Department of Veterans Affairs
Special Medical Advisory Group

September 9, 2020
Washington, DC
9:30am-2:15pm

MINUTES

Attendees:

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)
James H. Martin, M.D., Physician, Captain James A. Lovell Federal Health Care Center
Gregg S. Meyer, M.D., MS.c, Chief Clinical Officer of Partners Healthcare System.
Deborah Trautman, Ph.D., RN, Chief Executive Officer, American Association of Colleges of Nursing (AACN)
Jennifer Daley, M.D., FACP, Senior Medical Director, New England Region, Cigna Health Care
Lewis Sandy, M.D., FACP, Executive Vice President, Clinical Advancement, UnitedHealth Group
Thomas Lee, M.D., Chief Medical Officer, Press Ganey Associates, Inc
Michael Mittelman, O.D., 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 Headquarters
Arthur L. Kellermann, M.D., MPH, FACEP, Professor and Dean, F. Edward Hebert School of Medicine Uniformed Services University of the Health Sciences
John E. Prescott, M.D., Chief Academic Officer, Association of American Medical Colleges (AAMC)
Phillip R. Sandefur, D.D.S., Associate Director of Dental Laboratory Operations, VHA Office of Dentistry, Central Dental Laboratory
Terry Fulmer, Ph.D., RN, FAAN, President, The John A. Hartford Foundation

Committee Members Absent:

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

Invited Guests:

Francis J. Crosson, M.D., Chairman, Congressional Medicare Payment Advisory Commission (MedPAC)
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
Ross Taubman, D.P.M., President and Chief Medical Officer, Podiatry Insurance Company of America (PICA)
Howard Burris, M.D., Chief medical officer, President of Clinical Operations, and Executive Director of Drug Development at Sarah Cannon Research Institute, President of American Society of Clinical Oncology

Department of Veterans Affairs Staff and Presenters:

Richard Stone, M.D., Executive in Charge, Office of the Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs
Steven Lieberman, M.D., Acting Deputy Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs
Jon Jensen, Chief of Staff, Veterans Health Administration, Department of Veterans Affairs
Carolyn Clancy, M.D., Assistant Under Secretary for Health for Discovery, Education and Affiliate Networks, Veterans Health Administration, Department of Veterans Affairs
Rachel Ramoni, D.M.D., Sc.D., Chief Research and Development Officer, Veterans Health Administration, Department of Veterans Affairs
Beth Taylor, D.H.A., RN, Assistant Under Secretary for Health for Patient Care Services and Chief Nursing Officer, Veterans Health Administration, Department of Veterans Affairs
Scotte Hartronft, M.D., Executive Director, Geriatrics and Extended Care, Veterans Health Administration, Department of Veterans Affairs
Michael Kelley, M.D., National Program Director for Oncology, Specialty Care Services, Veterans Health Administration, Department of Veterans Affairs,
Chief, Hematology/Oncology Durham VAMC, Professor of Medicine, Duke University
Bruce Montgomery, M.D., Medicine and Oncology, University of Washington, Seattle Cancer Care Alliance, VA Puget Sound Health Care System
LaTonya Small, Program Specialist, VA Advisory Committee Management Office

SMAG Administrative Team:

Brenda Faas, Designated Federal Officer
Justin Warren Alternate Designated Federal Officer
Tasha Martin, Committee Manager
Dennis Lahl, Committee Manager

Call to order:

Brenda Faas, Designated Federal Officer called the meeting to order at 9:30am, September 9, 2020.

SMAG Committee Welcome:

Dr. Perlin welcomed the new and returning members to the meeting. He emphasized the importance of SMAG in supporting the Under Secretary for Health. He noted that while Congress functions as VA's "Board" with subcommittees of various jurisdiction, SMAG offers a group of individuals who bring deep subject matter expertise from a variety of complimentary disciplines to support the Mission of VA.

Opening Remarks:

Dr. Stone thanked the members for their time and expertise. He noted the agenda topics which were reflective of the current healthcare environment: Pandemic Response, emerging thoughts on Elder Care in America which is colored by the issues that arose during the pandemic, and the evolution of Precision Oncology. He noted that VA is the largest provider of oncology services in Nation, VA diagnoses new cancer diagnoses 200 times a day and cares for well over 50,000 Veterans with cancer.

Dr. Stone prepared the group for the showing of a video that displayed the tireless work of VA employees at the Alexandria VA Medical Center who had to transfer complex patients during hurricane Laura and the pandemic. Sixty-Nine patients were moved to as afar as way as 6 hours to other VA hospitals. The planning and successful execution of this event is a testament to the creatively, innovation, and cooperative nature of this healthcare system. Dr. Stone noted that VA has over 300 mobile assets all over the country that can be deployed in a crisis. **Dr. Perlin** expressed gratitude on behalf of the committee to the men and women of VA for their dedication during this event.

Dr. Perlin asked for minutes to be officially accepted. No amendments. Minutes officially accepted by consensus.

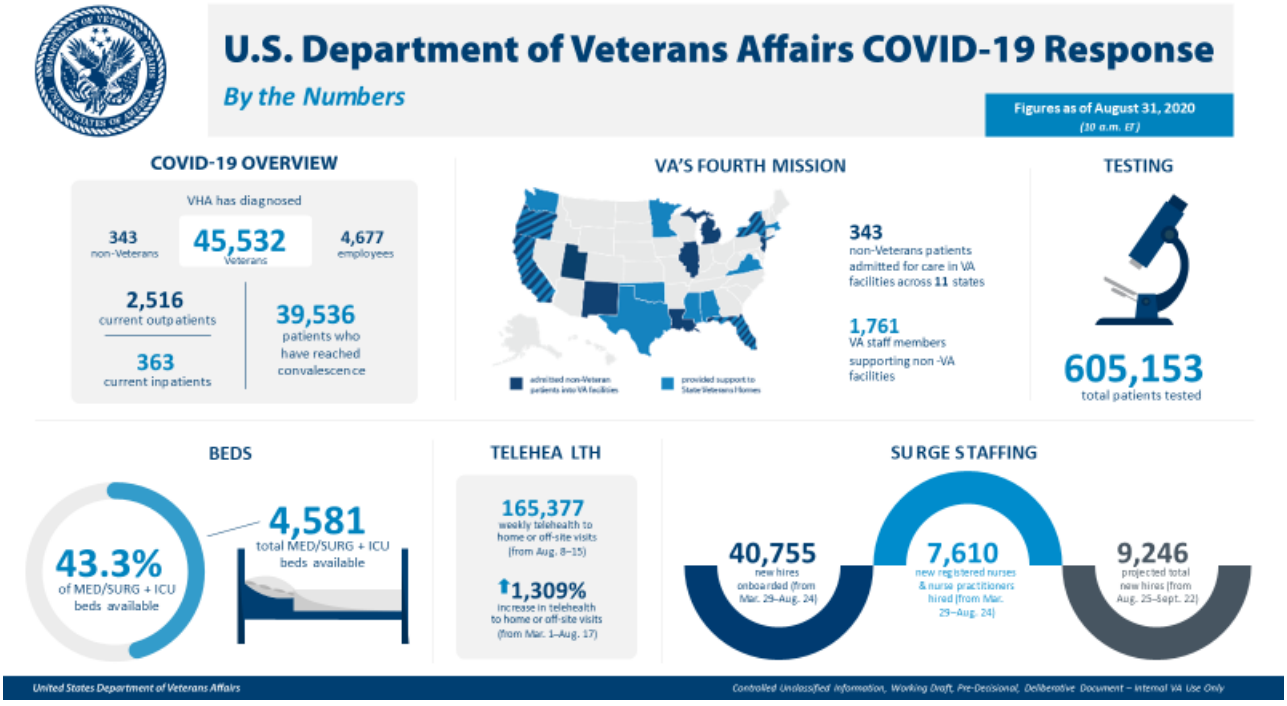
Pandemic Response:

Jon Jensen, Chief of Staff, Veterans Health Administration, Department of Veterans Affairs

Dr. Stone opened by stating that VA began intensely following the Coronavirus (COVID) in January early 2020. VA established a Health Operations Center (HOC) in conjunction with an Emergency Operations Center (EOC) which provided daily oversight of the evolution of the pandemic.

Mr. Jensen presentation reviewed the timeline of the pandemic and VA's response as events unfolded across the country. He began by explaining the functions of the HOC which was key in communicating with the field about real time operational logistics, bed capacity, local challenges

etc. He continued with discussing highlights of VA response. There was ongoing discussion about logistics specifically with the challenges in obtaining Personal Protective Equipment (PPE). VA's first positive COVID case was in Palo Alto from the cruise ships docked on the West Coast in March 2020, a Veteran and non-Veteran. VA's 4th Mission is to support the Nation in times of national emergency, which is how VA was able to treat non-Veteran patients. Positive COVID cases among Veterans in New Orleans were always higher than in the private sector, which VA was never sure why. VA participated in daily calls with other government agencies (FEMA, HHS and DoD) to discuss combined government response. The first Veteran death occurred around mid-March in Portland, Oregon and VA began to ramp up their response. Mr. Jensen stated that VA activated the 4th Mission in New York offering 50 beds as they were a hot spot. VHA Leadership determined they needed better forecasting – next hot spots, where do we need focused support, etc. Forecasting was filled through a contract with Mckinsey and continues today. Mr. Jensen discussed the challenges that were beginning to surface with State Veterans Homes and nursing homes in areas of staffing and leadership. VA's was asked by over 30 states to provide support in the forms of consultation, advice, PPE, personnel, equipment, testing, etc., in the areas of geriatric care. VA began to look at their own personnel and as employees were retiring, they need to increase the onboarding of staff. VA worked diligently to speed up the amount of time to hire to manage any potential staffing shortage. As the pandemic continued, VA was impacted by natural disasters such as Arizona Bush Fires, Hurricane Laura and social riots. Mr. Jensen closed his presentation by sharing data in the slide.



Dr. Stone acknowledged several VA leaders in the room starting with Dr. Steven Lieberman. Dr. Lieberman, Acting Deputy Under Secretary for Health, functioned as the VA Liaison to the Emergency Support Function (ESF) Team 8 – one of 15 teams that reported to Health and Human Services (HHS) during an emergency. He was the first VA representative ever to be included on this team. The Federal Emergency Management Agency (FEMA), HHS, Public Health Service, and

Department of Defense (DoD) now recognize VA for the nursing home support they provided. They now look at VA hospitals across the country for inpatient bed availability for civilians, if needed. Dr. Beth Taylor, Assistant Under Secretary for Health for Patient Care Services and Chief Nursing Officer, primarily focused was on the Nursing Corps – staffing, training and deployment capability. Ms. Deb Kramer, Acting Assistant Under Secretary for Health for Support, manages logistics, procurement, facilities, engineering, industrial hygiene, VA's Disaster Emergency Medical Personnel System, and the Canteen Service. Her main focus during the pandemic was PPE and equipment to protect Veterans and employees. Dr. Christine Bader has been working with Dr. Ediger on the COVID-19 VA Response Plan. As mentioned by Mr. Jensen earlier, Dr. Stone wanted to see what was coming to the United States based on what was happening in other countries. McKinsey was in 50 different countries and had resources to provide input from around the world. VA was trying to determine how to manage loss of staff; domestic production capacity and related concerns over the Strategic National Stockpile which is meant for the private sector. VA sent several Senior Executives to FEMA and HHS to develop relationships to be in the middle of the Federal response discussions. As VA prepared to support the country, VA offered Intensive Care Unit beds to take on the sickest patients. He noted that Dr. Lieberman worked with the Indian Health Service (IHS) to provide support to the tribes. Many tribes opted out of IHS, which then required VA to go into the tribes to take care of those sick patients as they would not go to IHS for services.

DISCUSSION:

Dr. Perlin recognized the VA COVID-19 Response Plan as "extraordinary" and noted the similarities with his own organization, specifically regard protecting people, patients and communities. He emphasized that, "You couldn't care for patients unless you care for staff, you couldn't care for staff unless you have certain necessities like Personal Protective Equipment (PPE), you couldn't have PPE in the context of supply chain deficiencies in the absence of absolutely 'un-training' from everything we were taught to do - disposal of 95 respirators, etc." He noted the actions of protecting supplies by "cohorting" patients and using the supply chain in a different way - Protecting supplies by using supplies in a different way. Testing was also a challenge as a negative result still required universal precautions. Patients still needed non-COVID care – many patients did not seek formal care. Dr. Perlin cited a New England Journal of Medicine Article about the reduction in coronary syndrome, stroke and other conditions in the month of April. He acknowledged the need for data to understand what would influence community outbreaks, e.g.travel, etc. He mentioned the importance of the bi-product of "accelerating learning" during this time – continuous improvement in the system. He believes that health care will face many challenges, there is a second surge – how to balance between the needs of COVID patients and everything else. Dr. Perlin acknowledged the discussion questions posed by VA to the committee:

1. What are your thoughts on the major challenges the health care industry faces over the next 4-5 months (i.e. COVID-19 and flu season, staffing, supplies, vaccine distribution, etc.)?
2. What are your thoughts on meeting demand for supplies given strains in the supply chain (i.e. PPE, testing materials, etc.)?
3. What are your thoughts on handling staffing including hiring, managing employee leave, remote employees, and retirement?
4. What are your thoughts on managing and building trust with patients and stakeholders including for clinical trials, vaccines, surveillance, contact tracing, and changes in process?

5. What are your thoughts on the mental health impacts of COVID-19, including isolation for older adults, vulnerable groups, those impacted by economic strain and others?
6. What are your thoughts on handling preventative care and encouraging individuals to come in for non-emergent care in order to prevent long-term health impacts?

Dr. Meyer recognized that life continued on in the background while everyone focused on COVID. Chronic disease continued to impact people and deaths related to stroke and myocardial infarction were the additional tolls. A lesson is that the healthcare system will not be able to shutdown again, meaning elective procedures will need to continue and staffing issues will be more acute during another pandemic. Dr. Meyer acknowledged that the benefit of limiting the function of a health care system is that those staff were able to be deployed to other areas like testing. It will be important to explore self-testing options due to the reality that the personnel who were available in March and April of 2020 will not be as available in future surges. He asked what VA is doing to pull patients who deferred care back into care to limit the secondary impact of the pandemic where people are not seeking care and chronic conditions turn into acute episodes.

Dr. Kellermann discussed his concern that the second waive will likely pose more challenges due to influenza season, people moving back inside and societal fatigue. He noted that more states and municipalities are opening, and it will be hard to revert to a more restrictive lifestyle. An important point he mentioned that was not in the list of major challenges posed by VA is the politicizing of the pandemic, which complicates the ability to motivate the country, communities and healthcare staff. He felt that active disinformation and a high level of distrust are creating complication and no agency, VA or DoD or academic medicine, can "hospitalize" their way out of this pandemic. He believes that we must have an "engaged population who does the right thing and follows the right pre-cautions". He stated that some people feel that a vaccine will rescue everyone or they don't care about a vaccine and are going to do what they want to do. The challenges that healthcare is facing may be bigger than previous months. He noted that the healthcare workforce is tired and many have paid a significant "psychic toll". He emphasized that healthcare cannot over prepare enough. There is critical need to prevent as many cases as possible and manage positive cases in an outpatient manner.

Dr. Mittelman raised concern that health care systems are not built for a pandemic, they are built for lifestyle – diabetes, hypertension, cardiac disease, etc. - moving from inpatient to outpatient care. He believes the second waive may be worse than the first waive and he is concerned that healthcare workers are burnt out. He is concerned that the healthcare infrastructure is strained, and not sure enough time has been spent rejuvenating to manage a second waive. He acknowledged challenges with the increase in chronic diseases that are not being treated and the backlog of procedures that need to be completed. He referenced the cost of the pandemic that will have the greatest impact on smaller community hospitals who may not be able to survive. He is also concerned about the disinformation, political discourse and the societal fatigue - "they think we can snap our fingers and we will have a vaccine". He sees little evidence of a vaccine dissemination plan for the country. He read a recent report, that said "only roughly 60% of a population will take the vaccine, which means we need to build the trust of the American people so they will take a vaccine".

Dr. Prescott feels the trust issue is huge. He stressed that VA has the Veterans trust and the population is looking for "who we can trust and what is the right information?" He asked, How is the

VA working with other federal agencies? – based on the reading materials is seems as if those relationships evolved. How will this impact VA's budget?

Dr. Akman asked how does VA operates among different states guidelines? What have you learned from VA having lower hospitalization rates than the civilian hospitals, except for New Orleans? Is it Veteran behavior, is it education, etc? What about health disparities among Veterans and what is the VA doing? What is VA seeing and doing to manage increased depression, suicide prevention, access to guns?

Dr. Fulmer asked about the experience of nursing home care during COVID in the VA. She works on a national and international project called Creative Age-Friendly Health System – which believed that "health system starts at your kitchen table and should get you through every setting back to your kitchen table". She noted that less than 0.5% of the population or 1.5 million people live in nursing homes, however, nursing homes had 8% of total COVID positive cases and 68,000 deaths. She asked what can the rest of the country learn from VA experience and the failure of nursing homes in other settings?

Dr. Trautman thanked VA leaders for being a role model for the rest of the country. She expressed that the VA guide to the pandemic response was a phenomenal resource and many of the members of the American Association of Nursing Colleges used it. She noted that the rise of misinformation was not created by the pandemic, but it highlighted the significant concern and that evidence alone is insufficient to guide people's decision making and action. Public opinion is shaped by emotion as well as personal beliefs. She feels that those employed in the health care have a responsibility to be strong educators and advocates in a nonpartisan way to bring evidence forward so others can gain a better understanding. She noted that the health and wellbeing of the health care workforce is important and was a concern prior to the pandemic. She announced good news that nursing education enrollment has not declined. She closed by saying that "we need to understand and roll-model what VA is doing, and other best practices are doing, to manage health disparities, which were not created by the pandemic, but definitely highlighted."

Dr. Crosson spoke of two assumptions regarding testing -facts and technology are changing daily so his comments are based on today's knowledge. Considering that resources are not infinite, he advised not to spend a lot of time on anti-body testing. The frequency of false positives based on his IT background, renders it less useful. Antigen testing has utility in screening out those who are positive, but reducing transmission rates, but there still are false negatives. He continued to suggest to use whatever technique can be used that is easiest to acquire the sample and provides the quickest results would be most useful for screening out employees. "RNA PCR testing" should be reserved for individuals who present with symptoms, in particular, when flu season begins. He reemphasized the comments previously raised regarding the vaccine. He feels there will be a major problem of anxiety spreading to get the vaccine when it is available. There will be a new divide with those who are immunized and those who are not. He concluded by saying that, "collectively and individually, we need to try to restore a sense of confidence in the utility of vaccinations will be vital for medical and social cohesion purposes".

Dr. Sandefur addressed the concerns related to dental with such a high risk related to aerosolization. The VA has the same architectural challenges that occur in private sector – some VA medical centers have open bays and some have doors. He reported that the VA offices of Dentistry, Engineering and Infectious Disease provided guidance to the VA clinics that addresses physical barriers, HVAC systems, UVC light, etc.

Dr. Lee first began by stating that VA did a great job in the roll-out of telemedicine. He explained that forwarding looking organizations that have a payer function are looking at telemedicine differently. They are determining how to integrate telemedicine and in-person care with certain diseases. He noted that the University of Pittsburgh Medical Center is looking at patients with diabetes and heart failure trying to integrate specialist through telemedicine, which is a different approach than most of healthcare who still look at RVUs. He expressed that VA has an opportunity to do even greater work by thinking differently in addressing access issues. Second, in predicting need, he believes the fall and winter will be "wild" with the flu and vaccine. He talked about a sophisticated prediction tool at the Mayo Clinic at the county level using Google search data and using artificial intelligence to make predictions better. The models have been getting better at predicting emergency room visit, Intensive Care Unit use, and the need for PPE in the 2-4 week time frame. It is a national resource and he has encouraged them to share.

Dr. Perlin recapped a few themes – trust, fatigue, and skepticism about the vaccine which are all even more of a concern with the onset of the flu season. Fragility of the community hospital, fragile public health infrastructure, and fatigue of health care works themselves. A positive side, nursing school enrollment remains robust. A summary of the questions include how to catch up on deferred care, impact on budget, how to work across different state guidelines, what is being discovered with health disparities, how is the elder population being managed, how is the health and well-being of the workforce being addressed, and thoughts on prioritizing testing. **Dr. Stone** began by stating that restoring the trust of the American Veteran in the VA Health Care System became a focus since 2015. VA has improved dramatically and now exceeded 90% in Veteran trust scores with the key being reliability. He asked Dr. Liberman to reflect on restoration of trust through the pandemic. **Dr. Lieberman** noted that VA took the pandemic very seriously because Veterans have a higher morbidity that similar non-Veteran population. VA took a quick stance in stopping routine visits, admission and visitors to nursing homes including spinal cord injury units. By taking actions early, he believes VA saved many lives. We continued to take care of urgent needs, throughout the pandemic VA was seeing urgent visits in less than one-day whether in-house or through community care. Telehealth and telephone appointments increased and e-consults expanded whereby a specialist reviews the consult and calls the patient to discuss the referral – all with the goal of limiting cancellations or delays in care. VA had approximately 3 million canceled appt and another 300,000 referrals to specialty care that were considered to be routine. Every facility worked to call each Veteran to offer follow-up services in the VA or in the community. Various modalities were used to communicate options to Veterans and to let them know VA was working for them.

Dr. Stone continued discussing the challenges in working across various state guidelines. He noted that VA does have federal supremacy, but is it less clear than the Department of Defense who has very clear laws. **Dr. Taylor** stated that VA has portability of licensure allowing VA clinicians to work in different states even if their license is from another state. The challenge is with the scope-of-practice which is important as VA implements the new electronic health record (EHR). She reported that VA must work to the lowest common denominator, for example, if a state does not allow a registered nurse to work under a medical staff approved protocol then that VA Medical Center must work to that standard so individual nurse or his/her license are not put at risk. With EHR, VA will need every discipline to have a standardized scope-of-practice so that staff are practicing at the same level regardless of state of licensure or the state they work in. In addition, this is important in virtual care as VA provides care across state lines.

Dr. Stone continued by talking about the repurposing of ambulatory nursing staff to critical care areas. VA shut down portions of ambulatory care clinics, which meant nurses were available. Online courses were available for the ambulatory nurses to allow them enough training to support the critical care nurses who were seeing an increase in complex patients. These courses did not turn an ambulatory nurse into critical care nurse, but guaranteed that the critical care nurse had support from a clinician who had some level of knowledge and allowed the certified critical care nurse to extend her capabilities. In addition, hospitals were becoming lonely places with no family allowed to visit. Deaths were occurring in this lonely environment which weighed on the nursing staff. Adding more nursing staff created network of support that was critical on many levels.

Dr. Stone continued in answering the budget related questions. He stated that he originally asked for $70 million which evolved into $170 million and congress eventually passed $17 billion (2-year funding). By the end of FY20, VA will have spent approximately $6 billion on the COVID-19 Response and by the end of the pandemic VA will likely spend about $15 billion. Dr. Stone was able to allow Medical Center Directors, who are normally held to tight fiscal constraints, to hire more staff. Over 40,000 staff were hired, growing the workforce by 11,000 employees. With the attrition rate of 9% per year, Dr. Stone feels that VA will be able to correct the over hiring in the coming years. As discussed previously, the over hiring was a good decision in order to manage the high depletion of employees who were not able to work for whatever reason.

Dr. Stone moved on to address the question of gender and ethnic disparity issues. VA has touted that disparities have been erased in Veterans who are diagnosed with prostate cancer. Not because VA is better at treating prostate cancer, but because VA controls co-morbidities and removes the economic disincentive for receiving care for diabetes and hypertension. Veterans are older – average age of Americans today is 38; average age of Veterans is 58; average age of male Veterans is 65; average age of women Veterans is 50. African American population in VA care has a higher testing rate and positive rate than Caucasian population, but mortality rate is NOT any higher. He is unsure why, but has a few theories: 1. 70% of Americans Veterans were deployed and had many immunizations prior to deployment. Their immune systems could be more robust. 2. VA is better than a non-integrated system in controlling co-morbidities. These two theories could be why Veterans have done better in all areas of the country, except New Orleans. In New Orleans Veterans have higher infection rates than the civilian population. In the previous 60 days, VA has seen a dramatic reduction in infection rates in the African American population, but Hispanic Veterans have remained high. The Native American population has also remained high and VA has been challenged in managing their co-morbidities.

Dr. Perlin closed the session by bestowing gratitude on behalf of the committee to VA and VHA leaders for their service supporting Veterans and the Nation during the pandemic.

VA Leadership Comments:

Brooks Tucker, Acting VA Chief of Staff, Department of Veterans Affairs

Mr. Tucker expressed his gratitude for SMAG, acknowledging their expertise and help in transforming VA. He continued by acknowledging the significant changes in VA in the past three and half years. He has seen a great improvement in the governance structure which allows for better information to flow from the field or front-line staff to the top leaders to make better

decisions. He believes the increase in trust scores over the past few years is not an accident. The scores are because of good leadership, good communication, and relationships at local and regional levels. Over the past few years, VA had the most ambitious legislative agenda in over a decade. The MISSION Act, Appeals Modernization, Caregiver Modernization and the modernization of the electronic health record all have transformed the public perception of VA. He mentioned the PREVENTS task force and the importance of mental health treatment/outreach in VA. He acknowledged the innovative ways VA has managed all aspects of the pandemic, which will impact VA for years to come. In closing, he stated that the collective wisdom and input of SMAG is crucial to creating innovative ways to improve VA processes. This will be most important as VA begins to see the convergence of the two big demographics - the older Vietnam Veteran who will be using more resources and the younger generation who wants VA to innovate and change the way VA cares for them.

Redefining Elder Care in America:

Beth Taylor, D.H.A., RN, Assistant Under Secretary for Health for Patient Care Services and Chief Nursing Officer, Veterans Health Administration, Department of Veterans Affairs

Scotte Hartronft, M.D., Executive Director, Geriatrics and Extended Care (GEC), Veterans Health Administration, Department of Veterans Affairs

Dr. Stone opened the session by acknowledging that VA Community Living Centers (CLC) are equivalent to community nursing homes, however, they operate at a higher level with physicians/geriatricians assigned to each ward and nursing staff at an acute care level. He stated that this may not be as cost effective as the private sector, however, as the pandemic hit, VA had low infection rates and was able to support hundreds of nursing homes across the Nation. He emphasized that an important part of the conversation is discussing the "interventions we ought to be doing with elder population in America that reduces institutionalization, prolongs independence, that promises the potential of living our lives out in our own homes, and how do we approach that as a healthcare system". He ended by stating that VA looks to intervene at an earlier age and with the hope of positively impacting the future directions of a Veteran's life.

Dr. Taylor began the presentation by acknowledging the current re-organization of VHA Central Office recently moved the GEC office under her leadership. She stated two significant reasons why VA fared better during the pandemic in the long-term care arena: 1. CLCs are within a system of care run by medical center leaders. CLCs include rehabilitation, hospice, palliative and geriatric-psych in addition to short-term and long-term stay. She noted that by being a part of a system of care, CLCs received support regarding logistics (Personal Protective Equipment included) and medical center leadership policies during a crisis. 2. Staffing of doctors and nurses is at a higher level than in typical private nursing homes. Staffing methodology in nursing is standardized in assessing the types and number of nurses and the number of registered nurses impacts patient outcomes.

Dr. Hartronft continued the presentation by referencing the top five challenges in managing an aging population.

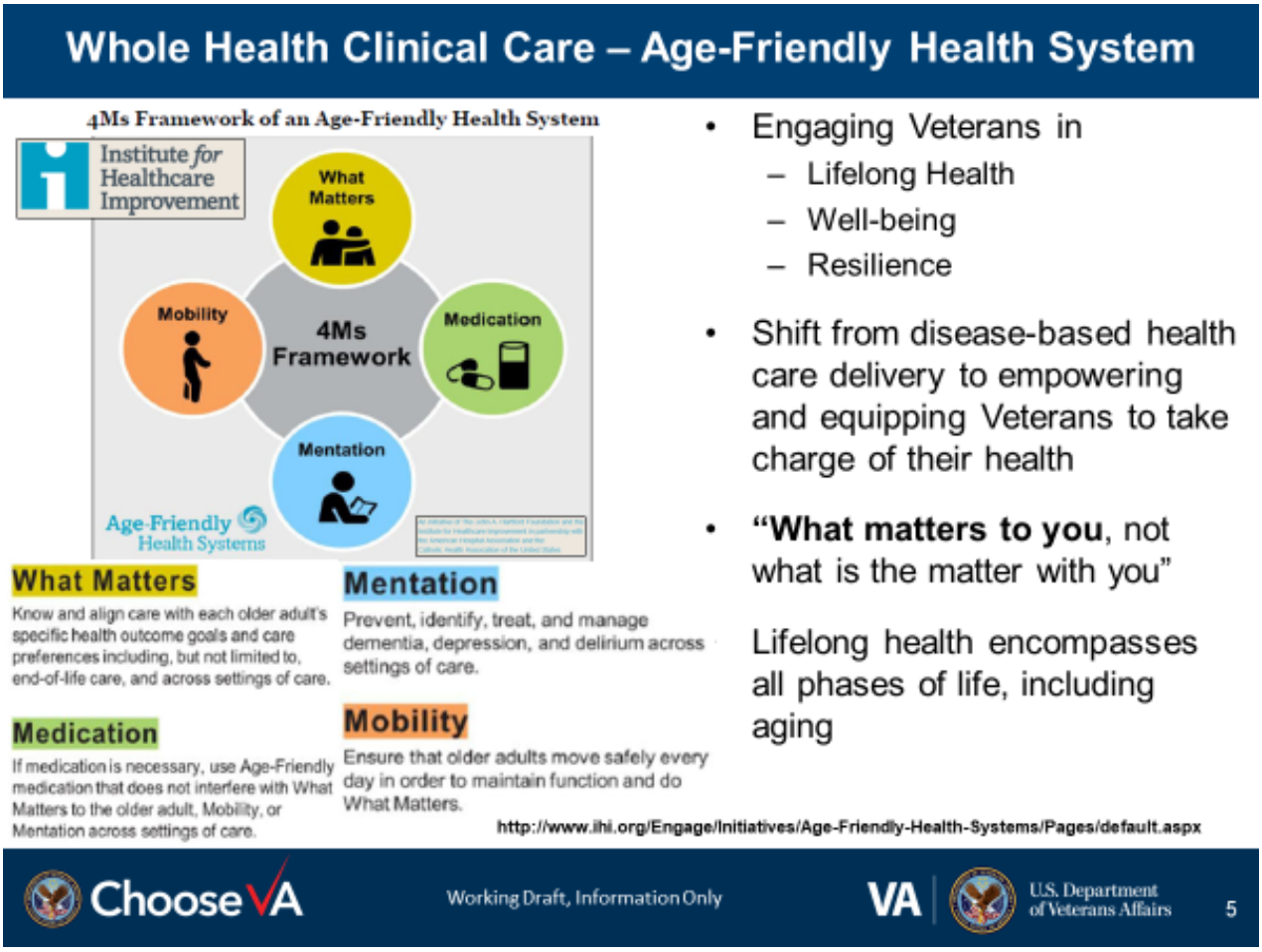
1. **Aging Veteran Population**: By 2037, Veterans over the age of 75 will increase by 72%

2. **Changing Veteran Needs**: By age 75, 57% of Americans will have greater than 3 chronic medical conditions. Studies show an association between Post Traumatic Stress Disorder and depressive disorders and an increased risk of dementia in military Veterans.
3. **Geriatric and palliative care workforce shortage**: There is no incentive in pay structure which is important when postgraduates are looking to pay off loans. If the VA medical center is limited in their GEC programs, it likely that they are also limited in the private sector which is often the case in highly rural areas.
4. **Rising health care costs**: Average cost for nursing home for VA was $98,000 in FY19. GEC Long Term Services and Support accounted for approximately 12% of total VHA budget and nursing home care was the largest contributor. VA must think outside the box to address these issues.

Dr. Hartronft summarized the variety of service VA has to offer stating that VA is unique in being able to cover a continuum of care for all ages. VA offers (for all ages) Ambulatory Care, Acute Inpatient Care, Home and Community Care, Facility-Based Care (CLCs) and Hospice Care. VA's goal is to keep Veterans as independent as possible and to be able to age in place in the least restrictive environment. GEC developed six strategies FY20-FY24:

1. **Expand Home and Community-Based Services**: Allow Veterans to age in place while reducing costs, improving Veterans outcomes and honoring Veterans choices.
2. **Modernize System of Healthy Aging**: Streamlining and standardizing processes and resources to facilitate a high-reliability approach to optimizing care of aging Veterans enterprise-wide.
3. **Modernize and Improve Facility-Based Care**: Aligning facility-based beds with demographic trends ensure access to quality institutional care for aging Veterans. For Veterans who can't stay in the home, ensure facilities can manage the complex patient that include geriatric psych, long term ventilator and dementia patients.
4. **Improve Access with Technology**: Expanding access and improving clinical care delivery by implementing the latest technology in virtual care. Focus on telehealth to increase agility with the inability to do home visits during pandemic. Expanding specialty tele-medicine like tele-urgent care and tele-triage throughout the emergency rooms.
5. **Increase Geriatrics Expertise**: Expand the workforce with geriatrics and palliative care expertise to meet the growing needs of Veterans. VA needs to keep a core cadre of geriatric expertise across all disciplines and to be able to teach within their disciplines.
6. **Develop Data Definitions and Processes**: Utilize data to improve communication and inform services for aging Veterans. VA needs to be talking the same language to support the other five pillars.

As VA moves to be a more age-friendly health care system under the umbrella of whole health clinical care, VA adopted the "4-M" model from the Institutes for Healthcare Improvement (IHI) – *4M: What Matters, Medication, Mentation and Mobility*. Adding a "sub m" under Mentation to acknowledge "mood" for mental health. (see slide below)



Dr. Hartronft discussed the pilot proposal, *Redefining Elder in America Project* (RECAP), that VA is submitting under the MISSION Act, Section 152, which encourages VA to use innovative ways to deliver care.

Pilot Strategy 1: Early Detection of high risk, high need Veterans through predictive analytics and coordinated care. This pilot uses a predictive analytics tool to comb through the electronic health record and the Clinical Corporate Data Warehouse to find the Veterans who are at the highest risk of institutionalization in the next two years. Then the Primary Care Team proactively reaches out to those high-risk Veterans to set up home care services rather than waiting for Veteran to declare theirs need for services, which may be too late to prevent nursing home care.

Pilot Strategy 2: Expand Home and Community Based Services and include a waiver. To reduce unnecessary spending, VA is requesting a waiver to be able to pay for room and board in a Medical Foster Home for highly service-connected Veterans. VA is mandated to pay for nursing home care for Priority 1a Veterans, but paying for room and board in a more independent setting is less costly.

Dr. Hartronft emphasized that VA hopes to assess at least 90% of the high-risk Veterans for preventative intervention home care services prior to nursing home placement. Currently only 30%

of Veterans receive non-institutional services. VA will be monitoring a variety of outcome measures: Veteran satisfaction, caregiver satisfaction, quality of life, caregiver burden, hospital admission rate, hospitalization length of stay, emergency room utilization, urgent care utilization, nursing home admission rate, nursing home average length of stay, and total healthcare expenditure.

DISCUSSION:

Dr. Meyer acknowledged the timeliness of this topic due to the pandemic and the challenges faced by our aging population.

Dr. Fulmer emphasized the importance of a "system of care' and the importance of the appropriate staffing which are key components of an age-friendly health care system. She discussed the "greatest success of the 20th century is longevity…we doubled life expectancy from 40 to 80ish…, but what we don't do well is take care of people when they become old and frail". She praised VA for leading this effort and addressing the continuum of care. The 4-M's are essential to aging, which were all impacted by the pandemic. Over 20 Emergency Departments are certified as age friendly.

Mr. Nuntavong asked about the number of geriatric Veterans using telehealth. He feels that the future of geriatric health care is telehealth. He mentioned that the American Legion is working with VA on the ATLAS Program – *Accessing Telehealth through Local Area Stations*. As per the VA website https://connectedcare.va.gov/partners/atlas, "VA has teamed up with public and private organizations to enhance underserved Veterans' access to VA health are by offering them convenient locations to receive VA care closer to home. The new option reduces obstacles such as long travel time to appointments and poor internet connectivity at home". **Dr. Hartronft** discussed VA's effort to increase the use of telehealth with a target of 25% across GEC programs. VA typically asks the Veteran their preference in using technology which can be by telephone, however, VA is using iPads to broaden the use of remote technology. Specialty Care Services are encouraged to use telehealth in CLCs to provide care where the Veteran is located. The pandemic pushed VA forward in telehealth with a 1037% increase in usage. **Dr. Stone** described the ATLAS Program as a partnership with Phillips to set up self-contained units and to allow Veterans to access care. He noted that there are less than 10 sites up and running and several are at Veteran of Foreign War and American Legions Posts. Dr. Stone stated that it is still not a place that Veterans think of for their healthcare and some of the old building can't manage the bandwidth. 90% of the population lives within 30 minutes of a Walmart, therefore, VA set up units in Walmart next to their pharmacies. Dr. Stone feels that we need to move forward with technology that is accessible in the home. VA delivered thousands of iPads to Veterans to support their connectivity. Under the Coronavirus Aid, Relief, and Economic Security (CARES) Act VA partnered with bandwidth providers to go into low density areas to provide bandwidth so VA could connect with Veterans.

Dr. Prescott suggested that VA consider using technology that the elder population already uses every day like the television. Dr. Stone agreed and stated that VA has thought about creating an app that can be added to the Apple TV - the Veteran would just click on it.

Dr. Akman asked how many Veterans receive their prescriptions by mail? Is VA seeing issues with Veterans getting their prescriptions by mail? **Dr. Stone** responded by saying that 6 million

prescription per month go out by US Postal Service (USPS), Fedex or United Parcel Service (UPS). Prescriptions are delivered, on average, in 2.82 days, with VA's standard of 3-5 days. Vendors are changed if there are challenges. He noted that the media reported a 25% increase in the number of days, that increase was from 2.3 days to 2.8 days. About 2.5% of the monthly prescriptions are not delivered within 5 days which equates to 152,000 prescription last month (August). This is an increase of about 0.3% from 6 months ago, which VA assumes is the impact of the Pandemic. UPS and Fedex are no more efficient than USPS. USPS is working with VA to create a barcode identifier, which will help to bring VA back into compliance.

Dr. Daley wanted to acknowledge that social determinants of health and elder abuse are precipitants for moving Veterans from one site of care to another.

Dr. Kellermann discussed three points: 1. VA has had an enormous impact on education and development of Geriatric Specialist with so many providers coming through VA for their training. 2. VA has done well within their facilities, but is challenged in influencing state and local leaders who define and develop social determinants of health. He suggested that VA needs to advocate more for Veteran in the community. 3. Develop the simplest interface for technology regardless of the device. Most consumer electronics are designed for younger tech savvy users. VA needs to partner with tech vendors to make devices simple so elder patients are confident in what they are using.

Dr. Mittelman asked what are you doing about prevention or wellness? - Aging in a healthy fashion. He emphasized the need to think about the population that is working towards this age, not just those in this age group.

Dr. Sandy suggested to consider broader risk factors than just clinical risk factors, underscoring social isolation. He continued, look at what drives institutionalization. People are so disconnected from health care that when they finally show up for an appointment they need institutionalization. Clinical predictive models may not capture all of those variables. Consider low cost interventions to address social isolation and loneliness.

Dr. Meyer thinks VA is positioned to be a national leader in geriatrics. He suggested VA "be bolder" with the pilot. The real power of VA is that VA is not just a clinical care delivering system, but also a social system. He suggested to pull together both clinical and social supports.

Dr. Taubman noted the major challenge of the workforce. How do you incentivize the workforce? **Dr. Hartronft** noted that he is working with Workforce Management and nursing to look at all aspects of recruitment and retention. **Dr. Taylor** stated that GEC is working with academic affiliates by offering scholarships. VA is thinking about what incentives can be offered to entice nursing staff into areas of need. VA doesn't receive the same number of nursing graduates coming in as the private sector. VA has been excelling at the geri-scholar program to train primary care providers on geriatric issues so they can have a more comfortable level higher level of training. They are also looking at training specialist and creating regional tele-geriatric hubs for consultation.

Dr. Perlin closed this session by summarizing: VA is a leader in Geriatrics; acknowledged VA's alignment to the Age-Friendly Movement; keep tech simple and familiar; many concerns about workforce - SMAG members can advocate for the future of health work force; acknowledged the

various ages ("young old, old-old and those who will be old") which created challenges controlling the narrative that the VA is for Veterans of all ages. VA published research on how they improved functional status and increasing longevity which is a testament of VA's work and impact.

National Precision Oncology Initiative:

Carolyn Clancy, M.D., Assistant Under Secretary for Health for Discovery, Education and Affiliate Networks, Veterans Health Administration, Department of Veterans Affairs

Rachel Ramoni, D.M.D., Sc.D., Chief Research and Development Officer, Veterans Health Administration, Department of Veterans Affairs

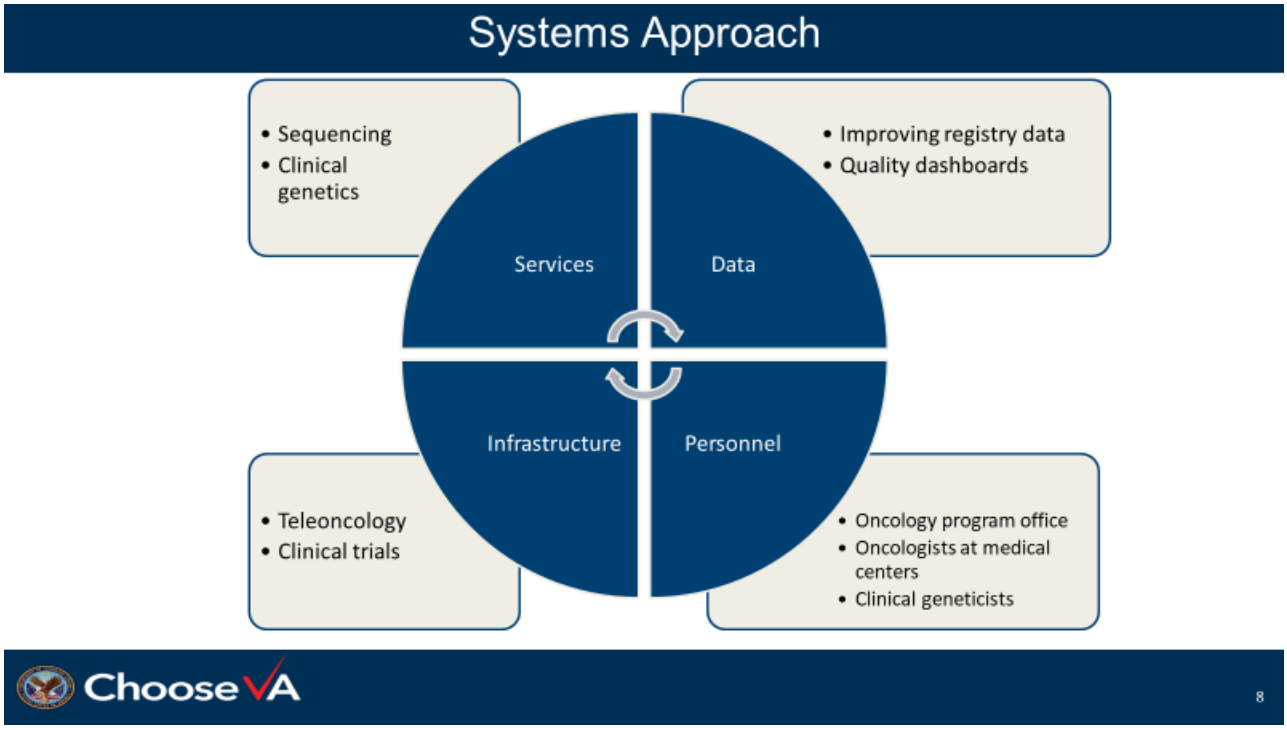
Dr. Clancy began the presentation by introducing a video of a Veteran who benefited from Precision Oncology. She noted that tele-oncology that was displayed in the video is now imbedded in the VA system. Dr. Clancy acknowledged the accomplishments of Dr. Ramoni's leadership and research staff to support the pandemic.

Dr. Ramoni discussed that every year 50,000 Veteran are diagnosed with cancer. 325,000 Veterans live with cancer. Six-percent of prostate cancer cases are Veterans. Dr. Ramoni asked the group to consider a few questions as she presents. 1. What are your recommendations for building a precision oncology system of excellence that reaches all Veterans? 2. What stakeholder groups should be made aware of VA's Precision Oncology Initiative, and how can we most effectively reach them? 3. With ~50,000 Veterans diagnosed with cancer each year, how should VA put its data and bio-samples to work to improve the well-being of Veterans and the Nation?

The goal of the Precision Oncology Initiative is to "create a system of excellence for precision oncology care where a Veteran, no matter where they live, can receive world-class precision oncology care". VA began with prostate cancer in FY20 and plans to explant to lung and breast cancers in FY21. VA wants to be the VA provider of choice for Veterans with cancer by offering personalize care based on a cancer's molecular characteristic which offers new, targeted treatment options. Precision Oncology is defined as "cancer that assesses patients' genetic information in order to diagnose, treat and/or prevent a person's disease". This approach enhances quality of life during cancer treatment by preventing medication side-effects.

She discussed that in 2016 the Prostate Cancer Foundation donated $50 Million to VA to fund research and to establish 12 Precision Oncology Centers of Excellence around the country. They began with prostate cancer since genetic testing for prostate cancer since it is very informative and well studied. In FY21, VA is focusing on the deadliest cancer, lung cancer. She was excited to say that VA research and clinical care work hand-in-hand. The Office of Research and Development is selected 18 VA sites in fall 2020 to foster clinical trials and advances in lung cancer. Those sites will focus on screening low dose CT scans, genetic testing and clinical trials.

VA has taken a systems approach to looking at the totality of the system rather than one area. VA is looking at data, infrastructure, personnel and services. (see slide below)



Dr. Ramoni noted that more than 50% of Veterans with cancer live in rural areas and Tele-Oncology has been a huge factor in reaching those Veterans. A grant from Bristol Myers Squibb Foundation allowed VA to establish a National Tele-Oncology Center in the VA Oncology Program Office which will allow for expansion of staffing in FY21.

Budget planning is always a challenge in oncology care. VA Office of Research and Development is funding a clinical trial to compare efficacy of Olaparib (~$187,000) and Carboplatin (~$74), two drugs that are at extreme price points over the life of a patient being treated for prostate cancer. The outcome of this study will not only help Veterans, but the broader health community.

DISCUSSION:

Dr. Kellermann acknowledged the strong existing partnership between the Military Health System, National Cancer Institute and VA through the Cancer Moonshot initiative, specifically the current precision oncology initiative the Mertha Cancer Center Research Program at Walter Reed and Uniformed Services University. If Veterans were diagnosed on active duty, their early toxic exposure they may lead to diagnosis later and the genomic data can be transferred to the VA. This partnership can deepen the level of expertise.

Dr. Burris noted that the VA presentation at the 2020 American Society of Clinical Oncology Virtual Meeting regarding VA's Precision Oncology Initiative was well received. He noted that 1 in 6 Americans live in rural area and 1 in 32 Americans live in a county without a cancer physician. He went on to emphasize that the advent of precision medicine next generation micro-profiling has changed the outcome for so many patients. He supports the step approach VA is taking by starting with prostate cancer then moving to lung and breast cancer. He supported the launch of this initiative for three reasons: 1. Managing the current patient, 2. Advance therapies for other patients through clinical trials, 3. Aggregation of data will drive decision making on where therapies should go. He continued by suggesting various stakeholder groups for VA to consider - Many

pharma companies that have ties with the military, any of the next generation sequencing companies and the companies that are coming out with blood-based technology to do sequential analysis. He concluded by stating that the health care world needs to know what VA is doing in this area.

Dr. Crosson asked if the low dose CT screening is targeted at any specific group(s), smokers? And what is the frequency, once a year or once every five years? **Dr. Kelley** responded by stating that screening is not targeted to smokers or any group. Less than 10% of Veterans in VA are being screened, which is the same across the country. Follow-up rate is higher in VA at 85-90%. **Dr. Clancy** noted that that VA launched a number of partnerships to expand screening. VA also has pilots to determine how to manage false positive screenings.

Dr. Sandy provided accolades to VA for this initiative. He noted that there is a range of views about when there is enough evidence to show effectiveness of next generation sequencing and in which cancers. When looking at the same data oncologists will have different views. VA is ideally positioned to address those different points of views.

Dr. Akman noted that the precision oncology Initiative is an example of the achievement capabilities of a large health system who can pull together larger resources not only in cancer, but in other areas such as heart disease. He asked about the use of artificial intelligence (AI) in cancer diagnostics or treatments within VA and what is the role of VA in Cancer Moonshot? **Dr. Clancy** responded by saying that the work continues under the Cancer Moonshot. The relationships and collaboration continue even though this was launched under the previous Presidential Administration. **Dr. Ramoni** stated that VA has a National AI Institute under the Office of Research and Development. VA has challenges within images being stored in different location, which must be resolved first. IT funding is a challenge and VA is looking at partnerships or being able to use research funding. **Dr. Kelly** noted that one of the problems is the very complex task of interpreting the genetic sequencing; The data is complex, whether a certain genetic change causes cancer and then can you target with a specific drug. VA partnered with IBM Watson to use machine learning and AI to scan the literature on a regular basis to interpret the results of the sequencing from clinical samples. VA completed a study of three groups of scientist interpreting results - the level of agreement was not high enough to one source. This effort will be sunsetting this year. **Dr. Clancy** noted the partnership between with the Defense Innovation Unit and Google augmenting pathologist reading of slides. Testing of this augmentation has been occurring with prostate cancer, but on a small scale. **Dr. Kellermann** stated that DoD is concern about information security related to whole genome sequencing in military population. This gives caution to unintended findings that may impact family members and other areas. **Dr. Stone** continued by acknowledging that this is medicine on the "cusp of a fundamental transformation" in health care with an entirely different approach to treatment. He pledged that VA is going to be at the forefront of this transformation and tele-oncology is going to be a key factor. We need to make sure that this data sits on top of the electronic health record so that researchers can access this information without great expense.

Dr. Prescott asked about the role of the academic affiliates? **Dr. Montgomery** noted that the academic programs recognize a great collaboration and the sharing of expertise and resources across the country. Dr. Montgomery and Dr. Ramoni noted several collaborations with top medical centers across the country.

Dr. Perlin concluded by summarizing the discussion. He noted the significance of offering the same level of expertise and treatment to rural Veterans as those living in urban areas. He noted

the architectural challenges of unifying data. Aggregation of information serves not only the individual, not only research, but advances knowledge broadly. VA is a learning health system that is supported by an information infrastructure. The use of "the cloud" to host data is key and cloud architecture must be able to manage analytics and advance data science.

Dr. Stone closed by emphasizing the importance of partnerships. He believes future partnerships may exceed a billion dollars and VA is laying that foundation now. He believes one area that could "de-rail" is how VA handles data. Secretary Wilkie brought in a data lead who is helping VA to think about managing data for the future, how to integrate DoD data, and how to manage data security.

BUSINESS MEETING:

Dr. Perlin asked for closing comments by the committee members reflecting on the meeting discussions or how members can promote the good work of VA.

Dr. Prescott reflected on how the "systemness" of VA has been able to respond to the pandemic. He suggested finding a way to describe or measure – "can we do it faster, better, more efficiently, what is working/not working? How do we continue to make the VA even better?" **Dr. Stone** commented by reflecting on one of his three pillars - becoming a "learning organization" – how to act like a system, how to assume ownership of those things you don't own when you want to make changes rapidly.

Dr. Taubman expressed that VA has set a high bar in creating a truly integrated system. How does VA share their accomplishments, so that the rest of the health care systems wants to achieve the same level of integration? **Dr. Stone** responded by acknowledging that Veterans advocacy groups are a voice for VA and the need for academic partners to help tell the VA story. **Mr. Nuntavong** noted that Veteran Service Organizations (VSO) are the biggest advocates because they are users of the system and gave a few examples of how the American Legion is promoting VA. He noted that VSOs go to congress to advocate for financial resources and other important issues.

Dr. Crosson reflected on his historical involvement with VA 10 years ago and noted the remarkable change in conversation among the leaders today. He echoed the sentiment that telling the VA story is important. He believes the "nation is thirsting for continuity, assurance and leadership and SMAG members can help to tell the story."

Dr. Daley noted that she would like to hear about managing the increase of anxiety, depression and suicide that is accelerating into the fall and winter due to pandemic. She suggested that VA present what they have learned about improving mental health in those areas and provide in a concise way to the private sector. **Dr. Stone** noted that as the unemployment rate increases among Veterans, VA anticipates an increased use of mental health services. He noted that marijuana use among Veterans has increased dramatically. A concentrated cannabis substance has been created and usage has gone "off the charts" accompanied by mental health psychosis and paranoia. He reported that VA will publish the suicide figures in October 2020.

Dr. Akman asked Dr. Stone about the other two pillars. He provided accolades that the VA was able to staff up due to pandemic quite rapidly. He reflected on the fact that the Mission of VA may be attractive to Gen Z and Millennials who have a desire to be involved in something bigger than themselves combined with the opportunity for professional development and career advancement.

A suggested topic may be homeless in the wake of the pandemic and higher rates of unemployment with the compounding issues of mental health and substance abuse. **Dr. Stone** responded by explaining his three pillars. 1. Restore the trust of the American people and Veterans in our system by becoming a highly reliable organization so they can trust the outcomes of VA processes. 2. Becoming a learning organization and 3. Modernize System – the centerpiece of modernizing is the electronic health record because it requires VA to go through 95% of the business process linked to the health record. Associated is supply chain modernization and two financial modernizations. VA is two years into a 7-10 year process.

Dr. Trautman echoed the comments already made. The VA has been a model for a long time showing the value of interprofessional practice and education model. She welcomes topics that continue to show this model.

Dr. Perlin closed the meeting by acknowledging the good employees and leaders of VA who work tirelessly to support the VA Mission. Meeting adjourned at 2:15pm E.D.T.

Minutes approved by:

Jonathan B. Perlin. M.D., Ph.D., MSHA, MACP, FACMI
Chairman, Special Medical Advisory Group