whatever we do.

I know that others will talk about what can we expect moving to the future, but I will tell you that there's a couple things just that are constants. One is that we continually have a change in leadership, which we don't often give enough emphasis to. So, it's so wonderful that, at the VA, at least within the Office of Academic Affairs and DEAN (Office of Discovery, Education and Affiliate Networks), that there has been a stability of leadership because a lot of times, at the academic medical centers, we're seeing the medical school Deans turnover of 30 to 35 Deans a year. So, getting that message out again and again to those people, and I guess that's coming back to part of the consistent messaging from the VA and the opportunities to address these groups, I think, is going to be important.

The final thing, regarding communication: Not all, but many academic leaders have come up through the ranks through maybe the clinical side or the research side, but much less on the educational side. SMAG and those who are planning should continually emphasize or realize that these leaders may need to be educated about education.

Dr. Winn: As a proud former recipient of a Career Development Award from the VA, I want to say that that program is something I would like to hear some comments on the value or the enhancing and augmenting of that because, for junior people coming in, that's an amazing sort of program to not only get in the VA, but to keep people doing research. I believe that the MSIs (Minority Serving Institutions) and the issues around trying to expand and enhance that, I think there are some significant opportunities. COVID has made many of us in academic settings recognize that the great resignation is not only real, it's not done. As you look towards the future of not only your trainees but how the VA can essentially ensure our Vets are getting not only the great care that they deserve, but also the research of developing the treatments for tomorrow today, how do you sort of see and what are your approaches to sort of stem the tide?

Regarding data: I think about the three great moves of science. In the late nineteenth century or twentieth century, it was a move more towards understanding matter and energy. 1950 comes along with Watson, Crick, and Franklin and we break Photo 51 with the DNA, and suddenly we're able to, for the first time, transform science by looking at the nature and understanding and studying human cells. As I think about the future, data is going to be central to that and the evolution of data science is going to be key in not only just driving hypotheses but understanding even from an applied perspective how we can make an impact on our various populations.

Dr. Ramoni: I think you raise some great points. I'll start with a framing conversation. Before, we treated our individual VA Medical Centers as individual units and, much like has happened in VHA to create a more unified enterprise, we ourselves are creating a more unified research enterprise. Before, it was just the medical centers competing against one another rather than treating ourselves as VA researchers. With that in mind, we are exploring the flexibilities that we have. We've been treating ourselves just like mini-NIH within the VA: we receive applications, we give out money, we receive applications, we give out money, but we have greater potential than that.

The career development awards are fantastic. They're a way to bring in people, cultivate them. Either they continue to have a strong connection to the VA, or they remain within the VA, but they take years to apply for. Can we find ways to speed up that process? Or as I said before, find high potential people or people who have established research programs that we would like to bring into the VA or that fill a need for us, expanding the diversity of our principal investigators, which is pitiful. We need to be much more proactive in bringing people in.

In terms of retention, I want to make it less painful to be a VA investigator. I was an investigator myself, so I know how it is to be an investigator. It's like running a small business with no reserves, whatsoever, and it's not fun. We went out, conducted listening tours, 30 sessions, before the pandemic. Now in our enterprise transformation, we're addressing some of those thorny issues: why does it take so long to hire people, why does it take so long to bring on a contracted research coordinator, setting up enterprise-wide contracts to bring on coordinators rather than having legal do that. I would love to hear your thoughts. Right now, people are, for the most part, just paid for like an independent investigator anywhere else. At VCU (Virginia Commonwealth University), for instance, you apply for these grants every so often and, “Am I going to get the grant again or is it all going to fall apart?” There's no reason why we can't invest in the careers of people who are looking for more stability; to offer them more long-term VA jobs, rather than having to compete every time for the research. As a researcher at an academic medical center, it was scary. You're looking not only for your funding, but you've got a post doc working for you who just had a baby. It's sort of a terror-filled endeavor. Offering people some stability, in exchange for this lone wolf doing research approach, I think, will be one way we want to look at.

In terms of data, I talked about the essential building blocks for a healthy research program. I can describe it as baking a cake. You can give me as much money in my research budget as you want, that's the flour, but if you don't give me any eggs, I'm going to create a bad-tasting cake. IT funds are essential for this, and I'm not blaming our IT colleagues, they have a very limited budget. But having the flexibility, for instance, to use some of our funds to fund the critical scientific infrastructure that involves data, I think would unlock a lot of the potential you hinted at.

Dr. Akman: I don't know everything that's going on at VA, so I may say things that you're already doing, and I suspect you probably are, but a couple of thoughts that I had around the workforce development, and that is around the intentionality or sort of strategic growth in certain identified areas. For example, if the outcome that we're looking for is around reducing health disparities among Veterans, then not only does the VA have an incredibly broad system that goes beyond health care, but if one is going to say, “Our audacious goal is to reduce health disparities among Veterans,” what do we need to do to do that? How do we build the workforce and create those cross-VA system synergies to focus the resources to do that? Part of my thought came in terms of the comments around a relationship with the HBCU and trying to build a more diverse workforce. I think we must think beyond that because we still have such a limited number of African Americans and Latinx folks coming into the healthcare pipelines. As you probably know, the LCME (Liaison Committee on Medical Education) requires medical schools to create the pipeline programs around trying

to create a diverse workforce, but here's a place where I think the VA, given its resources and national vision and scope, could potentially change the needle.

I remember, as Dean, I used to look at our diversity figures for our occupational therapy and physical therapy programs and physician assistant programs, and they were never good, but then you look at the national data of folks going into those fields and it's terrible, just terrible. The answer to creating a diverse workforce, which is a crucial part of addressing health disparities, is not going to be at the college or academic medical center level and we all know this. It's got to be before that. So, the question is, does the VA do anything in that sphere and can we think about that, in terms of what role the VA may have in helping create and enhance that pipeline and working with the national professional societies, who have a significant interest in creating a more diverse workforce in their particular professions?

This is not something that can happen overnight. I just feel that the HBCUs can't carry all the weight. They're not able to, given the needs, but they can be part of this whole conversation, obviously, in terms of what this pipeline might look like, and ultimately, so that the VA benefits from the efforts in these kinds of partnerships.

Dr. Bowman: First, the minority-serving institutions is one of our emphases, and we've created this geomapping, which is starting to get more use, so we can encourage the VAMCs to reach out to the close-by, minority-serving institutions. It's been used a little because it's still in an early phase, but we have discussed it with our National Advisory Council that works with OAA. I think that will be more widely available for our VAMCs to do outreach to those facilities, to see if they have trainees.

In terms of before they get to the health professions training level, that's not my baby. We did have a law that was passed maybe a year and a half ago and it's housed in another office. I think they are all HBCUs currently, to bring in students to come experience a VA in a defined parameter, and they're struggling around certain difficulties. It's implemented, except I think they have two students getting ready to go somewhere who are from high school, so it will take a while before that scales up. We did not have authority previously to undertake those programs. It's not under our office, but it's under an office that is extremely enthusiastic with a very gung-ho leader. I think we'll make more headway, but she has run into some barriers, so I'm hoping those are resolved, but I know that it's very common for medical schools and institutions to create programs for lower-level students, before you get to the health professions training aspect, of it to encourage them to enter the fields. We were glad that Congress gave us some authority to get started. Hopefully, it will blossom, and we'll figure out some of the legal hurdles that we still must overcome.

Dr. Ramoni: From the research perspective, this is where having this within DEAN is helpful. Representatives from Margie’s team were on a group that helped us come up with a program that was, in most cases, bringing undergraduates, but in one case, they're pushing ahead and looking to high school students to bring them into VA for some summer research experiences. We understood that if some of these people don't have a lot of money, I say that, growing up not having had a lot of money, it's important to pay people for their time over the summer. So, we've been able find ways to pay them and we expected just a handful of programs to apply to medical centers, but we got 40 applications and we're able to award 20 for the summer, so to be continued. I think you're right, that we

must both bring in qualified people who are already at that level for career development awards, but also look to the pipeline because it's going to take a while.

Dr. Akman: I'm glad to hear about these things. My sort of larger point and not just about the diverse workforce, is sort of to what end? So how are we really going to address healthcare disparities in the Vets? How do we think about that, as it relates to workforce development? How are we going to address issues around behavioral mental health and suicide thinking in an intentional way about workforce development and building that, with that intentionality of trying to drive down suicide rates and other aspects. It's just sort of a little bit different strategic way of thinking about sort of the Veterans' health as the outcome, as opposed to the process.

Dr. Ramoni: I must give Dr. Clancy a lot of credit for this by forming DEAN, she really encouraged us to connect with the other program offices in pursuit of outcome driven work, which is why we have this executive committee with some of our counterparts.

Dr. Clancy: I would connect one dot with something Dr. Perlin just said, though. What's clear in the great resignation is that one thing you hear a lot about is flexibility, which has not necessarily been a hallmark, and we don't plan for it. Your story, Rachel, about the grants running out and my post doc's having a baby: A VA I visited when I first came here, in North Carolina. They had something called gap providers because they had decided they were constantly getting into access issues, putting aside space and all this kind of stuff, because people had babies, they got in car accidents, and so forth.

Now as it turned out, at least as often as not, we would hire Dr. Perlin as a gap provider and the day he arrived, having gone through the credentialing we'd say, “Oh, no, you're on the green team now,” but nonetheless, the idea that you were planning for the eventuality that you needed, I don't think has really caught on, certainly in HR and VHA. I think it could and I think it's very consistent with the Secretary's focus on the human infrastructure and supporting the workforce, but it just struck me that that has not been a part of it, We’ve had the same “just-in-time approach” to hiring people that we've had to buying equipment and we see how well that worked during a pandemic; it's a huge part of the supply chain.

Dr. Winn: I hate to jump in, but I'm going to give a little bit of a gentle pushback on the HBCUs and MSIs and say the following things: When I became Cancer Center Director in 2019 and accepted the job here at Massey, I was the only African American at the time. When I look at many of these things that we're trying to, quote, “attract youth, attract others, attract diverse populations,” we sometimes are very blind to these pipeline programs that don't lead to the offices that are making the impact and being able to have the resources and the authority to sort of do some of these high-impact things about improving diversity. Sometimes we just think that the training alone is enough.

My pushback is that when I was at Colorado, I was on a missions team. They said, “Well, we can't beyond 4%, we've tried,” and I ended with 42% underrepresented minorities, a GPA that was higher than it had ever been, and an MCAT that was higher than had ever been at the University of Colorado. I think what we have is that we're not always getting the people with the expertise around the table, particularly in the connectedness of what the capacity of the MSIs have done. For example, I don't think many of us have recognized

that from a STEM (Science, Technology, Engineering, and Mathematics) sort of perspective, VSU, Virginia State. I hadn't known about it and just figured that out.

I would just make a gentle pushback that, as we're talking about pipelines, the goal of the pipelines is to where? I think that as we start bringing people around the table, particularly senior leaders, and having less of a leaky pipeline because having someone on a Career Development Award and losing them in the process, does not help our diversity.

We talk about not just the training focus but the training to what end, getting back to this whole context of how to impact our communities because many of the Vets that I've seen, they are from neighborhoods that I grew up in and want to make a difference and impact in those neighborhoods. I think that, while we are focusing on the end product, the Vets for sure, there is some element to being able to think about what is the appropriate diversity that will attract younger people and what expertise is coming to the table around disparities and diversity that could be added to the table.

And so, I will say that every time I take a negative sort, people get disappointed, I am actually very optimistic that, despite the great resignation, that there's some opportunities we could create, particularly among the MSIs and HBCUs that are now starting to recognize that there are avenues where we can all make impact. Again, I'm excited about what you all are doing, and again, great to be a representative. I tell everybody that I first started with a Career Development Award at the VA; that got me started in my career of doing research.

Dr. Taylor: A couple of comments and to pick up on a couple of threads of discussion here today. I do want to go back, Dr. Akman, and say I think your point on, you know, the junior high, high school students is so well taken. Having served in several facilities throughout the VA, locally, there are those programs, typically run through the volunteer service, and we have great junior high and high school students that then get scholarships, that then go on to some clinical professional program, and usually stay within the VA. But they're locally driven, they're not to scale, and your point, I think, is a great one in how do we take what's being done well in some local markets and bring that to scale to assist with our pipeline?

Dr. Perlin, your other comment about the pipeline: In VA, as we look to the next five years for the nursing corps, we're going to have to hire between 15,000-16,000 nurses per year for our enterprise. If I remember, and Dr. Begley can probably correct me if my statistic is wrong, but I think we graduate about 80,000, nationally, undergraduates. We have a tremendous need to figure out, and I'm interested in some comments on how we ensure that we have the number of nurses, and the nurses that are prepared, both as staff nurses and as nurse providers in specialty areas of practice, that we're going to need as an enterprise going forward. I've been very fortunate to work with our colleagues here today and talk about what we can do with scholarships and what we can do with nurse residencies on a much larger scale than what we have done thus far.

Then I would really be interested in your comments regarding nursing as we think not only about meeting our first and fourth mission assignments (First Mission: Veteran’s Health Care. Fourth Mission: Improve Nation’s preparedness for response to war, terrorism, national emergencies, and national disasters), but also the “come for the training, stay for

the research," making sure that that's an opportunity for pharmacists, for nurses, in this very rich system in which we practice.

Dr. Mittelman: I want to circle back to just one of the original questions: changes anticipated in education. I was at USU yesterday and we had a long discussion about this. We touch on virtual, we touch on artificial intelligence and informatics, but we don't really plan appropriately for that. Several people made the point about you must educate the educators. This requires long-term budgeting, long-term planning, and in fact, it involves training. Unless we make not only the opportunities but also the decision to move forward in enhancing the educational experiences, all we're going to do is admire the problem for many years. I'm being pragmatic.

I think, frankly, health science education must move in the direction of virtual education. We should be leading the way in Metaverse and artificial intelligence affecting medical informatics should be taught and leveraged. In our system, we talk about big data, we can leverage it in many ways. I've heard many different discussions about that with routine research or just clinical applications. I think, as we move forward with this discussion, certainly, as you're looking at reshaping medical education, this should be frontlined. As we look at rural health care, you have that provider out there, they may not be seeing the numbers and the acuity of cases that they need. What a great way to keep people's education and training up to where it needs to be.

Dr. Clancy: I realized that we don't have a national agenda in training. We have a national regulatory in training and it has very broad fences around which you better not stray, but then, within every institution, there's a huge amount of autonomy and license to kind of do your own thing. I'll just say I don't know if it's the same at VCU now, Dr. Winn, but one of my searing memories from six years there was of curriculum committee meetings. Oh, my God, that's all I will say about that experience.

We had, at that moment in time, a phenomenal educator leading the conversations who had the patience of Job, and we still didn't get anywhere. After a while, people would page themselves out of meetings and that's just within a single institution. I think, even though we don't run, with one exception: residencies, we are essentially leasing or leveraging slots and people's time and, frankly, paying for the academic infrastructure of all these institutions, so we have an opportunity to be more strategic. Which doesn't mean it will be easy, but that we could simply say, "We expect the future to look like this," and I'm looking for feedback and/or pushback on that very thought. Dr. Matthews, while I have the moment, does your group reach out to high schools? Do you want to just tell people about it?

Dr. Matthews: I had the fun for the last 10 years of running my own pipeline pathway program and it mainly started with a college curriculum but now we have a high school curriculum for underrepresented minorities in medicine, dentistry, and pharmacy. We've been to 27 states and now, of course we're completely virtual, and have an even global following, at least from our Google analytics, when we see who's signing on to our website.

Yes, there's a lot of programs like mine that anyone can partner with. We're always looking for partners, and they stretch across the pipeline. I think just to reiterate from that, Dr. Winn's point, I think, is critical. It's the phrase that is coming up in more kind of diversity

circles. We get so concerned about getting students onto the pipeline that we're not concerned about the leaps from the pipeline, how we retain people, how we keep them moving ahead. We're trying to turn the terminology in the field away from just "the pipeline" because that also means you lose them, and the water never really gets back into the pipe as opposed to the new phrase is "the highway." Let's remove barriers from the highway; let's keep them on the highway; if they get off at an exit, let's build a bridge to get them back on. Just metaphors, but there's a lot of different organizations at different points along the pipeline, and mine, we just stretch high school to college.

Dr. Wakefield: I really appreciated Dr. Winn's comments, as well. We talk a lot in a recent report (recently as in less than a year ago) from the National Academy of Medicine, titled, "The Future of Nursing: Achieving a Health Equity." There's a big section in that report that talks about education of nurses with the aim to strengthen health equity in the country, and it dives deeply into not just getting a more diverse, when I say diverse, I mean not just racial, ethnic diversity, but also geographic diversity, kids from low-income background and so on into nursing education. It talks a lot about the changes that are needed within those educational programs to retain students, support them while they're there, in addition to changing the curricula and in addition to identifying these students wherever they are.

There's a special nod to rural potential students, to your earlier point. A special nod to rural because we've got a higher proportion of nurses retiring out of rural areas than their urban counterparts, larger number that are age 65 and older. Then in urban areas, this problem is going to expand, not contract, so there are some prescriptive statements about what needs to happen, in terms of both bringing students in from rural areas into nursing education. In terms of reaching out and bringing them in, but also taking course work content out to where they are because this placement is not easy, if you talk about somebody who's got two young children and a part-time job. Those are some of the features that we talk about in service; it isn't diversity for diversity's sake, it's about how can we improve the quality of care that's delivered to a patient population, and of course we're talking about Veterans here today.

I'll stay with that point one second longer to say outreach, and thinking about pipeline programs, outreach to tribal colleges. Based on my experience, they're quite a different place than a lot of the HBCUs. You might have a nursing program or a medical school in a HBCU, and in a tribal college, at least in the part of the world where I'm from, you might have a home health aide program, you might have a CNA program, you might have an LPN program. Well, you know a little better than I do the proportion of individuals from American Indian and Alaskan native backgrounds that are in military service. So, I think about those minority serving institutions and the starting point that is really going to be quite different in how deliberative one needs to be, to make those connections. I also think about the VA hospital in my state and the three tribal colleges in that immediate area and what that potential might look like. So, if you've got a new opportunity at the VA to think about how you can leverage into that space, there might be something to be said about that.

This is probably prompt an "Are you kidding, Mary," response: that National Academy of Medicine report that I talked about, discussed a lot about public health emergencies and disasters. Why? Because some of the people that take the greatest hit are the folks who are already experiencing adverse impacts from the very social determinants of health area;

impoverished, they're less likely to be able to move out of that environment. We've spent time talking about educating nurses to work effectively in disaster environments with changes in climate. We're all talking about more of this happening in the country, and I think about the most recent pandemic.

Obviously, we don't pull back, and we pulled back for many different reasons, in terms of opportunities to educate, but this is about leaning in. This is about thinking forward, I think, and saying, “How could this look different next time?” How do we not only not have programs pulling back their students but leaning in and giving them some of the opportunities while working; VA was there in such a significant way. In terms of helping the public's health, I know because last year I was working for HHS a little bit with unaccompanied children at their request, and VA was there in lots of different environments helping. That's where you might think you would want at least nurses, maybe medical students, and others to connect and to be part of those missions, if you will, to learn in those environments. You see a piece of that reflected in the National Academy of Medicine, we dove down in that area so we can be smarter next time because there's going to be not less than this but probably more; it's not all going to look like this pandemic.

The last point I wanted to make is that I really liked your comment, Carolyn, on what can you do differently that you're not so hamstrung on the VA side of medical residency education, and other education for that matter. Could there be more of a pull because some of our leading-edge programs in nursing education efforts are really leaning into and have been encouraged by the advisory committees at HRSA, the Health Resources and Services Administration at HHS, for example, to lean into getting more curricular and sustained exposure to individuals in community settings, in all community settings. It isn't just to say to educate in hospitals, but it is to say where do people want to get their health care, where should we be focused on in terms of educating the next generation of providers, what do they need to know about the social determinants of health that individuals and families are wrestling with and place those students there. I am glad about that, but I think maybe in terms of partnering with some of the schools that are really leaning in this direction, I hadn't thought about the role that VA could play, maybe, in partnering with some of those leading-edge schools that are thinking along those lines and engaging more of that training in those environments and not being so restricted by financial and other pulls strictly into traditional medical centers and so on.

Dr. Kellermann: An ignorant question and quick observation, playing off Mary. I know you all have affiliations around the country with medical schools. Do you have affiliations with community colleges, whether it's LPNs (licensed practical nurse), OR techs (operating room technician)?

Dr. Bowman: The undergraduate health profession trainees. Yes, there are a large number.

Dr. Kellermann: Okay, good. The second thing is there were a lot of great ideas that kind of crashed in the pandemic because we got busy and stopped doing them. One of them that I had left behind tragically; I remember you all talking with great pride about your program where you were taking and repurposing medics and corpsmen in the VA. One of the things we [Virginia Commonwealth University] talked about, talked to HRSA, talked to

DoD, talked to VA about was that same concept of medics, corpsmen, PJs (pararescuemen), by purposing them with Telehealth to do primary care, outpatient, mental health, particularly in rural communities. That's an example, again, where your financial model would allow that. You don't need to worry so much about RVUs (relative value units), it would be the equivalent of an EMT (emergency medical technician), in EMS (emergency medical services) context, but supporting primary practice or tethering back to a VA that's 50, 100, or 150 miles away. That might be a way to align your research program and your teaching program, maybe with two, three, or four active medical centers around the country that might be interested in helping develop that. We [Virginia Commonwealth University] got a lot of the way there with DoD and then everything came to the pandemic and just got shelved, but I think that, as you know 10,000-11,000 medics, corpsmen are retiring every year and there are no jobs for them in the civilian sector. That would be a game changer for the Vets, but also a game changer for health care, and they know how to do trauma and emergency.

Dr. Sandy: My comment builds a little bit on what Dr. Wakefield was just commenting and it goes back to Dr. Clancy's initial comments to Secretary McDonough's about, who are our best partners from an academic point of view? It struck me that one of the dynamics between an entity like the VA and academic health centers is there's a lot of potential, perhaps some untapped leverage because many academic health centers are fundamentally reactive in nature. They respond to the environment and what they're exposed to, whether that's NIH financing, what's happening with specialty training, but the VA has a unique and multidimensional relationship with academic health centers.

This moment, it strikes me as an opportunity to potentially go beyond just the more operational and many excellent programmatic ideas to articulate what exactly do you want this partnership to look like in an enduring way between these huge institutional sectors? This is your chance to basically say, “This is what we need, as an institution, from you, as an institution,” and see what they come up with. You might be surprised because these institutions often have sort of diamonds in the rough all over the place that don't have enough visibility, but if you say, “this is what we're looking for,” you can have a huge impact on those institutions, even if you end up, you know, reestablishing a relationship that you already have.

My point is there's some significant potential leverage in moving the culture and operations of academic health centers, if you just start asking the question, “Are you the best partner for us, at this time, even though we've had a wonderful partnership heretofore?” You can get a lot of momentum and change established within these institutions, just some food for thought.

Dr. Meyer: When I see the questions that you're posed with, the first one is how can the VA lead requisite change in education and training? I would change that. The VA must, and you must for at least three reasons I see. The first is I'm not sure about other folks here, but I've confessed to a few of you that in a prior SMAG presentation on the restructuring of the VA, when I looked at the average age of plant number, I thought it was a typo. The fact that you are going to be rebuilding much of the system is an unprecedented opportunity.

I'd say the second one is that the VA is going to be pressed to do more on the education front. Just to peel it back and perhaps be a bit base about it, the reality is that academic health centers and academic medicine is funded by three cost shifts: the first one is healthy people offset the cost of the sick; the second is that public payers are offset by getting more from private payers; and the third is that clinical care offsets the cost of research and education. All three of those are under attack right now. The VA as a place that has some stability, and research and education is going to mean that it's going to have to take more of a leadership role.

I think the third reason is with the decisions that you're making, and clearly, they're difficult ones, the issue raised here about, we're going to have to possibly back off some of the care that's delivered at some of the facilities because the Vets are moving elsewhere. I texted with my daughter, a third-year medical student in Albany, who just finished her medicine rotation, who said, "I saw enough patients in Albany, but they weren't as sick as I think they should be." You're forcing yourselves to basically to shift care from inpatient elsewhere in a way that is going to be much more dramatic than anyone else, and so you are going to have the best classrooms in the entire country.

When I think about the first question about what are the changes in academic centers? We are becoming more dispersed. I do think that thinking about things like housing for trainees is going to be something that you're going to have to think about, my system now owns housing in several outlying facilities to help house trainees. The notion of leveraging the virtual care that you do, and think about home care, just tying this to the prior presentation, the Hospital at Home, what a great laboratory for training and a great laboratory for research. The other thing I would say is we're seeing that more care is moving out to the community, more care is moving to the home, and more care is being segmented. What I mean by that is segmented by certain populations: elderly complex, the folks who are just aging into to the Medicare age, folks who are otherwise young and healthy. Those segmented opportunities would be a terrific classroom. Frankly, the rest of academic medicine is struggling about how to build those relationships.

So just a couple of quick reflections on the conversation. First, I think for all of us, it is wonderful that academics are being considered in the discussion. Just think about that for a second, that is extraordinary. I have to say that, at least in my own health system, we don't always think about research and education when we're thinking about what we're going to be investing in in the future. The second thing, I've noticed just the opportunity to drive change and the opportunity for VA to be a leader here in changing the way that we provide training and education. The third is, more of a question: who's going to shape whom? On that front, is medical education going to inform your design or is, in fact, the VA design going to really inform the way we provide medical education. I would argue that we should pursue the latter but, others here, have supported the same idea.

The fourth one is, really thinking about where the areas where the VA could dominate in areas like big data, using virtual care in research and education, AI (artificial intelligence). These are places that really the VA could be ahead of the rest of the field. The notion that you can be leaders in diversity and equity and getting involved earlier in the pipeline, and I think those notions of leveraging all the environments that you're in are powerful opportunities as well, that we heard about from our colleagues here. Workforce and vertical integration, that you can develop those pipelines to create your workforce of the

future to fill these new types of facilities, providing care in new ways, again, is a huge opportunity for you.

I guess the final thing I would say is a former boss that Carolyn and I shared was quite fond of bumper stickers and I would highly recommend that you print 10,000 "Come for the education, Stay for the research" VA bumper stickers. I would be happy to put one on my car.

Dr. Clancy: Thank you from the bottom of my heart. These were hugely, very helpful comments. I will say, Gregg, in response to your hypothetical question, I think the one sentence I spoke near the end of this process to the Secretary, or wrote, that where it clicked for him was basically saying, “Care is moving so the education has got to move, too.” This has been very helpful. We look forward to reporting back at some future date.

Dr. Bowman: I just had one more point of information. We do have an attempt to help improve and increase rural VA education by having a program called RIFDI, which is Rural Interprofessional Faculty Development Initiative with the Office of Rural Health. We know from experience, that you train the people who are in this rural environment so that they feel comfortable with rural, they will stay. I did want to point out that we were doing that program, as well.

Additional remarks from the chat window:
Dr. Begley: *As opposed to availability of training, I’d love to hear any insights from your data review on the quality of the training (particularly in cases when inpatient volume is dwindling). Are the residents getting the cases that they need? It was one of our concerns as we developed the recommendations. Pipelines are built on relationships, role models and inspiration. Dr. Winn offers them all but we need more Dr. Winns.*

Dr. Sandy: *Agree with Dr. Perlin. Relative to nursing: AACN (American Association of Critical-Care Nurses) has endorsed a new curriculum for all BSN (Bachelor of Science in Nursing) programs that is competency based. (Called Essentials of Practice) that will have implications for all baccalaureate nursing programs.*

Dr. Kellerman: *Many successful programs target the 7-8th grade level students for initial exposure to health care professions.*

Dr. Taylor*: Some statistics for context: (RNs): 160K nurses graduate every year, 500K (!) are expected to retire/resign in 2022, and shortage expected to be 1.1 M as we enter 2023, and 80K qualified prospective nursing students are denied admission because of lack of faculty, slots, clinical placements.*

VA’s Quality of Care Priorities, National Leadership Role and Post-Pandemic Way Ahead:
Dr. Cox: Thank you for inviting us to be here today. I'm delighted to be able to talk with you about our quality and patient safety initiatives in the Veterans Health Administration. I'm the Assistant Under Secretary for Health for Quality and Patient Safety. That is an organization that was established almost two years ago, officially only about one-and-a-half years ago, when we last conducted a realignment of Central Office. I mentioned only because, in that realignment, VHA made the decision to place quality and patient safety at the same level as my colleagues here today. Dr. Clancy, Academics and Research; Dr.

Taylor as the Chief Nursing Officer; Dr. Scavella, previously Dr. Matthews, as the Chief Medical Officer, so they're all colleagues. Dr. Perlin will remember that when we were thinking about how to structure this, we sought his advice and that of other private sector organizations on how that placement should look. That actually relates to one of the discussion questions that we asked you to prepare for today. I want to thank Dr. Sandy and Dr. Wakefield for agreeing to be discussants.

I'm accompanied today, also, by Dr. Reena Duseja, who is sitting over here on the side. She is the newest member of our executive team and has the ambiguous title of Senior Advisor in the Office of Quality and Patient Safety. I want to give her the credit for an incredible background, among other things, an emergency physician like myself, not that that matters, and a Veteran of both government and academia, a wonderful addition to our team. She deserves all the credit for pulling together the materials and for helping me shape the discussion questions.

I'm also accompanied virtually by Dr. Joe Francis. Joe, otherwise known as Dr. Data, is the Director of our division for Measurement and Analytics and he's going to co-present with me in a few minutes when we talk about one of the rich sources of data and performance measures that we have at VA, that we report both publicly and internally.

Finally, I want to say I'm accompanied by Dr. Ernest Moy. Dr. Moy is the Executive Director of the Office of Health Equity. I heard previous discussions about the importance of health equity and social determinants of health. He's not part of my organization, but Ernie is a terrific partner and the developer and reporter of robust measures having to do with equity and social determinants that factors into the work that we do in quality and safety.

We inundated you with read-ahead material, but we wanted to give you a rich background in the variety of work that we do and in the variety of certain information that we have that we felt like would be useful to you, everything from how we're organized to a very encouraging systematic review of the peer-reviewed medical literature that is an ongoing review. We shared with you a preliminary version of it that shows how VA quality of care compares with that of the private sector and for Medicare hospitals. The fact is that there are lots of studies, and a growing number of them, that show that we compare very well. We provide care that's at least as good as or, in some cases, demonstratively better than the quality available outside the VA. That's not always been the public narrative and it continues to shift back and forth as the pendulums swing and the majorities change. I thought it was important to let you know that we are collecting information. My hope is that we'll be able to turn that into a presentation or publication or both at some time in the future.

There's a lot of information in the package about what we measure and how we measure it, and these are our main domains. It's a variation on the six domains of HRQ (Health Related Quality). The point I wanted to make here is that, while we have many measures that we track related to timeliness and access, to effectiveness and outcomes to patient safety, and to patient intervention centeredness, we're not so good at looking at efficiency. We're pretty good at looking at equity, I think Dr. Moy would agree. This relates to the second discussion question which has to do with how we might do a better job at assessing the value of Veterans' care, as well as the quality. Of course, we have very

different financial incentives from most of the rest of the country, and that factors into the discussion questions.

One thing my team touts clearly is that having data and looking at numbers by itself is nice, but it's not sufficient. Dashboards, measure summaries, are only good if you use that information and we have a very robust improvement arm in this organization. Starting with data, then working with facilities that we've identified using an algorithm called Epic, identified as those most in need of support, assistance with improvement, or engagement with us to help them with the item they're struggling the most with, whether that's access to care, a mental health outcome, primary care outcome, nursing retention. Our improvement teams collaborate with the other program offices and the subject-matter experts in other offices to provide customized, tailored engagements with facilities that are at the highest tiered, the highest need for improvement help and then identify opportunities working with the leadership teams of those facilities and help, basically, to coach them on what actions to take the ones that are the outliers and back at least towards the middle of the pack, if not above. The Center for Coordination uses this approach, every quarter, we identify facilities in three tiers, the highest one being those that you work most closely with; middle tier for those that who are starting to slip but haven't out to tier one yet or at graduates of tier one and are improving; and then the lower tier is basically everybody else. We base this on our SAIL (Strategic Analytics for Improvement and Learning) performance measure set, which has been around now for a decade. It became publicly available five years ago and that is our best tool for testing performance of an individual facility. So based on performance and SAIL and trend of performance and SAIL on the 30-odd measures in the model, we identify the facilities that are doing the best and those that could use some help, and we report that to Congress every quarter. What started as an internal comparative tool for quality improvement, in some ways became an external reporting system.

I mentioned SAIL, which we use to assess facilities, but only in the last year have we developed a data set for assessing system points. I try not to make up an acronym and give it a fancy name, but we just refer to this as our enterprise-level quality and safety measure set. What we are using this for is to identify our priorities as an enterprise, as an organization, for which measures are the most important and most reflect the quality and safety of care that we provide to Veterans: some of these are in the SAIL set, some of these are patient safety indicators, some of these are measures of access or Veteran satisfaction with care.

Dr. Francis: This is probably a concept that you may have heard a few years ago from the IHI (Institute for Healthcare Improvement) when they published a white paper called "Whole System Measures," and the point of their white paper is that it's important to look at health system performance at three levels: the Microsystem Level, which is the clinical work unit, the team, the community-based clinic; the Mesosystem Level, which for us might be the VISN level or a regional healthcare system; and then Macrolevel, the whole system. It's summarizing the overall system performance, with the idea being that we're not competing with one another, we're trying to move the entire system forward. We looked at that white paper and start talking about this when we were starting the Office of Quality and Patient Safety, we realized we did a really good job at the micro and the meso level, but we didn't have a great summary for the macro level, the whole-system level, that covered all the domains. We showed to groups past tables of HEDIS (healthcare

effectiveness data and information set) measures, for instance, but we really didn't have anything to show our success across the broad-spectrum. So, in a process that was extremely inclusive, involving the field, as well as our own offices, and activity that tried to blend our various complementary function (patient safety with the improvement functions with our measurement functions), we arrived at this set.

I want to say this is not a static product, these will evolve, and we would love to evolve them with some of your feedback. We've captured the domains of outcome, the domains of safety, for instance, avoidable adverse events, and other patient safety indicators. Probably two-thirds of these measures are measures that are commonly used in the U.S. healthcare system and are tied to CMS Care Compare and other payment programs, but we also have unique measures for VA that are important to us, that the private sector doesn't do. We try to look at system performance year-over-year to see if we are moving forward, we also have a way to compare ourselves to the community. This is an interactive chart which allows a deeper dive to see who's improving, who's sliding, where are we static in each of the domains, and what are some of our internal benchmarks for performance excellence.

There's a lot of red and pink [on the graph] which reflects the fact that the time window is capturing is the maximum impact of COVID. That includes our summer of Delta, as well as some of the early impact of Omicron, and it is no surprise, and it's been reported with private sector, that COVID has had an impact on quality metrics. A nice paper that was put out by our colleagues in CMS on the need for COVID energizing us to develop resilient systems, so for us, this is an important report card to see how we emerge as a stronger health system. We have an update for this which shows more green, and a lot more red, but it's still in a production and check mode before we bring it to this group. Even though we have seen deterioration within our system, some of the comparisons we have against the best available benchmark data (some of that's been delayed in the private sector side) is still quite favorable, particularly in the areas of hospital-acquired infection. We are quite proud of that because that has not been something easy to maintain with all the changes and challenges of staffing, backed-up emergency rooms, totally full ICUs (intensive care unit), and brand-new critical care wards, that were set up in wards that historically did just acute-care or subacute. We tracked this closely.

Dr. Cox: All this work is the context of our very ambitious effort for the entire Veterans Health Administration to become a high-reliability organization (HRO), and we've been on this journey for more than three years now. This year, we have expanded the implementation strategy to every VA Medical Center. We started with 18 sites, which itself wasn't ambitious enough, in year one, in 2019 and 2020. The following year, expanded to an additional 54 sites. That's one in each VISN the first year, three more in each VISN in year two, and then the pandemic intervened and so that cohort two got stretched out a little. Now cohort three is everybody: 130-plus medical centers, 107 or so healthcare systems and hospitals. We are emphasizing the importance of reducing preventable harm, creating a culture of safety in each of our facilities, and developing and demonstrating the commitment of our leaders and in a continuous process improvement as an underpinning for achieving that higher level of reliability. I wanted to put that in the context of why it's quality and patient safety. We think that it's team sport and that patient safety and the National Center for Patient Safety, part of our organization, is of co-equal importance.

We are also changing the way we think about how to engage with the field. We are undertaking a series of what we just expect to be semiannual engagements, twice-a-year engagements with VISN leadership, including not just the Network Directors but their team; each of them has a Quality Management Officer and Patient Safety Officer. Many of them have leaders for Systems Redesign, or Credentialing and Privileging, or Accreditation or other aspects of a quality and safety program. If you went around the country to the 18 VISNs, you would probably find 18 different ways of approaching this work, and you would find a lot of independence, so we are attempting to reduce that variation, identify opportunities for creating better alignment. That is where we're going to start talking to each other. April is the first of our scheduled series of quality and safety engagement with the leaders of one group of VISNs, those in the Southeast and then next month we're going to the upper Midwest and so on, so that twice year we cover the whole country. We're just going to ask, "What are you measuring and what are you monitoring at your quality and safety council meetings, and what are you worried about in your region and what are your priorities for quality and safety in your region?" We have some that are shared, HRO being a main one, but I know that there are many ways to approach this, and we are both going on a learning excursion but also doing some teaching and trying to create better alignment.

We're also seeking expertise from outside, specifically a recent report that our Office of Quality Management received from the NAHQ, the National Association for Healthcare Quality. We asked them to come in and examine a subset of our quality programs; a pilot and three VISNs. They've reviewed our work at Central Office and quality work at those three VISNs and made some observations. We are learning a lot about how we compare with the other organizations that they accredit and advise, and according to NHQ, our quality professionals don't do such a good job in worrying about things like payment model and healthcare value, which speaks to the second discussion question for today.

[Questions for Discussion from slide:
Who can QPS (quality patient safety) help elevate quality and patient safety priorities and leaders to be integral in VISN decision-making/governance, and what can we learn from other large private sector health systems?
As the largest integrated U.S. Health System, how can VHA/QPS approach a definition for value in its care delivery, using existing metrics? What do we know about the coast of care in VHA compared to other health systems and how should VHA define health care value?]

Dr. Moy: I wanted to say that we want the same safety and value because we do think that equity is a fundamental component of quality. We thought we were a very good fit in quality, safety, and value because equity is such a fundamental component. I think that equity is quality: you can't have good quality without equity and quality is all about equity. When you look inside VA, we do very well compared to others. We have very good reliable processes in care, and I personally think that equity is a way for us to take quality to the next step.

Dr. Sandy: It's an impressive and comprehensive program you've outlined. It was hard for me to think about, "What do I want to offer as answers to these two broad questions," but I'll take a stab at it. I think what we've heard from this presentation, and through all the meetings that I've participated in, has been the ongoing demonstrated commitment of VA

to quality and patient safety. What really comes through is you operate a comprehensive, data-driven improvement program that has leadership commitment associated with it and I always think this is the best way to deploy quality improvement is to have your own QI (quality improvement) program, follow the principles of quality improvement and that's what you're demonstrating. You said here's where we think we're good and here's where we think we can improve.

I have three comments on question one and then a couple of comments on question two. You know, how to elevate QPS and what can be learned. I think my three comments are really around frameworks, culture, and design. In framework, you identified that there is not a uniform QI framework that's being used and that different VISNs, different systems within the VISNs, have different ways that they're using it. I guess my reaction to that is that's not very common in healthcare delivery. I'm always impressed that there's a dynamic in QI in health care with a lot of ideological views about what is the best way to do QI. I think this is an area that there needs to be some balancing. I'm not a fan of either letting everybody do everything the way they want to do it, nor does it really work to have, “We're only going to do it this way with these methodologies.” There must be an appropriate balance between these two, and what is that balance is always a tough one. I think, following your basic principles of identification of a problem using data, trying something out, demonstrating what happens, those principles you will continue to follow; the framework issue is a tough one and I think it requires balance.

I think the second comment is around culture, how to elevate these priorities. I think that's my interpretation of it, about the push towards and the deployment of principles of high reliability. Even though it's labeled as a technical and tactical deployment, it's really a cultural deployment about how to think of the systems in which we deliver care, with culture defined as, “Here's the way we do things around here, and our aim is to have high reliability processes in place, a culture of psychological safety and of not tolerating known safety defects and identifying and addressing those.” I think continuing to focus on the culture, even as you deploy various program initiatives, is the second comment.

The third comment - I think there's a relationship to health equity. I was struck by the comment, that we have areas of emphasis. I think that, to advance health equity, it must be an explicit aim and an explicit objective; otherwise, it just gets sort of lost in all the other improvement that's being done. In one way this is not only related to equity, but also, it's sort of an underdeveloped area of quality systems, which is quality design. In health care, there tends to be an over-wading of improvement. Not surprising because there are so many things to improve. Not enough emphasis on how we design things in such a way they deliver quality, or they deliver equity. I think high-reliability thinking is largely about design, as well. Again, thinking about it, promoting the concept of design, in addition to focusing on improvement, would be my third comment around your question one.

On question two, and addressing the issue of value using existing metrics, I think the general approach that VA could pursue is around your very data-rich environment, you have many opportunities. You don't have the same claims-based, transaction-based systems within VA that the private sector, or even CMS does, but you can use very similar analytic approaches. I think the analytic approaches to answer these key questions are around total cost of care for defined populations and cost of care for episodes of care in defined conditions. We heard earlier today, for example, about some of the work that the

innovation center is doing. To determine value, value is a function of outcomes over cost, and you have the infrastructure for outcomes that we've already seen, and you'll have to construct your own version of cost. There are many ways to do it, but one simple way to look at how does VA compare to other health systems, is to develop, essentially, shadow pricing mechanisms, to emulate a fee schedule, and think conceptually if VA was seeking to develop its own value-based contract with whoever is paying the bill, which in this case is the Federal Government. How would you answer the question about, what is the value of care in the VA? You would have to construct your own comparable or benchmarks compared to the private sector to answer the question of outcomes over cost.

Dr. Wakefield: Dr. Sandy talked about culture. I wanted to just mention culture, governance, and operations, but he did a much better job with culture that I could have, so I'm going to go straight to the governance and operations. Having spent several years at HHS, when we thought about how to bake in a smarter focus in a priority area, a lot of what attention might have been given to that topic area was tied to where it sat in the organizational structure, whether it was a little bit higher on the org chart, whether it was a priority of the organization's leadership. So, thinking about your first question and VISNs, how do we drive this into the VISN, where was that office or that focus on the org chart? Was there attention from leadership? Were there adequate resources flowing to it or was the focus in a lateral office, peripheral, relevant to maybe the rest of the organization, but not tapped into?

The culture piece, I think, trumps virtually everything, but once you get past that, as a longer-term thought process, does one think about where is this nest, where are these individuals, their expertise nested within VISNs, and are they at the tables where they can inform the discussions that are occurring? Are issues in quality and patient safety tagged to virtually every high-level decision, conversation? If they're not, why aren't they? Sometimes it might be totally irrelevant, but many times it could be quite relevant and there may not be the right person or agenda item in high-level meetings in the government structure. I don't know how that flows into the organizational structure and processes at the VISN level, but I think there is something to be said for how this content gets operationalized and is made actionable at a high level within the VISNs. I think that's some of what you're asking, you're asking, how do we lift this up? It's culture, governance, and operations, I think. At the end of the Obama Administration, HSS was really struggling to put a stronger focus on quality and patient safety, and this took leadership engagement and creating an operations infrastructure and a steady and sustained focus on quality and patient safety. This wasn't just a “We'll talk about it once a quarter,” this was really driving it in, so it became a mainstream part of the conversation. Those are just a few ad hoc comments about the building it into operations.

I would ask another question: What might be crowding it out, in terms of planning forward and how do you hitch this topic to other discussion topics in priority areas that are flowing through? That's probably true at the headquarters level, as well as at the VISN level. Having a sense of what's crowding it out and is there a way to align this content with those other high-priority issue areas, if any of that is at all relevant. Obviously, in terms of learning from the private sector, having served on advisory boards in large health systems, we were always briefed on quality patient safety, risk management, et cetera. Again, it's

looking at where and how this fits into the tempo and focus of the organizations and how, over time, can you lift that up through the areas that I just talked about.

The other question I had is whether you can align some of your work even more strongly at the VISN level with of education. This was a thought I had in the earlier conversation, do you feel like residents, nursing students, et cetera, are learning about quality and patient safety in a substantive way? This is a bit of a one-off from the question you're asking, but because education is such a strong mission focus for VHA. Are next-generation healthcare providers, and I'm not talking about just the work that they do bedside or in a clinical area, able to get into the data, is there a way to think about a curriculum that's a little bit deeper, broader, sustained that will allow students to apply what they're increasingly learning in their curricula? I'm not suggesting that patient safety is brand-new in the curricula, but the efforts to try to really broaden with managing and massaging and analyzing large data sets. Is there an opportunity to sort of build that focus out? Also, medical schools are orienting more towards value-based health care. How can you marry up that work that you're doing with some of the expanded focus in these areas, in health professions education?

On the second question, approaching a definition for value, Dr. Sandy covered that, as well, though I would say it's interesting because, as you look across different sources of what value-driven health care is, even with bringing it straight to where most people are focused, when they think about a definition of value, there's a lot of variability in how this is operationalized. Even NQF (National Quality Forum) last year, had an interesting definition that sort of separated out value from health outcomes in a mission statement. There's latitude in how you operationalize that definition of healthcare value, but clearly there's something to be said for bringing people on the front lines into those conversations. How can you build a shared vision around that definition and associated principles and the work that ultimately feeds into more and more toward delivering value? How can you create expectations and opportunities and facilitate knowledge-sharing from VISN to VISN? My comment was going to be, I think, a lot of this is about brokering and creating environments where peers can share, not just within their VISN or within their health facility, but more comfortably sharing broadly with colleagues that might be a state removed or a healthcare facility removed from they're operating day to day. There's a lot of information sharing I think you can create that will accrue to strengthening this focus, but it's really through crafting the environments where people can share information and having leadership, where possible, as part of those conversations. Sharing ideas, sharing data, sharing the best practices, sharing evidence, and so on.

Dr. Kellermann: In the context of quality and safety, it seems to be the most important reason we care is because we want to improve outcomes. I just want to throw out my last crazy idea and that is that, if you look at the history of the VA, one of the most powerful sets of studies the VA ever did were the first VA cooperative studies on treating hypertension in the late 1950s, early 1960s. That was a game-changer not just for Vets but for the country. I will submit that you're in a position, uniquely because of the data analytic capabilities of the VA, the large number of patients, the ability to get people to do things in a standardized way, to look at the utility now of a cardiovascular polypill, a once-a-day treatment for primary prevention of cardiovascular disease. MI (myocardial infarction) coronary vascularization, stroke, are some of the biggest killers of Vets, biggest killers of

Americans, and biggest drivers of healthcare spending. You are in a system that cares so much about improving outcomes, but also, you've got to pay for care elsewhere, not just in the VA, so there's a big win-win for the VA.

Most recently, there was a meta-analysis in Lancet in August that suggested that this treatment, which is a once-a-day, cheap pill using generic drugs in combination, can reduce the incidents of these end points anywhere from 38-48%. If you run the numbers, if the VA got half of that benefit, that's going to be hundreds of millions and probably billions a year and would save thousands, if not tens of thousands of Vets' lives. There is compelling data around the world; there have been published studies in the U.S. but they have generally been small-scale, and a large-scale outcome study for four or five years could just take the lid off of this and make this a mainstream treatment, every bit the way VA's early research have stretched the quality and safety. The best way to get quality and safety is do something easy, simple that's powerful, consistently. I would submit that this type of an approach, where you literally will be mail-ordering Vets older than X age this once-a-day pill like when we grew up thinking we needed to take a vitamin every day. It could be just that kind of intervention, and I don't know a better health system in America to do it than the VA. Finally, because I know you're interested in getting the VISNs on board, you wouldn't have to do this at every VISN; you could do this in two or three. I'll be happy to recommend VISN 6 because I think they're interested, and I know a couple of other VISNs are, as well. It's doable, it's doable in your budget, and it could make a profound difference for the country, so thank you for indulging me with that off-the-wall idea.

Dr. Perlin: What I think is unique in American health care is the degree of diligence in scrutinizing performance. I'll tell you it just doesn't exist to that degree anywhere else, and not in this coordinated a fashion. I'll make my last comment first because it's responsive to Dr. Kellermann's suggestion. Whether it's that experiment or otherwise, whether it's primary research, pragmatic research, trials, or the implementation of a quality measure, VA is the natural platform for cluster randomized comparisons, whether it's by VISN or facility. If you implemented it at a couple of VISNs, whatever happens today, not only is it publishable, but if you subject it to that level of scrutiny, then you really know that your intervention works, and that's kind of a segue to my other comments.

The first is there were several comments on culture, and I think culture trumps all else. I know that if you ask the question, “How do you measure culture,” there's the Safety Culture State-of-the-Art Survey, but I would submit that we've all been to facilities that did well on the formal survey, but you know the culture isn't performing. This may be one of the environments where you can identify how to better assess culture. I think that's an area that's just ripe for research in the health services area but it's also, a jewel in the crown of VA's research activities. The next is, and I would ask you to assess whether the metrics, be the SAIL or otherwise, are they not just giving you a distribution of different levels of performance, but are they ultimately predictive of good or bad outcomes? That way you can validate longitudinally and hone in, and you may even be able to simplify factorial analysis and certain other things more levered to tell you what's going to be good or bad.

The final comment to question two is a little bit of history. Once upon a time, a very naïve Under Secretary thought, “Well, maybe you should actually take those attributes of performance over the cost per Veteran.” This was before STEEEP (safe, timely, effective,

efficient, equitable, patient centered) when VA's attributes were Quality, Access, Satisfaction, Functional Status, Community Health and, of course, Costs., I made a deal with OMB (Office of Management and Budget), if it goes up, keep me; if it doesn't improve, fire me. That was the level of accountability I wanted to impose on myself, by making it public. It wasn't as sophisticated as some of the other discussion where Dr. Sandy had some terrific suggestions, if you had to shadow price care what would that look like. I think you have the components for both the crude measures of value, as well as, what Dr. Sandy described, which is much more sophisticated.

Dr. Crosson: I do have one question. It has to do with how you think about the issue of the incentives to improve describe as three levels - the micro, the meso, the macro. One part of the question would be how do you think about incentives at each of those levels? This may be a subset of what people are calling culture, but I think you can break culture down in numerous elements. One of those elements is what is a motivator? Some of those motivators are incentives. Some of those are financial incentives, which may not be applicable here, but it can be because they don't have to be personal financial incentives. It could be resource incentives that enable actors at each one of those levels to have more resources to make improvements, but I've also seen in the history of my own organization that incentives can be both extremely effective or destructive. Certain kinds of incentives destroy intrinsic motivation in a sense of professionalism on the part of physicians, nurses, and others. I heard you talking about the support that you provide, the engagements: visiting, listening, talking, and providing advice, but how do you think about the issue of providing incentives and motivators within the culture you planned for?

Dr. Cox: That is a real challenge, and I think the culture and the question of incentives are closely linked. Very few, if any, VA employees that I have encountered, in a little over eight years are financially motivated. Nobody's in this business to make a fortune or to become famous. What motivates VA employees is the mission. It's their commitment to serving Veterans, and that's actually very powerful. It means that you can appeal to their desire to make sure that Veterans get safe, high-quality care and appeal to their sense of mission to accomplish that.

We are blessed to have a culture that is based on that, and, secondly, a tool in the form of our annual, all-employee survey. It gives us detail about the culture, all the way from the system level down to the small, five- or 10-person workgroup level. There's a patient safety survey component to this larger, all-employee survey, but this tells us about things like commitment, trust in leadership, psychological safety, freedoms, and identified problems. It gives us a good idea about how people are feeling regarding diversity and fairness and justice and so forth. We have selected some of our measures from that annual all-employee survey as indicator of how we're doing with improving the culture, including the safety culture.

Then regarding what you and Dr. Wakefield said, about engaging people and giving them opportunities to share and to learn from one another, that is exactly the focus of these engagements, specifically by not calling them site visits or assessments or certainly not inspections. We want a collaborative, bilateral exchange of information, and we're doing it, in part, for practical reasons because there's so many facilities, but also for cultural reasons. We're approaching this using how the VISNs have organized themselves already into consortia, groups of four or five VISNs in a region of the country, and those consortia,

already interact within their own group apart the way we interact as a larger system. I think that we're providing opportunities for the quality and safety professionals within that group of four or five VISNs in the country, learn from one another, asking them to fully participate in two half-day engagements and listen to each other's presentations and share ideas and share best practices, as well.

Dr. Crosson: Just one last note: when I'm talking about financial incentives, I'm certainly not talking personal ones, but anybody who's managing a facility, even at a department level, can gain or lose resources and those resources can be applied to the problems they face. That's a little bit different. I'm not recommending it; I'm just bringing it up because I've seen it in some ways be effective like that. If I look back on what we did in Kaiser Permanente, at what you would call the meso and macro-level, over the years was very public recognition of excellent performance on the part of units and then the part of individuals. I wouldn't say to increase competition, but maybe a little bit, but model the kind of performance, in particularly innovation, that then stimulated others to hope that they could achieve that level of recognition.

Dr. Meyer: In terms of the first question, I do think that, tied to what Dr. Wakefield said, and hearing the comments just made from Dr. Crosson, the whole science of positive deviance and using that as a motivator is powerful. Because of your measurement at the meso system, you have a great way of doing that VISN to VISN, which I think is truly excellent. I think, in terms of how can you elevate the quality of patient safety priorities, reflecting one of the earlier comments about balance, it is having what are existing metrics, but I also encourage you to explore, going to the next generation of measures and do more patient-reported outcomes because I think you actually have an opportunity to build that into your platform and, frankly, you'll be able to aggregate enough data on that very quickly. Even though there aren't national benchmarks for most of them, you could develop them very quickly and, again, take the lead.

On the second question, one point I wanted to just emphasize is to be able to capture what you consider that you do incredibly well. My definition of value is a little bit different than a lot of others. Mine is appropriateness, times outcomes, including both, clinical outcomes, and inpatient experience, divided by cost, and on the appropriateness front there's a lot to be said that the VA is leading. The whole notion of looking at quality and not just do we execute well, but do we design well, is something I think that you could incorporate into the way that you're trying to express value there.

To summarize a little bit from what I've heard from the conversation. The first thing I would say is the VA's ongoing commitment to quality and patient safety is terrific and laudable, and one of the things that I think is important for us all to recognize, is the incredible contributions that the VA has made. The field of quality, in general, and the care of Veterans over time, it's an amazing history and it's great to see that commitment continue. The second is the notion that equity is a major focus is something to be celebrated. What I would say is that, when I look currently at the macrosystem dashboard, I don't see things broken out by equity, so I'm sure that's coming, but I think to reflect it there is important.

We've heard plenty about culture and how important it is. Again, when I look at the big macrosystem dashboard, I don't see about workforce engagement, I don't see our culture being shared here, and I think that those will be important things. I know they're being

tracked, but they would be important to share. I do think the notion of leadership attention and how you hardwire and making sure the quality agenda is a routine part of operations, throughout the entirety of the system, they're powerful to have. I think we heard a couple of opportunities to align this work in quality with other work to tie in with a discussion earlier that we had on education. Then when we think how to cost-out, perhaps for some of the cost comparisons, by leveraging the work that Dr. Ghosh is doing, probably provide a nice tie-in to some of the work we heard about earlier.

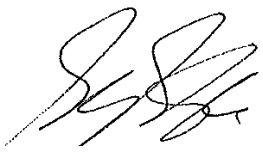
Then, on the last points: that whole notion of the power of the VA to do cluster randomized trials in a way that would be the envy of everyone, is something that could really be leveraged for the future. Thank you for what is terrific work. We know it's not easy, and the fact that you are keeping the commitment through it is so important to all of us.

Dr. Cox: I just want to comment about Dr. Wakefield's remark about incorporating quality safety into educational programs. I can't speak for all the various residency training programs that we have, but one area in which Dr. Bowman's office and ours do cooperate is there is a Chief Residency in Quality and Safety, which I think is a unique program at VA, and I think a fellowship with an additional post-grad year at the end of a standard internal medicine, family medicine, or general surgery residency. We teach those post graduate trainees the tools of quality improvement in patient safety, and then we help to retain as many of them as we can to apply what they've learned in our system. That is one area where a lot of effort is cosponsored by the National Center for Patient Safety and by academic affiliations.

Adjournment:
Dr. Meyer: Thank you all for a tremendous conversation. I hope our colleagues found it to be incredibly helpful. A couple of other thank yous. First, to Dr. Lieberman and his colleagues just for spending the day with us today and listening in on this session. A very special thank you to Selina and Dennis and the entire team here at the VA. I know from my own experience that making these hybrid meetings work, it's not easy, and you made it look easy, so thank you for that. Then a final thank you to Dr. Perlin for his leadership.

The meeting was adjourned at 3:29 p.m.

Minutes approved by:



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