

Special Medical Advisory Group (SMAG) Minutes

November 16, 2005

Welcome and Day's Charge:

The Principal Deputy Under Secretary for Health began the meeting by updating the group on the Department of Veterans Affairs' (VA) efforts to support evacuees of Hurricane Katrina. The Under Secretary for Health will provide more detail on the heroic work of VA employees in a presentation later this morning. The decision to either repair the existing VA facilities or construct new facilities on higher ground has not been made. VA will make this decision based on existing federal resources as well as in consultation with nearby university affiliates and medical facilities in the New Orleans area. The Chairman welcomed and introduced the new SMAG members and provided a brief overview of the day's agenda, which included pandemic influenza, VA's information technology reorganization, and the impact of obesity and diabetes on the veteran and military populations. Dr. Kussman also briefed the group on other significant issues that VA is currently addressing, including seamless transition, gulf war illness/syndrome and issues related to compensation and pension with regard to post-traumatic stress disorder (PTSD) and readjustment reactions.

Budget Update:

Jim McGaha from the Veterans Health Administration (VHA) Finance Office provided the group with a brief update on the Fiscal Year (FY) 06 budget, which was anticipated to change midnight Friday, November 18 or when the appropriations bill is passed. The FY06 budget was built on the assumption that Priority 8 veteran enrollment would still be suspended. The number of Priority 8 veterans is anticipated to decline. There were vigorous negotiations with the Office of Management and Budget (OMB) during the summer, and the President submitted a budget request for FY05 and a change for FY06. The change was a 5.2% increase over FY04 due to an increase of approximately 91,000 enrollees between FY05 and FY06. The VHA Finance Office expected the increase in enrollment to slowly decrease and subsequently decline. VA requested \$975 million and the president approved \$1.3 billion.

In general, medical full-time equivalents (FTE) numbers did not show much growth, with the exception of physicians, a group that continues to grow. Nursing FTE numbers fluctuated across all venues.

When VA submitted the FY06 budget, a number of policies proposed that could have resulted in savings (i.e., the \$250 annual enrollment fee) were not expected to be considered favorably. Currently, many Priority 7 and Priority 8 veterans are enrolled in VA because of high pharmaceutical costs. Despite the rollout of Medicare Part D, it is anticipated that many veterans will continue to use VA health benefits. Although Priority 8 enrollment continues to be suspended (since January 2003) and veterans currently receiving VA care will never be disenrolled, the number of Priority 8 veterans is expected to fluctuate because of the two-year combat eligibility exception.

The FY06 House and Senate Appropriations Bill Markup will continue to change in the \$29-31 billion range. The proposed budget will authorize seven major projects (Grants for State Extended Care Facilities). Interest in supporting this program was expressed.

National Response to Influenza Pandemic

Dr. Lawrence Deyton, Chief Consultant for the Public Health Strategic Healthcare Group, briefed the group on this topic. He provided history and background on influenza infection and its effect on the human population. Historically, there were three pandemics that caused great morbidity and mortality and each were the result of bird influenza. On November 1, 2005, plans to address Pandemic Influenza began and a group comprised of representatives from five agencies was convened to draft a National Strategy for Pandemic Flu. VA is represented by Carter Mecher, MD, Veterans Integrated Service Network (VISN) 7.

Control measures and prophylaxis can work if they are applied early and strategically. In November 2005, 124 human cases and sixty-three deaths were reported in Vietnam, Thailand and other southeast Asian countries. Currently, there has been no sustained human to human infection. The National Strategy for Pandemic Flu will revolve around three main pillars: preparedness and communication, surveillance and detection, and response and containment. There are nine steps in the VA-specific action plan (VA Pandemic Influenza Preparedness). To protect enrolled veterans and the VA healthcare system, VA established a stockpile of Oseltamivir (Tamiflu), the only available antiviral thought to be effective against the currently circulating strain of avian influenza (H5N1 influenza A). The oseltamivir stockpile is divided in 7 diverse geographic locations and distribution will be coordinated with the Centers for Disease Control and Prevention and the Department of Defense (DoD).

Oseltamivir is the only currently available drug to treat and prevent human avian influenza. It is manufactured by one foreign drug company, which has caused a worldwide shortage. In response, the Public Health Strategic Healthcare Group has developed a study to see if the oseltamivir supply might be extended by co-administration with probenecid, a drug that slows the elimination of some drugs. The study is now under review by Food and Drug Administration for funding. If the study proves to be successful, co-administration of oseltamivir with probenecid may double or triple the oseltamivir supply.

An FY 2006 supplemental budget request has been made to purchase vaccine. Other ongoing public health measures to fight infection include the "Don't Pass It On" Campaign, which encourages front line staff and patients to use standard public health practices.

At the conclusion of the discussion, questions were asked about the federal government's role in preventing avian influenza as well as VA's role as a national public health resource. At the local and Network levels, data and the electronic health record are two resources from which VA may draw upon. Given the recent media attention, it would be wise to take advantage of the public's current interest and prevent the spread of influenza.

Information Technology Reorganization

Mr. Craig Luigart, VHA Chief Information Officer presented and Dr. Robert Kolodner, VHA Chief Health Information Officer joined the meeting via video teleconference. Mr. Luigart began his presentation with background on VA's electronic health record known as the Veterans Health Information System and Technology Architecture (VistA) and its role in supporting secure, nationwide access to patients' health information to approximately 1300 sites of care. In addition its role as the patient's health record, VistA is also valuable for clinical research, quality reviews, claims adjudication and other health-related activities. While VistA is the largest and one of the best electronic medical record systems in the world, it will need to evolve to the next generation of information technology.

The current system consists primarily of 20+ year old software technology and business model and the costs to enhance and update VistA to meet current and emerging business needs could be high. Leveraging new developments in technology and clinical practice, with clinical input as the driver, will enable VA to provide higher quality care while also encouraging greater interaction with health care partners (i.e., non-VA providers) and demonstrating responsible stewardship of public funds.

As part of an effort to improve the way VHA does business, the Carnegie Mellon/Software Executive Institute independently assessed the Health_eVet program. A number of key recommendations are currently being implemented that involve the generation and prioritization of requirements, organizational transformation and program governance. Two primary Health_eVet goals are 1)to provide affordable “world class” support capability to veterans and 2)to ensure that the basic system infrastructure can support current and future system requirements. By 2012, the direct benefits would be greater coordination of care among VA and non-VA providers, less redundant data collection and better tracking of information for clinical and non-clinical functions and give patients the ability to communicate with VA providers electronically, refill prescriptions, and better manage their personal health records.

Near term objectives are to accelerate organization re-alignment, identification and hiring of highly experienced and proven major IT program managers, and the identification of processes and tools for program and process oversight and control. By the end of April, it is expected that VA will have the basis of a future requirements “Roadmap” and acquisition strategy to include business community validation of “critical” requirements, supporting integrated master program plans to include funding requirements, top level government structure in place and a communications strategy that fully articulates our purpose, goals and objectives and program detail that can be deployed internally to support organizational members and externally to support Congress, OMB and the public.

At the Senate hearing on October 20th, the Deputy Secretary made it clear how important an orderly transition was to the Department by involving the right people, have check points along the way and make whatever changes are need to make sure the organizational structure meets VA needs. The Secretary has also made it clear that all current services and service levels will be maintained and veterans and employees come first in any decisions that will be made and that this reorganization will be well-planned and executed.

Development of a realistic timeline with the basic expectation that a fully executed conversion to the Federalized model will take between 12 and 18 months.

VA's Role in National Disaster Relief

Dr. Perlin briefed the group on VA's role in National Disaster Relief particularly in light of the recent hurricanes. VA's fourth mission is to serve as DoD backup during national disasters. Dr. Perlin acknowledged the heroic efforts of VA employees and their families. Over 2,000 VA personnel volunteered and as a result, not one patient under VA care was harmed. Currently, the facilities are secured and a new ambulatory clinic is planned. The pharmacy database in the electronic medical record was available immediately. VA employees from all over the country came to the devastated Gulf Coast region to support the seven mobile clinics that were deployed. The Biloxi VA Medical Center was damaged by the storm, however it was one of two hospitals to survive the storm. The Gulfport VA Medical Center was destroyed by a thirty-two foot storm surge, however steps are being taken to rebuild in these communities.

Patient receiving teams were set up at the Houston under the leadership of Mr. Edgar Tucker. Houston did a remarkable job taking care of patients. Seventy-percent of VA employees were reassigned throughout VISN 16 and approximately twenty percent were reassigned out of the area. It was estimated that approximately \$1.39 billion would be needed to re-establish care in the Gulf region and some parts of Texas.

Deputy Secretary's Remarks

The Deputy Secretary thanked the SMAG for taking time out of their schedules to share their expertise and experience with VA. He complimented the Veterans Health Administration (VHA) for accomplishing its mission to care for veterans and commented on VHA's unique workforce, many of whom have been with VA for over 35 years. He briefly commented on the status of the budget and VA's plans to coordinate with other agencies to address influenza. Mr. Mansfield continued to encourage the medical community to care for our newest veterans from Operation Iraqi Freedom and Operation Enduring Freedom who have sustained significant injuries, including Traumatic Brain Injury. He also commented on the success of the electronic medical record, which has been adapted all over the world.

At the conclusion of his remarks, the Deputy Secretary thanked and presented certificates of appreciation to Dr. Patricia Hinton Walker and Dr. Steven Fagan for their service to the SMAG.

The Impact of Obesity on the Military and Veteran Population

Dr. Linda Kinsinger, Acting Director of the National Center for Health Promotion and Disease Prevention (NCP) presented to the group. Obesity is currently a major public health focus. She began by describing the scope of the problem in the general population. The obesity epidemic is the result of genetic, environmental and behavioral factors. In the last 40 years, the number of people, who are overweight, obese or extremely obese, has increased dramatically, including children. Aside from the medical consequences, the impact on healthcare costs is significant.

In the general population, ten percent of adults age 20 and over have diabetes and 21 percent of adults 60 and older have diabetes. The risk for diabetes is also higher in people of color and there appears could be a higher prevalence geographically in the south and west. The good news is that physical activity also appears to be increasing as well.

The overweight, obese or extremely obese population in the military population appears to be increasing, with men at twice the rate of women, although the rates of obesity are generally lower than the general population. The consequence is a decreased pool of eligible groups who may be recruited for service as well as a decrease in the retention of recruits, which impacts operational readiness. In 2002, TRICARE spent an estimated \$15 million on bariatric surgery.

Obesity also appears to be a significant problem in the veteran population. Many veterans have diabetes type II with other co-morbid conditions including renal failure and stroke. VA patients are heavier users of pharmaceuticals. Studies have proven that lifestyle interventions are twice as effective as medication. Sustaining weight loss appears to be the biggest challenge for veterans.

VA and DoD have collaborated to draft clinical practice guidelines to address the management of weight management and obesity. Patients are screened using Body Mass Index (BMI) as well as other risk factors, and all patients with a BMI greater than 30 are evaluated. The MOVE! Program is scheduled for implementation in FY 2006 (2nd Quarter). Currently 13 VA facilities

are doing bariatric surgery (approximately 800 cases). The National Institutes of Health (NIH) conducted a longitudinal study of bariatric surgery and perioperative outcomes. In an article in the Journal of the American Medical Association (JAMA), bariatric outcomes are better in younger women than older men.

Diabetic care in VA outperforms the industry in terms of care management. Research initiatives should include an evaluation of MOVE!, evaluation of diet, prescription drugs, surgical and other approaches to managing obesity. In addition, effective prevention strategies for patients with service-connected conditions who are at risk for future weight gain and obesity (i.e., special populations like Serious Mental Illness, Spinal Cord Injury, etc). Health disparities should also be evaluated in terms of access.

General Discussion

Proposed topics for the next SMAG meeting were discussed. They include:

- A broad discussion of VA's role in American medicine, given VA's recent role in relief efforts in the aftermath of Hurricane Katrina and its current participation in national discussions regarding pandemic flu
- A discussion on the translation of VA's quality and performance measures into effective patient care and meaningful outcomes
- A discussion on marketing/branding VA as an organization that consistently outperforms its image
- A discussion on opportunities to continuously transform the VA in terms of quality using tools like the electronic health record and educating providers on patient safety practices such as communication between physicians and nurses
- A discussion on VA as an ideal environment for collaborative education and systems thinking and the Office of Academic Affiliation's lead role in this initiative
- A discussion on generational changes, particularly in the nursing community and the need for delivery systems to attract Generation X and Y.
- A discussion on the decline of health literacy

The meeting adjourned at 2:21pm.