SMAG Members Present:

Jonathan B. Perlin (Chair), MD, PhD, MSHA, MACP, FACMI, President, Clinical Services and Chief Medical Officer, Hospital Corporation of America
James H. Martin, MD, Physician, Captain James A. Lovell Federal Health Care Center
Michelle Hamilton, DMD, PhD, Chief of Dental Service, Orlando VA Medical Center and Director of Research, VA Office of Dentistry
Thomas Lee, MD, Chief Medical Officer, Press Ganey Associates, Inc.
Richard Pollack, President and Chief Executive Office, American Hospital Association
Keith Cook, DPM, FACFAS, Director, Podiatric Medical Education and Residency Training, University Hospital, New Jersey
Arthur Kellermann, MD, MPH, FACE, Professor and Dean, School of Medicine Uniformed Services University of the Health Sciences
Jennifer Daley, MD, Senior Medical Director, New England Region, Cigna Health Care
Lewis Sandy, MD, FACP, Executive Vice President, Clinical Advancement, UnitedHealth Group
Gregg Meyer, MD, MSc, Chief Clinical Officer of Partners Healthcare System
Deborah Trautman, PhD, RN, Chief Executive Officer, American Association of Colleges of Nursing
Saul Levin, MD, MPA, Chief Executive Officer and Medical Director, American Psychiatric Association
Michael Mittelman, OD, MPH, MBA, FAAO, FACHE, Rear Admiral, USN (Ret.) President and Professor of Public Health, Salus University
Chanin Nuntavong, National Director, Veterans Affairs and Rehabilitation, The American Legion

SMAG Members unable to attend:

Karen Ignagni, President and CEO, Emblem Health Plan
John Prescott, MD, Chief Academic Officer, Association of American Medical Colleges

VA staff and Presenters:

Richard Stone, MD, Executive in Charge, Office of the Under Secretary for Health
Steven L. Lieberman, MD, Acting Principal Deputy Under Secretary for Health Veterans Health Administration
Lawrence Connell, Chief of Staff, Veterans Health Administration
Barbara Van Dahlen, PhD, Executive Director, PREVENTS Task Force
Joseph Francis, MD, Acting Chief Improvement and Analytics Officer
Michael Akinyele, MBA, Acting Executive Director, VA Innovation Center
Melissa Glynn, PhD, Assistant Secretary for Enterprise Integration
Leah Christensen, LCSW, Designated Federal Officer & Clinical Program Coordinator, Caregiver Support Program
Daniel L. Cooper, Vice Admiral USN (ret.), Chair, Veterans Assessment Tool for Caregiver Support Program Subcommittee
Heather Johnson, MSW, MPH, Managing Consultant, Lewin Group

Members of the Public:
See separate list

SMAG Committee Management Staff:
Brenda Faas, Designated Federal Officer
Justin Warren, Alternate Designated Federal Officer
Brittany Copeland, Committee Manager
Dennis Lahl, Committee Manager
Laura Lovinger, Committee Manager

Call to Order:

The meeting was called to order at 9:30 am by Brenda Faas. Ms. Faas stated that this was an official Federal Advisory Committee meeting and a quorum has been reached. She reminded the committee that there will be no time allotted for public comments; however the public was given the option to submit comments up to 4pm on the day prior to the meeting. Members of the public are not allowed to participate in the discussion. One public comment was submitted regarding the Veteran Functional Assessment Tool. Ms. Faas instructed members to read and consider the comment/document. There will be time later in the day to ask question if needed.

Committee Welcome:

Dr. Perlin: Dr. Perlin recognized the leadership of the staff who do a remarkable job of caring for those, in the words of Abraham Lincoln, who borne the battle. He acknowledged Dr. Stone and the former Under Secretary for Benefits, Admiral Daniel Cooper, as well as Dr. Stone's senior staff. Dr. Perlin introduced the new members to the SMAG Committee, Chanin Nuntavong, Art Kellermann, and Michael Mittelman.

Recommendations from Veterans Assessment Tool for Caregiver Support Program Subcommittee:

Presenters:
Leah Christensen, LCSW, Designated Federal Officer & Clinical Program Coordinator, Caregiver Support Program, Dept of Veterans Affairs
Daniel L. Cooper, Vice Admiral USN (ret.), Chair, Veterans Assessment Tool for Caregiver Support Program Subcommittee,
Heather Johnson, MSW, MPH, Managing Consultant, Lewin Group

Mr. Cooper began by summarizing the background of the subcommittee noting that it was established in June 2019 with a purpose to 1. Recommend one specific assessment, or a combination of assessments or item sets, that have been rigorously research and used by Medicare, Medicaid and/or other healthcare systems to assist in determining Veteran eligibility for the Program of Comprehensive Assistance for Family Caregivers (PCAFC); and 2. Develop recommendations for implementing the new assessment across VA Medical Centers. The subcommittee is comprised of eleven (11) members from Department of Veterans Affairs (VA), Department of Defense and non-VA members and was facilitated The Lewin Group.

The Caregiver Support Program (CSP) provides support and services for family caregivers of Veterans and helps both Veterans and caregivers navigate the VA Healthcare System. PCAFC is one program of CSP and provides additional support and services to family caregivers of eligible Veterans. PCAFC includes education and training, a monthly stipend, mental health services, assistance with travel, and enrollment in Civilian Health and Medical Program of the VA (CHAMPVA) amongst other services. This past August, PCAFC had enrolled 19,259 Veterans and their approved family caregivers. PCAFC has been limited by law to caregivers of eligible Veterans seriously injured after September 11th. MISSION Act expands the criteria to include caregivers of eligible Veterans of all eras. The purpose of our subcommittee is to draft recommendations for a Veteran Function Assessment based on our thorough review of existing assessments that have regularly used by researchers and proven reliable. The proposed assessment will be based on data collected from the Veteran and caregiver to determine the appropriate services. This assessment is one of seven requirements for determining Veteran PCAFC eligibility, specifically addressing requirement #3: The Veteran is in need of personal care services from another individual for a minimum of six continuous months due to: a) An inability to perform one or more activities of daily living (ADL); and/or b) A need for supervision or protection based on symptoms or residuals of a neurological or other impairment or injury.

Two recommendations for consideration:

1) Proceed with the recommended draft Veteran functional assessment *(based on a combination of the Functional Assessment Standardized Items (FASI) and Minnesota – MNCHOICES Assessment)*

The draft function assessment is for use in determining whether a Veteran requires personal care services from a caregiver, due to the Activities of Daily Living (ADL) limitation or supervision or protection. Every effort was made to streamline the assessment and make it as efficient and comprehensive as possible for VAMCs to complete.

2) *The VA should develop a comprehensive implementation plan for the functional assessment.*

The subcommittee strongly recommended that VA develop a comprehensive implementation plan prior to deploying the assessment. A standardized approach to conducting the functional assessment requires a strategic and methodical process for implementation. Based on their experience and expertise, the Subcommittee developed the following core elements for implementation of the functional assessment tool:

- **Assessor Qualifications**
    - Assessor Training - In order to support assessors in the administration of an objective, person-centered, quality assessment, the Subcommittee recommended that VA institute a robust training curricula to include at minimum:
        1. Curricula around program requirements, operational procedures, and the assessor role in the assessment process.
        2. Rigorous and thorough training curricula that educates assessors on PCAFC program eligibility, the assessment questions and responses, sample cases of

various Veteran populations and cohorts, person-centered practices, active listening, and motivational interviewing.
3. Trainings in the use of observation and probing questions.

- Assessor Requirements - As the FASI and MnCHOICES do not require extensive clinical expertise or specific licensing to administer, the Subcommittee recommended the following requirements of an assessor:
    1. Licensed social workers, nurses, or other clinical staff;
    2. Prior experience conducting assessments; and
    3. Robust training on PCAFC eligibility, target populations, and the recommended draft Veteran functional assessment.

- **Assessment Protocols**

    - Assessment Location - In order to facilitate a full understanding of the Veteran's functional limitations, the Subcommittee recommended the following assessment locations:
        1. The assessment should be administered in the Veteran's home when possible.
        2. If the home setting is not possible, feasible, or practical, the assessment may be conducted in an outpatient setting (e.g. VAMC or outpatient clinic). For example, if the Veteran has other medical appointments that will bring him or her to the VAMC, or if the VA determines that it is not safe to conduct the assessment in the home.

    - Assessor Consultation with Other Health Care Professionals - To assist in conducting the assessment, the Subcommittee recommended that VA develop a process for assessors to communicate with subject matter experts (e.g. traumatic brain injury) or the VA health care team.
        1. The assessor should have an established process for calling upon experts in specific health care fields when needed or indicated.
        2. Interdisciplinary team collaboration is encouraged.

    - Re-assessment Triggers - As Veteran or caregiver status may change, the Subcommittee recommends the following triggers for re-assessment:
        1. Regular intervals, minimum annually; and
        2. Upon significant change in health status of either the Veteran or the caregiver.
        3. The VA should use the adopted assessment for reassessments to document any changes in function and to maintain a historical record of standardized information for each Veteran over time.

    - Integration into the Health Record System Platform - The Subcommittee recommended VA integrate the draft Veteran functional assessment and scoring into applicable health record systems to fully support PCAFC. This will allow for data monitoring and analytics and enable VA to proactively drive continuous quality improvement.

- **Assessment Testing** - In addition to the draft Veteran functional assessment recommendation, the Subcommittee provided expert review of elements that constitute PCAFC eligibility. The Subcommittee recommended the following to facilitate standardized "scoring" of the assessment to match program eligibility criteria:
    1. After analyzing the scoring developed by VA,13 the Subcommittee recommended VA conduct predictive analytics to test the assessment elements, ensuring that the scoring supports eligibility requirement #3.
    2. The VA should also utilize a select number of assessors and case scenarios to further test specificity and sensitivity of the assessment.
    3. Based on the findings, the VA should refine the elements and scoring and test again to confirm it works as intended.

Discussion / Questions:

Based on your experiences, do you have other recommendations for implementing the recommended draft Veteran function assessment in a large scaled integrated health care system?

Dr. Trautman commended the group for coming up with a standardized and very methodical approach to develop and arrive at this recommendation. She emphasized the steps the subcommittee took to assure the assessment tool aligns with the eligibility and focuses on reducing redundancy and allows for assurance of consistency regardless who conducts the assessment. She also commended them on the comprehensiveness of the training and that the importance of observation and interviewing are noted to get the real answers. She was favorable at the interprofessional approach to being an assessor. She suggested that as the implementation is considered, VA look at all members of the healthcare team as able to assist with that assessment. She praised the in-home assessment noting that it will provide an opportunity to get the best information that will help ensure the support that is in place around the individual and their family.

She recognized the intent is to have a systematic approach to the implementation and there is more to be done in working through the details. She recognized the system challenges and local challenges, and those will be important to consider and think about, as those challenges may not be the same. She asked "how do you see a successful implementation and what is the ideal outcome? Is it increased volume or assuring the appropriate resources supporting the Veteran and family are in place?" **Ms. Johnson** noted that the subcommittee's charge was not specifically to reflect on the future of the outcomes. That will be the next step once the subcommittee's recommendations are formally adopted or however VA decided to move forward. **Mr. Cooper** acknowledged Dr. Trautman's question, noting the complexity of operating the same in different locations. An organization must have oversight. The subcommittee did not address this, but it is a vital component to the success of the functional assessment tool.

Dr. Meyer suggested to think about how VA can integrate this data collection into workflow through multiple modalities and sites. The integration into the health record is a great step forward. Collecting information on social determinants of health has improved vastly by making it a routine part of the workflow and removes the stigma; if everyone is asked the question, they'll get comfortable with it. "Is this for Veterans who are 100% disabled? I can think of

Veterans who do not have a 100% service-connected disability, but their social situation is such that, they need caregiver services." **Mr. Cooper** emphasized the importance of going into the home to see what is going on in the Veteran's life, in addition to talking to the caregiver themselves. **Ms. Johnson** noted that the home setting gives the assessor the ability to see Veterans in their home environments. The subcommittee suggested the assessors be trained to refer Veterans to other programs.

Dr. Lee expressed appreciation for collecting this information and wished the rest of healthcare did so. He noted that he has developed many survey tools in his career and not one of them worked well when they were first tried. He asked, "what kind of piloting has been done? Every tool I have been involved with ended up changing after we piloted it." **Ms. Christensen** noted that one of the reasons we recommended the Functional Assessment Standardized Items (FASI) tool is because it is a CMS-endorsed tool. It was part of a national project that was moving towards the standardized item set, which is used across the healthcare sector. In the development and validation of the FASI tool, it went through a very rigorous review process across the entire nation and CMS tested it amongst many populations. She stated that they are hoping that they will be able to reap the benefits of rigorous testing. Continued testing will be critical, which is being recommended as a part of the implementation plan.

Dr. Levin acknowledged that VA is the largest health system in the county which means VA is a leader and hopefully others will follow. Hopefully private sector programs will look at this model and find a way to integrate medical, mental health and substance abuse health records into one record, with privacy protection. Health and Human Services is certainly looking at regulations and rules to make sure that happens. Dr. Levin felt that it would be ideal to have physicians conducting home visits/assessment. In some of the countries around the world, physicians are given time off from clinical practice to see some of the more vulnerable patients, and it is built into their weekly time with patients. He urged VA to remember that the physicians need to participate.

He noted that if you do not specifically indicate mental health or substance abuse be considered then it can be forgotten. He suggested that mental health and substance abuse be added to the evaluation - 3.b) "need for supervision or protection based on symptoms or residuals of a neurological or other impairment or injury". He reported that 30% - 50% of patients have some mental illness and does not necessarily mean total disability from it. **Mr. Cooper** noted that the subcommittee discussed this topic frequently, but acknowledged that the report did not specifically denote mental health and substance abuse. He suggested the report be revised to include.

Dr. Mittelman agreed with the need to pilot or test the assessment tool and agreed with the importance of home visits. He was surprised that occupational therapy (OT) was not listed on the assessment since one of the core competencies for an OT is Activities of Daily Living (ADL). **Ms. Christensen** noted that an occupational therapist was on the subcommittee. The subcommittee did not want to exclude occupational therapists or any other type of clinician. As part of the report, the subcommittee fully believes that the assessor should have access, as

appropriate, based on the Veterans individual needs to be able to call upon any other type of clinical expert, to facilitate a broader understanding of needs for the functional assessment.

Mr. Pollack noted the importance of social determinants. He referenced an article in the National Academy of Medicine the day prior to the meeting discussing a consensus report that further emphasized the importance of social determinants in health care delivery.

He acknowledged that the subcommittee report and plan were very comprehensive, but "is the home visit going to pick up the differences between a 92-year-old who is relatively healthy with a support system versus a 95-year-old who has serious mental complications and no family support system at home. Will it pick those things up in the context of the actual tool in evaluating the assessment? This piece of understanding the assessment, beyond just functional status, is really important".

He suggested to have specialist or consultants available to those conducting assessments. He gave the example of The Joint Commission who has a central office to get additional advice on how to handle situations that may be unique to that situation. This also lends itself to evaluate how the central tool is working. **Mr. Cooper** noted that the subcommittee also emphasized that the person doing the assessment has access to headquarters to get to the right person at the right time, to make that type of decision. **Ms. Johnson** noted that the home assessment is one element of overall eligibility determination.

Dr. Hamilton asked if there was standard tool to assess the home environment. She noted that standardization may be challenging when you have a wide range of staff conducting assessments. "You mentioned the objective would be to integrate what the findings would be in the home, which is the best personalized healthcare we can get, but when it gets into the record, are you bringing a modality on site to assess while in the home?" **Ms. Christensen** stated that they would have to take that to VA for consideration regarding the overall implementation plan.

Dr. Sandy noted that for the record that The Lewin Group is a business unit of the UnitedHealthGroup, though he has had no involvement or knowledge of the activities. He suggested that as the implementation plan is developed, to use an interrater reliability measure to confirm standardization of the tool. This is particularly important with a diverse clinical staff and geographic location. Interrater reliability is a practice that is commonly used to help improve standardization.

Mr. Nuntavong noted that VA needs to be sure that time and resources to go into the home visits given the staffing shortages at some sites.

Dr. Stone stated that by law we are to begin the expansion of caregiver services. It was announced and we've informed Congress that will not be able to happen. The Veterans Health Administration (VHA) has a lot of experience in the geriatric care area, with well over 60,000 compromised Veterans in their home rather than institutions. With this experience, VHA understands the fact that these evaluations must take place in the home to get the social determinant components. The PCAFC has no standardized way to propose removal of Veterans

who are no longer appropriately being serviced by this program. This will require ongoing in-home evaluations and re-evaluations of Veterans. He agreed that an 100% service connection is not an appropriate standard, and that is being examined. He noted that this is extremely complex because no one has done this before. “Social determinant is what we have really struggled with - how to assess the caregiver’s ability to interact with the Veteran effectively. The law is clear on ADLs; it really is this social milieu that we are trying to evaluate.”

Dr. Lee stated that measures only get better when you use them. Working this out will benefit the country and not just this population.

Dr. Perlin summarized the suggestions/comments provided by SMAG members to be added to the report:

1. Include all appropriate professions as possible assessors (i.e. Occupational Therapist).
2. Testing the assessment should be a part of the implementation plan
3. Include measures of success in the implementation plan. The subcommittee was not tasked with this requirement, but VA should determine by what means they will validate the tool is working properly.
4. Be mindful that a person’s ability to cope with their current health condition does not correlate with their service-connected disability rating. When completing the assessment, be sure to consider the Veterans coping capacity.
5. Mental Health should be clearly identified as a factor in the functional assessment process.
6. A systematic assessment of the home environment is important.
7. The assessor should have access to consultation of specialty expertise when completing the assessment.
8. Ensure the VA Medical Centers have staffing and resources to adequately complete the in-home assessments.
9. Consider inter-rater reliability measurement for the assessment tool particularly amongst different professionals who may be completing assessment.
10. Assessments should be ongoing and are not a one-time event

Dr. Perlin requested a motion to vote on a total of three recommendations. Dr. Trautman moved and it was seconded Dr. Levin. Motioned carried unanimously.

MISSION Act Sec 152- Center for Innovation for Care and Payment Proposals:

Presenters:
Michael Akinyele, MBA, Acting Executive Director, VA Innovation Center, Dept of Veterans Affairs
Melissa Glynn, PhD, Assistant Secretary for Enterprise Integration, Dept of Veterans Affairs

Dr. Perlin introduced the topic by stating that SMAG is required to review section 152 of the MISSION Act.

Dr. Stone stated that section 152 of MISSION Act allows VA to request a waiver to regulation(s) that will let VA implement innovation pilots. He mentions that the over 65 years-old subpopulation

is the fastest growing population for VA, and Veterans are choosing VA over using their Medicare benefits. Given this fact, Dr. Stone asked the following questions for consideration:
"What is our relationship to Medicare? What is the role of a fully integrated healthcare system? What if we were a Medicare advantage type program? How would that allow us to interrelate to Health and Human Services and the Medicare program?"

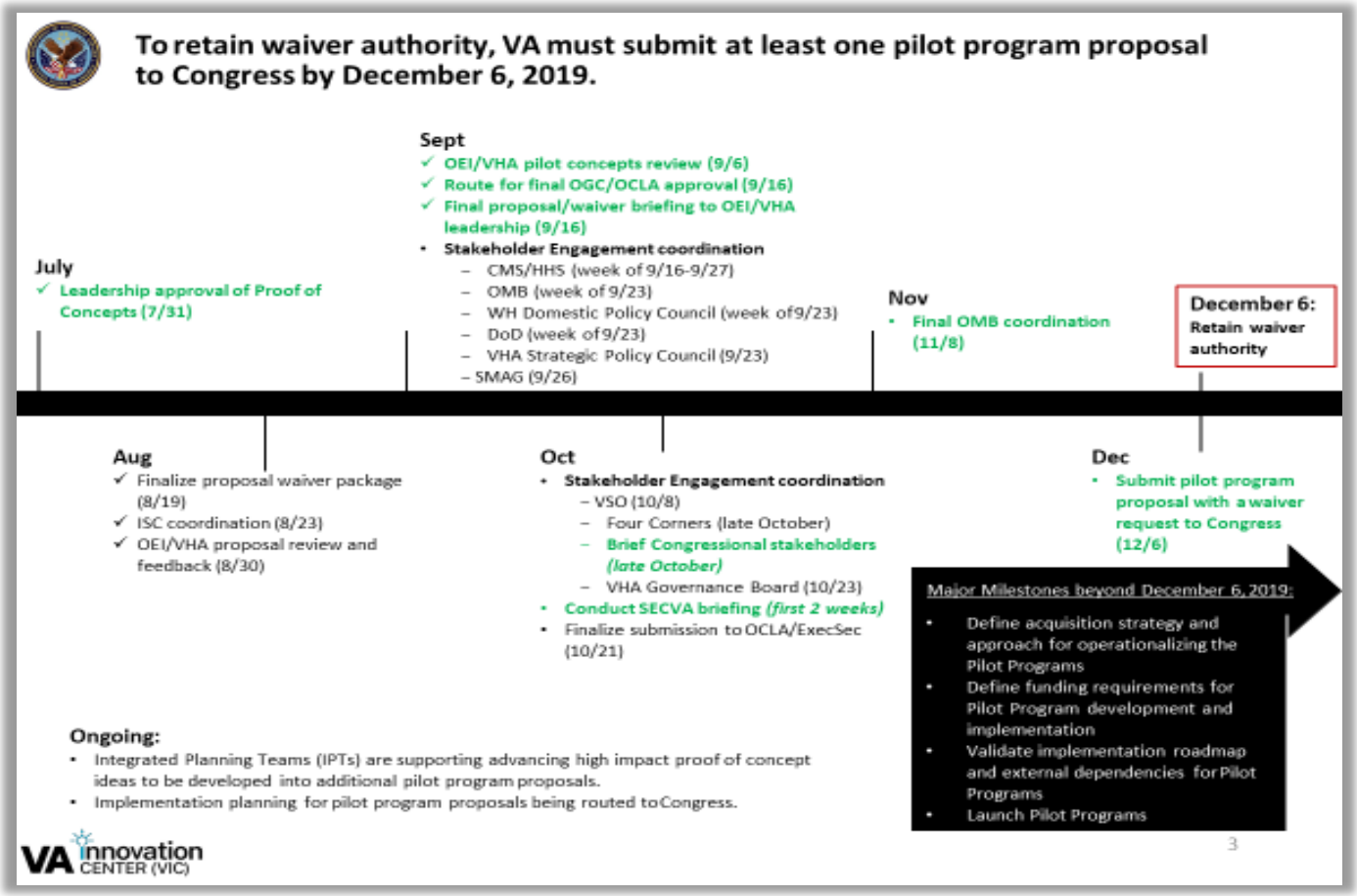
Dr. Stone concluded by stating there is room to develop innovative solutions to address this issue, but VA must ask Congress for waiver authority by December 6, 2019.

Dr. Glynn provided an overview of the agenda and timeline (see below) to introduce the topic.

Agenda
•Timeline towards December 6, 2019 waiver submission to Congress
•Congress and OMB vantage point on Federal health programs
•Summary of pilot program proposals
- Community Partnered Collaborations for Veterans (CPCV)
- Mental Healthcare for Diseases and Deaths of Despair (MHD3)
- Multi-eligible Veteran Care Improvement (MVCI)

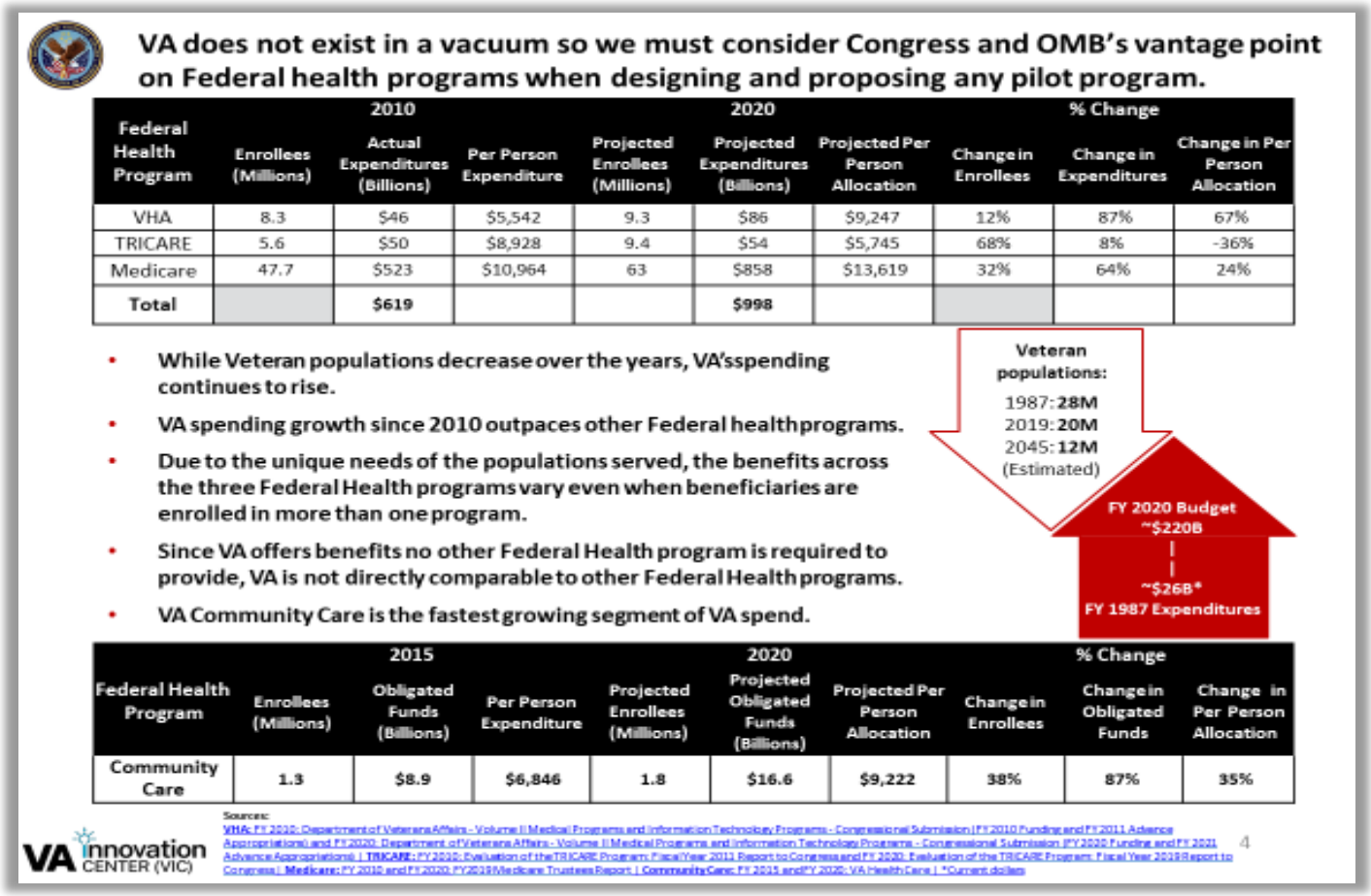
•Discussion questions

Timeline slide:



Dr. Glynn highlighted that as part of the coordination, Mr. Akinyele and Dr. Clancy have vetted the proposals. She stated that the question "How do we make sure a pilot proposal can be adopted and supported by the organization?" was used as key criteria for determining pilots.

She referred to the slide below to compare VHA, Tricare, and Medicare data and to show the overlap of patients over 65 years-old (VA and Medicare eligible patients). The goal is to be at the center of Veterans healthcare by understanding the crossover between VA care and Medicare.



VA does not exist in a vacuum so we must consider Congress and OMB's vantage point on Federal health programs when designing and proposing any pilot program.

Federal Health Program	2010 Enrollees (Millions)	2010 Actual Expenditures (Billions)	2010 Per Person Expenditure	2020 Projected Enrollees (Millions)	2020 Projected Expenditures (Billions)	2020 Projected Per Person Allocation	% Change Change in Enrollees	% Change Change in Expenditures	% Change Change in Per Person Allocation
VHA	8.3	$46	$5,542	9.3	$86	$9,247	12%	87%	67%
TRICARE	5.6	$50	$8,928	9.4	$54	$5,745	68%	8%	-36%
Medicare	47.7	$523	$10,964	63	$858	$13,619	32%	64%	24%
Total		**$619**			**$998**				

- While Veteran populations decrease over the years, VA'sspending continues to rise.
- VA spending growth since 2010 outpaces other Federal healthprograms.
- Due to the unique needs of the populations served, the benefits across the three Federal Health programs vary even when beneficiaries are enrolled in more than one program.
- Since VA offers benefits no other Federal Health program is required to provide, VA is not directly comparable to other Federal Health programs.
- VA Community Care is the fastest growing segment of VA spend.

Veteran populations:
1987: **28M**
2019: **20M**
2045: **12M**
(Estimated)

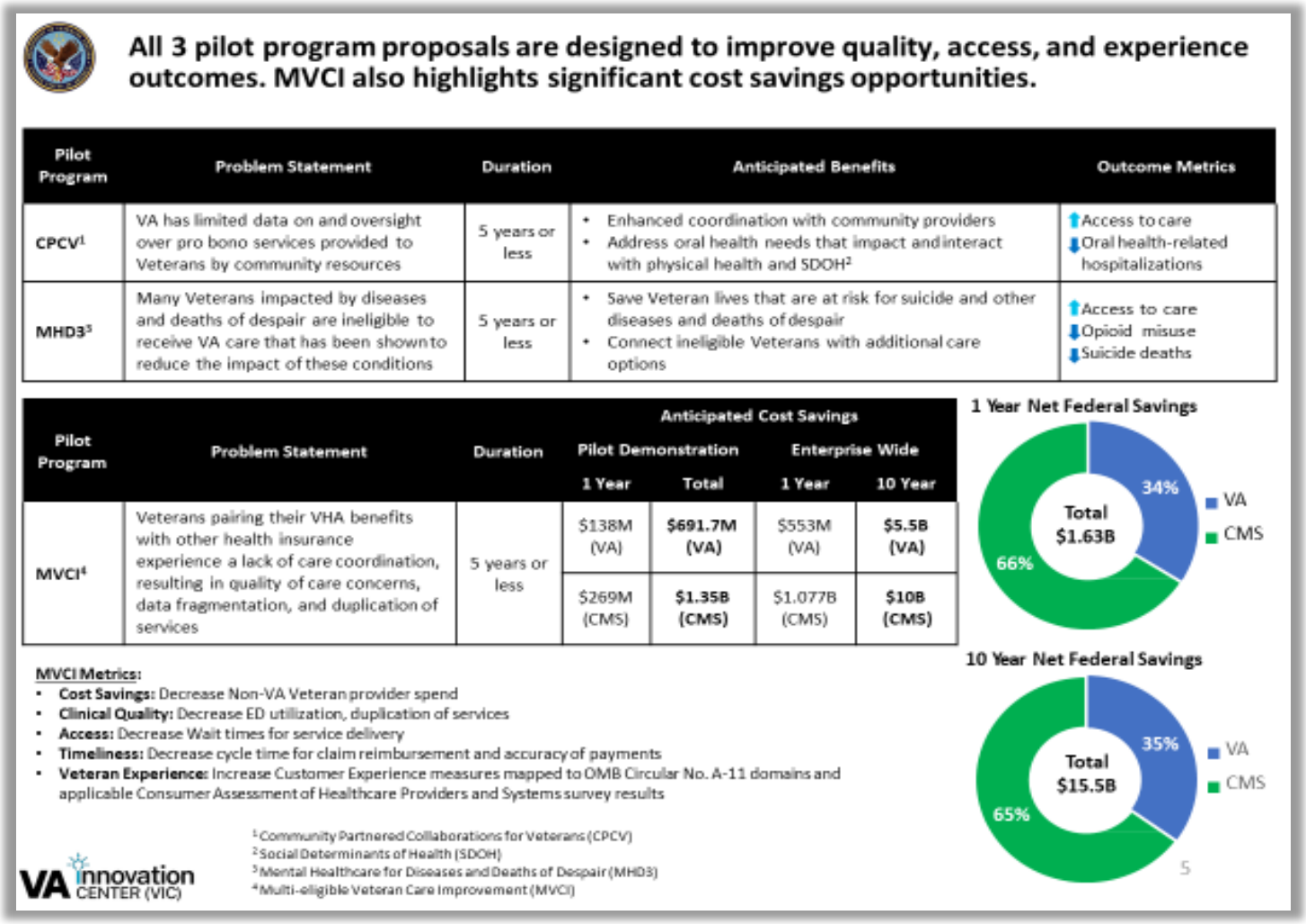
FY 2020 Budget ~$220B
~$26B*
FY 1987 Expenditures

Federal Health Program	2015 Enrollees (Millions)	2015 Obligated Funds (Billions)	2015 Per Person Expenditure	2020 Projected Enrollees (Millions)	2020 Projected Obligated Funds (Billions)	2020 Projected Per Person Allocation	% Change Change in Enrollees	% Change Change in Obligated Funds	% Change Change in Per Person Allocation
Community Care	1.3	$8.9	$6,846	1.8	$16.6	$9,222	38%	87%	35%

Sources:
VHA: FY 2010: Department of Veterans Affairs - Volume II Medical Programs and Information Technology Programs - Congressional Submission | FY 2010 Funding and FY 2011 Advance Appropriations and FY 2020: Department of Veterans Affairs - Volume II Medical Programs and Information Technology Programs - Congressional Submission |FY 2020 Funding and FY 2021 Advance Appropriations | **TRICARE:** FY 2010: Evaluation of the TRICARE Program: Fiscal Year 2011 Report to Congress and FY 2020: Evaluation of the TRICARE Program: Fiscal Year 2019 Report to Congress | **Medicare:** FY 2010 and FY 2020: FY2019 Medicare Trustees Report | **Community Care:** FY 2015 and FY 2020: VA Health Care | *Current dollars

VA innovation CENTER (VIC) 4

Mr. Akinyele provided an overview of the three proposed pilots referencing the slide below. The MVCI pilot will address key requirements of section 152 with the opportunity to realize a savings of an estimated 15 billion across VA and Center of Medicare and Medicaid Services (CMS). He also summarized that CPCV and MHD3 are pilots that are designed to expand care options to Veterans without any additional cost to VA.



All 3 pilot program proposals are designed to improve quality, access, and experience outcomes. MVCI also highlights significant cost savings opportunities.

Pilot Program	Problem Statement	Duration	Anticipated Benefits	Outcome Metrics
CPCV[1]	VA has limited data on and oversight over pro bono services provided to Veterans by community resources	5 years or less	• Enhanced coordination with community providers • Address oral health needs that impact and interact with physical health and SDOH[2]	⬆Access to care ⬇Oral health-related hospitalizations
MHD3[3]	Many Veterans impacted by diseases and deaths of despair are ineligible to receive VA care that has been shown to reduce the impact of these conditions	5 years or less	• Save Veteran lives that are at risk for suicide and other diseases and deaths of despair • Connect ineligible Veterans with additional care options	⬆Access to care ⬇Opioid misuse ⬇Suicide deaths

Pilot Program	Problem Statement	Duration	Anticipated Cost Savings			
			Pilot Demonstration		Enterprise Wide	
			1 Year	Total	1 Year	10 Year
MVCI[4]	Veterans pairing their VHA benefits with other health insurance experience a lack of care coordination, resulting in quality of care concerns, data fragmentation, and duplication of services	5 years or less	$138M (VA)	**$691.7M (VA)**	$553M (VA)	**$5.5B (VA)**
			$269M (CMS)	**$1.35B (CMS)**	$1.077B (CMS)	**$10B (CMS)**

MVCI Metrics:

- **Cost Savings:** Decrease Non-VA Veteran provider spend
- **Clinical Quality:** Decrease ED utilization, duplication of services
- **Access:** Decrease Wait times for service delivery
- **Timeliness:** Decrease cycle time for claim reimbursement and accuracy of payments
- **Veteran Experience:** Increase Customer Experience measures mapped to OMB Circular No. A-11 domains and applicable Consumer Assessment of Healthcare Providers and Systems survey results

VA innovation CENTER (VIC)

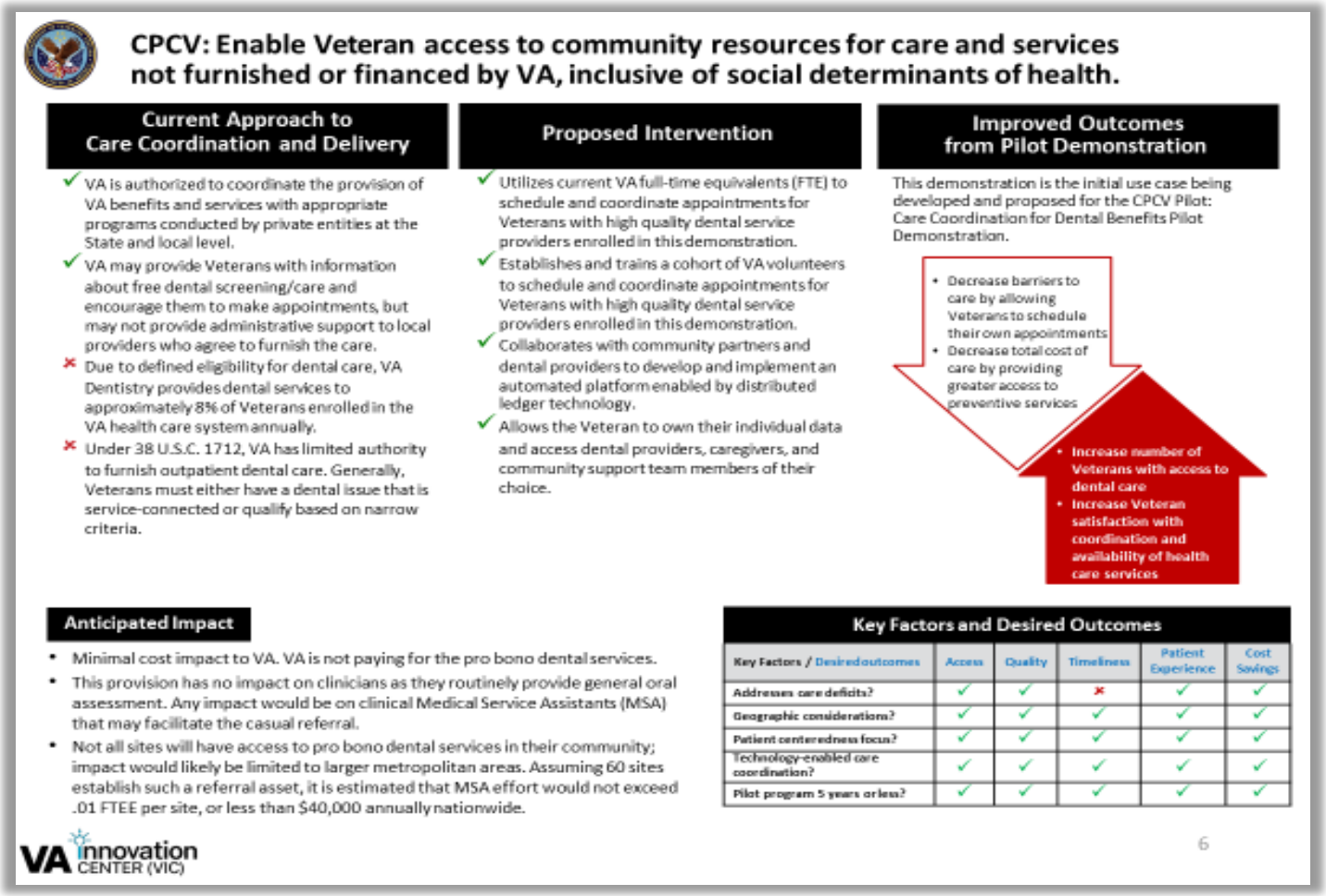
[1] Community Partnered Collaborations for Veterans (CPCV)
[2] Social Determinants of Health (SDOH)
[3] Mental Healthcare for Diseases and Deaths of Despair (MHD3)
[4] Multi-eligible Veteran Care Improvement (MVCI)

5

Community Partnered Collaborations for Veterans (CPCV):

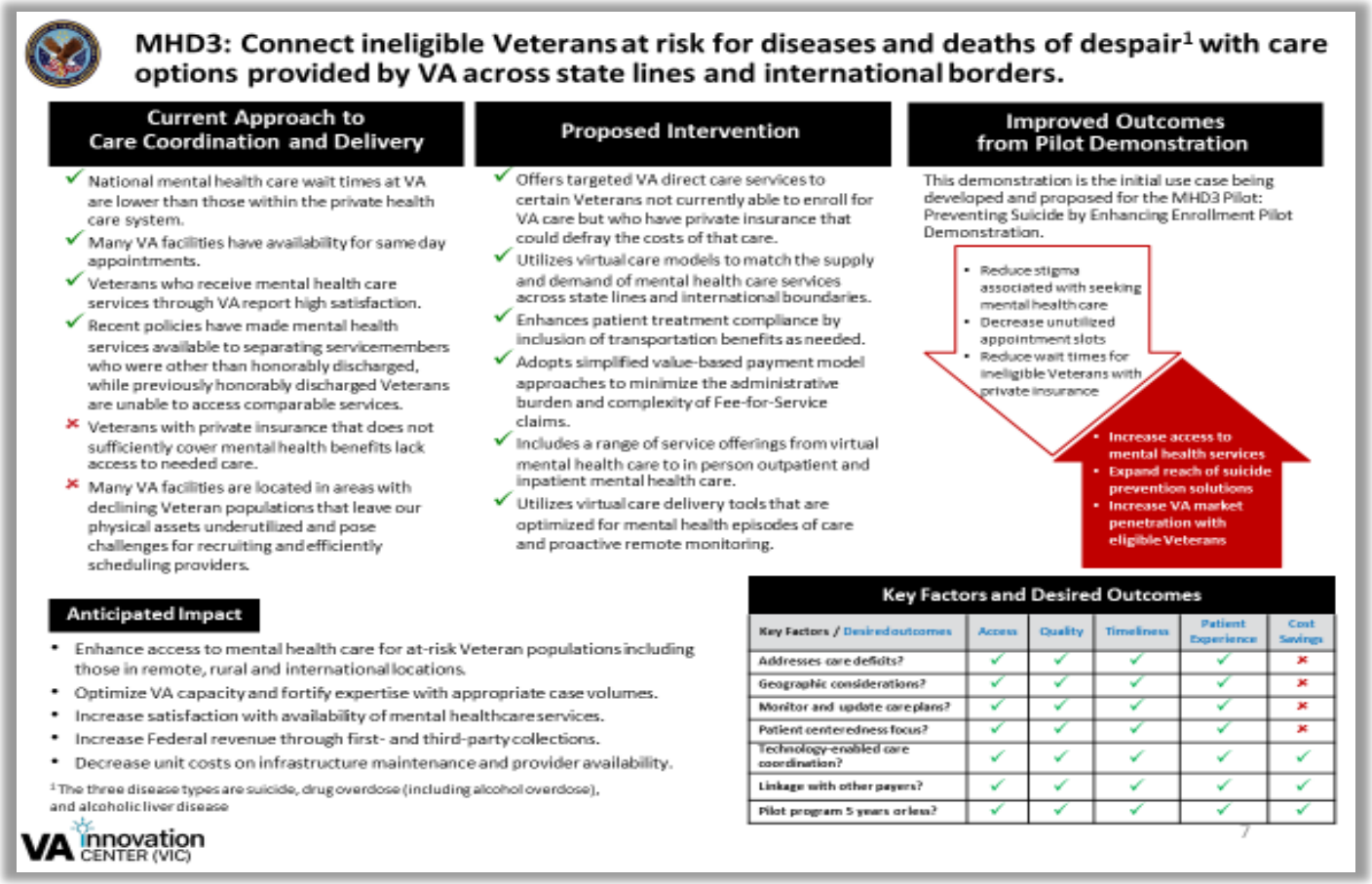
Mr. Akinyele stated that the problem VA needs to solve is how VA has limited data and oversight over pro bono services provided to Veterans in the community (outside of VA). The CPCV pilot is designed to provide Veterans with access to social support services and benefits that other public and private entities may provide at no cost to VA or Veterans. The initial pilot is focused on dental benefits. It aims to address VA's limited authority to provide outpatient dental care, typically, Veterans must have a dental issue that is service connected or qualify based on a very narrow criterion. Currently, only approximately 8% of enrollees are eligible to receive dental care. Given the limited number of Veterans that can receive dental care, this has been identified as an area of need. Studies have shown that poor oral health is correlated with avoidable emergency room visits (~2 million/year). The goal is to provide greater access to dental care in the hopes of decreasing the number of preventable emergency room visits, which will drive down costs.

CPCV Pilot



MHD3 (Mental Health Care for Disease, Death, and Despair):

Mr. Akinyele stated that the problem to be solved is the lack of access to VA Care for ineligible Veterans impacted by disease, death, and despair. Expand benefits to Vets who are currently ineligible to receive VA healthcare by using a Veterans existing insurance or other means to pay for VA services. The initial pilot is focused on VA's top clinical priority, suicide prevention. The goal of the pilot would be to sell access to VA's underutilized mental health capacity to Veterans who probably fall into Priority Group 7 and 8 and have private insurance or other means to purchase VA services



Multi-eligible Veteran Care Improvement (MVCI):

This pilot will provide the opportunity to bring all federal resources together that are directed at one individual, but through multiple agencies. The first opportunity to address this issue is to look at the overlap between VA enrollees and Medicare enrollees. The goal of this pilot is to improve care coordination among dual eligible Veterans (VA and Medicare) and eliminate duplication of services that may occur, which will lead to cost-savings. According to a study evaluated the recent clinical effectiveness of an integrated care management program for adults with chronic mental and physical needs found that patients who were in that program were approximately 60-70% less likely to use the emergency room and 50% less likely to be admitted to the hospital. The study

shows that care coordination can lead to cost-savings by reducing avoidable and costly health care visits. The next phase would be to investigate Veterans who overlap with TRICARE, Medicaid, and other programs.

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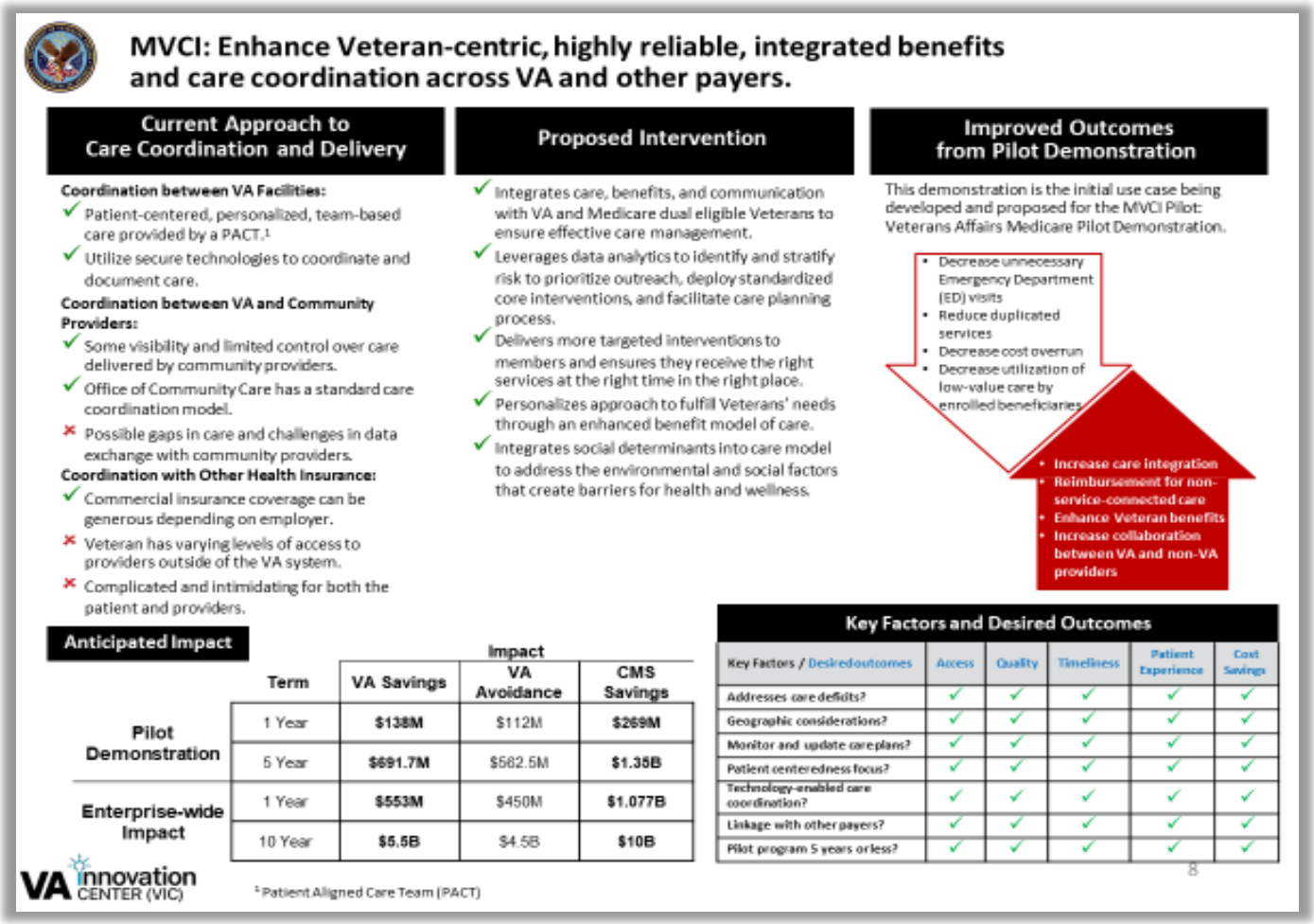
MVCI Pilot



Discussion / Questions:

What modifications should VA consider to increase the likelihood of success?

What additional care deficits should VA prioritize for exploration?

How can VA gain Congressional support for these pilot program proposals?

Dr. Sandy's comments:

Dr. Sandy asked, "What does dual eligible mean in this context?" Mr. Akinyele stated "VA and Medicare Eligible"**.** Dr. Sandy suggested to combine data and stories when talking with Congress. Show what the future will look like for a specific Veteran.

CPCV
Dr. Sandy commented that pro bono dental capacity seems to be a fixed resource. Noting that if the pilot works, it may crowd out access for other vulnerable populations in the community, which could lead to backlash. He asked if there is a way to create a win-win utilization of underserved capacity? He suggested that one way to create a win-win way may be to increase the capacity of the community.

MHD3
Requirements for mental health in the private insurance market could differ between "in" and "out of network" providers. There could be prior authorization requirements and utilization management protocols that would need to be addressed. Dr. Sandy asked, "how do commercial provisions fit the supply opportunity outlined in the pilot?" Dr. Sandy also mentioned that with private insurance, people go in and out of coverage. "How would this be addressed in the pilot?" The last comment on this pilot is to consider addressing smoking. The prevalence of smoking in people with behavioral health conditions is approximately double the rate than the rest of the population. There is opportunity to address this with the pilot focusing on mental health.

MVCI
He commented that taking a care management intervention and applying it across two reimbursement programs is conceptually appealing. However, there are very few care management programs that he has seen that save money in the first year. It usually takes a couple of years to figure out how the program works, to discover the right population to focus on, and to figure out what interventions reduce costs. He feels it always better to under promise and over deliver.

Mr. Pollack's comments:

Mr. Pollack asked about the mechanism to obtain real time feedback which will allow VA to make quick adjustments. He stated that having a "real-time feedback loop" from people "on the ground" is important. He also asked if there is a "measure of success"?

CPCV
Mr. Pollack asked, "how is VA identifying the providers who will do the volunteer dental care?". He noted that VA may have to utilize providers that are outside the immediate community and cast a wider net. There will be providers of all health services, not just dental, who will be willing to provide pro bono services to Veterans. Mr. Pollack suggested using Veteran Service Organizations to help with finding providers.

Mr. Pollack identified additional deficits that VA should prioritize for exploration**:**

- Issue of Hunger - establishing food pantry associated with providers (i.e. a prescription for food)
- Issue of Homelessness
- Bring together and coordinating federal programs (Food stamps, housing, etc.)

Mr. Pollack suggested that VA update Congress regularly and frequently - update more times than the minimum requirements. Keeping Congress informed is key to gaining congressional support. Mr. Pollack suggested the following activities to gain Congressional support:

- Regular hill briefings that are initiated by VA in order to frame the discussion
- Find members of Congress who will champion for these pilots
- Use testimonials from Veterans in pilot programs
- Utilize social media
- Invite Congress and local medial to do field visits

Mr. Nuntavong's Comments:

CPCV
Mr. Nuntavong testified in front of Congress last year about dental care. He emphasized the importance of dental care by recognizing that he saw his dentist more than he saw his physician while in the military. He would like to see more Veterans receive dental care.

MHD3
With there being a shortage of mental health providers across the country, Mr. Nuntavong wants to make sure that Veterans who are currently eligible for VA care, still receive mental health services if VA expands care to Veterans who are not currently eligible.

Dr. Hamilton's Comments:

CPCV
Dr. Hamilton stated that there will be a few challenges with implementing the CPCV pilot. She comments that pro bono is limiting. The American Dental Association who represents private sector dental providers will have to be involved with this pilot. She also asked the question of how will quality be addressed?

She continued to say that since most of the pro bono dental providers will not be VA employees, the standards will still need to remain high, and safe care will still need to be provided. She asked, "Who will oversee ensuring the standards of care are met?" Dr. Hamilton addressed the topic of post pro bono treatment by asking what are Veterans to do if not eligible for dental care? She warned that it would not be wise to start care and not continue the care. The VHA Office of Dentistry will need to be engaged address these issues.

Dr. Kellermann's Comments: Dr. Kellermann was in favor of the three pilot programs.

CPCV
He confirmed that routine dental care will help reduce the number of avoidable ER visits. Picking the first pilot sites and showing return on investment is crucial to success.

MHD3
Dr. Kellermann gave the names of resources that could help this pilot succeed. The first is the Defense Veterans Center for Integrated Pain Management. Chronic pain is clearly a major factor in despair and suicide and this organization has intervention strategies to help. The second resource he named was the Center for Deployment Psychology, which helps civilian private practice psychologists understand military culture. These resources will help providers better understand a Veterans' experience.

Dr. Levin's Comments:

He commended the VA for the three pilot programs. He is in favor of providing dental services to Veterans who are not currently eligible, because it is greatly needed.

MHD3
Dr. Levin stated that Medicare's suicide and mental health programs are "not as good as the VA's programs". When bringing Medicare in the VA system, make sure that VA's programs are not diluted. He also warned that VA will need to ensure that specialty mental health providers are not being replaced by less educated mental health providers who can treat patients through tele-health.

Dr. Daley's Comments:

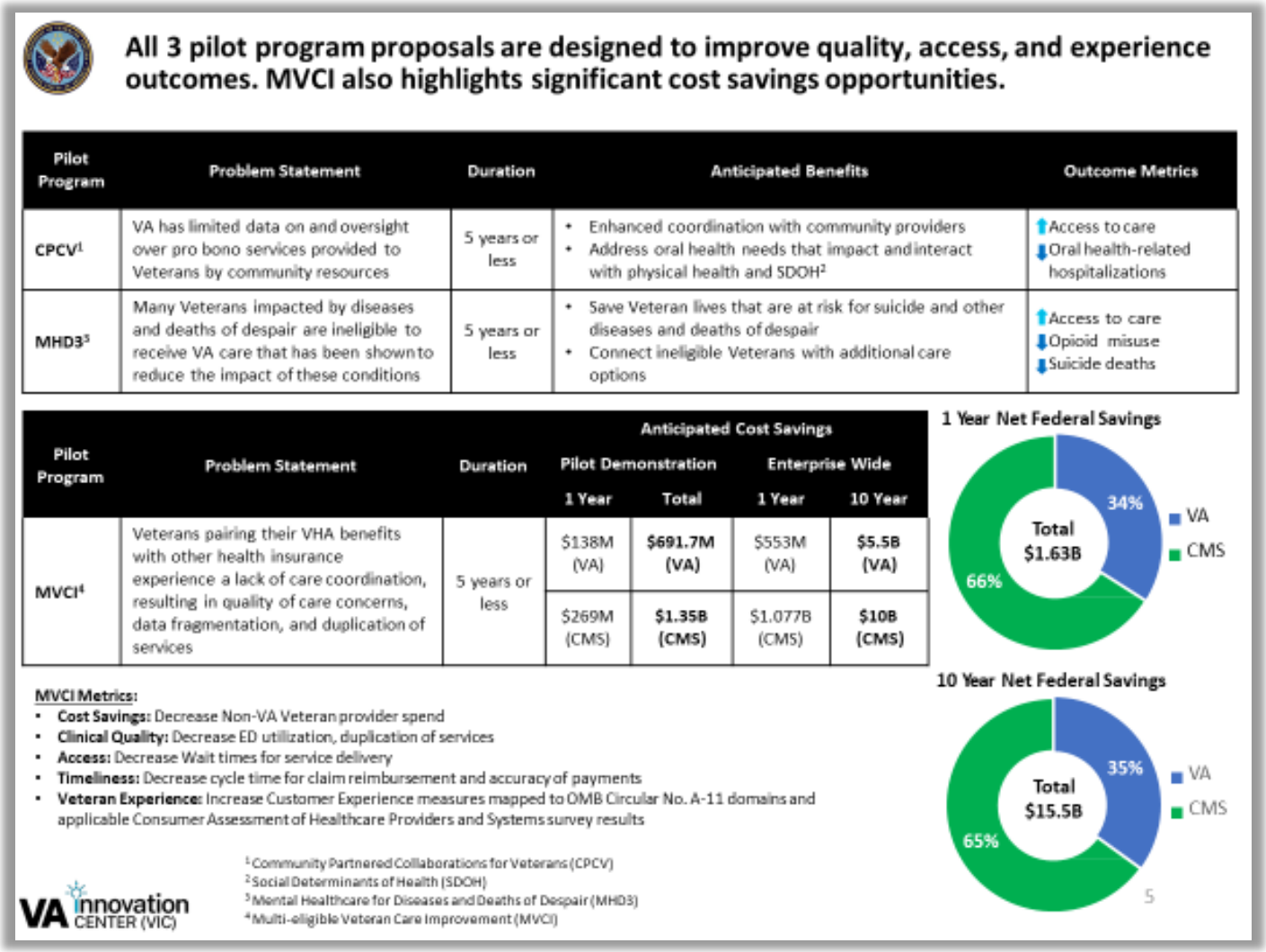
Dr. Daley asked, "Why are veterans coming back to VA if he/she is Medicare eligible? Is it the less expensive medication? What services does VA provide that Veterans cannot get through Medicare (in a timely manner or at the same quality)?" She was not sure of the answer and encouraged VA to find out what is driving that decision. She believed one of the reasons is that telehealth can be successful is that visits do not require a face-to-face meeting, which helps to reduce the stigma and makes it more likely for patients to share more information.

Dr. Meyer's Comments:

Dr. Meyer believed that these pilot programs will provide great opportunity to improve care. The CPCV program reminded him of a program that Massachusetts did called Community Partners. The Community Partners program has been successful and is now being extended to address housing and food insecurities. VA could model the CPCV program after Community Partners. He suggested another source to learn from is the National Association of State Health Policy, which often gathers people together who work on programs like CPCV and Community Partners.

MVCI

Dr. Meyer would like to see how VA will address people with triple eligibility (Military Retiree/VA/Medicare). He is in favor of starting these pilots out with a series of demonstrations. He suggested VA look back at CMS during 2002-2015 era with their demonstration programs. The Congressional Business Office (CBO) has documents that summarize the experience that can serve as a lessons learned guide. He then refers to slide 5, which has a list of metrics (see below). He proposed adding two other metrics: *provider experience and the ability to share information back and forth*. Dr. Meyer warned that for the first 18-24 months the data for the pilot programs will not be favorable and will probably result in cost increases. VA will have to be patient, but two areas that VA will see rapid improvement will be Veteran experience and provider experience. Dr. Meyer predicted that these changes will occur within 6 months, which can be used to keep Congress onboard while cost may be rising.



All 3 pilot program proposals are designed to improve quality, access, and experience outcomes. MVCI also highlights significant cost savings opportunities.

Pilot Program	Problem Statement	Duration	Anticipated Benefits	Outcome Metrics
CPCV[1]	VA has limited data on and oversight over pro bono services provided to Veterans by community resources	5 years or less	• Enhanced coordination with community providers • Address oral health needs that impact and interact with physical health and SDOH[2]	⬆Access to care ⬇Oral health-related hospitalizations
MHD3[3]	Many Veterans impacted by diseases and deaths of despair are ineligible to receive VA care that has been shown to reduce the impact of these conditions	5 years or less	• Save Veteran lives that are at risk for suicide and other diseases and deaths of despair • Connect ineligible Veterans with additional care options	⬆Access to care ⬇Opioid misuse ⬇Suicide deaths

Pilot Program	Problem Statement	Duration	Anticipated Cost Savings			
			Pilot Demonstration		Enterprise Wide	
			1 Year	Total	1 Year	10 Year
MVCI[4]	Veterans pairing their VHA benefits with other health insurance experience a lack of care coordination, resulting in quality of care concerns, data fragmentation, and duplication of services	5 years or less	$138M (VA)	**$691.7M (VA)**	$553M (VA)	**$5.5B (VA)**
			$269M (CMS)	**$1.35B (CMS)**	$1.077B (CMS)	**$10B (CMS)**

MVCI Metrics:
- **Cost Savings:** Decrease Non-VA Veteran provider spend
- **Clinical Quality:** Decrease ED utilization, duplication of services
- **Access:** Decrease Wait times for service delivery
- **Timeliness:** Decrease cycle time for claim reimbursement and accuracy of payments
- **Veteran Experience:** Increase Customer Experience measures mapped to OMB Circular No. A-11 domains and applicable Consumer Assessment of Healthcare Providers and Systems survey results

VA innovation CENTER (VIC)

[1] Community Partnered Collaborations for Veterans (CPCV)
[2] Social Determinants of Health (SDOH)
[3] Mental Healthcare for Diseases and Deaths of Despair (MHD3)
[4] Multi-eligible Veteran Care Improvement (MVCI)

5

Dr. Perlin summarized the comments noting a common theme is "how does VA make expanding care to Veterans a win-win for Veterans and providers".

He stated that “another person’s savings is another person’s expenditure”. He also asked, “What happens to the total cost of care when care coordination is improved?” Providers would love to help Veterans, but what are the challenges of providing Pro Bono work? In the conversation earlier it was mention that capacity could be an issue. There also could be an issue of imposing regulatory reporting requirements on providers which could make providing pro bono care a burden.

Dr. Stone provided closing comments. He noted that Veterans choose VA because, “They trust us, they trust because we understand them. We understand the complexity of the co-morbidities that they bring to us.” After the CHOICE Act was enacted, VA saw that 9 out of 10 Veterans choose to come back to VA after a single episode of care in the community and chose not to go back to the community again. The reason was that the Veterans felt that the community providers did not understand them.

Dr. Stone stated that VA is not providing truly wholistic care until VA can provide oral care services at a greater level than what is currently authorized. He feels that VA must engage all Veterans, even the ones that do not qualify for Mental Health services. He concluded by saying he is excited about the three pilots and that VA will need support from Veterans Service Organizations to get support from Congress.

PREVENTS Executive Order: Building the National Suicide Prevention Roadmap:

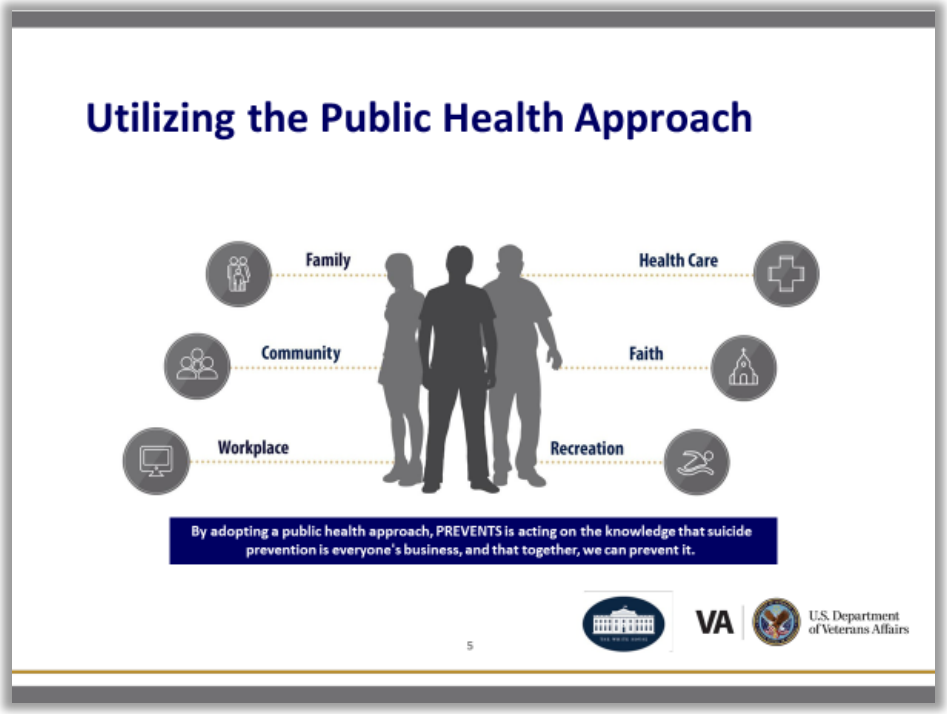
Presenter:
Barbara Van Dahlen, PhD, Executive Director, PREVENTS Task Force, Dept of Veterans Affairs

Dr. Stone introduced the presentation by stating his passion for this topic. He stated that he is very excited about the work of Dr. Van Dahlen on behalf of the Veterans Health Administration (VHA) and the President of the United States of America to fulfill the vision of changing the national dialogue. Dr. Stone continued to say that there is an intense isolation that occurs when a servicemember leaves the military. He feels that addressing the issue of isolation can be just as important as financial problems, relationship problems, and other illnesses. He expressed his frustration for VHA having an accessible mental health community, yet Veterans have come to VHA campuses, to commit acts of self-harm, resulting in death.

Dr. Van Dahlen briefly discussed PREVENTS Executive Order (EO) 13861 signed by the President on March 5, 2019. The EO directed the Secretary of the U.S. Department of Veterans Affairs (VA) and the Director of the White House Domestic Policy Council to co-chair and stand up an interagency government task force to develop a plan implementing a roadmap for the prevention of veteran suicide at the national and community level. The purpose of the PREVENTS Task Force is aimed at improving Veterans’ quality of life and lowering the Veteran suicide rate by developing a national public health Roadmap that integrates public and private entities to work across the nation.

The PREVENTS Roadmap is an all-hands-on-deck approach to integrate public and private entities across the nation to empower veterans and prevent suicide. The Roadmap will utilize a public health approach, focusing on changing the culture of mental health broadly and specifically how suicide is addressed nationally. It will focus on three key areas, consisting of *community integration*, *research strategies*, and *implementation strategies.* **NOTE:** A PREVENTS Subcommittee was established under SMAG to supplement the PREVENTS Task Force's goals.

Dr. Van Dahlen acknowledged that Veteran suicide cannot be resolved without addressing suicide nationally since suicide is a national crisis. By taking a public-health approach, it is the hope to lead the nation on suicide prevention by determining what solutions, gaps, and opportunities there are within the federal government. The public-health approach will include campaign message similar to "buckle up for safety" or "friends don't let friends drive drunk" campaigns, which is a cultural shift for suicide prevention. There is a focus on strategies for high-risk populations, such as Veterans, first responders, Native Americans, and people who have first degree relatives who have taken their own lives or attempted to take their own lives. There is engagement with faith-based communities and corporations who have been eager to help. Intense education is needed to change the narrative that suicide is only a mental health crisis and more education is needed so everyone can identify the risk factors for suicide, similar to how one can identify the risk factors for heart disease or diabetes.



Through research, risk factors for suicide are known:

- **Health factors**
  - Mental health challenges
  - **Substance misuse and addiction**
  - Serious or chronic health conditions and/or pain
  - Traumatic brain injury
- **Environmental factors**

    - Access to lethal means (e.g., drugs, firearms)
    - Prolonged stress
    - Financial issues
    - Stressful life events
    - Exposure to another person's suicide or to graphic or sensationalized accounts of suicide
    - Unemployment
    - Homelessness
- **Historical factors**
    - Previous suicide attempts
    - Family history of suicide
    - History of abuse, neglect, or trauma

Six (6) Lines of Effort have been created under the PREVENTS Subcommittee: **Lethal Means, Partnerships, Research Strategies, State and Local Action, Workforce and Professional Development, and Communications** – developing the PREVENTS Public Health Campaign.

Discussion / Questions:

How can we best leverage the opportunities and distribution channels for our PREVENTS messaging from your specific sector resources?

What are barriers of which we may not be aware that members may have knowledge of that could interfere with implementation of such a broad public health approach?

Dr. Levin commended Dr. Van Dahlen and VHA on all the hard work that has been done so far and agrees with the plan that she has presented. He commented that the Veterans Crisis Line phone number is too long for someone to dial in a crisis. The number should be a 3-digit number which is easier to remember and dial. He also commented is that every healthcare provider needs to start conducting proper suicide assessments. **Dr. Van Dahlen** is in agreement with a shorter phone number for Veterans who are in a crisis. She noted that the 988 number has been approved, but work still needs to be done to go live with national and VA phone line.

Dr. Perlin noted that before the next face to face SMAG meeting, there will need to be a virtual meeting to vote on the road map. He noted that fundamentally this plan requires culture change, but culture change takes time. He asked the question, "how does one reconcile the need that culture change takes time, but there is an urgent need to act quickly?" **Dr. Van Dahlen** responded by stating in 2013, when she began working on this subject, there was very little conversation and cultural awareness about mental health. Now people are talking about suicide more openly. There has also been a rise in mental health affinity groups, which is another example of the culture shift. Dr. Van Dahlen suggested that the federal government resources be used to target more people at risk for suicide. To save more lives, data is going to be used to find more people who need help. She also mentioned that the VA PREVENTS office is partnering with the VHA Suicide Prevention Office and Department of Defense's (DoD) equivalent to the suicide prevention to work together to change the culture.

Dr. Meyer is in favor of the idea of starting with awareness. He noted that this is exactly what is needed to de-stigmatize suicide. He believes the opportunity for partnerships is very vast and the community is willing to work with together. Dr. Meyer commented that a consequence of provider burnout can be suicide. He encouraged VHA to look at the suicide rates among providers. Provider suicides (nation-wide) are about 1.89x that of the general public. He has not seen any data on VA or DoD provider suicide rates but emphasizes the importance of caring for those who care for Veterans.

Dr. Lee noted that the work Dr. Van Dahlen is describing will not only help with suicide reduction it will also improve depression care for more people. He stated that zero-suicides should be the goal. He asked, "What is the percentage of Veterans who commit suicide by firearm?" **Dr. Stone** stated that the data can be found in the 2017 Suicide Report. The number of suicides that are firearm related is 70% of all Veteran death by suicide.

Mr. Nuntavong asked, "Who is on the PREVENTS task force?" He provided a word of caution by stating that he knows that suicide by lethal means (firearms) is a political hot topic and there's a division in our country about Second Amendment rights (gun ownership). **Dr. Van Dahlen** noted that the list of Task Force and Subcommittee members are in the SMAG member's binders**.** There is a lead or a co-lead on each workgroup or Line of Effort that comes from a federal agency. The workgroups have about 100 people total. This is not related to Second Amendment rights because the focus is on safety. Dr. Van Dahlen met with the Surgeon General, White House, VA, and DoD and stated that the taskforce must take on lethal means if the they are to have any credibility. VA has been working with shooting associations, and DoD is also focused on lethal means. This is about protecting people who are high risk, but it does not mean taking away guns permanently or even long term. The workgroups are also working with police departments and she believes that the culture regarding lethal means can change similar to the way the culture of drunk driving changed. The plan is to not politicize this effort and to continue the conversation with stakeholders.

Dr. Trautman stated that the she agrees with more education for health professions on suicide assessments. She stated that her organization, the American Association of Colleges of Nursing, did research on emergency medicine and found that patients provided better answers when using technology for screening versus face-to-face interviews. She would like to see technology infused with the lines of efforts to produce better outcomes**. Dr. Van Dahlen** noted that the workgroups are looking at technology. Large technology companies have agreed to provide assistance in helping with this problem. The workgroups are looking at tools such as "Talk Space" to help with this problem. She asked the SMAG for help with reaching and pushing out messaging healthcare providers.

Mr. Pollack applauded Dr. Van Dahlen for framing suicide as a public health issue. In terms of leveraging and distribution channels, Mr. Pollack stated that he has the access and influence with an organization that has a presence in every community in America to help with pushing Dr. Van Dahlen's messaging. **Dr. Van Dahlen** thanked Mr. Pollack for his willingness to help and

mentioned that the VA is also trying to push out messaging through universities and through state and local governments.

Dr. Kellermann stated that Dr. Van Dahlen is correct about addressing lethal means regarding suicide prevention. He stated that in 1992, the New England Journal of Medicine published a study regarding suicide in the home in relation to home ownership. This study showed a nearly five-fold increased risk of suicide if a person is in a home with a gun.

He suggested to frame the conversation in terms of "You are my Battle Buddy, you matter. You're really struggling right now. Why don't I keep your guns for a few days?" That is a strategy to keep Veterans who are at a high risk for suicide without permanently taking away his/her gun(s).

He noted that more can be done to make sure that every healthcare provider gets a basic knowledge of military culture, community, weapons, etc. More can be done to help prepare servicemembers for their post military careers. VSOs are critically important to engage during this process. Dr. Kellermann concluded his comment by asking Dr. Van Dahlen to engage Howard and Jean Somers since, they are good advocates to help the VA build support with Congress.

Dr. Hamilton asked, "What is being done to prevent suicide for servicemembers prior to their departure from military service?" **Dr. Van Dahlen** noted that the workgroups are not just looking at when servicemembers join the military. Risk factors for suicide can begin in childhood. The goal is to make sure every American understands the risk factors for suicide and to teach children emotional well-being, and how to talk about depression anxiety, and post-traumatic stress. DoD is also working closely with VA to focus on that transition period when leaving service.

Dr. Stone concluded the discussion by saying the VA must begin to reach sub-populations (Veterans, Active-duty members, national guard members, non-activated national guard and reserve members) to better focus prevention strategies. There must be honest dialogue about the role of opioids, substance abuse, and addiction plays in suicide.

With some individuals, death by suicide is an impulsive act and there needs to be more discussion on how to separate the decision versus the action. About 2000 times a day, Veterans call the Veterans Crisis Line (VCL). The number is difficult to remember, and the VA needs to change to a 3-digit number for the crisis line. There is a need to move away from crisis intervention only and move toward examining the risks of subpopulations.

Dr. Stone continued to say that there have been positive research advances. Last summer, VHA worked with Columbia University that gave suicide prevention contracts to survivors of a suicide attempt who were admitted to the emergency room. VHA now has multiple anecdotal reports of Veterans who were saved by those contracts. In order to achieve zero suicides, it will require continued dialogue that Dr. Van Dahlen is leading, just hiring more mental health professionals will not achieve this goal.

Dr. Perlin summarized the discussion by noting key points – provider burnout, secondary trauma, relationship to depression care, lethal means, education across different professions, use of technology for screening and perhaps soliciting answers that may not be given directly to others, use other organizations to amplify the role of VA as an educator of many health professionals who can impart knowledge about suicide prevention, gun knowledge, military and occupational exposures, issues of pre and post military transition, the resilience model – building of life skills.

Quality Standards in Community Care – MISSION Act

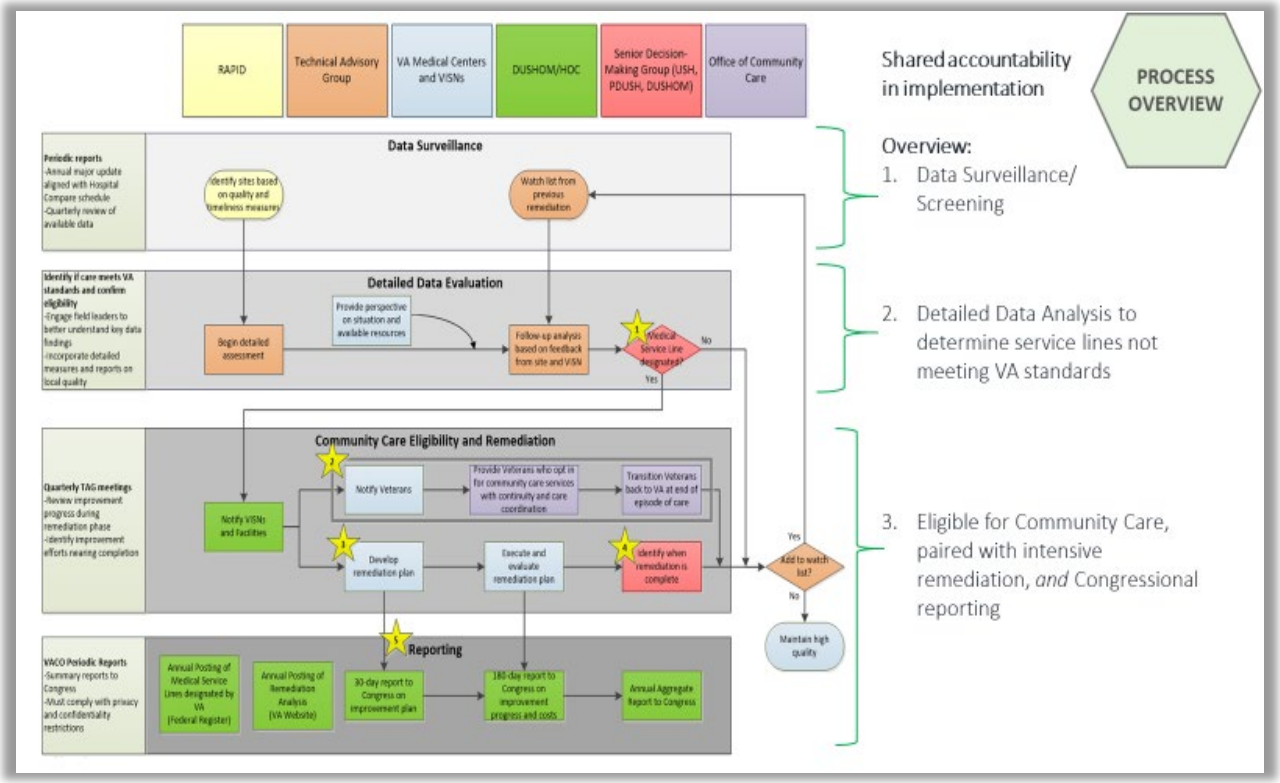
Presenter:
Joe Francis, MD, Acting Chief Improvement & Analytics Officer, Reporting, Analytics, Performance, Improvement and Deployment (RAPID) Office

Dr. Perlin framed the presentation / discussion by asking the group to weigh-in on the process to address the complex question about the assessment of quality within VA in terms of the implications of care outside VA as well as the assessment of quality more broadly as VA seeks to commission care in the community.

Dr. Stone acknowledge the complexity of "data" – who owns data, how do you govern data, etc. VA has been forced to openly present data on websites. How does the American Veteran who has been referred to the community know he is getting the same quality when coming to the VA? Why isn't the rest of American medicine publishing their quality data? How does anyone choosing healthcare make decisions? Dr. Francis has been an integral part of these conversation.

Dr. Francis noted that this a follow-on to the presentation that was given at the SMAG meeting in Charleston, SC on March 29, 2019. The pre-reading material outlined the previous presentation to show how VA developed the current quality standards for the MISSION Act. Dr. Francis stated that "Quality standards are aspirational - We want our care for Veterans to be timely, safe, effective, and Veteran centered." He stated that industry measures are inadequate and are used to measure ourselves – only sometimes able to get correlating measures in the community. The legislation used explicit language around "medical service line", which is a very granular comparison – "that is like saying is Dr. Smith or Dr. Jones the better Cardiologist – you can't do that today with standard measures." Dr. Francis stated that health care industry does not have transparent measures, therefore, VA uses what industry uses – Hospital Compare, HCAPS, Nursing Home Compare, HEDIS Measures, which are not as granular as the legislation intended and the White House, Congress and Health and Human Services recognized that. That led to the White House EO on transparency (*Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First*) on June 25, 2019. A Quality Roadmap is due to the White House in December 2019 – most media coverage has been focused on costs. The most important paragraph for VA is paragraph 4, which talked about quality measurement better and meaningful measures. The communtiy health care organizations are pusing back about reporting more measures. Dr. Francis' presentation focused on how VA is operationalizing the MISSION Act.

The first slide is a flow chart (see below) which is a process overview. Dr. Francis noted that they are not aligning two tables of numbers to see if "A" is greater than "B", and if so, send the care out. There is a deliberative process that has three steps involved with the fourth step being public reporting. The first path is a screening - VA is looking at wait times, experience scores hospital Compare, and HEDIS benchmarks. VA is also identifying potential sites that may be worthy of further exploration. The second phase is called "deliberation". This is when the data is presented



to the Technical Advisory Group (TAG). The Technical Advisory Group (TAG) is a multi-disciplinary, critical advisory group supporting VHA's MISSION Act-related processes to identify medical service lines within VA facilities that do not comply with established quality and timeliness standards.

> Membership: Medical Center and Network leadership; Key Program Office representatives (Patient Safety, Performance Improvement, Surgery, Geriatrics, Access, Health Equity, Health Care Ethics); Chiefs of Staff; Chief Medical Officers; Nurse Executives; Operations leadership; Medical Service Line leaders; Health Operations Center; Relevant Subject Matter Experts.

The TAG ensures consistent, fair and responsive application of the MISSION Act standards for quality and remediation requirements to ensure Veterans receive high value care best suited to their needs.

> REVIEW: Undertake routine expert review of quantitative and qualitative data sources
> ENGAGE: Work with the VISN and VAMC leadership to support effective analyses and decision-making
> RECOMMEND: Provide recommendations to support MISSION Act triggered decisions on community care eligibility and remediation actions to the PDUSH, DUSHOM and the VHA Executive in Charge

Dr. Francis noted that TAG has already met, and VA has a small number of sites that will be reviewed in the final meeting next week. VA is going to identify several sites where one or more measures may trigger "remediation". VA is trying to pivot from an internal comparison to a community comparison. Most of VA's metrics are based in primary care, the three medical service lines that are triggering remediation are in primary care. They are often triggering in markets that

are uniquely challenged by high growth in Veteran, low rates of availability in community and high rates of reliance on VA - often the measure is not the problem. It is a sign that pockets of our system are under stress.

Dr. Stone will receive a recommendation from the TAG regarding the remediation and by law, the SECVA makes the determination about the remediation plan, - *Section 109 of the MISSION Act* - "*Not less than 30 days after determining a medical service line is providing care that does not comply with the standards for quality established by the Secretary, the Secretary shall submit to Congress: …* ". VA must make a determination if there is "immediate jeopardy" and if so, they can offer the Veteran immediate care in the community under current eligibility criteria set forth by MISSION Act. VA hopes to never invoke this process, which means VA stays ahead of the community. On virtually every HEDIS measure for chronic disease management VA is 10, 15 and some 20 points ahead of the community. VA does not have a single VA hospital that has a higher risk adjusted mortality rate than the community according to Medicare. 1 out of 3 hospitals in the United States do not have enough data to compare to the private sector, which is a challenge in the quality realm. Dr. Daley pointed out that the reason for this is that the outcomes VA is looking at rare, and the smaller size the more data you have to have overtime to have a stable estimate. "If you have a process measure, you have a lot more in the denominator and you don't have that problem." Dr. Francis noted that there is always a discussion about using "outcomes measures" vs "process measures" in quality care.

Dr. Perlin noted that one challenge is that VA relies on the data that is available. Available data can be limiting and may not serve the intended purpose. Measuring small numbers or low rates of an event may not predict future occurring of those events in the next quarter from something that is aggregated. These limitations have been discussed at the Quality Summit under the EO reference earlier. What is the process of quality assessment of the measures in terms of needing to have something vs knowing the limitations of the data? **Dr. Francis** responded by saying that VA has the capability to drill into other systems and gain additional insights even if they may not be statistical insights. The TAG feels that qualitative data is important – Long Term Care Survey's, The Joint Commission Reports, Issue Briefs, Inspector General Reports, Employee Engagement, RN staffing and turn-over reports, etc. Dr. Francis provided an example of one VA Medical Center who is under remediation that reported high on PSI4 (Mortality among surgical patients with major complications). When further review was completed, the handful of deaths were in Orthopedics at facility with a large Nursing Home attached. The Veterans had fallen and fractured a hip and the surgical procedure is the best solution, but is also very high risk in these cases. Unfortunately, there is a high risk of mortality. We don't want to send the message to not complete high-risk surgeries if it the best solution. Sending Veterans to the community adds risk of fragmentation and we do not assess the impact or risk of fragmentation of care. VA is working on developing measures to identify risk of fragmentation.

Dr. Francis briefly noted the quality and timeliness measures (slides below) – there are many metrics that underly these measures to gain more context and understanding. He noted that the law required VA to look at quality and timeliness measures and in order to trigger remediation, a site must trigger two quality measures and one timeliness measure. Where a site has a timeliness issue, MISSION Act already provides access to the community if timeliness is not met. Most cases of remediation will likely be triggered by the "best medical interest" eligibility criteria, which is already built in to normal healthcare decisions on the best course of action for the Veteran. Dr. Francis's team will identify sites with one or more measures triggered even if the formal algorithm is not triggered. Those sites will be engaged to review and develop plans accordingly.

Quality Measures (Comparison with the Community)

DATA PROCESS

Standard	Quality Measures	Primary Care	Women's Health	Cardiology	Endocrinology
Timely Care	CAHPS access ratings (composite)[1]	X			
Effective Care	Smoking and tobacco cessation[2]	X			
	Influenza immunization[2]	X			
	Breast cancer screening[2]		X		
	Cervical cancer screening[2]		X		
	Controlling high blood pressure[2]	X		X	
	Risk-adjusted mortality rates for CHF[3]	X		X	
	Beta-blocker treatment[2]	X		X	
	Risk-adjusted mortality rate for AMI[3]			X	
	DM - Blood pressure control[2]	X			X
	DM - HbA1c poor control (A1C>9) [2]	X			X
Veteran-Centered Care	CAHPS provider rating[1]	X			
	CAHPS coordinated care ratings (composite)[1]	X			

1: Community comparison data from CAHPS Research Database; Measure not included in Network Director Performance Plan report
2: Community comparison data from HEDIS
3: Community comparison data from Centers for Medicare & Medicaid Services

Timeliness Measures (Internal VA Comparison)

DATA PROCESS

Timeliness Measures	Primary Care	Women's Health	Cardiology	Endocrinology
New patient wait time for appointments from create date (% seen within 30 days and average wait)	X	X*	X*	X*
CAHPS access ratings - routine care appointments (top and bottom box scores)	X	X*	X*	
CAHPS access ratings - care needed right away (top and bottom box scores)				
CAHPS access ratings – answers to medical questions (top and bottom box scores)				

*Not all facilities met minimum sample size requirements (60 appointments, 50 CAHPS responses)

For each VA Medical Service Line

VAMCs are flagged if performance is worse than **two standard deviations from the national average**.

VISNs are flagged if performance is worse than **one standard deviation from the national average**.

Discussion / Questions:

Should SMAG (or other deliberative body) have a role in review of remediation plans?

Is there additional feedback on the scope of information to be included in recommendations to Executive Leadership?

Are there cautions to be exercised that were not specifically addressed?

Discuss the challenges associated with providing evidence to support the conclusion of the Remediation Process.

Dr. Meyer thought this was a reasonable approach to start. He provided comments on three standards/metrics.

1. Patient Safety Indicator - The faster we can move off of this metric, the better.
2. Outpatient wait times – There is no standard in the private sector. The standards that VA has set are higher than in the community. VA must be thoughtful of the community healthcare facility that a Veteran is sent to because the quality may be worse than VA.
3. CG-CAHPS (The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey) - Medicare does not have a repository of that data, but there are many benchmarking resources that are available.

Dr. Meyer noted that VA will need to go electronic with clinical quality measures as soon as possible which should be included in the upcoming new electronic health record.

In terms of sending Veterans out to the community, one of the standards has to be the community provider's ability to get the information back to the VA, so care does not become fragmented.

Dr. Meyer feels SMAG must have a role in the review of remediation plans because this could become very political and the "cover" of a somewhat "external" group (SMAG) will be invaluable to the VA. Dr. Meyer's stated that his biggest fear is having a VA facility in the remediation process will be demoralizing for a staff. VA must remain mindful that the goal of the remediation process is to help improve the quality of the facilities and not chastise for poor performance.

Dr. Meyer concluded by saying that VA cannot wait for the outcome and will have to rely on the process. VA can have processes in which facilities have autonomy and when a facility reaches the conclusion of the remediation process, it can be validated later. VA should not put facilities "on hold", especially when the VA feels that facility has reached the proper standard.

Dr. Daley stated that VA is more transparent than other healthcare organizations. The problems that is created is that there will be a list of metrics by service line that other organizations do not have. This situation is hard to explain politically. When discussing these metrics, the focus will have to be data and anecdote driven and Congress will have to educated.

Dr. Daley comments on metrics/standards:
Case-mix Adjustment – There will be no comparative data
Risk Adjustment – Veterans have social determinants of health that are far greater than the non-Veteran population. Community healthcare organizations are not measuring this risk factor.

Dr. Daley comments on the Process

An outdated way to do quality improvement is looking for the facilities that are not doing well and looking to "bring them up" to a mean (average). That is not the proper way to do quality improvement. Quality improvement is taking the whole organization and moving them up the curve which results in the average increasing. The most impact will be from taking best practices from high performing VA facilities and spreading those practices across the VA system.

Dr. Daley felt that SMAG should be involved in reviewing the remediation plans.

Regarding exercising cautions, Dr. Daley felt that VA is already exercising all the caution that is possible. The biggest test will be if VA finds a facility that does not remediate and the facility must be reported, which could create a "firestorm".

Regarding challenges associated with providing evidence to support the conclusion of the remediation process, Dr. Daley stated that there will be enough evidence in the text around the metrics to be able to cushion decisions that are thoughtful and helpful. The facilities in remediation will feel bad, so it will be a challenge to motivate them.

Dr. Lee commented on the wait times and measures by saying private sector healthcare organizations are becoming less interested in wait times and other metrics because these metrics do not measure what is important to patients. In today's market, access means more than just getting your appointment, access means getting your needs met. People are willing to get their needs met without an appointment. For example, Kaiser Permanente has many patient interactions that are not doctor visits. There are no measures that have been developed that really capture what access means to today's healthcare consumers. He stated that what really matters is a patient's peace of mind. Wait times do not matter as a driver of overall peace of mind, but what does drive peace of mind is confidence in the clinician, teamwork, caring behavior and good communication. If the communication is good, it does not matter how long a patient waits. Patient experience is the real metric to focus on.

Dr. Kellermann asked if the VA community comparison data can be shared with the Defense Health Agency (DHA)? **Dr. Francis** stated that VA has been working with the Defense Health Agency regarding community comparison data. **Dr. Stone** stated that the team from DHA came and toured VHA's Joint Operation Center. The Joint Operation Center presents VHA's performance data every morning at 7:45 AM from the previous day. **Dr. Kellermann** noted that the vital signs effort is where 12 key measures were chosen that everyone in healthcare should do. He asked, "Are there any thoughts on a more limited yet high yield set of data that every healthcare organization can measure?" Most healthcare organizations can populate data from existing measures. This work may be hard, but it is important. **Dr. Francis stated "yes",** the idea is to have a parsimonious list of key indicators of high value. The vital signs report has faded a bit, but what has risen is the core quality measures collaborative. VA experts and others are looking at a sensible list of measures with the goal of making an impact.

Dr. Meyer stated that this is a quality assurance effort. There is another side to the spectrum. VA will find facilities that are outstanding across the board. He wondered what the opportunity is to start partnering together high performing with low performing facilities that are of similar size, geography, and population served.

Dr. Francis noted that his office, RAPID (Reporting, Analytics, Performance, Improvement and Deployment) allows staff from high performing facilities to speak to and mentor staff from low performing facilities and share best practices. He concluded by stating that access is not the strongest driver for patients. The strongest drivers are communication and care coordination.

Dr. Perlin stated that there is a great opportunity to capture information from high performers and share them with low performing. Getting feedback from these leaders is important. The practices may not be transferrable but there may be insights that could help improve a low performing facility. There is no "silver bullet".

Dr. Stone stated that when he arrived at VA a few years ago, VA could not measure itself against anybody but itself, as a result, a bell curve existed because no one could understand standard deviation and stars were attached to the rating system (1 star – bad; 5- good). He noted that no one wanted a 1-star facility even though all the 1-star facilities had a lower case adjusted mortality rate than the private sector hospitals that surrounded them. Congress was constantly asking why the VA had 1-star facilities. He continued by stating that when Joe Francis arrived, he discovered that 83-87% of our facilities never moved from their rating. Changing the dialogue has taken over a year, with only a little progress. VHA must come back to the SMAG for this discussion so we can get sense of where the thoughts among healthcare industry leaders. VA does not want to operate in a system where there will always be 1-star facilities and 5-star facilities because we cannot measure ourselves against anybody.

Dr. Stone continued by discussing VHA's All Employee Survey (AES) Scores. He stated that it was discovered that the 52% of nurses who identify themselves as delivering excellent care are in 4 and 5-star facilities. The 48% of nurses who said "we do not think we deliver excellent care" are in 1 and 2-star facilities. These nurses were defining themselves by stars even though their mortality rates, complication rates, infection rates were better than the community. That is the danger of using this type of model if you do not get it right. VA must continue to look at how we measure ourselves.

Dr. Meyer commented that he would like to keep hearing about suicide prevention efforts at each SMAG meeting. He concluded by saying the SMAG is willing to help VA do a better job of measuring their quality. **Dr. Stone** noted that Congressional staff do not want to hear something other than the star system. When EHRM goes live (Spring 2020) – the facilities of American Lake, WA; Seattle, WA; Spokane, WA will be pulled from the star system 6 months in advance and 24 months after. The facilities will still be monitored, but I would like to continue to discuss this topic at SMAG. **Dr. Meyer** stated that VA should not have to go to Congress and fight the battle of how to properly measure facilities alone. Many SMAG members have backgrounds in health services research.

Dr. Kellermann was impressed by thoughtful comments and was glad to see high level senior leaders from VHA who were engaged in the conversation.

Dr. Perlin and Dr. Stone thanked the SMAG members, presenters, and VHA Senior Leaders for their time.

Business Meeting:

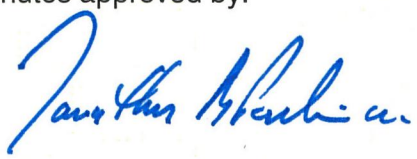
Three departing members received a certificate of appreciate for their contributions to the SMAG, Dr. Michelle Hamilton, Dr. Saul Levin, Dr. Keith Cook (absent) and Ms. Karen Ignagni (absent).

Mr. Chanin Nuntavong, Dr. Art Kellermann, and Dr. Michael Mittelman were honored with certificates for being newly appointed to the committee.

Adjournment:

The meeting adjourned at 3:30pm

Minutes approved by:



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