

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

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CREATING OPTIONS FOR VETERANS'  
EXPEDITED RECOVERY (COVER) COMMISSION

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OPEN SESSION

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THURSDAY  
DECEMBER 12, 2019

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The Commission met in the Capitol Hill  
Visitors Center, First Street N.E., Room SVC 212-  
10, Washington, D.C., at 9:00 a.m., Jake  
Leinenkugel, Chair, presiding.

PRESENT

JAKE LEINENKUGEL, Chair; Senior White House  
Advisor, Veterans Administration  
THOMAS E. BEEMAN, Ph.D., Rear Admiral, U.S. Navy  
(Ret.), Co-Chair; Executive in Residence,  
The University of Pennsylvania Health  
System  
COLONEL MATTHEW F. AMIDON, USMCR, Director,  
Military Service Initiative, George W.  
Bush Institute  
TOM HARVEY, U.S. Army (Ret.), Board Member,  
Milbank Memorial Fund  
WAYNE JONAS, M.D., U.S. Army (Ret.), Executive  
Director, Samueli Integrative Health  
Programs  
JAMIL S. KHAN, U.S. Marine Corps (Ret.)  
MATTHEW KUNTZ, U.S. Army (Ret.), Executive  
Director for the Montana National Alliance  
on Mental Illness (NAMI)

SHIRA MAGUEN, Ph.D., Mental Health Director of  
the OEF/OIF Integrated Care Clinic, San  
Francisco VA Medical Center  
MICHAEL POTOZNIAK, Ph.D., Captain, U.S. Army  
Reserve, Team Lead for Addiction Recovery  
Treatment Services, Martinez, California  
JOHN M. ROSE, Captain, U.S. Navy (Ret.), Board  
Member, National Alliance on Mental  
Illness

STAFF PRESENT

CASIN SPERO, Chief Advisor  
LUIS CARRILLO, Support Staff  
KATHRYN FAUSTMANN, Support Staff  
JOHN GOODRICH, Designated Federal Officer  
TAMARA GROZDANIC, Research Analyst, Sigma Health  
Consulting, LLC  
DANIEL HANLON, Stakeholder Relations  
JOHN KLOCEK, Alternate DFO  
WENDY LaRUE, Alternate DFO, Writer  
LAURA ANN McMAHON, Contracting Officer  
Representative; Alternate DFO  
JENNIFER MCKINNEY, Writer  
HANIFAH MOHAMAD, Research Assistant, Sigma Health  
Consulting, LLC  
STACEY POLLACK, Ph.D., Alternate DFO  
SALMAN SHAMSI, Program Manager, Sigma Health  
Consulting, LLC  
TRACY SHEWMAKE, Support Staff  
KENDRA WEAVER, Alternate DFO  
ALISON WHITEHEAD, Alternate DFO

ALSO PRESENT

RYAN BRITCH, Iraq and Afghanistan Veterans of  
America  
BERNIE EDLEMAN, Vietnam Veterans of America  
DEANNA McRAE, American Psychiatric Association  
JESSE POON, University of New Hampshire

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1 P-R-O-C-E-E-D-I-N-G-S

2 9:00 a.m.

3 CHAIR LEINENKUGEL: Good morning and  
4 welcome to the December 12, 2019 COVER Commission  
5 meeting here in this historic are of the Senate.  
6 And at this time I would like us to please rise  
7 and have Commissioner Jamil Khan lead us in the  
8 pledge of allegiance.

9 (Pledge of Allegiance.)

10 CHAIR LEINENKUGEL: At this point, I  
11 would like to welcome everybody to the meeting  
12 officially. We are now in session. And I would  
13 also to extend a welcome to the general public.  
14 I think that we'll have interaction throughout  
15 the day with various members of the public coming  
16 in, and also have some commentary set up for  
17 around 10:00 a.m.

18 And the main purpose of this meeting  
19 is that we have come over the last 17 months to  
20 ten very solid suggestions, recommendations that  
21 we will be sending to our constituents within the  
22 next 45 days.

1                   With that, I think it's appropriate  
2                   this time, being on the record once again, and  
3                   for general public personnel out there, for us to  
4                   introduce ourselves and give a little bit of a  
5                   background on who we are and how we've worked  
6                   together.

7                   And I would also like each  
8                   Commissioner, since we do have the time and  
9                   opportunity and this is going to be one of our  
10                  last public meetings, or one of our last meetings  
11                  in general before the report actually goes to  
12                  writing and then submission, for them to give an  
13                  overview very briefly on what they have learned  
14                  in the last 17 months of being on this commission  
15                  and their general outlook as far as the work that  
16                  has been created.

17                  So with that, I am going to go to my  
18                  co-chair and start with Admiral Tom Beeman. And  
19                  we'll do a counter-clockwise and end up with  
20                  myself at that point. So Admiral Tom Beeman,  
21                  please.

22                  CO-CHAIR BEEMAN: Jake, thank you very

1 much. It has been a privilege for me to serve on  
2 this commission. I have a background in  
3 healthcare leadership, having been a healthcare  
4 systems CEO for about 30 years and in the field  
5 for 45. In addition to that, I served in the US  
6 Navy for 33 years. My last assignment was as  
7 Assistant Deputy Surgeon General of the Reserve  
8 Two Star.

9           What I want to extend first and  
10 foremost is I have, I don't think enjoyed, never  
11 enjoyed such a wonderful group of colleagues who  
12 have focused so much on doing the right thing for  
13 those that we are called to serve. This, the  
14 professionalism of this team has been  
15 exceptionally rewarding. The authentic  
16 conversations that were engaged in. The deep  
17 care for veterans.

18           I don't know that we disagreed a lot,  
19 but when we did, it was because people had a  
20 passion to do the right thing to serve our  
21 veterans. I believe that the product that has  
22 been produced by this group and by the

1 exceptional team that we were assigned is one  
2 that we will first and foremost all be very proud  
3 of.

4 Probably we will extract a lot of our  
5 pride from the implementation by the VA of that,  
6 of the document and the many recommendations that  
7 are in it.

8 So the most important thing I want to  
9 do is extend my gratitude to our chairman, and to  
10 you, my fellow colleagues, on, we started out as  
11 colleagues. I would say we've moved from  
12 colleagues from friendship, and I really will  
13 value that in the years to come.

14 Thanks, Mr. Chairman.

15 CHAIR LEINENKUGEL: Thank you very  
16 much, Tom. At this time, Michael Potoczniak.

17 MR. POTOZNIAK: So I'm Mike  
18 Potoczniak, and I'm still serving as a major in  
19 the Army Reserves as a psychologist. I'm also  
20 working at the Department of Veterans Affairs as  
21 a Mental Health Director at the Santa Rosa Clinic  
22 in the San Francisco VA.

1                   And it's been, you know, definitely an  
2 honor to serve with everybody here, as well as  
3 interact with all the people that have come and  
4 come to our public meetings and issued, said what  
5 their comments were.

6                   And you know, the big thing about this  
7 commission for me is just watching how all of us,  
8 this commission started out I think with a lot of  
9 different press and different things about what  
10 it could be, what it was going to be.

11                   And the one thing that's so important  
12 to me just as an American is watching how people  
13 from very different political segments of the  
14 world being appointed by different people have  
15 come together and worked for the betterment of  
16 people who serve this country.

17                   And I just feel, you know, really  
18 proud that, you know, there was, we worked so  
19 well together and that we were able to kind of  
20 move past any differences that we had. And I  
21 really appreciate, Jake, your leadership in  
22 helping us get there.



1           It's truly what military service and  
2           service to your country is supposed to be. So  
3           you know, and I, just one last thing, you know,  
4           as a veteran who gets his care in the VA and  
5           also works at the VA, you know, I'm all in with  
6           this. And being able to make recommendations or  
7           even have a voice in this process is something  
8           that's a once-in-a-lifetime opportunity, so I  
9           appreciate working with everybody. Thank you.

10           CHAIR LEINENKUGEL: Thank you very  
11           much, Commissioner Potoczniak. At this time,  
12           Commissioner Shira Maguen.

13           MS. MAGUEN: Thank you so much. It  
14           has been a pleasure to be part of this  
15           commission. My background as a clinical  
16           psychologist, I have worked at the VA since 2001  
17           in both a clinical and research capacity. And  
18           it's really, and my area of focus is PTSD. It  
19           has been an absolute pleasure working with all of  
20           you.

21           I think one of the things that I've  
22           really appreciated is that I've learned something

1 from everyone on this commission and really  
2 appreciated our discussions. And also really  
3 appreciated the diversity of the perspectives  
4 that everyone brings to the table.

5 We are a very diverse group in terms  
6 of our backgrounds and our viewpoints, and I  
7 think that that's really added a tremendous  
8 important to this commission and those views that  
9 are represented. And I think that it's been  
10 incredible to see how we have melded those  
11 opinions together, and that everyone's been very  
12 respectful and thoughtful. And we've really  
13 grown together as a commission in presenting  
14 these recommendations.

15 So I want to express my appreciation  
16 to everyone for their service, and also just for  
17 the level of respect that's happened around this  
18 table.

19 I also, one thing that has been  
20 incredible for me as well is being able to go to  
21 the VAs, and also seeing the open arms that have  
22 extended to us and really being able to learn

1 from so many different people what has happened  
2 and what is happening at their VAs. And willing,  
3 people willing to take times out of their  
4 schedule to talk to us.

5 And this report I feel like really  
6 would have been in a very different place if  
7 people weren't being able to be open and honest  
8 with us. So I really appreciate that as well.  
9 So I'm looking forward to these last few days and  
10 the work that we still have to do. And just want  
11 to thank everyone again.

12 CHAIR LEINENKUGEL: Thank you very  
13 much, Commissioner Maguen. At this time,  
14 Commissioner Jack Rose.

15 MR. ROSE: Thank you very much, Mr.  
16 Chairman. I, too, feel that this is really an  
17 honor to be a part of this Commission. And I  
18 think the things that we are doing and attempting  
19 to do with the recommendations that we're going  
20 to bring forth are hopefully very helpful to our  
21 veterans. They are the primary reason that we  
22 are here.

1                   And I come to the Commission as a  
2                   retired Navy captain, 26 years. I also have been  
3                   a mental health advocate associated with the  
4                   National Alliance on Mental Illness for the last  
5                   19 years, both at the state and local level. And  
6                   my wife and I have two adult children who live  
7                   with mental illness.

8                   And I think as we all came together,  
9                   I think it's been very interesting with our  
10                  diverse backgrounds that I think we all have the  
11                  common mission in mind.

12                  And I think over the months, we have  
13                  all pulled on the line together. And it's not  
14                  always been a yes, sir, Jake, this is the way  
15                  we're going to do it. We've have good  
16                  discussions, and I think that has made our  
17                  product hopefully very effective.

18                  We're coming to a point in our  
19                  commission where we need to see what kind of  
20                  traction we can get with our recommendations.  
21                  And so, again, it's been a real honor serving on  
22                  this commission, and I look forward to this last

1 chapter. Thank you very much.

2 CHAIR LEINENKUGEL: Thank you,  
3 Commissioner Rose. At this time, I'll turn it  
4 over to Commissioner Tom Harvey.

5 MR. HARVEY: Thank you, Mr. Chairman.  
6 Thank all of you fellow commissioners. I have  
7 enjoyed the time we have spent together, and I  
8 think, as others have said, we've learned from  
9 each other and it has been a growing experience.

10 One of the things that I have always  
11 observed in my time dealing with the VA was the  
12 commitment of VA professional staff to the  
13 veterans that they serve. No one is rewarded for  
14 taking something away from veterans. And at  
15 times, you read stories that are critical of the  
16 VA. And I really do believe that those are  
17 aberrations.

18 CHAIR LEINENKUGEL: Excuse me, is your  
19 mic working?

20 MR. HARVEY: They are now. Let me  
21 start over again, thanking the Chairman and  
22 thanking everybody else on the Commission for the

1 time we've spent together and the journey we've  
2 made together.

3 One of the things that I've observed  
4 as we have done this is the commitment of the  
5 professional staff of the VA to the veterans that  
6 they are there to serve. And I'm always upset to  
7 read something negative about VA care.

8 And what I truly believe is those  
9 situations are aberrations and can be fixed and  
10 should be fixed. And that the overall commitment  
11 of the VA to caring for veterans is very solid.

12 When I was first appointed, I looked  
13 at that list of 19 or so different therapies that  
14 we were to consider, and I thought this is a  
15 little airy-fairy for me. I'm kind of a nuts-  
16 and-bolts, solid type of guy. We didn't have --  
17 we were looking evidence, and the general  
18 evidence in the healthcare area involves  
19 randomized, double-blind studies and such things.

20 Wayne Jonas raised a question with the  
21 Acting Secretary early on in our assemblage when  
22 he said, What evidence are you going to look at

1 when we deal with these things? Because you  
2 can't do that type of research on it.

3 And what I have come to conclude is  
4 that we have had enough anecdotal evidence that I  
5 am going to say that all of those 19 different  
6 therapies may have value in one or more  
7 situations, and I think that we should continue  
8 to look at them and try to figure that out.

9 And Wayne also gave us a copy of his  
10 book, How We Heal, indicating episodic, anecdotal  
11 stories about that. A particular concern of mine  
12 has been the issue of veteran suicide, and the  
13 numbers around 20 veterans today committing  
14 suicide causes you to, causes all of us, and  
15 properly so, to be disconcerted.

16 But, and I think that the body politic  
17 looks at that and says oh my, isn't this  
18 terrible. These poor veterans have been  
19 subjected to such stress from multiple  
20 deployments to Afghanistan or Iraq that they're  
21 coming back and committing suicide. In fact,  
22 suicide covers an incredible gamut.

1           And again, there have been articles  
2 about this and concerns expressed by the  
3 Department of Defense that people are committing  
4 suicide in basic training. They haven't deployed  
5 anywhere, they're just, you know, they've just  
6 come on active duty. So you've got that.

7           And then you have veterans sort of in  
8 midlife, where they may, the family may have  
9 broken up, they may have lost their job, there  
10 are various factors such as that that cause them  
11 to become despondent and commit suicide.

12           And I'm a Vietnam veteran, so the  
13 average Vietnam veteran's age is in the 70s. And  
14 you've got people in that category who may have  
15 lost their spouse, may have disassociated from  
16 their children. They are alone, they may have  
17 chronic illness, they may have chronic pain.

18           And each of those categories and  
19 everything else on the continuum among them means  
20 that each suicide is a little different from the  
21 other ones.

22           And I'm concerned that we haven't



1       adequately addressed that, and I don't know how  
2       to do it, other than, and, other than to continue  
3       research on it. So that's one of the things that  
4       I think is, it's something that we are going to  
5       have to be able to address as we discuss our work  
6       product with people outside this room.

7               So, once again, Mr. Chairman, thank  
8       you very much for your leadership. Thank you for  
9       the opportunity to serve, and thank you all for  
10      your friendship.

11              CHAIR LEINENKUGEL: Thank you,  
12      Commissioner Harvey. And now we'll turn to  
13      Commissioner Khan.

14              MR. KHAN: Jamil Khan means handsome  
15      conqueror. As a first-generation American, I  
16      enlisted in the United States Marine Corps. But  
17      before I was going to Parris Island, they found  
18      out I had a master's degree, so they put me in  
19      OCS program. I'm the first Pakistani-born US  
20      citizen who rose to the rank of lieutenant  
21      colonel when I retired.

22              All my life has been in combat, most

1 of it. And if not combat, then I was training  
2 others who were going in combat. So I'm 100% GI,  
3 government issue. I want to thank each one  
4 member here from the bottom of my heart for their  
5 sacrifices, what they have done for the nation,  
6 for the country, for the Corps, for their  
7 military service.

8 And that's going to affect the future  
9 generation. You are all part of my family, and  
10 especially the support staff. You are all part  
11 of us. Not only the ten Commissioners, but you  
12 are included in it, each one of you.

13 When I was given this honor, I took it  
14 as the nation was asking me, this was a call of  
15 duty. And to my passion that I am, I know I have  
16 transgressed in my life throughout my career. I  
17 have done things for which I was given medals.  
18 If I had failed, they would have court-martialed  
19 me, and that's a fact of life. I'm a straight  
20 shooter, I speak as I feel. And I represent  
21 every veteran who's getting the VA healthcare.

22 Like Tom Harvey said, VA healthcare

1 has improved tremendously in the last decade.  
2 However, the present condition in the society has  
3 created an environment where we have gaps in our  
4 family gaps. We miss having an aunt, uncle or  
5 sister, brother closer to us.

6 We as a society have been fragmented.  
7 Our children try to graduate from high school,  
8 they want to go as far away from their parents as  
9 possible. That was not true during World War I  
10 or World War II, or even Vietnam. But those  
11 things have changed. With the change, comes the  
12 change of human behavior.

13 Each veteran is different from another  
14 veteran, but we all come together because our  
15 bloodline is red. And my way of thinking of the  
16 entire world is we are all connected because of  
17 that bloodline. It doesn't matter what race we  
18 are from, what color we are, what religion we  
19 worship.

20 My message here is to myself, I owe it  
21 to those veterans to do the very best and speak  
22 out where there's a gap in our healthcare, but be

1 pragmatic and give recommendations that can be  
2 achieved.

3 Overall, wherever this is a, help is  
4 not available within the Department of Veterans  
5 Affairs, I'm a very strong proponent that we  
6 should use non-VA care wherever possible, within  
7 means. But the budget-wise, we should not be  
8 taking that budget away from the Department of  
9 Veterans Affairs.

10 Thank you very much. Again, I thank  
11 you all from the bottom of my heart. Mr.  
12 Chairman, I want to acknowledge it, you and I  
13 disagreed on quite a few things. From the bottom  
14 of my heart, I stand for those. Each word I  
15 said, I meant it. And I must say that I do  
16 apologize to all of you, because I know here and  
17 there, I've spoken. And I'll still speak out for  
18 the rest of my life.

19 God bless everyone, God bless you.  
20 Thank you.

21 CHAIR LEINENKUGEL: Thank you,  
22 Commissioner Khan. At this time, Commissioner

1 Matthew Kuntz.

2 MR. KUNTZ: Thank you, Mr. Chairman.  
3 I'm really honored to be part of this committee  
4 and to have grown together as friends with the  
5 people around this table and the staff in the  
6 past 13 months, I think I was last the one to  
7 sneak in under the wire.

8 And I dedicated my service here to my  
9 friends, Commander John Scott Hannon and Chaplain  
10 Mike Franklin, who were, you know, two of the top  
11 five friends of my life. And they were veterans  
12 that we couldn't save. And also I know my, we  
13 lost my step-brother after his tour in Iraq, and  
14 he is never far from my thoughts when working on  
15 this.

16 I'm really, really thankful to  
17 everyone for their hard work. And I think from a  
18 big picture, it's such an honor to be part of  
19 something that our country has struggled with  
20 since its inception. From the moment that George  
21 Washington got the British to get the heck out of  
22 here, we have been struggling with how do we care

1 for our veterans.

2 From the very moment that we became a  
3 country, we've been struggling. And I think that  
4 this commission fits right into that grand scheme  
5 of how we try to improve what we do for the folks  
6 that bear the burdens of battle, and I'm honored  
7 to be part of it.

8 It's been really an amazing journey  
9 for me to go to places like inner city Chicago  
10 and talk to their veterans, all the way to the  
11 Fort Belknap Indian reservations and the barren  
12 parts of north central Montana. And to hear the  
13 stories and to hear what we've done right and  
14 what we've wrong. And from the VA staff has  
15 opened up their arms.

16 And while we may have wandered through  
17 a dog and pony show or two, for the most part we  
18 were told this is what we're struggling with,  
19 this is what we're doing right. And help us come  
20 up with solutions. I'm really thankful for that.

21 I really want to thank the Chairman  
22 and his staff. And I think for just setting a

1 good tone for our ability to agree and disagree  
2 but always we move forward.

3 Every time that, finally, I guess from  
4 my own perspective looking at all these different  
5 methodologies, I did pick up a meditation  
6 practice last December. Because after watching  
7 this and learning this, if you're not grabbing  
8 part of it, then you're not paying attention. So  
9 I do value that as well, and I look forward to  
10 moving forward with everyone.

11 CHAIR LEINENKUGEL: Thank you very  
12 much, Commissioner Kuntz. At this time,  
13 Commissioner Dr. Wayne Jonas.

14 MR. JONAS: Thank you very much,  
15 Chairman. So it's a great pleasure and an honor  
16 also to be on this commission and serve this. I  
17 have to say, I probably never worked so hard.  
18 Thank you, Chairman, for driving us relentlessly  
19 to come back to these meetings prepared and  
20 having done our homework.

21 And thanks, also, to our Co-Chair,  
22 Commissioner Beeman, for giving us the emotional

1 support as we went through that process in  
2 putting things in perspective in those areas.

3 So you asked what have I learned over  
4 the last year, however long it's been. I think  
5 three key things I've learned, some of which I  
6 knew, but some of which I didn't know. So number  
7 one is that the people in the VA providing  
8 healthcare are incredibly dedicated,  
9 compassionate, and competent individuals, there's  
10 no question about it.

11 I already knew that, but when we were  
12 around from VA to VA and actually sat down with  
13 them and saw what they were doing and heard from  
14 them, interact with them, it's one thing to see  
15 it on paper, it's another thing to see it going  
16 on all over the country. And I thought that was  
17 just heartening, to me, to see that dedication.

18 The second thing I learned is that  
19 they're operating in a system that has been put  
20 together over centuries, centuries, a couple  
21 hundred years or close to that, which like the  
22 rest of the healthcare system has sort of had



1 things just added on as they come along. As new  
2 discovering happen and new technologies occur,  
3 etc., they're just sort of put in there.

4 And what we have now is a system that  
5 actually is not operating very well. This isn't  
6 just the VA, this is healthcare in general. We  
7 know that costs are going through the roof,  
8 outcomes are going down. The value of healthcare  
9 is getting worse. And the VA is caught in that.

10 And so more healthcare and simply  
11 access is not going to solve the issue. We have  
12 to actually redesign this area. And I was so --  
13 and that redesign needs to incorporate mental  
14 health, we neglect it in this country. And it  
15 needs to be done in the context of taking care of  
16 the whole person. There's no other way to do  
17 that.

18 And I think what's even more  
19 heartening is that the leadership actually wants  
20 to do this. They're already working on that.  
21 They've been involved in redesigning things for a  
22 long time. We saw lots of evidence for that, and

1 they actually would like to lead the nation in  
2 that, and that's incredible. I think there's  
3 probably no other system in the country that can  
4 actually do that.

5 And then finally the third thing that  
6 I learned is that the veterans themselves, just  
7 as they were dedicated when defending the country  
8 when they were in service and active duty, are  
9 equally dedicated to helping their own recovery  
10 if they're given the opportunity. They will  
11 respond to that as their new mission.

12 And that opportunity has to have both  
13 support, to allow them to do it, and  
14 accountability, so that they're responsible for  
15 their own behavior change in those areas. And  
16 that kind of a redesign is what's needed in those  
17 areas.

18 So I want to thank the VA staff. We  
19 had a lot of VA staff working hand and foot with  
20 us. We would come out with these sweeping  
21 requirements, like oh, we've got to look at all  
22 of this in the entire VA, and they would be like,

1 say okay, and go out and see if they could.

2 And then, you know, SIGMA then often  
3 would get a lot of that work and responded, I  
4 think, tremendously to that. So I want to  
5 really, really thank them for that. They were  
6 really there, responsive at the table any time we  
7 needed those things.

8 And also thank Wendy and her staff at  
9 the end for pulling together at the end for  
10 pulling together incredibly what looked to be a  
11 disorganized hodge-podge of things but now has  
12 gotten extremely well organized, and I think will  
13 make a compelling and does make a compelling case  
14 for the recommendations we've made.

15 So thank, you everybody, I'm going to  
16 miss you all.

17 CHAIR LEINENKUGEL: Thank you very  
18 much, Dr. Jonas. And we'll go to Commissioner  
19 Matthew Amidon.

20 MR. AMIDON: Thank you, Mr. Chair.  
21 And thank you for your leadership during the  
22 course of our COVER Commission. It has been

1 indeed my honor to be part of this. I think what  
2 it reveals is a diversity of background is met  
3 with a common objective of doing what's right for  
4 our veterans and their families, and I couldn't  
5 be more honored to join in that effort.

6 Still serving as a Marine Corps  
7 Reservist for 28 years now, so this is near and  
8 dear to my heart to ensure that those who've worn  
9 cloth of our nation are afforded the services  
10 that they deserve and need.

11 But I think, again, it's been a  
12 wonderful journey for me specifically, and a real  
13 shout-out to our VA staff, our subject matter  
14 experts, and our SIGMA support staff. We  
15 couldn't be here, wouldn't be here without you,  
16 Wendy, to you and your mastery of writing. Thank  
17 you so much.

18 I think what I'm most looking forward  
19 to is a report that balances the pragmatic and  
20 the aspirational that can be implemented in  
21 effective ways to positive outcomes for our  
22 veterans and their families.

1                   And in doing so as one of the  
2                   subcommittee structure leads, would like to  
3                   acknowledge the hard work of my fellow  
4                   commissioners, Kuntz and Rose, and your  
5                   leadership of work groups 4 and 5. Just, again,  
6                   honored and very inspired by your passion and  
7                   care as we move this forward.

8                   So to you, Mr. Chair, thank you again,  
9                   and certainly has been my honor. Thank you.

10                  CHAIR LEINENKUGEL: Thank you. Thank  
11                  you, Commissioner Amidon, and all Commissioners.  
12                  I have the opportunity, now that we have about 28  
13                  minutes before public comment, to share 28  
14                  minutes of Jake-isms with all of you.

15                  (Laughter.)

16                  CHAIR LEINENKUGEL: I'm going to take  
17                  a little more time today because there's a reason  
18                  for this, there's some people that don't really  
19                  know me. I'm pretty quiet. Believe it or not,  
20                  I'm an introvert. Most people say no you're not,  
21                  you're a true extravert.

22                  But what I have discovered in my time

1 since I was born in 1952 in a little town called  
2 Chippewa Falls, Wisconsin, was that my family  
3 came from Germany with a passion that they took  
4 from that, the old country, as we call it, to the  
5 new country, and that was brewing here.

6 And I grew up in a beer family, but  
7 I've done much more than just brew, drink, enjoy,  
8 and market beer. From five states to national,  
9 to international, as we are now in 31 military  
10 installations around the world. I'm very proud  
11 of that. Also growing the company 2000% over a  
12 25-year period of leadership with a fantastic  
13 team that has grown into a national brewer today.

14 I left that in 2014 after growing up  
15 in this small community in Wisconsin, in a  
16 neighborhood where everybody's father or mother  
17 served. Everybody except one, who at that time  
18 was a lone child and stayed and attended the  
19 family farm. So growing up in a community that  
20 was totally different because everybody served in  
21 World War II, father or mother.

22 And it was a collection of veterans,

1 veterans that at the time didn't seem to have  
2 issues, because they got together at the local  
3 American Legion or VFW, and they got together to  
4 discuss their trials and tribulations.

5 But mainly what they were concentrated  
6 on was building the new America, i.e., the  
7 greatest generation, that never seemed to  
8 complain or talk about their times of service in  
9 probably one of the largest and most important  
10 wars on two fronts that this country has seen to  
11 date.

12 So it was a memorable experience  
13 watching my Marine Corps father, who survived  
14 Saipan and Tinian, and talked about a wonderful  
15 general by the name of A.O. Smith and what a  
16 fantastic person and leader he was, and a  
17 gentleman and scholar. So I started to study a  
18 little more of A.O. Smith once I became a Marine.

19 And it's interesting that, I read a  
20 book that I recommended to some Commissioners  
21 about the Chosin Reservoir and leadership that  
22 A.O. Smith, who never really got the critical

1 acclaim that he should as being one of the finest  
2 generals that this country has produced.

3 So I would highly recommend that to  
4 all Commissioners and veterans as well. Hampton  
5 Sides is the author of this book, by the way.

6 That being said, and becoming a Marine  
7 after a father that was a Marine, I learned so  
8 much from my Marine Corps experience about  
9 diversity. Diversity of my Marines from every  
10 ethnicity that you could think of, every race,  
11 religion. And it's the first time that I was  
12 able to serve with people that had very different  
13 backgrounds than myself.

14 And I listened, I observed, and I  
15 learned more than I did during my college days in  
16 my Marine Corps days about bringing people  
17 together and doing what the Marines had been  
18 noted by the Chinese during the Boxer Rebellion  
19 of gung-ho, coming together and working together  
20 and what can be done. And I'll talk and reflect  
21 on that in just a minute.

22 My other experiences besides that were



1 seeing two of my sons become Marines. And both  
2 served honorably, and both had some sort of  
3 issues that were rectified, one by the VA, and  
4 the other by finding a person, his wife, that  
5 made an extreme connection and turned him around.  
6 So I was very thankful, as well as my wife, for  
7 that.

8 I also had the opportunity to have  
9 numerous healthcare experiences and backgrounds  
10 that most people don't know about. But I was on  
11 the Board of Directors for HSHS Hospital Systems  
12 out of Illinois that also had large hospitals  
13 throughout Wisconsin. And also was later asked  
14 to become a national advisor for Marshfield  
15 Clinic as they worked getting their expansion in  
16 Wisconsin, and became a Board of Director prior  
17 to coming to the VA in 2017.

18 So it was there that I learned more  
19 about healthcare systems and delivery, but also  
20 being around doctors and how they care for  
21 patients. And also my first interaction with  
22 customer service in that field outside of here.

1 And how customer service was becoming vital  
2 because of the competitive nature of various  
3 healthcare systems at that time.

4 So then I come to the VA only because  
5 of what happened when I retired in 2014. I was  
6 relaxing, and I think several people know this  
7 story of what happened in Phoenix. And I just  
8 said that could not actually have happened, it  
9 had to be, you know, something that was just not  
10 right and it's a one-off.

11 Well, it did happen, and there were  
12 access issues, there were waitlists. And it was  
13 a year later that it really shocked me because  
14 just 80 miles south of my hometown in Tomah,  
15 Wisconsin, we had something similar happen with a  
16 opiate cocktail delivered to a patient by the  
17 name of Sergeant Jason Simcakoski, who died in  
18 that facility. And that was the time I said  
19 something has to change and be done.

20 So I became activated, I got to know  
21 first of all the Simcakoski family. I still talk  
22 to the Simcakoski family, and they've been

1 wonderful about, as far as engaging themselves  
2 within the VA system and trying to help. And  
3 they've made great strides in Tomah, as well as  
4 the change of leadership.

5 And it's the first time that I saw a  
6 change of leadership within the VA make a  
7 dramatic difference. As I said to many  
8 Commissioners, I said that VA should be torn  
9 down. Because right after that happened, within  
10 six months they had another incident happen where  
11 they did not sterilize dental equipment, and  
12 there was over 300 veterans that were impacted by  
13 that particular incident.

14 And the change of leadership over the  
15 last three years, I've seen that be a change from  
16 the tear-down stage to this is a very well-run  
17 and necessary VA system that is doing great  
18 things, even within the mental health today,  
19 compared with three years ago. So with great  
20 leadership and great direction, found out that  
21 the system can change, and change for the better.

22 That on top of the fact that all of us

1 getting together and doing something that I  
2 thought was going to be extremely difficult. And  
3 as a lot of Commissioners will remember, I  
4 stated, if we get to 80% -- do you remember that?  
5 -- we should feel pretty good.

6 And I think we all agreed that that  
7 would be a pretty good goal to get to 80% of  
8 trying to answer and get to the right  
9 recommendations out of the five work groups that  
10 we had set up.

11 I believe we've done more than that.  
12 I think we're at 95-100%, I really do. And I  
13 felt that way last month. And it only came  
14 together because this group of Commissions, you  
15 other nine that spoke before me, made the  
16 difference.

17 You talk about my leadership, no, it  
18 was your leadership, it was your hard work, it  
19 was your daily work, your weekly calls, your  
20 coalescing as a true Commission team that took  
21 action to get to the right place.

22 And when we went through the initial

1 recommendations last month, to see the  
2 interaction, the debates, the discussion. But at  
3 the closure, when we all discussed where have we  
4 gotten to, I think to every Commissioner, as you  
5 stated earlier this morning, you should be very  
6 proud of the work.

7 I'm very proud of all of you, because  
8 I know how much work and -- everybody except me  
9 has like, has a day job. Oh, maybe my Co-Chair  
10 not as much either. But you've done an  
11 incredible amount of work and that's the term  
12 gung-ho that I wanted to refer back to.

13 You came together. You liked coming  
14 together. I think that the product that the  
15 general public is going to see, that our  
16 constituents, the Secretary, and the VA, SVAC,  
17 HVAC, and also the White House.

18 What we will deliver within the next  
19 45 days will be meaningful, impactful, and help  
20 veterans' healthcare, to Wayne's point, along  
21 with their total mental healthcare. With a  
22 hopefully new care delivery system that will make

1 a difference in saving veterans' lives and also  
2 make a difference in keeping some of the best of  
3 the best, like two of our Commissioners here  
4 within the VA system, to help those veterans.

5 So to all of you and to the general  
6 public, it's been a privilege and an honor, and  
7 I'm quite humbled to be part of a commission that  
8 I believe will make a difference for the future  
9 of our country and our veterans. Thank you very  
10 much.

11 So with that, and we are about 20  
12 minutes away from general public comments, I  
13 would like Wendy LaRue to at least use this time  
14 in the next ten minutes, and if we do have time  
15 without anybody coming in, we'll take a quick bio  
16 break. But Wendy, why don't you lay out the  
17 direction of where you want to see us go with  
18 what we have in front of us today.

19 MS. LARUE: So you have a report in  
20 front of you that is updated from what you  
21 received previously. And you've already seen all  
22 of the recommendation sections, so I just want to

1 quickly point out what is new here.

2           There's an introductory letter at the  
3 beginning, and I just want to make sure everyone  
4 understands that that will be published inside  
5 the report. Jake will have a second letter that  
6 will go on top it that's still in development.  
7 Also, all of the appendices are added here.

8           And probably the most interesting of  
9 those is just a little piece on our process for  
10 how we did our work, just as that little  
11 historical marker for anybody that reads the  
12 report.

13           I think that our best plan for today  
14 is to do a process similar to what we have done  
15 the last two meetings and just start at the  
16 beginning. Our work here today, as I see it, and  
17 Chairman Leinenkugel, you can add to that if you  
18 like or redirect, is to go through each  
19 recommendation and confirm that it reflects what  
20 the Commission wants to put forward.

21           We're not necessarily looking at  
22 commas and periods and nuances of word choice,

1 unless they affect the overall meaning. There's  
2 still some editing and proofreading and so forth  
3 that needs to go into this draft. But rather  
4 we're looking at the big ideas. Does this  
5 communicate the thing that we want our  
6 stakeholders to know.

7 And so I think ideally we would start  
8 with the Commissioner who feels most tied to that  
9 content. I realized early on it was easy because  
10 everything was divided by work groups. Now that  
11 we have consolidated our 30-some recommendations  
12 into ten, that's no longer quite the case. So it  
13 may be that multiple Commissioners will be  
14 talking about some of these recommendations.

15 But I think just a quick overview of  
16 the content for those who are here today who  
17 might not be familiar with the content, and then  
18 a discussion about does this indeed reflect what  
19 we want to reflect. You know, if suddenly  
20 somebody sees that we need additional  
21 implementation or something like that, this is  
22 the time to speak up.



1 Jennifer is sitting with the computer,  
2 the report on the computer. I realize you may  
3 not be able to see the pages. But if there are  
4 small changes, she is prepared to make them on  
5 the fly as we go. So that even as we leave here  
6 today, we should have a taken a nice step forward  
7 in preparing to be all done.

8 By the time we get to the end of the  
9 day, my goal is that we will have confirmed that  
10 these ten recommendations are the ones that you  
11 want to make and have the important content that  
12 you envisioned them to have. And then we will  
13 work on how we're going to do signatures, which  
14 we can talk about at the end of the day.

15 CHAIR LEINENKUGEL: Any questions by  
16 any Commissioners on the -- well, and I would  
17 agree, Wendy, that that is directionally exactly  
18 where we need to go, at least until we get  
19 through the entire report. I think it's also  
20 appropriate for me to acknowledge how this was,  
21 the work groups were broken up so the general  
22 public in session today has a feel for how we

1 became gung-ho for together.

2           It was really the two individuals on  
3 my left and my right that I learned on quite  
4 heavily, Colonel Matt Amidon and Admiral Tom  
5 Beeman, to basically be in charge of, Admiral  
6 Beeman work groups 1, 2, and 3, and Matt Amidon  
7 groups 4, 5.

8           And also you're going to hear mainly  
9 from the Commissioners that did the real heavy  
10 lifting with all five of those work groups.  
11 Mainly, again, Dr. Wayne Jones, Dr. Shira Maguen,  
12 Dr. Michael Potoczniak, Matt Kuntz, and also Jack  
13 Rose.

14           And certainly there was plenty of  
15 input by Tom Harvey and Jamil Khan as they worked  
16 on various work groups and intersected on  
17 numerous calls on a weekly basis. And also had a  
18 lot of input into each one of the work group  
19 outputs.

20           So with that, I think it'd be  
21 appropriate for us, at least myself, to take a  
22 quick, ten-minute bio break. And we'll convene

1 back here at 9:55 and prepare for general public  
2 comments. Okay.

3 (Whereupon, the above-entitled matter  
4 went off the record at 9:46 a.m. and resumed at  
5 10:00 a.m.)

6 CHAIR LEINENKUGEL: I'd like to open  
7 the general session now. This is the portion  
8 over the next hour where we give the opportunity  
9 for the general public to come forward with any  
10 commentary, any discussions, any question to the  
11 Commission. And I would like to ask if there is  
12 anybody from the general public available in the  
13 audience that wants to do that at this point.

14 If not, I will turn it over and just  
15 say, from an administrative standpoint over the  
16 next hour, that if anybody does come in that  
17 wants to be recognized and talk before the  
18 Commission, we will break and have that  
19 individual or group do that over the course of  
20 between 10:00 and 11:00.

21 With that, in order to get on with the  
22 mission of going through all the things that

1 Wendy earlier discussed, I would like to defer at  
2 first to Admiral Tom Beeman, who wants to add a  
3 commentary.

4 CO-CHAIR BEEMAN: Thanks, Mr.  
5 Chairman. I heard something yesterday and I just  
6 wanted to share it with the other Commissioners  
7 and the team, and it's come from the senior  
8 leadership at the VA. And it's really a reminder  
9 of us is that there's a tremendous amount of  
10 alienation in society overall, right.

11 Families have broken down, people have  
12 moved away from their faith-based support  
13 systems. Families really no longer live  
14 together, in many cases they don't have that  
15 support. A lot of our veterans, then, are coming  
16 out when they leave a very affiliative service,  
17 they're coming back to a community and world  
18 that's kind of broken down.

19 And that as we were looking at  
20 suicides, for example, although it's a very big  
21 challenge for us in the military with our  
22 veterans, it's a very, very big challenge in

1 general society as well.

2 And so to put all of this in  
3 perspective, the house isn't burning down, but we  
4 have a country that's dramatically changed from  
5 the World War I and II veterans, and even the  
6 Vietnam veterans that we were talking about  
7 earlier.

8 And I just thought it was a good  
9 reminder for me that this alienation is affecting  
10 the nation. And being cognizant that our  
11 veterans bring a set of values that may be  
12 different into a world that's so alienated I  
13 think can really be, impact them. And it's  
14 wonderful that we have the VA, which is sort of  
15 like that home they can go back to, because  
16 they're not going to get that.

17 And you know, I can speak for a  
18 civilian health system. We deliver really high  
19 quality care, but we don't deliver it with that  
20 same sense of community that you might get at a  
21 VA hospital. And so I just thought that --  
22 coming from top leadership in the VA, it reminded

1 me of the quality of leadership that they have  
2 and the sensitivity they have for the people they  
3 serve.

4 So I heard that from a servant leader,  
5 and I just wanted to remind us of it.

6 CHAIR LEINENKUGEL: Thank you for  
7 that, Commissioner Beeman. And I would also add  
8 that I totally agree with the commentary, not  
9 only from yourself but also what took place in  
10 senior leadership yesterday, and would agree in  
11 heart with what you just stated.

12 With that, Wendy, let's begin.

13 MS. LARUE: Okay, so the report  
14 actually starts with an introduction. Oh, okay,  
15 now it is. The report actually starts with an  
16 introduction, but that is not where we are going  
17 to start today. But I would like to plant a  
18 little seed about that section.

19 My colleague Jennifer pointed out that  
20 maybe we would like to call it something besides  
21 an introduction. And I don't have, I don't have  
22 words for that right now, but I think her point

1 that introduction is kind of boring and our  
2 content is not.

3 And so I would just invite everyone to  
4 think about what might we call that instead that  
5 would help our readers be more excited as they  
6 enter into our content. So just tuck that away,  
7 and in your --

8 MR. HARVEY: Wendy, oftentimes  
9 something starts out with an executive summary.  
10 Would that?

11 MS. LARUE: Oh, thank you for bringing  
12 that up. So I will tell you all that we are  
13 working on preparing an executive summary.  
14 Technically, though I know some in government  
15 don't do this practice, an executive summary is  
16 not part of the actual document. It's a separate  
17 document that you hand out to people that  
18 summarizes your big document for executives,  
19 right. That's where that came from.

20 And so I am preparing a separate  
21 document that will summarize all of the content,  
22 list the ten recommendations, give the overview

1 of the legislation and so forth. And I will send  
2 that you all sometime next week.

3 It won't include any new content, but  
4 it doesn't seem prudent to summarize the document  
5 until after we've settled on what the content is.  
6 And that's what we're doing today. So that's why  
7 you don't have that now. I just, I didn't want  
8 to spend time writing something that might  
9 change.

10 CHAIR LEINENKUGEL: Yeah, let me add,  
11 Wendy, if I may, Tom brings up an important point  
12 that we discussed earlier this morning. He was  
13 talking about the availability for Commissioners  
14 to have what we refer to as the elevator speech.

15 And the elevator speech, Commissioner  
16 Harvey, is really derived from an executive  
17 summary, which will basically point out the key  
18 hot topic areas that this commission has  
19 suggested and recommended to our four constituent  
20 parties, as I stated earlier today. But that's  
21 what the purpose of the executive summary would  
22 be.



1           So you sort of memorize the executive  
2 summary reports, and that becomes your talking  
3 points, besides the hundred pages or two hundred  
4 pages of additive documentation, or thousands of  
5 pages of additive documents.

6           MS. LARUE: And honestly, the beauty  
7 of doing an executive summary the right way is  
8 that it becomes your leave-behind piece. You,  
9 it's going to be a designed piece that'll be  
10 11x17 foldover if you choose to print it that  
11 way.

12           And it'll be a nice document if you go  
13 to visit constituents. To sit and talk through  
14 your points, it'll be really nice bullet point  
15 item for you, but also something to leave behind,  
16 because you're not going to want to carry around  
17 all of this.

18           CO-CHAIR BEEMAN: Wendy, I want to  
19 recommend that we consider calling that section  
20 Prologue and Opportunities. I think  
21 opportunities sort of suggests that, you know,  
22 they're going it, it's a positive thing. I think

1 introduction does get a little tedious. Prologue  
2 implies something, you know, and implies  
3 something interesting, this is setting the stage.

4 MR. ROSE: Thank you, Mr. Chairman.  
5 I think just another comment as we look through  
6 the recommendations and we talk about an elevator  
7 speech or how we're going to present this. I  
8 think another aspect of the presentation would be  
9 to, the relative timeline, how some of these  
10 recommendations can come forward.

11 There are some that are more doable in  
12 a shorter timeline, and they can build on some of  
13 our recommendations that are longer timeline.  
14 But I think that that is important, because some  
15 of these things we can start in a relatively  
16 short time. Thank you, sir.

17 MR. KUNTZ: So one more thought on the  
18 Prologue or the Opportunities. I do believe that  
19 it makes, it sometimes makes sense to have a  
20 quote and a pulling it together. And the one  
21 that I would like put up for consideration is by  
22 William Gibson.

1                   And it's, The future is already here,  
2                   it's just not evenly distributed. And I think  
3                   that out of what we've seen in the last 15  
4                   months, it's a standard quote for technology  
5                   companies around the world anyway from a sci-fi  
6                   writer, but it totally captures what we've seen.

7                   CHAIR LEINENKUGEL: I think that's  
8                   very appropriate, Matt, and something for all of  
9                   us to consider. It makes sense to me and I like  
10                  it.

11                  MR. KUNTZ: Thank you.

12                  MS. LARUE: So if at some point during  
13                  the day you get inspired to add to that  
14                  conversation and it's a natural time to do it, we  
15                  can just keep adding to the list. I'm already  
16                  making lots of notes. And we'll figure out a way  
17                  forward, but we've got some great ideas to get us  
18                  started.

19                  So with that, we're skipping the, what  
20                  may now be the Prologue and Opportunities, and  
21                  moving right into the recommendations themselves.  
22                  And recommendation one leads us to Commissioner

1 Jonas. So if you'd like to just --

2 MR. KUNTZ: Wendy, is there an  
3 appropriate time to talk about the order of the  
4 recommendations? Would that be at the beginning  
5 or when would you like to have that conversation?

6 MS. LARUE: I'm thinking about that.  
7 We can certainly have a conversation about order.  
8 I can explain why they're ordered the way they  
9 are right now if that's helpful.

10 MR. KUNTZ: And then I can explain why  
11 I think it might make sense them ordered a  
12 different way from a narrative standpoint.

13 MS. LARUE: Okay, so the  
14 recommendations as they stand right now, my  
15 thinking was kind of order of magnitude. If we  
16 say we want to transform the whole system, that  
17 seems to need to come first because everything  
18 else becomes somewhat predicated on that.

19 I mean, obviously every one of the  
20 other recommendations could be implemented  
21 without doing that, but they all work much better  
22 under a system that is Whole Health-oriented. So

1 that seems to be a logical place to start and it  
2 flows very nicely from that prologue.

3 The research recommendation ties very  
4 directly to what is in that first recommendation  
5 as you see it here. And actually refers back to  
6 it. So those two need to be side by side. And  
7 so that is why I chose to put those two first.

8 The third recommendation then is the  
9 one that has the voice of the veterans. And I  
10 honestly, having been out and talked to veterans  
11 over the bulk of the summer, it seemed important  
12 to get those voices up front. Because there were  
13 a number of veterans who had the perception that  
14 we didn't really want to hear their voice. And  
15 so I think that needs to be front and center as  
16 much as it makes sense.

17 And then all of the subsequent  
18 recommendations just ordered by kind of priority  
19 and what I heard in our content, our discussions  
20 as being top priorities.

21 CHAIR LEINENKUGEL: Wendy, if I may,  
22 seeing that we're in the --

1 MS. LARUE: I see that.

2 CHAIR LEINENKUGEL: We're in the  
3 public session, and we're honored and privileged  
4 to have one of the authors of our charge, our  
5 mission, as a commission here today. Congressman  
6 Gus Bilirakis, if you would, the dais is yours,  
7 sir, please.

8 REP. BILIRAKIS: Thank you so very  
9 much. I appreciate all you're doing on behalf of  
10 our heroes. And this was always a priority for  
11 me. It looks like it's coming to fruition, and  
12 I'm very, very pleased.

13 So this is why we run for Congress, to  
14 do good things like this and save lives. And you  
15 are going to do this. So I'm really looking  
16 forward to seeing the report and implementing a  
17 lot of these therapies, whether complementary or  
18 alternative therapies, into the VA.

19 So I do have some prepared remarks.  
20 But I'm not going to take very long. Because  
21 you're doing a lot of good work, and I can't wait  
22 to see the report. I know it's going to come

1 out, I was told, maybe the end of January, is  
2 that correct? Excellent.

3 So as the primary author and sponsor  
4 of the COVER Act which became Section 931  
5 Provision of the Comprehensive Addiction and  
6 Recovery Act, this Commission was born out of the  
7 belief that one size does not fit all, especially  
8 when it come to an issue as sensitive as meeting  
9 the mental health needs of our nation's heroes.

10 That's why the work that you are doing  
11 here is to very important. I'm confident the  
12 work you are embarking upon will save lives and  
13 hope that we can continue to transform the way  
14 the VA system as a whole approaches behavioral  
15 care.

16 I know that since the last time I was  
17 able to attend a meeting down in the James A.  
18 Haley, well he was, it might have been the first  
19 meeting. And I represent the Tampa Bay area, by  
20 the way. I know you've been working hard  
21 producing this report, and I'm very excited to  
22 see the recommendations produced as a result.

1           Whether it's things like art therapy,  
2           accelerated resolution therapy, hyperbaric oxygen  
3           therapy, yoga, outdoor sports, or acupuncture, et  
4           cetera, I mean, I've been around veterans most of  
5           my life, and I know that these therapies work.

6           But again, we want to make sure  
7           they're evidence-based, and that's why you're  
8           here. I've heard many stories, as I said, from  
9           my constituents, and veterans all over the  
10          country, about how an alternative or  
11          complementary treatment brought their lives back  
12          from the brink of ruin.

13          Of course, we want to protect the  
14          veteran by making sure the treatment is evidence-  
15          based and effective. That's why you're here  
16          doing this independent study and analysis. As  
17          you all know, too often our veterans return from  
18          war with debilitating PTS or TBI and are placed  
19          on and get addicted to opioids. While I know the  
20          medications could be part of the solution for  
21          some veterans, it shouldn't be the only option  
22          considered, in my opinion.



1                   Complementary and alternative  
2           therapies are so critical in this equation. But  
3           I also know that there are veterans that have a  
4           great deal of pain, and they do need pain  
5           medication, and they definitely need to get it.  
6           But again, there's nothing wrong with  
7           complementary therapies as well.

8                   So that's why I coupled this  
9           legislation, again, with the Promise Act which  
10          turned into Section 911 of CARA which required VA  
11          providers to receive training and utilize best  
12          practices, again, prescribing practices when  
13          treating with opioids.

14                   These two issues go hand in hand in my  
15          eyes. Substance abuse and mental health issues  
16          are often co-occurring in the general population  
17          as well. And the treatments the Commission  
18          approves for the VA to use will have the impact  
19          of treating these issues in a holistic manner  
20          which is very critical.

21                   I believe it is a key component of  
22          reducing the suicide rate within the veteran

1 community and helping service members  
2 successfully reintegrate into civilian life, two  
3 of our primary objectives.

4 Now, I will tell you again we want to  
5 make sure our veteran, if he or she needs it, has  
6 access to the pain medication as well if that's  
7 what the doctors recommend and, you know, based  
8 on the retraining that they'll receive as well.

9 This is why I'm also excited to see  
10 the final report which I know will be out very  
11 soon, and review the findings for potential  
12 further implementation into the VA system. The  
13 VA's Whole Health program is an excellent  
14 mechanism for this implementation. And I know  
15 it's already in the process of being set up at  
16 the VA Medical Centers across the country,  
17 including my area, Haley, and Bay Pines, so the  
18 Bill Young Hospital and located in St. Petersburg  
19 or around there.

20 Once the evidence is determined to be  
21 effective, these treatments actually being  
22 utilized for veterans is the most effective part

1 of the work you are doing. Again, I'd like to  
2 thank you for your service and your continued  
3 service working on this very important issue. I  
4 look forward to reviewing your findings and to  
5 seeing the implementation of your  
6 recommendations.

7           Additionally, I'd like to remind you  
8 that I'm here to be a resource to you. If you  
9 encounter any barriers, do not hesitate to reach  
10 out if you need anything. We've got to get this  
11 done, folks, for our heroes.

12           And I have a bad cold, as you can  
13 tell, but this is very important to me and my  
14 constituents. And I wanted to be here to thank  
15 you. And I look forward to seeing the report.  
16 Thank you very much. God bless you. God bless  
17 you for what you do. Thank you.

18           (Applause.)

19           CHAIR LEINENKUGEL: Congressman  
20 Bilirakis, thank you so much for your leadership  
21 and also for being there. Yes, you are correct  
22 when we first came down to one of our first site

1 visits at the VAMC in Tampa. And you'll be happy  
2 to note that the James Haley VAMC is so noted for  
3 its exceptional service and quality of care and  
4 delivery of care to our veterans in our report.

5 REP. BILIRAKIS: Excellent. Oh,  
6 that's wonderful.

7 CHAIR LEINENKUGEL: Thank you so much,  
8 sir, for being there for us.

9 REP. BILIRAKIS: Dr. Ruiz, who is the  
10 co-sponsor, the Democrat lead, I believe, plans  
11 to attend as well and give some remarks.

12 CHAIR LEINENKUGEL: Terrific. Thank  
13 you so much.

14 REP. BILIRAKIS: I appreciate it.  
15 Thank you.

16 CHAIR LEINENKUGEL: Any other general  
17 comments at this time from the general public?  
18 If not, we'll go right back to where I so  
19 conveniently interrupted you, Wendy, at that time  
20 when you were making some statements.

21 MS. LARUE: Okay, so this is what I  
22 would like to do, if it's okay with you, Matt, is

1       having explained that line of thinking, I think  
2       probably the best plan is to stew on that, put  
3       that over there in that parking lot with our name  
4       for that first section. And let's get through  
5       agreeing what the content is, and then we can  
6       come back at the end to that conversation about  
7       how to organize it.

8                 Because there may be things that come  
9       up today that none of us have thought about  
10       before. And that seems like a way forward that  
11       will keep that on the table but let us focus on  
12       getting the important part that we need to vote  
13       on first.

14                MR. POTOZNIAK: Just to add to what  
15       Matt also said, and also keeping in mind it's in  
16       the parking lot, you know, something that you  
17       said earlier about the voices of the veterans, I  
18       found the quotes to be, in the section with the  
19       focus group quotes, to be pretty impactful.

20                And, you know, we're used to getting  
21       reports with a lot of analysis, and a lot of --  
22       but I felt the quotes really captured a lot of

1 why we're doing what we're doing. And so part of  
2 what Matt was saying was kind of how, if we're  
3 reorganizing it, we might think of somehow front-  
4 loading that section. Because it does speak so  
5 eloquently to what we're doing in the parking  
6 lot.

7 MS. LARUE: As you know, that's one of  
8 my favorite sections.

9 MR. KUNTZ: And I guess, so for me, my  
10 only thing that's sitting in the parking lot is  
11 swapping one with three with the idea that, if we  
12 lead with what the veterans want, and then we say  
13 what the research says, and then we go into what  
14 our big recommendations are, we have a ton of  
15 credibility as we move in to transform the  
16 system.

17 MS. LARUE: Okay. So I think if we  
18 work through these today, and I think that that's  
19 the recommendation, then by the time we get to  
20 the end it should be an easy conversation.  
21 People will know yes or no based on what they  
22 hear today. Does that make sense?

1 All right. So then not worrying about  
2 order, we're just going to go with the order of  
3 the pages as they are at this moment. I will  
4 turn things over to Commissioner Jonas to talk  
5 about just an overview of what this  
6 recommendation is about and how we came to it.

7 And then after that we can have a  
8 formal discussion and call a vote for this  
9 particular recommendation. And we'll just move  
10 forward in that manner with each recommendation.  
11 So over to you, Wayne.

12 MR. JONAS: Thank you very much. And  
13 before I do that, I would like to make a  
14 suggestion on what was just discussed around  
15 order that might help. And, you know, we can  
16 again get to that later.

17 You know, my personal preference is  
18 the big picture down like you've described, but I  
19 really understand the power of the stories that  
20 came out of the qualitative research. And that  
21 was also one of my favorite sections. I hadn't  
22 seen a lot of that before, you know, the actual

1 detailed stuff in that. And it was really,  
2 really nice to read. I really did.

3 So one thought, just another way to do  
4 that, is that you talked about putting quotes in,  
5 for example. Very often, when there are sort of  
6 highlighted, higher type font things that you  
7 want people to sort of get the message, because  
8 they skim over it anyway, it may be that we want  
9 to take some of these more pithy, important  
10 quotes that support this sort of thing from the  
11 qualitative component and actually take some of  
12 those, separate from, instead of condensing them  
13 all into Number 3, is actually put them  
14 throughout the entire report, including right up  
15 front.

16 Because then, you know, you see the  
17 voice of the veteran spread throughout the entire  
18 thing. And so that's another option, I would  
19 think, that I'd just like to throw out on the  
20 table as a possible way to actually, you know,  
21 bring that there.

22 It doesn't mean dismantle Number 3, I



1 mean, it's still there, but it means pull out a  
2 few of those things and show, highlight, here's  
3 what the veterans are talking about throughout  
4 the entire thing that illustrate what we're  
5 doing.

6 MS. LARUE: We have ample content,  
7 just ---

8 MR. JONAS: Yeah.

9 MS. LARUE: -- just not time today,  
10 but if this is something, again, we can confirm,  
11 even at the end of the day, if Commissioners are  
12 comfortable with the idea that they leave here  
13 voting yes, but that some of that kind of content  
14 would be added even after this meeting, we have  
15 literally hundreds and hundreds of pages of  
16 transcripts.

17 MR. JONAS: Yeah.

18 MS. LARUE: What you see here is a  
19 small fraction of the really poignant things that  
20 were said to us by veterans. And because of the  
21 way the coding took place, it would be very easy  
22 to add veteran comments in virtually every

1 section.

2 Perhaps not the research section,  
3 that's pretty straightforward and clinical. But  
4 beyond that section, I don't see a section on  
5 this report that couldn't have veteran voice  
6 added to it. We just haven't had the opportunity  
7 to do that today.

8 So again, we'll put that on that list  
9 of things to revisit at the end of the day, that  
10 aren't essential to voting yes or no today, but  
11 may help make the report even stronger.

12 MR. JONAS: Yes. I think it would  
13 supercharge the entire the report if the quotes  
14 were actually, you know, because you have so many  
15 of them.

16 MS. LARUE: Oh, and we have new ones  
17 to add --

18 MR. JONAS: And I understand.

19 MS. LARUE: -- that we don't have to  
20 repeat.

21 MR. JONAS: And finding the ones that  
22 really are, you know, right on the mark, and

1 pithy, et cetera, and spreading those throughout,  
2 and I wouldn't exclude the research section,  
3 okay, at all in this area for that. Because  
4 patient-centered research is something that we  
5 actually made a recommendation for, bring the  
6 voice of the patient into the research decision  
7 making process up front.

8           And so again, you know, if there are  
9 some comments on, I think we just actually heard  
10 a comment on we know these things work, but we've  
11 got to have evidence-based. Well, what does that  
12 mean, evidence for who? Well, for the veteran,  
13 obviously, in those areas. So I would include  
14 that section in those areas. So thank you.

15           In terms of the actual Recommendation  
16 1, first of all I just want to commend you on  
17 having pulled that together and organized it  
18 under a single recommendation. When we were  
19 working on that, and I'm thinking there were all  
20 these things, how would that ever happen, and I  
21 thought you did an excellent job.

22           So I have very few sort of comments on

1 that, perhaps others do. There are some, a  
2 couple grammar, typo, other kinds of errors which  
3 you said don't worry about those. I actually  
4 went through and listed them. I'll send them to  
5 you so that you can look at them and all that  
6 kind of stuff in there. But I'm sure those will  
7 be kind of cleaned up.

8 In the one that you sent us, which  
9 looks like it's already been corrected in here,  
10 there was some confusion about the figures, the  
11 numbering of the figures, and then the wording  
12 around referring to the figures within the text.  
13 And it looks like, I haven't done it in detail,  
14 but it looks like that's all been corrected in  
15 those areas.

16 One thing that we might want to  
17 consider, because people, when they do look at  
18 figures then they kind of want to know what all  
19 those things were, and they can't necessarily  
20 find it in the text, we may want to put a caption  
21 underneath that that sort of briefly explains  
22 what are all those things in the figures. So

1 when anybody looks at that, they can kind of get  
2 the essence of that.

3 And I'm not sure if I did that or not,  
4 or sent a draft to you or not. I'll have to go  
5 back and look, but if you agree with that, I'd be  
6 happy to help write sort of a caption that goes  
7 underneath each figure that actually allows you  
8 to sort of look at the figure, read about what  
9 it's about, and understand it immediately without  
10 having to try to find an explanation for it in  
11 the text, okay. So that would be one thought  
12 about those areas.

13 And I've got a couple other things.

14 MS. LARUE: That's something easy to  
15 do. Just a point to consider on that is keeping  
16 a caption really short. Because if the caption  
17 starts to get to be the same size as the graphic  
18 ---

19 MR. JONAS: Yes, got to be short,  
20 right.

21 MS. LARUE: -- it kind of defeats the  
22 purpose of having a graphic to begin with.

1                   MR. JONAS: I agree, right. Yes, so  
2 then the other thing I wanted to, there's  
3 actually some data in here that's wrong. And  
4 it's not so much it's wrong, but that we didn't  
5 actually get the right data in there, because  
6 when we were first putting it together, we pulled  
7 data from early, early on.

8                   And during the course of looking at  
9 the information that was being collected,  
10 actually even as the Commission was being done,  
11 there were studies going on, we heard updates of  
12 those, you know, during the Commission meeting.  
13 And some of that actually didn't get in there.

14                   So there's a couple paragraphs in here  
15 where the data actually isn't, it's not actually  
16 data. And I can show you what it is. It was on  
17 Page 16 in the original thing. I think it's now  
18 been moved to Page 17.

19                   And it was specifically, and we heard  
20 a couple iterations of this during the course of  
21 the year. And starting down on the early  
22 analysis, which is like the second paragraph from

1 the bottom, those two paragraphs, those were  
2 brought in from very, very early in the  
3 Commission, out of a report that Whole Health  
4 provided to us.

5 But that was actually updated a couple  
6 times, actually. And even recently, there's been  
7 some data that was updated. And so that's not in  
8 here. And so I'd like to propose that we correct  
9 that and actually put the actual data in there  
10 from the early analysis that exists in that.

11 And I can pull that for you from the  
12 right sources and send that to you in there. So  
13 that was one sort of section correction that I  
14 think needs to be done.

15 What's described in the current report  
16 is really the modeling and the predictive  
17 component. It wasn't the actual data. It was  
18 the model that they said that they wanted to use  
19 in their estimates on that. So it actually is  
20 not data. Well, they now have data in those  
21 areas. So I think we should actually put the  
22 data in there. So that was just one, you know,

1 larger component that I thought we should put in  
2 there.

3 And then just again, fairly minor, but  
4 there are some updated references from current  
5 research. When we describe why, you know, it's  
6 important for the VA to now begin to build on  
7 what it's been doing to transform its own  
8 healthcare into this sort of new transformative  
9 model that has these characteristics of person-  
10 centered, relationship-based, recovery focused  
11 value payment components that are described in  
12 here, there's actually been new data from  
13 research literature reinforcing that and adding  
14 to that that has just come out in the last couple  
15 of months.

16 And I'd just to make sure we have the  
17 most updated references in that. And I'll go  
18 through and point out where that is. I'll give  
19 you an example of that.

20 You know, Journal of the American  
21 Medical Association just published a massive  
22 study on the rise in mortality in this country,



1 and why that's happening, and the fact that it  
2 has now happened for three years in a row, a huge  
3 study that was, you know, came out of University  
4 of Virginia and actually had a bunch of other  
5 authors on it.

6 It builds on an IOM report that was  
7 published in there, but it's actually much more  
8 updated data on that. So we should probably  
9 stick that in there. And there's a couple of  
10 other things like that we should put in there.

11 So that's pretty much all I had in  
12 terms of those areas in terms of changes. And so  
13 anyway, I'll stop there.

14 MS. LARUE: So let's start with those  
15 points. Everyone's comfortable with we'll make  
16 those changes, and you can vote on this  
17 recommendation knowing that there will be updates  
18 to the data?

19 MR. KUNTZ: I have, I guess one thing  
20 I'd like to bring up before we vote on this  
21 recommendation. It's on Page 26, right  
22 underneath both recovery-focused care and Whole

1 Health care. The on recovery-focused care,  
2 there's a bullet that says invest one billion  
3 dollars over the next five years to exhilarate  
4 this training and hire providers with recovery-  
5 focused skills and processes.

6 And then in the second sentence of the  
7 first Whole Health bullet is the funding of each  
8 medical center will be enough to support the  
9 initial costing of implementing the Whole Health  
10 system and is estimated \$2 billion over four  
11 years.

12 And I guess, from my perspective, I  
13 don't believe that we have done enough analysis  
14 on costing to be able to put that accurately in.

15 The Congressional Budget Office will  
16 do the costing analysis. We have not had a  
17 costing person to that team. We do have those  
18 recommendations very strongly. I think that if  
19 we just eliminated Bullet 3 under recovery-  
20 focused care, because the recommendation is  
21 described in Bullet 2, and then eliminated the  
22 second sentence under that first bullet on Whole

1 Health care, so basically the two sentences that  
2 say how many billions of dollars will be  
3 invested, we don't have that skill set. And the  
4 Congressional Budget Office will.

5 CHAIR LEINENKUGEL: And I concur. And  
6 thanks for bringing that forward. As far as a  
7 monetary amount, that is not in the scope of the  
8 Commission, but what I would recommend is that we  
9 at least keep the line in there that investment  
10 is going to be required and leave out the amount.

11 MR. KUNTZ: I fully agree, Mr.  
12 Chairman.

13 MR. JONAS: Yes, I agree with you on  
14 that. I think the data, I mean, this came from a  
15 projection based on information that we got from  
16 the VA that it was estimated to be about \$550  
17 million for going from the current Centers of  
18 Excellence to roll out what they were planning in  
19 the first year to another, I think, 56 or  
20 something like that.

21 But that doesn't necessarily mean  
22 that'll be what's required to do the entire VA.

1 So that should be left up to, you know, again,  
2 the bean counters in terms of figuring that out.

3 CHAIR LEINENKUGEL: Yes.

4 MR. JONAS: I think we should say  
5 sufficient amount be to roll it out or something  
6 like that.

7 CHAIR LEINENKUGEL: Exactly.

8 MR. JONAS: And then leave it up to  
9 them.

10 CHAIR LEINENKUGEL: I was just going  
11 to start to do a Wendy-ism here and say, you  
12 know, take out the amount and say investment  
13 required --

14 MR. JONAS: Appropriate --

15 CHAIR LEINENKUGEL: -- appropriate  
16 investment over the next five years, sufficient  
17 investment. The powers that be that will take  
18 this charge and move forward with it will do the  
19 costing and the analysis from recommendations on  
20 the amount required or needed. Or they will look  
21 within internally and see if the dollars can be  
22 resourced from other factions within their

1 budget.

2 But the key is to be able to  
3 substantiate the requirement of what's going to  
4 be needed based on your assessment, Wayne. I  
5 think we need to keep at least that marker in  
6 there without the dollar.

7 MR. JONAS: Right, I agree.

8 MR. HARVEY: Mr. Chairman, Wendy, in  
9 reading over what I got electronically from you  
10 awhile back, in the first section there's ---

11 MS. LARUE: Can I stop you one second?  
12 Because I have a question.

13 MR. HARVEY: Oh, sure, sure. Mine is  
14 totally separate.

15 MS. LARUE: Okay. So what I want to  
16 do is clarify, because this is something we can  
17 do right now. So some suggested language under  
18 the recovery-focused would be invest dedicated  
19 funds over the next five years sufficient to  
20 accelerate this training and hire providers with  
21 BLA, BLA, BLA.

22 And then I think we don't actually

1 have to take out the whole sentence under whole  
2 healthcare. We can say the funding for each  
3 medical center will be enough to support the  
4 initial cost of implementing the Whole Health  
5 system, period.

6 PARTICIPANT: Re-read the first one?

7 MS. LARUE: Re-read the first one?

8 Invest, take out one billion, dedicated funds and  
9 then after the word years, add sufficient. And  
10 we've got the other one. You ready?

11 PARTICIPANT: Yes.

12 MS. LARUE: Okay. All right, thank  
13 you.

14 MR. HARVEY: Okay. In reading over  
15 the initial, what we got electronically a week or  
16 so ago, in Section 1 there is reference to the  
17 Quadruple Aim stuff. And there's no definition  
18 of what that is. And it struck me that we ought  
19 to, that may have changed. But I was just  
20 reading the Quadruple Aim. But if you haven't  
21 sort of sat through some of this, what  
22 specifically is that? And it's ---

1 MS. LARUE: I know it's in here,  
2 because I remember a dash and the four items.

3 MR. HARVEY: Okay.

4 MS. LARUE: But what I will do is make  
5 a note to make sure that it's defined early on.

6 MR. HARVEY: Well, and early on, so  
7 that we don't get to, you know, Recommendation 3  
8 that then has a dash in the four items ---

9 MS. LARUE: I feel like it's somewhere  
10 in Recommendation 1 which may not be that  
11 anymore.

12 MR. HARVEY: It may well be. It's  
13 just that in looking over that edition of this, I  
14 didn't notice it early on.

15 MS. LARUE: And that may be something  
16 that we can work into the prologue so that it is  
17 at the very beginning. And that's where I'm  
18 going to put my sticky note. Thank you.

19 MR. JONAS: It needs to be defined  
20 when you use it, the first time you use that,  
21 right.

22 MS. LARUE: Right.

1                   MR. JONAS: There's a description of  
2                   it, but I think it's built into the improvement,  
3                   innovation improvement section which is later on.  
4                   And we've already used it a couple of times in  
5                   the beginning. So we should do that, yes.

6                   MS. LARUE: One of the things that I  
7                   will do over the next few weeks is actually read  
8                   from beginning to end when we know what the  
9                   beginning and end actually are. And it really  
10                  helps when you read things sequentially to notice  
11                  those sorts of things. So I have a sticky note  
12                  to remind me.

13                  MR. JONAS: You know, just a point on  
14                  this aspect, and again, to what extent you want  
15                  to define that I think is important, because it  
16                  plays off of what are the success metrics. What  
17                  do we mean by it's working, okay, it's happening?

18                  And also, it defines the quality  
19                  metrics of improvement too that the VA uses and  
20                  healthcare uses in those areas. When we were out  
21                  looking at both internal VA systems and then  
22                  looking at civilian systems that were taking care



1 of veterans to look at them, we had decided to  
2 use the Quadruple Aim as sort of the framework  
3 for that and even went to IHI where it sort of  
4 was invented and got their description of it.

5 We actually developed a very detailed  
6 list of types of metrics for each of the  
7 Quadruple Aims as options that are now being  
8 collected, most of which are already being  
9 collected within the VA, actually quite robustly  
10 within SAIL.

11 So there actually is a fair amount of  
12 detailed data behind this that we sort of  
13 describe in a couple sentences in terms of the  
14 findings in there, which is fine. I'm not  
15 suggesting that we change that. We don't  
16 necessarily want to increase that.

17 But I just wanted to point out to the  
18 Commissioners that the Quadruple Aim was not  
19 simply a picture saying, oh, here there is that  
20 you should look at. There's actually some very  
21 defined metrics that VA is collecting, and that  
22 the civilian sector is saying it should collect,

1 and in some cases doing, in many cases is not  
2 doing, that define what is quality care in those  
3 areas. I just wanted to point that out.

4 You know, we should somehow point to  
5 that. And the references are in there, but  
6 again, we don't want it to get lost, that this is  
7 a fairly robustly developed model that the entire  
8 healthcare system is saying we should go to and  
9 the VA is actually moving towards quite rapidly.

10 MR. ROSE: If I may, Mr. Chairman, I  
11 think when you talk about the Quadruple Aim, that  
12 was decided near the front end, because one of  
13 the tackers of Group 4 was sufficiency, and  
14 sufficiency across the board for our care, our  
15 mental health care in this specific area. So we  
16 need to, that should be part of it so there's no  
17 question what we mean by that.

18 CHAIR LEINENKUGEL: Thank you.

19 MS. LARUE: Okay. So there is one  
20 item that I believe needs to be added in the  
21 implementation, and I wanted to bring that up and  
22 thank Matt for pointing out that it was missing

1 from this report. And that is that at previous  
2 meetings we had talked about an exemption from  
3 the Paperwork Reduction Act in terms of using  
4 patient survey data as part of the continuous  
5 improvement process.

6 And last night, I remembered that we  
7 also had discussion about putting something to  
8 that effect in the research section. And I  
9 couldn't remember what we resolved. But this  
10 morning, in thinking about it, that is what I  
11 recall the decision was, was to consider that  
12 part of the continuous improvement process.

13 And right now, one of the challenges  
14 is that that data is subject to the Paperwork  
15 Reduction Act. So I will work with Dr. Jonas to  
16 add the correct words in the right place.

17 MR. JONAS: It's not in there.

18 MS. LARUE: Right, it's not anywhere  
19 in here, and thank you, Matt, for noticing that,  
20 because I think that's a really important  
21 implementation step that we don't want to lose.

22 MR. GOODRICH: Wendy, could I just

1 interject? I did talk to someone from Dr.  
2 Clancy's staff earlier this week. And they  
3 provided us some language that NIH uses. It's  
4 under the Cures Act, the 21st Century Cures Act.

5 And so I can share that with you, Dr.  
6 Jonas, and the rest of the team, for  
7 consideration to put it in the implementation  
8 steps. It wasn't like a panacea by any stretch  
9 of the imagination, but it might at least put us  
10 down the right path.

11 MS. LARUE: Perfect, thank you.

12 CO-CHAIR BERMAN: And just as an  
13 aside, it's befuddling to me how you could get  
14 patient information back and not use it as part  
15 of continuous quality improvement. I mean,  
16 that's what we do. We get questionnaires. It  
17 just boggles my mind that there's an issue there.

18 What I wanted to do is, although we're  
19 not using Robert's Rules of Order, at least we  
20 didn't adopt them, since we have a recommendation  
21 from a committee, I'd like to second that so we  
22 actually have something on the table that we can

1 take action. And then we can have real  
2 discussion on it. So I'd like to second the  
3 recommendation as it now stands and then ask Mr.  
4 Chairman to open it up for, you know, any final  
5 discussion so we can move on it.

6 (Off-microphone comment.)

7 CO-CHAIR BERMAN: The recommendation  
8 is that we adopt Recommendation Number 1,  
9 Transferring the --- plus the attendant  
10 information that we just talked about, and  
11 revisions.

12 CHAIR LEINENKUGEL: So what the co-  
13 chair is doing is establishing a method to the  
14 madness at this point as far as that is now  
15 accepted and seconded. But now formally, under  
16 Robert's Rules, we would have debate and  
17 discussion before an actual vote.

18 MR. HARVEY: But this then also  
19 includes the parking lot where Wendy has ---

20 CHAIR LEINENKUGEL: It does. It does  
21 include that.

22 MR. HARVEY: Yes?

1                   CHAIR LEINENKUGEL: Yes. So we're  
2                   having faith, trust, and confidence in Wendy to  
3                   go back and, over the course of the next three  
4                   weeks, to clean that up, Tom.

5                   Does that make sense to the rest of  
6                   the Commissioners as far as the process? So at  
7                   this point, we're in the discussion phase before  
8                   doing a first vote on proceeding with that  
9                   recommendation.

10                  Further discussion, Commissioners?  
11                  And the other point is you do not have to take  
12                  the time to allow or to say Mr. Chairman. Just  
13                  go blurt it out, please.

14                  MS. LARUE: Anything else?

15                  MR. AMBITION: I just want to be clear  
16                  that we're talking about this recommendation in  
17                  isolation to Commissioners Kuntz and Potoczniak  
18                  about the sequencing of events that will come  
19                  after we talk about each one in isolation, so  
20                  just to be clear on that.

21                  MS. LARUE: In theory, the order and  
22                  such is not really a matter that needs, it can be

1 resolved, but it doesn't need a vote. The  
2 recommendations are the part that you're voting  
3 on. Because that's the meat here. So yes, we're  
4 focusing on what is currently Recommendation 1.

5 MR. ROSE: As corrected.

6 MS. LARUE: As will be amended.

7 CHAIR LEINENKUGEL: Any further  
8 comments, amendments, corrections to  
9 Recommendation 1? If not, I would like to open  
10 this up to a formal vote by Commissioners, and  
11 we'll start with Commissioner Harvey. Let's do a  
12 yay or nay for proceeding.

13 MR. HARVEY: Yay.

14 MR. KHAN: Yay.

15 MR. JONAS: Yay.

16 MR. AMBITION: Yay.

17 CHAIR LEINENKUGEL: Yay.

18 CO-CHAIR BERMAN: Yay.

19 MR. KUNTZ: Yay.

20 MR. POCZNIAK: Yay.

21 MS. MAGUEN: Yay.

22 MR. ROSE: Yay.

1 CHAIR LEINENKUGEL: All yay, hurray.

2 MS. LARUE: We now have a  
3 recommendation. Congratulations.

4 CHAIR LEINENKUGEL: Congratulations.  
5 Wendy?

6 MS. LARUE: All right, moving ahead  
7 then to what is Page 32 in the printed copy that  
8 you have, this is our recommendation related to  
9 research and C.H. And I will turn things over to  
10 Commissioner Maguen to talk about that.

11 MS. MAGUEN: Great, thank you. So can  
12 you all hear me? There we go, that's a little  
13 better. There were a couple of things that I had  
14 sent you, Wendy, too, and that I wanted to just  
15 make sure we added all of these. They're pretty  
16 minor tweaks.

17 But in reading this over again, one of  
18 the things that I thought would be very helpful  
19 is to, I know that we're going to link up to the  
20 methods, but I thought, similar to what we're  
21 doing for the executive summaries, I suggested  
22 adding some language just about the methods up



1 front for us. And I suggested some language  
2 about how to do that.

3 But I think it will be important for  
4 people reading this to understand that we were  
5 looking at randomized controlled trials, that we  
6 were excluding observational studies, that we  
7 were looking specifically at evaluating the  
8 strength of the evidence and the quality of the  
9 research that was done.

10 And so I've definitely suggested  
11 language but feel like unless we put that up  
12 front people might not be able to track as well.  
13 So similar to what we're doing in the executive  
14 summaries, that will also be linked to the  
15 recommendations. So that was one suggestion that  
16 I had made.

17 Also, in the introduction I thought it  
18 would be helpful to move and define that the CIH  
19 modalities were pulled both from the legislation  
20 as well as from the Commissioners, adding some  
21 additional CIH modalities and additional  
22 treatment. So I wanted to spell that out up

1 front.

2 The other minor tweak that I'm going  
3 to suggest, throughout the section we refer to  
4 chronic insomnia disorder. And just to be  
5 consistent with DSM-5, I'm just recommending  
6 that we switch to just calling it insomnia  
7 disorder.

8 And then one additional thing that I  
9 think I would just want to run by Commissioners  
10 is, if you turn to the implementation section,  
11 and that is on Page, towards the very, very end,  
12 let's see, Page 48, I believe. So we have a  
13 section specifically that is focused on, let's  
14 see if I can find it here, that ensure that all  
15 studies include adequate representation of women  
16 and racial, ethnic minorities.

17 I'm going to suggest that we also put  
18 a sentence in there that there are going to be  
19 certain studies that we recommend that over  
20 sample for those populations. Because I think  
21 that, again, if we include those, that certain  
22 studies will include at least 20 percent.

1 I think we also want complementary  
2 studies that are going to over sample both women  
3 as well as racial and ethnic minorities, so we  
4 can answer some other research questions. And I  
5 want to call that out specifically. So those are  
6 just a couple of things that I sent in the edits  
7 that I recommended.

8 And other things are just more  
9 language. So that is what I have to add, you  
10 know, if people have any questions about anything  
11 that I just mentioned, or want any clarification.

12 MR. HARVEY: You say certain studies  
13 you'd want to oversample some of those.

14 MS. MAGUEN: Correct.

15 MR. HARVEY: Give me an example of  
16 that. Does that have to do with things like  
17 military sexual trauma or ---

18 MS. MAGUEN: Exactly, that's exactly  
19 right. So if a study, you know, one of our other  
20 recommendations is that we include military  
21 sexual trauma studies specifically focusing on  
22 that population. And so if we know that that

1 occurs more frequently in women, we want to  
2 oversample women and also include men. That's  
3 very important. But we want to oversample  
4 certain groups if we know that the problem is  
5 more prevalent in those groups.

6 MR. HARVEY: Agreed, thank you. Just  
7 wanted to clarify --

8 MS. MAGUEN: Thanks for the  
9 clarification.

10 MR. HARVEY: -- for my simple little  
11 mind.

12 MS. MAGUEN: That was a great  
13 clarification. So thank you for that.

14 MS. LARUE: Shira, Jennifer and I had  
15 a question last night when we were looking at  
16 acronyms.

17 MS. MAGUEN: Yes.

18 MS. LARUE: And we noticed that  
19 bipolar disorder had two different acronyms used.  
20 And we didn't get a chance to look it up in the  
21 DSM. But I thought you could probably answer  
22 that for us real quickly.

1 MS. MAGUEN: Absolutely.

2 MS. LARUE: So what is in here to  
3 date, there are some references that are BD and  
4 then the other's --

5 MS. MAGUEN: BPD, yes. So, and this  
6 is in reference to bipolar disorder, yes, so  
7 bipolar disorder specifically, yes. So I think  
8 BPD is usually used for borderline personality  
9 disorder. So I would definitely say that we want  
10 to, for the abbreviation for bipolar disorder, we  
11 want to stick to BD.

12 MS. LARUE: Okay, perfect. Thank you  
13 so much.

14 MS. MAGUEN: Sure.

15 (Off-microphone comment.)

16 MS. MAGUEN: Borderline personality  
17 disorder.

18 MS. LARUE: Okay, yes. We don't want  
19 to lead people to think we're talking about  
20 something we're not, so that's good to know.

21 Did you have anything else that you  
22 wanted add, Shira, before me move on?

1 MS. MAGUEN: I think that's it.

2 MR. KHAN: Just to comment. Any time  
3 you have an abbreviation, first time please use  
4 the entire, because there are places here where  
5 it has not been -- we've got so much technical  
6 language in there, that you lose the, you get BPD  
7 on the fourth page, it started on the first page.  
8 So I'm just sharing with you, it gets a little  
9 frustrating.

10 MS. LARUE: So we have actually spent  
11 quite a bit of time already working on acronyms.  
12 And I will tell you what our approach is.  
13 Because this report is extremely acronym heavy,  
14 usually the rule is the first mention in an  
15 entire report, but 200 pages ago is a long way  
16 back to remembering.

17 It assumes that somebody's reading  
18 every single page of the report, which is naive.  
19 So what we're doing is re-naming at the beginning  
20 of every recommendation. So in each  
21 recommendation, whatever is the first mention of  
22 something that gets an acronym, it will be

1 spelled out the first time.

2 And Jennifer has spent many hours  
3 already working on that. And that's something  
4 that we'll keep working on over the next couple  
5 of weeks. It's kind of a process of identifying  
6 all those acronyms and getting that straight.  
7 But know that we're doing even better than that  
8 by doing it with each recommendation.

9 MR. JONAS: Wendy, will there be a  
10 glossary also?

11 MS. LARUE: There is acronym list in  
12 the appendices. It's the very last one which  
13 makes it nice if you need to go to that list.  
14 You don't have to thumb through any pages. It's  
15 the end. And I credit Jennifer for that great  
16 idea. It just makes it really nice for our  
17 readers.

18 So I think if nobody has, Jack, did  
19 you want to add something?

20 MR. ROSE: No. That was it.

21 MS. LARUE: You had that look on your  
22 face.

1 MR. ROSE: Yes.

2 MS. LARUE: Okay. So I think then ---

3 (Simultaneous speaking.)

4 MR. KUNTZ: I guess that I just want  
5 to say thank you to Shira and the staff on this.  
6 Like, this recommendation took an enormous amount  
7 of work and trying to pull it off with limited  
8 resources, how you performed this is just  
9 remarkable, so thank you.

10 (Off-microphone comment.)

11 MS. MAGUEN: A compassionate and kind  
12 way, right.

13 (Laughter.)

14 MS. MAGUEN: Well, you know, I just  
15 want to also thank the work group, you know, the  
16 leadership of Tom Berman and also, you know, the  
17 SIGMA team and all of the support staff. This is  
18 definitely a team effort. And it literally  
19 required everyone that we had working on this  
20 full force. So thank you, I appreciate that.  
21 And it definitely takes a village.

22 CHAIR LEINENKUGEL: We do have a



1 formalized second. Is there any further  
2 discussion at this point?

3 Hearing none, we'll start again with  
4 Commissioner Harvey, yay or nay?

5 MR. HARVEY: Yay.

6 MR. KHAN: Yay.

7 MR. KUNTZ: Yay.

8 MR. JONAS: Yay.

9 MR. AMBITION: Yay.

10 CHAIR LEINENKUGEL: Yay.

11 CO-CHAIR BERMAN: Yay.

12 MR. POTOZNIAK: Yay.

13 MS. MAGUEN: Yay.

14 MR. ROSE: Yay.

15 CHAIR LEINENKUGEL: Hooray again.

16 MS. LARUE: All right, it's not even  
17 11 o'clock.

18 CHAIR LEINENKUGEL: And well done.  
19 Commissioner Maguen, thank you so much for the  
20 diligent work, and your team, and the support  
21 that was taken to get this done. We couldn't  
22 have done it without you, Shira. Thank you so

1 much.

2 MS. MAGUEN: Thank you.

3 MS. LARUE: Okay, so that ---

4 CHAIR LEINENKUGEL: Let's take a, I'm  
5 seeing that it's 11 o'clock. We're formally off  
6 of the public charge. Let's take a ten minute  
7 break, and we will proceed with Number 3. Let's  
8 make it 12 minutes, that means we'll be back in  
9 15.

10 (Whereupon, the above-entitled matter  
11 went off the record at 10:58 a.m. and resumed at  
12 11:16 a.m.)

13 CHAIR LEINENKUGEL: All right,  
14 Commissioners. We have gotten through and have  
15 approved unanimously Recommendations 1 and 2.  
16 And this time, we'll begin with Recommendation 3.  
17 Wendy?

18 MS. LARUE: All right. Recommendation  
19 3 was from Workgroup 2, and I'll turn things over  
20 to Mike Potoczniak to talk about that  
21 recommendation.

22 MR. POCZNIAK: There we go. So

1 Workgroup 2, I've been going back and forth with  
2 Wendy about any kind of needed changes. And most  
3 of those have gotten implemented or were  
4 addressed in some way. Just going through, this  
5 is a new version of it, so I wanted to just put  
6 in a few things.

7           You know, this Recommendation 3 is  
8 very, very broad. You know, it's a  
9 recommendation that is pretty broad and just is  
10 to implement the concerns, basically, that the  
11 veterans raised. And it's got a lot in the  
12 implementation. So on the surface, it doesn't  
13 seem, you know, to have, it seems to be very  
14 vague but is actually probably one of the most  
15 rich recommendations, I think.

16           One of the things I wanted to address  
17 was the idea that we're calling the peer support  
18 providers providers which usually, it's kind of  
19 a, yes, they're usually more like, that's usually  
20 like a licensed provider kind of thing. So that  
21 would just be one thing.

22           The peer support specialists would

1 make sense. And I think it's just a wording  
2 issue. If you work in the VA, providers  
3 typically are licensed, independent providers.  
4 So that would just be one thing to address. I  
5 didn't catch that until we looked at it.

6 MS. LARUE: So you bring up an  
7 interesting point that came up, again, last night  
8 when we were doing some continuing work. And  
9 again, not something that needs to be resolved  
10 here, but perhaps we can come up with some  
11 generic term that describes those people that  
12 aren't physicians, pas, nurse practitioners, and  
13 so forth.

14 Because we have peer support  
15 specialists in here. And then in another  
16 recommendation I think we talk about mental  
17 health technicians, things like that. And I  
18 think they would fall in that same category. So  
19 let's just remember to think about that and see  
20 if ---

21 MR. POTOZNIAK: There are some words,  
22 but they're not real great, like paraprofessional

1 is the one that's used most often, I think, in  
2 literature when you're talking about non-licensed  
3 mental health people. But I've always hated that  
4 word, because it feels very, like, parasitic.  
5 It's like ---

6 MS. LARUE: Non-licensed mental health  
7 professionals sounds like a really good term, if  
8 that's one you like.

9 MR. POTOZNIAK: Yes.

10 MR. ROSE: If I may, Mike, I mean,  
11 we've been talking about peer support specialists  
12 from the beginning. I think our veterans know  
13 peer support specialists. Maybe we need to do a  
14 better job of letting them know what they are,  
15 that they're available. But personally, I think  
16 it would not be correct to not include peer  
17 support specialists. Thank you.

18 MR. POTOZNIAK: Yes. So we can come  
19 up with terminology, I guess, peer support  
20 specialists. And then also, the one thing I did  
21 want to take, I mentioned this the last time, and  
22 it's a little bit of an issue for me, is around

1 the recommendation related to pay of peer support  
2 specialists.

3 Currently, peer support specialists  
4 are, you know, basically the majority of them sit  
5 in the GS-9 category which is also where marriage  
6 and family therapists start who are licensed  
7 people. So, I mean, they start at nines and they  
8 go to 11, I think, or something like that.

9 And so you have people that don't have  
10 a real education requirement who could be high  
11 school graduates that have a mental health  
12 experience who are becoming are becoming peer  
13 support specialists which is great. We need a  
14 diversity of background.

15 But going into a GS-9 in the Bay Area  
16 GS-9s make, you know, 89 grand, not bad for  
17 having a high school education. So I kind of  
18 want to push back, because as you start to kind  
19 of amp up pay you're going to start to maybe even  
20 close out people. There's got to be some reason  
21 for that.

22 And I feel like that part doesn't sit

1 well with me as a mental health provider, that  
2 people that went to school are going to be  
3 earning pretty much the same as somebody who  
4 didn't but had a mental health experience. So  
5 that was just my two cents on that one.

6 MR. HARVEY: Isn't this sort of in the  
7 same category as the other place where we took  
8 out some numbers, you know, to say be paid  
9 adequately or be paid, you know, in accordance  
10 with --

11 MR. POCZNIAK: Well, I mean, I guess  
12 my part is that I kind of feel like they are paid  
13 adequately.

14 MR. HARVEY: No, that may be so. But,  
15 I mean, rather than saying they should be, I  
16 mean, I don't have the background or the  
17 experience to say somebody should be a particular  
18 grade, but there's somebody who's doing this who  
19 could say the grade should be appropriate to the  
20 skill sets that --

21 CHAIR LEINENKUGEL: Let me interject,  
22 if I may, at this time as the Chair. I think

1 we're starting to conflate Recommendation 3 with  
2 Recommendation 8. So in order to stay away from  
3 that, what I really want to do is press the  
4 Commission at this point to really take a look at  
5 what I asked of Mike and Mike's workgroup, that  
6 being Commissioner Potoczniak.

7 And it's really the voice of the  
8 veterans on their mental health care. And there  
9 were three items that I said these are really  
10 going to be hard to get to. And I wonder if we  
11 answered the mail correctly on this  
12 recommendation.

13 It was perceptions, number one,  
14 perceptions regarding the available mental health  
15 treatments to them. Number two, the Commission  
16 was to consider the frequency which VA prescribes  
17 medication. And number three was that VA's  
18 outreach. What is the Secretary doing to do  
19 better outreach efforts to inform veterans about  
20 mental healthcare available to them?

21 Now, I think from the voice of the  
22 veteran, when you look at all of those things,



1 there's some very strong statements that were  
2 made. But I don't know if we have come to the  
3 conclusion or made a strong enough recommendation  
4 at this point. So I'm going to challenge us to  
5 work with Commissioner Potoczniak. And maybe I'm  
6 wrong. Maybe the mail has been answered on each  
7 of those. I just don't know if it's strong  
8 enough at this point.

9 Rather than talk about peer support  
10 specialists, that's why I say we don't want to  
11 conflate the two, we're going to talk about that  
12 in Recommendation 8 extensively. Does that make  
13 sense?

14 MR. POTOZNIAK: So are you thinking  
15 that you'd want to move the peer support stuff  
16 out of this recommendation?

17 CHAIR LEINENKUGEL: No, not at all.  
18 Because that was certainly the voice of the  
19 veteran feedback very much.

20 MR. POTOZNIAK: Yes.

21 CHAIR LEINENKUGEL: So it remains part  
22 of that, Mike. I'm just saying that we're going

1 to address, I think, what Tom was getting at  
2 earlier about incentivizing, or the pay, or  
3 whatever, over making a general statement to  
4 incentivize that role.

5 And then also, you know, how that  
6 term, to Jack's point, Commissioner Rose said we  
7 need to keep peer support specialists front and  
8 center. It is, and we're going to call that out  
9 in Number 8. But there's also a behavioral  
10 health specialist, we're talking about health  
11 coaches, chaplains, and I think that all goes  
12 back to Wayne's model ---

13 MS. LARUE: With ---

14 CHAIR LEINENKUGEL: Right.

15 CO-CHAIR BERMAN: Mr. Chairman, could  
16 we say something like assure that the requisite  
17 level of professional and support personnel are  
18 available to address the three issues that you  
19 said? I think we have to be careful about  
20 getting into pay, because pay should be related  
21 to level of education and those things.

22 I understand what Mike is saying about

1       paraprofessional. Unfortunately, the word  
2       professional implies you have a license. And  
3       paraprofessional implies you probably don't. And  
4       so that's what's used.

5                   But I would just suggest that  
6       something like support might be okay too.  
7       Because that's what they are. I mean, if you  
8       think about, they call them peer support for a  
9       reason. They're support personnel. So just a  
10      thought that we should make a more generalized  
11      comment. Rather than be predictive and  
12      prescriptive, we can maybe just suggest.

13                   MR. KUNTZ: I'm sorry, Mike, can you  
14      pinpoint the recommendation, just on the page,  
15      just so we can see where it fits in the report  
16      and what the actual language is?

17                   MS. LARUE: So Page 76 has, that's  
18      legislative peer support recommendation which  
19      says ensure funding is earmarked specifically for  
20      the continued development of peer support  
21      specialists. And then on Page 78, there are  
22      three items in the executive branch

1 implementation, establish peer support  
2 specialists as a necessary component.

3 MR. POTOZNIAK: Seventy-four is the  
4 page.

5 MS. LARUE: Okay. So it's outside of  
6 the ---

7 MR. POTOZNIAK: Yes.

8 MS. LARUE: -- the implementation  
9 then.

10 MR. POTOZNIAK: Yes, 74 is where it  
11 says VA should consider the merits of increasing  
12 pay to bolster recruitment and retention efforts.

13 MS. LARUE: Which paragraph?

14 MR. POTOZNIAK: That is the first  
15 paragraph on Page 74, about mid-way down the  
16 paragraph. It's not so much, you know, yes, it's  
17 not so much, yes, it is. But I think we're  
18 saying a lot, you know, in this report. And  
19 there's a lot of sensitivity about peer support  
20 specialists. And I think us coming out and  
21 saying that they're not paid enough is, it's just  
22 a piece of information I don't know that we need

1 to add, given that they kind of are, you know.

2 MR. HARVEY: Well, I don't know it's  
3 the kind of information we're equipped to, what I  
4 was trying to say is I can't tell you what a peer  
5 support specialist should be paid. Somebody in  
6 the personnel office can say, well, you know,  
7 this grade equates to this much education,  
8 equates to this much experience, you know.

9 MR. POTOZNIAK: Right.

10 MR. HARVEY: It's not my job to say  
11 what you should pay.

12 MS. LARUE: How about revising to say  
13 VA should consider ways to bolster recruitment  
14 and retention efforts and just take the pay part  
15 out of that?

16 MR. POTOZNIAK: Right.

17 MS. MAGUEN: I'll just add, I think,  
18 the other thing that is concerning, it says the  
19 turnover issue is a concern. And then it  
20 connects it to the pay, but we actually don't  
21 know, you know, I mean, there can be a lot of  
22 reasons for turnover, including not feeling like

1 you have enough support or other things. And it  
2 might not be a pay issue, right?

3 MR. POTOZNIAK: But the biggest issue  
4 really, when it comes to, and, Jake, I'm just  
5 noting that you basically told us to get into  
6 that part, but the one last piece of this, I  
7 think, is that we've also mentioned that peer  
8 support specialists, this is in Wayne's part, are  
9 not reimbursable on the VERA schedule which makes  
10 it very unattractive for facilities to increase  
11 the number of those people.

12 So it really does, it's not so much  
13 about the pay, it's much more about the facility  
14 putting out the amount of positions necessary.  
15 So I think, you know, if you put it out there, we  
16 had 150 applications for one peer support  
17 specialist recently. There's no problem getting  
18 them. It's a problem of getting the facility to  
19 do it. And so that's my two cents on that.

20 MR. KUNTZ: Mike, would you be --  
21 would it make sense for you -- like, the way that  
22 sentence currently reads is the turnover issue

1 among peer support specialists needs to be  
2 rectified, comma, and the VA should consider the  
3 merits of increasing pay to bolster recruitment  
4 and retention efforts.

5 Would you be okay with eliminating  
6 everything after rectified? So we're saying that  
7 the issue needs to be addressed, but we are not  
8 going more specifically --

9 MR. POTOZNIAK: I do.

10 MR. KUNTZ: -- into why.

11 MR. POTOZNIAK: Yeah, totally. So I  
12 had --

13 CHAIR LEINENKUGEL: Why are we not,  
14 Mike, addressing the VERA impact on peer support  
15 specialist via head count?

16 MR. POTOZNIAK: Via head count?

17 CHAIR LEINENKUGEL: Well, I look at --

18 MR. POTOZNIAK: Oh, okay. I hear  
19 what you're saying.

20 CHAIR LEINENKUGEL: I'm sorry. The  
21 issue that you just spoke to was that you get 150  
22 applicants, but there's only one position that's

1 required. And I think what we're talking about  
2 here or asking is the increased peer support  
3 specialist systemwide. And there's a reason  
4 we're doing that because for 15 months, we've  
5 heard loud and clear that they bring a heck of a  
6 lot of value --

7 MR. POTOZNIAK: So --

8 CHAIR LEINENKUGEL: -- to veterans.

9 MR. POTOZNIAK: So on page 78, I said  
10 basically that we should establish peer support  
11 specialists as a necessary component to a  
12 behavioral health interdisciplinary program team  
13 which is akin to the PACT team.

14 Currently, they're not part of the  
15 BHIP team. They're part of the clinic. And so  
16 if you make them a set part of the formula, then  
17 you would have -- it would be based on head count  
18 and based on density of veterans as opposed to  
19 just an add-on which is what they currently -- I  
20 mean, there's probably a more professional way of  
21 saying that, but that's what they are.

22 CHAIR LEINENKUGEL: Do you think it is



1 widely known within the VA system that VERA --  
2 and VERA is not accounting for the peer  
3 specialist optimization. If you do not have that  
4 particular statement that you just made and is  
5 probably factual. I know it's factual, right?

6 MR. POTOZNIAK: I hope so, yeah.

7 CHAIR LEINENKUGEL: Why would we not  
8 point that out in the paragraphs dealing with  
9 peer support?

10 MS. LARUE: So --

11 MR. POTOZNIAK: There is.

12 MS. LARUE: -- I think that that's  
13 what's in Recommendation 8. So maybe what we  
14 should do, based on the parking lot description,  
15 this will, no matter what, precede that. And we  
16 can add a reference here to that other  
17 recommendation.

18 MR. POTOZNIAK: Yeah, because it is  
19 part of -- I think Recommendation 8 is, folding  
20 them into the VERA --

21 MS. LARUE: Right.

22 MR. POTOZNIAK: -- so they would earn

1 VERA dollars for the facility. So I think part  
2 of what your concern is, Jake, is addressed in  
3 either page 78 or in Recommendation 8 where it  
4 does talk about VERA.

5 CHAIR LEINENKUGEL: I just found it.  
6 It's page 95. You're right. And that's when I  
7 said we're sort of conflating three and eight.

8 MS. LARUE: Right.

9 CHAIR LEINENKUGEL: My recommendation  
10 then would be we need to clean that up because,  
11 again, you're speaking about it in three, trying  
12 to make us solve in three. And then we come back  
13 to eight, are we saying the same thing?

14 MR. POTOZNIAK: We're not saying the  
15 same thing.

16 MS. LARUE: No.

17 MR. POTOZNIAK: It's we are saying  
18 that could be -- so it could be put together.  
19 But one of the -- because the veterans spoke  
20 about it in the focus groups, it's what landed it  
21 in this recommendation. And part of what they  
22 were saying is the lack of peer support

1 specialists. They were talking about the lack of  
2 them. So to address the lack of the number of  
3 them, I said, okay, let's make them part of a  
4 BHIP team.

5 CHAIR LEINENKUGEL: Apologize because  
6 I'm going back and forth looking between three  
7 and eight.

8 MR. POTOZNIAK: So --

9 CHAIR LEINENKUGEL: And you're exactly  
10 right. I mean, when you're listing now your  
11 three major points under peer support, Mike, you  
12 address every one of those needs dealing  
13 specifically from the voice of the veteran of  
14 what you heard and then calling out why you think  
15 the increase is needed.

16 MR. POTOZNIAK: Right.

17 MS. LARUE: I think then referring to  
18 8 so that our readers who actually read from  
19 beginning to end know that we are aware that  
20 we're addressing that in two places is -- we need  
21 to do that.

22 So Jake, you brought up something.

1 You were talking the charges for this workgroup,  
2 and you mentioned prescription medication. And I  
3 think you were alluding to the lack of reference  
4 to that here.

5 And I did want to make the point that  
6 a small section could be composed to add to this  
7 from the focus group material. It was not one of  
8 the most prominent things, but I can tell you  
9 what -- the veterans who brought up prescription  
10 medication tended to say things, like, all they  
11 want to do is medicate me, and I want to do these  
12 other things. So I had to get a different  
13 doctor. Or I'm really trying to -- worked hard  
14 to get off medication.

15 So it does support the concept that  
16 veterans are interested in CIH and having their  
17 care be something more than the standard talk  
18 therapy and medication. So if that's something  
19 that you would like added, I think that there's  
20 enough content to make a small section --  
21 subsection to add that to this discussion.

22 CHAIR LEINENKUGEL: Personally, I

1 believe it's important because it's something  
2 that was spelled out as one of our charges  
3 through the legislation for us to review or get  
4 input back from the veterans. And so you already  
5 told me that you and Mike got input back.

6 So I would at least include something  
7 that we have listened to the voice of the  
8 veterans. And then also I think from the  
9 clinical side, you have to take them through  
10 which we are doing to the evidence-based  
11 practices of why it is necessary to start out in  
12 the medication realm, if you will, to begin with  
13 and probably stay with to some degree.

14 But it's a matter of degree if they  
15 have complementary or integrative health that  
16 actually does. To Wayne's point, does it act as  
17 a placebo? And if it comes down a recovery path  
18 for well being, so be it. And so that's great,  
19 right?

20 MS. LARUE: Placebos work, right?

21 CHAIR LEINENKUGEL: But you have to  
22 remember. I mean, I heard three years ago when I

1 first came on board from the voice of the  
2 veterans that in their eyes, there was a lot of  
3 overmedication. I think that's why the  
4 congressional writeup asked us to review that and  
5 ask the veterans about that.

6 And I think that in many cases, there  
7 are veterans that don't or did not early on. I  
8 think the care is so much better now on the  
9 clinical side with PACT teams, and we've  
10 discovered that in our 17 months about having  
11 great conversations with why they need to start  
12 on this path.

13 MS. LARUE: So what I can say with  
14 confidence, though it was not one of the most  
15 prominent themes, that's what I tried to pick out  
16 to include here, not a single veteran said, I  
17 wish I could be medicated more. So what would be  
18 added would be commentary about looking for  
19 alternatives to medication.

20 MR. POTOZNIAK: Yeah, I guess I hear  
21 what Jake is saying. We should comment on that  
22 because it is part of the charge. I don't know

1 if the feedback is truly representative of kind  
2 of the topic.

3 That's the only issue is if you have  
4 a lot of veterans saying basically we're getting  
5 meds shoved in our face, there are veterans out  
6 there that definitely would -- they weren't in  
7 these focus groups. But there are definitely  
8 lots of veterans out there that'll say, it's hard  
9 for me to get the medication I need. They just  
10 weren't represented in the focus groups.

11 And so I'm worried that the message  
12 would be sent in this report that we're kind of  
13 saying veterans want less of this, when actually  
14 the wait list for psychiatry are super long, so -  
15 -

16 MS. LARUE: So I have --

17 MR. POTOZNIAK: So it's --

18 MS. LARUE: -- a point to ask for  
19 clarification. When you say, those that don't  
20 get the medication they need, are the not getting  
21 care at all?

22 MR. POTOZNIAK: Yeah, either -- well,

1 either they're not getting -- they can't get a  
2 psychiatry appointment. They need to get their  
3 meds transferred and they're having difficulty  
4 with that.

5 Like, there's lots of issues when it  
6 comes to medication that aren't really in the  
7 focus groups because they're speaking -- you're  
8 talking about a very -- we talked about this  
9 being a convenience sample. And basically, the  
10 people that showed up are the people that are in  
11 the system most times.

12 MS. LARUE: Right.

13 MR. POTOZNIAK: And so therefore,  
14 they've been offered psychiatry and either  
15 refused it or had a bad experience with  
16 medication which happens. But you have also  
17 plenty of people that weren't there that have  
18 good experiences, didn't speak up because it's  
19 not a problem for them. And also people that  
20 have tried to get appointments and can't because  
21 there's a lack of availability.

22 There's whole systems that don't have



1 psychiatry, whole sections of healthcare systems.

2 So I guess I get worried about using that as  
3 answering -- using that section, using those  
4 quotes to answer that part of the charge.

5 MS. LARUE: I guess if the charge is  
6 in the spirit of considering CIH options as what  
7 they are, complementary care, I feel pretty  
8 confident that the content that we could add  
9 could be couched in those terms without  
10 misrepresenting what the veteran said.

11 I mean, people, they love their yoga  
12 and their tai chi and their acupuncture. And  
13 they find a lot of value in that. And I think  
14 that a lot of the quotes about medication are  
15 tied to, don't take away my yoga because that's  
16 helping me too. So I think it could be done in a  
17 way that wouldn't discount people who are not  
18 getting care.

19 CHAIR LEINENKUGEL: Okay.

20 MS. LARUE: So we can work -- if  
21 everyone is comfortable with it, we're going to  
22 add that. Then Mike and I can work together on

1 making sure that it doesn't accidentally imply  
2 something about the clinical reality that is not  
3 correct.

4 MR. ROSE: If I may, on this, I mean,  
5 we've talked about it before, and we say that  
6 each veteran is an individual. And so we need to  
7 have a toolkit that is available for that  
8 individual. And just so we state it properly  
9 because maybe that medication may not work for an  
10 individual. But the CIH may work, and I think we  
11 have to keep that in mind.

12 Thank you.

13 MR. JONAS: I think that would be a  
14 great approach to do this. And it's consistent  
15 then with what we've talked about in  
16 Recommendation 1 too which is saying there needs  
17 to be a personalized plan for each veteran.

18 Because we've seen this in the opioid  
19 epidemic. It's just, like, we way overused drugs  
20 for pain management and neglected some of the  
21 non-drug approaches. And then the response to  
22 that was, well, just take away the opioids,

1 right? Now we're seeing a backlash. Wait a  
2 minute. I can't get my opioids, and I need them.  
3 And I have cancer or I have whatever.

4 And so it really needs to be  
5 integrated and personalized to each. So it has  
6 to be appropriate delivery of good evidence-based  
7 grounded care for that particular individual and  
8 customized to that. That's where personalized  
9 care comes in, and I think that's what the  
10 veterans are actually asking for.

11 CO-CHAIR BEEMAN: I also have a  
12 suggestion to consider, and it would be a  
13 generalized statement that might go like this  
14 because there's so many comments that we can't  
15 address every single comment to say during the  
16 course of its discovery, the COVER Commission had  
17 the privilege of hearing from hundreds of  
18 veterans and getting input.

19 We would recommend that since the  
20 Commission cannot address every comment that a  
21 high-level task force be empowered with expedited  
22 powers within six months to address those that

1 are not specifically covered by the Commission.

2 What I'm worried about is you had  
3 somebody out there. He or she made a comment.  
4 The ten things don't necessarily address that.  
5 But I think if the VA with the undersecretary  
6 appoints the Assistant Chief of Staff to take a  
7 look at these with about five people across the  
8 system and say, are we addressing these? Are we  
9 not?

10 We have a six-month time period to  
11 address these in and then publish them as part of  
12 the overall educational thing. It may help us  
13 deal with some of these loose ends that we can't  
14 get to. Just it's a thought.

15 CHAIR LEINENKUGEL: I like that, and  
16 I like it because it's transparent. And it also  
17 answers the mail as far as outreach, better  
18 outreach to veterans.

19 And I think, Mike, that you've done a  
20 great job of linking back to number one when I  
21 looked at access to mental health care and your  
22 eight or nine bullet points that you had on page

1 77 as well. I just read those seeing that they  
2 were done. So it's matched up better now, Wendy,  
3 than what it was.

4 What I would also recommend on top of  
5 what Admiral Beeman just stated was that there be  
6 something in there that we've discussed for 16  
7 months now and along with the Secretary. Why is  
8 the VA not doing what the private sector is doing  
9 as far as better communicating and receiving  
10 feedback on a daily basis from their veteran  
11 population that is receiving care?

12 So it's answering the five basic  
13 questions that we all talked about at the  
14 previous meeting. So somewhere in there I would  
15 say, and I would imagine knowing the current  
16 Secretary and the executive in charge that we are  
17 working on this diligently to do it.

18 But I think that from the Commission,  
19 we should make a note of that, that this should  
20 be a new ongoing common practice to outreach to  
21 those veterans, first of all, on available care  
22 but also how was their care. Are they getting

1 better in their eyes? Are they receiving the  
2 best care that they deserve for their mental  
3 health issues? Is that fair?

4 MR. POCZNIAK: Yeah.

5 CO-CHAIR BEEMAN: I think you could  
6 actually include that in the recommendation and  
7 say, and develop a feedback mechanism that  
8 specifically addresses.

9 What I'm afraid might happen is Mike's  
10 group went through an awful lot to collect all of  
11 this information, and people went all over the  
12 country to collect it. And we if we don't have  
13 some mechanism to continue to review that, all of  
14 that resource will just be lost.

15 And so getting a formalized mechanism  
16 together to address it, I think, is a way not to  
17 lose it. Because I don't think we're going to be  
18 able in one week, one month, or one year to be  
19 able to address all the concerns they have out  
20 there. But I think the VA can.

21 MS. LARUE: Tom, do you see that as  
22 something that Congress needs to make VA do, or

1 that VA can do that on their own?

2 CO-CHAIR BEEMAN: I think the VA  
3 leadership -- I don't think it's a congressional  
4 issue. I think the VA -- any good leadership  
5 team, and they seem like they are, wants to deal  
6 with the feedback. I think if we provide the  
7 feedback an sort of urge them to -- I don't think  
8 we should urge the report back to Congress on it.

9 I think it's the way you run an  
10 organization. You get feedback from both your  
11 staff that provide the services from the people  
12 that you serve and you try to make improvements.  
13 I'm just worried that we might lose all this good  
14 stuff that we came up with.

15 MS. LARUE: So based on that  
16 clarification, I would recommend two things. One  
17 being that we add an Executive Branch subhead at  
18 the top of everything that's there that is an  
19 overarching Executive Branch recommendation that  
20 captures all of this.

21 And then the other would be to add the  
22 reference to -- we talked to lots of veterans and

1 this is a snapshot. And VA needs to keep doing  
2 this. And the concept of doing what is done in  
3 the public sector every day to the letter which  
4 is the very reason why we will not be signing the  
5 actual letter today but rather providing  
6 signatures because we wanted to have the  
7 flexibility to make changes there.

8 The reason I recommend that is exactly  
9 what you're saying. We don't want to lose that  
10 content. And I think if the veterans are what  
11 comes first, making sure that it's in that  
12 letter, probably that'll be the most read part of  
13 our report. So getting it there as well is not  
14 overkill, I believe.

15 MR. POTOZNIAK: So I want to just be  
16 sensitive to get through any other comments I  
17 had. Did anybody else want to talk about --

18 MS. MAGUEN: I was going to say that  
19 I really love this section because I think you  
20 guys did a fantastic job of really making the  
21 voices come alive and also balancing kind of the  
22 positive with the negative. So I really



1 appreciate the concerted effort to include  
2 quotations from both of those experience. So I  
3 think that this will -- and I also love sort of  
4 making that come to life even more through  
5 embedding quotations throughout.

6 One -- these are very, very minor  
7 tweaks. But some thoughts that I had. I was  
8 really struck by the implementation piece about -  
9 - or the veterans quotation about being taken to  
10 collection for community care. And I'm wondering  
11 if one piece that we want to add is more  
12 education about the process of community care and  
13 having a patient facing document.

14 And this may already exist, but I'm  
15 not aware of this, where you hand something to  
16 the veteran saying, here's the process. You're  
17 going to be responsible for these payments or  
18 sometimes the VA will cover all of it.

19 So whatever it is, to really outline  
20 that and have some kind of -- that we recommend  
21 that some kind of a document be handed out so  
22 that people understand the process a lot better.

1 And I think that can really help with surprise  
2 around these kind of situations.

3 MR. POTOZNIAK: The difficulty -- I  
4 agree. Difficulty with a document like that is  
5 that it would have to be customized for  
6 eligibility groups.

7 MS. MAGUEN: Right. I see that.

8 MR. POTOZNIAK: And because it's  
9 drastically different from Eligibility 1 to  
10 Eligibility -- what is it, 9? So it's very -- it  
11 can be very different. So a simple document  
12 makes sense. But you'd be alerting people to  
13 things that they may not experience in that  
14 document.

15 MS. MAGUEN: Right, yeah. So I think  
16 what I'm struggling with, and I don't have the  
17 perfect solution to this, is just creating  
18 something that can just really provide some  
19 background for the veterans. Because I think  
20 oftentimes what happens is that they might not  
21 have the full knowledge.

22 And so there's gaps in terms of the

1 knowledge that they have when they're seeking  
2 community care. And then they're surprised by  
3 certain things that happen. So I'm very open to  
4 how we want to say that. But just recognizing  
5 that something like that could be helpful.

6 MR. KHAN: If I may add to it, peer  
7 support specialists, that link to my knowledge --  
8 because I am one of them. And even otherwise  
9 when I go and see my psychiatrist, I have to fill  
10 out certain information. It is included in sales  
11 data. And I don't know how the hierarchy is  
12 looking at it. But this feedback that we are  
13 trying to get is available in the system.

14 So my question to you guys are whoever  
15 you interviewed, X, Y, Z veterans, they do not  
16 give the complete pictures of the veterans  
17 community. I personally know veterans who are  
18 living on opioid. So they wanted themself to get  
19 off of it. They were taken off of it. But then  
20 they had pain.

21 So the provider gave them Tylenol,  
22 liquid form. That liquid form is 100 percent

1 alcohol. Now they're trying to get away from  
2 alcohol. Now they have the same issue. It's a  
3 clinic which is giving them the medicine. And  
4 for them, they're living much worse than ever  
5 before.

6 So I think be cautious of the group  
7 that you interviewed. Just like Admiral Beeman  
8 mentioned, that we are not looking at the entire  
9 picture. We are just taking what was given to  
10 us.

11 Thank you.

12 MR. POTOZNIAK: Thanks, Jamil.

13 MS. LARUE: Mike, I'm wondering if  
14 that education piece could be handled under the  
15 transition issue because I think one of the big  
16 problems is service members come from federal  
17 healthcare. And so they don't get that education  
18 at 18 or 22 on how to deal with insurance.

19 And that, I think, is where the  
20 disconnect happens, that they don't understand if  
21 I miss an appointment, I'm going to be charged  
22 for that. And oh, I don't have money to pay for

1 150-dollar appointment that I didn't go to.

2 MR. POTOZNIAK: Yeah, that could be  
3 captured in that area, I think, yeah.

4 MS. LARUE: Okay.

5 MR. KUNTZ: Wendy, I had two more  
6 pieces on this section. So one on page 76 under  
7 the second -- or it's the fourth heading down  
8 under complementary and integrative health. We  
9 have a pretty substantial white paper that was  
10 developed by Duty 5 that I would like to see  
11 referenced as an appendix if there's someone from  
12 Congress that wants to know kind of why that one  
13 is there and why it came, that there is more  
14 data.

15 And then on page 77, the second bullet  
16 from the bottom. And I'm really grateful for  
17 this one. Part of it was generated out of the  
18 Montana visit and what we saw. It says, rural  
19 veterans should have painless access to care.  
20 And I guess I would prefer that we use a term  
21 like seamless. Pain is pretty specific in this  
22 context.

1 Thank you.

2 MR. POTOZNIAK: So there were two  
3 other points I wanted to make. Actually, maybe  
4 only one being we've kind of talked about it. So  
5 the one about eligibility difficulties, I just  
6 wanted to say this one was part of the -- we  
7 haven't really talked about this as much.

8 But this kind of, for me, came out of  
9 the Fort Belknap visit which is you have combat  
10 veterans sitting in Montana that have tried for  
11 two or three years to get eligibility completed  
12 for the VA. And that is totally unacceptable.

13 And so you have to consider that  
14 veterans don't understand. Like, there's so much  
15 information given to you at discharge, et cetera,  
16 et cetera, that you can't process. And it would  
17 be so much easier to automatically have veterans  
18 -- combat veterans registered.

19 It's just they're entitled to the  
20 service. Why not register them there? Why make  
21 them come down from Fort Belknap to get  
22 registered two hours away and then have to go

1 back home to get more documentation, and then go  
2 back again and then give up because they can't do  
3 it.

4 If the VA is trying to improve access  
5 and reaching out to veterans and helping with  
6 veteran suicide, you've got to remove some of the  
7 basis barriers. And that eligibility system is  
8 the most archaic part of the VA.

9 So I just wanted to emphasize that  
10 because we hadn't really talked about it as much  
11 and that did come out of a breathtaking visit to  
12 Fort Belknap where it was just amazing how much  
13 people had been trying to get basic eligibility  
14 for the VA. And they're combat veterans sitting  
15 there not able to get basic services.

16 CHAIR LEINENKUGEL: I think every  
17 Commissioner 100 percent agrees with that, Mike,  
18 and fully supportive of that, seeing that for my  
19 three years and it's ongoing.

20 And I gave a couple of Commissioners  
21 a great side story to that about a Vietnam  
22 veteran who I approached, I'm not going to go

1 into detail at this meeting, that had no idea  
2 that he was even eligible for VA care. Over 35  
3 years and found out that he did, and he started.  
4 He got enrolled. It was seamless. It was  
5 painless. And he's been amazed at the quality of  
6 care, and all of this took place in the last two  
7 months to that story.

8 But you're right. Eligibility needs  
9 to be cleaned up. I love the portal idea, but I  
10 think it should be done prior to that service  
11 member being discharged. And I think that's  
12 called out as one of the action steps as well.  
13 So well done.

14 MR. POTOZNIAK: Yeah, thank you.

15 CO-CHAIR BEEMAN: One of the  
16 challenges about a huge bureaucracy, and I think  
17 we can look to the military. The way they run  
18 them is that you can -- and big systems like the  
19 Navy and the Army. You have protocols you have  
20 to follow. But it's really your sergeants and  
21 your lieutenants that get to make the independent  
22 decision making that addresses some of this



1 stuff.

2 And one of the things I would think  
3 the VA would want to look at is, do our  
4 lieutenants have the flexibility to make mistakes  
5 but to help veterans as opposed to, you know  
6 what? We have a book here that says you can't do  
7 it. And so that's just a thought.

8 Having said that and also back to my  
9 earlier comment, I would be okay with that one  
10 proviso about it being in the letter -- it  
11 doesn't have to be in the document -- that says,  
12 we have a unique opportunity here. We collected  
13 data. It took us a lot to get the data. You  
14 might as well use it kind of thing.

15 But having heard everyone, with the  
16 revisions that both Mike and you all suggested,  
17 I'd like to second Mike's recommendation from  
18 this task force and then ask the Chairman to put  
19 this out for discussion.

20 CHAIR LEINENKUGEL: We have a formal  
21 second to Commissioner Potoczniak's  
22 Recommendation 3. Is there any further

1 discussion at this point?

2 (No audible response.)

3 CHAIR LEINENKUGEL: Hearing none, I  
4 would like to start again with Commissioner Tom  
5 Harvey. Yay or nay?

6 MR. HARVEY: Yay.

7 MR. KHAN: Yay.

8 MR. KUNTZ: Yay.

9 MR. JONAS: What are we actually  
10 voting on? We're not voting on the entire  
11 recommendation, right?

12 CHAIR LEINENKUGEL: Three.

13 MR. JONAS: I'd like to defer because  
14 I don't know if there's been sufficient  
15 discussion on changes -- the actual changes that  
16 need to be made in this at this point. I mean, I  
17 had some additional things I wanted to ask about,  
18 so --

19 CHAIR LEINENKUGEL: Then let's hold.  
20 I asked Wayne if there was further discussion.  
21 You deferred.

22 MR. JONAS: I thought there was a

1 specific --

2 CHAIR LEINENKUGEL: So now we will  
3 rewind the tape --

4 MR. JONAS: I'm sorry.

5 CHAIR LEINENKUGEL: -- while we have  
6 three yays, and let's have further discussion.

7 MR. JONAS: I apologize.

8 CHAIR LEINENKUGEL: No problem.

9 MR. JONAS: My sense is that part of  
10 what this entire discussion was and what  
11 Commissioner Beeman recommended is -- in terms of  
12 the committee and this type of thing is that the  
13 VA needs to improve its responsiveness to  
14 veterans in a realtime basis. And it needs to  
15 develop tools and systems that personalize the  
16 care so that it can actually respond to the needs  
17 of the veterans on an individual basis.

18 I don't see a recommendation at all to  
19 that, and it needs to be proactive which is a  
20 particular requirement. And actually, I see a  
21 lot of recommendations in there that say do this  
22 and that. Provide access to specific things that

1 came out of the groups.

2 But I don't see anything in here that  
3 actually addresses this overarching thing,  
4 Chairman, that I think you were trying to get at  
5 earlier. And I'm just wondering if that needs to  
6 be put in here. Or is that a bridge too far at  
7 this point?

8 And then I had a second question which  
9 I just didn't understand. Under the bottom of  
10 page 75, it says, adopt the Improved Well-Being  
11 for Veterans Act to help provide grants to  
12 support -- I just don't know what that is. I  
13 don't know what the Improved Veterans' Well-Being  
14 Act is or what's in that.

15 So anyway, those were just --

16 CHAIR LEINENKUGEL: Good point.

17 MR. JONAS: -- a few things.

18 CHAIR LEINENKUGEL: I mean, that's why  
19 I spent 45 minutes going back and re-reading  
20 everything that was put together by Wendy and  
21 Mike and the team that worked on this. And just  
22 on the Executive Branch of what we're asking,

1 there are a lot things to your point.

2 I look at these as action steps and  
3 are they actually -- again, to use the reference,  
4 in turn -- answering the mail as to what that  
5 particular workgroup was supposed to do. I  
6 believe they do after I read them extensively now  
7 in the last 15 minutes.

8 Going through in my mind, Wayne,  
9 probably what you're struggling with, are we  
10 really getting to the main things that came out  
11 of the surveys and focus groups -- I should say  
12 focus groups -- that came out loud and clear?  
13 And I had the same trepidations you did until I  
14 went through each one and then saw the linkage  
15 of, okay, what do we expect the VA, Congress, or  
16 the Executive Branch to do?

17 And to me, it works now because, I  
18 mean, there's a -- I'll just use the very first  
19 one. Address barriers that contribute to  
20 eligibility difficulties in the VA. We just got  
21 done discussing that. We all agreed to that. We  
22 all know that needs to be done.

1                   Similar to the VA claims portal, the  
2 VA should create an eligibility portal online  
3 that will allow veterans to upload eligibility  
4 documents. That is an essential call out and  
5 step and call to action for the VA to take.

6                   And I think that when I went through  
7 each one, Wayne, it got me to where three came  
8 out from the voice of the veteran. And also  
9 deals loud and clear with peer support to what  
10 Jack referenced earlier. And I said, well, maybe  
11 we're conflating the two. So I went ahead to  
12 look at eight and we're really not.

13                   They both are standalones because one  
14 is the voice of the veteran and the other one is  
15 an actual recommendation of how to implement that  
16 even better within the entire system which we go  
17 back to your number one.

18                   CO-CHAIR BEEMAN: Jake, I don't  
19 disagree. My worry is there's 380,000 VA  
20 employees and six million people that actually  
21 get services. So we could have 6,380,000  
22 different recommendations based on everybody

1 having one thought.

2 And I think trying to address some of  
3 the things that we heard is good. But I agree  
4 with Wayne to having an overarching  
5 recommendation that says, develop a feedback  
6 mechanism for those we serve and create a  
7 mechanism to address that feedback and integrate  
8 it into quality is much more important than --  
9 because we could've done 500 other veterans and  
10 gotten 500 other issues.

11 The key here is let's not lose what we  
12 heard. But in addition to that, there doesn't  
13 seem to be a formal mechanism at the local or  
14 national level to address some of these issues or  
15 they wouldn't keep coming up.

16 CHAIR LEINENKUGEL: And I think that's  
17 what we as a Commission have been discussing at  
18 least the last six months, at least. And I think  
19 I did say the same thing about half an hour ago  
20 is that actually they're in the report. So what  
21 I think you're calling out, both Commissioner  
22 Jonas and Commissioner Beeman, is it should be in

1 the recommendation.

2 And so what I would suggest at this  
3 point is that we parking lot that particular  
4 piece and have Wendy and Mike work on the wording  
5 along with Admiral Beeman and myself and Dr.  
6 Jonas. Does that make sense as far as including  
7 that as an action item for the VA to take?

8 MR. POTOZNIAK: So are we talking  
9 about adding a recommendation, or --

10 CHAIR LEINENKUGEL: Yes.

11 MR. POTOZNIAK: Oh, okay.

12 MR. JONAS: We can vote on it  
13 currently, but then that would need to be voted  
14 on, developed and voted on separately. Or I  
15 mean, is that what you're talking about?

16 CHAIR LEINENKUGEL: No.

17 MR. JONAS: No? Okay.

18 CHAIR LEINENKUGEL: No, I was going to  
19 include that piece which is an action item for  
20 the VA to do under the recommendation that we're  
21 currently voting on. So it would not be a  
22 separate recommendation. It would be --



1 MR. JONAS: No, no. I agree. I  
2 agree.

3 CHAIR LEINENKUGEL: -- an action step.

4 MR. JONAS: But the vote might be done  
5 separately on that. Or should we table the  
6 entire vote until that's been put in?

7 CHAIR LEINENKUGEL: Yeah, I think that  
8 we're going to have to have some trust. And  
9 Wayne, you will see the document again. So I  
10 think the right thing to do at this time is that  
11 somebody is taking notes and we have parking lot  
12 items at this point.

13 So every one of those parking lot  
14 items, at the end of this meeting after the vote  
15 will be given back to each Commissioner and who's  
16 responsible and by when to complete the parking  
17 lot items. And then there'll be a turnaround  
18 time for us to review prior to the final report  
19 to make sure that those have been written and  
20 included as noted. Matt.

21 MR. KUNTZ: We already have that as a  
22 recommendation. I mean, that is -- the whole

1 thing that you talked about was that feedback  
2 loop. And I mean, we have 20 pages discussing  
3 that. And yes, it may make sense to come after  
4 the veterans' experience as Mike and I suggested  
5 before.

6 But if we add another recommendation  
7 for another feedback loop -- you captured this.  
8 You captured this in your recommendation. And  
9 maybe we need to talk about how the  
10 recommendations are linked. But it was fully  
11 covered in your recommendation.

12 The feedback loop, the system that  
13 learns from the veterans' experience, the talk of  
14 the clinicians, that is in that person centered  
15 recommendation. So that would be my -- instead  
16 of adding additional implementation steps, refer  
17 back to the --

18 CO-CHAIR BEEMAN: I'm fine with that.  
19 I don't disagree. I just worry that we can't  
20 focus on each individual thought that somebody  
21 had on whatever particular day. And you know how  
22 a lot of this becomes anecdotal. You go to your

1 doctor's office. You wait 15 minutes. You get  
2 really PO'd, and that's what you remember.

3 The fact that he gave you exceptional  
4 care or she did, you forget. And maybe it  
5 happened that day, so that's what you're thinking  
6 about. And I agree. I think Wayne has it in his  
7 section. The VA has to have a systematic way to  
8 get feedback from both its staff as well as the  
9 people they serve. And they have to have a  
10 formal mechanism to then address those issues.

11 I mean, there's not an organization  
12 that I've ever been associated with that is a  
13 quality organization that doesn't have that kind  
14 of feedback loop. I think it is probably  
15 adequately addressed. One of the problems is, is  
16 that we're going through these things and we  
17 forget there's another place in the document.  
18 And I think that's good that you brought that  
19 out.

20 So you know, again, I go back to  
21 earlier. If you know, if Dr. Jonas is satisfied  
22 for what we have in one, that based on what we've

1 heard and the amendments we've already made, I'd  
2 like to second -- again, second what Dr.  
3 Potoczniak came up with. Because I think it was  
4 very thoughtful and laborious. I can't even tell  
5 you how laborious it was.

6 MR. POCOCZNIAK: Well, let me just say  
7 straight out this document, the interviews would  
8 not have been possible without Wendy who made the  
9 tremendous effort in this whole series of  
10 implementation steps and gathering all the data  
11 and all that other stuff. So I just want to make  
12 sure Wendy gets some props for doing that. And  
13 really, it's been a pleasure working with you.

14 MR. HARVEY: Several months ago, we  
15 heard from Dr. Lynda Davis about, I guess, the  
16 SAIL program. I don't know what the acronym  
17 stands for. But wouldn't she, if she were here,  
18 say, this is what we do? We are trying to  
19 solicit feedback and articulate --

20 CHAIR LEINENKUGEL: And I know Lynda.  
21 And Lynda, yeah, it was not SAIL. It's Veteran  
22 Experience Office, and they do have a new

1 technology now that is doing just that, Tom. And  
2 it's supposed to get there. So I think what  
3 we're doing is just reinforcing the obvious.

4 MR. HARVEY: Rather than saying you  
5 should recreate another entity or another office  
6 to do it.

7 CHAIR LEINENKUGEL: And I think the  
8 way the entire report is written, 100-plus pages  
9 at this point with all the actions steps from  
10 each branch. When you look at it holistically,  
11 going to back to Wayne, starting with number one  
12 -- and I'll get back to you. A lot of things are  
13 already there like Admiral Beeman stated.

14 So a couple of these are going to be,  
15 I'm glad that the Commission addressed it. Yes,  
16 it's probably still something that's out there.  
17 But we have fixes for it. And I would venture to  
18 say that in most cases, the VA is doing a lot of  
19 the things that we're asking or looking at. So  
20 it's going to be -- it's going to reinforce what  
21 I hope faster implementation. Or all of us  
22 Commissioners hope is faster implementation.

1                   And then the big piece is, are they  
2 willing to do what Wayne in the workgroup and the  
3 rest of the Commissioners voted on with  
4 Recommendation 1, which is a big ask but the  
5 right thing to do if you're going to have the  
6 best mental health and healthcare system in the  
7 world for our veterans. And that's what that is  
8 all about.

9                   So I think at this time, I heard a  
10 second on Recommendation 3. For the last time,  
11 is there any further discussion on Recommendation  
12 3?

13                   (No audible response.)

14                   CHAIR LEINENKUGEL: Hearing none, if  
15 I may start again with Commissioner Harvey.

16                   MR. HARVEY: Yay.

17                   MR. KHAN: Yay.

18                   MR. KUNTZ: Yay.

19                   MR. JONAS: Yay.

20                   MR. AMIDON: Yay.

21                   CHAIR LEINENKUGEL: Yay.

22                   CO-CHAIR BEEMAN: Yay.

1 MR. POTOCHNIAK: Yay.

2 MS. MAGUEN: Yay.

3 MR. ROSE: Yay.

4 CHAIR LEINENKUGEL: Unanimously yay'd  
5 by the Commission, and thank you for that. And  
6 thank you, Commissioner Potoczniak, for the great  
7 work along with Wendy and the entire support team  
8 for getting us through a very difficult thing. I  
9 know you struggled with, Mike, personally,  
10 through all the hoops for the first six months,  
11 and it got to the finish line. Well done.

12 I think we have time to jump into  
13 Recommendation 4 before our lunch break.

14 MS. LARUE: I think so. So  
15 Recommendation 4 starts on page 80. And Matt, I  
16 think this is yours.

17 MR. KUNTZ: All right. Thanks, Wendy.  
18 So Recommendation 4 came out of Duty 5, specific  
19 Duty 5A. And a lot of -- that focus on suicide  
20 prevention, while the committee was at work,  
21 different things were happening around the  
22 country. And there was a new Commission started

1 by the President last march, I believe. And we  
2 made a change in leadership in suicide  
3 prevention.

4 So it was a really active time for  
5 suicide prevention, and our group tried to focus  
6 on super specific things that we could add that  
7 would deliver some value to the larger ecosystem  
8 of suicide for veterans.

9 And we had the main focus, and I will  
10 cover the findings. The risk assessment in  
11 suicide prevention research, there was pretty  
12 clear evidence that we need more. We just don't  
13 have enough research to be able to say about how  
14 to prevent veteran suicide. That systematic  
15 review that we relied on for that statement is  
16 very clear. We took the language directly from  
17 there.

18 But one of the more -- the second  
19 piece is one or more proven suicide prevention  
20 methodologies has been fully utilized as a  
21 suicide assessment and follow engagement program  
22 in the emergency rooms. And that was one of the



1 ones that was really highlighted by Dr. Stanley  
2 in her -- when we went to Columbia Psychiatry.

3           It's a well developed program. It's  
4 got a lot of research behind it. And it does  
5 make sense that those veterans that come to care  
6 at the emergency room that are suicidal, we do  
7 need a more consistent way of engaging them. And  
8 while there may be an ability to do that in the  
9 flagship VAs, how about some of those other  
10 facilities?

11           So this is a way to provide that via  
12 telehealth and it has a lot of evidence behind  
13 it. And then also just that logic of those folks  
14 are in serious need. And if we have an evidence-  
15 based way -- bless you -- to deal with it, it  
16 makes sense.

17           The next one up is the lethal means  
18 storage options. And basically when the veterans  
19 are counseled to go find some help in storing  
20 their weapons, that's great. But what does that  
21 mean for it actually on the ground? Who do they  
22 work with? And this would create a grant program

1 to help those communities develop those lethal  
2 means storage options.

3 And what's nice about a community  
4 grant program is working within mental health and  
5 being involved with commitments. The commitment  
6 laws vary from state to state. The gun laws vary  
7 from state to state. So the VA is not going to  
8 wade into that. The federal government is not  
9 going to wade into that. That is a local level  
10 thing. But it's critical for the VA to make sure  
11 that those options are available for the veterans  
12 that need them.

13 The next piece that we focused on was  
14 kind of the overall suicide messaging platform  
15 for the VA and how to describe suicide. And we  
16 saw this on a number of different occasions where  
17 people would focus on mental health or they would  
18 focus on this or that. And it would kind of get  
19 lost in the weeds, and the suggestion was to  
20 create a larger platform that would include both  
21 environmental factors and the susceptibility.

22 Really developed with Dr. Mann of

1 Columbia Psychiatry. They've had that diathesis-  
2 stress model, a version about that for decades  
3 that has stood up well within the research and  
4 saying the suicide prevention model has to be  
5 able to cover things like adverse childhood  
6 experience.

7           It has to be able to cover -- have the  
8 flexibility to cover people with mental illness  
9 who are at higher risk of it but also include  
10 divorce and the reality that divorce is a risk  
11 factor for suicide. But not everybody that gets  
12 a divorce goes suicidal. So that model has that  
13 flexibility, and that is the kind of guidance  
14 that the VA can help give our local communities  
15 that are working to develop suicide prevention  
16 programs.

17           One of the other pieces that seems a  
18 little bit unrelated at first is the VA  
19 disability rating system. But work is a critical  
20 part of mental health. And not being successful  
21 in your career is a high risk factor for suicide.  
22 And Dr. Shana Bakken's presentation to our

1 Commission on March 12th really highlighted that.

2 And what this is saying is that the VA  
3 should eliminate the penalties for veterans that  
4 do go try and develop their vocation, even though  
5 they have benefits. And this will allow the  
6 veteran to continue to try to engage in vocation  
7 without worrying that they may do well for a  
8 while, lose their benefits, and then have their  
9 mental health symptoms come back up and end up in  
10 a worse state than they were before.

11 So this supports -- provides a  
12 baseline support for that veteran's recovery that  
13 can't be taken away. So these are really  
14 specific issues. And as you go into the  
15 implementation steps, it does add support for the  
16 public health model that's been utilized really  
17 well in Arizona as we saw and then as some of the  
18 Commissioners saw in Montana as well.

19 Are there any questions?

20 MR. POTOZNIAK: One small question or  
21 point. The -- about revising or about the  
22 evidence of employment part. I guess my only

1 exception to that would be for the unemployable  
2 veterans, the people that achieve 100 percent  
3 through means of being unemployed because that  
4 part -- that's a major part of it, right?

5 And if they're not, I can see  
6 something being implemented where it says, okay,  
7 we can't look at employment. So then how do you  
8 even judge employability basically? Because  
9 there is that. You know what I'm talking about?

10 MR. KUNTZ: Yeah. So this  
11 recommendation would not be in terms of setting  
12 them. But just the idea that, okay, if you're  
13 100 percent, go try and do something. Like,  
14 okay, we deemed you unemployable, so your  
15 disability rating has been set. But the idea  
16 that -- so this is not to help people gain the  
17 system.

18 But once that rating is set that you  
19 can go get on a Fiverr website and have somebody  
20 pay you to do drawings or go try to drive for  
21 Uber. Go try to do something without the fear  
22 that your benefits might get taken away. So it's

1 not in terms of setting. It has nothing to do  
2 with setting. It's purely in terms of not taking  
3 them away.

4 MR. POTOZNIAK: So a little bit --  
5 but a little bit different because the 100  
6 percent rating, right? The 100 IU or  
7 unemployability rating is usually -- so you only  
8 get that when you are unemployed.

9 So if you start working, you lose your  
10 unemployment status and then you will go back to  
11 70 percent, 60 percent, or whatever it is. So  
12 when you're unemployed because of your symptoms,  
13 right, you may have a 70 percent rating, right?  
14 But then become 100 percent because the symptoms  
15 have gotten so bad with that rating that you're  
16 now -- we say that you cannot work.

17 And if you do work, we will take away  
18 that unemployability status. So that's a whole  
19 class of people that I just want to make sure  
20 you're aware of because it's a large group of 100  
21 percent people that literally the VA has said, if  
22 you work, this goes away.

1           And it's different than the ratings --  
2 all the other ratings, the 100 percenters that  
3 are not on employability. Like, there is a class  
4 of people they just said, we're giving this to  
5 you because you can't work. And if you do start  
6 working, you lose this.

7           So there's a little bit of a piece I  
8 just want to make sure you're aware of it in  
9 saying that because it would definitely get  
10 brought up. You can't -- you would -- like, see  
11 what I'm saying?

12           MR. KUNTZ: Yeah.

13           MR. POTOZNIAK: Okay.

14           MR. KHAN: If I may add to it, Mike,  
15 you're right. The unemployability, 100 percent,  
16 is a different category. But if a veteran is  
17 given 100 percent disability, total, they can't  
18 go back to work. That condition is not for them.  
19 But unemployability, yes, you're right there  
20 because then they lose their 100 percent is  
21 reverted back to 70 percent. I just want to make  
22 sure that clarification.

1           MR. ROSE: If I may, though, back to  
2 the other point, not the 100 percent  
3 unemployability. I mean, you see that so many  
4 times in the civilian community. Work is such an  
5 important part of your recovery. And it's a  
6 tradeoff between how much you make and what your  
7 benefit is. And you go so high and you're  
8 working and then you lose your benefit.

9           I mean, it's the same way here. If  
10 somebody is working, I hope that doesn't end up  
11 in losing your benefit because they need both.  
12 They really do. And I'm not talking about 100  
13 percent. I'm talking about the range in between.

14           MR. POTOZNIAK: To get the  
15 unemployability status, you have to have a rating  
16 to start off with that I believe is 70 percent or  
17 something like the 70 percent. And so you're  
18 given this status, and some people maintain it  
19 for a very long time.

20           And so you don't lose the whole thing,  
21 but you will lose a huge chunk of your benefits  
22 when you start working again. And I just -- some



1 people stay on it for a very long time.

2 MR. KUNTZ: And I guess that that's my  
3 point is that we've set up a system that  
4 penalizes people for working. And we've set up a  
5 system that -- I've seen it. I've seen people  
6 not even try because they're so worried that  
7 they've get reduced and then something bad will  
8 happen in that job which there's a high  
9 likelihood that'll happen. And then they're out  
10 of it. Like, so then how they care for their  
11 family.

12 I mean, this recommendation is about  
13 -- or this subpiece of this recommendation is  
14 about setting up a penalty for people to try  
15 employment. And yeah, the VA has a lot of  
16 different ways that they try to do that. But  
17 that is the goal is we've got all of these  
18 employment systems.

19 And I was with a lady from vocational  
20 rehab said was we get these veterans ready to go  
21 to work. And then they're so terrified that  
22 they're going to lose their benefits that then

1 they don't engage. And because -- and that's  
2 what we're trying to get at on this  
3 recommendation.

4 And I think that there's probably  
5 plenty of nuance that you could pull into it or  
6 out of it. But that is the overall takeaway is  
7 that vocational -- making vocation a risk.

8 MR. POTOZNIAK: So what I would just  
9 propose as far as implementation goes with this  
10 is that you somehow exempt the IU people out of  
11 that process because the process is good. What  
12 you're talking about is good with probably 90  
13 percent of the veterans out there, right, that  
14 have regular ratings. It makes sense what you're  
15 saying. But you got to keep in mind that you got  
16 to -- if you don't exempt those people with  
17 unemployability, I don't know what happens to  
18 that at that point. So if you exempt the  
19 unemployable status people, then this  
20 recommendation or implementation makes more sense  
21 to me. If you don't, then it kind of -- I don't  
22 know what they're going to do with the

1 unemployment status.

2 MR. HARVEY: As a practical matter, I  
3 don't think the VA very often takes the  
4 disability payment away. I think that, I mean  
5 theoretically they can do that. As a practical  
6 matter, has anybody ever seen that happen?

7 MR. KUNTZ: And it did come up in Fort  
8 Belknap, exactly this came up with one of the  
9 veterans that we talked to. And because they had  
10 a tribal veterans rep that was able to resolve it  
11 was the only way that they were able to get it  
12 fixed.

13 So I guess you bring up a very good  
14 point, Commissioner Potoczniak. I do think that  
15 the VA has the capacity to create a veterans  
16 rating that doesn't penalize people for working.  
17 And this may require them to go back to the  
18 drawing board for some ways. Like what is a  
19 benefit system that doesn't penalize people for  
20 working or create the threat that they could be  
21 penalized for working? And do think that they  
22 may need to address that. But I believe that the

1 VA is capable of rising to that challenge.

2 CHAIR LEINENKUGEL: Yeah, if we're  
3 going to do the right thing for our veterans,  
4 which is what this Commission is all about, first  
5 of all, with mental health and now incorporating  
6 it in total health, with whole health. To that  
7 point, Matt, it fits perfectly as far as what has  
8 been one of the obstacles.

9 And it also relates back to potential  
10 suicidality by not being able to be employed,  
11 which the current Secretary and I think the  
12 executive in charge of VHA would also agree to  
13 some degree to explore that, that it needs to be  
14 because they know that a job is important.  
15 Family structure is important. Being married and  
16 remaining married is important, your kids around  
17 you, et cetera, et cetera. We just had that  
18 conversation yesterday.

19 So that being said, 17 months ago I  
20 probably would've disagreed with this because I'm  
21 looking at, oh, boy. How much is this going to  
22 cost? What I've learned is: so what? Let's err

1 on the side of the veterans. Let's make it  
2 easier for our veterans. And these veterans are  
3 not making a lot of money. And they have served  
4 their country. They're less than the 1 percent.  
5 So I think what you're asking and requesting is  
6 absolutely appropriate, and it matches with what  
7 the Commission is about.

8 MR. KUNTZ: Thank you, Mr. Chairman.

9 CO-CHAIR BEEMAN: I have one question  
10 and that's just for clarification, because I'm  
11 hearing what Mike is saying, but I'm not sure I  
12 completely understand the issue.

13 If we said something as a modifier at  
14 the end of the sentence that said something like:  
15 additionally, it is recommended that those deemed  
16 unemployable not be affected at all if they try  
17 to seek some meaningful work. Is that what I'm  
18 hearing you say, or is that already covered?

19 MR. POTOZNIAK: I get -- here's the  
20 thing. A lot of -- so there's a sizable portion  
21 of those veterans that are on like hospital  
22 status, right? You get unemployability when you

1 go into the hospital. Sometimes it's short  
2 lived; sometimes it's longer.

3 And so the fear that I have is if it's  
4 not addressed in the implementation steps is that  
5 the VA will -- it could happen where people -- we  
6 could be actually affecting veterans' benefits if  
7 they do it the wrong way. I actually -- while I  
8 love the VA that I work for, I don't know that  
9 implementation-wise it always is going to fall in  
10 the favor of the veteran. I'm just going to be  
11 straight out about it. It's politics.

12 And so there are veterans that  
13 literally that are rated at 70 percent, become  
14 100 percent unemployable, and they need that.  
15 And if the VA decides to basically get rid of  
16 that or alter it in a way that makes it more  
17 difficult to obtain, then you could lose the  
18 unemployability status for large groups of  
19 veterans.

20 MR. KUNTZ: You make a good point  
21 about the short-term unemployability.

22 MR. ROSE: But just back to your

1 example, Mike. Okay. So a person goes in the  
2 hospital. And so he's there. He's unemployable.  
3 How long does it take him once he's out of the  
4 hospital and in recovery to get so he can be  
5 employed?

6 MR. POTOZNIAK: So if a veteran is  
7 like in a domiciliary --

8 MR. ROSE: Okay.

9 MR. POTOZNIAK: -- he could be in  
10 that domiciliary for six months, seven. I mean,  
11 it could go on for a while. And then exactly  
12 when do you we -- just because you're discharged,  
13 do we now say that you're ready to work? It's  
14 hard to gauge, and so that's why veterans will  
15 stay on that list sometimes for years. I mean  
16 you can speak to that probably even more than I  
17 can. Just because it becomes this thing like  
18 when is somebody done with regular disability?  
19 That's really in the private sector. And that's  
20 the VA's form of disability is this unemployable  
21 status for people. But it's lumped in with all  
22 the benefit. Their regular rating, it gets added

1 on. So yeah, anyway.

2 MR. ROSE: Thank you.

3 MR. KHAN: In most cases, for example,  
4 a veteran has a surgery. They remove his one  
5 leg. While he's in the hospital, he's 100  
6 percent. He's given unemployability. Then he  
7 recovers and they give him the artificial limb.  
8 He's back to employable. So the VA will take  
9 that unemployability away from him. And this  
10 happens in a lot of surgical specialities.  
11 Thank you.

12 MR. KUNTZ: So from drafting this  
13 standpoint, I think that where this would go is  
14 we have it on page 85, the Executive Branch  
15 recommendations, Revised 38 CFR Chapter 1, Part  
16 4, to ensure that no evidence of unemployment of  
17 a veteran will be used to reduce their veteran's  
18 benefits.

19 And I think that adding long-term  
20 veterans' benefits --- or Mike, if you know or if  
21 someone on the team can come up with the kind of  
22 unemployment that's for surgery or something that



1 is really short lived by design because it's  
2 supposed to be.

3 MR. POTOZNIAK: So it would exempt  
4 the IU ratings which is that's what that is.  
5 Because those are the ones I'm talking about.

6 MR. KUNTZ: Okay.

7 MR. POTOZNIAK: Individual  
8 unemployability.

9 MR. HARVEY: Is that what that  
10 reference to 38 CFR is?

11 MR. POTOZNIAK: Yeah, it would be in  
12 that. It would be in that. It's lumped in with  
13 that. So if you're addressing -- if you're  
14 basically saying, don't look at unemployability  
15 or don't look at employment status as a sign of  
16 -- to affect the ratings basically. You just  
17 want to make sure that then they don't mess with  
18 the unemployability thing which works fairly  
19 well.

20 And it specifically addresses  
21 employment. And veterans -- certain veterans do  
22 need that, that are rated at 70 percent but can't

1 work anymore so they're 100. And so yeah, you'd  
2 want to amend that or put something in basically  
3 exempting the IU status so they don't mess with  
4 that.

5 MR. KHAN: You can just add the word  
6 after benefits, of individual unemployability.  
7 That'll complete the sentence.

8 MR. KUNTZ: I'm afraid about having it  
9 be that specific. Like long-term disability  
10 seems like it avoids the short term, you know,  
11 and we can work with the subject experts to find  
12 out exactly what part of that reg fits in to what  
13 you're describing. But I think as long as we  
14 say, will not be used to reduce their long-term  
15 benefits. Do -- I mean, do --

16 MR. POTOZNIAK: The terminology is  
17 wrong because we don't do anything -- like the VA  
18 doesn't have long term or short term. It has  
19 permanent and it has temporary, right? And so  
20 the ones you're speaking about are permanent and  
21 temporary ratings. Okay? You don't want those  
22 touched. But you do want the individual -- you

1 want to exempt the individual unemployability  
2 ratings separately because the temporary and --  
3 that's what you're talking as long term. So  
4 temporary and permanent are long term.

5 MR. KUNTZ: I guess from my  
6 recommendation, Mr. Chairman, is that we would  
7 move on this with the idea that Dr. Potoczniak  
8 and I would work with Wendy to ensure that the  
9 language in that particular implementation step  
10 hits the right spot because I don't think it's  
11 realistic for us to go back and forth on  
12 administrative roles right now.

13 CHAIR LEINENKUGEL: I was just going  
14 to get to that point. But thanks, Commissioner  
15 Kuntz. And if you and Commissioner Potoczniak  
16 along with Wendy will parking lot that, we know  
17 where it's headed which is a matter of -- it's  
18 more than semantics at this point because it does  
19 deal with money and ratings. But I think that  
20 every Commissioner, unless they have further  
21 discussion -- and I have not heard a second yet.

22 MR. JONAS: I'll second it.

1 CHAIR LEINENKUGEL: I've heard a  
2 couple of seconds. Further discussion?

3 MR. JONAS: I have just a minor -- I  
4 hope will be a minor thing on the same area.  
5 It's just a wording -- a slight wording change  
6 because it's a little confusing the way it reads  
7 to me. It says: ensure that no evidence of  
8 employment will ensure -- maybe could we say,  
9 ensure that evidence of employment of the veteran  
10 will not be used to reduce the veteran benefits.  
11 It seems to me that's a clearer statement of what  
12 it is we want to do, so anyway.

13 MR. POCZNIAK: Second.

14 MR. JONAS: Okay. That's the only  
15 thing I would change.

16 MS. LARUE: Yeah, and I'll just add  
17 one more quick thing. I would also recommend --  
18 it's great -- the section on SAFE VET is great.  
19 I think that what I would add is just a very -- a  
20 one-sentence description so that people who  
21 aren't familiar with that program, you kind of  
22 hit the key points of what that program is aimed

1 to do.

2 MR. KUNTZ: Perfect. Thank you.

3 CHAIR LEINENKUGEL: Further  
4 discussion?

5 (No audible response.)

6 CHAIR LEINENKUGEL: All excellent, and  
7 I would like to start with Commissioner Harvey  
8 once again.

9 MR. HARVEY: Yay.

10 MR. KHAN: Yay.

11 MR. KUNTZ: Yay.

12 MR. JONAS: Yay.

13 MR. AMIDON: Yay.

14 CHAIR LEINENKUGEL: Yay.

15 CO-CHAIR BEEMAN: Yay.

16 MR. POTOZNIAK: Yay.

17 MS. MAGUEN: Yay.

18 MR. ROSE: Yay.

19 CHAIR LEINENKUGEL: Unanimous on the  
20 yays. For Recommendation 4, Commissioner Kuntz,  
21 extremely well done, Matt, you and your team.  
22 Thank you so much.

1 MR. KUNTZ: Thank you.

2 CHAIR LEINENKUGEL: I think at this  
3 point if the Commissioners agree, we could  
4 probably take -- John, what would you recommend  
5 as far as a lunch break? And I know there's a  
6 cafeteria on this floor.

7 MR. GOODRICH: Yeah, and it's pretty  
8 -- it's got lots of good food. So I would say 30  
9 to 45 minutes.

10 CHAIR LEINENKUGEL: Let's do 45  
11 minutes. So let's be back at 1330, 1:30 civilian  
12 time. Wendy, in your eyes, do you think that  
13 will allow us enough time to get through the  
14 remainder of the agenda?

15 MS. LARUE: I do.

16 CHAIR LEINENKUGEL: You do?

17 MS. LARUE: I do. I think that the  
18 sections with the most content have already been  
19 addressed. So --

20 CHAIR LEINENKUGEL: Agreed. Perfect.

21 MS. LARUE: -- I think things will  
22 move quickly after lunch.

1 CHAIR LEINENKUGEL: 1:30. Thank you  
2 very much.

3 (Whereupon, the above-entitled matter  
4 went off the record at 12:40 p.m. and resumed at  
5 1:33 p.m.)

6 CHAIR LEINENKUGEL: Good afternoon and  
7 welcome to the December 12th COVER Commission.  
8 This is the afternoon session. We had very  
9 robust discussions, debates, and deliberations  
10 and approvals of Recommendations 1 through 4  
11 earlier this morning. We also had a general  
12 public comment by Congressman Gus Bilirakis. And  
13 at this time, I'm going to turn back to Wendy  
14 LaRue. And Wendy, I think we are going to start  
15 with Recommendation No. 5, correct?

16 MS. LARUE: So we are indeed on  
17 Recommendation 5 which is about treatment  
18 resistant depression and turn things back over to  
19 Matt to introduce that.

20 MR. KUNTZ: All right. Thanks, Wendy.  
21 So this recommendation is provide universal  
22 access to effective care for treatment resistant

1 depression for all veterans in the mental health  
2 system.

3           This is a very real issue. It is  
4 recognized in the VA and Department of Defense's  
5 clinical practice guidelines. When we conducted  
6 our analysis, and it wasn't referenced in here.  
7 But we did find that there's very little  
8 treatment being delivered through transcranial  
9 magnetic stimulation and electroconvulsive  
10 therapy. And it was almost -- well I guess, for  
11 me, it was shock the conscience numbers because  
12 it is in the clinical practice guidelines. It is  
13 a major part of the care. And there are states  
14 like mine where you can't access this care.

15           And so it is something that, for me,  
16 having seen one veteran that I love that couldn't  
17 get this kind of care and we lost him. If it's  
18 in the clinical practice guidelines, it should be  
19 available. But I do think that, Wendy, it's  
20 worth the discussion on -- it was John Klocek  
21 pulled that data and whether it's -- how we  
22 integrate it into this section. But I do think



1 that it's a very clear statement that the issue  
2 -- I mean there are regions of the country that  
3 things in the clinical practice guidelines are  
4 not being offered in. Any questions?

5 CO-CHAIR BEEMAN: Just a comment on  
6 ECT. I think the number of practitioners is  
7 limited because it hasn't been done for a while,  
8 and now it's had a resurgence. We have the  
9 experts here; I feel silly talking about. But I  
10 know my wife had to actually be recalled in her  
11 medical center because she had expertise to work  
12 with a psychiatrist doing it. And I think what  
13 happens maybe in a state that's got a low  
14 population is the number of psychiatrists that  
15 are qualified to do it is fairly low. It may  
16 almost be nonexistent.

17 So maybe looking at the training and  
18 availability as something. You know, to mandate  
19 something that isn't available to anybody might  
20 be difficult, you know. And maybe the  
21 transportation of the patient is what we're  
22 talking about -- giving them access to it, but it

1 may not be available in every state.

2 MR. KUNTZ: Yeah. So Admiral Beeman,  
3 you bring up a very good point. I can say from  
4 living in a state where the VA does not provide  
5 this service, it is available in the private  
6 sector. We do have other entities in our state.  
7 And even in Helena, when we talk about  
8 transcranial magnetic stimulation, seven miles  
9 away there's a psychiatrist with two machines.  
10 The Billings clinic is doing ECT. So it's not --  
11 it is a chosen unavailability.

12 MR. ROSE: So Matt, with that, so it  
13 would be a community outreach situation in those  
14 locales where you have the technology, you have  
15 the expertise, and it is the matter of the VA  
16 crossing that bridge?

17 MR. KUNTZ: So from this  
18 recommendation is to make it available. And I  
19 think a big part of it is the reporting because  
20 if there's no reporting that this isn't being  
21 done for big parts, it's very hard. Like people  
22 just don't know. But it is letting the VA know

1 that we are -- that Congress is paying attention  
2 and this is a level of care that needs to be  
3 available to our veterans, especially because for  
4 depression, there's a high percentage of folks  
5 that do not respond. And I don't have the exact  
6 number on me. But we had like -- it was like  
7 2,000 veterans in that data pool that were  
8 getting these services across the country. I  
9 mean, it was a shock the conscience small number  
10 when we know this is part of the treatment base  
11 that needs to be understood and built in.

12 MR. POTOZNIAK: And part of the  
13 problem with it not being offered in VAs or  
14 talked about more, or I think that giving it  
15 press is a good idea because providers choose  
16 their treatment options based on what's  
17 available, you know, and what's talked about. So  
18 it's kind of like essentially when you say ECT, I  
19 realize I probably haven't thought of ECT in a  
20 while. And part of the reason is because it  
21 falls into that -- I hate to say it, but that  
22 like too hard pile because it's like oh, I don't

1 even -- I wouldn't even know where to start with  
2 that in our system. Like I know that San  
3 Francisco offers it, but it does happen that way.

4 And so unless it's -- with these kind  
5 of treatments, I feel like if they're not  
6 advocated for, they fall -- they just kind of  
7 vaporize as being like -- but it's effective.  
8 It's just that it's not really advocated for.  
9 You have to advocate for it. So I appreciate  
10 this.

11 MR. KUNTZ: Thank you. And I think  
12 that one of the other things that comes is like  
13 from talking to our local VA about it is with  
14 TMS, they didn't understand that most of it is  
15 provided by a technician. This isn't going to  
16 absorb all of your psychiatry time because it's  
17 not a psychiatrist running that machine every  
18 time it's turned on or working with a veteran.  
19 This is a technician level of care. So at least  
20 opening the door about what these are and  
21 ensuring that more veterans can access it.

22 MR. JONAS: I had a question. Was

1 there a reason in this? I think it looked like  
2 the recommendation's goal is to -- actually the  
3 primary one is to partner with the National  
4 Institute of Mental Health to advance the  
5 precision mental health initiative.

6 MR. KUNTZ: That's a different  
7 recommendation.

8 MR. JONAS: Oh, I'm sorry. I'm on No.  
9 6. Sorry. Backtrack, you're on No. 5, right?  
10 How did I miss that? Be right back.

11 MR. ROSE: Mr. Chairman, I would  
12 second the motion for No. 6.

13 CHAIR LEINENKUGEL: We have a second  
14 for No. 5.

15 CHAIR LEINENKUGEL: It is. And this  
16 is, again --

17 MR. ROSE: No. 5.

18 CHAIR LEINENKUGEL: -- Recommendation  
19 5, provide universal access to effective care for  
20 treatment resistant depression for all veterans  
21 in the VA mental health system. And this was  
22 Commissioner Kuntz. Further discussion after the

1 second at this point?

2 MR. JONAS: I found my question.

3 Sorry. I was on the --

4 CHAIR LEINENKUGEL: Sure.

5 MR. JONAS: -- wrong one. What I was  
6 -- the list that you have here of ECT and TMS, I  
7 mean I'm just wondering why these were sort of  
8 pulled out. For example, I think it was just --  
9 this was just last week, so it's fairly new data.  
10 There was a good, randomized study showing that a  
11 certain type yoga for treatment resistant  
12 depression actually was quite profoundly  
13 effective and it was published in a major  
14 journal. But you're talking about really making  
15 those kinds of this available, right?

16 MR. KUNTZ: That will -- if it comes  
17 into -- what we had to go from was not something  
18 published last week, and this is a broad  
19 recommendation. And the evidence that we  
20 utilized is by laying out the VA and the  
21 Department of Defense's clinical practice  
22 guidelines as they exist, what they have defined

1 as evidence-based care. And then using their  
2 data to say this is how many veterans actually  
3 got that.

4 MR. JONAS: Got you.

5 MR. KUNTZ: And so it was a one-to-  
6 one. But this recommendation does have the  
7 flexibility for -- I think as ketamine has come  
8 along, yoga. I mean if other things end up  
9 hitting that VA clinical practice guideline or if  
10 the VA wants to highlight something that's not in  
11 their guidelines, but yeah, we've added --

12 MR. JONAS: Make them available.

13 MR. KUNTZ: -- yoga for thousands of  
14 veterans to help deliver. It's just focusing at  
15 that --

16 MR. JONAS: So you just took the  
17 guidelines as they currently exist and say, make  
18 sure these are available?

19 MR. KUNTZ: Yeah.

20 MR. JONAS: Got it. Okay, understand.

21 MR. KUNTZ: Yeah, we didn't want to  
22 have the fight in this section about what should

1 or should not be in the clinical practice  
2 guidelines. Just focusing on the clinical  
3 practice guidelines as they exist now.

4 MS. LARUE: And as I recall from John  
5 Klocek's work, basically more people are getting  
6 yoga than TMS, which is kind of shocking. So  
7 I'll work with John to try and capture more of  
8 that in here in a paragraph because I recall  
9 looking at those numbers as well and being blown  
10 away by the fact that something I can hear an ad  
11 on the radio every day driving to work, only  
12 2,000 veterans are getting that care.

13 MR. KUNTZ: And especially for like  
14 our state, that is something covered by insurance  
15 for people that hit a certain criteria. And if  
16 our insurance providers believe that it's  
17 necessary, and if it's in the clinical practice  
18 guidelines, it is something that they need to  
19 move on.

20 CHAIR LEINENKUGEL: Any further  
21 discussion, Commissioners? Question? Okay.

22 (No audible response.)



1 CHAIR LEINENKUGEL: Tom?

2 MR. HARVEY: Aye.

3 CHAIR LEINENKUGEL: Jamil?

4 MR. KHAN: Aye.

5 MR. KUNTZ: Aye.

6 MR. JONAS: Aye.

7 MR. AMIDON: Aye.

8 CHAIR LEINENKUGEL: Aye.

9 CO-CHAIR BEEMAN: Yay.

10 MR. POTOZNIAK: Yay.

11 MS. MAGUEN: Yay.

12 MR. ROSE: Yay.

13 CHAIR LEINENKUGEL: A couple of yays  
14 and ayes, all meaning yes, approved unanimously.  
15 Once again, Commissioner Kuntz, on Recommendation  
16 5, well done. We move forward with Recommendation  
17 6.

18 MS. LARUE: And No. 6 starts on page  
19 89, and this is about VA's precision mental  
20 health efforts. And again, Matt.

21 MR. KUNTZ: Thank you. So this  
22 recommendation is to expand the VA's precision

1 mental health efforts in partnership with the  
2 National Institute of Mental Health to more  
3 effectively diagnose and treat mental health  
4 conditions. Where this began for our Commission  
5 was at Palo Alto when Dr. Amit Etkin presented to  
6 us. It is a big -- I guess a big issue that  
7 National Institute of Mental Health and others  
8 have been working on for years and trying to  
9 provide more specific analysis of how we can  
10 ensure that the veteran gets the right care at  
11 the right time.

12           And it's a scientifically moving  
13 target. And what this recommendation is, is to  
14 get the VA to really continue to expand and  
15 support their precision mental health initiative.  
16 And to highlight what Dr. Etkin was working on at  
17 the time and that was later published was with  
18 veterans with post-traumatic stress disorder.  
19 What he had identified was if their memory wasn't  
20 working optimally, it was very hard for them to  
21 have a good response to cognitive exposure  
22 therapy because that relied on the memories. And

1 therefore, it didn't work. But if you didn't  
2 know that, the veteran would receive that care,  
3 and they wouldn't be able to benefit from it.

4           Some of the additional really  
5 interesting testimony on this came from Dr.  
6 Trivedi at the University of Texas Southwestern.  
7 He leads the EMBARC study which I'm sorry. I  
8 don't know exactly what that stands for, but it  
9 is a big acronym. But it's a longitudinal study  
10 looking at developing biosignatures to better  
11 understand how to treat depression. So this is an  
12 active part of the field, and Congress has  
13 already been active on it. And they have  
14 specifically been working on it as part of the  
15 precision mental health initiative and the  
16 bipartisan Commander John Scott Hannon Veterans  
17 Mental Health Care Improvement Act.

18           And as part of that, I guess I'll get  
19 pretty personal on this was that that was my  
20 friend and he was a Navy SEAL commander. And he  
21 had post-traumatic stress disorder and substance  
22 abuse disorder. And he really valiantly fought

1 those two conditions and was able to really get a  
2 handle on his trauma symptoms, was able to  
3 overcome his substance abuse. And that was when  
4 we figured out the bipolar disorder. And it was  
5 the bipolar disorder that we lost him to. And in  
6 spending time with his family after the death,  
7 and I mean we had worked so hard. But his sister  
8 said: I just wished that we had known about the  
9 bipolar disorder earlier. The Navy is willing to  
10 spend money on their SEALs. Everybody was  
11 engaged in this, but we just didn't know what he  
12 had. And by the time they were ready that they  
13 knew what he had, he was so fragile that anything  
14 that went wrong was life threatening.

15 So that was the purpose behind that  
16 legislation, and I know that when we talked about  
17 this in October, Dr. Jonas had brought up: why  
18 don't we include a bunch of different agencies?  
19 Why don't we do a bunch of those things? And I  
20 think that -- and the reason for this one was,  
21 was that is an existing bill that was well  
22 thought out and this is a difficult thing. It's

1 a difficult hurdle to try to jump. So for us to  
2 make additional requirements past the existing  
3 legislation was unrealistic for my opinion. Are  
4 there any questions?

5 MR. ROSE: Mr. Chairman, I would  
6 second Recommendation No. 6.

7 CHAIR LEINENKUGEL: Thank you,  
8 Commissioner Rose. Any further discussion or  
9 deliberations or questions from any of the  
10 Commissioners after the second?

11 (No audible response.)

12 CHAIR LEINENKUGEL: Hearing none, I'll  
13 start with Commissioner Harvey.

14 MR. HARVEY: Aye.

15 MR. KHAN: Aye.

16 MR. KUNTZ: Aye.

17 MR. JONAS: Yay.

18 MR. AMIDON: Yay.

19 CHAIR LEINENKUGEL: Yay.

20 CO-CHAIR BEEMAN: Yay.

21 MR. POCZNIAK: Yay.

22 MS. MAGUEN: Yay.

1 MR. ROSE: Yay.

2 CHAIR LEINENKUGEL: Unanimous once  
3 again. Well done, Commissioner Kuntz.

4 MR. KUNTZ: Thank you, sir.

5 CHAIR LEINENKUGEL: And Initiative  
6 Recommendation No. 6, and we'll move to  
7 Recommendation No. 7 at this time.

8 MS. LARUE: So we are on page 92, and  
9 this is on gaps in practice. And again, this is  
10 yours as well, right, Matt?

11 MR. KUNTZ: Thank you, Wendy. So as  
12 some of you may remember from October that this  
13 was a very contentious recommendation. And it  
14 wasn't because no one believed in the reasoning  
15 behind it; it was about the language. And Admiral  
16 Beeman had some great recommendations.  
17 Commissioner Rose had some solid points. And we  
18 tried to bring those through, and Wendy was great  
19 in sussing out both of those sides. And this is  
20 the recommendation that we have before you, is:  
21 identify and rectify availability gaps for  
22 evidence-based psychotherapeutic interventions.

1                   And probably the most blatant place  
2 where I saw this in my time as a Commissioner was  
3 on our trip to Chicago. And there was Lovell and  
4 Jackie Brown. And when we went to -- Jesse  
5 Brown, I'm sorry. So when we went to Lovell,  
6 they really bragged about how they utilized eye  
7 movement -- EMDR, eye movement desensitization  
8 and reprocessing, which thankfully I won't have  
9 to say four times. But they really bragged about  
10 how their veterans loved it. It was a key part  
11 of how they served their veterans, and they said  
12 it was essential to their care. They said it was  
13 an evidence-based practice that had been  
14 highlighted by Secretary Shulkin.

15                   And then we went down Jesse Brown,  
16 like 35 miles away in the same VISN. They shared  
17 staff. And in some ways, the staff did go back  
18 and forth. You might start at one and go to the  
19 other later on in your career. And it just  
20 wasn't offered at all. It wasn't part of their  
21 treatment. It wasn't something that they valued.  
22 And those veterans who would've benefitted from

1 it if they had been at Lovell wouldn't even know  
2 about it if they were at Jesse Brown. And that  
3 was -- the fact that it was that close and we saw  
4 them both on the same day helped highlight the  
5 issue.

6 And then we did a really big data  
7 analysis. And I really want to say that Yesenia  
8 Castillo did an amazing job with SIGMA to compile  
9 all of these and just to show that there were so  
10 many different interventions, and that there was  
11 a large variety of what was out there. And  
12 again, like we're not mandating that this be  
13 fixed for everybody, but just if you go to the  
14 Executive Branch recommendations -- there's no  
15 legislative recommendations, but the Executive  
16 Branch recommendations, the first one comes from  
17 Admiral Beeman.

18 Conduct a gap analysis throughout the  
19 VA healthcare system of the use and availability  
20 of psychotherapeutic interventions, recommended  
21 and widely used clinical practice guidelines.  
22 That came from Dr. Maguen because it was more



1 than just what the DoD and the VA had outlined,  
2 and then share the results across the enterprise.  
3 And Commissioner Rose then was very forceful in  
4 saying that they should adopt a plan with  
5 measurable, time-limited steps to address gaps  
6 that limit veterans' access to care that is  
7 essential to treating their condition. So that  
8 was how we tried to take these two steps and  
9 weave them together with what we talked about in  
10 October.

11 MR. KHAN: Mr. Chairman, I make the  
12 motion.

13 MR. AMIDON: Second.

14 MS. MAGUEN: Well I just have a quick  
15 question before we do that. So the thing that I  
16 just want to make sure in terms of the problem is  
17 so I think the first sentence is great. We've  
18 moved towards an evidence-based model of  
19 medicine, yet the availability of different  
20 evidence-based therapies varies widely. The part  
21 that I think that we discussed last time which we  
22 may want to include there too just has to do

1 about the clarity of -- I think that we had a  
2 whole discussion about why some programs are  
3 included and others are not, right? So to have  
4 more clarity about that and what is available and  
5 what's not.

6 And so in addition to the gap  
7 analysis, just a clear indication of what people  
8 can get and where and why certain things are not  
9 offered if that decision has been made, right?  
10 Because if you do a gap analysis but there are  
11 certain reasons why things are not included and  
12 we're not aware of those reasons, that's -- do  
13 you see? There's a missing piece there. So I  
14 just want to kind of highlight that.

15 MR. KUNTZ: I think that makes a lot  
16 of sense. Can you say where you would add that  
17 in that first bullet?

18 MS. MAGUEN: Sure. I think that maybe  
19 either after the first sentence before the  
20 example or even after the example. But just to  
21 kind of highlight that part of the issue, it's  
22 not only doing a gap analysis. It's maybe

1 understanding -- because we had talked about how  
2 -- the rollouts, right, and how CPT and PE are  
3 specifically targeted as part of the treatments  
4 that the VA rolls out. EMDR is not.

5 And so there's a -- in addition to the  
6 gap analysis, I think there has to be clarity  
7 about why certain things are and are not  
8 included. If you just do a gap analysis and find  
9 that EMDR isn't provided at a certain number of  
10 facilities, you're still not getting at that core  
11 issue of what I think you're trying to bring up.

12 MR. KUNTZ: So -- and I guess just --  
13 that was a really important point, Dr. Maguen.  
14 So I always like to focus on the part of the  
15 document. And just to get really specifically,  
16 there's the text where I think that you're right,  
17 that we should flesh out a little bit more in the  
18 text. But more important, making sure that your  
19 recommendation hits the implementation step. So  
20 conduct -- and Admiral Beeman, please weigh in  
21 because your view of what I thought a gap  
22 analysis might include that. But maybe we need

1 to make it more specific. So a gap analysis with  
2 like description of why the gap exists.

3 MS. LARUE: I have a suggestion of  
4 words. A comma at the end of that and then  
5 adding, and report on why certain interventions  
6 are not widely implemented, may capture  
7 everything that we need.

8 MS. MAGUEN: Yeah, that makes sense.  
9 Just to be clear that just because we recognize  
10 that certain things aren't provided at a certain  
11 clinic, there may be a reason for that. And if  
12 we don't understand the reason, then it's -- the  
13 gap analysis isn't going to go a long way if we  
14 just have the numbers but not understanding the  
15 reason behind that.

16 So I agree maybe with just better  
17 understanding implementation or why certain  
18 treatments are provided -- training for certain  
19 treatments are provided, or some language around  
20 the clarification of why those gaps may exist,  
21 understanding at a systemic level.

22 MR. POTOZNIAK: Well it's also about

1 -- it's about why certain therapies are chosen  
2 essentially to be on the rollouts and why certain  
3 ones aren't. So for EMDR to be offered uniformly  
4 or any of these therapies, they would have to be  
5 on a national rollout. And there's plenty of  
6 therapies that are, right, nationally rolled out  
7 through the VA.

8 And so basically what you're kind of  
9 looking at is: why are some therapies chosen, and  
10 why are some therapies not chosen? Because it's  
11 chosen at the top and not at the -- well it's  
12 chosen in mental health in VACO as to why this  
13 gets included and that doesn't get included. And  
14 they made that decision to not do EMDR for some  
15 reason. So you just want to know -- the gap  
16 analysis would really be like: why aren't these  
17 therapies offered on the national rollout?

18 MS. MAGUEN: So I've added to my  
19 amendment to say, and report on why certain  
20 interventions are not widely implemented or are  
21 excluded from VA-wide rollout. That works? All  
22 righty.

1                   MR. KUNTZ: And I just want to say  
2 thank you for bringing that in because it's  
3 exactly what we saw. And without an  
4 understanding of why, it doesn't make sense. So  
5 thank you.

6                   MS. MAGUEN: No, absolutely. I just  
7 want to add, too. If we do some analysis and  
8 find that there's a very legitimate and strong  
9 reason for why certain things were left out, we  
10 want to just make sure we acknowledge that,  
11 right? So I think that that's an important  
12 piece.

13                   MR. KUNTZ: Absolutely. And I think  
14 that that is -- there is plenty of reason or that  
15 within this, the VA does have the ability to say  
16 that it's an incredibly expensive copyrighted  
17 therapy that is only two percentage points more  
18 effective than the one that we get for free. And  
19 that is why we chose this one instead of that  
20 one, and that's why it's not offered in VA's  
21 system.

22                   So I think it does have the ability

1 for them to state that. But without stating it,  
2 you've got veterans and their families wondering,  
3 you know, in a non-transparent environment what  
4 care they can access and why some care isn't  
5 available.

6 CHAIR LEINENKUGEL: Does this change  
7 your wording of Recommendation 7 at all with  
8 these additives that we have?

9 MR. KUNTZ: No, sir.

10 CHAIR LEINENKUGEL: Perfect. We had  
11 a second by Jamil. Any further discussions,  
12 questions of Commissioner Kuntz?

13 (No audible response.)

14 CHAIR LEINENKUGEL: Hearing none,  
15 Commissioner Harvey?

16 MR. HARVEY: Aye.

17 MR. KHAN: Aye.

18 MR. KUNTZ: Aye.

19 MR. JONAS: Yay.

20 MR. AMIDON: Yay.

21 CHAIR LEINENKUGEL: Yay.

22 CO-CHAIR BEEMAN: Yay.

1 MR. POTOZNIAK: Yay.

2 MS. MAGUEN: Yay.

3 MR. ROSE: Yay.

4 CHAIR LEINENKUGEL: Unanimously yay.

5 Recommendation 7, again, Commissioner Kuntz,  
6 thank you very much. Moving on to Recommendation  
7 8.

8 MS. LARUE: That puts us on page 95  
9 and brings us back to the peer support discussion  
10 that we touched on earlier. And again, Matt.

11 MR. KUNTZ: Thank you, Wendy. So this  
12 recommendation is to recognize and incentivize  
13 the roles of peer support specialists, behavioral  
14 health specialists, health coaches, and chaplains  
15 and mental health care in the Veterans Equitable  
16 Resource Allocation system. For the purposes of  
17 this, I will referring to it as VERA from now on.

18 And I think that Dr. Potoczniak  
19 brought this up really well earlier that VERA is  
20 why healthcare administrators choose to adopt  
21 certain positions or not. And if these positions  
22 are not recognized in VERA, those healthcare



1 administrators are going to be fighting an uphill  
2 battle for these parts of the systems that we saw  
3 evidence behind and appear to be very effective,  
4 especially on the civilian side.

5 In a capitated rate environment, these  
6 kind of positions do very well, and they're a  
7 critical part of the system. So while we're  
8 working on the overall model, we're making the  
9 recommendation that these ones be added in now.

10 And I do want to highlight that one of these  
11 positions is effectively creating a new position  
12 within the VA to parallel what is already offered  
13 by the Department of Defense. So we are saying  
14 that behavioral health specialists, which are  
15 utilized within the Department of Defense, will  
16 be within this mix, but they will be separate  
17 from peer support specialists.

18 And I want to highlight that part of  
19 the debate from last time was what a peer support  
20 specialist is, and why it is what it is. And the  
21 VA does have a very specific term, peer support  
22 specialist, which we referenced in Chinman et

1 al., 2013. So that is a term of art within the  
2 VA system which is why we added behavioral health  
3 specialist to say like Harvard said that you  
4 don't need to be someone to has a mental health  
5 condition to serve this population.

6 So we did add that in for the folks at  
7 that side of the table that said: the DoD does  
8 this, and there's places like Harvard that have  
9 really added to their system through these  
10 positions. And then not only to create the  
11 position but to ensure that they hit the VERA  
12 system as well so we don't have to wait five or  
13 10 years for that.

14 MS. LARUE: I wanted to bring up just  
15 a quick point of order because it will change the  
16 words at the top there. Jennifer had noticed  
17 last night when we were doing acronyms, the DoD  
18 term is a behavioral health technician. And  
19 that's what we talk about in the body. So I  
20 think it's really important that that's reflected  
21 in the words on top because that changes that the  
22 top-level recommendation. I didn't want to just

1 do that in the editing process.

2 MR. KUNTZ: Nice catch, Jennifer.

3 Thank you.

4 CHAIR LEINENKUGEL: Hearing a second  
5 of Recommendation No. 8, any further discussion,  
6 debate, or deliberations or questions at this  
7 time from any Commissioners? If not --

8 MR. POTOZNIAK: Let me just --

9 CHAIR LEINENKUGEL: Sorry.

10 MR. POTOZNIAK: Just one correction.  
11 DoD actually does call them behavioral health  
12 specialists, not technicians.

13 MS. LARUE: Okay.

14 CHAIR LEINENKUGEL: So that changed  
15 now.

16 MR. KUNTZ: Double thank you.

17 CHAIR LEINENKUGEL: Are we sure?

18 MR. POTOZNIAK: Because there are  
19 behavioral health techs, but that's a separate  
20 thing. Behavioral health specialists are the DoD  
21 equivalent.

22 MS. LARUE: Okay. So this Defense

1 Health Agency citation, I'm assuming that the  
2 technician's term came from there. So I just  
3 want to make sure that what's in the body and  
4 what we're going to refer people to if they get  
5 curious is reflective of what we're actually  
6 saying. So we can definitely pursue this outside  
7 and still vote on this, but I just want to point  
8 that out. We may need to tweak this paragraph a  
9 little bit so that we're not referring people to  
10 a document that contradicts --

11 CHAIR LEINENKUGEL: Will you please --

12 MS. LARUE: -- our terminology.

13 CHAIR LEINENKUGEL: -- highlight that  
14 in the parking lot as far as a follow-up action?  
15 And we'll leave it at this point as --

16 MR. KUNTZ: And I want to ask that Dr.  
17 Potoczniak be lead on that.

18 CHAIR LEINENKUGEL: You just did.

19 Well done.

20 MR. KUNTZ: Thank you.

21 MR. POCZNIAK: Well you can ask all  
22 you want.

1 (Laughter.)

2 CHAIR LEINENKUGEL: We're good at  
3 asking, and you will follow up. With that, is  
4 there any further discussion? Any questions or  
5 comments after the specialist technician debate?

6 MR. ROSE: Mr. Chairman, just one  
7 comment back to peer support specialist. VA  
8 hires peer specialists and peer support  
9 technicians. Is that the verbiage we want?

10 MR. KHAN: What page? Hang on.

11 MR. ROSE: I right on page 95, peer  
12 support specialist. I think it should say, VA  
13 hires peer support specialist. It's got -- and  
14 delete peer support technicians.

15 MR. KUNTZ: So actually in that  
16 document, it does say very specifically the VA  
17 hires peer specialists and peer support  
18 technicians. And then --- and it does lay it  
19 out, so they are using both terms. And that's  
20 why we lumped it into that. And that's what they  
21 did in the document too.

22 MR. ROSE: Okay.

1           MR. KUNTZ: So they refer that the VA  
2 is using these. But according to that document,  
3 there is really no difference between those two.

4           CHAIR LEINENKUGEL: That Chinman  
5 document of 2013?

6           MR. KUNTZ: Yes.

7           MR. ROSE: Okay, thanks.

8           MR. AMIDON: I just had a --- to  
9 Commissioner Potoczniak's commentary on either a  
10 behavioral health specialist or technician, I  
11 want to make sure our recommendation is specific  
12 not only to the name but the clinical services  
13 being provided. Does a technician and a  
14 specialist -- this inventory list of things, is  
15 it differentiated by those two roles? Would we  
16 have to adjust that as well based on whether  
17 there is a specialist or a technician? Because  
18 that's material to the recommendation.

19           CHAIR LEINENKUGEL: It's at page 97,  
20 I think.

21           MR. AMIDON: Page 97 at the top. And  
22 not for now, but I'm wondering if we can

1 appropriately vote on the recommendation if this  
2 inventory list is different based on specialist  
3 or technician?

4 MR. POCZNIAK: This is what  
5 behavioral health specialist does.

6 MR. AMIDON: Okay, fair enough. I  
7 just wanted to make sure we reconciled that.

8 CHAIR LEINENKUGEL: This is a parking  
9 lot item only for the clarity of the technician  
10 and specialist terminology that will be worked on  
11 by Commissioner Potoczniak along with Dr. Wendy  
12 LaRue. And we'll be hearing back within the next  
13 10 days at least as to the parking lot items and  
14 the rectification prior to the final writing.

15 With that, we had a second and no  
16 further discussion or questions. Commissioner  
17 Harvey.

18 MR. HARVEY: Yay.

19 MR. KHAN: Yay.

20 MR. KUNTZ: Yay.

21 MR. JONAS: Aye. Oh, I'm sorry. Yay.

22 MR. AMIDON: Yay.

1 CHAIR LEINENKUGEL: Yay.

2 CO-CHAIR BEEMAN: Yay.

3 MR. POTOZNIAK: Yay.

4 MS. MAGUEN: Yay.

5 MR. ROSE: Yay.

6 CHAIR LEINENKUGEL: Unanimously passed  
7 and approved with the parking lot addition to  
8 come in the next 10 working days. Thank you  
9 again, Commissioner Kuntz, for Recommendation 8,  
10 unanimously accepted and approved by the  
11 Commissioners. Move on to Recommendation 9.

12 MS. LARUE: And that puts us at page  
13 100. Woo-hoo. And this recommendation is about  
14 the benefits and costs of medical cannabis. And  
15 I know that some conversation that occurred  
16 yesterday on the Hill.

17 PARTICIPANT: I think -- did you steal  
18 a cup from them?

19 CHAIR LEINENKUGEL: I did. I procured  
20 a cup that I will take back.

21 MS. LARUE: And that is now on the  
22 record -- along with cannabis, which is a little



1 odd.

2 (Laughter.)

3 CHAIR LEINENKUGEL: What? Do you  
4 think this will become Commission glassware?

5 (Laughter.)

6 MR. SPERO: So I think it was brought  
7 up to Jake and Admiral Beeman yesterday that a  
8 more effective way to word this or to present  
9 this recommendation may be to -- as opposed to  
10 directing the VA to conduct the research that it  
11 really should be -- on cannabis more specifically  
12 from a federal perspective, it should be the FDA.  
13 They're the ones who evaluate prescription  
14 medications and determine if -- so saying that  
15 the VA should determine that maybe is not really  
16 in their lane -- in the VA's lane.

17 While they may support it, VA  
18 resources may be engaged to conduct the research  
19 that specifically having the VA in the driver's  
20 seat may not be the most effectively way to get  
21 this done. So I think Jake had some thoughts on  
22 how to kind of tweak this a little bit to make it

1 a little bit more actionable.

2 CHAIR LEINENKUGEL: I think Admiral  
3 Beeman and I were both with an individual that  
4 gave us really good guidance in order to get this  
5 moved forward because it is out of scope within  
6 the VA because they need compliance and direction  
7 by the FDA. So the wording, I think, Admiral  
8 Beeman, was something that was suggested and I  
9 asked Casin to write it down. So somewhere in  
10 your book, I know you were taking some notes.

11 MR. SPERO: It wasn't super specific.  
12 But we are specifically saying in here: ensure  
13 that VA practitioners are updated on this  
14 research. So that's one thing, but then in the  
15 implementation phase there's conduct research and  
16 things like that.

17 Maybe it should say something more  
18 like: work --- or legislatively, somebody needs  
19 to tell the FDA to go do something. I mean,  
20 that's for you all to decide. But I think it's  
21 more in the implementation than in like the  
22 recommendation itself, Jake, is what he was

1 saying.

2 CO-CHAIR BEEMAN: So I have a question  
3 on this. Basically what I think we understood is  
4 the VA shouldn't be the lead on this for a lot of  
5 reasons. One, you don't want to be leading with  
6 your neck and realizing that this may be a no-go  
7 and perhaps shouldn't be a go.

8 But I think we initially felt that  
9 enough veterans were employing this that we  
10 should at least address it. But I think what we  
11 heard yesterday is to say: the VA will  
12 collaborate, cooperate with the FDA and any other  
13 agency as appropriate. I wouldn't take it much  
14 further than that. It may be that the VA has a  
15 great group of people to study because they're  
16 already using it. But I know that we just don't  
17 want to be the lead on this. So we have to be, I  
18 think, circumspect about the way we say this. We  
19 can collaborate and cooperate, but we're not  
20 going to recommend that they take a lead on this.  
21 Is that what you heard, Mr. Chairman?

22 CHAIR LEINENKUGEL: It is. And I was

1 trying to come up with the exact wording again.

2 MS. LARUE: I have words.

3 CHAIR LEINENKUGEL: But FDA needs to  
4 take the lead in this. I mean I think that we  
5 keep the recommendation because of what Tom just  
6 said. We've heard anecdotally again, but there's  
7 also been surveys from the American Legion that  
8 about 2 million veterans are self-medicating with  
9 medical cannabis or cannabis.

10 So that being said, it's a relatively  
11 high number. And there's also been a lot of  
12 confusion as to the ability that I think after  
13 the last meeting we've gotten cleared up as to  
14 what the VA clinicians can actually talk to their  
15 patients -- veteran patients about the use of  
16 cannabis or not talk to them about.

17 So I think we need to clean this up  
18 and come up with more precise wording with the  
19 collaboration between FDA and VA and other  
20 agencies to explore the benefits, risks and  
21 costs. And we did not have risk in our original  
22 one.

1                   But the more that you read and hear  
2                   from practitioners, a couple of them here as  
3                   Commissioners and recent articles I read, there's  
4                   short-term and long-term psychotic downside to  
5                   this. So I mean, that's somewhat known already.  
6                   So I think there needs to be a lot more  
7                   discussion, research, and interaction with our  
8                   veterans if there truly are two million that are  
9                   self medicating.

10                   CO-CHAIR BEEMAN: So Mr. Chairman,  
11                   since this -- we can't make recommendations to  
12                   the FDA that I know of. Maybe we should say  
13                   something like, the VA should follow FDA  
14                   guidelines and cooperate when requested to assess  
15                   efficacy of these treatments, or something like  
16                   that.

17                   So that the only thing we can do is  
18                   recommend that the VA collaborate. We can't tell  
19                   the VA to -- they can't go out and study this  
20                   because if it's not being studied by the FDA,  
21                   they don't have any independent authority to say  
22                   that we're going to use this drug or not.

1 MS. LARUE: So in choosing wording, a  
2 strong verb at the beginning is helpful.

3 MR. SPERO: We can provide a  
4 recommendation for that, though.

5 CO-CHAIR BEEMAN: Oh, we can?

6 MS. LARUE: Yeah.

7 MR. SPERO: Yeah, with the  
8 legislation, we can make recommendations to all  
9 federal agencies.

10 CO-CHAIR BEEMAN: Oh, cool.

11 MS. LARUE: So a top level that would  
12 say to VA, stay in this game, because I'm hearing  
13 that as an undercurrent of concern, would be  
14 collaborate with the Food and Drug Administration  
15 and other agencies as appropriate to explore the  
16 benefits, risks, and costs of medical cannabis  
17 and then just all the words that are there.

18 CO-CHAIR BEEMAN: I actually would  
19 push back a little bit. I think that encourage  
20 the FDA to study and the VA to cooperate is much  
21 better. I don't think this is something that we  
22 want the VA to take a lead on or to call up the

1 FDA and say, you study. I think Congress has to  
2 direct the FDA to study.

3 CHAIR LEINENKUGEL: I don't know if  
4 the FDA has to study more than give the approval  
5 to the VA to progress with -- and I could be  
6 wrong -- progress with doing what we want them to  
7 do and that is research.

8 I think that was the intent, to  
9 research with probably a robust audience of  
10 veterans that anecdotally claim that they've had  
11 numerous benefits come from this, whether it's  
12 anxiety, sleep disorder, blah, blah, blah. You  
13 hear them all.

14 And also using less opiates. We at  
15 least owe them the right to find out if it's  
16 actually working for them. And is there actually  
17 larger downsides, short and long term, that  
18 they're unaware of -- we're unaware of?

19 So I think it is right for this  
20 Commission to bring this forward. It's getting  
21 the precise wording coming out of yesterday's  
22 conversation that we might as well take the time

1 to get. And I'll turn it to you, Matt. Go right  
2 ahead.

3 MR. KUNTZ: Thank you, Mr. Chairman.  
4 So the recommendation is to conduct research and  
5 the benefits and cost of medical cannabis and  
6 psychedelic drugs. I'm sure that VA  
7 practitioners are up to date on this research and  
8 their ability to discuss these benefits and costs  
9 with veterans.

10 That is our recommendation. Our  
11 recommendation does not say that the VA should be  
12 in the forefront of this research. That is the  
13 recommendation as it stands.

14 And then the implementation steps are  
15 ensure that VA researchers have a streamlined  
16 pathway to safely conduct research on the medical  
17 use of cannabis and psychedelics including 3, 4-  
18 Methylenedioxymethamphetamine, MDMA.

19 The next one is ensure that NIDA, the  
20 National Institute of Drug Abuse, develop strains  
21 of cannabis with tetrahydrocannabinol levels  
22 equivalent of those being used by medical



1 cannabis users in the state where medical  
2 cannabis is legal.

3 The next ones are for the Executive  
4 Branch, conduct research in the positive and  
5 negative effects on veterans' mental health of  
6 medical cannabis and psychedelics including MDMA.  
7 Provide VA providers with up-to-date information  
8 on research related to the use of medical  
9 cannabis and psychedelics including MDMA.

10 The next one is educate VA providers  
11 about their ability to discuss the benefits and  
12 possible negative effects of medical cannabis  
13 with veterans in their care.

14 So that is our book that we have. And  
15 I guess from my experience working with people  
16 who presented to the FDA, so whether it's a drug  
17 company or a medical technology, the FDA does not  
18 conduct the research. They are more the cop.  
19 They are the judge of whether or not the research  
20 is valid.

21 So I don't think that we can really  
22 tell the FDA that they need to be conducting the

1 research. I mean, maybe it is another area, NIMH  
2 or something like that. But I don't know if we  
3 could truly just point this back at the FDA.

4 CO-CHAIR BEEMAN: Well, I think it's  
5 problematic if we recommend that a drug that's so  
6 controversial and being so much lobbying. I  
7 mean, the lobbying that's happening in Congress  
8 and all over the nation in state legislatures  
9 around cannabis is beyond belief.

10 And I don't think the VA -- it's  
11 appropriate for the VA to take the lead, whether  
12 or not -- and that's why I said, let's  
13 collaborate, cooperate with FDA, NIH, or any  
14 other agency. But we have the research material  
15 to do that. But I think what this is suggesting  
16 is we actually take the lead. And I think that's  
17 problematic.

18 MR. KUNTZ: So in the document, the  
19 spot where I see that that could possibly be --  
20 and I don't -- and I had talked to Wendy about  
21 that. It's on page 101, the second paragraph.  
22 And it says, the VA should be on the forefront of

1 the research, because there's nothing in our  
2 implementation steps that says the VA should take  
3 the lead. And I think that that would make sense  
4 to pull that one out.

5 What we were trying to -- during our  
6 discussion at the October meeting. And that's  
7 what I did have a problem with that paragraph was  
8 what isn't really adequately stated was in the  
9 October meeting, we highlighted that these  
10 medical cannabis and psychedelics can have  
11 negative consequences. And right now, the ones  
12 conducting these studies are the people that are  
13 pushing them.

14 There's no one conducting the research  
15 that's really looking at the negative effects,  
16 and that's why if we leave it entirely up to the  
17 people working with the FDA, that means we may  
18 not find out about the negative consequences  
19 until a decade or two down the road.

20 So that's why I don't think that  
21 there's anything wrong with if we take out the  
22 forefront but that the VA does do research

1 because in particular the number of veterans that  
2 come into the emergency room in psychosis that  
3 have THC levels in their blood would seem like  
4 the exact kind of study that the VA could do in  
5 ways that no one else could do.

6 So that's why I think that it's right  
7 to take out the forefront. It's right to take  
8 out the lead. But if we're not studying the  
9 negative effects on veterans, then we're just  
10 leaving it to basically the cannabis and  
11 psilocybin pharmaceutical companies to determine  
12 that.

13 CO-CHAIR BEEMAN: And we know how that  
14 turns out.

15 MR. KUNTZ: Exactly. So that was what  
16 we did. I didn't word that right in that  
17 paragraph because this is in some ways more of a  
18 constraint in staying that the VA needs to stay  
19 in the game because there's positives and  
20 negatives. But I don't know if our  
21 implementation steps are necessarily wrong, and I  
22 don't know if our recommendation is wrong.

1 MS. LARUE: I have a quick question  
2 about the meeting yesterday. Was the perception  
3 that this was a recommendation for VA to be a  
4 leader in cannabis prescription versus research?  
5 Do you know? Because nothing here -- this reads  
6 as a cautionary recommendation, not a pro  
7 cannabis recommendation in my mind. And that  
8 maybe part of the issue.

9 CHAIR LEINENKUGEL: It is. It was  
10 construed, I believe -- and I don't want to speak  
11 for the individual. But I'll also reflect back  
12 with Tom and Casin was in the room as well. It  
13 seemed to be a potential huge red flag negative  
14 to the VA.

15 MS. LARUE: So perhaps early, right in  
16 that problem statement, we could just add a  
17 sentence or two that says basically, this is not  
18 a -- we're not -- the problem is not that we need  
19 to prescribe cannabis but rather than we have  
20 many, many veterans who are using it and we don't  
21 understand if that's actually as helpful as they  
22 think it is. And we need to do that research.

1                   CHAIR LEINENKUGEL: I think it's even  
2 more than that, Wendy. And that's why I think  
3 Admiral Beeman was trying to get the FDA  
4 involved. And I know the individual was very  
5 clear because there will be a perception if this  
6 wording -- it may be a perception -- comes out  
7 that the COVER Commission is basically  
8 recommending and ordering the VA to conduct  
9 research rather than explaining that the VA may  
10 love to do the research, but there are certain  
11 steps.

12                   And I think Matt already had them in  
13 the documentation here with the FDA and then the  
14 prescribed type of cannabis that would be used as  
15 a control, that process for approval. So it's  
16 sort of in there. But I think we need to be  
17 cautious and maybe go back and get the correct  
18 wording that's going to be more suitable and  
19 acceptable.

20                   MS. LARUE: I'm also wondering --  
21 you've added risks and costs. I wonder about the  
22 value of removing benefits. That seems to be a

1 red flag because the first thing you see is  
2 benefits, and this sounds specifically pro  
3 cannabis. And then oh, yeah, they threw in that  
4 other stuff. But if we say, research the risks  
5 and costs, and those are things we don't know  
6 about, that's where the concern lies, right?

7 CO-CHAIR BEEMAN: How about a positive  
8 statement that gets us a little off the hook and  
9 says, engage with other federal agencies to  
10 research the benefits and costs of medical  
11 cannabis and psychedelic drugs?

12 The key is engagement with the people  
13 that actually can make the decision. I think the  
14 worry is -- and I would agree with that. My  
15 health system, the same thing. You know what?  
16 We're not taking a big lead in medical cannabis.  
17 We're seeing some bad stuff that's happening in  
18 our emergency departments where some kids have  
19 taken it. And so we don't want to be the lead on  
20 this.

21 Having said that, I think it's  
22 appropriate for the VA with two million potential

1 users to engage with others to allow that group  
2 of people to be studied but not to be the one  
3 that's on, unfortunately, the bleeding edge of  
4 this stuff. And I think it's a hot potato in  
5 Congress.

6 And the last thing that the VA needs  
7 is to be a hot potato and say, well, the VA  
8 recommended this and Congress won't approve of it  
9 and then have everybody mad at the VA or Congress  
10 mad at the VA which, to me, would be even worse.

11 MR. KHAN: So just to comment,  
12 listening to both of you, I would not make this  
13 recommendation. I wouldn't even touch this thing  
14 because we want VA -- we want to give VA more  
15 power to do things, not to get in a position  
16 where it becomes more adversarial since you both  
17 have already reached the higher level.

18 MR. POTOZNIAK: Yeah. I mean, I  
19 think even being from the Left Coast, I  
20 definitely struggle with this recommendation  
21 after being a clinician in addiction treatment  
22 for ten years and seeing slews and slews and



1 veterans on pot that they don't -- a lot -- I  
2 mean, there may be two million veterans that self  
3 medicate with cannabis. But there are millions  
4 more alcoholics that claim it's helping them too.

5 And I don't know -- I'm not at the  
6 place yet in my mind where I can say that this  
7 avenue is actually a good one because I've  
8 actually seen many more adverse consequences of  
9 personality changes, psychosis. And people don't  
10 like to mention it as a gateway drug, but it is  
11 for some people.

12 CHAIR LEINENKUGEL: And let me tell  
13 you the person we talked to yesterday brought  
14 that out. The 18 to 24 year olds, and 33 percent  
15 of that population has either tried or is using  
16 cannabis at this point and it's accelerating.

17 MR. POTOZNIAK: And at a different  
18 time in history, we might call that an epidemic.

19 CHAIR LEINENKUGEL: Right. But here's  
20 the importance of why I believe we need to do  
21 this. And it's not -- as we discovered yesterday  
22 and thought about it last night up through this

1 morning, it's not just potential benefits. And  
2 that's a word I want to put in because I want to  
3 leave it, Mike, for this reason.

4           There is going to be, if there is not  
5 already, an epidemic. There are side effects and  
6 downsides that you have seen and notice in your  
7 clinical practices. There potentially may be  
8 some benefits. We don't know what we really  
9 don't know if we don't do the due diligence that  
10 I think we owe our veterans to research it.

11           And we should be researching and not  
12 just for our veterans but I think for our country  
13 because this is something that is now in two-  
14 thirds of our states. It's coming fast to a lot  
15 of other states.

16           So I mean, it's going to be there  
17 until it's researched and until what you as  
18 clinicians, as Commissioners have discovered in  
19 emergency rooms and with other veterans something  
20 that I think we need to find answers to which  
21 will probably be more risks than benefits.

22           CO-CHAIR BEEMAN: So Jake, you just

1       said something that's critical for me and that is  
2       I would like to hear something like engage with  
3       other federal agencies to assess the potential  
4       benefits and risk of medical cannabis in the  
5       treatment of these conditions.

6                I like the risk piece because there's  
7       an implication to me here that we think it's good  
8       and we should -- we don't know if it's good.  
9       Everybody is rushing to judgment because they've  
10      been wanting to do this for years. And so that's  
11      a potential --

12             MS. MAGUEN: Yeah. I would go a step  
13      further and maybe start with the short and long-  
14      term risks. So having the benefits be a  
15      secondary piece if we're going to go this route  
16      and to really lead with short and long-term risks  
17      and costs.

18             CHAIR LEINENKUGEL: Well, I like that  
19      even better, Shira, because --

20             MR. ROSE: You want to do both.

21             (Simultaneous speaking.)

22             CHAIR LEINENKUGEL: I think there has

1 to be potential. It's --

2 MS. MAGUEN: Yeah, because we -- I  
3 mean, I think we --

4 CHAIR LEINENKUGEL: -- passive.

5 MS. MAGUEN: Right. I mean -- or we  
6 could say, long-term -- yeah, I mean, I think  
7 potential makes it so that it's more we're in the  
8 process of discovery and that's what research is  
9 about. But then I would have the benefits be a  
10 clause that's secondary. Potential benefit,  
11 yeah.

12 MR. JONAS: You want to do both risk  
13 and benefits when you're doing the research.  
14 That's what you're trying to weigh with the  
15 research in those areas. So they should be  
16 embedded in that. But what we're really talking  
17 about is doing research, right? Because we just  
18 don't know. It's gaps.

19 And so rather than table the whole  
20 thing because it is an important area, especially  
21 for veterans that are using it a lot, I suggest  
22 we -- in the spirit of simplification perhaps do

1 a compromise and roll this into the research  
2 recommendations of Recommendation No. 2 and put  
3 it up fairly high instead of making it a separate  
4 recommendation. Because it is do more research  
5 basically on risk and benefits. And we've  
6 already said that about a bunch of other stuff.

7 CHAIR LEINENKUGEL: That's absolutely  
8 brilliant because it takes this out of being a  
9 major headline and puts it into the context of  
10 what we truly are asking for is research. It  
11 does not ignore it and then you'd go through the  
12 normal research channels as well to get to that  
13 place which is FDA and NIDA.

14 MR. POTOZNIAK: Mr. Chair, I second  
15 that option.

16 MS. MAGUEN: Okay. Hold on. My only  
17 thought on that would be that we really framed  
18 everything around very specific searches that we  
19 did. And so I'm just worried about putting this  
20 in and it not being a clear link to the searches  
21 that we did.

22 So we did look at cannabinoids, but

1 that's very, very different than looking at this  
2 particular piece. So I don't want people to read  
3 it and there's a flow. And then all of a sudden,  
4 there's this thing that doesn't go along.

5 MR. ROSE: We did, however, point out  
6 --

7 CHAIR LEINENKUGEL: We did all of that  
8 work. You're right.

9 MR. ROSE: Right. We did, however,  
10 point out that there were as we didn't look at  
11 under the systematic reviews but are still  
12 important. And this, I think, falls into it.

13 MS. LARUE: Frankly, I think it's a  
14 lot of work to make this integrated where it  
15 makes sense in that section. I think for less  
16 work, we can work on the tone here. For example,  
17 using Tom's suggested words for the  
18 recommendation and changing the order. I think  
19 saying risks first versus benefits first connotes  
20 a completely different intention in the  
21 recommendation.

22 If you look at the background right

1 now, it talks about the cutting edge research  
2 which presumably is promoting cannabis use,  
3 psychedelic use and so forth. And I think if we  
4 perceive that or follow it, the beginning and the  
5 end is always way people read, with an important  
6 message that about two million veterans are self  
7 medicating and we don't understand what is  
8 happening because they are doing that.

9 That, again, would change the tone of  
10 this dramatically and capture that we are not  
11 promoting cannabis use. We are promoting  
12 understanding what's going to happen because the  
13 veterans are doing it anyhow.

14 And that's a completely different tone  
15 than what's here right now. But it would take a  
16 tweak at the top in one paragraph versus hours of  
17 work to integrate something that wasn't written  
18 to go with the other section.

19 MR. KHAN: Wendy, in focus group  
20 questions, was there any info given by the  
21 veterans?

22 PARTICIPANT: We're not taking any

1 questions now.

2 (Laughter.)

3 MR. KHAN: No, no, I'm just asking  
4 because another place that you can put it is in  
5 number three because it is the -- it's coming  
6 from the veterans. And if they're taking it, you  
7 can put it in number three condition.

8 MS. LARUE: Honestly, that would be a  
9 stretch. It did come up in some of the focus  
10 groups. One person with chronic pain said it  
11 didn't even touch his pain. But I think not in  
12 the spirit of --

13 CHAIR LEINENKUGEL: You know what?  
14 Let me step in here.

15 MS. LARUE: -- this is a recent  
16 recommendation.

17 CHAIR LEINENKUGEL: Let's not hide the  
18 fact we've had it out there. We discussed it  
19 last month. We got to this place last month. We  
20 got some really good feedback yesterday.

21 So we're in the midst right now and I  
22 think we're really close that I would vote to



1 keep this as a standalone, to not hide it, to be  
2 up front with the selective rephrasing and risks  
3 being the highlighted. And I think we all agreed  
4 with that as a major change.

5 And I would still leave it passive  
6 with the potential risks and benefits because to  
7 Wayne's point, that's what the research is for.  
8 And basically what we're asking is legislatively  
9 do something that clears the path for the VA to  
10 use their research teams, which are some of the  
11 best in the world, that has a population that's  
12 already self medicating as a subset group to do  
13 the research on.

14 I think that's really what we're  
15 asking and probably going to find out because in  
16 the last two months I've heard from the  
17 clinicians on this Commission that there's  
18 potential major downside rather than what we're  
19 hearing from the anecdotal stories, right?

20 MS. MAGUEN: Right. And then just  
21 that we don't know the long-term effects because  
22 those --

1 CHAIR LEINENKUGEL: We don't know what  
2 we don't know as I said, correct.

3 MS. MAGUEN: Yeah. I also just want  
4 to add too. I know that there is already  
5 existing legislation. So I think it would look  
6 better if we were able to cite some of that here.  
7 So I know, like, the American Psychological  
8 Association has certain positions, and there's  
9 already legislation out there. So to incorporate  
10 that maybe would be a good step as well.

11 CHAIR LEINENKUGEL: The last piece,  
12 Matt, wasn't there four or five pieces of  
13 legislation that we're aware of, both on -- on  
14 both sides currently pending in some form?

15 MR. KUNTZ: I know there was a very  
16 big one with HVAC that they were working on. I'm  
17 not sure exactly how this fits into those. And  
18 those pieces of legislation maybe more for or  
19 against than what we're looking for.

20 So in this particular one, while we're  
21 trying to get our other ones picked up and  
22 weaving them into existing legislation, if we

1 don't want to be on the for side of this, we may  
2 not -- we're specifically going really pragmatic.  
3 And that may -- in this particular one, it may be  
4 better to avoid legislative --

5 CO-CHAIR BEEMAN: I agree with that,  
6 Matt, and I think so. I think findings has to be  
7 toned down a little bit because it basically  
8 says, in spite of the evidence that it's great,  
9 the federal government is blocking the adoption  
10 of this. I'd rather see us say something like  
11 you just said, the VA will follow federal  
12 guidelines and will cooperate with other federal  
13 agencies in studying as appropriate.

14 I mean, that's the kind of tone down  
15 I'd like to see because what's happened is  
16 everybody rushed to judgment on this. And now  
17 we're just starting to see the beginning stuff  
18 that's starting to impact people in emergency  
19 departments and some young people. Where there  
20 was some benefit early on, there's some other  
21 issues that are starting to happen.

22 And so I think -- Wendy, I think

1 Jake's idea of keeping it the way it was with the  
2 changes we've just talked about, I could support.  
3 And I'd like to support the motion that's on the  
4 floor with those changes.

5 CHAIR LEINENKUGEL: Can we go back?  
6 Wendy, did you write down the recommended  
7 paraphrasing of the Recommendation 9 with some of  
8 the changes at this point?

9 MS. LARUE: I have lots of different  
10 versions of it here. But in essence --

11 CHAIR LEINENKUGEL: Let's try to work  
12 through.

13 MS. LARUE: -- we want to collaborate  
14 -- or engage with other federal agencies to  
15 explore the potential risks and benefits of  
16 medical cannabis and psychedelics, blah, blah,  
17 blah, the rest of that.

18 MR. ROSE: Do we have research in  
19 there somewhere?

20 MS. LARUE: I think we changed  
21 research to explore. But we can go back to  
22 research.

1 MS. MAGUEN: And I think we also  
2 wanted something about short and long term in  
3 there as well.

4 MS. LARUE: Short and long-term  
5 potential risk and benefits.

6 MS. MAGUEN: Yes, just as long as  
7 those phrases are in there so it's not only the  
8 short term that we want to study but really the  
9 longitudinal effects as well.

10 MR. ROSE: And the research piece.

11 MS. LARUE: So do we want to go back  
12 to research instead of explore as a more specific  
13 term?

14 CHAIR LEINENKUGEL: Yes, because we're  
15 asking for research, yeah.

16 CO-CHAIR BEEMAN: I think what I had  
17 recommended was engage with other federal  
18 agencies.

19 MS. LARUE: Yes.

20 CO-CHAIR BEEMAN: I think that's still  
21 important because I think it lets them take the  
22 lead. And the other thing you can say about the

1 research, and make VA research competencies  
2 available as necessary, or something like that.

3 MS. LARUE: That would be a good  
4 implementation --

5 CO-CHAIR BEEMAN: Right.

6 MS. LARUE: -- step.

7 CO-CHAIR BEEMAN: Okay.

8 MS. LARUE: Because we're going to get  
9 real worry here shortly. But that tells VA this  
10 is the part we want you to do.

11 CO-CHAIR BEEMAN: Right.

12 CHAIR LEINENKUGEL: Let's take a ten-  
13 minute break. And Tom, if you would stay  
14 available. Matt, this is yours. Let's everyone  
15 else take a 10, 15-minute bio break, be back in  
16 here 1500, 3:00 o'clock civilian time, so that we  
17 can get some wording on this that we can then  
18 vote on. Does that make sense?

19 (Whereupon, the above-entitled matter  
20 went off the record at 2:45 p.m. and resumed at  
21 3:04 p.m.)

22 CHAIR LEINENKUGEL: Commissioners and

1 general public, welcome to the -- what I  
2 anticipate to be the final session of today's  
3 recommendations being forwarded. And at this  
4 time, we'll go back to the work that we've had  
5 done on Recommendation 9, and I'll, again, defer  
6 to Commissioner Kuntz. Matt.

7 MR. KUNTZ: Thank you, Mr. Chairman.

8 Up on the slide is the new version of the  
9 recommendation. Engage with other federal  
10 agencies as appropriate to research the potential  
11 short and long-term risks as well as benefits of  
12 medical cannabis and psychedelic drugs. That is  
13 the recommendation.

14 Before there's a second, I want to  
15 give just one kind of statement. The people that  
16 I work with, I do see negative things from  
17 marijuana. But what's interesting is from the  
18 group that I see, it's usually going into mania  
19 from using marijuana. So they're biologically  
20 susceptible to go into mania. It's not  
21 everybody. It's a small subsection.

22 But what's interesting about that

1 group is it's often the same group that goes into  
2 mania when they get prescribed an antidepressant.  
3 So if you have bipolar disorder, some of these  
4 things, you can respond very negatively to  
5 substances.

6 So that's something I see every day,  
7 and I am glad that we're at least giving these  
8 tools to look at it more because it does -- it  
9 may be how we figure out what causes the negative  
10 effect of that antidepressant. We start by  
11 discovering what causes the negative effect of  
12 cannabis.

13 So thank you.

14 MR. ROSE: I would second  
15 Recommendation No. 9 as amended.

16 CHAIR LEINENKUGEL: Thank you,  
17 Commissioner Rose. Any further discussion,  
18 comments, questions of the new, enhanced  
19 Recommendation 9?

20 MS. MAGUEN: I was going to say I  
21 really like the way that this is worded now.  
22 Just to your point about certain groups being at



1 higher risk. If you think that that's very  
2 important in what you've seen, you might just  
3 want to mention that as part of the  
4 implementation in the research to particularly  
5 study particular groups that might be at risk.  
6 And I don't know. If you feel like that's  
7 important, I would mention it there too.

8 MR. KUNTZ: Thank you.

9 MR. POTOZNIAK: And I would just add  
10 on to what Shira said. There also is the  
11 research around the increased risk of psychosis  
12 which is separate from the mania. And I've seen  
13 a few cases -- because I deal with the volume of  
14 substance use, I've seen a few cases of kind of  
15 irreversible, like, non-medication responded  
16 psychosis which is different than the mania, so -  
17 -

18 MR. ROSE: I think also with people  
19 that are diagnosed with schizophrenia young and  
20 they start using marijuana. That can really make  
21 it much worse.

22 CHAIR LEINENKUGEL: Any further

1        comments, questions?  If not, we'll go to  
2        Commissioner Harvey.

3                    MR. HARVEY:  Aye.

4                    MR. KHAN:  Nay.

5                    MR. KUNTZ:  Aye.

6                    MR. JONAS:  Yay.

7                    MR. AMIDON:  Yay.

8                    CHAIR LEINENKUGEL:  Yay.

9                    CO-CHAIR BEEMAN:  Yay.

10                   MR. POTOZNIAK:  Yay.

11                   MS. MAGUEN:  Yay.

12                   MR. ROSE:  Yay.

13                   CHAIR LEINENKUGEL:  We have nine yays,  
14        one nay.  The Recommendation No. 9 passes.  And  
15        thank you, Matt Kuntz, and also Commissioners for  
16        the work that you did on the rewording which I  
17        think is a much stronger recommendation at this  
18        point and much more what I would call edible  
19        going forward with our constituents as well.

20                   So with that, let's go to  
21        Recommendation 10.

22                   MS. LARUE:  This is on page 102, and

1 this is regarding veterans' safety and  
2 transportation.

3 MR. KUNTZ: Thank you, everyone. The  
4 recommendation is ensure that veterans can safely  
5 access care by reviewing and updating  
6 transportation and security processes throughout  
7 the VA system. I want to point out just for the  
8 drafter's sake, the problem does need to be  
9 expanded in that section to cover security as  
10 well. The problem section currently just covers  
11 transportation.

12 So we have two different issues here,  
13 and transportation is one thing that we saw in a  
14 number of different locations and the  
15 difficulties. And it's also something that while  
16 we were in session, the transportation industry  
17 was changing.

18 For instance, when I use Google Maps  
19 to figure out how to get to our conference  
20 center, scooters started showing up while we were  
21 in session. So the transportation system is  
22 changing. Being from rural American, before my

1 first Commission meeting, I did not know how to  
2 use Uber. Like, had to use Uber to be a member  
3 of this Commission.

4 And so it is something that is  
5 changing while we were here. And I think that  
6 the reality is that the VA transportation system  
7 needs to continue to try to keep up with what's  
8 going on in the rest of the world and how people  
9 get places.

10 We used a snapshot from a VHA  
11 directive to try to explain how complex the VA  
12 health care transportation system is. That  
13 snapshot was one of the more hard to understand  
14 couple of paragraphs that I have ever read.

15 So we use that to highlight that's  
16 what's out there. But the reality is, is even  
17 just looking at Google Maps, you can see that the  
18 transportation system is changing. And this  
19 recommendation tasks the VA with trying to keep  
20 up with that.

21 And again, while we were engaged as a  
22 Commission, Commissioner Khan brought up the

1 security challenges and Dr. Potoczniak mentioned  
2 how that does relate to real life and preventing  
3 suicides on VA campuses. So we were looking at  
4 that.

5 But at the same time, the Inspector  
6 General's office looked at the VA and highlighted  
7 some very serious issues and provided some very  
8 serious recommendations. So we incorporated  
9 those in our recommendation and basically saying  
10 that that's where we expect the VA to go.

11 Security is a part of getting veterans  
12 the health care that they need. And we agree  
13 with Secretary Wilkie in his statement that  
14 realignment of the VA police force will be the  
15 most extensive since the creation of the police  
16 force. It will fundamentally change  
17 standardization and oversight of the enterprise.

18 So there's an issue that needed to be  
19 addressed. This statement from Secretary Wilkie  
20 I believe was from October of this year. So it  
21 was something that we saw too in this  
22 recommendation for this.

1 Any questions?

2 MR. KHAN: Chairman, I would like to  
3 second it, sir.

4 CHAIR LEINENKUGEL: Thank you, Jamil.  
5 We have a second on the floor to Recommendation  
6 10. Are there any other comments, concerns,  
7 questions in that regards to this recommendation?

8 MR. POTOZNIAK: Yeah, I'd like to  
9 just -- in looking at the -- oh, where is it?  
10 It's in the implementation. One thing that could  
11 be done that might make it a little bit easier  
12 and gear it towards mental health is right now  
13 the way that special transportation is set up,  
14 mental health diagnoses don't qualify for  
15 requiring transportation.

16 So if you have somebody who has a  
17 traumatic brain injury or has post-traumatic  
18 stress and really has difficulty navigating, you  
19 can't order transportation for them under special  
20 mode. You can only do for physical conditions.

21 So something that -- and that's out of  
22 the clinicians hands. So even if I have somebody

1 that is homebound because of mental health  
2 reasons, I can't get them transportation, you  
3 know? So something that could be put into  
4 implementation is to change that part and allow  
5 transportation -- special mode transportation to  
6 be ordered for people with mental health  
7 conditions.

8 MR. KUNTZ: Wendy, did you get that?  
9 Okay. I support that being added to the  
10 recommendation. I think it makes sense to have  
11 that as its own standalone bullet under the first  
12 bullet in Executive Branch.

13 CHAIR LEINENKUGEL: Yeah. I think,  
14 Matt, my comment was on this since last month,  
15 that specificity is going to rule the day coming  
16 out of this because it is so broad. When you're  
17 talking -- the recommendation is strong. Ensure  
18 that veterans can safely access care by reviewing  
19 and updating transportation and security  
20 processes throughout the VA system.

21 I think there's a lot in that that the  
22 VA would have to implement that we're unaware of.

1 And I think it goes back to on the security side  
2 a problem that's already been identified from an  
3 IG that the Secretary has made a predominant  
4 statement about.

5 And so this is one of the points of  
6 possibly being redundant. Or you could reflect  
7 and say, we want to make sure that he's going to  
8 actually do this. So I mean, you have to put it  
9 in the context because the problem has been  
10 identified. Security is aware of it. Secretary  
11 has promised action.

12 So I mean, is that the intent here, to  
13 ensure that that actually is coming from this  
14 Commission? Hey, we know you identified the  
15 problem on the security side. Now we're stating  
16 the obvious that -- or the unobvious that either  
17 we don't trust him to implement it or the VA to  
18 implement or both.

19 MR. ROSE: I think just the way the  
20 timing came out on this, though. I mean, this is  
21 something that we pulled out before that  
22 announcement was made. So I think if the



1 Secretary has already made that or has made that  
2 something he wants to accomplish, this just adds  
3 more support to it from what we've seen during  
4 our Commission.

5 MR. KUNTZ: And I think I agree with  
6 Commissioner Rose in that this is a big change  
7 and we're very glad that the Secretary is behind  
8 it. He's going to have to have support from SVAC  
9 and HVAC, and this report will provide a little  
10 bit more fuel for him to put in that engine.

11 MR. ROSE: And one other thing, if I  
12 may, going back to the transportation. I mean,  
13 the point that Mike brought out, I mean, that's  
14 critical. I mean, people with mental illness  
15 need that transportation maybe more than somebody  
16 else.

17 The mental health system, whether  
18 you're in the VA or on the outside, is very  
19 difficult to navigate. And if you have to get  
20 from point A to point B and you cannot have that  
21 transportation provided, you're in bad shape.

22 Thank you.

1                   CHAIR LEINENKUGEL: Yeah. I mean, I'm  
2 perplexed by that, and I think that that's why  
3 it's a necessary one to have as far as  
4 transportation for just what you stated, Jack,  
5 and Mike brought out here that I was unaware of.

6                   But I mean, Uber, as we talked about  
7 in the last few months, has been trying to make a  
8 connection with the VA to do something along  
9 these lines. And also the missed appointment  
10 type of situation to greatly deviate from that as  
11 a potential possibility.

12                   So I like it. I wonder if we just --  
13 and Matt has already had under transportation  
14 some of those other rideshare things, et cetera.  
15 So I think it's deep enough. All right?

16                   MR. KUNTZ: Thank you.

17                   CHAIR LEINENKUGEL: And we had a  
18 second from Jamil. Any further comments,  
19 recommendations?

20                   (No audible response.)

21                   CHAIR LEINENKUGEL: Hearing none,  
22 Commissioner Harvey?

1 MR. HARVEY: Aye.

2 MR. KHAN: Aye.

3 MR. KUNTZ: Yay.

4 MR. JONAS: Yay.

5 MR. AMIDON: Yay.

6 CHAIR LEINENKUGEL: Yay.

7 CO-CHAIR BEEMAN: Yay.

8 MR. POTOZNIAK: Yay.

9 MS. MAGUEN: Yay.

10 MR. ROSE: Yay.

11 MS. LARUE: Super yay.

12 (Laughter.)

13 CHAIR LEINENKUGEL: Now we're going to  
14 move on to number 11. Oh, there is no 11.

15 MS. LARUE: See, when you --

16 CHAIR LEINENKUGEL: Started with 30.

17 MS. LARUE: When you get down to ten,  
18 it goes a lot faster, doesn't it? But the very  
19 most important thing needs to happen still and  
20 that is collecting signatures. So I want to  
21 briefly explain how we are going to do this. I  
22 even brought a sample.

1                   MR. KUNTZ: Wendy, we still need to  
2 talk about the order.

3                   MS. LARUE: Oh, yes.

4                   MR. KUNTZ: That had been put in the  
5 parking lot.

6                   MS. LARUE: Yes, we do. We should do  
7 that first and then come back. So the proposal  
8 was to move what is currently Recommendation 3 to  
9 be Recommendation 1 and then just file things  
10 back. So the current Recommendation 1 --

11                   MR. KUNTZ: No, no. I'm sorry. It  
12 was to swap one and three. So two would still  
13 stay where two is.

14                   MS. LARUE: With research?

15                   MR. KUNTZ: We would start out with  
16 the veterans' perspective, move into the  
17 research, and then begin with the bigger --

18                   MS. LARUE: The bigger picture?

19                   MR. KUNTZ: Yeah.

20                   MS. LARUE: Okay.

21                   MR. KUNTZ: So that --

22                   MR. AMIDON: Commissioner, can I ask

1 one question, though? Would that still presume -  
2 - to your point, there's additional information  
3 from the veteran source that we can sprinkle in  
4 throughout. Is it not mutually exclusive that  
5 way?

6 MR. KUNTZ: I think that it still is  
7 a good idea to add in the veterans' perspectives  
8 wherever. This is a different motion. But  
9 either way, I think that quotes and however we  
10 want to sprinkle this. But the main thing is, is  
11 from my perspective, when I read it, that  
12 veterans' perspective piece gave us a ton of  
13 credibility.

14 That research piece gave us a ton of  
15 credibility, and then you start moving in to the  
16 meat of the recommendations. And it reads as a  
17 lawyer building a case saying, boom, boom. We  
18 studied this. We studied this. We studied this.  
19 And then we move into this big VA transformation  
20 recommendation.

21 I think it's incredibly powerful. If  
22 you start out with a giant recommendation without

1 letting people know what got us there, for me, it  
2 doesn't feel as powerful.

3 CO-CHAIR BEEMAN: Matt, this is Tom.  
4 I want to support your recommendation. I was  
5 fine up until this point. You said you were a  
6 lawyer. And I thought, oh, that's right. He's  
7 lawyer.

8 (Laughter.)

9 CO-CHAIR BEEMAN: The only other  
10 suggestion I have, and it gets back to what the  
11 other Matt was saying. And that is I would like  
12 to recommend that maybe you and Wendy look at  
13 some of the quotes and we take one to two quotes  
14 that are relevant to each section and use them on  
15 top of the section that says --

16 CHAIR LEINENKUGEL: Voice of the  
17 veteran.

18 CO-CHAIR BEEMAN: -- the voice of the  
19 veteran. Actually, so it's woven throughout each  
20 one. So you have -- like you said, we're going  
21 to have a quote in the beginning which I really  
22 liked. But have a quote from a veteran, one or

1 two.

2 Like, for transformation, we see  
3 there's problems with the system or maybe I got  
4 sent here. You could put a quote that's  
5 relevant. And I don't know of a quote, so I'm  
6 sure you could really parse them out, so --

7 MS. LARUE: So my friends --

8 CO-CHAIR BEEMAN: No? Are you telling  
9 me no?

10 MS. LARUE: Not no. Not no.  
11 Qualified yes. Jennifer and I were actually  
12 discussing this very topic at lunch today, and  
13 we're not fans of callout boxes, per se. They  
14 usually are handled poorly and actually detract  
15 from important content.

16 But we have great quotes. And what we  
17 have not done is a tremendous amount of design  
18 work partly because we're limited to just the two  
19 of us to put this together and partly time, and  
20 so we believe that we can highlight each  
21 recommendation a little more with some design  
22 work revolving around a key quote for each one.

1 I don't think that precludes us from  
2 integrating some more quotes into the body of the  
3 text. Because for many of these recommendations,  
4 there are things that come to mind just -- I  
5 don't even have to read back to know where to  
6 find them.

7 And because we have used NVivo to code  
8 the text, it's just a matter of doing a word  
9 search. It's not hard. It's all right there.  
10 It's all labeled in a way that makes that  
11 contextualization really simple.

12 CO-CHAIR BEEMAN: You sold me. So I  
13 want to come out and support of the different --  
14 of the new order of things --

15 MR. KHAN: Mr. Chairman --

16 CO-CHAIR BEEMAN: -- with the  
17 understanding that we would pepper the thing with  
18 quotes.

19 MS. LARUE: You're going to be blown  
20 away.

21 MR. KHAN: Sir, I concur with making  
22 present Recommendation 3 as number one, and I



1 would like to put a quote, I only have one life  
2 to give. So Wendy, you can write it down.

3 (Laughter.)

4 CHAIR LEINENKUGEL: So let's go back  
5 to the actual order for the new proposed  
6 recommendation.

7 MR. JONAS: Can I offer a  
8 counterargument here first?

9 CHAIR LEINENKUGEL: Yes, you can.

10 MR. JONAS: Thank you. So I disagree  
11 with swapping those out. I'm a forest before the  
12 trees kind of guy, and I think the first  
13 recommendation lays out the forest and says, this  
14 is what needs to happen. There's ample  
15 justification within it as to how the VA is  
16 already attempting to do that and how our health  
17 care system is already going in that direction.

18 The other recommendations then fill in  
19 that. For example, in Recommendation 3, we even  
20 suggested that it's referring back to  
21 Recommendation 1 to say, person centered. We  
22 need to do more about that. See Recommendation 1

1 rather than putting in an additional overarching  
2 component.

3 And in the evidence-based component,  
4 fundamentally, what we found that is that, gee,  
5 there isn't enough research there if we use this  
6 kind of methodology. And so having that up above  
7 the overarching model recommendation would again  
8 bring in some things that are pointing to now a  
9 recommendation that's down in the third part.

10 And so I'm in favor of leaving it the  
11 way it is. And at the same time, I think the  
12 voice of the veterans is absolutely essential.  
13 And we should have both the quotes spread  
14 throughout the entire document including right at  
15 the beginning if we can find a good quote from  
16 these components where the veteran says, this is  
17 what happens, and Recommendation 3 and its full  
18 components with its references. That would, I  
19 think, reinforce that component.

20 So that's my suggestion.

21 CHAIR LEINENKUGEL: Commissioner  
22 Jones, I forgot to add you sound like a lawyer as

1 well.

2 MR. JONAS: And I'm not a lawyer.

3 CHAIR LEINENKUGEL: You're making a  
4 strong case and argument as well, but we know  
5 you're a doctor, so -

6 MR. ROSE: Mr. Chairman, if I may make  
7 a comment. If we do not put the fires out, we  
8 will have neither trees nor forest. Thank you.

9 MS. LARUE: So a point to think about  
10 as the rhetorician sitting at the table is  
11 message. And I think each of you just needs to  
12 really think hard about what your priority is.  
13 We've talked a lot about stakeholders. And  
14 frequently, we talk about Congress, the  
15 President, the Secretary and so forth. The  
16 veterans are also stakeholders.

17 And I can tell you from all the visits  
18 this summer that there were quite a few veterans  
19 who did not think that we really were there to  
20 listen to them. They thought that what I spent  
21 my summer doing was a charade, and some were very  
22 vocal. And they have an organization where they

1 have talked about the fact that they think our  
2 work is a charade.

3 So I think what you need to think  
4 about, and I don't have -- I'm not leaning either  
5 way. I think you as Commissioners need to make a  
6 decision based on this.

7 Is making it clear to that stakeholder  
8 group that you did take them seriously, does that  
9 outweigh what you need to say to the other  
10 stakeholder groups in terms of priority? And  
11 that will determine whether you need to  
12 acknowledge what they have to say first or speak  
13 to Congress and the Secretary first.

14 CO-CHAIR BEEMAN: So my eminent  
15 colleague, Dr. Jonas, I really support his -- the  
16 concept of the transformation. But for me, this  
17 isn't a strike issue. I think by saying we  
18 talked to the veterans, we did research, and  
19 we've come up with a transformative system works  
20 in my mind, and I can convince myself of that.

21 So even though I liked the original  
22 thing, I have come to believe that it's not a

1 strike issue for me. And I think it's a logical  
2 thing to do. So that's why I support it. I just  
3 wanted you to know.

4 MR. JONAS: So I would be open to that  
5 if we can make sure we frame it just the way you  
6 just said it. Okay? Which is in the  
7 introduction and the description as to the way  
8 it's organized, here is why we're presenting it  
9 in this way. The first principle in the new  
10 model is person centered, right? So that --

11 MR. JONAS: Wayne --

12 MR. JONAS: -- illustrates that.

13 CHAIR LEINENKUGEL: -- it bolstered  
14 this discussion. I think that this is going to  
15 lead into a stronger executive summary as well.

16 MS. LARUE: You bring up the other  
17 point that Jennifer and I discussed at lunch  
18 which is that the introduction must be changed  
19 because it is couched in the order that things  
20 are now. And it won't take much work to say, we  
21 lay out these things so that you will understand  
22 this transformational model. Just the end of the

1 introduction is going to have to --

2 MR. JONAS: You've talked me into it.

3 I agree.

4 MS. MAGUEN: I was just going to add  
5 one more quick thing. So I do still think we  
6 have to deal with the piece where we reference.  
7 So in the recommendation that is about the  
8 research, we do reference the model. So I just  
9 wanted to add that logistical piece, yeah.

10 MS. LARUE: Just so you know, those  
11 sorts of nitty-gritty things like cross  
12 referencing and so forth, that is on mine and  
13 Jennifer's list for the next couple of weeks.  
14 It's just part of the process of prepping for  
15 publication. So no one needs to worry about  
16 cross referencing to the wrong number and  
17 whatever. We'll check all of those. Well, it's  
18 briefly addressed in the introduction as to will  
19 be, anyhow.

20 Okay. So now can I get to --

21 CHAIR LEINENKUGEL: No.

22 MS. LARUE: No?

1 CHAIR LEINENKUGEL: No.

2 (Laughter.)

3 MS. LARUE: Nobody better leave  
4 without signing.

5 CHAIR LEINENKUGEL: I think we need a  
6 formal vote on this, and I'm waiting for a  
7 second.

8 MR. ROSE: Second.

9 CHAIR LEINENKUGEL: And what is the  
10 actual reorder now?

11 MR. ROSE: The reorder would be to  
12 replace number one --

13 CHAIR LEINENKUGEL: So it's --

14 MR. ROSE: -- with three.

15 CHAIR LEINENKUGEL: Yeah, got it.

16 MR. ROSE: Swap number one with three,  
17 keep two where it is.

18 MS. LARUE: Swapping.

19 CHAIR LEINENKUGEL: Swap order.  
20 Three, two, one. I wanted that to be clear,  
21 right?

22 MR. ROSE: Three, two, one?

1 CHAIR LEINENKUGEL: Yes.

2 MR. ROSE: Three, two, one.

3 CHAIR LEINENKUGEL: And do I hear any  
4 second at this point?

5 MR. ROSE: Second.

6 CHAIR LEINENKUGEL: Any further  
7 discussion, questions, comments? If not --

8 MR. HARVEY: Aye.

9 MR. KHAN: Aye.

10 MR. KUNTZ: Yay.

11 MR. JONAS: Yay.

12 MR. AMIDON: Aye.

13 CHAIR LEINENKUGEL: Yay.

14 CO-CHAIR BEEMAN: Yay.

15 MR. POTOZNIAK: Yay.

16 MS. MAGUEN: Yay.

17 MR. ROSE: Yay.

18 CHAIR LEINENKUGEL: Unanimous, three,  
19 two, one.

20 MS. LARUE: Okay. No one may leave  
21 the room.

22 CHAIR LEINENKUGEL: Can we formally



1 close? At this time, this is the last  
2 opportunity for today and for this Commission.  
3 And we already made comments from each  
4 Commissioner at the start of this meeting on  
5 December 12th.

6 And I, again, want to congratulate and  
7 thank the Commissioners for your diligence, your  
8 hard work. You've heard me talk about it the  
9 last couple of months but also the term, gung-ho,  
10 and this group has been gung-ho.

11 But I think that we're onto something  
12 big, bigger than I ever anticipated 17 months ago  
13 to be honest with all of you. First time  
14 Commission and being able to work and disagree  
15 and deliberate and debate and then come back to a  
16 three, two, one is pretty neat.

17 And to get it down from the 30-plus  
18 recommendations distilled tightly, I believe, to  
19 10 very solid things that will matter for our  
20 core customer as Commissioner Amidon just said  
21 which are our veterans and doing the right things  
22 for them and their mental health care.

1                   Just fabulous work, Commissioners. I  
2                   can't thank you enough because on a weekly basis,  
3                   all of you did more than I ever thought would be  
4                   done with this Commission. So thanks for  
5                   allowing me to be able to be part of your lives  
6                   over the last 17 months in making a difference, I  
7                   believe.

8                   We'll find out in 90 days or so for  
9                   the VA and for SVAC, HVAC, and certainly the  
10                  White House, to take these recommendations and  
11                  implement them properly to make a stronger  
12                  Veterans Affairs Association for our veterans.

13                  That being said, are there any other  
14                  comments of any other Commissioners at this time?

15                  CO-CHAIR BEEMAN: I just wanted to  
16                  thank Casin and his leadership and the rest of  
17                  the team. I felt that they were always there  
18                  with us, urging us on. The professionalism of  
19                  the VA staff was beyond compare, and I just  
20                  wanted to extend that to all of you. And I know  
21                  everyone feels the same way, so --

22                  MR. KHAN: You all have my phone

1 number, 24/7 I'm available to help any one of  
2 you. Thank you.

3 CHAIR LEINENKUGEL: No other comments  
4 at this time. I officially adjourn the meeting  
5 of the COVER Commission, December 12th, 2019.  
6 Thanks again.

7 (Whereupon, the above-entitled matter  
8 went off the record at 3:34 p.m.)

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Before: US DVA

Date: 12-12-19

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