Department of Veterans Affairs
Advisory Committee on Prosthetics and Special-Disabilities Programs
October 17-18, 2023
Hybrid Meeting (In-Person and WebEx)
Minutes

Tuesday, October 17 (Day One)

Committee Members Present:

Brigadier General Arthur F. "Chip" Diehl III (Retired), Chair
Felecia Banks, Ph.D.
Andrew "Drew" Contreras, PT, DPT
Charles Ellis Jr., Ph.D.
Steven Gard, Ph.D.
Marlis Gonzalez-Fernandez, M.D., Ph.D.
Russell Gore, M.D.
David Gorman
Flora Hammond, M.D.
Linda Hood, Ph.D.

Guests/Pending New Members Present:

Arthi Amin, Ph.D.
Timothy Hornik

Committee Members Absent:

Isaac Alston
Shaun Castle

Department of Veterans Affairs Staff Present:

Ajit Pai, M.D., Executive Director, VHA Office of Rehabilitation & Prosthetic Services
Rachel McArdle, Ph.D., Deputy Executive Director, VHA Office of Rehabilitation & Prosthetic Services
Lauren Racoosin, AuD, Designated Federal Officer
Judy Schafer, Ph.D., Alternate Designated Federal Officer
Linda Picon, Alternate Designated Federal Officer
Dennis Lahl, Office of Patient Care Services
Sonya Skinker, Rehabilitation and Prosthetic Services, Committee Support
Sally Mahmood, AuD, Audiologist, Rehabilitation Planning Specialist

VHA Staff Presenters:

David Otto, National Director, Recreation Therapy & Creative Arts Therapy Services
Nicole (Niki) Sandlan, National Director, Blind Rehabilitation Services
Steven Miska, Executive Director, PACT Act Project Management Office
Penny Nechanicky, National Director, Prosthetics & Sensory Aids Service
James Marfield, Associate Director, National Recruitment Service

Public Attendees:

Stuart Cohen
Sidath Viranga Panangala

The Advisory Committee on Prosthetics and Special-Disabilities Programs convened on October 17 at 8:30 a.m. (ET) in Washington, DC at the Lafayette Building, 811 Vermont Avenue, NW, Room 3166, and via WebEx video-teleconferencing, with Brigadier General Arthur "Chip" Diehl III (Ret.), Chair, presiding.

Lauren Racoosin, Designated Federal Officer, welcomed everyone and began the meeting with the roll call. A quorum was present, and the meeting was called to order at 8:30 a.m. Dr. Racoosin proceeded with a review of the rules of engagement, the VA Secretary's priorities, the VHA Under Secretary for Health's priorities, and a review of past Committee Recommendations.

General Diehl welcomed the Committee members and asked them to introduce themselves by name, position and location.

Dr. Ajit Pai, Executive Director, Office of Rehabilitation and Prosthetic Services (RPS) welcomed the Committee and acknowledged the importance of the Committee's work. He provided an overview of VHA RPS. He noted that the RPS programs touch over 50% of the Veterans that receive healthcare within VA. Dr. Pai spoke about the many program offices in RPS, their innovations in clinical care, and how their extensive work aligns with the VA Secretary's priorities.

Dr. Racoosin reminded the Committee of the importance of Recommendations. She noted how impactful the Committee's work is--listening, synthesizing the information and then formulating into Recommendations. To date, none of the Committee's Recommendations have been declined or turned back by the Secretary; he has signed off on all of them. Some recommendations take a bit longer than others to come into action, but the Committee is seen and heard, and the Committee's work impacts the future direction of VHA's RPS national programs.

Dr. Racoosin reviewed the agenda and reminded the Committee that national program offices that fall under RPS present to the Committee once per year at which time they will share highlights to provide a snapshot of their work and accomplishments. In addition to the Program Office presentations, the following offices have been asked to present and to address the outstanding recommendation in their area or to inform the Committee of an important related program: Workforce Management, PACT Act, Whole Health, Geriatrics and Extended Care, and the Neurology Subcommittees.

Dr. Racoosin introduced Dr. Judy Schafer and Ms. Linda Picon, Alternate Designated Federal Officers, who will be monitoring chat and email communications.

General Diehl suggested a brief break before the first presentation. The meeting went off record at 9:15 a.m. and resumed at 9:30 a.m.

General Diehl introduced Mr. David Otto, National Director, Recreation Therapy and Creative Arts Therapy Service (RTCATS).

Presentation: Recreation Therapy and Creative Arts Therapy Service (RTCAATS)

Mr. Otto presented the following:

- RTCATS Mission:
    - Improve and enrich bio-psyche-social functioning
    - Maintain or improve functional independence and life quality
    - Provide evidenced based clinical interventions
- RTCATS Vision:
    - To provide therapy-based patient centered care that integrates function, quality and brings meaning to one's life.
- RTCATS Philosophy:
    - Enhance physical, cognitive, emotional, social and leisure development

Mr. Otto shared the geo-map which highlighted the areas of the country where RTCATS services are available. 108 music therapists make up the majority of RTCATS with art therapists (57) the next prevalent. There are five dance and movement therapists with only one drama therapist. An additional 86 full time staff were onboarded since last year at same time and a full time Deputy Director for the Program Office was hired.

Mr. Otto reported on the modernization efforts of RTCATS:

- VHA Directive 1172.05 was published and provides policy for the National Recreation Creative Arts Therapy Services to ensure services and program share consistent practice standards.
- Draft National Standards were developed for five distinct professional, trained and credentialed staff. Standards include evaluation, treatment, consultation, education, health maintenance and coaching, as well as program development

and oversight. Standards are focused on having a therapist work at the highest licensure, certification and training.
    - Art Therapy
    - Dance Movement Therapy
    - Drama Therapy
    - Music Therapy
    - Recreation Therapy

- Established a multidisciplinary field advisory subcommittee to educate, train and promote the use of adaptive assistive technology for Veterans.
- Established standardized staffing guidelines for community living centers.
- Publication in BMC Health Services Research, "*Rapid implementation of Veterans Health Administration Creative Arts Therapies: Survey Evaluation of Adoption and Adaptation"*

Planned Expansion of Creative Arts Therapies:

- Building Partnerships with other offices
- Staffing-added 49 new facilities across enterprise
- Funding Support for:
    - Creative Arts Festival
    - Special projects and initiatives
    - Virtual Reality
- Arts and Humanities Virtual Workshops to help develop community partnerships
- Telerehabilitation Initiatives help reach rural Veterans

Expanding Whole Health/Complementary and Integrated Health Offerings:

- Commander Scott Hannon Veteran Mental Health Act, Section 203

Evaluate programs such as animal therapy, equine therapy, agrotherapy, adaptive sports, recreation, creative arts therapy.

- Provide Veterans access to these programs.
- Puppies Assisting Wounded Servicemembers for Veterans Therapy Act (PAWS) - five pilot facilities, focused on PTSD.
- Section 203 COMPACT Act-Interagency Task Force on Outdoor Recreation
    - VA and 7 other Federal agencies working together to build a framework, evaluating the use of public lands for Veterans, caregivers and families and making recommendations on ways to improve access/reduce barriers.

Challenges:

- Credentialing/onboarding therapists
- Hiring in rural locations-looking at virtual care or clinical resource hubs
- Employee Continuing Education Units for providers-limited capacity to develop pre-approved continuing education units to support certification renewal.

- Staffing for recreation therapy and recreation assistants-need more consistency in Community Living Centers (CLC).

Future Directions:

- Staff training
- Develop future talent
- Education, training and promotion of use of adaptive and assistive technology
- Modernizing Resources to support Clinical Services
- Expanding access for Creative Arts Therapists

Following the presentation, a period of questions and discussion ensued.

Dr. Russell (Rusty) Gore asked about primary referral sources for recreation and art therapy services. Who is referring for these services? What is the sense of supply and demand? Is VA meeting demand for the services? Is there a need for growth?

Mr. Otto shared that referrals come from primary care, geriatric and extended care providers, psychologists, and many other bed services in medical centers. In addition, recreation therapy supports many mental health programs. Music therapists now can get a neurologic music therapy credential and have a huge impact on Veterans with stroke, Parkinson's and other neurologic disorders. 75% of workload is inpatient services; outpatient services are much smaller due to staffing. In addition, when a consult is received, staff at that facility may not have that expertise. They use inter-facility consults or telehealth with Subject Matter Experts (SME) around the country. Extra help is needed to support inter-facility consults and to help support efforts across the nation. Clinical resource hubs with a team of SME, could support VISN virtually. Adaptive sports for outpatient population are very specialized and require current knowledge and equipment as things change rapidly.

Dr. Pai added that once recreation therapy resources become available, many services realize the benefit and start sending referrals.

Dr. Gore asked about the three-year pilot study mentioned, specifically about the outcome measures used. Mr. Otto noted that the focus was on quality of life and satisfaction. The outcome measure was conducted by Mental Health Service.

Dr. Arthi Amin, asked with respect to standardizing practice, how the therapists communicate their successes and failures across the geo map.

Mr. Otto explained that each facility participates in quality improvement programs. Within VISNs, rehabilitation and extended care clinical communities develop competencies. These standardized competencies are piloted and tracked for staff to ensure their work is effective. Mr. Otto also mentioned some new software platforms

which host a series of patient reported outcome measures patient which will help track improvement. Mr. Otto reviews the outcome measures that are available to the community on a national call, to make sure the staff are using and sharing information.

General Diehl asked if there is a relationship or training collaboration, we could develop with the universities to help programs expand and to train our staff.

Mr. Otto acknowledged that he would like to see growth, partnership and other opportunities with universities and academic programs. Benefits include evaluation and evidence-based research on the effectiveness of some of our resources and programs.

Dr. Banks asked for a sense of what partnerships look like with other rehabilitation teams outside of recreation therapy and creative arts therapy.

Mr. Otto offered to connect her with Dr. Clark who is part of VA' s Civic Development and Community Engagement Office. That office works to expose students to different programs and opportunities in healthcare while they are in their early course work.

With no further questions, the Committee paused for a brief break.

At 10:45 a.m. the meeting resumed, and General Diehl introduced Ms. Niki Sandlan, National Director, Blind Rehabilitation Service (BRS).

Presentation: Blind Rehabilitation Service (BRS)

Ms. Sandlan opened by recognizing October as Blind Awareness Month and this upcoming Monday as White Cane Safety Day, which recognizes the importance of canes to maximizing ability to get around safely and lead a full life.

Ms. Sandlan presented the following:

BRS mission is to provide early intervention to maximize adjustment, independence and quality of life for Veterans with a visual impairment.

BRS Programmatic Components:

- BRS is a tiered system of care.
- VHA is the only national system to completely integrate rehabilitation services for Veterans with visual impairments.
- BRS continuum of care integrates with other services to provide care from wide range of vision impairments-low vision to blindness.
- When basic low vision care is no longer sufficient, care may be received at an appropriate setting.
    - 166 Visual Impairment Service Team (VIST) Coordinators at 159 MC

    - 109 Blind Rehabilitation Outpatient Specialists (BROS)
    - 21 Intermediate Low Vision Clinics (ILVC)
    - 22 Advanced Low Vision Clinics (ALVC)
    - 9 Visual Impairment Service Outpatient Rehabilitation Program (VISOR)
    - 13 Blind Rehabilitation Centers (BRC)
- Comprehensive Blind and Vision Rehabilitation includes:
    - Lifetime Care Coordination
    - Whole Health and Wellness
    - Orientation and Mobility
    - Adaptive Vision Skills
    - Assistive Technology
    - Activities of Daily Living
    - Adaptive Recreation
    - Adjustment to Sight Loss Counseling
    - Specialty Programs
        - Independent living program
        - Family training program
        - Power mobility
        - TBI-related Visual Deficits
- Demographics:
    - VIST Roster: 63,561 Veterans (54% legally blind, 46% visually impaired)
    - 78% Veterans on roster are 65 years old or older
    - Majority (48%) are Vietnam era Veterans/
    - Primary Cause of Vision Loss:
        - Macular Degeneration (28.49%)
        - Glaucoma (18.92%)
        - Retinal disorders (13.45%)
        - Brain injury/acquired brain injury (10.17%)
        - Other (28.95%)
- Update: Recommendation to Promote Sensory Health Integration in the Whole Health Model
    - Objectives:
        - Promote Sensory Health into Whole Health model for patient self-management of sensory health
        - Establish multi-disciplinary workgroup
        - Identify best alignment of sensory health in whole health circle
        - Sensory health is important because if one can’t see and hear the instructions, one cannot process the information, make an informed decision or complete the task

    - Plan:
        - Established workgroup with representation from Whole Health, Audiology and Blind Rehabilitation Program Offices (April 2023)

        - Created BRS Dual Sensory subject matter expert workgroup.
        - Designed professional development opportunities (webinars, training)
    - Review and revise circle of health (goal: December 2023)
    - Identify gaps in the assessment of sensory health that can be added to personal health inventory (goal: December 2023)
    - Challenges-shortage of providers for certification as certified low vision therapist, CLVT and CATIS, computer certified assistive technology instructor specialist. Important because more than 75 % of r3eferrals are technology related and currently 4% of staff have CATIS certification. Of those, half are in administrative roles, within enterprise about 10 CATIS.
    - Partnership with Office of Rural Health-concept to create virtual assistive technology hub that will provide services to include evaluation training, troubleshooting, funding supported staff and hope to expand.

- Partnership with workforce management funding typically used for students coming into VA, looking to see if can use for current VA employees interested in professional development.
    - Two-year service agreement, to VA for funds. Class starting in November with 17 employees. Salus University. Continuing conversation with N. Illinois University.

- Improving the Veteran Experience; Partnership with Office of Patient Experience
    - Objective: to better understand pre-admission (to Blind Rehabilitation Centers (BRC)) process for Veterans
    - Process: interviewed Veterans, BRC administrative and clinical providers, 960 data points gathered and synthesized
    - Discovery:
        - Variability in the BRC admission experience for Veterans
        - Veterans unclear about BRC capabilities.
        - Pending approvals from doctors managing conditions unrelated to visual impairment, cause delays
        - Concerns expressed about individualized needs (medicine, dietary) during BRC stay.
    - Opportunities:
        - Standardize Veteran communication during admission process.
        - Improve access for complex cases.
        - Evaluate referral stakeholders.

- Innovation: Partnership with Office of Healthcare Innovation and Learning

- Objective: Explore use of virtual reality (VR) in BRS training programs
- Project: Cooperative Research and Development Agreement established at Birmingham BRC
    - 4-year study
    - VR used to administer clinical assessments and experiences.
        - Questionnaires
        - Visual Acuity, Contrast Sensitivity, Reaction Time
        - Guided relaxation
        - 360-degree travel-explore scenic destinations
        - 360-degree scuba dive experience, exploring coral reef/fish

Following the presentation, a period of questions and discussion ensued.

Dr. Amin expressed appreciation for how BRS is leveraging the Assistive Technology (AT) Hub. She asked about goals for the workforce, with so few people certified.

Ms. Sandlan noted that before the training opportunity came about there was a tremendous amount of cross training. They are finding ways but are now needed to provide more AT trainings as well as professional development. There is more demand for telehealth and ability to receive training within comfort of their own home. Hoping to build up program to expand preceptors. Insights from the pandemic and need for virtual training help BRS to do a better job in meeting Veterans where they are. Need to stay current; need to add virtual reality to next layer of innovation.

Dr. Amin asked if BRS had to track glaucoma and macular degeneration to something active duty specific to which Ms. Sandlan replied no; tracking was not required.

Dr. Amin asked about leveraging general innovations or advancements where general population is also going through diabetes related glaucoma. Ms. Sandlan touched on a partnership with eye services and optometry to fill in the gaps. She plans to report on the status of this partnership next year.

Dr. Hammond expressed appreciation for BRS, it's partnerships and its collaboration with Audiology to make things accessible to Veterans.

The meeting went off the record at 11:25 a.m. and resumed at 11:31 a.m.

General Diehl Introduced Mr. Steven Miska, Senior Advisor to the Secretary, Office of the PACT Act which provides oversight, development, adoption and implementation of the Pact Act.

Presentation: Office of the PACT Act

Mr. Miska provided an overview of the PACT Act. PACT Act is the acronym used for the formal name-Sergeant First Class Health Robinson Promise to Address Comprehensive Toxics (PACT) Act of 2022.

Mr. Miska noted that there are 3 principles applied to PACT Act implementation: 1) Veteran centric, 2) Collaborative (with VSOs and Congress, survivors, family members caregivers), and 3) Transparent.

The Pact Act took 23 different buckets of various cancers and other types of conditions and made them presumptive. By law we are able to conclude that if a Veteran has manifested in that condition, it was because of service. The Veteran no longer has the onus of proof. VA has received over a million claims since the law was signed last August. PACT act has opened up possible healthcare to millions more Veterans.

Overview from slides:

- New law expanding VA health care and benefits for Veterans exposed to burn pits and other toxic substances.
- The PACT Act expands and extends eligibility for VA health care for Veterans with topic exposures and the Vietnam, Gulf War and Post-9/11 eras.
- Key components:
    - Expands eligibility for VA healthcare for Veterans with toxic exposures.
    - Improves decision-making process regarding presumptive conditions.
    - Each enrolled Veteran will receive initial toxic exposure screening and follow up screening every 5 years.
    - Toxic exposure-related education and training for VA healthcare staff
    - Requires research studies on Veteran health trends and cancer rates during these eras.
    - VA to build stronger, more skilled workforce to meet demand for benefits/services.
    - Authorizes 31 new facilities, providing greater access to VA health care.
- Gulf War Era and Post-9/11 Eligibility: Presumptive conditions for Veterans serving in any of these locations or time periods (including airspace above).
    - On or after August 2, 1990
        - Bahrain, Iraq, Kuwait Oman, Qatar, Saudi Arabia, Somalia, United Arab Emirates
    - On or after September 11, 2001
        - Afghanistan, Djibouti, Egypt, Jordan, Lebanon, Syria, Uzbekistan, Yemen
- PACT Act includes radiation exposure presumptive for specific response missions.

- Long list of conditions presumed to be service-connected due to various in-service toxic exposures. VA encourages all eligible Veterans and survivors to file claim. Among the many conditions, a few examples are asthma, high blood pressure, many cancers, chronic rhinitis, sinusitis and bronchitis.
- Reviewed healthcare enrollment eligibility.
- Toxic Exposure Screening is a quick series of questions to identify and document any potential exposures to toxins during military service; completed once every 5 years; at VA Medical Centers and clinics; supports health plans and informed whole health care.
- Under Pact Act, survivor may be eligible for benefits.
- Noted an increase in PACT Act-related Scams. Applications should be submitted directly to VA.

Following the presentation, a period of questions and discussion ensued

Mr. Miska shared the public facing dashboard on the website www.VA.gov/PACT Website is updated every 2 weeks with statistics on how many Veterans have applied, how many claims have been approved, as well as benefits and outreach events.

Mr. Gorman asked if during the past year there has shown a need for any additional disabilities or conditions to be added to the PACT Act.

Mr. Miska discussed the process for presumptive conditions and shared that three new conditions have been announced. Presumptive process allows VA to streamline traditional scientific process to determine that conditions are related to a particular exposure. The process refinement continues to ensure it is in accordance with the law. Mr. Miska noted collaboration with Department of Defense (DoD) to identify conditions due to certain exposures and refine workforce protections to mitigate potential exposures.

Mr. Miska encouraged everyone to join the effort in getting the word out not just for Veterans but for survivors as well.

Dr. Hood asked if there are resources or programs in place for reaching out through staff education and through community health resources or if that is a developing area, Mr. Miska noted programs inside VA that are leading the staff training and awareness effort. May need to develop tools to train community care providers.

Dr. Pai noted great strides have been made in getting information out to a variety of disciplines across VHA and that there is a requirement for all providers to complete training on toxic exposures and the PACT Act.

Mr. Gorman asked if community providers for disability are being included in education as far as toxic exposure. Mr. Miska referred to the standards examiners are required to maintain and noted that when VHA does exam and when we're able to leverage VHA providers, there will probably be a better outcome.

Mr. Miska noted that VSOs provide a vital partnership role and with VSO help, Veterans have greater likelihood of success.

Mr. Hornik shared that signing up for the program and the opportunity to talk with primary care or a toxic exposure team is sometimes a barrier. Mr. Miska noted that rural areas are historically difficult to reach; VA is committed to making sure we reach all.

The Committee recessed at 12:15 p.m. for lunch. The transcriptionist went off the record at 12:17 p.m. and resumed at 1:15 p.m.

The Committee reconvened at 1:15 p.m. at which time Dr. Racoosin confirmed roll call and that a quorum was present.

General Diehl introduced Penny Nechanicky, National Director, Prosthetic and Sensory Aids Service.

Presentation: Prosthetic and Sensory Aids Services

Ms. Nechanicky presented the following to the Committee:

Prosthetic and Sensory Aids Service (PSAS) Overview

- Largest and most comprehensive provider of prosthetic devices and sensory aids
- Provides medically appropriate equipment, supplies and services that optimize Veteran health and independence
- Ensures devices and services are strategically sourced and consistent with clinical need.
- Services include orthotic and prosthetic services, restorations, home oxygen, dog insurance
- Devices include durable medical equipment and supplies, wheelchairs and accessories, eyeglasses, blind aids, low vision aids, Hearing aids and assistive listening devices, Health monitoring equipment, artificial limbs/custom braces, surgical implants, adapted sports and recreational equipment.
- Benefit Programs: automobile adaptive equipment, clothing allowance, home improvements and structural alterations
- Ordering for Prosthetic items was discussed.
- PSAS budget for FY23 VA obligated 4.3B to provide 22.7M devices/items to 3.5M Veterans. Breakdown of budget was discussed.
- PSAS working to meet VA Priorities:

    - Goal 1: Hire faster and more competitively. **Technical Career Field Program**
    - Goal 2: Connect Veterans to soonest/best care. **Supply chain improvements.**
    - Goal 3: Serve Veterans with military environmental exposures **PACT Act**
    - Goal 4: Accelerate VA's journey to High Reliability Organization **PSAS National Education Series**
- Currently maintain 111 National Contracts
- Outcomes: Use outpatient survey (V Signals) to receive feedback on Veterans experience
- Challenges and the Way Forward:
    - Improving access by streamlining supply chain processes including acquisitions and contracting vehicles
    - Policy updates including new PAS Directive and statutory guidelines of Cleland Dole Act of 2022
    - Continue to improve processes for Community Care
    - Modernization & Education Efforts-Electronic Health Record, Supply Chain, Procurement, National Education Series.

A period of questions and discussion ensued.

Dr. Amin asked about the role and interest level of industry and companies wanting to participate in contracting process**.** Ms. Nechanicky noted three components necessary for success in any contract—clinician, industry, contracting/requirements. VA sponsors a small business administration national conference each year and conversations happen then. Conversations with vendors can be very informative and are ok as long as not during active solicitation. PSAS encourages staff and clinical liaisons to participate.

Mr. Gorman asked about an implantable sleep apnea device called *Inspire* to replace mask and hoses of current equipment. Ms. Nechanicky noted it was available but that not everyone is a candidate. Other non-PAP related therapies are considered before providing PAP machines, but PAP is still the number one way to treat sleep apnea.

General Diehl asked if the Committee could be of help to PSAS. Ms. Nechanicky noted great improvements being made in PSAS; additional staff is always helpful but moving in right direction. She acknowledged great support from Dr. Pai.

Dr. Gonzalez-Fernandez asked what the process for obtaining devices when available contracted ones are not adequate. Ms. Nechanicky shared that PSAS tries to emphasize contracts because of efficiencies but sometimes, depending on need, a more customized or different device is indicated. Through purchase cards, connected to Veteran's medical record there is the option for customization.

Discussion

The Committee engaged in robust discussion from 2:00-3:00 p. m. over the presentations heard and worked towards developing potential recommendations.

Mr. Gorman suggested that VA keep looking at reviewing and considering literature related to PACT Act and exposures.

Dr. Hood commented on the connection between research programs on toxins and any mechanism to facilitate getting that information to VA.

Dr. Pai shared that the War Related Injuries and Illnesses Research Center in NJ is specific towards toxic exposure and that these specialized research centers collaborate amongst themselves, across VA healthcare and with outside entities as well as NIH. He suggested setting up a time to hear from them in the future.

General Diehl asked Dr. Racoosin to share information about the next meeting.
Dr. Racoosin shared that by charter the Committee is required to have 2 meetings a year; the Committee typically meets in the spring and the fall. It has been suggested and encouraged by ACMO, and interest expressed by the Committee, to do another site visit to one of the special events. Dr. Racoosin proposed the next meeting take place during the week of July 25-30th in New Orleans. She is working on details and likely we would meet day before and then be there for some of the activities. She is proposing a shorter business meeting with just program office presentations to allow time to visit the events, the health fair, to see educational materials/resources, and to meet with Veterans and learn from their experiences. Volunteer opportunities may be available.

Conversation resumed with open dialogue, reviewing ideas, thoughts, and reflections on the earlier presentations.

The transcriptionist went off record at 2:53 p.m. and returned at 3:03 p.m. to commence formal presentations again. General Diehl introduced Mr. James Marfield, Associate Director, National Recruitment Service, Workforce Recruitment and Retention Service, Workforce Management and Consulting (WMC).

Guest Presentation: Office of Workforce Recruitment and Retention Service Workforce Management and Consulting (WMC)

Mr. Marfield reviewed FY23 VHA Shortage Occupations (clinical, nonclinical, nurse and physician). Mr. Marfield shared the Enhanced Recruitment and Onboarding Model and the importance of recruiters for achieving VA's goal of hiring faster and more competitively. He discussed the best practices for pre-recruitment and considers

recruitment an ongoing process. He discussed best practices for onboarding new employees. Retention essential; VA must be proactive in retaining healthcare talent.

Mr. Marfield shared that moving forward WMC will continue hiring; leverage strategies in VHA FY 2023; Rural Recruitment and Hiring Plan; leverage incentives and flexibilities; recruit from all sources; VA trainee Recruiting Events; conduct hiring fairs; exhibit at 40+ national conferences; and employ incentives (monetary).

In response to a request to clarify jargon, Mr. Marfield shared that VA has personnel systems which define how we hire and manage federal employees. Administrative Roles fall under a system called Title 5 which is very regulated from a recruiting standpoint. It is a merit system with little agility in process when recruiting. Title 38 has a lot of agility to respond to need for more flexibility when hiring nurses and doctors and technicians. Allied Health fields fall under Hybrid Title 38 which has some flexibilities of Title 38 as it is non-competitive but does have Veterans' preference. Some hard to recruit positions can be exempted. First and foremost, always want to hire best talent.

Mr. Marfield discussed the Stay in VA initiative, in which WMC will talk to employees before they give notice to see if there is an intervention or remedy to get them to stay.

A period of questions and discussion ensued.

General Diehl asked specifically about the Committee's outstanding Recommendation. Mr. Marfield noted that they have a lot of data but need to leverage it.

Dr. Banks asked about any initiatives that focused on increasing diversity in the workplace. Mr. Marfield noted VA is engaging in recruitment marketing to diversity audiences, investing money and creating visibility about VA careers, including attendance at diversity-centric conferences.

Dr. Racoosin indicated that she would follow up with Mr. Marfield to see if he could specifically address the outstanding Committee Recommendation.

Following Mr. Marfield's presentation, Dr. Racoosin announced that the Committee meeting would begin again at 8:30 a.m. (ET) the next day.

General Diehl thanked everyone and adjourned the meeting, whereupon the transcriptionist went off record at 3:48 p.m. and the Federal Advisory Committee meeting recessed for the day.

Wednesday, October 18, 2023 (Day Two)

Committee Members Present:

Brigadier General Arthur F. “Chip” Diehl III (Retired), Chair
Felecia Banks, Ph.D.
Charles Ellis Jr., Ph.D.,
Steven Gard, Ph.D.
Marlis Gonzalez-Fernandez, M.D., Ph.D.
Russell Gore, M.D.
David Gorman
Flora Hammond, M.D.
Linda Hood, Ph.D.

Guests/Pending New Members Present:

Arthi Amin, Ph.D.
Timothy Hornik

Committee Members Absent:

Isaac Alston
Shaun Castle
Andrew “Drew” Contreras, PT, DPT

Department of Veterans Affairs Staff Present:

Ajit Pai, M.D., Executive Director, VHA Office of Rehabilitation & Prosthetic Services
Rachel McArdle, Ph.D., Deputy Executive Director, VHA Office of Rehabilitation & Prosthetic Services
Lauren Racoosin, AuD, Designated Federal Officer
Judy Schafer, Ph.D., Alternate Designated Federal Officer
Linda Picon, Alternate Designated Federal Officer
Dennis Lahl, Office of Patient Care Services
Sonya Skinker, Committee Support
Sally Mahmood, AuD, Audiologist, Rehabilitation Planning Specialist

VHA Staff Presenters:

Cheryl Schmitz, Deputy Executive Director, Office of Geriatrics & Extended Care
Nan Musson, National Speech Pathology Program Lead
Rachel McArdle, Ph.D., Acting National Director, Audiology & Speech Pathology Service

Rachel McArdle, Ph.D., Acting National Director, National Veterans Sports Programs & Special Events
Donna Faraone, Associate Director, Whole Health System Development
Cassandra Griffin, Health System Specialist
Glenn Graham, M.D., Deputy Director Neurology, Founder and Executive Director VA National TeleStroke Program, Acting National Director, Neurology Centers of Excellence

Public Attendees:

Stuart Cohen
Sidath Viranga Panangala

Dr. Racoosin welcomed the Committee to Day Two of the Advisory Committee meeting at 8:27 a.m. (ET) Roll call was completed; a quorum was established. Dr. Racoosin introduced Dr. LaTonya Small, Advisory Committee Management Office, who joined the meeting in person.

General Diehl welcomed the Committee to the second day of the meeting and reviewed the agenda. The Committee will hear from the Office of Geriatrics & Extended Care as taking care of aging Veterans has been an important focus of this Committee.

General Diehl reminded the committee to listen and to be open to consider Recommendations based on the presentations. He also reminded the Committee of the opportunity to form subcommittees to further examine and draft potential Recommendations following the meeting.

General Diehl opened the floor for any discussion or thoughts from Day One.

Dr. Amin noted the recruitment and retention concerns are not just specific to VA, they are nation-wide and asked how we stretch the few resources we have; how do we build a bench for the future; how do we build up a team to meet the needs and demands?

Dr Pai shared information about a new program that VA is working on called Integrated Critical Staffing Program which will consider these concerns. It would be interesting to have Workforce Management come back to focus on how that program works and specifically with respect to our outstanding Recommendation.

Dr. Amin noted that VA is in a unique position, being so large and so broad, to innovate and address the shortage that exists here and in the private sector.

General Diehl shared that he sits on a community college board, and they are also discussing this concern and that partnering students with career opportunities may help address the challenge.

General Diehl introduced Cheryl Schmitz, Deputy Executive Director, VHA Office of Geriatrics & Extended Care.

Presentation: Office of Geriatrics and Extended Care Programs (GEC)

Ms. Schmitz provided an overview of GEC Programs.

Background:

- 90% adults over 65 want to remain in their current homes as they age
- VHA has over 4M Veterans 65 and older and over 1.5M rural enrollees over 65
- VHA is working hard to increase use of Home and Community-Based Services to meet needs and preferences of Veterans and to allow for aging in place

Geriatrics and Extended Care (GEC) Continuum of Care for all Veterans:

- Ambulatory Care
- Inpatient Acute Care
- Home and Community Based Long Term Care
- Facility Based Care
- Hospice Care

Demographics: VHA Enrollees in general, significantly more older individuals

- VHA 47% of all enrollees (all ages) are 65 & +; US population equivalent 17%
- VHA 55% of all enrollees (all ages) are 65 & +; US population equivalent 20%

Demographic Trends suggest significant increase in enrollees of women Veterans.

Aging in Place and VA Home Care Service Expansion

- Per CDC, aging in place is the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income or ability level
- VA provided home and community-based services to >450,000 Veterans in FY23
- Current VA Home Care Expansion includes Veteran Directed Care programs at all VAMCs; Medical Foster Home programs at all VAMCs; 75 additional Home-Based Primary Care teams over 3 years
- GAO identified challenges for meeting the needs of aging veterans which include addressing workforce shortages; aligning care geographically (including rural Veterans); meeting needs for specialty care
    - Geriatrics and Palliative Care Specialty has a shortage of geriatricians
    - Demand exceeds supply

- Although not a GEC Program, Ms. Schmitz highlighted the VA Caregiver Support Program which provides peer support, mentoring, skills training coaching, telephone support and referrals to available resources to Veterans' caregivers.

Ms. Schmitz directed the Committee to the resources on the GEC website for more information. Link to website: Geriatrics and Extended Care Home (va.gov)

A period of questions and discussion ensued.

Mr. Gorman asked about eligibility and whether there was a hierarchy of eligibility for long-term care services (foster home, nursing home care in VA, community facilities).

Ms. Schmitz noted that most home-based programs are based on level of clinical need. If eligible for VA care, Veteran is eligible for programs.

For facility-based care, whether CLC, community or state Veteran home, eligibility is based on service connectedness. With seventy percent or more service connection, VA is responsible for paying for nursing care. Many times, it depends on where space is available. If it is community nursing home, generally Veteran and caregiver are given options based on where they would like to be. They are encouraged to visit facilities and choose themselves.

Mr. Hornik noted that home-based Primary Care is fantastic and has enabled so many blinded Veterans to have a much better place within healthcare, to receive services and to age in place. This is especially true for rural Veterans.

Mr. Hornik asked about biometric equipment which are inaccessible to blinded Veterans. Ms. Schmitz noted that they do have teams that pilot innovative technologies.

Dr. Banks applauded GEC for presenting such a comprehensive program and asked where home modifications, adaptations and compensatory strategies fit into the model.

Ms. Schmitz noted that the actual approving and installing ramps falls within another office. GEC does play a role in the request or referral for those items with PSAS. Team is responsible for the assessment.

Dr. Pai added clarification. All home safety, equipment, is based on clinical need as determined by either core home-based Primary Care team or facility-based Primary Care or another clinician. Primary Care teams work in concert with Rehabilitation therapies especially OT. Prescription goes to PSAS, and device is procured for Veteran. VHA and VBA coordinate the home improvements structural alterations grant. Application goes in through VBA and Veterans can receive funding that goes to a contractor to modify their home, for safety needs or their medical condition.

Dr. Gore noted that they are seeing a 40% increase in CLC demands and 20% increase on nursing home side and is trying to get a sense on service supply and demand. He asked what the current capacity was in terms of the needs of Veterans and how many are being referred external to VA. Is there a plan to meet future demand?

Ms. Schmitz noted that right now they can meet demand with the range of available options. Realistically, relying on community facilities, is not sustainable cost-wise. Currently working on ensuring there are more beds in particular regions where people retire as they age. Working on building internally as well as modernizing contracting and other things involving community nursing home partners. Currently long stay Veterans in nursing homes are not part of the community care network. Doesn't fall under same oversight. Working on getting process in place and including that long stay care within community network. Trying to make sure ready for demand.

Dr. Gore asked on behalf of Sean Castle's previously expressed concerns, if VA is meeting the needs of the special disabilities group including spinal cord injured Veterans and Veterans with TBI. Memory centers will not accept patients with TBI; nursing homes can't handle their cognitive and behavioral needs; primary caregivers are often no longer available. In Georgia alone there's a 70% shortfall in beds compared to the needs of the TBI community. Committee recognizes importance and need.

Ms. Schmitz—agreed on the need to advocate. GEC is working on staff training; on skills for CLC staff to care for these Veterans. These sites are better prepared than community nursing home to care for Veterans. Working internally to build a more robust VA program. Appreciates our advocating.

The Committee paused for a brief 10-minute break. The meeting went off the record at 9:34 a. m. and resumed at 9:46 a.m.

General Diehl introduced Dr. Rachel McArdle, Deputy Executive Director, Rehabilitation and Prosthetic Services, Acting National Director, Audiology and Speech Pathology. Dr. McArdle was joined by Ms. Nan Musson, National Speech Pathology Lead.

Presentation: Audiology and Speech Pathology Services

Dr. McArdle reported on workload trends for Audiology. FY23 data is comparable to FY 22 and rebounding from the low of the pandemic (captured in FY21 data) but not quite at pre-pandemic numbers. Staffing shows an increase in audiology health technicians (up 22), a decrease (down 16) in Audiologists, and an increase (up 200) in points of care. Audiology workload is 97% outpatient and 3% inpatient. Workload trends for Speech Pathology show an increase (up 8) in staffing with encounters stable compared to 2022. Speech Pathology workload is 45% inpatient and 55% outpatient.

- Community Care referrals continue to grow for Audiology and Speech Pathology
- Virtual care continued to increase from FY 2020 to FY 2022 for both Audiology and Speech Pathology. FY 2023 numbers are not yet complete.
- ATLAS Program: Accessing Telehealth through Local Area Stations
    - To enhance accessibility of VA Health care and help bridge digital divide
    - TeleAudiology pilot with VA Video Connect at one non-VA facility (Veterans of Foreign Wars Post in Eureka, Montana)
- Plans to expand virtual care portfolio include:
    - Integrating tablet-based testing in home based primary care and primary care clinics
    - Increasing Clinical Video Telehealth (CVT) services, focus on rural and highly rural Veterans, clinical resource hubs
    - Promote virtual hearing aid aftercare
    - Expand asynchronous telehealth automated audiometry in primary care and Atlas sites.
    - Advance training resources for all TeleAudiology roles
    - Support boothless audiometry
- Audiology National Contracts include Hearing aids, Cochlear Implants and Auditory Osseiointegrated Implants
- Outcome measures: International Outcome Inventory for Hearing Aids (IOI-HA)
    - VA has collected 810,993 IOI-HA outcomes to date
    - Reported responses are consistently high for Veterans receiving hearing health services, within VA, both face to face and telehealth encounters, exceeding published outcomes in the general population
- Opportunities and the Way Forward-Audiology:
    - Expand Access through Virtual Care
        - Automated audiometry, tablet-based audiometry, expand ATLAS.
    - Study Veteran's Journey to access audiology care-rural and urban
    - Joint VA-DoD initiatives:
        - Council of Accreditation for Occupational Hearing Conservation
        - Tinnitus Practice Guidelines
        - VA to join as sponsor for National Academies of Sciences, Engineering, Medicine (NASEM) study on Meaningful Outcomes in Adult Hearing Healthcare

Ms. Nan Musson presented on a couple of the many projects that Speech Pathology has been engaged in this past year.

- Opportunities and the Way Forward-Speech Pathology, Enterprise-Wide Standardized Interventions and Outcomes
    - Rural Health Resources Center Pilots include:
        - Access to Swallowing Treatment: Head and Neck Cancer
        - Gender Affirming Program with Speech (GAPS)

        - Accessible Care for Cognition, Speech and Swallowing-Parkinson's Disease (ACCSS-PD)
        - Amyotrophic Lateral Sclerosis (ACCSS-ALS)
- Speech Pathology-plays a role in many domains of care and is included in more than 11 VHA Directives
- Enterprise wide working on standardization of equipment, software, workflow, imaging and interfacing with electronic health care records

A period of questions and discussion ensued.

Dr. Amin asked questions about the ATLAS sites and how they work and the services they provide.

Dr. Hood asked about the use of tablets at the ATLAS sites. Dr. McArdle noted they were successful with a majority of Veterans. Working to adapt for dual sensory impaired Veterans.

Dr. Hood asked about toxic exposure and the Pact Act and acknowledged the issue of noise exposure and the interactions with other toxins. She inquired if tinnitus was also included as it has an interactive effect on neural function.

Dr. Schafer noted that noise and hearing loss are not presumptive; they still require a medical opinion. If an exposure is reported, screening is completed and if positive they are sent for application.

ASPS has been providing education to clinicians; looking into secondary concerns; toxic exposures causing hearing loss. Dr. Mc Ardle noted an increase in compensation and pension (disability) examinations. Dr. Hood asked about capacity. ASPS is a few days above the standard (28 days). Looking at automation and virtual care, to expand capacity. PACT Act screenings to Veterans have been a great outreach effort.

Dr. Hood asked about to hearing loss, aging and cognitive decline and how it fit into current audiology program.

Dr. McArdle reported that ASPS is tracking on that, working with Whole health, making sure Veterans are given the opportunity to have hearing aids, eyeglasses whatever they need. ASPS is direct access and is working with GEC and Primary Care.

ASPS considers hearing loss a vital sign and it should be for one that is checked in Primary Care, especially in older population.
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General Diehl introduced Dr. Rachel McArdle, Deputy Executive Director, Rehabilitation and Prosthetic Services, Acting National Director, Acting National Director, National Veterans Sports and Special-Events Program Office.

Presentation: National Veterans Sports and Special-Events Programs

Dr. McArdle shared an overview of the National Veterans Sports Programs & Special Events which aim to:

- Introduce Veterans with disabilities to adaptive sports and therapeutic arts thorough National Rehabilitation Events and Adaptive Sports Grants to highlight the benefits of ongoing participation
- Train VA clinical rehab providers on how to integrate adaptive sports and therapeutic arts into their rehabilitation plans of care
- Collaborate and communicate with community partners for support

Dr. McArdle reviewed the special events:

- National Veterans Wheelchair Games, co-presented by VA and PVA, largest wheelchair sports rehabilitation event for individuals with disabilities in the USA
- National Veterans Creative Arts Competition & Festival-open to Veterans with any disability, co-sponsored by American Legion Auxiliary
- National Veterans Golden Age Games-55 years and older, Olympic style sport competition, education sessions on sports, wellness and fitness with *Fitness for Life* the motto
- National Disabled Veterans Winter Sports Clinic-serves Veterans with traumatic brain injuries, spinal cord injuries, limb loss, visual impairments and certain neurological conditions, co-sponsored by DAV
- National Disabled Veterans Golf Clinic-adaptive golf and golf instructions provided by PGA and LPGA instructors, range of other recreational sports, educational and networking opportunities for Veterans, caregivers, volunteers and staff, co—sponsor DAV
- National Veterans Sports Clinic-promotes value of rehabilitation through adaptive summer sports; improve independence; achieve healthier lifestyle; enjoy higher quality of life

VA Adaptive Sports Grant Programs

- Grant program funds adaptive sports programming for Veterans and members of the Armed Forces with disabilities; trains providers that serve the participants
- Funds go to non-Federal Government entities with significant experience in managing a large-scale adaptive sport program
- Awards are 1 year and up to 750K
- In FY23, 91 grants provided to 87 organizations, 77 sports/14 equine

Veterans Monthly Assistance Allowance

- $2 Million authorized annually
- Veteran athletes must be nationally or internationally classified in a sport and eligible for paralympic competition or hold 30% service-connected disability rating and be selected to the national Olympic team
- Veteran athletes must meet the published minimum performance standard for a sport and must have a training plan
- Veterans Monthly Assistance Allowance supports 179 athletes, 32 sports and 72 National Team members

Dr. McArdle reported on the October 2022 Recommendation which asked RPS/VHA Patient Care Services/VHA Communications to develop a plan and report progress to the Committee at October 2023 meeting.

The Recommendation Action Plan was to develop a coordinated communication plan and toolkit with promotional materials and to identify and engage with media. Also, to broadcast and highlight programs via traditional and social media platforms.

Dr. McArdle noted that the 2023 outreach includes podcasts, articles TV, radio and newspaper articles. She reported the following activities:

- Monthly grand rounds hosted by NVSP&SE reach approximately 250 attendees each month
- Providers4Vets platform on salesforce, provides a network to find others providing adaptive sports opportunities, to connect and leverage best practices
- Sports4Vets list serve distributes information regularly to approximately 600 VA staff members

A period of questions and discussion ensued. Questions arose regarding the funding and training assistance grants and challenges with the funding cap.

Mr. Hornik suggested the need to find a way to push forward an increase in funding caps. He believes it is something the Veterans Service Organizations (VSO) could collaborate on. He noted there used to be an emerging athlete's standard which helped Veterans that don't meet the top standard to get stipend, train and then reach that level.

Following the presentation, the committee took a brief recess, and went off record at 11:11 a.m. Meeting resumed at 11:21 a.m.

General Diehl introduced Donna Faraone, Associate Director, Whole Health System Development, Office of Patient Centered Care and Cultural Transformation. Ms. Faraone was invited to share an overview of the Whole Health Model and to report on

the Committee's Recommendation related to integrating sensory health into the Whole Health system. Ms. Faraone was joined by Mr. Cassandra Griffin, from the Office of Patient Centered Care and Cultural Transformation.

Presentation: Office of Patient Centered Care & Cultural Transformation (Whole Health)

Ms. Faraone began with a 1-minute video that encapsulate the Veterans' experience in a whole health framework, focusing on what matters to each person. She shared an overview of the Whole Health Model and its emphasis on what matters most to the Veteran. The Whole Health approach empowers and equips people to take charge of their health and well-being, and to live their life to the fullest.

Ms. Faraone showed utilization data which demonstrated that the number of Veterans participating in Whole Health has increased, including virtual Whole Health.

Veterans who used Whole Health services reported greater engagement in:

- healthcare and self-care
- mission, aspiration and purpose
- mental health therapies
- perceptions of care being more patient centered
- perceived stress and overall, wellbeing

Ms. Faraone shared references and articles which highlighted Whole Health outcomes. She discussed VA Strategic Planning, both short and long-term goals for Whole Health.

Office of Patient Centered Care and Cultural Transformation long-range planning framework (2024-35) includes:

- Implementation of Whole Health System
- Evaluation of outcomes and impact of Whole Health
- Support research into Whole Health
- Expand collaborations with program offices and VISNs in support of Whole Health approach to care
- Develop and offer Whole Health education to train field staff
- Develop infrastructure in field to respond to well-being and needs of employees
- Referenced directives 1137 Provision of complementary and Integrative Health (Dec 2022) and 1445 Whole health system (expected 10/23)

Ms. Faraone reported on the 2022 FAC Recommendation on Integration of Sensory Health into the Whole Health model.

2022 FAC Recommendation: Whole Health will work with Audiology and Speech Pathology Service (ASPS) and with Blind Rehabilitation Service (BRS) to develop strategies to include sensory health in the Whole Health model for patient management and clinical care. VHA should develop this plan over the next 12 months and report progress to the Committee during their meeting in October 2023.

Actions:

- Initiated weekly/biweekly meetings commencing April 2023
- Agreed upon fact sheet development, understanding disparities, education and training, integrating sensory health into Whole Health model (Whole Health system, circle of health and other resources and tools)

Accomplishments through Sept 30, 2023

- Launched e-fact sheet for ASPS; BRS Fact Sheet in progress
- Whole Health education offerings scheduled for Audiology and exploring additional opportunities for sensory health providers
- Presentations to Joint VA-DoD Conference (March 2023), Audiology Online (September 2023)
- BRS identified five Subject Matter Experts (SME) to participate in workgroups, ASPS SME identification in progress
- Marketing use of appropriate coding and exploring how to identify Veterans with sensory health during visits.
- Planning sessions with key stakeholders in December 2023 to review resources

Coding and tracking numbers for Whole Health were flat through January 2023. However, after January 2023 presentation to ASPS National Team Call and March 2023 presentation at joint VA-DoD conference, the numbers increased remarkably.

Summary and the Way Forward:

Office of Patient Centered Care and Cultural Transformation, Audiology and Speech Pathology Service and Blind Rehabilitation Service will continue their collaboration to:

- Continue work on the identified actions in FY 23/24
- Collaborate on opportunities to develop/Improve Whole Health and other resources relevant for the sensory health population
- Collect and analyze data to identify (and address) potential whole health disparities that may exist among the sensory health population (e.g., access to Whole Health services, Whole Health service delivery challenges)
- Identify potential gaps and set expectations
- Expand Whole Health integration enterprise-wide

A period of questions and discussion ensued.

Dr. Amin asked how Whole Health Office manages to balance timeliness and clinical care as well as the patient-centered care goals.

Ms. Faraone explained that it is not only a theoretical change but also a shift in approach and culture. Change management takes time and buy-in from all stakeholders including the Veterans. Changes are subtle. Whole Health is working hard to shift the culture, taking seriously the charge to embrace Veterans, families, and caregivers, as well as the employees that are providing the care.

Ms. Faraone concluded her presentation with a Whole Health demonstration, leading the committee through a brief meditation.

The Committee adjourned at 12:08 p.m. for lunch.
The Committee reconvened at 1:27. p.m. following roll call and confirmation that quorum had been reached.

General Diehl introduced Dr. Glenn Graham, Deputy Director, Neurology, VHA Neurology Centers of Excellence, for a report on the Centers which comprise the subcommittees of this parent committee.

Presentation: Office of Neurology, Neurology Subcommittees

Dr. Graham presented an overview of the 4 Neurology Centers of Excellence which:

- Provide subspecialty neurology care to Veterans nationwide
- Provide education and training to medical personnel, Veterans and caregivers
- Obtain research funding and conduct research
- Need help recruiting and retaining neurologists (general and subspecialty) as well as allied health professionals. (Limited by pay constraints)
- Expansion plans in place to meet growing needs as fiscal resources allow
- Neurology Centers in future will be managed as a unified enterprise with increased collaborations within and between the Centers, telehealth programs and Neurology program office

Parkinson's Disease Research Education and Clinical Centers (PADRECC)

- Established in 2001
- Legally codified in 2006 by Title 38 U.S.C. 501, 7301(b), § 7329
- Mission: to provide comprehensive, state of the art care, to assure highest quality of life for Veterans afflicted with Parkinson's disease and related movement disorders; to advance investigation into the cause, treatment and cure for those disorders; and to enhance understanding of those disorders by developing education programs for practitioners, patients and caregivers
- PADRECC sites: San Francisco, West Los Angeles, Portland Seattle, Houston, Philadelphia, Richmond

- PADRECCs are involved in clinical care, education of fellows, nurse educators, residents and medical students, and research

Multiple Sclerosis Centers of Excellence (MSCoEs)

- MS affects >50,000 in VA healthcare system and is increasing
- MS therapies are among costliest drugs for VA
- 2 MSCoE (East and West) each covering half of the US
- Expansion of MSCoE is needed to fund staff to deliver care to underserved and rural Veterans, establish national coordination for MSCoE system of care
- MSCoE-Baltimore and DC (East) Seattle and Portland (West)
- Accomplishments 2023 include:
    - Published MS System of Care Directive 1101.06
    - MSCoE Baseline Project: identify locations of care and need.
    - Established standardized MRI protocol for MS
    - Initiated MS therapy guidance document for broader medical community
    - Advances in informatics; surveillance registry
    - Research studies DoD study using telehealth to counsel Veterans with fatigue related to MS
    - Education for Veterans and providers including podcasts, e-letter articles, support groups, lectures and special programs

Epilepsy Centers of Excellence

- Centers established by PL 2162:
    - Established national network of care to Veterans with epilepsy.
    - Coordinate and provide education opportunities to Veterans, caregivers and family members.
    - Training and education for health care professionals
    - Utilization of national VA databases to inform providers and policy makers
    - Conduct state-of-the-art research
    - Implement informatics and technology foundation
- 2023 Accomplishments include:
    - Implementation of governance structure
    - Addition of 2 new sites
    - Design of new medical center site designations
    - Provided over 11,000 patient encounters
- TeleEEG
- VA Mind-Brain Program:
    - Manages functional neurological disorders and neurologic disorders with neuropsychiatric comorbidities
    - Training provided to clinicians-group and individualized and TMS courses
    - Provide consultation, integrated care and neurobehavioral therapy in collaboration with VA ECoE and VA National Tele-Mental Health Tele-Seizures Clinic

    - Facilitate use of *Managing Epilepsy Well Network Interventions*
    - Program collaborates with other researchers and with VA clinicians who manage Veterans with complex neuropsychiatric conditions

Headache Centers of Excellence (HCoE):

- Established 2018
- Realigned from Physical Medicine & Rehabilitation to Neurology Program Office in FY 2023
- Over 5 years program has seen pronounced growth and development of a system wide network of headache care and communities of practice
- Congressional request to create “at least 28” HCoE; currently 21 sites at least 1 in each VISN; plan to add 4 more in FY 2024 for a total of 25; greatest unmet need is in southern tier of country
- Headache is associated with higher rates of suicide
- Burn pit exposure is associated with higher rates of headache

HCoE Accomplishments

- Increased number of headache medicine certified healthcare professionals within HCoE from 1 to 22
- Created VA/DoD headache clinical practice guideline (CPG) in 2020; second CPG released October 2023
- Developed staffing model for interdisciplinary headache care
- Formalized structure
- Created infusion protocols and SOPs related to incorporating Clinical Pharmacy Specialist into headache care
- Updated Prosthetics and Sensory Aid Services neuromodulation for headache guidance documents
- Healthcare operations

Challenges:

- Adult population is aging
- Likelihood of neurologic disease increases with age
- Neurology demand (stroke, Parkinson’s and dementia) rising
- Shortage of neurologists
- Recruiting and retention of EEG Technicians a challenge; national shortage confounded by lower pay and no approval of special pay incentives

A period of questions and discussion ensued.

Dr. Racoosin reviewed the process for subcommittees to bring recommendations to the parent committee. She asked Dr. Graham if he wanted to bring forward any.

Dr. Graham's single ask was in having more abilities to use incentives to recruit and retain specialized personnel. Specifically, hard to get specialists, neurologists and EEG techs are hard to recruit and retain due to pay scale being less than private sector. Dr. Graham noted a challenge with EEG techs by the way they are classified. Another is flexibility to manage neurology clinic programs as an enterprise and not in separate buckets, hoping to share positions and encourage collaboration.

Dr. Pai asked if neurology worked with WMC to create specific Qualification Standards for EEG techs. He said yes but that there was no real path forward as the clinicians all get lumped together. They need to have incentives for techs. Overall, very few techs. He is hoping they can train within VA and maybe they would stay with in VA. ILEAD may work on educational opportunities within VA to create a training program or apprenticeship, to provide certification and ensure competency. Developing own workforce through VA would help in rural areas.

Dr. Amin asked if the 4 different CoE are separate stand-alone structures. Dr. Graham explained that there is some overlap. Portland and Seattle have representation for all four centers. However, some only have one center represented. Working to draw maps, expand, and more consistently align regions.

Dr. Graham explained that a few larger VAMCs get extra resources and good care in neurological subspecialties, but the goal is to spread the wealth through education, telemedicine, e-consults, and video referrals. The new Integrated Veteran Care Office looks at access and leveraging the capacity of the Centers to offer services to more Veterans, especially those in rural areas.

Discussion

At 2:15 p.m. the Committee entered into a period of discussion on the presentations and worked to formulate Recommendations. The following topics were discussed:

- Desire to increase cap on funding for athletes
- Recruitment and retention with a focus and emphasis on diversity
- Qualification Standards needed (more specific) for EEG tech
- Intentional plan to bring new staff to VA through training paths, including specific programs to increase diversity throughout the system.
- Need to address recruitment and retention.

It was suggested that a work group be set up to gather more information from other entities within VHA, set up conversations surrounding recruitment and retention and with consideration for diversity recruitment. Work group could identify unique qualifications and skills of EEG techs and suggest development of Qualification Standards.

- TBI and spinal cord injury recommendation related to extended care for Veterans with special disabilities. Significant conversation ensued regarding collaboration between GEC, RPS, Spinal Cord Injury/Disorders/Traumatic Brain Injury/Stroke

The Committee coalesced on a Recommendation regarding Extended Care programs, especially for special-disability populations. General Diehl concluded the discussion with a draft Recommendation which read:

> *The Committee recommends that VHA Office of Geriatrics and Extended Care (GEC) lead and partner with the VHA Spinal Cord Injury and Disorders Program (SCI&D) and VHA Rehabilitation and Prosthetic Service (RPS) to determine the current state of extended care resources available to meet the needs for Veterans with Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Stroke, and Acquired Brain Injury and to determine the projected needs for this population as they age. GEC will consider all available resources and will develop strategies to meet these needs over time for this high-risk population. GEC will work with SCI&D and RPS program offices to develop strategies and a plan and will report back to the Committee in October 2024.*

Draft will be circulated to Committee following the meeting, for reflection, comment and concurrence.

Dr. Racoosin reminded the committee to return any outstanding forms to Sonya and noted that we will be sending requests again in early 2024. Annual ethics training and completion of Form 450 are requirements for Committee membership.

General Diehl provided concluding remarks and thanked the Committee for their time and active participation. He wished everyone happy holidays.

The meeting was adjourned at 3:47 p.m.
The transcriptionist went off record at 3:47 p.m.

LAUREN RACOOSIN

Digitally signed by LAUREN RACOOSIN
Date: 2023.12.18 12:31:21 -05'00'

Lauren Racoosin, Designated Federal Officer — Date

Arthur F. Diehl, III, Committee Chair — Dec 15, 2023 Date