**MINUTES**

**Committee Members Present:**

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

James H. Martin, M.D., Physician, Captain James A. Lovell Federal Health Care Center (Virtual)

Gregg S. Meyer, M.D., MSc, Chief Clinical Officer of Partners Healthcare System (Virtual)

Deborah Trautman, Ph.D., RN, Chief Executive Officer, American Association of Colleges of Nursing (AACN) **(Virtual)**

Jennifer Daley, M.D., FACP, Senior Medical Director, New England Region, Cigna Health Care (Virtual)

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

Thomas Lee, M.D., Chief Medical Officer, Press Ganey Associates, Inc (Virtual)

Michael Mittelman, O.D., MPH, MBA, FAAO, FACHE, Rear Admiral, USN (Ret.) President and Professor of Public Health, Salus University (In person)

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

**Arthur L. Kellerman**, M.D., MPH, FACEP, Professor and Dean, F. Edward Hebert School of Medicine Uniformed Services University of the Health Sciences (In person)

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

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

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

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

Francis J. Crosson, M.D.,Chairman, Congressional Medicare Payment Advisory Commission **(Virtual)**

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)**

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

**Committee Members Absent:** None

**Department of Veterans Affairs Staff and Presenters:**

Richard Stone, M.D., Acting Executive in Charge, Veterans Health Administration (In person)

Steven Lieberman, M.D., Acting Deputy Under Secretary for Health, Veterans Health Administration (In person)

Jennifer MacDonald, M.D., Senior Advisor to the Acting Deputy Secretary, Department of Veterans Affairs (In person)

Erica Scavella, M.D., Associate Deputy Director, Office of Risk Management, Veterans Health Administration

William Gunner, M.D., Executive Director, VA National Center for Patient Safety (Virtual)

Susan Kirsh, M.D., Acting Deputy Under Secretary for Health for Access, Veterans Heath Administration (Virtual)

David Carroll, M.D., Office of Mental Health & Suicide Prevention Director, Veterans Heath Administration (Virtual)

Matthew Miller, Ph.D., Office of Mental Health & Suicide Prevention Director, Veterans Heath Administration (Virtual)

Kameron Matthews, M.D., Assistant Under Secretary for Health for Clinical Services, Veterans Heath Administration (In person)

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

Ryan Vega, Chief Officer, Office of Healthcare Innovation & Learning, Veterans Health Administration (In person)

Deborah Kramer, Acting Assistant Under Secretary for Health for Support, Veterans Health Administration (In person)

Michael Brennan, Ph.D., Executive Director, VA’s Office of Construction & Facilities Management (In person)

Marjorie Bowman, M.D., Chief Academic Affiliations Officer, Veterans Health Administration (In person)

LaTonya Small, Ed.D., Program Specialist, VA Advisory Committee Management Office (Virtual)

**Members of the Public:**

Sidath Viranga Panangala, Specialist in Veterans Policy, Team Lead, Veterans Health and Benefits Issues, Congressional Research Service, Domestic Social Policy Division (Virtual)

James Moss, Assistant Director, Veterans Health Policy, NVS and VFW VAVS National Representative (Virtual)

Robyn Bash, Vice President of Government Relations and Public Policy Operations, American Hospital Association (Virtual)

Rene Campos, Military Officers Association of America (Virtual)

Meggan Thomas, MPH, Veterans Casework Consultant, NVS (Virtual)

**SMAG Administrative Team:**

Gabrielle Petersen, Designated Federal Officer (In person)

Selina Meiners, Alternate Designated Federal Officer (Virtual)

Laura Lovinger, Committee Manager (In person)

Leilani Felan, Committee Manager (In person)

Marcus Murray, Committee Manager (In person)

Dennis Lahl, Committee Manager (In person)

**Call to Order:**

Gabrielle Petersen, Designated Federal Officer, called the meeting to order at 9:30 a.m., March 26, 2021.

**SMAG Introduction Remarks**

**Dr. Perlin**: Thank you for making the time for this important work. I think all of us in healthcare, especially those at VA, are working extraordinarily hard. Let me just recognize Dr. Stone, the Acting Deputy Under Secretary for Health, and the entire VHA team for their extraordinary work. They put together a remarkable COVID response. Really, it's quite instructive for those of us who have direct care responsibilities. In addition to that, like so many others, their balance in the COVID response, community response, and the core mission. So, a heartfelt thanks to all the VA leadership and frontline staff who are serving that mission each day. Also, want to recognize one of our fellow clinical leaders who is making history: Dr. Carolyn Clancy, who is serving as the Acting Deputy Secretary. I think that those of you know/work with Dr. Clancy, that she's just a remarkable individual and extraordinary researcher. In addition to recognizing Dr. Clancy in her role as Acting Deputy Secretary, it gives me great pleasure to identify that Gregg Meyer as the vice chair of the Special Medical Advisory Group. At the end of this year, he will succeed me in chairing this group. So, my congratulations and appreciation to Dr. Clancy and to Gregg Meyer. It is a moment of transition.

**Dr. Meyer**: I would just say, I think everyone recognizes that following you with your masterful leadership and your amazing facilitation is going to be quite a challenge. You've set the bar high. But with that said, it's an honor and privilege to serve. So, thank you for this opportunity.

**Dr. Perlin**: Well, thank you for those kind words, Gregg. But the truth is that you'll be getting a step up. I think you'll experience that as Gregg assumes that role. It's also a time for transition, and it's bittersweet because these are individuals have both served with distinction and our friends: Friends of VA, friends of Veterans, and individually friends as well. Just want to recognize each of these four individuals: Jennifer Daley, Tom Lee, Jim Martin, and Deb Trautman for their extraordinary service to the SMAG. I would like to throw in a virtual round of applause for these individuals. I see Rick Pollack here. Our predecessor at the American Hospital Association once upon a time. You never really leave this group, so the truth of matter is that you're with us, so we'll be calling on you, and hope that you never do leave. Please know how much that is appreciated. I know we have a very full agenda, but just maybe a couple of comments from each of you on what you hope for the future for us. Please start with Deb Trautman.

**Dr. Trautman**: Well, thank you so much. It's just been an honor and a privilege to serve on this committee. I will continue to support the community, most certainly, and recognize the great leadership that has occurred there. And Jonathan, thank you very much. You've been an extraordinary. Thank you.

**Dr. Perlin**: Thank you for those very, very kind words. Dr. Martin is not available. Okay. I see Tom Lee right in front of me. Good morning, Tom.

**Dr. Lee**: I joined when Ashish Jha was operating a group for Secretary Shinseki. And it's been exhilarating. I mean, I went because Ashish was a friend, but I was really impressed with the people I met then. And the people that I met in the many years since have been terrific, mission driven. I've been so impressed and I feel that I will continue to be rooting for the success of the VA, and the individuals, and the good work by publicizing it through NEJM Catalyst, which I edit, but trying to help in every other way as well.

**Dr. Perlin**: Thanks for your great practical leadership through NEJM Catalyst. It's quite extraordinary. And now, Jennifer Daley. Thank you so much for all your service as well. Jennifer.

**Dr. Daley**: Oh, thank you. So, I figured out this morning that this is my 30th year of serving the VA and that I'm sad to be leaving the committee. It's been a wonderful experience and I've enjoyed all the people that I've met. And any way I can help, I'm always available. Thank you so much for this experience. It's been wonderful.

**Dr. Perlin**: Well, thank you for that. I think the comments are also testament to the role the VA plays through American healthcare, health services, research, and health leadership. Tom mentioned Ashish Jha. Ashish Jha was a young individual, post-residency, interested in health services, research, and management. He came to VA. Jha wanted a job in quality. We didn't have one. We created one. Ashish was the first Under Secretary Special Fellow in Quality. Things seemed to have worked out okay. He's now a Dean of Public Health, and I suspect you've seen his work on the news on COVID. The VA is just so incredibly important in the texture of American health care. In addition, there are rising stars. I'm just looking across the screen. I have the privilege of working a little bit with Kameron Matthews, not only through VA, but through the National Quality Forum. Kameron, I really appreciate your leadership and hope you'll reintroduce to the group.

**Dr. Matthews**: Thank you so much, Dr. Perlin. I'm just excited to, number one, be in this role. I still feel quite new. For those who I haven't met, again, Kameron Matthews. Previously served as the Assistant Under Secretary for Community Care. And I think talked with many of you as individuals about different issues over the past couple of years. Now, as Chief Medical Officer, of course following Dr. Lieberman's leadership with our COVID response, but also lately more headfirst into our EHR modernization effort, which in and of itself is a massive feat. Excited to be here, hopefully having good conversations.

**Dr. Perlin**: Well, thank you so much for all your terrific leadership. We so look forward to working with you with the Special Medical Advisory Group. And finally, I also want to welcome Dr. Beth Taylor to the group as well.

**Dr. Taylor**: Hi, Dr. Perlin. Thank you so much. I'm joining virtually today. It's such a privilege to be working with Dr. Matthews, Dr. Stone, Dr. Lieberman, and the team. I'm the Assistant Under Secretary for Health for Patient Care Services and Chief Nursing Officer. So, the partner-in-crime with Dr. Matthews, and so pleased to be part of his group today. Thank you.

**Dr. Perlin**: Wonderful to have you here. Without further ado, again, thanks to each one of you for your service to the Special Medical Advisory Group. Let me turn now to Dr. Steven Lieberman for some opening remarks. And Steve, I know that these roles are incredibly difficult, that the hours are very long. So please know that's appreciated, as are all of you.

**Dr. Lieberman**: Good morning, everyone. Thank you for joining us today. Dr. Stone, as Dr. Perlin mentioned, will be here a little later. He and I, and the rest of us, really enjoy this meeting. We look forward to it, look forward to learning from all of you and getting your advice. And he's sorry to miss even five minutes of it. He had to attend something with the Secretary this morning. We must thank Dr. Perlin for his continued leadership. He’s just done an outstanding job for us, and we just so appreciate your insights, advice, and everything else. Welcome, Dr. Meyer. We look forward to continuing to work with you in your new position. We'd also like to thank all our individuals that are rotating off this group, and really appreciate each one of you, and my long-time friend and colleague, Dr. Daley, a special thanks to you for your time. Dr. Matthews certainly mentioned about how busy we are with our Electronic Health Record Modernization. Moving forward, we have a strategic review for 12 weeks to look at what's going on, to try to identify what improvements we might make. We are busy with our new wave of enrollment in our caregiver program. As for the generations in Vietnam Veterans and older generations, to date, since we rolled out on October 1st, we've had over 66,000 applications. So, our team is very busy with that. And then of course, we're quite busy with COVID. Again, as all of you are, we are focused on our vaccination program. To date, about a third of Veterans that receive care at VA have received at least one vaccination or the Janssen vaccine. You may have heard about the Save Lives Act that was just signed off on earlier this week by President Biden. So now, we now have an additional nine million Veterans out there who are not enrolled for healthcare, who are now eligible for vaccination at VA, as well as spouses of Veterans, and caregivers of Veterans. Our facilities across the country are very busy gearing up for this. It's certainly contingent to having an adequate vaccine supply. Looking forward to a later date from the operation, which is formerly known as Operation Warp Speed. Hoping they're going to be increasing our supply in the coming weeks so we can be more successful with this new law. So, looking forward to today's presentations and discussion, and I will turn it back to you, Dr. Perlin.

**Dr. Perlin**: Thanks so much, Dr. Lieberman for all the comments you made, we really have three extraordinarily important topics today for conversation. The actual presentation is quite limited. It's about 10 minutes, and that means that the major time is really allowed for discussion. I'm sure you've seen the agenda and you would agree that there is no more important topic than the first one, which is suicide prevention. The second topic today will be on recapitalization strategy for VA. I think those of you who know the system intimately, know infrastructure is on the older side. The concept of what a contemporary health system looks like also has changed from bricks and mortar to a combination of bricks and mortar, and if you will, digital bricks. The third topic is innovation. It's a core competency. I also think that's a unifying feature. I know Rick Pollack across the AHA membership has really been observing innovation that's been accelerated as a necessity in the context of COVID, as have so many others. Tom, certainly, your team published on that area. How that's really incorporated as a more sophisticated core competency is part of that discussion. I'd like to ask, if it's not been asked earlier, that the three individuals who have a particular background and relevance to each of these areas be prepared to perhaps kick off the conversation. And I hope our resident psychiatrist makes initial comments on suicide prevention activity. Chanin, as our Veteran Service Organization leader, the notion of recapitalization and making sure that VA is robust for Veterans, I think it has salience for you. And I hope you'll be willing to kick off the conversation there. There are any number of people to turn to in innovation, but who perhaps actually turn to Tom Lee. I think, as I mentioned, Catalyst has been really focusing on innovative strategies. Through the breadth of your experience, you see innovation as a place to fit many dimensions, including intellectual property, dimension, and institutions that create. Rick, if I might put you on the spot. Innovation is also one of the areas that the American Hospital Association has been quite focused on. Obviously, we want commentary from each one of you and your insights, but just to get the ball rolling. Let me just ask members of the commission if there's anything that you'd like to get on the table before we embark into the actual topics of the agenda.

**Dr. Perlin**: Okay. Well, with that, let us go to the first topic. Maybe Dr. Lieberman, we'll ask you to introduce each topic and the VA leaders associated with them.

**VHA Response: Mental Health, Suicide Prevention, COVID-19:**

**Dr. Lieberman**: Wonderful. For our first presentation, VHA Response: Mental Health, Suicide Prevention, COVID-19, I'm pleased to introduce two of our top leaders in mental health: Dr. David Carroll, who has been on our leadership team for many years at headquarters, and he is the Executive Director for the Office of Mental Health and Suicide Prevention. And then also appointed more recently, Dr. Matthew Miller, who is our Director of Suicide Prevention Program, also in the Office of Mental Health and Suicide Prevention. And previously was over our suicide call centers, and so has a lot of experience in this area. Just so fortunate to have those two individuals on our leadership team.

**Dr. Carroll**: Thank you, Dr. Lieberman and Dr. Perlin. Matt and I are enormously grateful for the opportunity to talk with you today, but more importantly to listen and learn from you, and to get your input on where we can and need to go in our Mental Health and Suicide Prevention Program and your thoughts on how we can get there. We did send some materials to you in advance, and if you have any questions about them, either today or at some other time, we'd be happy to discuss those with you. We tried to provide materials regarding specifically what we have done in mental health and suicide prevention in response to the COVID-19 pandemic, and information about how we applied a public health model to that response, as we do to all that we do in mental health and suicide prevention, we gave a rather detailed outline of activities in our Suicide Prevention Program. There were two articles that were recently published by VA researchers and team members in our office looking at the very successful pivot, from our perspective, we were able to make in terms of tele-mental health. And then also an article to guide our thinking about further application of a public health model to all that we do. And certainly, the application of a public health model is so important to what we do in mental health and suicide prevention to ensure that we are looking at what we are doing within the organization from a clinical perspective, but also to fulfill our mission to serve all Veterans and what we are doing, what we are encouraging communities to do. It's not just within VHA, but it's in the communities in which Veterans live, and work, and live their lives. And that community presence is such an important component of our public health approach across the board: in mental health and suicide prevention, in things that we are doing that are following that model for all Veterans, and in things that we're doing for selected groups that may be at a particular risk. And then finally, the targeted strategies, both clinically and from a community-based perspective for those individuals that we are most intent on reaching or that need special services. As you saw in the materials that we sent, we had some success over this past year in those strategies, both the clinically based strategies, as well as the community-based strategies, both within mental health and suicide prevention. At the end of fiscal year 20, which had those first very difficult moments of the COVID pandemic for all of us across the system, through a very robust application of, and most importantly, because of the amazing work that all of our providers and staff did in our field facilities, we actually, last year, maintained around 92% of the workload that we have the previous year in Mental Health and Suicide Prevention. And we also were able to double down over this last year through February of 2021. But over this last full year of the pandemic, we were able to double down in some key initiatives in our Suicide Prevention Program, our predictive analytics program targeting those at greatest risk. And we'd be happy to talk some more about that. Also in our safety planning and the emergency department, which we know is a critical factor based upon research that was done within VA, we have put in place an outreach program to Veterans who are identified as high risk for suicide and who tested positive for COVID over the last year. In our tele-mental health operation, there was a rapid shift to phone engagement. In April of 2020, we made over 980,000 telephone contacts with Veterans in mental health. But over the past year, we have seen a shift to more video virtual visits. And in February, the most recently ended month, we had over 452,000 VA video visits to Veterans often in their homes. Over 100,000 of those were for group visits, which has been one of the things that has trended a bit slower. I think we're making progress and using our skill and our experience in tele-mental health. But, we have more to do. And our greatest concern, frankly, is not what's happened over the last year or the last month or the last week or even what we're doing today, frankly, but our greatest concern and what we want to talk about with you today is tomorrow. The key issues for us, as I said, are about moving forward. It's not about going back or getting over it or settling back into a routine, but it's really doing the both/and thing. And both/and is a phrase that I use a great deal. It's about maintaining safety and doing preventative health things. It's about providing in person care as well as virtual care, helping our employees to work virtually and to be on site. And the most important thing to me on this slide probably is the next line about how do we achieve and sustain meaningful change now, and advanced strategic long-term goals at the same time and learn to use data in new ways so we can continue to promote and provide access to health care that supports wellbeing in the time, manner and place that is best for the Veteran and serves their needs the best? How do we engage in proactive outreach to Veterans who are not in our system? And either to bring them into our system, or to make sure that they get connected to care and other resources in their community. We have a wonderful workforce in mental health and suicide prevention; that's why we've been successful over this last year. I think, we've had the privilege to support them, but the people working at all our medical centers and clinics across the country are the real heroes here. We're here to support them, and then through that continue to build trust. I'm going to talk about our last slide and then turn over to Dr. Miller for some comments. These are the questions that we'd really like to get your input on today. Again, how can we do all the things that we need to do and must do now to ensure continuity of care and suicide prevention services, but also to kind of move beyond where we are? What is the frontier for us? How do we move into the future and apply all that we know about public health, all that we know about technologies and do that in a way that we can demonstrate and measure success using quadruple aim principles and find that balance between current operations and innovations and strategic planning.

**Dr. Miller**: Pleasure to be with you all and thank you. The Suicide Prevention Strategic Plan has two primary components. The first component is called Suicide Prevention 2.0 and the second component is called Suicide Prevention Now. They come together to create a vision metaphorically speaking, for the direction that we need to head to turn the curve and align with regards to Veteran suicide. Many of you are well acquainted with our annual report and with the data. Veteran Suicide has been about 6,000 annually since about 2008, while simultaneously across the nation it's risen in count from a count perspective, over 40%. There are some anchors of hope that are reflected within our annual report, such as VHA Care Matters. We saw from 2017 to 2018, a 2.4% decrease in VHA Veteran suicide rates, but simultaneously, we saw a 2.5% increase in non-VHA Veteran suicide rates. From 2005 to 2018, we've seen a significant decrease. Statistically significant, practically significant decrease in suicide rates for Veterans in VHA care, diagnosed with depression, Veterans in VHA care diagnosed with an anxiety disorder, and Veterans in VHA care diagnosed with a substance use disorder. We've seen increases in women Veteran suicide rates such that they are at 2.2 times greater risk than non-Veteran women in the American population. But, we have seen a decrease in suicide rates for women that are in VHA care. All this plays into and is relevant to our strategic planning. The strategic planning and the vision that I was referring to is a bit bifocal in nature. There's a component that allows us to see further into the future and there's a component that allows us to see what's immediately in front of us. And that is integrated and streamlined. The “into the future” component of the bifocal is the SP 2.0. This takes what Dr. Farrell described and stated as the public health approach, which means, practically speaking, the full prioritization on clinically based interventions and community-based interventions. The 2.0 plan has a six-year plan for increasing access to evidence-based services for suicide prevention. It also includes a three-pronged plan for the roll out of community-based intervention services and program evaluation therein. But right now, 17 Veterans per day are dying by suicide. What can we do right now to make a meaningful difference as we're simultaneously engaging in the rollout of our longer-term strategic plan? That's where SP Now comes in. You can see in front of you the five planks that constitute the SP Now plan, but the story is a little more important that's behind that. The story is going through the team, me, and asking, what do we have to accomplish this year to turn the curve, to flatten the line, on Veteran suicide? 468 additional lives need to be saved. The follow up question is, how did we do it? What's right in front of us? From that, we apply the theory of marginal gains in view from a public health perspective, and we look for ways where we can make incremental gains and when you put those incremental gains together, we're going to get to 468 lives saved at least. That's where these components of the plan come in and their specific actions associated with the...Dr. Carroll mentioned, frontier language. I think it's excellent that today we have Dr. Clancy, we have Ryan Vega because a lot of our thinking in this area emanates from some work done by, I believe, someone that Ryan knows and they have been in his academic department. But that's for Boise's work from 2014 on frontier versus fortress building, and some of the innovation lessons that can be applied to healthcare across America within the VA and within suicide prevention. That's where the thinking comes in and helps to inform a lot of what we're doing with 2.0 and with Suicide Prevention Now as well.

**Dr. Carroll**: Great. Thanks Matt. And with that, Dr. Perlin, we're ready to listen and get feedback from the members of the advisory group. Again, we're very grateful for this opportunity.

**Dr. Perlin**: Well, first thanks to you and Dr. Miller for your terrific comments and more importantly, the work behind it. We're going to turn momentarily to Jake Crosson. So maybe just a short factual answer on this, and he wrote in chat he was aware of the effectiveness of tele-mental health services, maybe a short answer to that, and I'd like to turn to Dr. Akman for formal kickoff of discussion.

**Dr. Carroll**: Sure, and I wrote back to Dr. Crosson, but I couldn't figure out how to reply all, Dr. Perlin. But as far as effectiveness, I'd start with satisfaction. Veterans have consistently indicated very high rates of satisfaction with tele-mental health care. I think that the most recent data was somewhere around 85% were satisfied or very satisfied with it. Also, data collected over the last year indicated that almost a third, 30% or so, prefer it to in-person onsite care. As far as effectiveness, it's been looked at through several studies, and our tele-mental health services have always been demonstrated to be as effective as onsite care in terms of the delivery, therapy, or consultation to Veterans.

**Dr. Perlin**: Great. I just know that NPA may have the distinction of experience in tele-mental health. Even from my days back, I have to remember the fastest way to reach the most rural Veterans had no access; not only the critical access areas of the continental United States, but even, some of the remote Pacific islands.

**Dr. Carroll**: Yes; it's been wonderful for that. I should also mention Dr. Perlin that most recently I've looked, 97% of all our mental health providers have done one or more tele-mental health visits. It's part of the toolkit that every mental health provider has. It's not a separate service, but it's just a modality and we're eager to apply it across the board.

**Dr. Perlin**: Great. Thank you so much for that. A great question. And then to transition to Dr. Ackman, appreciate the presentation. You're brought in both the components of the self-care for caregivers in both challenging time and a challenging area, as well as the importance of innovation. We hope our conversation to kick us off I'd like to pick no one better than on Dr. Ackman.

**Dr. Akman**: Good morning everybody. First of all, let me just say the VA response in this area is pretty impressive. It really is a remarkably robust response to a very, very complicated matter. And especially given the enormity of this population and the size and the complexity of the patient population. Obviously, I'm in a very high level of looking at what you're doing, and it's hard for me to get into the weeds. I just think, first of all, as you well know, as a backdrop, we're talking about sort of these external trends as it relates to gun ownership, I suspect, which it continues to increase. And I suspect our Veterans are more likely to own weapons and guns, which is particularly relevant to this issue. And that's one of the things I'd like to hear more about as we look at the lethal means safety issue, but I suspect that a great concern to anybody working in the field of suicide and mental health as it relates to our Veterans. Obviously the other huge, external trend is not exactly a trend, it's COVID and the increased rates of depression, anxiety, suicide, and really not only from the fears that come along with developing COVID, but the sense of isolation, which I think many of the studies have found to be particularly problematic as it relates to mental health. Whether it's isolation at home from the community, from your loved ones and even in the hospital I think that so much of the morbidity, the psychological morbidity of COVID relates to isolation. One of the issues, the questions from me becomes how effective is tele-mental health in breaking that down. Obviously, it's going to be somewhat effective and what are we learning from tele-mental health during COVID that we didn't know prior to COVID? What can we take from our experience in COVID to continue to provide top-notch, evidence-based mental health services. In particular, as it focuses on suicide and how effective is tele-mental health in reducing suicide rates. This is where I think really the VA in particular, given the size of the entire operation, can really be particularly useful to the field and helpful to the field once that data starts flowing in. And maybe it already is, to begin to really look at sort of a deeper dive at what's effective in tele-mental health as it relates to suicide prevention. I think as we begin to think about innovation, obviously digital responsive learning and tele-psychiatry health, tele-mental health are going to continue to be important for us going forward, perhaps even more so. Especially as we think about our Vets who are unable to get into actual facilities. So, as you begin to look at all the data as it relates to sort of different populations, different aspects of psychiatric problems, I think that's going to be a particular help to the field of the tele-psychiatry. I was also very impressed with, again, the public health model, issues related to wellness, targeted strategies with different populations. Again, part of the challenge is just the enormity of the population and the complexity. I was obviously pleased to hear that in many ways your efforts are working. As you look at those individuals in VA healthcare versus those who are not, beginning to see drops in suicide rates compared to those who are not, and we're seeing increases. Obviously, something's working and I suspect it's both a combination of the number of programs that you have, but also there are probably specific aspects of programs that are working in individuals that are probably worth knowing about and understanding whether it's those individuals who have substance abuse problems or who have medical illnesses. One of the things that we've noticed at GW in terms of medically ill patients, sort of the different levels of despondency, despair, and depression, and utilizing a set of modules developed by Dr. Jim Griffith called the Hope Modules, where we are retraining our therapists and our internists to specifically address issues of personal agency and hopelessness and begin to help individuals see themselves as more effective. I bet some of your clinicians are using these Hope Modules, but I think what we're finding is that in particular, our internal medicine docs, our primary care docs have found these useful as sort of bedside psychotherapy for medically ill and out of using bedside, that could be in the clinics for engaging patients around their despair, their despondency and their depression. But the flip side is we looked to the VA as really one of the leader’s model of integrated care around primary care and mental health care. So again, the field is learning about treating depression and suicide from the VA in this model. But, that's another area. Again, utilizing something like these Hope Modules into the system-These modules would help in terms of data gathering at a level that doesn't exist right now, but I think some of this particular bedside method of engagement, but could be helpful to the field. I was interested in learning more about the parking garage, how that developed, the parking garage innovation or intervention, and thinking about that. I loved the basic idea. I assume that you were beginning to see people who were making attempts, who were on the campus on site of medical centers who were committing suicide or making attempts. I'd like to hear more about that. Again, this is something that the field can learn from. What I think just in terms of going forward, what do we learn from COVID? How are we taking our lessons learned and utilizing that going forward, in all areas, not just mental health and suicide prevention, but all areas. But I think as your data and your response is showing that it's probably going to be most effective in terms of depression and mental health intervention. Just in terms of an overall response, it's impressive. It seems to me the VA, as a learning environment, a learning culture where there is feedback that's being generated back to leadership about program development, that I have to believe is impressive.

**Dr. Perlin**: No, I think that's a terrific kickoff to the conversation. So many things there, ranging from the context of COVID and lethal means to the role of innovation, digital response, public health model, subgroup targeting, a Hope Model agency, general leadership in this juxtaposition of mental health in the context of COVID, and your question, what generalizes? I particularly appreciate the very specific question, whether the issue of isolation can actually be broached through tele-mental health, which engages to a degree, but not to the extent in real life, there’s also a question about leveraging social media to monitor and engage Veterans who have mental health challenges? Let's get back to Drs. Carroll and Miller, and then let's engage in broader discussion, but thank you so much, for those terrific comments.

**Dr. Miller**: I was just providing some feedback, Dr. Carroll, on the question regarding assessment and screening, so I'll loop back to that. Incredibly rich comments provided there and material. I'll try to progress through them as linearly and thoroughly as possible. Starting with COVID, probably one of the most frequently asked questions that Dr. Carroll and I are pleased to field and respond to is what's the relationship between COVID, Veterans and suicide, and suicide prevention? There are two aspects to addressing that question. There's what we know. And there's what we don't know. What we don't know will be filled in largely by the data that the CDC provides nationwide regarding that mortality morbidity across a calendar year to include death by suicide. And then that data is screened and evaluated for Veteran’s status sent to us and that's where our annual report comes from. In a year or two, we'll have an increasing sense of possible associations between COVID and the data that's available from the CDC regarding suicide rates in the nation and within the Veteran population. In the meantime, the analogy that I've used is that like the old Polaroid picture, where you're trying to snap a photo and you snap the photo, and then you're looking at it, you're shaking it and you're watching it as the image emerges. We're doing much of the same, presently, where we're looking at the picture, we can see the images emerging, we can make some reasonable action-oriented recommendations and conclusions from the images that are emerging. We are deriving our images from issue briefs that are provided from the field VA medical centers to central office regarding Veteran Suicide. That signal indicates that there has not been an increase in suicide attempts or in suicide death as reported by issue briefs. That ends up being about 33% of 33% of the total population once the CDC data comes out. So again, you can see that that's a signal, but, nonetheless, good news. Another signal point is that which is occurring with our VCL. Are we seeing calls go up or are we seeing calls go down? Initially, we saw a tremendous spike. March of last year there was about a 20-25% increase right away. We started then documenting and linking that to COVID specificity. We found that about 20- 25% of the calls were COVID-related and primarily motivated. That number of percent of calls regarding COVID went down to about 5% over the summer and has maintained around 2%. We have seen an initial significant increase, as I mentioned in call volume, but that was also paired with the deployment, the soft launch of 9-8-8. total, we're looking at about a 20- 25% increase in overall call volume. ER visits within the VA related to suicidal behaviors have not increased. High red flag either activation or reactivation have not increased. Putting the signals together, we are keeping our eyes very carefully on this. We are attending to ways that we can intervene, but the signals do not indicate an increase in attempts or suicide death. One practical thing that this has led to for us, we developed a way to flag Veterans in VHA care who are positive COVID and have a high-risk flag for suicide. Through that flagging process to their clinical care teams, we have initiated extra additional outreach and more intensive services to make sure that we're circling around these Veterans during these times. Telehealth in COVID, we're learning that you can do assessment well via telehealth. You can do a suicide crisis assessment well. This has implications to access, staffing and recruiting, which I think will be meaningful. We're learning that you can do interventions well, cognitive behavioral therapy for suicide prevention can be and has studied to be an effective intervention. That's what we'll be doing to help bridge the divide that sometimes occurs to access, geographically. We're learning that you can engage crisis counseling through telehealth and you can take a Veterans crisis line with over a thousand personnel, you can move them from three brick and mortar call centers, and you can allow them to work remotely, so that they are not a risk to each other in that work environment, and operations of 2,000+ calls per day, 100 emergency dispatches, answering the phone within eight seconds or less still happened. That was a tremendous lesson learned for us. And that's going to be something that'll positively impact us with 9-8-8 rolling out in 2022. Lethal means safety: important topic. A few data points to keep in mind, which I think you nicely presented. First, 70% of Veteran suicides are secondary to firearms. Second, over 50% of Veterans who respond report that they own a firearm. Third, 33% of Veterans report safe storage of firearms, while two thirds report that they do not store with ammunition separate from the firearm and firearm locked away. Within our lethal means approach, obviously this is an important factor to consider if 70% of deaths are due to firearms. We are very careful to distinguish between lethal means safety and lethal means restriction. We focus on safety. Under safety, we focus on two categories: clinical interventions and community intervention. There's significant progress that could be made in both, and your feedback and collaboration, both in clinical and community-based interventions would be valuable. From a population perspective, you mentioned that complexity. You're right. And that's why you'll see in our annual report, comparisons and consideration across different segments of the population, VHA, non-VHA, psychological sorts of foundations and bases versus upstream bases and considerations. You saw it reach a point where for the first time we were able to integrate race consideration into our annual report and we looked very carefully at geographical consideration: regions of the nation, urban and rural. In suicide prevention, within that, I think an important thing to keep in mind in population is there are some differences between the psychological aspect of suicide and the upstream consideration. That's where the importance of clinical interventions versus community-based interventions, come in. Finally, hope, this is exactly why we incorporated, under Dr. Stone's leadership, a new section in our annual report, which is Anchors of Hope. It is critically important that you are honest, forthright, and transparent in this subject, but in so doing, you also share points of hope honestly. And so that's where that section of our report emanated from, and we believe strongly in the value and importance of hope applied to suicide prevention. I'll conclude with those comments.

**Dr. Perlin**: Thanks. I see your comments on the initial kickoff have generated several comments. I've got Drs. Crosson, Lee, Fulmer, Mittleman, Meyer, Nuntavong and Kellerman in that order.

**Dr. Crosson**: John, mine was asked and answered, thanks.

**Dr. Perlin**: Perfect. Tom Lee.

**Dr. Lee**: We have a little chat exchange about this, but maybe Dr. Carroll can elaborate a bit. I know it's not the major focus, but caregiver mental health has been a subject of great interest and importance in home care providers outside that the VA can get in touch with, particularly among nurses. When you measure engagements, stress and so on, doctors have had a tough time with nurses and respiratory technicians has been difficult. I'm wondering, what are you seeing and what special measures are you applying currently to try to support caregivers as they go through a very difficult time.

**Dr. Carroll**: Yeah, thanks Dr. Lee. And as I said in the chat, I think this has been part of our public health approach. I think we've been trying to look at employees, staff, clinicians, especially those working in emergency departments or intensive care units, as well as family caregivers who may be at home and feeling very, very isolated. So I think we have put together a toolkit for caregivers, a toolkit for our employees, as well as support for how to get comfortable wearing a mask, for example, how do you manage your stress and anxiety during the pandemic, both from a patient or family point of view, as well as from a clinical point of view. We could have a long discussion, but in the interest of time I'll just say one more thing about this, but there's been a very robust response across VA. We've worked with our colleagues in emergency medicine that have a twice weekly talk show, if you will, to support providers within the VA, work with our whole health colleagues that are putting out weekly living Whole Health blogs to employees, work with chaplain service and certainly to provide support when an employee dies, not only to the family, but, but to the community. So I think this has been very gratifying to me personally and professionally to see how I think we've come together across the organization to really think and act intentionally, both for employees, clinicians, as well as family caregivers who are facing much more difficult stresses and great to see that now we're going to be able to help family caregivers with vaccinations as well.

**Dr. Perlin**: Thanks for that. As a transition, just to note, I can tell you honestly, I used to think the quadruple aim of introducing caregiver’s self-care was self-indulgent. I no longer feel that way, I think the stresses on the caregivers, the juxtaposition that's really the subject of this conversation between the isolation and risks and pressures of COVID, along with the mental health issues. Just to be very clear about this, this has some of the social determinants that are disproportionately represented in the Veteran population that uses care. It's really a potent conversation and one that takes a toll, not only context for Veterans, but for the context of the care providers.

**Dr. Mittelman**: I'm amazed the technology works. First, congratulations, this multi-faceted program is fantastic. I was concerned, I didn't hear any mention of social media in your communication plans. You're dealing with multi-generational Veterans, I suspect, and so they all have different modes of communication, both sending and receiving. I'm curious as to what you're doing to both monitor the social engagements on social media, as well as pushing information out. There's a lot of false information that might in fact be out there.

**Dr. Miller**: I was unfamiliar with the term paid media before I joined the VCL, but paid media covers that outreach that you engage in a planful, strategic way in terms of messaging. It also includes as a vehicle, social media. On the slide where we were talking about SP now, number five under SP now that's paid media. The plan, regarding paid media right now, we're focused on three campaigns. We have a campaign specifically addressing increased awareness and engagement of the Veterans Crisis Line. We have a campaign focused on “Be There”, and it's really designed to help Veterans and family members and the community understand the importance and value of so-called small things within suicide prevention, as well as to provide them with some links to some important tools, such as how to start the conversation if you're concerned. The third campaign focuses on lethal means safety. This is a campaign that has a segment that's addressed to clinicians and care providers. It has a segment that's addressed directly to Veterans. It has a segment that's directed to caregivers, family members and the community. We track our paid media progress very carefully. Really what we're watching for, however, is how the metric demonstrate a movement from awareness and indices of awareness, to engagement into our suicide prevention, resources, and activity. I've shared this story with Dr. Clancy and Dr. Carroll, and I'll share with you real briefly the importance of paid media and moving from awareness to engagement. Someone mentioned in the chat, a behavioral health autopsy. Yes, we do them. We, we do them for Veterans in VHA care and engage a very thorough review of medical record, family interviews and the like. I was reading our last behavioral health autopsy report, and I was reading about one in particular Veteran who died by suicide, and in the report and his situation, it was talking about the fact that a pair of jeans...inside the pair of jeans was a card and the card was the VCL and the VCL number. And that really hit me hard in terms of you can be aware, but do you engage? And really our paid media is focusing on the Veteran population on ways that we can increase and convert awareness into that engagement. I hope to not read another account of the card in the pocket, with the Veteran, not with us. Social monitoring, I'll conclude, a tricky area. Ethically and legally we are not engaged in active social media monitoring outside of .gov resources and website. There are many ethical and legal questions regarding doing so and any opinions are very much welcome.

**Dr. Fulmer**: I know that the very nature of VA care is so much more empowered to have continuity of care across settings. Your nursing home experience during all of this is something that I'd like to read more about, so if you can chat about that. Also, racial disparities in what you've examined during this time around mental health would be helpful. And I'd just be happy to read whatever you might chat in.

**Dr. Meyer**: First and foremost, on behalf of all Veterans, thank you for all the amazing efforts that you folks are making. I would also note, I just lost a staff member to a gun suicide last week, and the materials that you have on lethal means safety, on the web, are terrific. And I never saw that before until after I got the pre-read and I looked at it considering this event that I had happen last week. just think getting the word out about that, about what you have there, you have a great podcast, you have great slideshows. It is a terrific set of materials. My quick question for you to answer at the end is, I'm blown away by the variety of programs that you have, and the segmentation that you have, but what I wonder is, it looks like there are literally a thousand flowers blooming trying to address this incredibly tragic problem. And the question is, how you systematically evaluate it, because at some point you've got to prune the garden and see which ones are really going to be working the best. I'm just interested in the evaluation built up behind all those programs in the pre-read, and the pre-read was terrific so thank you.

**Dr. Prescott**: One was just the number of Veteran suicides per day. Again, it was answered in there that the number is 17. But for a long time, I'd heard 22. A question about how do you get things from the field? Your counselors, how do they raise an issue, or a project, or a solution, or what they might think gives a solution to a particular issue? Because this seems very top down. And then last thing was, again, just to follow up on the comments that someone else just made, lethal means safety was a brand-new concept to me until I did this reading. I'm an emergency physician, been following the VA, and I didn't know about this, until I read about it, and then. It's incredibly important. So, thank you, but again, I just had never heard about it, and not that I would be the one that should, but it wasn't out there for me.

**Dr. Sandy**: I really love the comprehensive approach. My only suggestion was could you involve Veterans and caregivers in bottom-up innovation, a hackathon approach. And it looks like you're already on that. I think it's even like a focused area, particularly in lethal means safety, given the data that you presented would be an area to explore.

**Mr. Nuntavong**: Yesterday, SECVA was asked by Congress, is there a way to get data at a more rapid rate? We know that we're two years behind on suicide data, and I think in order to move forward, especially during times of COVID, if we can get the most recent data, it would help better assess the needs of the Veterans. And then my comment is that tele-mental health, it works, when people have access. The folks in rural locations don't have broadband access, and tele-mental health doesn't work when you're out in the rural locations. There's also a situation where sometimes Veterans may not feel comfortable on this site talking about suicidal ideations in their home, where a family member may be able to hear the conversation. There may be some reluctance to do so. I know friends who have called the Suicide Veteran's hotline from their car, which is probably not the safest location for them to be at. So, wanted to know if VA was looking into accessing those Veterans in rural locations. And I have a list of questions that I can bring them up another time. Thank you.

**Dr. Kellerman**: Thank you Dr. Chairman. One observation and a couple of quick questions. The observation is there are very few silver linings with COVID, but one, I think, has been our health systems shove into embracing telehealth after years of dragging our feet. And that goes for payers as well as healthcare providers. And along with that, the fact that, I think, we now have a generation of up and coming residents and students who are going to be much more comfortable with this modality than they would have been, but for the forced experience of the last 12 plus months. Second is a question. One technology we haven't really talked about much today is digital screening of patients, say primary care or otherwise. Whether it's on the web, or you're in clinic and you’re handed a tablet to screen for both behavioral health issues, as well as physical health issues. I know there was some work done some years ago in emergency departments that showed that patients are more willing to disclose to a touch screen computer, or a tablet, than they are to even licensed mental health social worker. There's something about that face-to-face stigma that people feel a little more comfortable. Maybe it's a generational thing, but to what degree is that embraced or being looked at in the VA? And then third, we've talked a bit about this, but how are we doing, or how are you all doing with a handoff of new Veterans that are coming out of active duty into the VA, which are clearly a group that may have significant experiences, and has kept it bottled up in the military health system, and now transitioning to the VA system? I know for example, having been close friends with Howard and James Summers, their advocacy for the whole concept of identifying a network of support, and handing that over as well as the new Veterans themselves.

**Dr. Perlin**: And Jeff that comes back around to you, as a question to put on the table, but also as I move to Drs. Carroll and Miller, just to take stock of the points that have been made about nursing homes, rural disparities, scope of programs, need for evaluation, more detail on the lethal means safety, kudos for that. The bottom-up, hackathon approach, data challenges, the constraints of home, and the context in which a Veteran may try to respond, as well as broadband. The capacity for digital screening. Dr. Kellerman remembered that accurate work on that at Walter Reed, finding that service members and other eligible individuals, would indicate in that, but wouldn't indicate in a live interview. And the unique challenges of new Veterans.

**Dr. Ackman**: I really want to, again, compliment folks at the VA for all of your terrific work, and what you continue to learn, and put into practice. And I was also struck by the anecdote about the Vet with the phone number in the pocket. The notion of what do you learn from each individual suicide? How can that lead you to implement something new in terms of practice? And that's very helpful to hear about that. There's so much on the table about COVID and guns, and social determinants, and public health. I think about what we as a country learn from VA efforts, VA health efforts in this area. And thinking about what's happened recently in Atlanta and Boulder, and the notion of gun violence as a public health issue, which tends to be for some politicians, sort of a third-rail discussion. But I'm really pleased to see how the VA has thought about tackling this in terms of gun safety versus gun restrictions, because there's probably not another sub-population in the country that is such at risk for suicide by gun violence, as our Vets. And I suspect that as the system, and folks in the system, continue to drill down and learn more about those 17 Suicides a day, that again, one of the gaps tends to be, what's not in our control? Which of course there's a lot that's not in our control, but again, of those 17 a day, at the 70% or whatever, that are due to firearms, how do we focus even more of our efforts on that link between the firearm and the suicide? I just commend you on your efforts. And I suspect this is where a lot of your focus continues to be.

**Dr. Perlin**: Thanks so much for that Jeff. Drs. Carroll and Miller, in the last couple of minutes, I know it may not be possible to expand in detail on each of the line items, but anything you want to highlight in closing comments?

**Dr. Carroll**: I'll jump in and I'm going to leave time for Matt, but I think we really appreciate these comments. They align with several things that we're already doing and give us some additional ideas for things to do. And some opportunities. We do have systematic evaluation built into our Suicide Prevention 2.0 and now plans. I'm just going to hit a few things quickly. We continue to work closely with DoD on the transitioning service members, and are looking to do more in that regard, and with the recent legislation we're going to have some more opportunities for that. And the bottom-up approach, I think trying to learn what's working well in the field and then spreading that rather than just relying on a top-down approach, that's important. And the last comment I'll make before turning to Matt is I want to underscore the importance of, and our commitment to look at racial disparity, health inequities in general, looking at our data to ensure that services are equally available to all, that any trends, in our death data, that is an important part of it. And certainly that's been an important part of all of our experience over the last year, is really our healthcare systems have really stepped up to address racial equity, diversity, inclusion, and unfortunately there's much more to do in that space. But with that, and we're committed to do it, with that I'll give the last word to Matt.

**Dr. Miller**: Number one, I made a mistake. At least one an hour, a much higher rate. The mistake I made was a miscommunication regarding top-down versus bottom-up. Perhaps I presented as if these are good ideas from me. They are not. Our ideas and plans come from the field. Our implementation in SP 2.0 of Cognitive Behavioral Therapy for Suicide Prevention comes from Ann Arbor, and pilot studies they did across VISN 10 regarding that the outcome. Our implementation of a vet-to-vet-based outreach program in the community, under community-based interventions in SP 2.0 comes from the Together with Veterans Program, and was implemented boots to the ground. It’s really bottom-up. And I apologize if I made it appear as if I am the originator of the good idea, I am definitely not. Number two, data. Really good point made about that. It was raised in the hearing. I just want to emphasize, I think you need two types of data under surveillance for suicide prevention. We need the CDC data. We need the data that is the highest reliability and validity, and that takes time across 50 States and U.S. territories to gather. What we don't have, and why I think we see gaps, is we do not have a good early warning suicide surveillance system across the nation. We need to add to that longer-term picture from the CDC a comprehensive early warning surveillance system across the nation. Third, and final, how do we pick? I sat through a presentation last week where I was literally given three pages of correlation, coefficients for death, suicide, and outcomes. And I sat there thinking, "What do I do?" I can't chase three pages of itemized things here. We look at the data. We look at taking the biggest impact possible in the most actionable ways. And we look at change innovation processes, such as an aggregated approach to that, outlined in the article that I highlighted at the start. Do we have more to learn? Yes. And happy to continue to receive your input on that. That concludes my comments. Thank you.

**Dr. Meyer**: I would just say that I think that, again, as mentioned earlier, there are such a wide range of programs here. And I think that there's been such an incredible segmenting of the population. But my sense is that some of these are surely more successful than others. And I do think that building in that robust evaluation capacity with all of these is important, and my sense, and Drs. Carroll and Miller, you can correct me, there was such a demand for new programs, because of the crisis here, that thinking about evaluation up front may have not been top of mind at times, but now it's the time to, I think, to really start to build in that capacity. And I do think bringing a standard methodology across evaluating different programs, would be really, helpful.

***VHA Recapitalization Strategy***

**Dr. Liebermann**: I would like to echo my appreciation for Dr.’s Carroll and Miller and the whole team and really all of our staff across the country, our suicide prevention coordinators at every VA facility are as busy as any of our staff are across the country. Even though we’ve mostly been hearing about COVID, this has been our number one clinical priority in our organization for years now and continues and again I appreciate all the hard work that’s been going on in the background, so thank you. So, moving on our next topic, which is about VHA Recapitalization Strategy. For those of you who have had the opportunity to go through the prereading, it is rather striking how aged our facilities are, with having a total of 111 facilities that are 50 or more years old. We have been planning and thinking a lot on this topic and we’re really looking forward to presenting to you and getting your input. Leading this discussion is Ms. Debra Kramer. She’s just fresh off of testimony on the hill this week, and she did a great job with that. She has been serving in our role as Acting Under Secretary for Health for Support in Veterans Health Administration and she’s actually the first individual who has officially served in that position, and we’re really appreciative for her leadership.

**Debra Kramer:** Thanks Dr. Liebermann, I appreciate that. Good morning everyone! Just as a preface on why this discussion is coming up. You’ve probably read news of the 3 trillion-dollar Infrastructure and Jobs Act that’s forth coming. Within that infrastructure act, we don’t know what the size it is going to be yet, lots of discussion yet to come. There is opportunity for VHA to recapitalize some of our aging infrastructure. We have plans for short, mid and long term, but what we’d like to do today is ask all of you to step into your respective time machines and step forward 10 years. What we don’t want to do is do what we’ve been doing today in terms of designing our new facilities. So, when we look at the longer-term replacement of our infrastructure, what we want to talk about is what health care will look like in 10 years. We’re going to join by two people: Dr. Kam Matthews, I’m going to step aside and let her take this seat for a moment to let her lead this part of the discussion. We’re going to start on what healthcare looks like in the future and start talking about the infrastructure and predict what it would look like in the future.

**Dr. Matthews:** I think this is probably one of the more exciting conversations that I have had the privilege of being a part of. In my prior role with Community Care, I did serve as the three-way co-chair of Market Assessment Health System Optimization effort, which essentially under Mission Act and prior activities, we’re determining what the future footprint of our health system looks like. It's been several years in process and we're still really working through assessments of our 96 markets across the country and there's a lot of room for, I would say, positivity and innovation, to be honest. As we really think about what should our footprint look like and indeed, should we limit ourselves, arguably not given even our prior conversation, to a physical footprint—That there is an even broader perspective that we perhaps need to be projecting with regard to delivery models—How does virtual care factor into that and also, does VA care even need to continue to be within VA walls? That's actually one statement that we've regularly raised. And then of course optimizing that ratio between services to reach all Veterans. And of course, our current physical footprint is not able to do so while ensuring access and high-quality care for Veterans. As Deb and actually all of us are faced with this more immediate question if we are really looking at infrastructure and potential more immediate question of how can we analyze our health care system, the question turns to our current footprint and how we actually might modernize. Deb described, and it was on the prior slide, just the, I'm sure actually some of you even experienced it, but just the reality of the status of affairs of some of our facilities, whether it's cosmetic versus actual plumbing and physical construction issues on some of our facilities really clearly speaks to the need that we need a revitalization in many affect around the country separate from us even then carving out what should this look like with regard to the market assessment. So, I think that conversation today really, that we wanted to learn from you and really have a dialogue about is as the question stays on the screen in the next 10 years. What are we projecting? How are you in your own health? How should VA be looking at their own health care delivery model? What sort of factors, clearly the obvious one of the past 15 months is the pandemic, but what else should we be anticipating an appropriate response to? And then really when it comes down to being, continuing to be, that we have in healthcare, how can VA continue to push innovation, where should we be exploring opportunities that allow us to push that margin, deliver quality, but also improve access to Veterans and not just but not just focus it in those urban centers—not just focus it around our academic affiliations? We need to have a broader approach clearly with the increase in ratio of rural Veterans, and so I think our historical approach to where our physical footprint is right now no longer is sufficient and calls for an enterprise strategy of how we answer all of these questions so I'd love to hear thoughts, approaches, where you see VA going, where you see really the future health care delivery going over the next 10 years and how VA can continue to take the lead in that.

**Dr. Perlin:** Exceptionally important topic with a juxtaposition of multiple courses. Just to offer perspective between the infrastructure opportunities you alluded to, the age of the footprint, and the question of a complex delivery model of the future, and how outsiders like COVID that may change, as well as digital. The role of the VSO is so critically important in formalizing the voice of the Veteran, so appreciate Chanin making the first comments.

**Mr. Nuntavong**: We look forward to seeing the market assessment and hopefully contributing to the Air Commission on decisions made on the VA infrastructure. I think us as Veteran Service Organizations, we've seen a number of Veterans seek VA care, especially during times of COVID either because they lost the care that they previously had privately or that they are seeing that VA care is a much better option for them and their healthcare. I think over the next 10 years, we'd love to see more specialty care directed to VA and possibly more the primary care functions moved out of that because the VA infrastructure is best suited for specialty care, things like MST and PTSD and these chronic brain injuries—things that are very associated to military Veterans and their conditions. We think that VA rural care is vital and getting care to those Veterans out in those rural areas are very important, you know either through CBOCs with military installations or community care. As VA does and continues to do a great job being the top tier provider of health care, you're going to see more and more folks seek that from VA. So, I think, you know, you’re doing a fantastic job and we just want to make sure that Veterans everywhere have that care that they need, so thank you.

**Dr. Perlin:** Some things to throw in the mix are not only, what is the delivery care model, but, you know, VA has four statutory missions, in addition to caring for Veterans—research, academic, backup to the country in times of disaster, so I feel like I am making a good segway to Dr. Prescott.

**Dr. Prescott**: I appreciate this presentation, Dr. Matthews and I just think that again, how will education change in the future, how will research change in the future, are all questions that will need to be asked as you're looking at the infrastructure too, and again, it's not just the buildings—It's the people that are going to be staffing. That are going to be out there and any affiliations are critically important to success for the care of the Veterans and the research that's ongoing in the process. So again, just how are they going to be changing our questions and what is the impact they will have on the multiple missions that the VA has and that was the only comment/slash question.

**Dr. Matthews**: I appreciate the conversation and remember having a conversation about just this point with Dr. Clancy in early 2020, acknowledging the importance of our affiliation agreements and needing to assure true partnership in maintaining our mission with regard to education and research, but at the same time, part of the conversation needs to explore the future of our graduate medical education system (requirements related to inpatient/outpatient services, across any given specialty, how is the entire academic sector looking at the future of health care delivery and how, particularly, resident physicians are being trained, considering the anticipated changes in delivery models (virtual care, but there not necessarily being that formality around training for virtual care, outpatient, correctional medicine, etc.). There’s a lot that could be addressed via collaboration with VA and even in regard to training to how requirements are set.

**Dr. MacDonald**: Dr. Matthews’ comments—One of the things we've been thinking about deeply in VA is how we approach those four missions and aim them toward a common target if you will. Start with and begin with the end in mind and really think about this as a people-first endeavor. How do we understand the Veteran and caregiver and their families and survivors—all of these beneficiaries? How do we understand their needs from an individual and population health perspective and then how do we aim our missions towards access and outcomes for them and carry that back, if you will, into infrastructure, and tying those together towards that common aim is something we believe is really important. Certainly a complex endeavor and one, as was just pointed out, with many stakeholders involved, including our academic affiliates who are critical partners for us. They are critical partners, as Chanin has mentioned as well in rural areas, as the more innovation and academic experience an advancement opportunity we can create in those areas, the better recruitment and retention that have. So, again, beginning with our stakeholders in mind beginning with Veterans and mind and our service to them, one of the things we're really contemplating and would love to hear from this esteemed group on this is how we aim those missions how we aim our initiatives and ultimately infrastructure toward that end?

**Dr. Meyer**: First of all, I want to just acknowledge the fact that this is an incredible, unprecedented opportunity to be able to really rethink structure/how we deliver health care. I don’t know of anything on this scale–maybe our California Seismic Rebuilding was something that was like this size, but this is really a huge, huge, opportunity, and I guess experience to learn from the California Seismic Rebuilding—What to do, what not to do. I also think that there is a tremendous opportunity to really think about the way that the health care is getting virtualized. You know, what we know from work in my organization looking at 2030 is that there will be a virtual care everywhere. Digital experience and navigation is going to be really important and there’s going to be a lot of disruption by non-traditional players in health care, and thinking about how we construct this new system around those future modalities is great. And finally, how can we make this work with other initiatives of and, in particular, ensure that this new structure is going to be green and whether or not there could be a very strong preference with the construction/contract being steered toward Veteran or Veteran-owned organizations because that would really, really, help out the Veteran community. Thank you!

**Dr. MacDonald**: I think this is so essential, Dr. Meyer that that we think of not just what we’ve seen before, but what is possible in the future and look to what the normal may be 10 years from now by the time it takes us to get any new construction or other endeavors implemented, whether telehealth will be the default in our operation and how that can imply more equitable access, more extensive access, a greener system, and how, as you pointed out, that we can really make sure that as this enormous endeavor, really the future of American health care, that we can be sure that it is directed towards the benefit (service disabled, Veteran-owned businesses) of those who have the most stake in the system and to the benefit of the communities who may need this growth and this type of investment. Complex area. We believe this is going to require the esteemed brain power of this group—Really the power of the whole of government and really strong and robust relationships across strategic partners and the private sector as well. Thank you for raising this, it's certainly the direction we’re thinking in.

**Dr. Crosson**: I realize I have two comments. I want to respond to Dr. Meyer. Based on my years with Kaiser Permanente, and as you say, we had a mandate from the state now some 25 years ago or so to retrofit our 30+ hospitals in California which we began to do about 20 years ago. If there's a lesson from that, I think it's in the area of do it now so we jumped in we can talk about funding sources maybe in a minute or two, but we jumped in with both feet and got going very quickly replacing hospitals that need to be replaced and then retrofitting others that could be retrofitted—I think well beyond some of the other hospital systems in the state and it turned out to be a scary, but good decision because, as you probably know the cost of infrastructure building, whether the retrofitting or complete replacement, has done nothing but go up and it's continuing to go up, so if there's a lesson there from our experiences, it is do it now as much as possible. My second comment has to do the long-term assessment of in person visits (brick and mortar) versus virtual visits and how that's going to play out overtime and of course, we don't know. We know that it's going to change post COVID. I think one element that is important to keep in mind in analyzing the trends that we're going to see is how the visits are paid for because I think we're going to see a divergence we already have. We did really before the pandemic between settings where essentially we have a population based payment system or a capitation or a salary system for physicians and in that setting, largely, the use of virtual visits can be viewed as cost saving, as well as the other attributes that contribute to that whereas, I think in the fee-for-service environment ,where this is going to be tracked also we're going to have more of a contentious situation as we try to understand whether in the fee-for-service world, the use of tele-medicine is substituted or additive, and so I think in terms of thinking about the VA and its future planning, it would be important to think about where in the system, essentially, it looks like telehealth may be a cost saving and additive and where in other settings, based on the payment to physicians, it could be just the opposite. And I’ll end with a question, which is a little bit off base in terms of the discussion list we had, but it has to do with where the money for recapitalization might come from. I understand that the infrastructure bill that we're going to see potentially this year is one source of that, but I've also wonder, and again this is based on my prior experience at Kaiser Permanente with our recapitalization work over the last couple of decades, is there an opportunity for private placement bonds? It's going to be a demand I think for fixed income opportunities going forward it appears, and is there such a thing or could there be envisioned a source of funding for the recapitalization of the VHA through some sort of private placement bonds? Thank you.

**Dr. Mittleman**: As you are getting ready to look at partners and develop partnerships, whether private-private or public-private, it’s going to be important. I know you're thinking about this, but there needs to be a conscious effort to assure that you're maintaining a clear VA presence so when Veterans are seeking for care, they feel comfortable with the culture. You see that in mental health and other venues. So as you reach out, it’s going to be really important that the Veteran feels comfortable, whether it be a virtual environment or whether it is brick and mortar. MHS is going through a huge metamorphosis right now. They're restructuring. What do they look like for GME purposes, readiness purposes? This is a wonderful opportunity for the largest health systems in the country primarily to start working together. I don't know at what level this is occurring or if it is occurring at all, but I think that's something that you really need to be looking. We've got great opportunities and examples, but why not think about doing something with the military, as opposed to just VA?

**Dr. MacDonald**: One of the first pieces of your statement about really making sure that Veterans still understand that they're coming to VA—that they're coming to a place that they know and feel welcome in and is familiar. If I can boil that down to a word, I think it’s trust. And certainly, that's how we need to lead forward. There's going to be potentially an enormous amount of change here and if we do that on a foundation of trust, alongside federal Veterans alongside, our employees and our strategic partners, then I think we advance the whole-of-American healthcare. But this can’t be, to your point, a VA-focused endeavor. This has to be an outward, trust-centered, really open and transparent endeavor and this is where we will certainly need the input of our Veteran Service Organizations, of all of you, and certainly of our key interagency partners. This is an open conversation with the Department of Defense and also the Indian Health Service about how the critical assets hospitals, about how elements of the federal system could come together to really a synergistic model. Those conversations are beginning and more to follow, but certainly a key element of the consideration.

**Dr. Matthews:** Appreciate the recognition of making sure that Veterans understand and trust what services they are receiving. I think the challenge that we are willing to accept and explore is, how do we make sure we match those services, provide care coordination to meet the Veterans where they are versus them coming to us? I think there is plenty of room to explore a larger federal approach (not just VA). I think the other piece that needs broader exploration as well (in line with virtual) are home-based services. We have a strong history with our home-based primary care. If you couple that along with caregiver services, opportunities, and partnerships that provides to what VA provides as a whole—Thinking outside the box to meet Veterans where they are to meet their needs—is so critical.

(Dr. Stone arrives from a media event at the Memorial for Women’s Veterans at Arlington

and Dr. Perlin recaps points discussed thus far for him.)

**Dr. Akman**: I am going to address the issue facilities because I have a feeling that the sort of the challenge between sort of the individual priorities of senators and the overall strategy the VA is going to look a little bit like a combination between Lord of the Flies and Hunger Games when the legislation gets to the Senate to sort of look at overall recapitalization strategy for the VA versus individual senators getting their earmarks, which I guess are now going to be allowed, so good luck with that. What I really wanted to look at is 10 years into the future as it relates to health care has to do with the health care disparities and we've touched on this. Dr. McDonald talked about the people-first endeavor and how we think about sort of the components of that. The whole issue of equity is so important to President Biden and his administration, that it seems to me there is a real opportunity here to think about, in particular, the piece of that disparity issue that actually, I think John Prescott touched on, has to do really with the health care workforce and how that diversifies over time, as well as the leadership of VA centrally, as well as regionally at different locations around the country, and I think that we know that, on the one hand, you know less than 3% of black men enter medicine or make up less than 3% of all positions in medicine, so we have a challenge is this sort of the pipeline side bringing a diversified healthcare workforce to the table, but it seems to me that few organizations or institutions have the opportunity to make a difference in health care workforce diversity as the VA does and thinking of itself not only in terms of its education mission, but in terms of the relevance or improving health disparities by diversifying its workforce. And there's plenty of data to the looks at that issue and I think there's an opportunity here and again, I don't know what I don't know in terms of what's actually happening within the VA on this issue, but when I looked at how robust and complex and thoughtful the response to mental health, depression, and suicide is in the VA and how many different ways of thinking about addressing this problem, I think you have an opportunity to do the same thing as it relates to health disparities and the workforce, and you know, begin to truly look at, what's the goal in 10 years as it relates to a diversified workforce, as it relates to reducing health disparities within the VA, whether it's around social determinants, etc.? But there's an opportunity here and I think, in particular given the administration that we now have and the importance of these issues across the entire organization, across the entire government I think you probably could put a pretty robust package together in the infrastructure bill that relates to this issue. And maybe we are already doing that.

**Dr. MacDonald**: This couldn't be more important. Thank you so much for raising it and this is in line literally and I think many of us in the room when we say “people first,” what we really mean there is that we have to design it in a way that is on its fundamental foundation an immutable foundation of diversity, equity and inclusion, and I completely agree that there's an opportunity here for us to look at how that plays out and how that operationalizes within VA, how that translates into our virtual and our physical infrastructure, but also thinking about ourselves and harkening back to the comments about the interagency in our strategic partners, how we do that in a whole-of-government way and think about the impacts of our decision time on communities and in places where there may not be excellent access to health care, and that may mean access to technology for access to health care, in part. Thinking through this and really keeping this on that foundation of diversity, equity, and inclusion is pivotal and central to our thinking on this and would love to ask anyone else if they have thoughts on this.

**Dr. Stone:** As I think about the structure of this system that grew up in the 1940s with the primary focus being on the academic affiliations, put a VA hospital every place there is an academic affiliate so that we could recruit and retain the best of American healthcare. The question you begin to ask is in the next generation. As we recapitalize, is that still a valid strategy? When I look at the nature of retail giants, of somebody like Walmart that has spent their entire time looking at where are Americans? How do we reach into retail deserts? We all recognize that there are health care desert cities. We are specifically in Kansas City. We are trusted in Kansas City because we're part of the community and therefore when you think about equity and diversity and inclusion, black male Veterans in that community are taking their vaccines at some of the highest rates in the country. How do we preserve those relationships while we get ready to recap? How do we then preserve our workforce/academic affiliations that drives much of our research? Are America's universities still in the right spots? Are the medical schools? Is the strategy that Dr. Hawley really grew up in 1946 to 1949 still the right strategy as we look forward to a future recapitalization? But it all comes back to meeting the Veteran where they are and reviewing the equity and inequity issues of America's health care systems as they exist today.

**Mr. Taubman:** As someone who's not worked in the VA throughout my career or even academia, and now working for malpractice insurance carrier, I'm fascinated by the conversation and I think there might be some lessons from business that we can apply to the VA, and I think the concept of trying to figure out if we're trying to build this from scratch, would we build it the way it is now? And I think most of us would probably say no, we have to do something different. And I think about using destructive theory types of things to break down the individual components, whether disparities or some of the other things that we talked about to address those things. In my industry, a lot of work going on that that are finding small solutions to an individual problem that then you can aggregate with other solutions to leverage and get ourselves there, so that's one thought about if we're going to compete against ourselves, how do we disrupt ourselves as a lesson in trying to move forward? I think the comments, specifically that Dr. Stone just spoke about, you have to be talking to your customer, your/our patients, the Veterans that are using the system. What do they want? What do they need? How do we meet them where they are? That’s central, but more specifically, I wonder what initiatives and opportunities are going on in the non-clinical aspect of the Veterans Administration that create cost savings, especially things like leveraging remote work and things like that that end up allowing the infrastructure costs that are nonclinical to be decreased that can be repurposed into recapitalizing the clinical areas, and I’d be interested if there are initiatives going on in those areas?

**Dr. Stone**: Because the VBA (Veterans Benefits Administration) is primarily working remotely, there are efficiencies in the fact that their workforce is completely distributed. How it would affect the delivery of care for our Veteran population is difficult to really anticipate. They have moved towards a lot of remote based comp. and pen. work, and so that compensation work that they do remotely, I think goes well. I think our difficulty is trying to understand what is future of health care? I missed the discussion this morning with our mental health providers. I am not sure mental health will ever go back to face-to-face visits. It will all be technology-enabled in our systems and delivered from the comfort of your home, which I think draws in people more effectively, but there is clearly the need to be able to deliver face-to-face and hands-on care in especially the highly technical portions of health care delivery, and as we think about how we do that and move from very complex facilities to more effective outreach with smaller facilities that are technologically enabled to deliver the diagnostic capabilities that we’re going to need for the future, the question we're trying to answer is: What does a hospital without beds look like? What do hospitals with short stay beds look like? Where do you put them? How do you effectively respond to an emergency in America that might take down portions of the community healthcare system where you have to bring in mobile assets and fold them on which immediately requires that you create oxygen and gas delivery and all the things that get into the higher cost delivery systems. As I think about maximizing out point-of-service delivery that does not need technology-enabling, clearly our ability to use various sensing devices for the future will go a long way. What we will discuss later in some of our innovation work that will continue to reduce our need to be in the presence of a patient. But, there will still be a need for facilities to deliver a lot of the hands-on technology that medicine can deliver.

**Dr. Perlin:** It is quite apparent the number of contingencies: The model of care, the model of work, the social/environmental context is extraordinarily broad. The challenge you have operationally is to find out where you have to focus/simplify. Forecasting the future is very difficult. We’re going through that exercise in our org. Two major threats are care model transformation (What does it look like? Where is it?) and digital transformation (Digital intelligence, automation, patient/caregiver journey). We share this challenge.

**Dr. Pollack**: This is a very interesting discussion, good to be with all of you today and as you referenced in the paper and in some of the comments, those of us in the private sector certainly welcome the opportunity to continue to build on the partnerships that are already in place and certainly want to step up and help you in filling any gaps in terms of access. John this reminds me of some of the discussions we've had in other venues about redefining age because that's exactly what we're doing here in terms of hospitals and you know, we can all stipulate that you know we're always going to need the building for doing you know doing emergency care, trauma care, sophisticated diagnostics and sophisticated surgeries, but clearly to the point that Dr. Stone made, you know, we're moving to hospitals without walls in some respects and the thing, when I hear all these discussions among hospitals and health systems, one of the key things of course, is what is the demand for the service? What is going to be the big demand for the service and then you structure obviously the future infrastructure around what those services are going to be, and what we see in the research at least, and then the data, is that there's going to be such an incredible demand and resource consumption in the management of chronic conditions and that's where we're going to end up spending an awful lot of resources and that takes you to ok, if that's where we're going to spend resources and the need is going to be, how do you construct the system around that notion? I'm just curious if in the VA system you see that same pattern in terms of where the need and resource consumption will be. I might add, somebody used the word essential hospitals or essential access. The interesting thing about this notion is that we have roughly 1500 critical-access hospitals in this country, 25 beds or less and what's interesting is that you know, the management of chronic conditions, people don't need to leave their community to get that service—they don't have to. And people don't want to leave their community by and large to get service and it creates a whole different set of opportunities and I would also just throw into your thinking, you know, Congress in December in one of the many COVID relief bills, they did include an interesting item championed by Senator Grassley called “Rural Emergency Hospitals” where it allows these critical access hospitals actually to have a capacity without an inpatient capacity and it allows them to transition to a whole different model of providing care in rural communities that builds on this notion that the management of chronic conditions is really going to be focused. So I am just curious if you have that same issue within the VA structure?

**Dr. Stone**: We absolutely do. Remember that by the end of this decade will move from 1.7 million Veterans over age 75 to 2.8 million veterans over age 75, so we are actually caring for more than 200,000 Veterans in their homes in what we call the “Choose Home Initiative.” And as wonderful as that is and it's where I have said over and over again I want to be cared for as I age is in my home, it costs us a little over $125,000 a year institution-wise for a Veteran in a chronic living facility. It costs us between $25,000 and $30,000 a year to care for Veterans in their home. Even as robust as those are. I think the second issue that we're dealing with is it is the progression of diseases of obesity and diabetes, resulting in renal distance and we spend about $8 billion annually in the end-stage renal disease. Therefore, we're in a very active partnership with a company called Virta Health looking at a behavioral modification in their reduction of the progression of diabetes and specifically, we've taken about 500 Veterans who voluntarily come into the program. We do behavioral counseling with them using electronically enabled devices and have been shown that about a year later, about 50% are off of all their diabetic medications and it's really about behavioral modification, not about that we have brilliance in some special diet. It really is having a partner present that reduces the need for potential comorbidity interventions.

**Dr. Trautman:** Thanks so much Jonathan and again, I appreciate the opportunity to be here and the conversation is so important as we consider the future. I think of another quote that I would like to share in that is in the book of “The Future of the Profession”. Many of you may be aware there's a quote in the very beginning by John Maynard, an economist, and he says “the challenge of the future is not so much the generation of new ideas, but escaping of the old ones” and I certainly find that in my experiences, so as we shape this future, we’re really going to push ourselves and I know that VA will as well to let go of some of those old ideas. I believe that's already been stated—the importance of staying increase diversity within the health professions workforce. I do think that we are going to see this continue to grow over that the next several years and hopefully indefinitely until we have a look that better matches the population and then lastly I would like to make a comment and I know that the VA has already been a leader in this area, but that we continue to see that the future should reflect increased interprofessional education and practice, so those are just the comments to add to the conversation thank you.

**Dr. Daley**: So, I wanted to talk about a couple of trends that I've been following in terms of the conversation about what health care is going to look like in 10 years. One is the revolutions of pharmacy because we're going to see an enormous number of molecules come out to treat chronic illness in oncology. A lot of them are much less toxic than what we used to use in the past. They can be given orally, they can be given at home with an injection, and I think we're going to be able to move a lot of that care into the home or into infusion facilities that have a relatively low overhead in comparison to the average hospital. The second trend is the movement of surgery to ambulatory surgery, so there are some futurists who say that 70 to 90% of the surgeries that we're now doing in patient will be done outpatient in 10 years because of the miniaturization of technology and we're seeing those trends now in, you know, say they had the knee surgery, cholecystectomy, and some of the common operations, so I think if you think about the bricks and mortar strategy, we need to be thinking about where can we put infusion centers? How can we convert our hospitals to places where ambulatory surgery’s done frequently, and I really commend the VA I think you're in the perfect place to redesign rural health care. I don't have the answer, but I think collectively as an organization, you can really tackle that problem and make care much better for not only the Veterans who live in rural areas, but the other people who live in rural areas.

**Dr. Perlin:** Quick comments, Dr. Daley, I appreciate it. I can’t help but look at Dr. Crosson and think that this issue of new molecules/biologics will not only be very powerful, centralized, and expensive.

**Dr. Crosson:** It’s a big deal and there’s a lot of discussion on the hill about using pharmaceutical costs as a piggy bank. It will play out quite dramatically, I think.

**Dr. Sandefur**: Just kind of have more of a brick and mortar kind of comment that I was kind of thinking more along the lines of care model of innovations that one of our questions. In my time in the VA, I’ve always having such a great appreciation of who we are as an organization where I think we are so much different than civilian sector because we're comprehensive we have all healthcare under our umbrella, from optometry and dental and many others. That doesn't necessarily play out in the civilian sector, so with that kind of environment, I really think there’s a great opportunity for, as we move forward, to synergize on different specialties, so normally where mental health and medical may be sort of stovepiped in a way, in my time as chief of staff, I just remember, to use an example, I remember sometimes some of the most severe mental health patients would also have very severe medical condition and some of our biggest challenges were finding the correct placement for those kinds of patients in our VISN and it was very challenging at times and I just think moving forward, something strategically to think about it is an opportunity we have that others in the civilian sector may not have is to build a team that’s a hybrid of the mental health and medical that could be regionalized to take care of patients that are in that kind of situation. But, those are some of the challenges and that is just one example. I think there are many others that can be beneficial to consider as you recapitalize in your development strategy. That's all I had thank you.

**Dr. Perlin:** One of the big strategic challenges is how do you think about being broadly accessible, both virtually and expand necessarily physically, whether directly or through relationships with others while simultaneously being efficient in that regard. But, also retaining what I think is the magic, which is the systemness that VA can provide in terms of meeting the spectrum of bio, psycho, and social needs. So, that’s the magic. How do you keep the magic and improve the magic, given all of the components this conversation has raised.

**Mr. Nuntavog**: I appreciate that, so the last major comprehensive review VA did was the Cares Review back in 2000-time frame. I think my question would be, will VA be looking at reducing funding request for infrastructure during the market assessment over the next couple years? And the air commission, what is budgeting for the current facilities look like because that could have a significant impact on the care that Veterans could receive while these assessments are going on?

**Ms. Kramer:** We’re trying to separate the air commission discussion from this one. Those

decisions have yet to be made, so I think we have to keep a clean line between the two.

**Dr. Stone**: I think that one of the things the Cares Act brought the Air Commission to light or the Mission Act that brought the Air Commission to light was very clear that we have to continue to make good business decisions throughout the time we’re getting ready for the Air Commission. As you know, our budget provides about $4B a year in resources towards the sustainment of facilities. There’s separate funding for new or replacement facilities. Since about 65-70% of facilities are +50 years old, needs are probably in range of $20-22B to bring us up to C level. If we simply correct the $22B in deficiencies, the next 10-15-20 years, we will be in worse shape than we are today because haven’t fundamentally replaced facilities we need to, and dialogue that we have to have is, should we simply replace wat we’ve got, or do we make it look different to make sure we meet the needs of Veterans in the manner this robust discussion draws us to.

**Ms. Kramer:** Many are historical buildings make it hard to just repair/reconfigure things because of limitations (example: IT lines). We have to look at replacing things we have, as well as repairing…More at home- based, outpatient, and ambulatory care, so we’re not building a totally different infrastructure that takes even more money to sustain.

**Dr. Sandy**: Trend towards home/community-based care versus facility. Differential costs will be different 10 years from now to today. Tech. advances provide opportunity to build new care model to bring special culture/ethos of VA to Veteran. Historically, that’s only been provided via centralized facility model. But that won’t be true in the future. Thinking in parallel to new care model along with modernization of facility is quite important.

**Dr. Kellerman**: Any future infrastructure VA builds—Encourage you to build for post-COVID world. As we sit in this room divided with plexiglass barriers. At university, one of smartest things they did after SARS and Anthrax was they put one of their units as negative pressure capable without turning it on and when we had a major increase in ICU cases we were able to activate a 2nd critical care unit that had not been engineered for that purpose and it was a god sent. I recently pulled plug on relocating our dental school’s clinical practice into new ambulatory care facility when I saw the floor plan and how closely packed all the dental chairs would have been to each other because that was crazy. Hope that we all balance engineering and high cost of building new facilities and consider the potential for future airborne pandemics like this. Airborne safe—We can do better. In the past many hospitals had 3-4 negative pressure rooms if they were lucky in ER and maybe none upstairs.

**Dr. Perlin:** This is both an enviable and unenviable challenge.

**Dr. Meyer**: Great, wide-ranging conversation. Virtualization impact to how we’re going to finance it. This is unprecedented opportunity for VA to take leadership role in redefining how structure is applied to the delivery/improvement of health care. 18-year old report called leadership by example—States that as a nation, we have a lot to learn from federal health programs and the VA in particular. Not to be locked into current ideas—And also rethink how we can redistribute health care via technology and balance it with infrastructure issues.

**Dr. Stone**: I appreciate SMAG. Can’t overemphasize how invaluable discussion is. We do believe there is a future model. I was down in S. Ga. with/Walmart leadership and looking at their view and understanding of what healthcare deserts are and what they thought their role was in the retail industry in creating areas where their customers could correct dental or healthcare problems. I am faced with a Congress that will want over $1B in construction in every one of their districts. I am respectful of that, but there’s a future model here that’s emerging. It has emerged because of the pandemic, shown us ways to do business that is different. It is of more value to the Veteran and to the consumer of healthcare. There’s a redefinition of what we can do remotely and with facilities that do not require the level of investment. I am acutely aware that it costs me about a million dollars of that to build long-term care facilities and I would estimate the 10-11,000 Vets that I am operating today will need to grow into 14-15,000 range which means I will then have a $4-5B investment if I can’t move some of that care into the “Choose Home” initiative. As we think about the maintenance of where each of us want to be for the future, it is clear that my earlier comments were correct and I would bet 100% would say please leave me in my home as long as I can and connect me to my healthcare providers. The isolation that we’ve all experienced, even in relation to our own healthcare providers and our difficulties in having our systems delivered to us, what we have needed during this year has called into reflection of what the future is. We are going to work hard to be an example for the U.S. healthcare system with new ways to approach this as the taxpayers/reps come to the realization that an infrastructure bill will exist, it will include the VA, and some amount of money will be given to us to be good stewards of. The dialogue you’ve had will also help lead us with our constituencies and advocates, specifically VSOs, to help have the dialogue we need in order to drive consensus to what healthcare for the future really looks like. I finished rereading some of the original work done after WW2 and how VA (Dr. Hawley) interacted with Congress and decided things and how the hospitals couldn’t go in everybody’s districts, but had to go in association with the major academic medical centers in America that has driven us to where we all today. I think we are in a very similar situation today.

**Dr. Perlin**: Terrific! Thank you so much for that since I was writing down your thoughts I came up with 5 R’s here: rethinking, redistribution, redressing inequities, responding to emerging needs, both the Veterans and the environment and society, and retaining the magic of systemness which I think is uniquely VA and the Veteran identity.

***Innovation as a Core Competency for Health Systems***

**Dr. Perlin:** I know that as Rick Pollack alluded to earlier, the AHA is doing work on

innovation space that reflects the work going on across membership. Anyone in our

general area of interest has been preoccupied with innovation during COVID, which has

served as an extraordinary accelerator of innovation by necessity.

**Dr. Stone:** Innovation as core competency is something I think all of us in healthcare pride

ourselves in. In gov., our innovators are under substantial restrictions, both in cash flow

and how we hold patents. We have seen extraordinary innovation in 3D printing and other

areas over this last year. We recognize there is very substantial value in the innovation

occurred and we have funded as part of our emergency response. It has called into

question how we handle, work with, and retain innovators. We have traditionally used for

intellectual property our academic partners to help move inventions to marketplace, but we

are beginning to reexamine, are doing this correctly? We want to get your thoughts on how your organizations are handling intellectual property. How are inventions handled to ensure we maintain our innovator reports and treat them appropriately to ensure they spend our careers with us?

**Dr. Clancy:** Ryan and I have discussed how innovation the sustained focus on innovation

fits into what the post-pandemic “new normal” challenge looks like for healthcare.

**Dr. Vega**: Innovation’s importance accelerated during COVID and how vital it will be to healthcare in the next decade. Three questions to explore: 1: Value-based investment. How do we begin to really understand long-term investments that don’t have a near term ROI, but will pay off for the way we deliver care in the future? How do you manage cash-flow shortages to enable those investments in non-times of crisis? 2: How do you perceive how innovation becomes part of the core operation? That it’s not just some island where a lot of fireworks are going off, but that these solutions/inventions do become a part of the way we deliver care/service? 3: All of the intellectual capital that resides within our front-line, clinicians, and staff that are driving these transformational changes creates an incredible unique opportunity, not solely to have self-sustaining innovation, but to also continue to incentivize the work that transforms not just care within the VA, but care for Americans across the country. Numbers of examples. Three stories: 1. Couple of weeks ago, VA received compassionate use authorization from the FDA on a medical device that up until that point did not exist. A Veteran in Charleston had a greater form of hearing loss. The actual external auditory canals of his ear had completely collapsed. Every commercial product had failed. Veteran was an Engineer in Korean War, so he had developed some strong mechanism to keep canals open, but they were going to resort to surgery. What additive manufacturing gives us was the ability to create something we never thought we could create—Rapid prototype and design, layer by layer, manufacturing new devices that never existed. Part of the investment that was made by the agency during the pandemic allowed us to receive FDA clearance because now we have three sites registered with FDA as medical device manufacturers, as well as a quite robust quality record management system that allows us to adhere to federal regulations. Using that to advance clinical service and to provide this Veteran with a one-off solution that prevented a surgery is why we make this investment. But it isn’t always easy and clear to put money into a startup that we know long term will transform care across this country. But it’s hard to realize it right now and when operations of the day are front and center. 2. Explosion of remote temperature monitoring via a mat for diabetic ulcer prevention. We’ve been working on this solution since about 2017. The literature for using thermographic sensing (think of it as a thermometer for a diabetic foot) dates back to 2008/9. What we saw through our own studies and a study published by Kaiser was an almost near elimination of diabetic ulcers. What we’re talking about is the prevention of amputations, prevention of life-long care through use of mat the patient literally stands on. The adherence rate is close to 96%. This solution took off at 40+ VA medical centers because of the pandemic, giving VA the opportunity to monitor chronic disease like never before. The data is staggering; in FY19 VA spent $3.2B on diabetic care (amputations, orthotics, prosthetics), not including the cost expenditures we saw in the community. For a solution that cost $3500 that prevents amputations at a rate of 98%, you would say “sign me up”. That’s what we are seeing from big payers. Though not considered good enough for COVID to scale something. How do these solutions become part of the core operation to the way that we deliver care? 3. Finally, that it gives us opportunities from direct to commercial pathways, protect intellectual capital, incentivize, continue to reinvest in innovation, and build a self-sustaining model.

**Dr. Lee:** Any org. I have been part of, the challenge is often deciding what you are going to do/what you are going to focus on. Second is spreading what seems to be good. Third is deciding to kill a project that isn’t going anywhere. I’d be interested in how your groups thinks about these qualitative challenges.

**Dr. Stone:** How do we decide what to focus on and how does an inventor who has a great idea get a voice? Shark tank is in the middle, but let’s talk about focus first.

**Dr. Vega:** Important consideration that needs to be made in the discovery of what you focus on. Must align strategic priorities and successful innovation does that well. Equally have to listen to the voice of the customer (patient and patient-provider relationship because focusing on a solution at expense of workflow of clinician doesn’t actually benefit the patient at all). Greatest example we have of seen of this is the electronic medical record. Hard for me to see how it is of value to clinician. Now, for administrators, and systems and optimizing billing, I see it. Start with discovery around using things like human-centered design and understanding qualitative voice of Veteran. What are the Veteran needs and want? Trying to forecast out, as well as understanding what they aren’t aware of that is coming down the pike. I don’t know of many Veterans who would say, “I want 3D printing,” but when you show them examples of benefit to them/their colleagues, they do. Forecasting helps align the needs/voice of Veterans with strategic priorities, which needs to be starting points. Now, during pandemic, there’s also been, “How do you meet business needs?” This is how 3D printing really took off because it allows us to rapidly prototype and because of the investment of the past decade, put VA in a unique place in its ability to support RAPID testing and support the FDA and NIH and the global world around validating what designs were safe/effective to be printed and put into clinical production. Short answer to what you focus on is mostly what the customer needs that is aligned to strategic priorities of organization. While we’re not focused on inventing the next Apple Watch, we are focused on Veterans who use them and making that information and data more readily available and translated into knowledge that impacts our ability to deliver care to them or allows clinicians a better understanding of what’s happening to Veterans outside of the VA.

**Dr. Lee:** But how do you spread things and how do you decide to kill projects that are going nowhere. I know a guy who says Singapore Health has more pilots than Singapore airlines because they can’t kill their pilot projects. I am not expecting miracles, but those are two core dimensions of having a good innovation program.

**Dr. Perlin:** Hardest thing is rejection and saying no. Discipline to really focus on what it is that will come to market. Steve Jobs did this. They dwindled 300 projects down to 17.

**Dr. Pollack:** One of the biggest challenges in not only stopping a pilot, but making the decision in a timely way. To not decide and allow things to bump along is a dangerous cycle to be caught in. Innovation has so many dimensions, but reflecting on current events effect long-term trends, and one thing we’re all thinking, is what have we learned from the COVID experience relevant to innovation going forward? When thinking about that, there are several things on people’s minds: What’s the future of the public health infrastructure given? It is so drastically under-funded. What’s an innovative approach to emergency readiness in the future given the fact that we didn’t have any meaningful contact tracing mechanisms in place and stockpiles weren’t there when we needed them? How can we use AI and predictive analysis when dealing with public health programs? Rethinking supply chain and innovating it? Hospital operations—alternative sites of care, staffing models, recapitalization, expanding scope of practice, which is a big issue on the private side which people are thinking of? Chairman talked about how it’s important to think about physical plant for future. Recapitalization beyond just telehealth. What are the implications for monitoring and wearables? The movement of care from not only inpatient/outpatient, but to retail? COVID aside, there are other initiatives we have been focused on. One is making sure impact of new entrances into marketplace. Many viewed as predators to disintegrate healthcare system (by not taking care of poor people, for example). Alt. payment models: Moving away from fee for service to a population health and addressing the social determinacy of care. What are these models? What do we need to do in terms of understanding? Working with Dr. Fulmer on age-friendly care (senior group)? Creating next generation of leaders via fellowship series? Cybersecurity has to go into innovation. We also created an innovation fund and that is more than investing in ROI, but making sure people creating products are doing things that are going to be useful on front lines.

**Dr. Kellerman:** Fav. project at RAND looked at high-value innovation and pointed out that

while America is recognized worldwide for innovation healthcare, the way the American health marketplace works is you only get rewarded if it is better and you can command really high prices for it. Otherwise, no one is going to invest in going to scale, which is why pharmaceuticals are more expensive. The VA shouldn’t do that because it needs to find cost-lowering, high-impact technologies. An example is the whole concept of the cardiovascular polypill—A once-a-day pill to reduce heart attack, stroke, cardiovascular death. That could be a game changer and save the VA, and the whole country (½ of American have undiagnosed of hypertension). Another concept is modeling from the military is the idea of requirements. “VA needs X—We will fund the best idea to solve X.” Companies can go head-to-head to come up with best products (clot-promoting bandage). Probably can’t do this in federal gov. Could be even better: “We’re going to give a prize of $30, $50 million to first person who solves ‘x’ in most cost-effective way.” But I think those two ideas of high impact lowering cost technologies and “here are VA top 5/6 requirements” (via RFP or prize) could do wonders.

**Dr. Clancy:** Great questions Tom. When to stop is always tricky (hurt feelings). Ryan’s team is really building muscle/muscle memory for spreading across system. Content and size of innovation and change is important. Issue of what to choose and when to stop, my sense is people are chasing stuff that’s got a short-term ROI. VA doesn’t think in those terms. Equation is harder on our side. I think the way Ryan framed this in terms of human-centered design is helpful. We also have a challenge of budget (There’s one big budget that gets parceled out to the VISNs and facilities—Linked to brick and mortar). We’ve just been through a year where it’s all been upended and that’s not how we’ve been operating. Now, we are testing predictive technology shown to dramatically reduce lower extremity amputations for Veterans; funded today out of an essential budget out of prosthetics. I’d be interested in hearing from any of you on how that works.

**Dr. Crosson:** Two comments: 1. How do you decide what to do initially? This derives from two decades involved in participation/observation inside of Kaiser. Thesis for a long time has been that best ideas come from bottom-up. We’ve spent a fair amount of time and money honoring those individuals and their work in somewhat of a competitive way. During my time at AMA, there were a lot of ideas about how to improve physician practice over time, but how to disseminate those ideas? Recommend people look at AMA’s website called “Steps Forward.” We created a series of modules that could be accessed online by physicians/physician practices in 3 modes: 5-min. read, middle ground, and detailed level of info. that needed to go to less sophisticated practices to take them through each step. It’s been quite successful over 5-6 years. Last comment is after all of that, the principle to spend 20% of time getting best ideas and 80% of distribution and dissemination.

**Dr. Vega:** We have a model that has evolved quite nicely. It’s called sparsely spread investment. It’s a VC module funding allows us to de-risk from early stage-on as program/innovation modernization matures; funds about 100 projects a year. Investees are also enrolled in an accelerator, so we’re investing in the individual as much as we’re investing in the idea. Evolution of the model allows 10% success turn over rate, 10% can go to IPO. Challenge becomes when constrained and not able to multi-year plan- for how to invest the scale more rapidly and those individuals don’t have the luxury of going to raise capital individually, which creates a bottleneck of slowing down. Centering around Kaiser’s model of investing in the ideas of those who are seeing the problems every day has led to not just tech-centered projects, but one that was presented this morning was a 10-week course for LGBTQ Veterans-It’s amazing because it was actually developed by Veterans. It has spread to over 40+ VA Medical Centers, but it has matured through pipeline, invested every year in growing amounts and put leaders behind it front and center on national stage. Good qualitative/quantitative data coming out of it, but when you hear Veterans, there are 2 comments that stick out: One is “I was going to kill myself up until I found this course. I finally feel accepted” and “I would have come to the VA much sooner if I knew this course was available.” You are hearing 2 different paradigms of clinical and operational/admin. impact of folks saying, “If I would have known this existed, I would have chosen your company yesterday.” That’s an important one from competitive standpoint and clinical impact at time when equity is becoming front and center, certainly accelerated by pandemic. But the idea that we have a system that can invest in those types of practices, there’s no other traditional mechanism that exists and we can delayer and decouple some of the bureaucracy and allow some of those providers a national platform to scale quickly is one of the true successes of VA within the past 5-6 years regarding innovation. But how do you resource that (the expensive operations which isn’t always the best decision) and funding it becomes the ever-pressing challenge. You can over-fund innovation and actually disincentive people to participate where pilots never amount to more and so what. But if you make it competitive, that allows/fosters real culture of innovation that makes things excel quicker through the pipeline.

**Dr. Meyer:** When I think about what makes some innovation programs successful: Dedicated fund, good business development team, and incentives. VA has series of special challenges, but solutions are looking at more closely at what’s going on in military health system. Incentives one is hard—How are you going to hold on to an innovative workforce? You’re not. My org. doesn’t do great job of that either, but there are many people who are anxious to be in that environment to do that work. VA’s value proposition is that it can take long view. Second is you have this incredible laboratory with amazing scale, and ability to crowdsource is unparalleled. Third is power of non-monetary incentives. Folks working in VA are looking for something more than that. Ability to project their work faster nationally.

**Dr. Perlin:** VA has innovated so much, from liver transplants to CTs. What would you do differently to create a more charged environment for innovation?

**Dr. Mittleman:** I wrote down value proposition, but defined it differently: What is value proposition to provider and patient, and patient/provider relationship and how do you define that. How do you reward that, and better relationships are created, which creates better trust. In our organization, it has been really important to culture innovation—Small percentage will proceed until apprehended, but majority are just trying to get their “thing” out. Word may not be out due to diverse population. How do you design incentive/reward system? It’s not always about the money—But rather, just recognition. Money is important too. But, don’t limit yourself. Think outside the box.

**Dr. Vega:** Financial piece is essential particularly because we are on the bleeding edge of work around additive manufacturing and its role in healthcare delivery. The work we will do around informatics because it has such broad applicability. VA is better positioned than most to be able to think about large population health management, solutions that can be layered onto clinical care modalities, but couple that with ability to test payment modalities. That intellectual capital is priceless, but someone could probably put a price on it. Creating new pathways for developing better partnerships could give a far more reaching and impactful model. How do you get there? Though a challenge for VA, some of them being legislative challenges, and lack of other transactional authority which the military has and allows them to make early stage investments through co-development with companies which allows them to create equity shares that grow in perpetuity. These companies can invest! Looking at the regulatory component is one piece. So VA must be creative in setting up infrastructure to protect VA intellectual capital. We should use our people/their ideas to our advantage.

**Dr. Stone:** I am struggling here too. How do we take truly valuable intellectual property and under the constraints that we operate under, how do we partner with industry to bring it into production capacity, amplify its value and bring it back to the organization to fund future innovation. Though DOD is better positioned for this. VHA has a single production agreement that reimburses VA on a per unit basis (Dr. Vega confirms). That’s the first and only innovative idea of how to bring this to life. VHA was given a generous capital to seed several innovations, but now we need to put this into a viable model to sustain through non-crisis.

**Dr. Sandy:** Understand challenge. Looking for analogy. What is VA like? A little like gigantic university that has to develop its technology transfer apparatus. It’s a little like a massive system like Kaiser which has financing and it’s like a national health system. From our world in United Health, all of the above are some of the comments being made: joint ventures, investment funds, building relationships, supporting individual entrepreneurs. But, were a commercial entity and can get a financial return on these initiatives whereas VA is a budgeted system. How do we figure out how VA gets rewarded within a budgeted system? Most fundamental nut to crack. Not so much the resource. It’s more solving that issue which is more of a management and culture issue.

**Dr. Perlin:** Those are terrific comments because it really takes us back to Tom Lee’s terrific insights in the beginning. Solving problems is the easy part, it’s not only what to do, but spreading what’s good, and killing what’s not. Dr. Stone, Dr. Clancy, what is your executive apparatus to receive input through Ryan? How do you know what your filter is? While it’s great to encourage innovation/have a broad aperture for seeking best ideas, you got to figure out what to put your bet on. The challenge of realizing the value of the intellectual property achieved may take legislative agenda, regulatory change, or partnership. DoD apparatus-Can’t help but look at John Prescott—They have an academic apparatus avail. I think in our organization, we are cautious (too much so) as to what we invest in. Kaiser—and correct me—had a breath of innovative products. We’re also somewhat even extreme in our organization with a very regiment process for deciding what to scale up and nothing makes it past a milestone if it doesn’t meet the goals that are set. And that doesn’t rule out/preclude retooling whatever project/idea is so it can scale, but the discipline to say no is great. And actually, the part that is a work in progress is this notion of partnership, which may offer a degree of freedom. Certainly, it does for us. But I agree that there’s a breadth of possibility within VA system and characteristics that Lou just offered of university-like, health system-like and public-entity-like. There may be pieces that can help you translate this opportunity (the broad aperture) to the discipline (the process) to the commercialization that you see that allows a revenue stream to help support the system and encourage the individuals.

**Dr. Crosson:** What to approve/stop is a critical one that Tom brought up early in the process. When I think back over how we manage that, on one hand, creating the incentives that I talked about, which are not financial was very important in stimulating ideas, but then you have the problem of getting too many ideas...And how do you figure out what to prioritize/kill and in the end, senior management has to have say. What we were able to institute over time was a peer-review system so the ideas that came forward didn’t just go up to senior-level management to say yes/no b/c there’s a derivative set of problems that occur with that mechanism. But intermediary in the decision-making process was a group of peers whose job it was to progressively review and make recommendations. People who didn’t get through this process were still disappointed, but at least they felt their peers had had a chance to render that judgement, realizing in the end that you’ve gotta have top-level management making the critical decisions, but this was really helpful over a period of time.

**Dr. Meyer:** Thinking about what you could do do more closely with the military and…There is another mechanism and perhaps the VA has a similar mechanism. The Henry M. Jackson for the Advancement of Military Medicine is often a go-between with funders and researchers in the military, and it does provide a means of moving money in a legal/transparent way between private and public sector or public sector actors. I think that could be very powerful. And the other idea I put in here is that there are times when, even if you’re not going to get some piece of the equity or financial return, that the company that you work with can offer the VA the opportunity to be able to use the products that you helped them with and derivative products or the next generation products in perpetuity and over time, that if you’re using those products and they are doing what you’re expecting them to do, they should be mitigating some costs. That’s a lot more of a long-term/indirect means of funding some of this work, but it’s just another mechanism that is a lot easier than creating your own venture fund.

**Dr. Stone:** Within our individual research center’s oversight boards that do have the ability to move some funds around, but we have not coordinated that nationally. They are each held locally and primarily facilitate some local research dollars that can come in from outside sources.

**Dr. Clancy:** You’re speaking about our research and education foundations and actually there are about 80 of them. For whatever reason, the Baltimore one is one that tends to be used for some headquarters-oriented work, but that could be another mechanism. In terms of what Gregg was saying about that ongoing relationship with the manufacturer could be helpful, I think we are actively seeking legal authority to take advantage of that. For example, had we’d gotten in earlier with the diabetic foot pad, we probably could have gotten it a lot cheaper.

**Dr. Vega:** That’s it. We invested so much capital into a product that I think is going to be a game-changer in the market. Optum, United Health, are all after the solution. We’re going to pay full cost. That’s a legislative change that has to be made. We have those opportunities where we see the loss and the challenge going forward is how do we right that ship.

**Dr. Perlin:** The value may not be directly financial. So, if you take that diabetic foot pad. Perhaps your agreement with manufacturers is actually not military, but on every box, it says developed in partnership with the U.S. Dept. of Veterans Affairs. The convergence between the realities of the capabilities of VA and the quality of care and some things that are asserted without much caution and things that reinforce value could have more utility than direct financial enumeration.

**Dr. Clancy:** Actually, where I thought you were going with that John was the notion that how energizing that is toward the workforce. When someone has a great idea, and working with Ryan’s team, they actually have an opportunity to spread that. Which could be something kind of technological and something way far away from that.

**Dr. Vega:** The long short of it is there was a nurse researcher who came up with a care bundle that showed to reduce ammonia, went through our Shark Tank Diffusion process. Now, where it is is there is a collaborative between the CDC, ADA…Front and center is VA leading a national effort across American healthcare to combat and reduce ammonia based upon the work, replication, and our drive to spread this practice to show the impact it could have on morbidity and mortality. There’s a large cost reduction in it, but it saves lives. That’s an incredible platform we now have to show that these either sometimes small investments pay off to the broader American health system. So if you’re a taxpayer or Veteran and you say, what are we getting for all this and how is it helping to better American healthcare, that’s is a great example. So it’s a one-off in that sense, but certainly it is making a difference to the fact that these other larger organizations have come and put VA as the leader—That it started there and is branded as such—I hope has a big impact on perception at large.

**Dr. Perlin:** What is the nurse’s name? I think that gets back to Dr. Clancy’s point about the positive effect on morale. I always think about the positive effect on the broader populous and Congress, but that is so well taken. The nurse that will never leave my memory is the one who was returning a car and barcoded in and that was the genesis of barcoding mediation. So there’s a long history there. I think we’ve hit the end of this topic. This is a broad, complex topic that organizations struggle with, redefine, and has many common features. What are you going to do, what are you not going to do, and how are you going to spread it, and finding out what the apparatus is, which may be equally complex in the VA context for both incentivizing, funding, scaling, finding mechanisms for partnership for development, including commercialization or general utility and the publicity of that are all very complex topics and ones that perhaps a separate task force looking at what the academic centers for doing specifically the health systems are doing and maybe a resource. AHA queried the number of health systems that were standing up this innovation if not even a venture investment apparatus and then what is occurring in other sectors of government like DARPA and the Henry Jackson foundation. Academic health systems have contended this as a core competency. John?

**Dr. Prescott:** I have been just absorbing/listening. Great comments/suggestions. I appreciate the morale part for innovators trying to make a difference and are driven by mission. Academic Affiliates value their opportunity to innovate and to innovate with their VA counterparts.

**Dr. Meyer:** Good convo. Lots of ideas for our colleagues to follow up on. Speaking on behalf of rest of members, all of us stand at the ready to help at any time. I would be more delighted to help anyone who wanted to meet with our organization’s teams, and I am sure the same is true.

**Dr.** **Clancy:** I found your feedback/comments very helpful. Not because we came up with a silver bullet, but because I think we came up with more dimensions for the lens that we are using as this continues to expand across VHA. Gregg, I didn’t love hearing it, but when you said, “You won’t keep innovative people forever”—I needed to hear that. Ok, but if you are constantly engaging others, that’s a good thing as well. So next year, we will be back to tell you about all the financial capital we’ve acquired through tech transfer and what not (joking). So, this has been very helpful.

**Dr. Stone:** We were very honored that Congress was compelled to vote unanimously to expand our immunization responsibilities. I described our responsibility to vaccinate 6 million American Veterans efforts as a herculean effort, one that required us to go across the nation to include running airplanes into remote areas of Alaska and Western Montana. The team has done spectacular work and has been a model. 50 and 75,000 vaccinations a day and in response to that, Congress awarded us with being asked to vaccinate about 33 million Americans. When the President signed it Wednesday, the phones stared ringing Thursday, and so we’re deep into expanding our vaccination capacity tremendously and we will be briefing the Secretary on pilots in some areas. The expectations is for us to move quickly. We move our vaccination rate toward 600,000 vaccinations a week. How quickly we can do that doesn’t depend on the number of vaccinators, but rather, our ability to handle the administrative load of getting data to the CDC, which drives future vaccine availability. That has become a rapid, all-consuming effort. Please to not infer that we’re not incredibly excited about getting this done for the American people. We are very proud to be able to do it—It’s just a monumental undertaking while still operating all of our other missions. Secondly, the Secretary has asked for a look under the hood over the next 10-12 weeks at our EHR deployment. This is an 8-10-year process and it’s tough. We’re continuing to do hard work and I am pleased with the evolution of the team as we’ve gone into this 12-week process and how the Acting DEPSEC has led us to this point that we can take a good hard look at what we did in Spokane and that we make sure when we roll out to other parts of the country, we do well. To all of you who have experienced the rollout of EHRs know the incredible effect on efficiency on your business systems, and we experienced all of those in miniature in Spokane and will continue to experience them as we go to other areas of the nation. It’s made a lot of news. I think it’s being really well-handled, and I am very pleased with the partnership with Dr. Clancy and the Secretary. Think about what DoD dealt with in their first 4 sites and how they had a 17-month delay before they went to their next site and how well they are doing today in response to that. I don’t think we will be going through an analysis for that period of time, but when you’re looking at a $16 billion program, I think it’s a wise decision to look under the hood. This is my favorite day of the year because I get to hear from people who I have such admiration for, lay out problems we are dealing with, listen to how you think about them. It either reassures me that I am on the right track or motivates me to turn in the right direction. I know you have many other things you could be doing, so it is an honor that you spend your time with us.

**Dr.** **Perlin:** It was exciting that the DC VAMC administered the vaccine to the president.

**Dr. Prescott:** What is the priority ranking for vaccines?

**Dr. Stone:** We’re going to have to priority rank the same way. Vast majority of vaccines are done by VetText followed by automated registration for appts. that don’t require human intervention up to the amount of vaccine available, making that available to non-Veterans not in the system is a tough one. Our estimate is about 15 min. of administrative time to get people registered for every vaccine and we’re going to actually piggyback of a number of states. I was actually up in the Bronx looking at the New York system actually giving some vaccine up in the Bronx area with FEMA where we were looking at some of their software systems that the state of New York was using. We are going to try to piggyback off of some of that, but we have to prioritize as we move through. We are now, in many areas of the country, moving to open scheduling because we’ve got such movement. Our idea has been to consume every bit of vaccine delivered to us on a Monday by the time the next shipment comes the following Monday. And then be standing in line by Friday afternoon in front of the former Operation Warp Speed to say we can take a little more. They’ve done great with us. I think this coming week we will be up to 240,000 first doses. Our thought is in order to do this portion of the population in a timely manner, we’ll probably need to up to somewhere between 500-600,000 first doses each week and that’s about where we’ve built the system. The system was built to deliver between 100 and 300,000 doses a day. As we run up to Saturday and Sunday, we’ll run 72-75,000 doses a day, so it’s a good model. A good test for it was when we mandated the influenza vaccine for our employees last year. That gave us the ability to move this and test the system. Little did we know at that time that we were testing a system that would have such broad application.

**Dr. Prescott:** Incredibly exciting. Want to wish you and the entire VA team good luck with this. It’s such good news!

**Dr.** **Meyer:** Thanks to all, nice combination of topics. We are grateful for VA.

**Dr. Perlin** closed the meeting by acknowledging the four members departing, thanking them for their service, welcomed Dr. Matthews and Dr. Taylor, and mentioned new members will be brought on in the future. He welcomed Dr. Meyer as vice-chair. He also thanked the employees and leaders of VA who work tirelessly to support the VA Mission. Meeting adjourned at 2:50 p.m. E.D.T. Next meeting scheduled for Thur., Sept. 30. 2021.

Minutes approved by:



Jonathan B. Perlin. M.D., Ph.D., MSHA, MACP, FACMI

Chairman, Special Medical Advisory Group