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| **VISN 1 Management Advisory Council**  **October 11, 2018** | |
| Topic | **Discussion** | | **Action Items** |
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| **Welcome Remarks/** **Our Network Today**  Ryan Lilly, MPA, VISN 1 Network Director | * Ryan Lilly introduced himself as the new Network Director. * He said the VISN should be a resource to help the medical centers – we are focused on it. * He said the VISN was in good shape, which is not matching public opinion. * We are not in crisis, but we do have some challenges. * Our employee engagement and innovation are our strengths. * Our challenge is to end the variability between medical centers. * We are not just healthcare, we are also suicide prevention, housing, and improving lives. * ICARE, our core values – we challenge our employees to show these. * Domains of Value – there are five, but our focus is on the top three: patients, quality and cost. We added the last two because we must succeed in them. We want to be an employer of choice, and we want to give back to our community – this includes suicide prevention. * Growth – our growth of users is flat – it is a challenge to us. The population is going down. Our Outreach is working to increase enrollment, and we need VSOs to help us. Give us feedback on what you hear. One of the excuses we hear is that they don’t want to take a space that another Veteran could use. However, the opposite is true; the most Veterans who use VA healthcare services, the more money we get, and can provide more services. He hope more will sign up; we want to give them care, that is better than found on the outside. * Budget – it is nice that we are getting increases in our budget; both sides in Congress support the VA budget and our needs. * Staffing – we are in good shape; we can deliver care to patients. * We have the best access to care, and our SAIL scores are second best. Our patients are satisfied with their care; exceeds the national level – we can do more to be more patient-friendly. An employee satisfaction is #1. * Looking forward – VISION 2020 has three goals, that we are working on how to map and measure. * Top 10% - When you look at the numbers from the private sector, their data availability, we are more transparent. The top 10% is measured with CMS, the Center for Medicare payments – they must include access to care website to choose a site quality – compare us with the private sector. * World class – this can be hard to measure. * Employee experience – We use the FEVS survey – VA does poorly, 17th place out of 18 – NASA is #1. * Getting to 2020 – * Care in the Community – we have a changed mission, embracing non-VA providers to fill in gaps in care, in a more deliberate way. The Mission Act is on a different level, that will provide better management of care, if VA can’t provide it, through purchased care. Right now, it is a confusing process of keeping records and paying bills. The goal is to be more deliberate, how to make it seamless, to educate staff on how to do it, and let the patients know what to expect – consult, time, preference, records exchange – and avoid having to print out copies of their records to take to appointments. Also, what the provider can expect. The medical center will coordinate care – it is our responsibility to coordinate care – to standardize, and provide the most care. * Access – 95% of primary care, mental health and specialty care patients seen in 30 days. We do well in primary care, very well in mental health, not so well in specialty care. * Q. Call Centers – it is not 30 seconds because the recording is too long – a message was timed at 56 seconds. * A. Will take a look. * Capital assets – we have old buildings, campuses with large areas, and towers, that can’t renovate easily. We need improvements for all. Other VISNs have newer hospitals than we do. * Q. Possible to invest in CBOCs? * A. Yes, that is one approach, to lease space. * We have an age-gap in our Veteran population, and there is a huge need for long-term care. We have the worst infrastructure, because the model shifted to having a more home-like atmosphere, with small houses. It is hard to make our hospitals more home-like and less institutional. The demand may go down for hospitals. * Q. The Chelsea home – in 1949 had open wards where you can see outside the room, never intended for long-term care – must build a new community living center. * A. Very expensive construction costs. * The VISN has the oldest patient population in the US, and most really need long-term care. Looking at grants to add beds to meet new regulations, but it is a funding challenge; 23% the true cost of care. Using telehealth to keep Veterans in their own homes. * Q. What about those that are ambulatory? * A. We need a plan, a facility master plan; the lag time in the pipeline is 3-4 years away. We will need a new plan in a year or two, whatever makes sense. Will use facility condition assessments versus replacement cost. For example, West Haven’s façade is a shell; it was a bad design, water got in, so now we need to replace it. * Q. Standards of care change? * A. We were planning to contract it, when the codes changed. * Education – we shifted focus; suicides are a challenge. We need to focus on this, get them into the VA, give them access – how to get them in? Working with police, clergy, etc. to educate them. * Q. Community care – Healthnet is no more? * A. Providers can sign up online. Triwest is a bridge now, under a community care network contract for provider agreements with medical centers. Triwest with adopt Healthnet soon – June 2019 should be in place and Mission Act goes live. | | Will take a look  Give Ryan Dr. Vargas’ info |
| **Veterans Benefits Administration Briefings** Suzanne DeNeau-Galley, Director, Hartford Regional Office | * Suzanne DeNeau-Galley said her office serves Connecticut, and they have recently renovated their area, and offered to give tours of their workspace, and to give demos on processing. | |  |
| Julie Carie, Director, **Togus** Regional Office | * Julie Carie said her office is ‘small but mighty,’ located on Togus’ 500-acre campus. The Maine Veteran population is 111 thousand, but they are also in the National Work Queue. They have 197 employees doing both VSC and VRE. * She highlighted the numbers of compensation recipients, survivor benefits recipients, and the amount of money their office puts into the economy. * VSC – three days in queue, or under. * 100 outreach events in FY18, partnering with VHA to attend town halls, etc. * VRE – positive closure goal was 85, the percent of goal was 111% Veterans back to work. They added a counselor in Bangor, which is a large area to cover. * Proud of their milestone - #1 in third quarter – she is proud of her employees, and gives a shout out to their VSOs and partners. | |  |
| E. J. McQuade, Director, **Providence** Regional Office | * E. J. McQuade said his office serves RI, and recently used this slide deck to brief the governor to show the dollars paid to VBA beneficiaries, and paid to VA employees. He said there are 275 employees in Providence, a primary tenant. * The emphasis is on VRE, increasing staffing of counselors for this important program. * Partnering with local employers, such as Electric Boat and public schools, to find jobs for Veterans completing the program. * Veterans also find gainful employment in the Regional Office; some employees are still serving – making contributions to the RI economy. * Offering employment helps prevent underemployment that might lead to suicide. * RI schools use Ch. 31; a big part of helping the schools survive. Offer reasonable accommodation, support, contribution; always hiring via VRE; stay agile, non-competitive hiring. | |  |
| Bradley Mayes, Director, **Boston** Regional Office | [5 – Boston RO – Mayes](https://prezi.com/view/O2fpNJdcpKfnF77j0UVW/) (open in Chrome)   * Bradley Mayes said his office serves Massachusetts, New Hampshire and Vermont. * Massachusetts overview – 300 thousand Veterans; nearly $1billion comp payments. Award by end of October a $10 million project to move from three to two floors to be all on Floor 15 in the JFK building in Boston, and served by both elevator towers. Going paperless allowed them to vacate a floor; $10 million in rent saved. It will be a phased project to rebuild and return Floor 14. * New Hampshire – Changes in Manchester -- $290 million in comp and pen; grown to 60 employees. We are very effective in NH – best year since 2010. * Vermont – high performing - $124 million comp payments – co-located with the medical center, has a fantastic relationship with VBA and VHA and State Veterans Homes – it is not like this everywhere. * Performance update – National Program – work queue. 366 thousand inventory, 86 thousand backlog – timely decisions in 98.7 days. In FY18, completed 1.2 million, national; 11 thousand, Boston (shares access capacity with others – gets from others), 5 thousand, Manchester (gives to others), 3 thousand, WRJ (gives to others). * Q. Denials vs grants? * A. See annual benefits report. * VRE – Boston had growth to 1904; Manchester 526; WRJ 427. Entitlement decisions for VRE, more coming in. Average days – Boston 109; Manchester 61; WRJ 34. Hiring 12 more counselors – not in national queue yet, slower in Boston. Boston has 9 counselors, Manchester 3, WRJ 1, and we are working to knock the times down. * Q. Numbers of patients limited? * A. We have an influx of work – Congress helped, gave us the 1 to 25 ratio for VRE. * Appeals - He then showed a video about RAMP, coming in February 2019. Veterans can opt into RAMP and out of the old process. Two routes: Higher Level Review at Regional office, using information already on file; or Supplemental Claim, if there is missing information or new information. This gives a faster resolution on appeals – 125 days versus 3-5 years. It allows VA to create different lanes; RAMP is in the federal register now. * If a Veteran opts in, they have nothing to lose – the duty to assist in the Regional Office if not at the board. A higher review can be requested if not happy – it can go to Supplemental or can file an NOD and go to the board. It is not in docket order. There are three lanes for the board: Evidence – new information to the board; Direct Docket – no hearing; Hearing Docket. * Q. There is misinformation on Facebook – Do you lose the Effective Date? * A. No – opting in – how to choose a docket – proceed with appeal on Form 9, election letter – Veteran can choose docket. * Q. Certification – regional office? * A. The time for a Form 9 – can be a delay to certify. Add resource to appeals, consolidate it – Boston will not be an appeals processing site. After February 2019, all appeals will be under the new process, and Veterans will be stuck if they chose not to opt in. * Q. Letters to Veterans with invitation? * A. Older appeals will be first asked to opt in, until February 2019. They can opt in without a letter. * Q. Letters reducing rating -improve? * A. For certain types of disabilities, it is not static. Evaluate the claim, assign rating, future review on it, order exam. Keep review or increase it – may say it will never get better – due process to provide evidence to not reduce. Code sheet – look in records to see if static. | | Send to Debra Law |
| **Anthony Russo, CPS**  Community Recovery Connections Team | * Tony asked to address the group about working with Veterans in recovery, and a program that he wanted to share with the VSOs to get the word out to Veterans about Weekly Coffee Socials. * These Socials are designed to get Veterans back into the community, since many feel lost after leaving the military and have a need to find comradery. These Socials combat social isolation, and provide information on education and benefits, and bringing uniques to hospitals. * He needed help in spreading the word outside of Massachusetts – asked for help in New Hampshire. They are looking to help the younger Vets, and also referrals from Mental Health, combat isolation. | |  |
| National Cemetery Administration OverviewRobert Belcher, Program Support Assistant | * Robert Belcher was not able to attend today. | |  |
| Care in the CommunitySandra Davidson, VISN 1 Business Office | * Sandra Davidson said she wanted to give an overview of the Mission Act, update on Healthnet, improving technology, building a high performing network, and what the future state will be. * The Mission Act was designed to make access to healthcare seamless to Veterans, VA staff and providers. It will take one year to deploy, with new rules and processes. Costing $5.2 billion in the short term, funding March 2019. Long term, 2019 sunset. Expand the program to include unusual and excessive burden to get care locally. * Mission Act highlights: payment reimbursement rates, CMS rates. New vendor to be awarded maybe in 2019. High performing network, provide dental care. VA schedules, they pay claims for us. Caregiver program expands, can put provider agreements in place other than CCN. * Q. Legal brief? Ask Tom Pasakarnis to brief us? * A. The NH caveat continues 20 miles. We will see who can brief them – maybe Joe Durand or Christian Cunningham – we need more detail. * Q. Not pay for exam, just treatment – 12 visits in calendar year – CMS? * A. Not all fall under CMS – obgyn/dentist/acupuncture – control in place or pay based under schedule – historical payments, paid by contractor if CMS doesn’t apply. Standard episodes of care – based on clinical guidelines reviewed yearly. Provider could request additional services. Medical necessity – VA just adopted. * Q. Request for the number of visits CMS * A. Standardize care, make sure all facilities do it – elevate to national. * Caregiver program – expanded * Healthnet – contract ended, continue to provide services, claims – 120-day timeline. End of March 2019, stop new claims. Not referring to Healthnet for scheduling, is now back with VA. * New technology – 866# - National – Veteran or provider or Healthnet question, to address concerns in transition period. On the list of Veterans with care past September, reached out to them so ensure their care continues. Six thousand authorizations, tracked all to zero. * Q. Choice – covers comp and pen exams – distance eligibility covered under different money. * A. That is being resolved in the new contract. Eligibility to June 6, 2019 is the same – 30 days/40 miles/ no services available. * Under new technology, VA takes back care scheduling – VISN 1 has $6.2 million to supplement staff in community care. In @018/2019, new processes and tools, such as the Consult Tool Box and New Consult – will improve documentation, recording all contacts with Veterans. Secure email under Virtru Pro shares with community providers. Standardized episodes of care like private sector, manage care and costs. * Healthcare Referral Manager – VISNs 1,4 and 19 are early adopters – it started today, provides real-time records access. Being tested in Maine, soon in all of VISN 1. Teach providers how to use it. * New authorization system will replace fee-based system. * Community Care Network – contract being awarded – pharmacy, urgent care, DME in the community. Must be enrolled in VA – will pay claims for VA * Current versus Future – new contract (CCN) gives ability to run reports for VA care and non-VA care. Four regions, four vendors, based on insurance companies, competitive with carriers – similar to Tricare/DoD. * Building an integrated VA-Community Health Network – starts with VA * FY19 is a big transfer year – FY20 should function as planned * Q. Communications with VHA? Secure messaging can schedule appointments but not with the proper doctor. * A. Ask MyHealtheVet/medical centers to triage properly – signage for points of contact not at main campus. * Q. Healthnet transition – tell providers to use ebenefits? * A. Use these tools if medical records are wanted – Virtu Pro – but faxing still works. New design model for clinically integrated teams. | | Dr. Vargas |
| **VISN 1 Strategic Planning** Tammy Krueger,VISN 1 Strategic Planner | * Tammy Krueger said she wanted to give feedback on how the topics and strengths discussed last time were included with the new ND assessments for strategic priorities. * Not as strong areas – access, coordination of care. * New – community living centers * Employee engagement, capital assets suicide. * Feedback – 3 questions   Question 1:  What are you hearing about the VA(VISN) CLCs?   * VT – never heard of it * Brockton – families and Veterans provide feedback that the care received is great.  One thing to note is that VHA requires contracting with only 5-star private facilities, however, the VA CLC is only 1-star; the mis-match in ratings is a little disconcerting * Manchester – Receive good reports.  Heard about an expansion consideration and possibly that WRJ might be getting a CLC.  Manchester can only support short term stays in the CLC and eviction notices may be evicting Veterans when they may need to continue residency.  The four rooms have palliative care. * Miscellaneous response:  Do all facilities have hospice and palliative care? * Bedford, Manchester, Brockton and Maine have it, Providence is contracted.   Question 2:  Any concerns related to CLCs?   * (see above) star rating mismatch between contracted private facilities and our own CLCs * (see above) Manchester’s short term residency requirement and eviction letters going out to Veterans of the CLC when their time is up even though the Veterans may need to stay longer   Question 3:  Any gap concerns with CLCs? Locations?   * Transitional period – programs like Adult Daycare and Home health need more attention * Programs falling under different areas like VBA, VHA, etc. that make it difficult for individuals assist Veterans efficiently and effectively * Lack of consistency in what services are provided/available everywhere (e.g. Manchester only Short Term CLC?) * Bad papers – results in Veterans getting turned away for care despite DD214 and other paperwork saying Veterans is eligible for care * Better communicate the good news stories of VHA and the services available to Veterans (e.g. PET CT) * Whole health for life – discussion occurred surrounding this topic and a VISN employee elaborated the program is robust and alive and continuing with the roll out process through much of 2019. | | Get more information on this  Get him in? |
| **Q and A Session** | * Brianna Camera gave a follow-up on questions from last session about telephones, phone trees. In 2013, it was mandated that VA ‘fix the phones’ to improve customer satisfaction. Requirements included better messaging, but the length of the message grew too long. We may have some flexibility, but may add to the length of it. Going forward, will look into it, like at Manchester, and changes were made so no police answered the main line. At facility listening sessions at the local level, challenges were found at each. The call center is difficult for Veterans accessing primary care and specialty care. * Ryan Lilly said they are looking for a new director for White River Junction, the job sent out September 26. Panel scrubbed October 2, the list of best qualified October 16, then Vetting for 30-60 days – January 2019 would be the earliest a new director would be in place. | | Include guidance in minutes.  Link to phone number directory |
| Pluses and Deltas | Pluses   * Lunch * Parking * More Time, not rushed (due to less one speaker) * All VBA Regional Office Directors briefed * Fewer slides/handouts   Deltas   * Weather * Light turnout * Provide fewer paper slides – save paper – send briefings to MAC members beforehand * Poor access to wi-fi | | Requested topic for mini-MAC 7 Nov 18 is Veteran Transportation |
| Adjourn | Any more questions or comments? Thank you for coming. We are adjourned. | |  |

Recorder: Carol Sobel, Public Affairs Specialist

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Maureen Heard, Communications Officer

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