UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

CREATING OPTIONS FOR VETERANS'
EXPEDITED RECOVERY (COVER) COMMISSION

OPEN SESSION

THURSDAY
SEPTEMBER 12, 2019

The Commission met in Suite 150A at the VHA National Conference Center, 2011 Crystal Drive, Crystal City, Virginia, at 9:00 a.m., Jake Leinenkugel, Chair, presiding.

PRESENT

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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 POTOCZNIAK, 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 (NAMI)

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CHAIR LEINENKUGEL: Good morning, everybody. Welcome to the COVER Commission meeting that is officially now in session. At this time, I would like Commissioner Khan to lead us in the Pledge of Allegiance.

DR. KHAN: Please join us.

(Pledge of Allegiance.)

DR. KHAN: Thank you.

CHAIR LEINENKUGEL: I would like to begin by introducing, to the general public and to attendees, the Commissioners that are currently present. And I'll start with myself, and we'll go around the table.

Jake Leinenkugel, Chairman, COVER Commission, Marine Corps veteran, family of Marines, and also a Marine and veteran advocate, and very proud to be part of this Commission.

MR. ROSE: Jack Rose, a Navy veteran, 26 years. I've also spent the last 19 years with
the National Alliance on Mental Illness, both at
the state and local level. And we have two adult
children who have lived with mental illness. And
I, too, am very proud to be a part of this
Commission.

Thank you, and good morning.

DR. POTOCZNIAK: Mike Potoczniak. I'm
an Army veteran and currently the Mental Health
Director at the Santa Rosa Clinic of the San
Francisco VA. Yes, happy to be on this
Commission. And thanks.

DR. MAGUEN: Hi. I'm Shira Maguen.
I'm a clinical psychologist by training.
Currently work at the San Francisco VA. I've
been with the VA system since 2001, and, in
addition to that, Workgroup 3 lead.

MR. HARVEY: My name is Tom Harvey.
I'm a veteran. I'm an Army veteran. I spent two
and a half years in Vietnam as an infantry
officer. I also spent much of my career working
on issues relating to veterans as Staff Director
of the Senate Veterans Affairs Committee, Deputy
Administrator of the VA, and Assistant Secretary of the VA for Congressional Relations. It's an honor to serve on this Commission with all of you.

COLONEL AMIDON: Good morning. Matt Amidon, Marine Corps, still serving as a Reservist, 27 years. And in my civilian capacity, I'm the Director of the Military Service Initiative at the George W. Bush Institute in Dallas, Texas. Thank you.

DR. KHAN: Good morning. Jamil Khan, United States Marine, Vietnam through Desert Shield/Desert Storm. It's an honor to be part of this Commission, and thank you very much.

DR. JONAS: So, I'm Wayne Jonas. I'm a family physician, an Army veteran, 24 years. I still see military and veterans in the clinic, and I'm very interested in whole-person care, which includes their mental health. And I've said this before, but I'll say it this time. I'm actually a four-generation veteran. My great-great-grandfather was a veteran, my grandfather,
my father. So, a long way for them, all Army, by the way.

(Laughter.)

MR. KUNTZ: I'm Matt Kuntz. I am a peacetime Army veteran. Got into mental health after losing a family member that was a servicemember to post-traumatic stress. And I am the Director of NAMI Montana, the National Alliance on Mental Illness for Montana, and then, also, the Director of the Center for Mental Health Research and Recovery at Montana State. I'm excited to be here.

CHAIR LEINENKUGEL: Thank you, Commissioners.

And I also want to note that Admiral Tom Beeman, another Commissioner, is the only Commission member that has been excused from this meeting, as six months ago he had a planned visit to see a good friend outside the country. So, he will be made aware of all the findings and discoveries and other further action items in relation to milestones and outputs that are
required coming out of this particular meeting.

So, that being said, I want to start
with what happened yesterday with five
Commissioners. We had the opportunity, through
the diligence of our support staff and Staff
Director and Hill representative, to be able to
go up and meet for the first time directly with
SVAC-HVAC staff, and also some key Members of
Congress, in order to see their awareness
situational updates as far as COVER, which came
out of the CARA legislation of 2016, and
certainly have an opportunity for the five
Commissioners to explain to them where we
currently are and where we need to go.

And also, we were delighted to learn
that there was a high receptivity, higher than
anticipated, into the outputs and outcomes of the
COVER Commission. And I would like to turn to
those Commissioners to give a brief synopsis of
their view and take from that particular day.
So, I'll start with Dr. Shira Maguen. Thank you.

DR. MAGUEN: Thank you.
I thought it was a very productive meeting. It was excellent to meet with both HVAC and SVAC staff. And I thought that everyone asked excellent questions. They were well-prepared. And it was also very good to hear about how they are thinking several steps ahead about the recommendations that we are going to make. I also heard loud and clear that they are ready for our recommendations and are hoping to get our deliverables as soon as possible. So, I think we will live up to that.

CHAIR LEINENKUGEL: Commissioner Harvey?

MR. HARVEY: I missed the afternoon meetings with the House Veterans Affairs Committee. I was there for the meeting with the State Veterans Affairs Committee. And obviously, they have two staff persons who are very much engaged in what we’re doing, to include one young woman who recently joined their staff from the National Alliance on Mental Illness, who’s very knowledgeable about that. And I was pleased to
see they were as engaged in what we are doing as we are.

CHAIR LEINENKUGEL: Commissioner Amidon?

COLONEL AMIDON: Again, I thought it was a very valuable and rewarding experience, the day on the Hill. I was also taken with their level of precise knowledge to Commissioner Maguen's comments on the questions they were asking, even specific to your Workgroup. So, I mean, I was very aware of their deep knowledge in what we're doing.

In addition to that, I think it was important to say that the way that some of the five legislative mandates are written can allow for scope and scale of many, many years of great effort. And so, they were accepting of some of the constraints that we are going to declare and are operating under as a Commission and seemed very accepting of that. So, it was good to hear that as well.

CHAIR LEINENKUGEL: Commissioner
MR. KUNTZ: So, from my perspective, I just want to start out by thanking Casin Spero and Dan Hanlon for their work in setting up the meetings. I've been to the Hill for quite a few times as a veterans advocate, and you can tell when your staff sets you up to succeed. And I'm really grateful for their work.

And it was obvious that our efforts are important to current legislative expectations, and they expect us to deliver a quality product. And they were also excited by the team that we brought before them. So, I'm really looking forward to where we go in the next few months to meet those expectations.

CHAIR LEINENKUGEL: Yes, and after that meeting -- and I thank you, Commissioners, for attending -- I thought it would be very beneficial for next month in October, and we'll get into more specifics as far as milestones and some deadline issues that we need to discuss as a Commission in this particular general session,
that it would behoove us and for HVAC-SVAC members to have the Workgroup leads. And I would certainly ask our Staff Director and, also, Hill representative, both Casin and Dan, to set up the Workgroup leads Commissioners to probably make that October visit, and then, also their overall leads to attend as well.

So, I think that that would make a lot of sense for further updates, because we were asked by both SVAC and HVAC, and a couple of also Congressionals, if we were going to be able to meet the deadline, which I, as the Chairman, told them that that is certainly our full intent. We know that we have a lot of things to discuss today that are probably pending. And I think that the general public needs to be aware of a couple of the issues that we have. Later in the day, we will be talking to each Workgroup lead as to the status and updates as to the current state of where they are with each of their particular Workgroup statuses; and also, how we need to get to outcomes.
So, it's a good time to talk about milestones to completion because, as a group of Commissioners, we came up with guiding principles that we talked about way back in April, of how we were going to operate together. And as Chairman, I think that we have done an exceptional job as a group of 10 to work in partnership in a very partisan way to actually tackle the subject of veteran mental health care within the VA and, also, looking at those veterans that are not currently being served by the VA, and how are their mental health care issues being met or served.

So, with that, we know that we set dates, saying that most of our data collection and work would be completed by the end of summer. Looking at my calendar, that's about two weeks away, officially, as the end of summer. We are getting close, but we do have gaps. And I know that it would be a pretty good time, after I sort of prefaced for the general public and for those on the call what the COVER Commission was
actually mandated as far as a time point.

We started back in July of 2018, and we were given 18 months to complete our outputs and final report, which would put us in the middle of January 2020 for that draft to be presented to the White House, the Secretary of Veterans Affairs, the Senate Veterans' Affairs Committee, and the House Veterans' Affairs Committee. Those are our key constituents.

And so, with that original mandate, the Commissioners agreed that we would be on time and on budget, and we're pretty much on track for that in most all cases. And we'll further talk about that in the October meeting.

So, as a group of Commissioners, we have been talking about some of the gaps, the data, the research that's required for us to get to solid recommendations that are going to make an impactful difference to each one of our constituents, that they can take and either say, boy, that's a great idea, a great suggestion; we need to legislatively mandate this, or get it
into a better practice mode, within the VA and
maybe looking at outside partners to help our
veterans in assistance with better mental health
care.

So, I would like to open it up at this
time, and I think just an open floor because we
did talk earlier offline that the end of summer
is now. It is September. We have meetings
scheduled for October, November, December to
complete and finalize and write and draft the
work for presentation to our constituents, which
really is not a lot of time, when you're looking
at about 100 days to completion. And there's
still a lot of moving parts within each one of
the Workgroups.

So, for the general public's sake, we
know that coming in October we have meetings
scheduled that I cannot, I don't believe, give
the time to because I'll have to ask our DFO if
that's been in The Federal Register or not yet.

MR. GOODRICH: Not as of yet.

CHAIR LEINENKUGEL: Not as of yet, but
there will be an October meeting, and those dates will be forthcoming as well as November and December, with more than likely open general public sessions as well.

So, we know that there's a lot of things that have to be completed, and I would like to have some open discussion for the general public, so that they are aware of not only the amount of work, but the context and sometimes the difficulty of compiling this much data and research, and getting to solid recommendations and suggestions that each one of our Workgroup leads deals with. So, I would like to have an open session about some of the gaps in our research and data collection, so that our partners that are in the room, whether they're our VA subject matter experts or our outside contract groups that help us, and namely, Sigma, in research data collection and extrapolation, are well aware of what some of our gaps are, and just so that it's out in the open.

Because we're going to have to stop at
some point with the research, the analysis, and
come up with the recommendations. And when I say
that, that has to start now, if we're going to
meet the writing time schedule that we'll talk
about later in the general open session as well
on writing the report.

So, I'll open it up. I'll start with
Workgroup 1 at this point, just a top over line,
because they all will be presenting specific
proposals and recommendations and a deeper dive
into each one of their Workgroups later in the
session. But this is mainly for our partners in
the room to understand what some of our issues
are or some of our worries are at this point of
what needs to be done in order for us to get to
the recommendation and deliberation stage.

So, with that, if I may start with
you, Wayne? Commissioner Jonas.

DR. JONAS: Okay. Great. Thank you
very much, Chairman.

Yes, so, later today, I'll give sort
of an overview of where we are in Duty Group 1
and sort of what our core questions are to
address the duty. Just as a reminder, we're
looking at models, models of care, the efficacy
of that for mental health, and specifically at
wellness-based outcomes. So, that's the charge
of that.

And we've laid out a research pathway
that involves several steps and several
components. And I think on the top line is that
we will be more than 80 percent collected in
terms of the data and information that we need,
even with some of the gaps that I think will
still remain after that, which will be fine.

So, we're moving along in actually
answering those questions and filling in the
information. I think the hope originally that we
wanted to do, to really cover what services,
models, and approaches that were available for
all veterans, both inside and outside the VA.
We've had a great overview of what's in the VA.
We've made many trips. We've met with
individuals. We've had expert presentation,
especially from the VA. So, we're pretty good on that. We've got that information around the models that are being used for mental health, around approaches for complementary and integrative medicine or health, about integration components of that within the VA.

However, as has been pointed out many times, the vast majority of veterans are taken care of outside the VA. And so, one of the questions is, are those types of services available and is there a capacity for the delivery of those types of things, and what types of models are there out there?

So, the ideal way to do this would be to survey the entire health system around these areas. And that is a pretty massive task. We explored that, but given the resources and constraints, and, also, just trying to define it clearly, so that you can actually ask the right questions. We actually went to several top-level systems, civilian systems, and had presentations from them from around the country and got a
pretty good idea of what they were doing. And so, we have formulated a survey that could begin to get at that, but it's still not been completely tested and validated and seen whether it could be done in those areas.

And so, one of the gaps that I think we will have is a difficulty in being able to get a comprehensive evaluation. We would like to send it out to a few of the top-level systems. We've already sent it out to one, and they're in the process of looking at it, providing information back. And then, we'll send it out to a few more after that.

I think that will be the cherry on the cake. I think we already actually have a pretty good idea of what's out there, what we are doing, and filling in information using internet research in a more systematic assessment of top quality systems in different categories around the country. So, we will have all of that information. And we are, then, evaluating sort of the wellness-based outcomes, using a fairly
systematic evaluation, systematic review method, literature review method in those areas.

So, it would be, the ideal component, the 100 percent solution would be to survey the entire country, find out what they're doing in this area. And maybe that's something that can be done in the future, and we may make a recommendation that that be done, to get a better idea of that. And we will be able to offer examples so far of the types of questions that need to be asked in order to get that information. So, that will be good, and then, we will have, like I said, the 80 percent solution in those areas.

I think one of the challenges that we found in looking at models is especially around wellness-based outcomes, because most of the quality models don't do that. Most of the quality models in health care, including the Quadruple Aim, measure things like outcomes, like cost, like satisfaction, and the outcomes are usually clinical outcomes. They're disease-
based. They're not wellness-based. So, it's sort of hard to find those.

And so, one of the things we're going to be looking for is what wellness-based outcomes are there that look like they could be useful and point to some examples of that. We've got several of those. And then, getting some expert input on that.

And so, part of our plan is, very soon actually, the beginning of October, is heading up to Boston where we're not only going to look at some of the clinical integration at the Boston VA there, but also talk with the folks doing that evaluation up there, both in the VA and, then, get some input from outside experts who do this all the time; for example, from the Institute for Healthcare Improvement, which developed the Triple Aim from which the Quadruple Aim came, and some other experts in these areas that are around. So, that will help us fill in that particular area.

And so, I think, by the time we're in
the process of filling in the writing and that
type stuff, we will have more than enough.

CHAIR LEINENKUGEL: Yes, I would like
to ask you, Commissioner Jonas, to explain to the
general public and some others that may be
unaware of the difference between clinical
outcomes and wellness outcomes, why you believe
from your career as being a doctor and really
focusing on wellness, what the difference is
between clinical and wellness and why you believe
wellness outcomes would be a critical component
for us moving forward.

DR. JONAS: Yes, I would be happy to
do that.

So, one of the long-time
recommendations that's been around by the
National Academy of Medicine and others has been
to do more patient-centered or person-centered
care. The original "Crossing the Quality Chasm,"
a landmark study that came out in 2001, said put
the patient in the center of the decision-making
process.
And that's not what we do in medicine. Okay? In medicine we have a very medical-centric approach, where the disease and the diagnosis are in the middle, and then, we try to figure out what's the matter and what to do about it. And if it happens to align with patients' goals and interests, and if it doesn't happen to align, then we try to make them do it anyway. And that's called compliance issues.

And that's a challenge. When you break your leg, you want that. When you get an infection, when you have a heart attack, it's like, you know, don't tell me whether I want to come in the hospital; please take me into the hospital and save my life, right? And we've got a great system for that, and we do a lot of that.

For current complex, chronic illnesses, it's not so easy and applying that model is actually producing some problems in our country in terms of costs, increasing costs, declining outcomes, et cetera. So, we need to actually adopt more of a person-centered model,
like was recommended by the IOM and many other folks since then.

And the VA has been doing that over a period of decades. They've been actually, you know, adopting person-centered outcomes through the PACTs, the Patient-Aligned Care Team, by incorporating more and more mental health components, which have traditionally neglected within health care, and integrating that into primary care, where a lot of mental health issues come up. And so, they have been moving that along. And now, with the whole-health effort, they're just going the next step further to try to do that.

And so, the wellness-based outcomes, the well-being-based outcomes, which is a way better term, are ones that actually put the patient, put the person in the center, find out what's important for them, and then, identify their particular determinants of health, you know, whether they're mental and social or emotional issues, whether they're behavior and
lifestyle issues, whether they're social need
issues. And then, facilitating that process, so
that they can be successful in improving quality
of life and actually fulfill what they're here to
do, their mission and purpose.

And so, that's the kind of direction
that health care in general has been trying to
move towards. The VA has been doing it. And I
think we're going to look at that and say, you
know, can we do that in a more robust and
accelerated way? Can we make some
recommendations that can be useful and practical
to the VA and to those who take care of veterans
outside the VA, to be able to do that better?

CHAIR LEINENKUGEL: Thank you,
Commissioner Jonas. It was helpful.

I would like to transition to
Commissioner Potoczniak at this time for a brief
update as far as some of his status and gaps.

DR. POTOCZNIAK: Sure. So, we've gone
around and kind of visited, similar to what Dr.
Jonas just said, we've gone around and we've hard
informally what veterans' experience with mental health has been in the VA, in the different areas, whether it be rural or urban. So, we've informally heard their experience with VA.

And we've heard some pretty good themes, even on the reservation also, about different themes that people had with seeking care for mental health in the VA. And so, that's been very helpful.

We've also gone through a process of kind of incorporating data from other research that looks and discusses veterans' experience. So, that's been something that's been ongoing through this process, and specifically looking at veterans' experience with CIH and their general experience with the different empirically-based treatments in the VA.

So, we've heard a lot over the past year, and I think now we're currently involved in conducting focus groups with veterans in the different VISNs within VA to hear kind of in a more formal way what their experience is. And
we've started to identify themes. Thank you to Casin Spero and Wendy, going out and collecting that data, as well as Sigma for doing some of the virtual and in-person focus groups. There are some themes that we're going to be picking up on and making recommendations from. So, I think we're on track to do that.

And I think that's where we're at right now.

CHAIR LEINENKUGEL: Thank you.

Appreciate it.

DR. POTOCZNIAK: No problem.

CHAIR LEINENKUGEL: Dr. Maguen, if you would, Workgroup 3.

DR. MAGUEN: Great. So, just as a reminder to the public, Workgroup 3 is looking at examining the existing research on complementary and integrative health treatments, and specifically for mental health. And we're looking at how that applies to veterans specifically.

We are in the process of doing several
reviews for eight different mental health outcomes. And so, we're well underway in doing those reviews. Four of those reviews have been completed and discussed. One was actually delivered yesterday. So, we're going to be looking at that over the next few days. And the remaining three reviews will be delivered by October 15.

So, our hope is -- and you'll be hearing a lot more about this today -- to start discussing some of the recommendations that have come out of Workgroup 3. We will be doing that after lunch to get everyone's feedback specifically on those recommendations.

So, that's, in a nutshell, where we are at.

CHAIR LEINENKUGEL: Thank you very much, Commissioner.

Commissioner Rose, Workgroup 4?

MR. ROSE: Yes, sir. We are looking at the sufficiency of the resources within the Department to ensure the delivery of good mental
health care to our veterans. So, actually, I think this really kind of encapsulates the entire Commission and the duties that we're trying to accomplish.

And so, in doing so, we have approached, as Dr. Jonas said, the Quadruple Aim Program, and we have gone out and visited different facilities. We've had numerous experts come in, both inside and outside the VA, to take a look at just the level of mental health.

We have started to provide some recommendations. We have an analytical plan that we are working with. And I think it's extremely important for us all to look, as, again, Dr. Jonas had mentioned. But each one of the veterans are individuals. So, if we can work with the individual, and especially with mental health, deal with a recovery program that gives the veteran a better life and a better reason to be alive and go forward with that life.

And I think we are gathering a great deal of information. I think some of the things
that we have seen in our studies so far, and one of those is the extreme importance of the veteran peer support. Here you have a person who is in recovery who has walked the walk, so to speak, and they have been a tremendous outreach to help the veteran, and not only those veterans that are currently in the VA, but also to bring veterans that are not in the VA into that system of care.

So, I think we're all working together. We've got a common goal. We have a target, and we are going to achieve that target.

Thank you, sir.

CHAIR LEINENKUGEL: Thank you, Commissioner Rose.

Commissioner Kuntz, Duty 5.

MR. KUNTZ: All right. I've been really grateful for the staff that has supported Duty 5 and all of the Commissioners.

We have a multi-pronged task, which I have to repeatedly check the COVER Commission's notes to make sure that I get it right, word for word. But it is, it has been a lot of different
angles that we've had to explore, the first one being suicide prevention. And I think that the reality in the field, as we've seen it, is that it is very hard to research suicide prevention because of the numbers, and just there are statistical challenges that make it hard to research suicide prevention.

And we've explored that and the systematic data. We kind of looked at -- there's a number of different models that people think about with suicide. So, I think that that's probably something that we were fortunate to be able to explore. Because of the statistic and scientific challenges of doing broad-scale research on just suicide prevention, then you've got to think about your model and you've got to think about other ways to analyze it. So, we've worked hard on that.

And we are having audio difficulties. So, I apologize for anyone on the call.

And three of our tasks have also been a little bit more of really deep dives with the
data. And we've worked closely with Dr. John Klocek to come up with some rough starting points for where we're at. And I'm excited about what he's developed and running them by the Commissioners to see what we need to do to maybe do a little bit deeper dive. But I do think that the white paper process that we began in January has come to fruition and will guide Duty 5 forward on those.

We also had a white paper done on what is one of the more challenging pieces. Let me make sure I get it right. Analyzing the efforts of the Department to expand complementary and integrative health treatments viable to the recovery of veterans with mental health issues. So, how has the VA been rolling out these complementary and integrative treatments?

And we worked to have a white paper done looking specifically at how the VA has rolled out those treatments for outpatients, because the majority of VA care is provided with outpatients. And then, also, the funding has
actually been spent on, with the idea that either VA staff or outside contractors, you know, if you're paying for it, it's valuable. That's how you're showing the value. So, we're working towards that with a white paper that is almost complete, and that's been really helpful in seeing what is out there in scope.

And so, there are two kind of gaps that I would like to tackle, like two more people to come have talk, and what level they should be at. One is Dr. David Gordon, the Director of the National Institute of Mental Health. I've been involved with inviting him to come present to us, because that was one of the things that Congress asked, is: how does this relate to what NIMH is doing? And we heard that a number of times yesterday.

And I do think it would be valuable for us to hear it directly from the Director, what they're looking at for mental health and diagnostics, and the challenges, because this isn't just a VA challenge. It's not just
something that the VA should be blamed for. Some
of them are kind of states of the science, and
it's nice to get an outside party with a lot of
money involved in research on that.

The other one is, in trying to compare
how the VA has made practices like yoga and tai
chi available, I think it will be important to
compare them to another health system that has
done it in terms of millions of people, not just
thousands or hundreds. So, I've been chasing
that down for several months, finding a group
that can do that.

The Medicare Advantage plans seem to
be very dialed in at making exercise, yoga, tai
chi, available to millions of people. It's part
of how they do business, whether it's Silver
Sneakers or UnitedHealthcare. And
UnitedHealthcare is willing to present to us
about how they make that available to millions of
their beneficiaries, if we're interested.

I certainly think it's important for
Duty 5 to get that, just so we can look at how
the VA is doing. But if that is part of what the
broader group wants to consider, we can have
that.

CHAIR LEINENKUGEL: Yes, I think
that's a real good recommendation, Commissioner
Kuntz, and something that certainly for the
October session we could certainly block an hour
or two. And I'm looking over at Casin and John
at this point, but I think that, as
Commissioners, it would be beneficial.

Does anybody not agree?

COLONEL AMIDON: It would just be to
learn the scope and scale with which they're
delivering that? And would it be to hear the
take rates from their patient population as well?

MR. KUNTZ: The take rates, I think if
we can get an in-depth on what you want to hear,
and that was one of the things that UnitedHealth
moved away from Silver Sneakers because they
weren't happy with the take rates.

COLONEL AMIDON: Yes, it would be
great to learn what they thought they knew, what
they knew along the way, how they've adjusted, and what their programmatic -- you know, can you tie it to other health outcomes, the whole Quadruple Aim concept?

MR. KUNTZ: Right. And it's nice because they are in a position where they are the health care entities, so they have a reason to want to reduce costs for health care. This is part of what they do for that, and they do it in a really big way. Because I don't think it's fair to compare the VA to something that has a thousand members. You know, you need apples to apples at some level.

COLONEL AMIDON: I was just thinking in terms of additive value to the workers as well. You mentioned yoga and tai chi. You all have a list of things. Would you need to know if United does --

MR. KUNTZ: Yes, they --

COLONEL AMIDON: In other words, a portfolio of delivery that correlates to their applications?
MR. KUNTZ: Yes. Yes, I think it's really interesting. And as you've added, exercise, so they do have all of those different studios that people can subscribe to. So, it would be helpful to give them the list that Dr. Maguen's been working on.

COLONEL AMIDON: Conservation of the space, too. I think Humana had their Bold Gold. I don't know how that interrelates.

DR. JONAS: Yes, we had a presentation on that. We have to add on a summary of that, actually. Maybe we can get it to you or something.

CHAIR LEINENKUGEL: Are you okay with that, then, Commissioner Amidon, as far as the intent with it?

COLONEL AMIDON: Yes.

CHAIR LEINENKUGEL: And, yes, we should be looking at each one of these additional requests as, is it going to have the additive value that we're seeking for the outcomes and recommendations? And I would say that, in this
case, that Dr. Gordon and, also, your follow-up.

Dr. Jonas?

DR. JONAS: Well, as you just mentioned, I like the idea very much of having Dr. Gordon come and talk about that. We might want to also ask -- and maybe it could be done at the same time -- Dr. Helene Langevin, who is the Director of the National Center for Complementary and Integrative Health at NIH, to ask the same questions.

They have just come out with an $80 million RFA where they're funding, jointly with the VA and the DoD, on an integrative health care focused on pain. It would be nice to find out, do they have any plans or are there any discussions --

CHAIR LEINENKUGEL: That would be nice.

DR. JONAS: -- in mental health, right?

CHAIR LEINENKUGEL: Right. That makes sense. So why don't you add that on as a follow-
up for the October session as well?

Anything else? Yes, Commissioner Rose?

MR. ROSE: Yes, I think that that's an important part to share with the public, that we, as a Commission, talk to each other. We have conference calls. We participate in maybe three different groups going through in this process. And so, as we learn something, we share something. And again, it's important to get to the final product that we are trying to do. It's extremely important.

Thank you.

CHAIR LEINENKUGEL: Commissioner Rose, thank you. And thanks for clarifying that. That should have been part of the beginning. But, no, this work, this group of Commissioners has been highly integrative, highly collaborative, and very supportive of each Workgroup phase, and there's a lot of mixing in between Workgroups of Commissioners as well. So, it's good to note to the general public and staff members.
At this point in time, I think what I would like to do is take a quick, 15-minute break.

I know we're having some audio problems. Maybe they've been corrected. But if we could work further on that? And I apologize on behalf of the Commission. I thought that the audio would be well set up in the particular facility that we are in. We'll continue to work on that.

And we'll do a break until 10:05 a.m. We'll come back with further discussion on next steps and we'll talk and discuss about writing the report, so that there's a clear vision for each one of the Commissioners of what it's going to take in the next 100 days to get there. And we'll also ask the writer at the time to give us some more in-depth as to the timeframe and the crunch that we're currently under in order to meet our objectives.

So, 10:05 a.m. Break.

(Whereupon, the above-entitled matter
went off the record at 9:51 a.m. and resumed at 10:22 a.m.)

CHAIR LEINENKUGEL: All right. I'll call the COVER Commission back in session at this point. Thank you.

I think that we are now up on a better audio system. So, we'll get that input back from the general public.

And we just talked about milestones for report completion, how we're going to be addressing gaps in our research and data collection; and also, now that it's time to speed up the process as far as changing gears from going from research analysis to actually make our suggestions/strong recommendations for VA mental health care.

I thought it would behoove all of us, and the general public, to have Dr. Wendy LaRue at this time, who was brought onboard by the Commission to be our head writer, give the Commissioners and the staff members and support staff, and also the general public on the call,
how to go about writing a Commission-type report
and what it's going to take; and also, the time
 crunch that we're under, so that there is a sense
 of urgency gained not only from us, but also our
support staff.

So, at this point, Dr. LaRue?

DR. LaRUE: Thank you.

So, I think probably the best place to
start when talking about this topic is the end
and work about from there to think about what
that looks like.

With a late January report, we would
need to have a generally-approved report, the one
that you all raise your hand and say, "Yes, I
support his," at the December meeting. So, it's
easy to think, oh, we have until January, but we
really don't. So, automatically, you can cut off
a month of time from that.

To get to that report that you approve
in December, ideally, you would see a good part
of it, and not necessarily final content, but
some solid drafts at the November meeting. So,
you might be thinking now it's almost the middle
of September. And so, we're really talking about
six weeks from now, which is not very much time,
or maybe eight weeks from now. It's not very
much time. And so, there's a lot of work that
needs to be done between now and then.

Ideally, a good starting place would
be figuring out what we think our recommendations
will be. And I realize that we're still
collecting some data, and we can backfill where
we need to with data. But if we don't have a
roadmap for where we're going, we're not going to
get there by December.

With that in mind, I have a request
that Jake has said he will back. And that is, if
all the Workgroups could send a list of your
current thoughts on recommendations by next
Friday, close of business next Friday, so that I
can start to look at them? My guess is that
there will be a lot of overlap from Workgroup to
Workgroup, just based on my experience of sitting
in on Workgroup calls.
CHAIR LEINENKUGEL: Wendy, let me interrupt for a minute, if I could.

DR. LaRUE: Sure.

CHAIR LEINENKUGEL: You're on a roll.

I also see Casin, and I was going to ask him to start time-lining this on the white board, which he is currently doing, for those that can't see. But we will have that. It will also be transcribed in our notes. And then, we'll discuss as a Commission about actionable items and reasonable standards, as far as the timing, once you're finished.

DR. LaRUE: Okay.

CHAIR LEINENKUGEL: So, keep going, Wendy.

DR. LaRUE: So, I think where I was is, by next Friday, if all of the Workgroups could provide tentative recommendations, and just send whatever is on your mind. Because what I will do with them in the next few days after that is look to see where there is overlap. For example, I know that several Workgroups have
talked about the need for further research on
various topics. And so, getting everybody's
recommendations, I'll be able to see where
there's overlap and help consolidate.

Our ultimate goal should be somewhere
in the neighborhood of 20 to 25 overarching
recommendations. And you should think of those
as very broad commandments of what should be
done. So, recommendations start with verbs, as
we've talked about before, because we want action
from the recommendations.

And then, the implementation part of
the recommendations will be in line with what
some might consider sub-recommendations. So,
those will be the nitty-gritty these are the
things that you need to do, Congress, VA,
whomever the recommendation is geared toward, to
make this big, overarching thing happen.

My guess is that, as I'm seeing the
things that you send me, I'll be able to take
some groups' recommendations and pull something
out to put over them, and some of those things
that you've sent as recommendations will actually become sub-recommendations.

MR. GOODRICH: Wendy, this is John Goodrich, the DFO.

Just to clarify, when you're asking for the recommendations, those would be recommendations from the subcommittees directly to you, not to be shared amongst all Commissioners --

DR. LaRUE: Correct.

MR. GOODRICH: -- because we would, then, discuss those in October.

DR. LaRUE: Correct.

MR. GOODRICH: So, please, when the Workgroup leads send those recommendations, they should only go to Casin, Wendy, and myself. We can distribute them among the staff, but please don't send them to the entire Commissioner group, just so that we avoid the appearance of deliberations until we're back in a public meeting.

DR. LaRUE: Thank you.
CHAIR LEINENKUGEL: Thank you for that, John. It's very necessary to point out that there's rules and regulations under FACA that this Commission has to adhere to, and well-pointed.

DR. POTOCZNIK: I'm just wondering from a Workgroup 2 standpoint, it's going to be very hard for us to come up with recommendations by Friday.

DR. LaRUE: My guess would be that you might have some things on your mind --

DR. POTOCZNIK: Correct.

DR. LaRUE: -- and really have to shift as we get more data in. But the general topics I think we probably know right now. And there's writing that can be done even if we don't know what the specific recommendation is. So, if we know we need a recommendation on how VA does outreach to veterans to get them in to get mental health care, we may still be collecting data on what veterans say would be the best way to communicate with them, but we can still do some
of the background writing for a recommendation
that will talk about that. So, even if you don't
know specifically what you are going to
recommend, if you could even say, "We'll need a
recommendation on how VA contacts or reaches out
to veterans to get them in for mental health
care," that would be correctly sufficient.

DR. POTOCZNIAK: Well, we'll talk
about that.

DR. LaRUE: Is that helpful?

MR. SPERO: And, Wendy, I mean, you
can't write all the Workgroups' recommendations
at once, too. So, maybe Workgroup 2, because of
the challenges we've had --

DR. LaRUE: Right, right.

MR. SPERO: -- is pushed, but
generally --

DR. LaRUE: I can only write one page
at a time.

(Laughter.)

That said, if everybody waits -- a lot
of people are perplexed with the idea of that
limitation -- if everyone waits until the last minute, you see where that gets to be a problem.

And we talked earlier about the possibility of getting some staff that would be sort of as needed part-time, possibly a graphic designer. We've talked previously about getting some additional writing help. But, even with that, we're under a pretty serious time crunch. So, the more we can put together, the better.

Also, this exercise will just help us make sure that we're not producing things in a vacuum and, then, realizing that we either have conflicting recommendations or multiple groups are working on the very same recommendation.

I will be doing a lot of writing. I would hope that I will be doing even more editing. And so, I know that the Workgroups have been -- I see all the email traffic -- the Workgroups have been collecting lots of research studies, articles that support the directions that they seem to be going. And I am aware of all of that. Think about one person processing
that times five groups, not just the ones that
you're working on.

So, once we figure out what the
recommendations should be, anything that's
already written is going to be helpful, even if
it's chunks of material. And then, having the
actual articles or links to them to go with the
recommendations is going to be key. We can't
start from scratch on that.

So, just keep those things in mind.

But the starting point is, what do you plan to
recommend?

COLONEL AMIDON: Is the plan, to avoid
redundancy in recommendations and efficiency in
communication, that we will spend some time
looking at those overlaps, percolating what would
be recommendations into under thematic
delineations? Like, to your point, outreach is a
subcomponent of strategy communications. A lot
of what we're talking about could be enterprise
efficiency, bureaucratic barriers. Are we
thinking of top-line themes that would, then,
have cascading recommendations, so we have
efficiency in sort of context?

   DR. LaRUE: That is what I would hope
to do from getting this information next week.

   COLONEL AMIDON: Okay.

   DR. LaRUE: Because until we can see
where everybody is heading, it's hard to know
what the big categories are.

   COLONEL AMIDON: Right.

   DR. LaRUE: I would think, ideally, we
have a few categories into which our 20 to 25
recommendations fall.

   COLONEL AMIDON: Right.

   DR. LaRUE: So that there are arms of
VHA that do different things.

   COLONEL AMIDON: Right, right.

   DR. LaRUE: And this arm can, then,
cherry-pick what they care about in our report.

   COLONEL AMIDON: And we can create a
one-pager.

   DR. LaRUE: Right. Well, and
actually, past Commission experience, that is
exactly what we've done --

COLONEL AMIDON: Yes.

DR. LaRUE: -- is taken -- or the last Commission that Jennifer and I worked where we published about 3,000 pages worth of content, nobody is going to read all 3,000 pieces. They could read what they care about. So, we did a lot of repackaging in different ways for different interest groups.

And somebody mentioned this earlier, but the most important part of our report, when it's all done, will be the executive summary. And we can produce like fold-over brochure-type things that have the executive summary with enumerated recommendations, just easy things to go out and socialize what the recommendations are.

DR. KHAN: Dr. LaRue, you already have recommendations from 4 and 5 and partly from 1. How can the rest of the Commissioners can see it, so they're not rewriting the same subject?

DR. LaRUE: So, that gets tricky with
what John was mentioning earlier. You can't do
deliberation outside of a public meeting. But
that's why I'm asking to collect all of the
recommendations. And I will take the time to
categorize them, to see where there is overlap.
And then, at the October meeting we can go
through whatever structure seems to arise from
all I get.

DR. KHAN: I think the question is,
there are already about eight or nine
recommendations written that have been submitted
to you through -- at that particular time, John,
you were not in for it -- I think Wendy was and
maybe Casin. Yes, so did you see my
recommendation? If you didn't see it, but at
that time we were told to send it to --

MR. SPERO: Yes, we have them, Jamil.

DR. LaRUE: Right.

DR. KHAN: I think what I'm sharing
is, if Mike sees it, something that Jamil has
already written, then he will not be writing
about it. That's what I'm asking about.
MR. SPERO: So, Jamil, that has to be shared in open sessions when we do that. And so, I think today's some of that is probably going to get shared, where we are already at, when the Workgroups do their individual updates later. The problem is, as you develop new ones --

DR. KHAN: Sure. Got it.

MR. SPERO: -- you know, we have to be together and open and transparent.

CHAIR LEINENKUGEL: And there's nothing wrong with having redundancy within the Commissioners' recommendations. Because, by September 20th, at that time we will know what is redundant and what needs to be streamlined, and we'll get back in open session and discuss those or individual Workgroups, to say that you have some commonality with another Workgroup. So, we'll be able to figure that out once we get to that September 20th.

And thank you for bringing that date out. You know, it's like tomorrow. But I think, Wendy, this is helpful. We need to continue the
discussion and questions because it's very
important about workflow and timing.

Just so the general public knows, the
majority of these folks have day jobs and are
extremely busy doing numerous other things in
relationship to that. So I just want everyone to
be aware that there are a lot of extra hours
going into this process outside of their general
practitioner jobs or duties that they have in the
civilian world.

So, Wendy, thanks, number one, for
clarifying the Friday date.

Any other comments from the
Commissioners about that particular date? Any
consternation or concerns?

Also, do you need to be more
definitive? I think it's pretty clear. You gave
us that, by November, we're looking at a solid
draft. And the November timeframe meeting,
again, can't be discussed publicly at this point
because it's not in The Federal Register, but the
earlier in November, the better. Right?
DR. LaRUE: Right. Well, I would think at each of those reviews in November and December that Commissioners would want to have a week or so to actually read the report before they have to comment on it.

(Laughter.)

So, you can think about those dates, back up a week, and then, you see what the actual work time is, because there's no work time while you're reviewing.

CHAIR LEINENKUGEL: Right. How much time is actually spent on the development of a very clear, concise, actionable executive summary?

DR. LaRUE: Once we have a solid report, a good executive summary is easy.

CHAIR LEINENKUGEL: Okay.

DR. LaRUE: And because that's the most important part -- you know, if we have good, solid recommendations, we move forward as quickly as possible on that, then that part writes itself.
CHAIR LEINENKUGEL: Thank you.

Commissioners, any other questions of Dr. LaRue at this point? Comments?

Thank you very much, Wendy. That was helpful.

DR. LaRUE: All right. Thank you.

MR. ROSE: Thanks so much, Wendy.

CHAIR LEINENKUGEL: So, we are ahead of schedule. And obviously, the audio system is much better than what it was during the first hour, or we would have been pinged by the general public that did that earlier. So that is good. I think everybody is speaking up.

Tom, is it better from the Commissioners' standpoint?

(Laughter.)

I think that let's do the start, because what I'm trying to do, if we have the opportunity, is to leave more time at the end of the day, since now there is this sense of urgency to get the recommendations, to actually get through the updates on Workgroup 1 and 3. And
there's a lot of meat on the bone for both Dr. Jonas and Mr. Maguen to discuss with us today. So, I'm thinking that's going to be a couple of hours.

So, Wayne, I don't know if you are prepared or ready to begin at this point to go through the Workgroup 1 update and all of your requests and needs. If you are ready, thumbs-up, let's do that. And then, let's plan on breaking for lunch, and then, coming back with, Shira, if you would, Workgroup 3.

DR. MAGUEN: Absolutely.

CHAIR LEINENKUGEL: Because, again, all these are very important, but I know Wayne has a large deck here for us to review and it's all very pertinent material.

So, Dr. Jonas?

DR. JONAS: Thank you. I appreciate that.

And, yes, I asked to print out a lot of materials in it, just so that people have the full materials there. But I can do a pretty good
summary of it for our discussion here and sort of where we are. I already talked a little bit about some of the gaps, but let me put the context around what we're doing and sort of where those fit in.

So, I think, first of all, just to orient people around what this duty is, unlike some of the others that have multiple subsections of what they're doing, this is a single duty, right, although there are subsections built into it, if you look at it. But I just want to show it's a single duty. It really is in many ways sort of an overarching one.

I am hoping what I can do is -- and I've heard this already this morning, as folks have gone around and talked about their gaps -- I've seen immediate overlaps between the types of recommendations around models of care, which this duty is about, and things that other folks have said. And so, that kind of synergistic integration I think will be a part of what we want to make sure happens, so that the report
comes out and it's both coherent, clear, and that type of thing.

And so, this Duty Group is really to look at the efficacy -- that is, how well it works -- around the evidence-based therapy model. So, this is the framework. A model is a framework that organizes your thinking around delivery of a service. And then, look at how that's being done for mental health for veterans, and then, identify how to improve those. So, how do you improve those models? What are some of the recommendations that can be made, and especially around wellness-based components, which is the last part of that phrase we talked a little bit about?

Thank you for your question, Chairman, about what's the difference between a clinical outcome and a wellness outcome. We've been discussing that, describing that. Actually, Tom Beeman and others on that group, and Shira and I, have had, I think, some very nice discussions about what does it mean actually to do this.
So, those are the tasks. We have sort of split that up into three, maybe four, major types of information that we need to gather. Much of it we've already seen, but just to clarify, when you look at mental health and integrative health or whole health, there are basically three main models that exist.

One in mental health is the stepped care or the comprehensive care model. It goes by different names, but we've seen that presented a number of times. That currently is in operation for mental health.

There is the integration of mental health into primary care. So, there's the PACT model, which is the primary care delivery model, and then, there's the integration of the mental health into that, the Primary Care-Mental Health Integration Model, and we've heard that.

And then, there's sort of the new kid on the block, which is the whole health-complementary, which is the community-based whole health kind of approaches in those areas.
So, those are the three ones that we're looking at. All of those have moved more really -- again, not to confuse terminology -- but all of those have been moving more and more toward taking care of the whole person. Mental health, by bringing the mental health component into the actual regular and routine care of patients, whether they have a diagnosis or not -- and many in primary care and outside of the formal mental health services need behavior and mental health support in some way, even though they might not hang around with a diagnosis. We saw that in suicide prevention. Half of the people never saw a mental health professional or never got an actual mental health diagnosis. So, it's beyond that.

And so, those are the three models we're looking at, and there are some nice descriptions of those. There's some graphics of those. It's fairly easy to describe those. That will be background kind of material.

The other thing we've been looking at
is the Quadruple Aim, is the framework for that, and to what extent do health systems utilize those. That really is largely the national model, both inside and outside the VA, for determining quality in health care. And I think it's a challenge to actually find systems that actually look at all four of those things. Usually, quality improvement things will look at one aspect of it or another aspect of it, but very rarely are there systems that actually put them all together and analyze them in a way where you can actually look the offsets of one aim against another.

It's easy to do costs, right? You just stop paying for stuff, right? So, you can lower costs; just don't provide the services, but that doesn't have a very good impact on the other aims. And so, balancing those aims out is sort of key.

We talked about the wellness-based outcomes. And so, this is an area right now that I think we still have some gaps in, but we've got
a plan to kind of fill that in. This has to do with putting the flourishing of the veteran in the center of the care model, and then, surrounding health care as supportive aspects to help make that happen. Obviously, in chronic illness and in mental health, that's key in those areas.

So, that's the basic sort of approach that we're taking to these areas. We're, again, looking at inside and outside that.

I'll pause right there and see if there's any questions. Because, then, I'll go on to the method, the methodology that we're doing and what data we're actually collecting. But maybe I should stop right there and just ask if there's any comments/questions from that now.

MR. ROSE: Dr. Jonas, just one thing, as mental health advocate. If you look at the diagnoses of mental illness, that can be a very touchy situation, and it's not like having some type of medical disorder -- heart, liver, whatever. So, that's kind of a different animal.
DR. JONAS: It is. No, that's right, and it's been widely acknowledged and there's lots of data out there to show that, in general, our health care system neglects mental health. We pay for and do things to the body very effectively and we'll do that type of thing, but when it comes to mental health, we're just not very good at it. You know, it's because it's more difficult. It's more difficult to measure. It's more difficult to know what it is. Frankly, I think we have a habit of physicalizing everything and sort of ignoring the social and emotional parts of the human being and the mental and spiritual parts of a human being.

And part of what we heard over and over and over again from veterans for sure, patients, family members, and providers is that you've got to take whole-person modeling. You've got to incorporate those things and acknowledge them, and not make them sort of secondary types of things or optional things in terms of looking at them.
So, that clearly has to be strongly embedded in one of our recommendations around what does a new model look like. What does a full-person model look like?

MR. ROSE: Thank you.

DR. JONAS: So that's great. Other thoughts on that?

I will just add, just before I get into the methodology thing, just even this morning I could see immediate links to a lot of what other folks were talking about. The recovery model that you talked about in those areas was key.

Methodologies for getting evidence, I mean, qualitative evidence is as important for getting information to make decisions around clinical delivery as randomized control trials are and clinical conditions. And yet, we have an approach that uses a hierarchy of evidence, that puts the randomized control trial at the top, and then, because of that, tends to ignore other things like good qualitative evidence. And so
it's harder to get that evidence because we don't
value it as much, and it's just not out there
when we're looking.

So we need to have not only more
whole-person or a more whole-person-oriented
approach, person-oriented approach in terms of
delivery, we need also to have a whole-person-
oriented approach for collecting evidence and
analyzing the evidence. And there are some great
things out there. We've actually talked about
other ways to do that, external validity issues,
qualitative evidence, that type of thing,
implementation science, person-centered evidence,
like what PCORI is doing and others that we've
heard from, AHRQ, and that type of thing.

So, again, I think that dovetails in
on the evidence recommendations, and we've
started to put some of those discussions into the
-- evidence component.

DR. MAGUEN: I just want to add,

too --

DR. JONAS: Yes.
DR. MAGUEN: -- I think that the point you made is quite important. And I think just big picture, what we're doing in this Commission with all the Workgroups and our work as a whole is really collecting data on both sort of the qualitative and quantitative end. So, really, we're utilizing as a whole Commission very much a mixed-methods approach --

DR. JONAS: That's right.

DR. MAGUEN: -- and doing that in unison. So, in between Workgroup 2, actually, 1 through 5, we're giving a lot of thought to that.

DR. JONAS: Right.

DR. MAGUEN: So, I think that's a critical component to acknowledge --

DR. JONAS: Exactly.

DR. MAGUEN: -- the work we're doing as a whole.

DR. JONAS: No, I agree, and you've said the right term there. That's the term of art right now that's used, is mixed methods. And I think we should, you know, say yes on that, but
we actually should say, well, what are those methods and how are they integrated; how are they put together? What are some of the analytical approaches and frameworks -- again, thinking of research models -- that are doing that? And there's a number of good examples out there. We should just point to them and say, hey, VA needs to take its evidence evaluation if it's going to be consistent with these kind of delivery approaches and evolve that in the direction of that kind of mixed methods, where we value evidence that is specific to the use of different populations that are making decisions about health care that aren't just payers, right, and that kind of thing. Hopefully, that will come out of that and be consistent with those.

So, any other thoughts or comments?

And then, I'll tell you about the methodology that we're using.

CHAIR LEINENKUGEL: It's always interesting, Dr. Jonas. You know, as the Chair, I'm sitting here, now that there's a sense of
urgency to write recommendations, and just from
your 10-minute overview, about two
recommendations popped into my head, although
I'll keep them mute at this point. But, I mean,
it's an interesting evolution of conversation now
as far as what can we do differently when you're
looking at efficacy of the Secretary of VA model
with evidence-based.

DR. JONAS: Right.

CHAIR LEINENKUGEL: And then, also,
including there's that very important note that I
stopped you earlier on about the wellness-based
outcomes.

DR. JONAS: Right.

CHAIR LEINENKUGEL: I mean, there's a
lot going on with just your small one task there.

DR. JONAS: Right. Yes, and

hopefully, this will help. Hopefully, what we
can do can help.

We haven't written or proposed in our
Duty Group any draft recommendations at this
point because we've been kind of both collecting
information, but also stepping back and saying,
wait a minute; we need to know what's going on in
other areas to make what we say valuable and
consistent with what's going on in those areas.

So, I feel, given the timeline that's
going on, I feel a little bit nervous about
saying, God, we've got to get them out. And
then, I'm thinking, well, wait a minute; let's
get them right. And once they get out, I think
we'll be able to write them pretty easily, but I
haven't even done that yet.

CHAIR LEINENKUGEL: Yes, I didn't say
that they would be two solid recommendations.

(Laughter.)

DR. JONAS: No, but I think now
sharing those, those kinds of drafts and others,
it's time to do that.

CHAIR LEINENKUGEL: Okay.

DR. JONAS: So, part of my task, and
our task, over the next month is to really begin
to stick those together and, then, look how they
dovetail with other groups in a consistent way,
so that they are supportive and useful in those areas. So, that would be one of the things.

I know, Shira, you and Tom and Jamil and others around the group. So, I'm going to put that now more upfront in terms of let's start doing that, okay, even as we finish collecting the data.

Now, in terms of the data collection, if I can move on to that, I think I talked a little bit about that, but just to give a summary of that. There's several things that we're doing to collect data. No. 1, there's a number of reports that have been out there. I mean, obviously, the one that the Institute of Medicine did on mental health, a massive one that is still pretty fresh and new, that's an example of one.

I just gave the Chairman a book from the Institute of Medicine that was published in 2009 that was an overview of complementary and integrative health. There's others out there.

So, we've look at a lot of the major ones that relate to mental health and whole
health especially. And I have asked Sigma, and they have done this. Those are available. I think they've all been released, but we'll make sure they get around or they are loaded on that.

They're doing sort of a structured summary of all of those, because some of them are huge and they're very difficult to go through. So, they're doing a structured summary. So, those would be available for people to look into.

And also, Wendy, you will be able to tap into it in order to do some of your writing, because it is new writing around that, but it's linked directly back to that data, those areas. So, that's one thing that they're doing.

The second thing is that we've talked about how do we get information around the models that are out there and the outcomes that are being used in the VA and outside the VA. We received most of the stuff from the VA, but one of the major gaps was what's going on out in the community for community care.

And so, I mentioned the challenges
around trying to get that comprehensively in the
country, and that really isn't possible in the
timeline, what we have. But what we did do is we
have developed a methodology for internet
assessment of selective top systems from around
the country.

And so, we used an objective approach
to identify those groups and classify them into
different types of hospital systems. When people
talk about, oh, where are the best systems in the
world, I always think about the ones that are
these major systems that are listed every year as
the top-ranked systems using one methodology.
Usually U.S. New & World Report is what they use.

There's other more objective
methodologies that are out there. IBM Truven has
been doing those for years that's based on CMS
and other quality measures. They rank the top
100 hospitals and they put them into categories
from large to small, to rural, to medium, et
ce tera.

And so, we went through those, and
then, selected five in each of the five categories that they have that are in that. And then, Sigma is now going through and doing an internet collection of the information around that.

I think the internet collection will be valuable because it's the kind of thing that the public could theoretically do, or at least they're publicly-available information sources. When you ask a health system to tell us all the great stuff they're doing, they'll be happy to tell us all the great stuff they're doing. That doesn't mean they're actually doing it.

(Laughter.)

And so that is not necessarily helpful in terms of knowing is that a place I can go. It's not available to your average veteran or family member or provider that wants to find out, is this available, or even the VA, when they're trying to assess systems that are out there that they might want to contract with community care. Most of the time they have to go to publicly-
available sources to do that. It's very
difficult to collect it separately.

And so, we thought this would actually
provide a useful biopsy of what's available in
those areas. The initial ones we've looked at,
we can already see quite a bit of gaps in there,
but that's the state of the data, right? It's
still what you get when you go out there.

And so, that will be completed. It's
in the process of being done right now. That
will be completed. We'll have a nice hierarchy.

We did develop a pretty comprehensive
survey, and it had a lot of input in it from a
variety of people. It's big. It's complex.
It's something, if you said to somebody, if they
weren't forced to do, they probably wouldn't do
it. And Geisinger was kind enough to say they're
actually going to do it. And that was about a
month ago, and they still haven't gotten it back
from them. That just tells you immediately that
it's probably unlikely we're going to get a whole
lot of other systems to do that. So, it will
have to be simplified.

But the nice thing about it, it is an overview of the kind of information that we want to see systems collecting and doing to provide this kind of whole-person care. So, I think it will be useful later, and we may get some information out of that. It would need to be refined, solidified, validated.

One of the things that we might suggest that the VA at some point do is actually refine that and actually begin to do that, or somebody else in the --

CHAIR LEINENKUGEL: Wayne, could I make a recommendation? And I should have done this earlier when I saw your list. To possibly, now that you're struggling because it is so -- I call it "an intense survey" --

DR. JONAS: Yes, intense.

CHAIR LEINENKUGEL: -- but very well done and necessary for what I think you're looking for, and we are as a Commission. To include possibly Marshfield Clinic --
CHAIR LEINENKUGEL: -- because, again, I have an affiliation; I'll disclose that to the general public. I'm a former Board member. And also, that is my clinic of choice outside of VA care, which I am not eligible for.

So, that being said, I think that they would be responsive and it will also give you, give us, a pretty good aspect of rural northwest and now expanded eastern Wisconsin and the UP of Michigan --

DR. JONAS: Uh-hum.

CHAIR LEINENKUGEL: -- which they have clinicians and providers in.

DR. JONAS: Okay.

CHAIR LEINENKUGEL: And also, I know that they would be very receptive if the Commission were to participate, if you find it of value.

DR. JONAS: I think that would be valuable. I think, instead of just sending it sort of randomly out, which we talked -- not
randomly, but we had had actually proposed to do this to some of the larger systems. I think we still need to have it refined, evaluated. We need volunteer systems that are willing to spend the time to help us develop it further. And if by the end of the report we've done that a few times, that will actually move it along very nicely.

So, if there are groups that are willing to do that -- Geisinger already is doing that. If Marshfield gives us that kind of another test case on that, it would be helpful. So, if you wanted to put me in touch with that, I could contact them.

CHAIR LEINENKUGEL: I'll help you out with that.

DR. JONAS: We can do that in a break. So, that I think is where we will continue to fill in that information. We won't get the ideal thing, the ideal thing without a dilatory aspect. But we will get, I think, what we need, and the public will know what we intend
to do.

The final dataset that we're looking at is a summary of quality of the VA and non-VA care for veterans. There has been a number of studies doing that kind of quality assessment, most of them not in mental health actually. But there are some others that have done that.

An example, I think, Matt, you put this in the Commissioners' thing, this recent summary from the RAND, research from the RAND which is "Improving the Quality of Mental Health Care for Veterans" that actually does that. So, these are excellent. These are rigorous, systematic evaluations of that information.

And we have done a literature search and collected all of these types of studies that are there. We're now going through, with Sigma's help, in terms of doing summary analyses of those studies, so that we'll actually have an up-to-date biopsy of all the current studies that have been done doing this kind of comparative evaluation in all areas of health care, including
mental health.

And then, a second part of that, there have been studies that have looked specifically at outcome differences, looking at things like satisfaction, for example, access, that type of thing. So, that's a second category that we're going to be doing a summary table on.

So, we will be able to provide sort of a current update of the recent research that's been done on quality in those areas. All that I think will be, should be completed in the next month, except the survey part, which is a developmental item. Hopefully, we'll have that towards the end.

And that's sort of where we're at.

DR. KHAN: We need to give the recommendations by the 20th?

DR. JONAS: We do. So, like I say, I'm going to be getting our group to really start focusing on recommendations, and we'll try to collect the ones that are out there in the other groups, and then, try to make sure what we're
doing has consistency in terms of supporting those types of recommendations. We'll be doing that in the next month, although I am gone for the next two weeks. So, I'll be doing some of that while I'm on the planes, in those areas, and then, hopefully, bring it back in a coherent way for the Working Group to begin to look at in those areas.

I think that kind of does it for me. I could talk a little bit about the Boston visit, if you would like. That might be helpful.

CHAIR LEINENKUGEL: Yes.

DR. JONAS: Do we have time for that?

CHAIR LEINENKUGEL: I'd find it helpful.

DR. JONAS: So let me stop there for a minute before I switch gears here. Are there any thoughts and comments for this?

I actually do have a question on our writing the recommendations for my group. Would you like to see them as developed as possible or would you like to see them in small snippets? It
sounds to me, given the urgency of the timeline, it might be better to kind of deliver the whole thing, and then, ask you to take the time to kind of do a deep dive and have a discussion of that over several of our meetings, if that's okay. I mean, I think that would accelerate it, if that's okay.

I could spend a fair amount of time looking at the other recommendations, coming up with some for models, for the model components, kind of flesh out the action items or the subcomponents the best I can do them at this point, then bring that as a whole to the group, the Working Group, for our discussion and that kind of thing. Would that be a useful approach to doing this?

DR. LaRUE: So, I think something to keep in mind is --

CHAIR LEINENKUGEL: Dr. LaRue, hold on. This is Dr. Wendy LaRue responding to Commissioner Jonas' query, again, concerning timing of recommendations.
DR. LaRUE: Yes, so something to keep in mind about the structure of the report is that there will be two main sections. One section will be the recommendations and the backup of those recommendations that's very specific to the precise language of the recommendations. And the other major section will be, in essence, the research report by Workgroup.

So, it sounds like what you're talking about will largely be that second part, the sort of research behind everything.

DR. JONAS: No, I'm not talking about that.

DR. LaRUE: Oh, okay.

DR. JONAS: I just did a summary of that research that's going on. But, right now, what I'm talking about is, what's the best approach to begin the process of doing the recommendations? Okay? So, the research is going on, but we haven't done any of the recommendations.

DR. LaRUE: Right. So, I would go
back to what I said earlier, which is you
probably at least know the areas where you need
to have recommendations, even if you don't know
the precise direction.

DR. JONAS: No, we've got a lot of
information already. I mean, a lot of the
research that we're filling the gaps in with that
I just summarized is going to be helpful in terms
of justifying some of what we're doing. It may
alter some of what we're doing, but we've got
enough now that I think we can begin the process
of doing the recommendations.

But my question was what would the
best process for doing that be to try to
accelerate it? To write all of those and some of
the sub-recommendations in as much detail as
possible for our deliberation, okay, or just send
the top-level ones out, and then, come back again
for the sub-recommendations? I mean, I think if
we did them as a -- I don't want to overwhelm the
group with --

CHAIR LEINENKUGEL: I think Wendy is
saying that, if by September 20th, you could do
and/or, it would be great.

        DR. JONAS: That's what I was thinking, given the timeline, yes.

        DR. LaRUE: Yes.

        DR. JONAS: Okay. Great.

        DR. LaRUE: If all you can give me on September 20th is these are the big ideas, that's fantastic. If you can give me, these are the big ideas and these are the ones that fall under it, that's even more fantastic, because it will help me see the overlap.

        DR. JONAS: All right.

        DR. LaRUE: The more, the better.

        DR. JONAS: However, I would like to make sure the Workgroup, the Duty Group, actually has seen them, has the ability to have input and everything before I send them.

        DR. LaRUE: Well, then, that's why I'm thinking close of business Friday. That gives everybody a full week to have their regular meetings.
DR. JONAS: So, you want them by September 20th?

(Laughter.)

DR. LAARUE: I really do.

DR. MAGUEN: So, we're going to be able to be on a call before they get sent out.

CHAIR LEINENKUGEL: You may, as Commissioner Workgroup leads, actually need multiple calls the following week. They may be for half an hour each. I don't know. But, with the condensed timeframe and with six business days basically to do the "writer's ask," which we concurred with, at least in a simplistic form, to use Dr. LaRue's context, I think that approach can be done. But I know, Wayne, you're talking about travel.

DR. JONAS: Yes.

CHAIR LEINENKUGEL: You may have to certainly probably have someone fill in. But I would use the time in closed session today and tomorrow to answer those questions.

DR. JONAS: Okay. That's great, and
we can have that discussion.

    So, we usually have our calls or do these calls on Friday. Okay? We're not doing it this time because we're having this meeting on Friday. We'll have discussion around that. Next Friday, which is the 20th, that would be next Friday. So, there was no time on our current schedule when we could actually have a Duty Group discussion about this before the deadline she just said.

    DR. MAGUEN: Unless we do that, and then, it gets sent. So, we can meet on a call, and then, it gets sent by close of business. So, we'll have a chance to touch base, and then, you send it later in the day.

    DR. POTOCZNIAK: Let me just ask, I know you can only write one page at a time. There are some people here that have recommendations that have probably already written up. Is there any way that it could be like a two-phase thing where those people get you all those by Friday, and then, the next set of
people who aren't quite ready to do that would be
by the next Friday?

    DR. LaRUE: That's an interesting
question.

    DR. POTOCZNIAK: Because you can't,
like you said, you can't really write it all --
    DR. LaRUE: What that would preclude
is the ability to see all of it in a big picture,
and that's really what I think is vital.

    MR. SPERO: Can I jump in here? So,
I wasn't aware of the September 20th plan before.
I don't really know where that came from, but I
actually agreed with Mike's point. Even with
Workgroup time today, I don't see how that gives
us enough time.

    DR. LaRUE: So, if we said Tuesday the
next week, would that --

    MR. SPERO: If we had asked three
weeks ago for them to schedule calls next week --
as you said, Jake, everybody has full-time jobs
here. So, I just don't think a September 20th
date -- if you have recommendations, I think we
should try to get them in. But I think we need
to be understanding of people's time and --

CHAIR LEINENKUGEL: I did ask, and
Wayne rose it, and Mike replied to it. And now
you interjected. But I did ask earlier in the
meeting if everybody was fine with September
20th. And so, now is round two in the debate
deliberation to come up with a firm date that all
Commissioners will agree to.

(Laughter.)

So, that is back in play right now.

We will, as the Commissioners, make that
decision, and then, let Dr. LaRue know that. But
I would say, since we're on that topic, what do
the rest of the Workgroup leads, besides Dr.
Jonas at this point and Dr. Potoczniak,
recommend?

Commissioner Rose?

MR. ROSE: Yes. Group 4, and we will
do our best to make that September 20th deadline.

CHAIR LEINENKUGEL: Okay.

MR. ROSE: And we've already got some
in the works. And so, we will do our best to meet that.

        COLONEL AMIDON: Acknowledging that this is the first phase of recommendation development, so we have our Workgroup call Monday-Tuesday-ish.

        CHAIR LEINENKUGEL: So, Workgroups 4 and 5, which is Commissioner Kuntz -- and I think, Matt, would you agree September 20th would be doable for the initial recommendations?

        MR. KUNTZ: Yes, we've been pushing this out and getting Duty 5 ready for two months.

        CHAIR LEINENKUGEL: And Commissioner Amidon is the lead of Group 4 and 5 as well. So, do you concur with September 20th?

        COLONEL AMIDON: To get initial stuff? Yes.

        CHAIR LEINENKUGEL: Okay. So, 4 and 5 have got concurrence on September 20th. So, Wendy, that's helpful, right?

        Let's go 1, 2, and 3. And Admiral Beeman is not here, but, Dr. Jonas, what date
would make sense with you? And certainly you've
got the two other Commissioners, Maguen and
Potocznjak, right across from you. So, let's get
a preferred date, a test date.

DR. JONAS: Well, I mean, my concern
is time for us to discuss it. That's my concern.
Right now, there's no time to discuss it.

CHAIR LEINENKUGEL: Amongst your
Workgroup?

DR. JONAS: Among our Workgroup, yes.

That's my concern.

CHAIR LEINENKUGEL: Yes.

DR. JONAS: I mean, I can put them out
as a preliminary thing for our discussion by next
week, okay, especially after these couple of
days. They will not have yet incorporated the
kind of cross-tabulation that we've been talking
about here. We don't have time to do that
because we haven't actually seen them.

MR. KUNTZ: And we didn't do that.

I'll just say, like what I requested from Duty 5
was everybody submit. We're expecting overlap.
Let's fire them downrange, and we can get working on them after that.

DR. LaRUE: I would suggest that this first around is not about -- you don't need to edit things out. This is the brainstorm; these are all our ideas. And at the October meeting is the paring things out, if that's helpful.

DR. JONAS: So, I cannot do the call on the 20th because I'm actually running an all-day meeting in Europe on the 20th, unless it's -- I don't know what the time difference is, but maybe I can do that on the 20th, but it will probably be 3:00 in the morning or something. Nine o'clock California time is six o'clock.

Anyway, I'll look at that, but I don't think I can do it on the 20th. I'm running an all-day meeting on the 20th.

CHAIR LEINENKUGEL: Dr. Jonas, could you do some of this over email and get consensus through email?

DR. JONAS: Sure. Yes. But what I'm saying is that I might --
CHAIR LEINENKUGEL: Then, you can have
discussion, if you want, right?

DR. JONAS: We can have a discussion
actually when we're doing our deliberation at our
subgroup tomorrow or later this afternoon, and
we'll try to figure that out. So, I can't
actually answer the question right now, but I can
get it to you.

MR. SPERO: So, can we table the date
until tomorrow morning for the final date for all
Workgroups?

CHAIR LEINENKUGEL: I think that's
smart, yes. I think it's the right thing to do
because we'll go through Workgroup sessions later
this afternoon in closed. And that's a good
idea.

DR. JONAS: All right. And then, we
can get a date.

MR. SPERO: I mean, from the staff's
perspective, I think this thing is for you guys
all to be comfortable, but also --

CHAIR LEINENKUGEL: You're also
looking at your workload as well. We understand that.

MR. SPERO: Well, Wendy’s workload, working with the staff. But I think we want to be sensitive to Wayne’s point that he doesn’t want to put up recommendations on behalf of Workgroup 1, even if they are just for deliberation. You know, the Workgroup does need agreement. So, I think that’s a fair point that we need to consider.

And to Mike’s point, we’re just finishing collecting the basic information. He needs to really add that last piece in. I definitely want to make sure we’re -- you know, you are all comfortable as a group. We’ll do what we can to get you there.

DR. POTOCZNIAK: I think just to add for Workgroup 2, because I know we are going around, for Workgroup 2, what I would need, at least to even come up with potential kind of recommendations is what themes we’re seeing from you guys that are out there in the field right
now. And then, we can always refine it as you do
the coding and stuff like that. But I'd be okay
with making those recommendations, the potential
kind of recommendations, because I have an idea
of what we're probably going to hear, but I don't
know how it's coming out in your focus groups,
right?

DR. LaRUE: I can probably get that to
you before we leave for today.

MR. SPERO: And I was going to suggest
to you, actually, something. If you like during
your Workgroup time tomorrow in open meeting,
Wendy and I would be happy to have a discussion
with all of this of the themes that we picked up
over the past month, as we've been going through
these.

COLONEL AMIDON: That would be the
best idea.

MR. KUNTZ: I have one other request I
guess on just kind of procedurally. I would like
for any of the recommendations that Commissioners
in a group to move forward, I mean, if there is
one Commissioner that the rest of their Duty
doesn't agree, that should still come to the rest
of us. If that group doesn't like it, that
doesn't mean that it doesn't go forward. So, if
a Commissioner has a recommendation, I want to
make sure that it at least gets to the Board and
the rest of us have the chance to vote on it, if
a Commissioner cares about it that much.

CHAIR LEINENKUGEL: I don't think any
Commissioners have any concerns with what you're
requesting.

COLONEL AMIDON: My assumption was,
yes, the first tranche is all captured and the
recommendations, however precise or defined, to
Mike's point. We may not know the data to drive
the recommendation, but we have a delete button.

(Laughter.)

CHAIR LEINENKUGEL: Like I said
earlier to Dr. Jonas, I have two potential
recommendations. I don't know if they're good or
not.

(Laughter.)
I think to your point, Commissioner Kuntz, I think that we would all agree that this first go-round, as Commissioner Amidon said, is a free-for-all grab bag. Throw them out there, and then, we're going to get back and have the debate, discussion, deliberation, and all.

DR. JONAS: I think that's great. I just want to make sure my Workgroup has the time to have the first grab at the grab bag.

CHAIR LEINENKUGEL: Understand.

DR. JONAS: That's all.

CHAIR LEINENKUGEL: And it makes it much clearer, as we said earlier, and Casin stated again that we all have other jobs, except for me, which is golf, obviously.

(Laughter.)

Wayne, thank you very much.

DR. JONAS: Thank you. I'm finished.

CHAIR LEINENKUGEL: Any other order of business at this point in time?

If not, what I thought we would do is break for an early lunch, seeing that we are
ahead of schedule.

I think we've made great progress as a Commission in a very short amount of time here as far as concurrence and, also, a little bit of pushback as far as timing to Dr. LaRue's request, which I appreciate and I wanted it to get out in the open, so that there is that sense of urgency, but also clarity as far as 100 days is not a long period of time to do the amount of work that we have to do. So, I think all the Commissioners are well aware of that. I think that, once closed session meetings go into place, it will become much clearer.

And to other Commissioners' request, in particular, Dr. Jonas, we'll come back with a better time period for the initial recommendations by tomorrow morning. Is that agreed upon by all the Commissioners?

So, at this point, I would like to officially break at 11:25 and have us back here -- Casin, John, 12:45? Give everybody a good hour-plus to chat, decompress, catch lunch.
And we'll do a 12:45 startup in open session again to go on to Duty 3 and Commissioner Maguen.

MR. SPERO: I'll just say, did we get through the Boston --

CHAIR LEINENKUGEL: We didn't. I'd like to do that.

MR. SPERO: Do we want to just start with that after lunch then?

CHAIR LEINENKUGEL: Let's do Wayne's overview of Boston, because it's a full one-page coverage, if you don't mind doing that.

DR. JONAS: Okay.

CHAIR LEINENKUGEL: And we can do that after lunch.

DR. JONAS: After lunch is fine.

CHAIR LEINENKUGEL: Yes. Great.

MR. SPERO: And then, we'll go into Workgroup 3?

CHAIR LEINENKUGEL: Correct.

MR. SPERO: Okay. Perfect.

CHAIR LEINENKUGEL: All right.

Thanks.
We are presently closed and on lunch.

(Whereupon, the above-entitled matter went off the record at 11:23 a.m. and resumed at 12:50 p.m.)

CHAIR LEINENKUGEL: Good afternoon, everybody. This is the COVER Commission open session meeting of September 12th in Washington, D.C., and at this point in time coming out of a lunch break.

As we noted in the morning session we were going to go to Workgroup 3, which is led by Commissioner Shira Maguen.

And, Shira, if you would, please begin the update on Workgroup 3.

DR. MAGUEN: Thank you so much, Chairman.

So, as a reminder for those on the call, I know that the Commissioners are all aware of Duty 3's scope, but I wanted to just read it one more time. So, our duty is going to "Examine the available research on complementary and integrative health treatment therapies for mental
health issues and identify what benefits could be made with the inclusion of such treatments for veterans."

In order to accomplish this, we're examining several different mental health modalities as well as several different mental health conditions. And so, we're examining PTSD, opioid use disorder, alcohol use disorder, suicidal behavior, depression, bipolar disorder, generalized anxiety disorder, and insomnia.

I want to also remind people of the Workgroup membership here. Thomas Beeman is the subcommittee lead for Duties 1, 2, and 3, including ours. In addition to myself, the Commissioners are Mike Potoczniak, Jack Rose, Wayne Jonas. Alison Whitehead is our ADFO. Our mental health subject matter experts are John Klocek, Kendra Weaver, Stacey Pollack, and Sigma support, Shannon Beattie and Hanifah Mohamed.

I want to just update everyone on what we have completed up to date. After I do that, I'm looking forward to sharing some of the
working recommendations that have come out of
this Workgroup and want to get Commissioners'
feedback on those that we have been discussing on
the call for Workgroup 3.

So, first, I wanted to just remind
people that the post-traumatic stress disorder
systematic review and executive summary was
completed on April 4th, 2019. The opioid use
disorder systematic review and executive summary
was completed June 5th, 2019. Alcohol use
disorder was completed on June 14th, 2019, and
the suicide risk systematic review was completed
on August 24th, 2019.

We currently have the major depressive
disorder systematic review and executive summary
completed. I mean, we just received that
yesterday, so the Workgroup is going to be
reviewing those findings and discussing working
recommendations for that on our next call.

I want to now move, given that we have
four finished reports and executive summaries and
have working recommendations, I want to move to
those for the Commissioners to discuss and review. Again, I want to emphasize that these are working recommendations that we're now going to put up for deliberations.

Embedded in these recommendations are some of the findings. So, you'll see that I'm going to summarize for all of you where we found evidence, where we did not find evidence, as well as the strength of the evidence, for each of these mental health conditions.

Okay. So, the first condition, as I mentioned -- this is the one that we started with -- is post-traumatic stress disorder. I'm just going to read the recommendations out loud.

To provide a frame, we have made four different recommendations that are specific to mental health disorders and related behaviors. And then, we also have recommendations that we've made that really fall under the umbrella of applicable to all disorders. I'm going to be going over all of those with you today.

First, for post-traumatic stress
disorder, I'm going to specifically highlight the areas in which there were not any randomized control trials. And so, our first recommendation is "To conduct and fund research related to complementary and integrative health treatment interventions." And PTSD, in particular, and then, particularly multi-site trials.

Again, we want to conduct or fund research in these areas, and specifically, we think that multi-site trials are the way to do this. So that we're not only looking at one specific area of the country, but really doing a deeper dive and looking at how these treatments might affect people at different parts of the country within different cultures.

So, more specifically, we found that there were not any RCTs for PTSD outcomes with the following modalities: art therapy, cannabinoids -- and I will say here that, with cannabinoids, an RCT was conducted, but never published. So, we saw and we found that that RCT was conducted, but we can't get those results to
date.

COLONEL AMIDON: Do we know who conducted them?

DR. MAGUEN: We do, yes, and I have that information.

COLONEL AMIDON: Oh, okay. Thanks. Great.

DR. MAGUEN: Yes. Music therapy, tai chi, service dogs, chiropractic care, hyperbaric oxygen therapy. There were two RCTs containing a small percentage of PTSD patients, but the PTSD subgroups were not separately analyzed. So, we really don't have any information about the PTSD outcomes, in particular. And then, massage therapy.

Again, these are the conditions in which there were not any RCTs. And now, I'm going to move to the conditions where there were some trials. Now this is, again, part of that first recommendation.

The following modalities had low strength of evidence with respect to PTSD
outcomes due to methodological and study design issues. So, further studies may be required. And just as a reminder to Commissioners, what we did, when we found studies that existed, we evaluated each study based on the Cochrane 2.0 Rules of Bias. And so, we wanted to really find, is the quality of the study strong or are there problems, both methodological and study design issues, that might lower our extent of what we're willing to resolve about some of these studies?

Basically, what we found: low strength of evidence for accelerated resolution therapy, acupuncture, equine therapy, exercise, healing touch, relaxation therapy, and TMS.

Then, there were additional studies that were done. I'll just read the recommendation. "To conduct/fund research studying CIH modalities as an adjunct treatment to evidence-based PTSD psychotherapies and medication, since these trials would mirror how" -- sorry, let me just go back for one second -- "since these trials would mirror how treatment is
generally provided in clinics."

What we have done in the searches is we have looked at these CIH modalities as both a monotherapy -- so, if it's used alone in looking at whether or not it improves PTSD -- as well as an adjunctive therapy, which means that people were able to receive evidence-based treatments for psychotherapy related to PTSD or medications related to PTSD.

And so, what we really recommend, and what we really believe should happen, is that these studies really will mirror what happens in our clinics. We know that when someone comes in for PTSD, we want them to receive what we know works best. And so, we envision CIH being used in conjunction with those treatments that we know work best, rather than as a monotherapy.

And so, we want the studies that are done to mirror that because, otherwise, it's not reflecting what actually happens in clinical care. So, there are different ways to do that, including pragmatic trials, but we really
strongly believe that that should mirror what happens in our clinical work. As an example, acupuncture could be studied as an adjunctive treatment to the standard of PTSD clinical care; i.e., PTSD psychotherapy plus acupuncture.

Any questions about those first two recommendations so far?

Okay. Maybe what I can do is go through all of the PTSD ones, and then, open it up for questions. And then, we'll just keep going as we move along. But, hopefully, you are getting a sense of what we found in the systematic reviews: that, overall, there were few studies that were actually RCTs and that those that we did find, the strength of the evidence was low.

Yes?

MR. KUNTZ: Shira, this looks great. I think it's really solid, I guess. Just kind of wondered, do you think that this kind of recommendation is similar to what you would do if you were to take PTSD out and just say mental
health conditions? I mean, transdiagnostically --

    DR. MAGUEN: Yes. And so, I think that the way that we've structured it, the way that we have for the conditions initially, I think that when we sit down with Wendy, there will be a big umbrella about conducting research, for the research and what that will look like, and it will be specified by each condition. But the way that I've done it this way initially is for us to really get an understanding of, by disorder, where the studies exist and where they're lacking.

    But I do see us having a larger umbrella under which -- so, you will see, for each disorder that I go through, there's a parallel structure, and I'm thinking ahead to being able to consolidate under one general --

    MR. KUNTZ: Yes, that is what I was guessing. So, okay. Great.

    DR. MAGUEN: That's right, yes. So, yes.
MR. KUNTZ: Thank you.

DR. MAGUEN: Yes. Thanks for highlighting that.

And that's going to be for each disorder that I go through, I'm going to review with all of you where there was no data, where there was some data, but the strength of the evidence was either low or medium.

MR. KUNTZ: Okay. Thank you.

DR. MAGUEN: Good question.

Any other questions at this point?

COLONEL AMIDON: I just wanted to make sure it was clear to me. So, the threshold within which you decided whether there was data or no data was based on whether an RCT had been applied to the combined conditions, not the monotherapy? And I know that this would make it probably an infinite project, but other --

DR. MAGUEN: Yes.

COLONEL AMIDON: -- call is "research"; I may be misusing the word -- that were more qualitative in their approach, per Dr.
Jonas previously, that just would make it too much scope and scale?

DR. MAGUEN: That's right.

COLONEL AMIDON: Okay. Volumes --

DR. MAGUEN: Right. Originally, when we came up with the PICO tables, that's right, we wanted to do something that was manageable.

COLONEL AMIDON: Yes.

DR. MAGUEN: We already felt like five, and then, extended to eight conditions --

COLONEL AMIDON: Right.

DR. MAGUEN: -- would have been a lot of work, which it was. And so, if you should look at the reports, they're between 100 and 150 pages for each condition.

COLONEL AMIDON: Yes.

DR. MAGUEN: So, it's a tremendous scope of work.

COLONEL AMIDON: Yes.

DR. MAGUEN: So, yes, the PICO tables really specify that we would look at RCTs and highlighted each of, you know, the population
that we were going to look at, the interventions, et cetera. Those interventions, again, were all based on VA/DoD guidelines or other organizations that had guidelines, if the VA/DoD did not have any.

COLONEL AMIDON: Thank you.

DR. MAGUEN: You're welcome.

DR. POTOCZNIK: But, basically, what you are seeing is that there's almost no like solid support for any of those modalities? Even though there are some that have low quality research done, there's no like big kind of study that kind of has found that acupuncture, for example, is really effective with PTSD? The VA offers all these things, but --

DR. MAGUEN: Yes.

DR. POTOCZNIK: Yes.

DR. MAGUEN: Yes, and I will say, too, I know we had part of this conversation yesterday, too. But I think the studies that don't exist are, for example, using CIH modalities to get people engaged in PTSD care.
So, if they're not willing to do the evidence-based treatment for PTSD, we heard when we went to some of the VAs, "Well, I went on a veterans' biking trip. I heard about treatments that veterans were engaged in. I was more open to doing those treatments as a result."

So, that was an example of how CIH led to that veteran being more open to mental health treatment. So, those studies also don't really exist. And I know that that's a way in which many veterans get involved in CIH treatments.

So, yes.

MR. ROSE: I mean, this brings up the point, though, that having these, quote, "modalities," that you can offer and treat the individual veteran. It's not one-size-fits all. It may get the veteran in the door to additional treatment, but you've got it out there.

DR. MAGUEN: Yes.

MR. ROSE: And you get more people involved.

DR. MAGUEN: Yes, that's right. And
so, I mean, that's a very important point.

That's why we're looking at large-scale RCTs,
because it allows us to kind of compile the data.
Because it's not going to be -- one veteran may
benefit from one treatment and not from the
other.

MR. ROSE: Right.

DR. MAGUEN: So, we're kind of looking
at the larger scope now and seeing what does the
research tell us. But, yes, a very important
point.

DR. POTOCZNIAK: Was exercise in
there?

DR. MAGUEN: Yes, it is. Yes.

DR. POTOCZNIAK: Wow. That's
surprising.

DR. MAGUEN: Yes. Yes. Again, there
were, with PTSD, there are some studies for
exercise, but there were some methodological
issues with some of those studies.

DR. POTOCZNIAK: That's surprising,
though, there's not more done on that with
veterans because veterans all love when you tell them to go exercise to cure something.

DR. MAGUEN: Yes. And again, that doesn't mean that there's not pilot trials. There are several pilot trials out there.

DR. POTOCZNIAK: Yes.

DR. MAGUEN: But it just means that they haven't gotten -- and I know of one trial that's actually ongoing right now that's specifically looking at exercise and PTSD. But, again, this is the drawback to doing it at one point in time, is that you're not getting all the moving pieces necessarily, but just getting a flash in time, so up to the point where we're doing the search.

DR. POTOCZNIAK: It almost seems that would need to be almost longitudinal research for exercise because people do it for short periods, and then, give up on it. Is it, in fact, sustained over time, and all that other stuff?

DR. MAGUEN: Right. There are all kinds of methodological issues when you're trying
to conduct an exercise study, too. For example, with a treatment, oftentimes if it's an individual therapy, you have the person come in once a week for that individual therapy, or if it's mass, maybe more. But, in general, it's not more than once a week. With exercise, you're hoping that they're going to do it at least three times a week, ideally, right? And so, there are all kinds of design issues that make this kind of research extremely complicated. And then, you have to have a matching condition where you're asking veterans to come in three times a week for something. And we know, with scheduling and busy lives and barriers to coming in the first place, that becomes very complex. So, yes.

Good, very good discussion. Any other thoughts before we move on to the next recommendation?

Okay. Great.

I do want to say that Recommendation 3 is about specific treatments, including mindfulness-based stress reduction, MBSR, or
mantra meditation. In our searches we did find that there was more evidence for those two specific modalities. So, our recommendation is to include structured or manualized forms of meditation as a routinely available adjunctive treatment intervention for PTSD, such as mindfulness-based stress reduction or mantra meditation.

I will say that I know that in a lot of clinics this is already happening. So, again, if we look at implementation, that is something that is happening on some level across some clinics, but, then, it, again, varies from VA to VA.

Recommendation No. 4 is "To conduct or fund implementation science studies that focus on how to best integrate CIH modalities into current standard practice in mental health and primary care." Multi-site trials would be particularly helpful.

So, this recommendation is specifically about how do we take the knowledge
that we have and understand how we implement it within a system. And so, for example, when CPT and PE were rolled out to the VA, it was very important for implementation scientists to come in and say, "Here's a system that currently exists. We're taking these modalities and introducing them into the system."

In many clinics it was already happening during the time of the rollout, but the implementation scientists were able to come in and say: here's how we can create a system that will be accepting of these treatments. Here are the things that would need to be treated. Let's evaluate not only what happens when you introduce this to a system, but how we can help support the continued implementation of these particular modalities into a system.

So, it's really about how this gets integrated/implemented; what are the barriers to doing so? And so, we have to understand not only what should be implemented, but also how to do that within the system.
So, in the same way that whole health has been rolled out, and there have been studies about how to implement that in the system, the same way we would want to do that for CIH modalities within the whole health system. As we have heard about a lot of those studies from Ben Kligler, a lot of those studies are ongoing.

Yes?

MR. ROSE: Shira, when you talk about CIH modalities, would it not be better to kind of bring those in a little bit or keep it open and say, "CIH modalities," or should it be specific which ones would be maybe, based on your research to date, which ones might be better to start at?

DR. MAGUEN: Yes. Yes.

MR. ROSE: I don't know. Just --

DR. MAGUEN: No, absolutely, yes. I think that, again, once we get into deliberations, we're going to get into the nitty-gritty of that. I think, right now, what I'm trying to do is kind of give a broad overview of the directions and get feedback and get sort of
input from the Commissioners, just like what you are giving. And so, I think our goal is, as we're working with Wendy LaRue, is to also get more and more specific. So, that is very much what we're -- I think the ultimate recommendations will be very specific in their scope. So, yes.

MR. ROSE: Thank you.

DR. MAGUEN: Thank you.

Okay. Good. Any other questions about that implementation size piece, in particular?

Okay. Okay. Great. So Recommendation No. 5 is "To address barriers in conducting CIH research to accelerate information that can be gleaned from these studies." For example, logistical and systematic barriers and stigma. So, it is somewhat related to Recommendation No. 4, but, again, I think that this is really related to, once we get the CIH research out there and what's effective and what's not effective, we want to also make sure
that we're really, really aware of what the
barriers are to sort of implementation, but also
to just using these treatments.

We're learning a lot from the focus
groups, for example, about what are some of the
system-level barriers, but also some of the
personal-level barriers. And so, I think
barriers can be both at the individual as well as
the systemic level. So, logistical sometimes can
be a huge barrier as well for people to make it
to a yoga class or to make it to an acupuncture
session. And so, all of those are important to
look at. So, we can't do this in a bubble. We
really have to be aware of some of the barriers
that exist in conducting both the research and
the information that can be gleaned from the
studies as well.

So, I think that if there are no
questions about that, in particular, I'm going to
move to Recommendation 6. "Make results of CIH
studies more accessible to providers and
patients, so that it can easily be disseminated
and linked to shared decision-making."

    So, I think this is one that we have been talking about quite a bit in our Workgroup. And so, we're doing all of this hard work. And if we don't get it into a form that is digestible and accessible to providers and patients, then it's not going to get out to the very people that we're hoping to serve.

    And so, we have had a lot of discussion about creating bubble maps, so that those can be used as a tool to say, like you can sit down with your patient and say, "Look, here is where the strength of the evidence is. Here is the modality that you want to use. Here is where it falls on our bubble map. Let's have a conversation about whether that could be helpful for you and what that means."

    And so, bringing the patient into the conversation about the evidence that exists for a particular CIH modality as well as personal -- right, because I think patient preferences is always a part of that conversation. Certainly
within the whole health model, it's tailored to
that individual. So, we want to learn -- we want
them to have all of the information about what
their preferences are, what the strength of the
evidence is, what their barriers are to
participating in a particular modality. So, all
of that can get discussed with any particular
patient. And so, from our end, we have to make
sure that those materials are accessible and
translatable to providers and patients.

Okay. So, I think that that, in a
 nutshell, is six recommendations just for PTSD.
Any thoughts about those? Any concerns? Yes?

MR. KUNTZ: I guess I was just
wondering if we could just -- do you think it
would be accurate to say we are in just kind of a
low science area with these? There just hasn't
been that much research in some basic level. Is
that accurate? Maybe we'll have to come out with
that kind of a statement --

DR. MAGUEN: Yes, I think that --

MR. KUNTZ: -- to be able to explain
why these recommendations make sense?

DR. MAGUEN: Yes. So, I think that
that is going to be in the first part of the
report. So, there's going to be a lot leading up
to these recommendations in terms of framing our
findings, framing the scope of what we did. And
then, the recommendations will come after that.

And so, hopefully, the context will be
extremely helpful. But, yes, I would say that
most modalities, more often than not, there is no
research on a particular CIH modality. And so, I
think that that statement that you made is
accurate.

And so, as you know, part of these
were listed in the legislation, and then, part of
these were also ones that we believed were
important to look at because of a number -- you
know, they're important to veterans. We believed
from our own work that these were important to
look at. And so, those were ones that were added
as well. So, it's both the legislation as well
as the ones that the Commissioners added, too.
So, yes. If you take those as a whole, more often than not, there are not RCTs that specifically look at those modalities.

COLONEL AMIDON: And your recommendation, just from sort of a broader context, is that, after we deliver the report, maybe it would be wise to go do, in the 30 subsequent days after the report is delivered, kind of key stakeholder engagement, wherein you could chat about this recommendation with the NIHs and the DoDs of the world to see if there is collaborative research opportunity? This isn't necessarily a VA problem set. It could be --

DR. MAGUEN: Yes.

COLONEL AMIDON: -- an entirety of the system problem set?

DR. MAGUEN: Yes, and that is exactly -- you'll see that in the recommendations for all disorders that we make, that is exactly the direction that we're headed. And so, we can recommend all of the studies that we want, but until we kind of set up and recommend an
infrastructure for that to happen -- and that necessarily involves cross-system collaboration because this can't be done by any one system, any one bubble.

COLONEL AMIDON: Right.

DR. MAGUEN: So it really has to be across systems. And I think there are good models for that. So the good news is that the Pain Collaboratory --

COLONEL AMIDON: Right.

DR. MAGUEN: -- has forged really good ground with how to do some of those studies. So, we will definitely be getting to that. So, thank you for that. We're on the same page.

COLONEL AMIDON: Yes.

DR. POTOCZNIK: So when we make these recommendations that more research be done, the question is where does that go? Because it's like you would go to -- because we're really recommending this, right, to --

CHAIR LEINENKUGEL: It's a great question, and I think that that comes with the
follow-up Workgroup discussions, especially what we heard from Wendy this morning about being more specific as to implementation and verbalizing with key verbs who we want to own that. In particular, saying --

MR. SPERO: Congress should direct --

CHAIR LEINENKUGEL: Correct. VA should --

MR. SPERO: These government agencies conduct --

DR. LaRUE: That's the implementation steps. It's like budget, $5 million to go to something rather --

CHAIR LEINENKUGEL: Mike, to your point, well get to much more specific recommendations, but these are just great step-builders that you're presenting right now, Shira, right on the mark.

DR. MAGUEN: Okay. Good. Yes, exactly. Right. I think, again, keeping in mind that these are working. The way that I view this is just that way, that these are building blocks
to be able to get us to discuss the specificity
that we need in a recommendation, guided by
someone who has, by people who have a lot of
experience in this area in how to make our
recommendations digestible.

CHAIR LEINENKUGEL: Right.

DR. MAGUEN: Okay. Great. Okay. So,
moving on, if no one else has questions about
PTSD, I want to share our opioid use disorder
recommendations. Again, as I mentioned,
Recommendation 1 is structured in a very similar
way. We are recommending "To conduct/fund
research related to CIH treatment interventions
and OUD, particularly multi-site trials." That's
going to be a theme throughout.

More specifically, we found that there
were not any randomized control trials for OUD
with the following modalities. And again, you
see here that this is really the majority of the
modalities. There was very little research with
OUD.

I want to specifically point out here
that there are studies, for example, on pain, which is reason why many people start using opioids. But we are, again, looking at conditions. And so, that's important to note here.

COLONEL AMIDON: Will there be any attempt, just I guess yes or no, to prioritize those modalities below in order to sort of live life in the research lane?

DR. MAGUEN: Yes, I think that that is something --

(Simultaneous speaking.)

DR. MAGUEN: That's right. That's right. So, eventually, I think we have to, for budgetary reasons, be able to kind of prioritize these. But I think that's going to require further deliberation/discussion amongst the Workgroup and the Commissioners as a whole.

Okay. So, these are areas in which there was some evidence. So, exercise and some acupuncture studies have low strength in evidence with respect to OUD outcomes due to
methodological and study design issues. Again, further studies might be required. So, there were some studies with exercise, and there were some acupuncture studies as well that were done. However, acupuncture in those with OUD, there were some studies that had moderate evidence with reducing depression, but not any of the OUD-specific outcomes. Okay. So this is, again, just as a reminder, in our tables we looked at OUD-specific outcomes, like cravings, methadone consumption, but we also looked at, because we know that comorbidity is an issue, does it reduce depression? Or do some of these modalities increase well-being and quality of life? And so, we looked at a number of different outcomes. But what we did find was that acupuncture was helpful with reducing depression, but not any of the OUD outcomes. So, I want to make sure that that's clear to people because it's a bit of an indirect relationship in terms of what we were hoping to see, in particular. Okay. Again, take-home message here: very few
studies with OUD and CIH modalities.

This was a recommendation that I think is important because we don't only want to focus on treatment, but also prevention as well. And so, you'll see this echoed when we talk about alcohol use disorder as well. "Conduct more research with OUD patients to ensure prevention of overdose." So, looking at naloxone and CIH modalities. Really thinking about this, not only from a treatment, but from a prevention perspective as well.

DR. POTOCZNIAK: Meaning naltrexone or buprenorphine?

DR. MAGUEN: So, basically, if we're thinking about this from a prevention perspective, to think about how --


DR. MAGUEN: Yes, that's right.

DR. POTOCZNIAK: Okay.

DR. MAGUEN: So, we want to be thinking about not only how we are treating
people when there's already a problem, but how
are we going to think about preventing overdose
and more difficult problems.

DR. POTOCZNIAK: Got you.

DR. MAGUEN: Yes. So, good. Any
questions about that?

So Recommendation No. 3, and I think
this goes back to the point that I was making
before. There are pain management studies that
are out there. So we want to leverage pain
management research that exists and conduct
studies with these modalities that include
patients with OUD. For example, while yoga has
shown to be helpful with pain management, there
are no studies that focus on yoga and OUD.

So, this goes back to, Matt Amidon,
your question about how we prioritize. I think,
with OUD, here is some information about how we
might want to prioritize those studies by looking
at what's been done in pain, and then, really
increase the studies with this particular
population, so we can make sure it impacts those
people, in particular.

Okay. And then, finally,

Recommendation No. 4, "Conduct studies with medication-assisted treatment and CIH modalities." This is where, Mike, the question, that's the one that you were looking for, right?

DR. POTOCZNIAK: Yes.

DR. MAGUEN: So, again, naltrexone, suboxone, building on the services that VA is already delivering. We want to look at -- again, this is not a monotherapy, but in combination with what we already are doing in the VA, and focus in on specifically those types of studies that look at medication-assisted treatment.

All right. Any thoughts about OUD? Are we missing anything that people can think of? Anything that you want to add to the discussion before we move on to alcohol use disorder?

DR. POTOCZNIAK: I think it's just striking in a lot of ways how much of this is offered for and paid for by the VA, but is not founded in anything that was real, except
veterans' experience saying like, "Wow, I liked this," or whatever it was.

But it is just striking me because I have seen your -- I know what's coming next also with the rest of them.

DR. MAGUEN: Right, right.

(Laughter.)

DR. POTOCZNIAK: And it just goes on and on and on about -- I mean, it's noteworthy, I think, that not only are we providing these, but we're also paying community care clinicians to do these things. That is health care money that is being spent -- not necessarily that it's bad, but I think it is just notable that we don't have anything backing it up.

COLONEL AMIDON: And to the economics of the cost-benefit analysis.

DR. POTOCZNIAK: And there is a tremendous cost to this stuff. It's not cheap.

COLONEL AMIDON: And it would be interesting, I guess, as an adjunct, just history matters here, and that certainly matters in this.
This is a snapshot in time, but what was the growth? How long, I guess from your perspective, did it take to get all of these modalities offered within the VA portfolio to just start?

DR. POTOCZNIAK: Right. And it's not just, you know --

COLONEL AMIDON: We're not guiding them in any way.

DR. POTOCZNIAK: No, but I think the scope of it can be lost on non-mental health people, because it's like we've spent how much time -- like when you think of CBT for depression or PE for post-traumatic stress disorder, we have spent so much time figuring out how many sessions is effective, how do we do the treatment, what style do we do the treatment, what environment do we do the treatment, who provides it. And we've kind of talked about those things forever and ever over years to make sure that it works, and to make sure that it's cost-effective.

And so, then, when you bring in things like equine therapy, which I know is useful to a
lot of people, but we don't know how often. We
don't know what kind of horses, what kind of --
like we don't know that stuff. And it's not just
research; it's also research -- it's research
plus. Like it's a lot of research. Think of how
much research goes into CBT alone, and has gone
into CBT alone, and we're still researching it.
And yet, it's a gold standard.

DR. MAGUEN: And I'll add onto that.

I think that if you look at, for example, CBT and
PE research, what we know is that the trials were
done and, then, we've looked at it in the mixed-
method way, right? And so, I think to add onto
that, I think it's important not only to do the
studies that look at what dose is it effective
in, how is it best delivered, but, then, to do
the companion piece, which is to talk to patients
who have done CBT and PE and understand like what
was their experience; what was best for them;
what were their preferences; what were their
barriers, right? And so, these things have to
necessarily also go hand-in-hand, so you can get
at that nitty-gritty detail, not only through the RCTs, but also talking to patients and understanding the qualitative, in addition to the quantitative data.

MR. KUNTZ: While we were touring Columbia, they have a leading equine program there, and they said, you know, there's no RCTs on this. It probably costs about 5 to 10 million bucks to run one.

MR. SPERO: I think it was if they wanted to do MRIs with it, it was 9 million; without it was 5 million.

MR. KUNTZ: Yes.

DR. POTOCZNIAK: And that's one.

MR. KUNTZ: And that's one. So that's exactly what I'm saying. It makes me wonder, just to plant it in your clinician-researcher heads, are pragmatic trials, since we already have these going in the system, is that the only way to really try to capture what we're spending our money on and if it works? Because I exactly want to point out that 10 million bucks for one
thing, I've been told by SVAC they couldn't find $3 million for something else. So, is that kind of institute pragmatic studies the only realistic way to go with that?

DR. POTOCZNIAK: I think that if you're paying -- certainly, part of it is I think so because the ramifications of not knowing whether it works is billions, you know, and that's at the cost of other forms of treatment to veterans, right? So, I think it is important to do RCTs, if you're going to offer it. If you're not going to offer it, that's -- or if it's going to be offered by volunteer people, or captured under rec therapy, but when it's used -- like, right now, in the VA we can order equine therapy for community care. And there are no boundaries at all on how that's provided because there's nothing to say what works.

So, if you don't do RCTs, you have the situation where there are no boundaries on how big it can get. If it's researched, it can be like six or seven sessions of equine therapy
works under these conditions, on a ranch, in
these. But if you don't do that research, you're
paying for whatever the person on the outside is
going to offer, and that could go on forever.

MR. KUNTZ: I guess I was wondering
about pragmatic trials or more of a records-based
analysis of who is going for equine therapy and
does their hospitalization rate decrease, and the
things that you may be able to find. Because the
VA is actively paying for all these things, we
have the records.

DR. MAGUEN: So, that is an excellent
question. I think, ideally, the answer would be,
yes, the hope is that you would be able to track
that in the medical record. However,
unfortunately, when the patient goes to equine
therapy, there's not a pre and post measure done.
Because when community care is done, a lot of
times there's not necessarily any measurement
that they have to bring back to the VA system.

And so, I think that there's been a
lot of advocacy, and I know that's part of some
of the work that people are working on for the
future, to be able to eventually collect those
data from community providers. But, as you know,
it's very hard to get community providers
reimbursed for work, never mind having them sort
of be able to fill out pre and post measures,
right?

DR. POTOCZNIAK: They don't even turn
in the records.

MR. KUNTZ: Well, I guess what I was
saying is if you know that they went out to do
this, and you have their records, and did their
medications decrease, did their hospitalization
rate change, something in that record that may
suggest positive or negative outcome.

DR. POTOCZNIAK: What would make that
so difficult is that veterans rarely -- you would
never, I don't know if you would ever find a
veteran that you could cleanly study, like a
group of veterans, because usually they're doing
-- some are doing equine therapy. Some are also
doing chiropractic. Some are doing acupuncture.
Some are doing none. Some of them did it for a little while and discontinued. Some of it for -- that's all they do in the VA is that, you know.

DR. MAGUEN: And they change their medication a few times during the course --

DR. POTOCZNIAK: And it all happens independently. So, you would always be looking at what change was responsible for what, and you would never be able to say like anything cleanly, that this --

COLONEL AMIDON: You can't keep any variable constant.

DR. POTOCZNIAK: Because it's a constant -- you can't control the psychiatrist that changed it from sertraline to citalopram to, you know -- who knows what that was? So frequently, veterans are just inundated with a bunch of treatment at the same time. So, it's a hard thing to do for records research on that.

DR. KHAN: So, listening to what you are saying, the way I am looking at it is we should improve the VA system to capture the
results of these things being done. Now sharing
with you, in Wisconsin we have farmers who have
their own horses. And the BCOCs and the
psychiatrists, they have connections with,
collaboration with non-VA care. So, too long VA
care -- my psychologist, he sends me to equine
therapy. As a non-VA, it's in my record.

    DR. MAGUEN: Yes.

    DR. KHAN: It goes back to that
psychologist to capture it. So, if we emphasize
on capturing that information, that will be less
expensive than trying to go through -- I mean,
I'm talking about dollar-wise, you know.

    DR. MAGUEN: Yes. Well, I don't know
if you had a chance to look, but in the RAND
report one of the things that they do bring up
specifically as a recommendation is "Improve
monitoring and performance measurements via
community care program." So, that is an explicit
recommendation for research, and I do think that
that is important, for the reasons that we are
highlighting here. It will help us better
understand, if people are doing these things in
the community, we will have some data to look at.
For any experience that they had outside, was
that actually effective? And if that's where the
CIH treatments are being done in some cases, then
that could be monitored.

Yes, thank you. I think it's an
important point and very related to what we're
talking about. But I think there also needs to
be -- we're undergoing right now a time of
change, a big change in terms of community care.
So, there is a lot of refinements that are being
made. And I know people are thinking about this,
but I think that part of what our work will
depend on is those systems being in place. And
we don't know how long that's going to take to
have that, but we know that we're thinking about
it. RAND was clearly thinking about it and
advocating for it, too.

But there has to be, in the same way
that VA is focused on measurement-based care,
right -- and so, we are collecting data here.
And if our veterans are getting care outside the community, it also behooves us to collect measurement-based care outside, so we can compare and see how they're doing overall. So, it's important.

DR. JONAS: I think we have, later on, when we get to some general recommendations -- you're going through the modalities now, unless you did that first?

DR. MAGUEN: No, I'm saving that for last, yes.

DR. JONAS: Yes. So, at the end, I think we have a couple of generic recommendations that I think get at what you all are talking about, which is that there needs to be, I mean, clearly, there needs to be more research done, period. I mean, that's going to be a general recommendation here.

DR. MAGUEN: Yes.

DR. JONAS: It's just these things are important. People are using them. We don't know how to do it. Okay?
DR. POTOCZNIAK: The VA is opening departments on it.

DR. JONAS: Yes.

DR. POTOCZNIAK: And we don't know whether it works.

DR. JONAS: Invest in research. Invest in finding out. So, that's going to have to be one.

But I think, beyond that, we've also discussed -- and I think Shira will get to those -- you know, there needs to be more thinking about creating an evidence-based informed -- strategies for research that allow for more ready applications and decision-making about measure-based and evidence-based practice.

DR. MAGUEN: Right.

DR. JONAS: And so, that means, okay, well, do you need a randomized control trial on every little component? No. Okay. So, then, what, then, takes it to the threshold of we're saying, that particular thing, well, you need to do a randomized control trial on, and the other
things, you know, other types of evidence we can collect would be sufficient? What is that strategy?

And there is a lot of writing about it. I gave this book to the Chairman here that was an Institute of Medicine's report several years ago on CAM. They called them CAM modalities. It's the same types of things. And they have an extensive discussion of the need to create strategies and example strategies of how to address these very issues. So, we should probably look at that, pull it in. We have some of the same recommendations that are in there.

DR. MAGUEN: Yes, yes.

DR. JONAS: But that would be background in those areas. They talk about whole systems approaches. They talk about external validity. They talk about qualitative research, all the validity, those kinds of things.

And this isn't isolated to CIH, though. I mean, these are the same issues. I mean, we do back pain surgery to the tune of $41
billion a year in this country, and 80 percent of
it isn't evidence-based; it's unnecessary, okay?
Because you can't do a blinded, you don't do
double-blind surgery studies. So, they do use
stuff that would never -- that would have the
same poor quality, if you looked at it using the
same lens.

DR. POTOCZNIAK: But when you have
treatments that do work for things like PTSD and
substance use and opioid dependence, and you're
paying -- because the money has to come from
somewhere. So, with the back surgery-type stuff,
sometimes it's for lack -- it's out of
desperation that we do things --

DR. JONAS: Right.

DR. POTOCZNIAK: -- that aren't
researched well. But, in these situations, the
money has to come from somewhere. So, sometimes
it's going to come from things that do work and
fund things that maybe work or don't work.

DR. JONAS: Yes. We're already doing
that. We're doing a lot of back surgery. A lot
of money is going into it. The evidence in back 
pain shows that yoga actually is probably just as 
effective for most functional back pain, half of 
which, or whatever, are getting surgery. So, we 
ought to be investing in it.

So, it needs to be a consistent, 
overall strategy, and especially is it addressing 
questions that are important to veterans and that 
are expanding sort of lens? And there's 
different methodologies that allow you to kind of 
do that. That's about a strategy, and I think we 
have some suggestions along those lines.

DR. MAGUEN: Yes. Yes.

DR. JONAS: Then, when you have to 
actually differentiate the placebo component and 
you separate it out and do that, then you have to 
do rigorous types of research on the placebo 
components and that kind of stuff, if it's 
possible.

DR. MAGUEN: Right.

COLONEL AMIDON: I guess from a 
customer perspective, though, the differentiation
between evidence-based and yoga within VA and
back surgery and yoga in the private sector would
be somebody who chooses to engage in yoga vis
back surgery in the private sector is, thus,
going to pay for it themselves, correct?

DR. JONAS: It's not because it works.
It's because a lot of them have got to pay for
it.

COLONEL AMIDON: Yes.

DR. JONAS: So, it gets to a Michael's
question about where are we putting the money.

DR. MAGUEN: Yes.

DR. JONAS: Which, ultimately, that's
what they have to decide, right, where are we
going to put the money?

DR. MAGUEN: Right.

DR. JONAS: Because you can't do
everything, as Michael says.

DR. MAGUEN: Right.

DR. POTOCZNIAK: And the heart's in
the right place, right? I mean, there's all
these things. What it shows to me is the
desperation which the VA is willing to go to to
help heal veterans.

   DR. JONAS: That's right.

   DR. POTOCZNIAK: It's like we're
willing to do anything. I think what we need to
look at now is, okay, does any of this work,
though?

   DR. JONAS: Correct.

   DR. POTOCZNIAK: A lot of whole health
was deployed during the height of the Iraq War,
is when it started. And so, there's a lot of
desperation out there to get something. And I
think we do have some things that work, but,
then, you have these things that may or may not.

   DR. JONAS: And you have to
distinguish between, you know, answering the
question of does it work. Is it because we've
tested it and it doesn't work, or it's just never
been tested? With what we have we don't know.

   DR. MAGUEN: Yes.

   DR. JONAS: Those are two different
reasons for saying maybe we shouldn't pay for it,
right?

DR. MAGUEN: Well, and I think just, again, going back to the yoga example, we know that for things like, as you were mentioning, for pain yoga works, right? And so, those trials have been done. So, this goes back to the issue of comorbidity, right?

So, the veteran is coming in and they have PTSD and they have pain and they have alcohol use disorder, and you recommend yoga. That's why we're looking at the whole person, right? We're not just looking at the disorders. So, that's a key piece here, that the recommendation to do yoga and the whole health model, in and of itself, is taking all of that into account and saying, okay, what are your preferences? What's important to you? Okay, you have back pain and you have a preference for non-medication modalities. Let's start you out with yoga and see where we go from there. Right? And so, it's looking at everything that's going on with the person.
DR. JONAS: And the big question is, how do you do that kind of a strategy, that kind of an approach and, also, make decisions in that space?

DR. MAGUEN: Right.

DR. JONAS: I mean, we know the answer to that.

DR. MAGUEN: Right. Yes.

MR. KUNTZ: Should we get back into -- I'm sorry.

DR. MAGUEN: Yes, there's a lot going, there's a lot of good discussion to be had. But, yes, let's get back into the alcohol use order search that was done.

And so, our Recommendation No. 1 -- so, again, I've listed all of the CIH interventions in which there were not any RCTs here. You can see again, overall, more studies do not have any, including yoga here, including service dogs, tai chi, massage therapy, so with AUD, none of these studies exist.

And then, there are some studies --
acupuncture, cannabinoids, exercise, meditation, music therapy, relaxation therapy, and TMS studies -- there were some studies that were done in the AUD area, but they had low strength of evidence, again, due to methodological and study design issues. Again, further study might be required.

And there is some limited evidence to suggest that meditation used in the context of mindfulness-based relapse prevention can reduce cravings, post-intervention alcohol or drug consumption, and perceived stress. Okay? So, very specific. As you can tell, there was some limited evidence to suggest --

DR. POTOCZNIAK: So, cannabinoids had a low strength of evidence?

DR. MAGUEN: Low strength of evidence. Again, there was a study, but there were a lot of problems with the methods.

DR. POTOCZNIAK: It's interesting to consider cannabinoids a treatment for AUD.

DR. MAGUEN: Right, right. There
might be ethical --

DR. POTOCZNIAK: That's super-controversial.

DR. MAGUEN: Yes, yes. Right. And so, that's a whole other can of worms, but I think it looks here like there's -- you know, the study that was done, although it was done, we could talk about the ethical issues, but, again, there's methodological problems despite all of that.

DR. POTOCZNIAK: Yes.

DR. MAGUEN: So, yes, there's a lot more to say about that, I believe.

DR. JONAS: Well, that's sort of what we do with methadone, isn't it?

(Laughter.)

DR. POTOCZNIAK: It is, but --

DR. JONAS: It's what methadone is.

Take that, instead of this; it's not as bad.

MR. HARVEY: The lesser of two evils.

DR. JONAS: That's right.

DR. MAGUEN: So, good. Let me go on
to say -- unless there's any further comments? I feel like we could talk about that one for quite some time probably.

DR. POTOCZNIAK: I could go on, but --

DR. MAGUEN: Okay. We can table that and get back to that.

So, "To conduct/fund studies that focus on prevention." Again, you will see a common theme here, that we're not only looking at treating it, but we really want to focus on prevention, too. Developing AUD, using CIH modalities, given the public health issue of alcohol use among veterans. So, we want to be thinking preventatively with OUD, with AUD, and, of course, with suicide, but we'll get to that in a second.

Yes?

DR. JONAS: I would just make one point, and maybe we'll talk about it later. But, you know, there's so much emphasis right now on opioids, and, yes, it's a problem. Alcohol is a much bigger public health problem, I mean, if you
just look at the damage --

DR. MAGUEN: The scope.

DR. JONAS: -- and the scope of it.

I don't know if we want to somehow point that out, because a lot of times people lose the forest for the tree, you know. And so, do we want to --

DR. MAGUEN: Yes, yes, absolutely.

And I think, again, the public health issue here is tremendous.

DR. POTOCZNIAK: And similarly, you make this later on, but similar to your PTSD recommendation, it would almost seem that it would be important to mix -- or maybe it was the OUD one -- but to mix CIH with naltrexone, like medication-assisted treatment for the --

DR. MAGUEN: Yes.

DR. POTOCZNIAK: Because that's the current trend, is to engage MAT with AUD. And also, to really look at programs that integrate CIH.

DR. MAGUEN: Right.
DR. POTOCZNIAK: Because there's two schools, like in AUD, of treatment, right? There's programs that integrate CIH, and frequently, they're the ones that are open to more harm-reduction-type stuff.

And then there is old school 12-step.

Kind of they might do a little motivational enhancement, but there's like, you know --

DR. JONAS: Six months. Six months first.

DR. POTOCZNIAK: Yes, exactly. So, there's two separate schools. That would actually be a very easy controlled kind of easy research because you have such a divide between those programs, what works better, essentially?

DR. MAGUEN: Uh-hum.

DR. POTOCZNIAK: So, it almost seems like we would want to plug at that a little bit in some way, to look at programs, integrated programs.

DR. MAGUEN: Yes. Let's see, because I think that is one of the overall
recommendations. Let's see if it actually fits what you're saying to some extent.

DR. POTOCZNIK: Okay.

DR. MAGUEN: Are you talking more about like residential --

DR. POTOCZNIK: Residential or intensive outpatient.

DR. MAGUEN: Yes. Good.

DR. POTOCZNIK: Because usually those are similar. They all offer, you know, a lot of the IOPs in the VA offer CIH. But, then, you have certain VAs, especially older-school VAs, that don't at all.

DR. MAGUEN: Yes.

DR. POTOCZNIK: And so, who's running the program?

DR. MAGUEN: Yes.

DR. POTOCZNIK: And there's nothing to force one to move forward or backward. It's like that person, they've owned it for 20 years.

This is what works.

DR. MAGUEN: Yes.
DR. POTOCZNIAK: But if we had something that actually said CIH, when integrated, would help, it would make people move forward.

DR. MAGUEN: Yes. Good. When we get to the general recommendations, let me know if you think the wording of that is sufficient, or if we need to add to that, we can do that. I think, originally, we had it in several, and then, we moved it to the general because it was capturing different areas. So, we'll stay tuned about that, and we can circle back to that. It's an excellent point.

So, suicidal behavior, this is our last formal search that we have results on. Like I said, we're going to talk about depression when we have our Workgroup call next week. So, suicidal behavior is a little bit unusual because really it's important for us to look at separately, but, as we know, that's not a mental health diagnosis. It's a behavior.

DR. POTOCZNIAK: It's a V code, right?
DR. MAGUEN: Yes, I think it's -- in terms of diagnosis, you can diagnose, you know, you can put in a V code for it, but it's not a typical diagnosis per se. So, it's more of the behavior, but very important to look at, nonetheless.

Again, speaking about comorbidity, you can have suicidal behavior, as we know, with many different diagnoses. So, I think that, here again, more specifically, we found that there were not any RCTs for all of the following modalities. Again, the majority of these modalities do not have an RCT in those with suicidal behavior.

Again, as a reminder, research with individuals with suicidal behavior is very difficult to do. Outcomes are very difficult to track. So, there's a lot of challenges that we've talked about on our calls and over the last few days amongst the Commissioners, just about the challenges of doing behavior with individuals who have suicidal behaviors and tracking that.
So, the following modalities had low strength of evidence with respect to suicidal ideation outcomes due to methodological and study design issues. So, further studies might be required. Exercise, relaxation training, and TMS, so there was some evidence, but, again, low. Exercise examined in conjunction with CBT versus CBT alone was done in one study and demonstrated a potentially promising result. Yet, further research is needed.

Again, I think I spoke to some of you about this particular study where they looked at exercise with CBT versus CBT alone. These are the kinds of studies that we would want to see happening. Again, we don't want to take someone with suicidal behavior and just have them exercise, right? We want something that we know is going to be evidence-based therapy specifically, whether that be CBT or medication, et cetera. Bilateral TMS also seemed most promising for suicidal behavior, but, again, further study is needed.
And again, the strength of the evidence across the board is not as strong as we would want in some of these studies, but there were some hints at least of which direction to go from some of the preliminary studies that have been done.

MR. ROSE: Shira?

DR. MAGUEN: Yes?

MR. ROSE: On the suicidal behavior --

DR. MAGUEN: Yes?

MR. ROSE: -- is that just they have thought about suicidal behavior or they have made an attempt? What is that?

DR. MAGUEN: Right. Well, I think that, again, it varies in terms of the studies. And so, we would have to kind of break it down. But these are in individuals who either have ideation or behavior, yes. Yes.

MR. ROSE: Okay. Thank you.

DR. MAGUEN: Yes, you're welcome.

Okay. Good. And then, our next recommendation is, "To conduct or fund research
studying CIH modalities as an adjunct treatment to evidence-based psychotherapies for suicide risk and medication, since these trials would mirror how treatment is generally provided in the clinics." Again, you will find that this is a familiar recommendation, that we're really stressing that we don't want any CIH modality used alone with patients who are suicidal or exhibit suicidal behavior. For example, TMS could be studied as an adjunctive treatment to cognitive behavior therapy, similar to what we saw done with exercise.

Okay. So do you have questions about that before we move to applicable to all disorder recommendations?

Okay. So now we're starting to get into oversight and implementation recommendations. Again, we recognize that we can make the most beautiful recommendations, but that, unless we have a very tight structure in place to make sure that the recommendations are received and that there is oversight to carrying
them out, we're not going to do justice to sort
of the work that we've done here.

So the first recommendation is
"Oversight and implementation of these
recommendations should be assisted by several VA
FACA groups, including the Special Medical
Advisory Group, National Research Advisory
Council, Advisory Committee on the Readjustment
of Veterans, and Advisory Committee Management
Office. These groups should address the topic of
CIH research and the needs for veterans, the CIH
research needs for veterans particularly."

So, any questions about that
recommendation?

CHAIR LEINENKUGEL: Yes. How did you
get to those groups, Shira? I'm just curious.

DR. MAGUEN: So, we consulted
specifically with John Goodrich and were sort of
advised. We looked into which ones would be
directly related to veterans and which ones could
have oversight that would be related to the areas
that we were looking into.
CHAIR LEINENKUGEL: Let me ask another follow-up question to that.

DR. MAGUEN: Sure.

CHAIR LEINENKUGEL: Do these advisory groups actually either mitigate, implement, extrapolate, get in front of the Secretary, USH, and actually follow up on implementation plans or ideas for implementation? That would be my question.

DR. MAGUEN: Yes. So, I think that what we're really thinking of is a multi-pronged approach, right. So, this is one of several things that we're going to recommend. I don't think any one of these is going to work in a nutshell. We've talked about stakeholders, in addition to that.

I think that what we have to do -- and we're just starting to think about this -- is really set the stage to how this going to be received and who are going to be the champions that really carry out this work.

CHAIR LEINENKUGEL: I think it's
critical.

DR. MAGUEN: Yes, I agree.

CHAIR LEINENKUGEL: I love seeing some of those groups up there. I just don't know how actionable they are.

DR. MAGUEN: Right.

CHAIR LEINENKUGEL: And they may be, but I love the oversight and implementation phraseology that you're using there. I think that needs to become a model for the rest of us to consider once we make recommendations.

DR. MAGUEN: Yes.

CHAIR LEINENKUGEL: That there has got to be some sort of oversight and implementation for our suggestions/recommendations.

DR. MAGUEN: Yes, agree. And I would love to get more input about those who have had more experience with these groups, in particular, about some of the questions that you were asking about or some advice about that. What are sort of the limits of these groups? How far can they take us? What are going to be some of their
strengths; what are going to be some of their weaknesses in helping us kind of achieve the goal? So, I think it's an important point.

DR. JONAS: Yes. I mean, a group that's not up there, for example, is the review panels.

CHAIR LEINENKUGEL: Is the what, Wayne?

DR. JONAS: The review panels.

DR. MAGUEN: The research review panels, you mean?

DR. JONAS: Yes. The research comes in. Review panels have to do peer review to see how well they're done.

DR. MAGUEN: Yes.

DR. JONAS: If they have nobody that has any experience with CIH on it, then they go, "I don't know." And those usually get pushed to the side. I've been on a number of those.

And that's a problem at NIH. It's why the whole Center was developed, because there was nobody within NIH that had any expertise in it.
The VA has been pushing things into those areas, but they actually don't have a review panel for this.

DR. MAGUEN: Yes.

DR. JONAS: So, they have to cede it in and that kind of stuff.

DR. MAGUEN: Yes. Well, I think the VA also works a little bit different than NIH. So, the NIH review process, there is a specific panel for this particular issue, but, for the VA, you can submit a grant under HSR&D or clinical or under rehab, right?

DR. JONAS: Yes.

DR. MAGUEN: And within those, what they will do is, then, try to find the experts that have expertise in that area.

DR. JONAS: Yes.

DR. MAGUEN: So, you apply under one of the three larger groups.

DR. JONAS: Right.

DR. MAGUEN: And then, that is kind of done for you.
DR. JONAS: Yes, it is. It's designed a little different than NIH.

DR. MAGUEN: Exactly.

DR. JONAS: The process of reviewing is pretty much the same. They have a go-to set of folks that have time to do it --

DR. MAGUEN: Yes, agree.

DR. JONAS: -- and people to do it. And then, they try to supplement it --

DR. MAGUEN: Right.

DR. JONAS: -- with people with particular expertise or in some cases -- but the most effective ones at NIH were special emphasis panels, where they put together an emphasis panel specifically to do a topic that was not normally done within the standard processes that they use, to make sure they have the kind of expertise.

DR. MAGUEN: Yes.

DR. JONAS: But that's all part of the standard review process.

DR. MAGUEN: Right. And so, we might want to add a recommendation that's based on --
DR. JONAS: Yes.

DR. MAGUEN: -- gathering a special emphasis panel. You know what I mean? That might be something that we want to --

DR. JONAS: Or I think if we feel that these areas deserve more emphasis because there's such a paucity of research, and if the VA is going to start investing in it, that they design a way to put it more permanently into their standard review processes.

DR. MAGUEN: Right.

DR. JONAS: If it was NIH, you would ask them to set up a review group on it, right? VA, there may be a different way to do that.

DR. MAGUEN: Yes, absolutely.

MR. ROSE: I have a question. Who actually pulled these together to set this panel up? Who does that?

DR. JONAS: So, HSR&D has an entire bureaucracy that does it, manages it. A very rigorous, formal, structured process where they bring in reviewers and distribute all the
applications that come in. They solicit applications. If they want to see an area done, let people know that they're going to set aside some money to do it. So, then, all the researchers are coming out of the woodwork and apply, and that's how you move it forward.

MR. ROSE: How long does that take to set up?

DR. JONAS: Well, it takes a long time. I mean, at the NIH, which I'm more familiar with the overall process -- I mean, I've been on review panels in the VA, but I've never overseen the overall process, where at NIH I have. If you're a new investigator or even if an established investigator, and you really want to do it, and you know you're a good researcher, you can anticipate applying, minimum, two, probably three or four, times before you actually get your grant funded. And each time it will take, you know, the fastest would be three months. Probably most of the time it's six months each time, because it has to go to the review panel,
and then, it has to go above that to be approved by the advisory group.

And I don't know if any of those advisory groups are the ones that do it, but, then, it has to be actually approved by the advisory group to say, yes, the review is good, but our priorities are this. And then, they might not fund it for other reasons. Okay?

You can get a good scientific evaluation and still not get it funded because the advisory group says, "No, we decided we were going to do that this year."

DR. MAGUEN: And I'll just add that, by the way, we have talked about NIMH and we have talked about VA, but there is also DoD, right, which we haven't mentioned.

DR. JONAS: Right.

DR. MAGUEN: And the DoD grant application process is quite different. And so, DoD will fund things, they'll make calls for things and fund things potentially within the first round that you submit it.
DR. JONAS: Yes, that's true.

DR. MAGUEN: And so, it's a very different system that the DoD has. And so, one of the recommendations that we're going to be getting to is saying that no one system should oversee this, but we really should be working together across this. And so, we're going to get to that.

But I think what you're hearing is that it's NIH, VA, and DoD have different processes.

DR. POTOCZNIAK: How about SAMHSA?

DR. MAGUEN: SAMHSA is also -- I'm not as familiar with SAMHSA.

DR. JONAS: PCORI has its own process.

DR. MAGUEN: Yes.

DR. JONAS: Yes, the reason why DoD is able to do it faster is because they don't even do a call until they already have the money. They already have the money and they're ready, and they have to distribute it within a short period of time; whereas, the NIH can kind of
float it. They could do something saying, well, if we get good applications, we'll find the money and do it. And then --

MR. ROSE: Okay. Thank you.

DR. MAGUEN: You're welcome.

Let's see. So, we've talked about applicable to all disorders. This slide was Recommendation 1.

And Recommendation 2, "Oversight should be delegated under the Executive Branch implementation, ensuring that action takes place by having Congress direct the orders for CIH research." Again, we're trying to think of just working recommendations that are talking about where oversight should be delegated. So, that's not lost in the shuffle.

Recommendation No. 3, "Ensure that all studies include adequate representation of women, at least 20 percent." So, we were just talking last night about how the number of women veterans are growing at quite a fast pace, and that we're already at at least, you know, getting up to 20
percent, and certainly we'll be there in the next few years.

And so, I think it's important to make sure that not only are women adequately represented, but that racial and ethnic minorities are also adequately represented in research. In research, there's a way to do that. And so, some of these groups that distribute the funds will monitor and ask you to report out on your representation of women and racial and ethnic minorities. So, we have to make sure that that's reflected in the research that is being done.

DR. POTOČNIKA: And the effect of the requirement could also even be higher if you really consider that CIH is probably most integrated into the women's clinics and stuff like that. So, there's probably, I would say, with CIH, the utilization of CIH is probably more heavy on the female veteran side. They probably use it more often. And so, I wonder, with the people that you use CIH, I would wonder what the
percentage of women is. I would bet you it's closer to 30 to 40 percent.

DR. MAGUEN: Yes.

DR. POTOCZNIAK: Yes.

DR. MAGUEN: Well, I think it's an excellent point, right. So, we absolutely have to make sure it's at least 20 percent, and perhaps even more than that, right, depending on what we find in terms of the percentage of people actually using it.

Recommendation No. 4, "Given the paucity of studies with individuals with MST and CIH modalities, studies should be funded that include veterans with MST exposure." And so, one of the things that we looked at, in particular, when we were doing some of the searches is we wanted to see if there were any MST studies, in particular. As we discussed as part of our Workgroup, we think that MST is an issue that's critical to examine in the VA system. And so, we want to make sure -- and MST is not only seen in individuals with PTSD, but depression and alcohol
uses. So, across really all of these disorders we see people who have experienced military sexual trauma, and we want to make sure that that population does not get lost in the shuffle as well, men and women with MST.

DR. POTOCZNIAK: And I don't know if anybody saw the study that just came out --

DR. MAGUEN: Yes.

DR. POTOCZNIAK: -- that they estimate about 10,000 men a year are affected by MST in the military. So, like that's DoD people.

DR. MAGUEN: Yes.

DR. POTOCZNIAK: So, that's a tremendous -- I think over the past decade, they said, probably close to 100,000 men, which is a ton of people.

DR. MAGUEN: Yes.

COLONEL AMIDON: Who did that study?

DR. POTOCZNIAK: I can forward it to you.

COLONEL AMIDON: Yes.

DR. POTOCZNIAK: It was all over the
news, though.

COLONEL AMIDON: Yes.

DR. MAGUEN: So, The New York Times has an article as well, I think from yesterday, that was covering men and MST.

DR. POTOCZNIAK: Basically, it said that -- what was it? -- that they've always seen it as kind of a women's issue, but in the military they actually said, even though the percentage of women affected is much higher, the numbers are either similar or greater on the male side.

DR. LaRUE: A surprising number of our focus group male participants have mentioned at least --

DR. POTOCZNIAK: Yes, victims of it.

DR. MAGUEN: I'm glad to hear that those folks are represented in our focus groups because it really is something that is, unfortunately, so stigmatized, I mean among men and women, that we are just not seeing as many men represented in research.
DR. LaRUE: It was interesting the way they mentioned it versus women mentioned it because they just start listing letters, PTSD, blah, blah, blah, and MST, where women will say, "MST. I was raped." So, it's very different in how they present it, but I was surprised how often it came up.

DR. MAGUEN: Thank you for sharing that.

DR. POTOCZNIAK: The other thing they said was only four out of five, or only one out of five men tended to report it, even in the research, not just legal, but even in the research. They wondered. It was obviously much greater.

DR. MAGUEN: Yes. There have been studies on that, too, showing that over time people will come out. The rates are different over time, as people potentially get more comfortable or some treatment or out of it.

DR. POTOCZNIAK: Just further away from the military.
DR. MAGUEN: Yes, right. There's all of that, too, as you get further away from the trauma.

So, yes, I think we want to call this out to make sure that this is a population that we really want to see represented in the research, men and women with MST.

So, Recommendation No. 5, "Prioritize modalities or studies that can positively impact multiple comorbidities simultaneously and have a track record of safety." Again, we are talking a lot about how do we prioritize, and this is one way we can prioritize, is thinking about, for those people who are coming in who have PTSD and depression and pain, and maybe are abusing alcohol as well, what are some of the modalities that we can think of, again, in a sort of transdiagnostic way, are helpful for people? So, we want to deal with that.

Recommendation No. 6, okay, "Request and fund a consensus study by the National Academy of Medicine on salutogenesis models of
research. This study should develop a framework for setting priorities and optimizing methodologies focused on building resilience, enhancing health promotion, improving function, fostering well-being, rather than using a pathogenic; i.e., disease treatment, model."

Again, this is going back to the point of resilience and specifically looking at a model of research that really fosters well-being rather than a disease model.

"This study should explore the rationale, approaches, priority, processes, and ways to enhance funding of studies on how veterans can better enhance their existing resilience capacity, ability to enhance well-being, and tap inherent healing and recovery processes of veterans."

So, this is really speaking to the point of a focus on well-being, resilience. We know that there are inherent strengths in people that we want to foster and to really look at a model of research that enhances those strengths
in veterans.

Any questions about that? I think that this will not be new to anyone. This is something that has been -- we've been talking a lot about resilience in this Commission. And so, this is speaking to that, in particular.

Do you want to say anything?

DR. JONAS: Well, I was just going to say I'm going to try to reinforce this with the model discussion about --

DR. MAGUEN: Good.

DR. JONAS: -- resilience, well-being, and whole-person --

DR. MAGUEN: Exactly. And so, I think, again, the beauty of this is, this is going to echo throughout many of the Workgroups. This is the crosstalk we've been having.

Okay. Good. And No. 7, "Establish a committee made up of veterans with oversight and approval authority for VA-funded research on CIH." So, we want to hear from the veterans, again, if we think about veterans' voices being
represented not only in the research, but also of the oversight piece. "The purpose of this committee would be to assure that VA research is developed and funded based on veteran preferences and needs. The committee should be made up of a diverse group of veterans representative of current populations and ensuring sufficient representation across gender and race, ethnicity, and age."

Any questions about that? I think that's pretty straightforward. We want to see the people who are using these treatments represented in oversight and approval and making their voices be heard.

DR. JONAS: May I just point one thing out here?

DR. MAGUEN: Please.

DR. JONAS: I think this is great. There is a bomb in there. No, no. Let me rephrase that.

DR. MAGUEN: Oh, okay.

DR. JONAS: There is something in this
recommendation that is potentially explosive
socially.

(Laughter.)

It's the word approval. Because, right now, there are committees that have, you know, patients and the public, and all that stuff represented. It's standard. Okay? But they don't say that they need to be part of the oversight and approval in there.

And so if VA were to do that, that would be revolutionary. It would be revolutionary. Even PCORI, who was told to do that, didn't figure out how to do it.

DR. MAGUEN: Right. And so, I think, yes, it's something for us to think about, you know, whether --

DR. JONAS: What does it mean?

MR. ROSE: Think about it as a team. Right. I mean, also, the approval can also be about what studies get funded, you know, to approve that.

DR. JONAS: That's what I mean.
DR. MAGUEN: Yes.

DR. JONAS: Specifically, it's about what gets funded.

DR. MAGUEN: Right.

DR. JONAS: And who has control over the purse. And if the veterans actually had control over it, that would be pretty radical to be changing that.

DR. MAGUEN: Right. So, PCORI, that is in their model, right?

DR. JONAS: Yes, there are some examples, yes.

DR. MAGUEN: Right. I think, too, it's about how we think about how veterans get incorporated into the process, too, right? So, if the whole health model is about the veteran, shouldn't they have a say at the table in the research, too?

DR. JONAS: Right, exactly.

CHAIR LEINENKUGEL: This is very interesting, and Wayne beat me to the punch for explosiveness.
DR. MAGUEN: Sorry.

(Laughter.)

CHAIR LEINENKUGEL: But it's great to see.

DR. JONAS: There's an explosive issue.

CHAIR LEINENKUGEL: But Recommendation 7 is going to need a lot of Commissioner discussion. And I'll give you my two cents from just, again, the 18 months, the amount of groups that bring veterans that have done a CIH modality that has, in their eyes, just about completely -- I will not say "cured" --

DR. JONAS: Helped them in recovery.

CHAIR LEINENKUGEL: -- but put them on the right recovery path, okay, outside of the evidence base. And you are going to run into staunch believers for each one of those out of the veteran covert subset, male and female.

I've seen enough of them. I've touched enough of them. I've listened to enough of them. And it's going to be the power and the
vocality of the group. So, not that they're
wrong, but you started out with basically saying
we just have not researched this.

DR. MAGUEN: Right.

CHAIR LEINENKUGEL: And we don't know
what we don't know.

DR. MAGUEN: Right.

CHAIR LEINENKUGEL: So now, we're
going to a phase that, okay, we do believe that
some veterans, on top of the evidence base,
probably get some sort of other means of support
from one or a couple of these other ones. Again,
we don't know for sure, right?

DR. MAGUEN: Right, right.

CHAIR LEINENKUGEL: So, when you get
into establishing committees or groups to make
approvals or recommendations, this will create
who gets a seat at the table out of all of these
groups, and how big is this going to be? So, I
mean, we can table it. We could spend a lot of
time on this. But I think you just need to keep
aware of that.
DR. MAGUEN: Yes, of course.

CHAIR LEINENKUGEL: Because I think it's a great thing to do. It's going to be a very difficult thing to implement.

DR. MAGUEN: And I think, too, I mean, to also think about, you know, when we say "veteran," there are already veterans that are a part of the oversight and approval authority. I mean, in VA there are a huge number of veterans that are already at the table. And so, I appreciate sort of the --

DR. JONAS: Let's develop that even better --

(Laughter.)

DR. MAGUEN: Yes.

DR. JONAS: -- related to research is more relevant and rigorous.

DR. MAGUEN: Right. I mean, think about the number. I know like on review panels that I've been on there already are veterans on it, because they're a psychologist, because they're already in the groups that we're looking
to have oversight and approval anyway.

And so, I think, again, we should talk more about the expertise or who we would see at the table, but I think that I guess I see this as already happening to some extent. But just to make sure that there are -- the same ways that we have people who are at the table who make the decisions are the ones that have knowledge in this area, we want to get the people at the table who have knowledge in this area.

MR. ROSE: How effective have they been so far, these groups that have the veterans onboard at the table making some decisions that you are aware of?

DR. JONAS: Great question. Great question.

DR. MAGUEN: Yes. I don't think there's any data on that.

DR. JONAS: In my experience, it goes all the way from the range of they're just tokens that are just sticking on and they don't say much, they don't actually feel like they have
power and authority, all the way to quite a lot of input in those areas. So, how effective that is, I don't know.

MR. ROSE: What makes the difference between those two you talked about?

DR. JONAS: I think the ones that are very effective, actually some of the best ones are in NCI, so the National Cancer Institute, because they've actually been working on this for a long time. And NIAID, when the whole AIDS stuff came up, and the patients said, "We think you should move this forward and we think you should pay attention to our interests," and all that kind of stuff, they set up whole processes where they trained patients basically and families on how to work in these kinds of panels.

Okay. So, that they were empowered. They knew what their role was. They actually knew enough about the science and the methodology that they could have conversations there. They had to train people that could do that. Otherwise, they would get kind of shoved aside, and the interests
of the patients wouldn't be represented.

I mean, you know, you see this when you walk into a hospital. Suddenly, they're saying do this; do that. And if the patient doesn't want to do it, you need a patient advocate with you who's not you who is sick, right? But this is sort of the equivalent of the research done.

DR. MAGUEN: I'll just also give another example, since we brought up PCORI. For example, if a PCORI study is funded, veterans are necessarily part of a group of researchers. So, they are veterans who are psychologists, who are psychiatrists, veterans who are just stakeholders. So, it can be the broad range, MSWs, you know, people who have enough knowledge to sort of be part of the team, but also give their input. Whatever their hat is, they give some input on the research process and, then, when the data come out, it's run also by the whole group of researchers, including the veteran stakeholders.
So, I think there are already processes that are models of this in place. And I just want to make that point because I think it's an important one. This is something that in some systems this is already happening.

DR. JONAS: Exactly. And there's actually textbooks written on methodologies for how to incorporate subjects, people who are in research, into the actual methodology. It's called community-based participatory research. And there's an entire methodology for it, and there's textbooks written about how to do it, so that the people are not simply subjects. Okay? But you actually have involvement in executing the research. There it is.

MR. ROSE: Thank you.

DR. MAGUEN: Yes. Okay. So, we can definitely come back to this.

So, Recommendation No. 8, "Conduct studies of whole health implementation that specifically exam mental health and functional outcomes." One of the things that we heard from
Ben Kligler is that they are doing incredible work to look at some outcomes, but there isn't, unfortunately, any information on the mental health outcomes, as we heard about in Atlanta. And so, this is specifically to call out that we want to look at mental health and related functional outcomes in terms of whole health implementation. And I know that that's also an area that their group is hoping to go in the future. So, I think that's aligned with where they're hoping to go as well.

Recommendation No. 9. And there's only one more. So, thank you for hanging in with me. I know these are a lot to go through. "Examine mental health and functional outcomes of residential programs that integrate mental health plus a combination of CIH modalities compared to similar mental health programs that do not have CIH components."

And, Mike, this was kind of getting at a little bit of what you were bringing up.

DR. POTOCZNIAK: Yes.
DR. MAGUEN: And please feel free, if you think that there should be tweaks to this, to let me know.

But I think this is really getting at the point that Mike was raising, that there are already systems in place, whether it's residential or IOP programs, that integrate mental health plus CIH modalities. So, let's look at those. Let's do those studies, so we can learn about systems that are already in place, if that's beneficial.

DR. POTOCZNIK: You might add, you may, I mean, you might add "residential or intensive outpatient programs" --

DR. MAGUEN: Yes. That's right.

DR. POTOCZNIK: -- because a lot of the people that get treated for AUD and OUD are typically part of some sort of intensive outpatient model.

DR. MAGUEN: Yes. Right. Okay.

Any other thoughts about that?

MR. SPERO: Would it be helpful,
because this was a lot to take in, I think --

DR. MAGUEN: Yes.

MR. SPERO: We can send this PowerPoint around to the group to think about, now that it's out there.

DR. MAGUEN: Yes, please.

MR. SPERO: So, we'll do that at the conclusion of the meeting.

DR. MAGUEN: Yes, I appreciate that because this is a lot to take in. I'm trying to keep us moving at a reasonable pace, but I also understand, for those of you who have not been on the Workgroup, it's a lot to take in. So, we're kind of incorporating presenting the results of the searches, the result of some of our deliberations, and it's been a multiple-month process. So, yes.

CHAIR LEINENKUGEL: Yes, it's a lot of work.

DR. MAGUEN: It's a lot of work, yes.

MR. KUNTZ: But you guys did great.

I mean, that's a lot of work to see you get to
where you're at.

CHAIR LEINENKUGEL: One slide left.

DR. MAGUEN: That's right. That's right. We are almost there. So, okay.

No. 10, last but not least, and I think that this, hopefully, will look familiar.

"Establish a collaborative VA and DoD oversight committee that would lead to" -- and we can add "NIH" there as well -- "that would lead to a joint-funded research" -- example: VA, DoD, NIH -- "such as the Pain Management Collaboratory," as we were talking about earlier today. Again, a model like this exists and has recently been rolled out. "And ultimately, development of a Center for Integrative Health Research."

So, we kind of gave an example of something like being called "The Warrior Care Mental Health Collaborative," right? So, this idea that there's a center where this research can actually be done that's really a collaborative and an across-agency center where these kinds of research studies are happening.
I know that's a big one, and it's something that we kind of talked about in our Workgroup. We can open it up to discussion and conversation.

But I think that, with the direction that health care and mental health care is headed, we just think that the kinds of studies that need to be funded really require weighing-in from the VA side, the DoD side, and the NIH side. Again, we're not doing it just in one agency, but that the agencies are talking to each other and having shared goals, and where the money is going together.

CHAIR LEINENKUGEL: Yes, I think that the timing is absolutely critical, and the timing is actually right at this point in time as far as the climate on the Hill that we say yesterday, Shira, if you remember --

DR. MAGUEN: Yes, I do.

CHAIR LEINENKUGEL: -- to certainly move forward with something like this.

DR. MAGUEN: Great. Great. Thank
you.

DR. KHAN: That's a great job.

DR. MAGUEN: Thank you. Thank you.

It's a huge team. I think I started out with acknowledgment to everyone who is on the team from Commissioner, the VA side, and the Sigma side. It truly has been a really great group effort, and we appreciate everyone's support.

This doesn't happen in a vacuum, right? So, I appreciate everyone's support that's both on the Workgroup and all the conversations that we've had, also, outside of the Workgroup as well.

CHAIR LEINENKUGEL: And it should be noted that an absolutely fantastic job on the Hill with both HVAC and SVAC yesterday, extremely well-buttoned-up and presented, and they were all amazed at the horsepower I think that you had on your team working on this; and also, where the Commission is under your Workgroup right now.

So, just really well done, Shira.

DR. MAGUEN: Thank you. Thank you.

It's a good village that I have here.
CHAIR LEINENKUGEL: Thank you, Shira.

Any other questions at this time?

Because it is a time check, 2:26, and we've got 34 minutes to do basically two things under the open session. Are we ready to move on those, Casin?

MR. SPERO: So, we need to do a little Atlanta travel summary, go over our Workgroup site visits in Atlanta just briefly. And then, we'll make sure that the information we gather there is added to the transcript of this meeting.

CHAIR LEINENKUGEL: The Atlanta site group thing is something that we just wanted to make sure that we got on the record. All the Workgroups had feedback. So, this would be just be for the general public and for the actual record of why the Commission was at the Atlanta site visit, why we chose Atlanta, some of the big ahas that came out of that particular COVER Commission meeting at that time.

So, I think that let's let the Commissioners think about that first case, and
then, let's go back to Wayne, who's going to give us the Boston site visit overview. And then, we'll conclude with Atlanta. Does that make sense?

MR. SPERO: It works for me.

DR. JONAS: Yes, so I passed around a little overview of sort of why Boston. It might fill in some gaps for what we're doing here. And I laid out some of the goals.

My understanding from talking with a number of people in the VA and some outside the VA is that Boston has two things that would be of value to look at. One is the integration of whole health into actual clinical delivery sites. That's been a challenge. We've seen a lot of examples where groups are running, where individual projects have been incorporated into whole health, if they were already there, because they were so, some of them, well-developed and that stuff, not called that, but they were doing the same thing, were brought in.

But the folks up in Boston, I have
been told, have been trying to sort of systematically embed a process whereby whole health is part of the clinical delivery services. So, the patient health inventory, personalized health plans, et cetera, are part of what the clinicians actually get involved in, because that's usually the big gap. That's usually the challenge, is to get the clinicians to understand what their role is in that. So, the group up there is doing that, working on that. So, it would be good to get an overview of that.

Ben listed three people up there who he thought would be good to do that:

Michael Charness, who was their Chief of Staff who oversees that. If we got on the phone and talked with him, he could probably flesh out for us what needs to be done.

Ed Phillips is focused specifically on lifestyle. There's lifestyle medicine which is lifestyle change and that type of stuff, and he's the lead in the VA for doing that. So, we have to kind of look at that.
Elizabeth Recupero is, I think, a primary care person that was also mentioned up there.

Also up there we talked about the wellness measures and how do we measure wellness, how do you kind of know what it is. And so, Dawne Vogt is the lead in the VA for developing those components. She's also up there. So, we thought it would be great to get a download from her on that. You know, where are they? What are they doing? How are they developing that and what's been validated, whether they plan to bring any news in measurement systems?

So, that would be the primary reason for going to Boston VA. And the thought is, if we spent a day there with that, and whatever other things Charness comes out with, that that would be worth a trip.

The other two things we wanted to look at was this whole issue of quality assessment models and metrics. What is the current state from the experts that are looking at those? And
Boston, not everybody is in Boston, but there are
two groups that do a lot of that.

IHI that developed the Triple Aim is
up there. I talked to Don Berwick who he started
IHI, and that kind of stuff. We're going to have
a call with Maureen Bisognano who is also a
former IHI person about these components; and to
see if we can get some advice from some of the
experts and have a discussion with them about how
do you go about assessing the Quadruple Aim. We
could show them what we're planning to do, what
we're doing, get their feedback from that.

And then, some of them are in Boston,
some of them are not, and if they are willing to
participate, we could maybe just have them come
in virtually, if we had a place to do it.

There's a number of folks that have
been doing VA/non-VA health care quality
comparison. I have listed some of the main ones
down there. This is based on two things, our
literature search and ones we already know about.

The Dartmouth Center for Health Care
Quality is right up there, and a number of these studies have come out with them. And several people are up there. Weeks from Dartmouth is there. We could ask him if he would participate in that. And then, some of the RAND folks are also up there. We could ask them to call in.

So, the thought is, if we went up and spent at the VA looking at those first items, and then, maybe spent a half a day where we asked some of these other folks to give us input, sent them the questions, perhaps do it over at IHI, which is a little different place in Boston, but they have centers and stuff like that; that that would be a worthwhile trip.

Anyway, that's the idea. And so, feedback welcome. Anybody who wants to come virtually or personally?

CHAIR LEINENKUGEL: Well, Wayne, it's a great one-pager.

Personally, from the Chairman's position, I look at No. 3 under your first piece of rationale as being right on the mark. It goes
back to an earlier discussion this morning. It's the direction of wellness outcomes. That would be very interesting, I think, for all of us, as all of these will.

At the bottom of your page, though, 3, 4, and 5, if we can get something, because I think that's one of the missing links at this point in time. And how in the next few weeks are we going to be able to get some of that feedback or measurement for inclusion in our report, or at least discussion amongst Committee members?

DR. JONAS: I don't know what the best process is for doing that. I would leave it open to both VA and the other folks to know what the best process is to do that. Right now, the days that had been set aside are the 8th and the 9th of October. That's fairly soon. So, that would give us information pretty soon. We'll be able to fill these gaps in pretty soon. And if we were able to send out a request that they brief and present us, find a place to do it, or we set up a process to do it, then we could get as many
of these subject matter experts at the bottom
there who might be willing to participate in
that; lay out the questions. And then, the VA
folks, I don't know, I think you would probably
have to contact Michael Charness and help
organize. And I'd be happy to talk with him
about it with you all.

COLONEL AMIDON: It might be worth a
flyby to the Home Base folks, too, which is part
of that work based in Boston doing their two-week
IOP funded by Wounded Warrior Project. And they
are to the point of where a veteran can engage in
the non-VA care, a lot of them. It's very known
in the State of Massachusetts that Home Base is
one of the other places to go that's right there
by the downtown,

DR. JONAS: It's right there in the
downtown? Okay. It sounds great.

COLONEL AMIDON: It's just like Emory
or the Network for Warrior Care. If you're
there, it makes sense to go.

DR. JONAS: Yes, that makes sense.
CHAIR LEINENKUGEL: So, from the process piece -- and then, I don't know if most Commissioners feel the way I do -- I think that you address three of them laying right there with 3, 4, and 5 that we have not really come to a deeper solution to or comparing the two, whether it's VA versus non-VA. And I think that at some point we've got to get better at that because I think we're going to be questioned that: have you done or gotten at least a comparison between VA versus non-VA on those three items?

DR. JONAS: We are doing a literature analysis of what is the current studies that have looked at this.

CHAIR LEINENKUGEL: Right.

DR. JONAS: Yes, so we will have that. But it would be great to hear from some of these people that actually do, to say, you know, "What do you find," especially in mental health because there's not a lot in mental health. I mean, we can ask them.

MR. ROSE: I would think -- their
impression and what they think of the interaction between VA and Federally-Qualified Health Centers. We've talked about that. We've had questions, go back to --

DR. JONAS: Yes. And then, we had folks from the medical, or AHRQ, not AHRQ -- I'm sorry -- but HRSA who came and presented on that. And they're a huge network. They didn't actually have any good data on how many veterans they take care of.

MR. ROSE: No, they didn't. They didn't have that at all.

DR. JONAS: And that question was re-asked, and I don't know that they answered. Maybe they don't have it.

MR. ROSE: I don't think they actually have it. I don't think they actually have it.

CHAIR LEINENKUGEL: We haven't heard back. So, it would be interesting --

DR. JONAS: I mean, they gave a number which was ridiculously small. I mean, it was they take care of 24 million people and they said
it was like -- I forget what the number was, but it was like, come on; it's got to be more than that. And then, they said, well, we actually don't have a systematic way of capturing if you're a veteran or not.

CHAIR LEINENKUGEL: Wayne, what are your dates that you are doing the trip?

DR. JONAS: So, right now, I think we have the 8th and the 9th set aside for that. So, that's pretty quick. So, it would be great if we could --

CHAIR LEINENKUGEL: And who at this point in time, besides you, Wayne, would be going?

DR. JONAS: I don't know. Anybody who wants to, I guess.

MR. SPERO: We can't do more than five. We just don't have the time to get approval to have more than five people travel.

MR. GOODRICH: When we initially did the call, I think every Commissioner wanted to go. I think there were eight, eight people who
indicated an interest.

    COLONEL AMIDON: I am no longer interested.

    CHAIR LEINENKUGEL: I will be out. So, all of a sudden, you've got three less.

    MR. SPERO: The limit is five.

    CHAIR LEINENKUGEL: Why don't we work this offline? We'll get the Boston trip. You'll have your five, your support.

    DR. POTOCZNIK: I think given visiting the Warriors here, and as much as I wouldn't want to add another trip to my schedule, it kind of fits a little bit with what I do. I mean, I could see going to it.

    CHAIR LEINENKUGEL: It's your call.

    DR. POTOCZNIK: Okay.

    CHAIR LEINENKUGEL: Two?

    MR. ROSE: Three maybe.

    DR. POTOCZNIK: What's the dates again?

    DR. JONAS: The 8th and 9th.

    COLONEL AMIDON: Dawne's at the
National Center for PTSD in White River Junction.

DR. MAGUEN: No, no, she's in Boston.

CHAIR LEINENKUGEL: So, we'll move to the last piece on the open agenda today, and that is a synopsis and an overview as to our site visit to Atlanta, which took place two weeks ago. I believe it was back August 25th and 26th.

The purpose really was that we have not, as a Commission group, really been to a one-star SAIL facility and, also, at the same time to explore other things that take place within mental health care within a large VISN and veteran-centric area such as Georgia. And so, it was another good opportunity for us to go in as a group.

We also saw some other things that I think were enlightening, and I would like each group to have a quick overview, so that we have time to do that.

MR. ROSE: I think, all in all, with Group 4, it was quite an enlightening visit. We saw a huge transition in the leadership of what
they were going through. I think the Wounded Warrior Program at Emory was pretty amazing for what they do with $25,000. Is that right?

COLONEL AMIDON: Per.

MR. ROSE: Per. Two days. And it's actually outpatient, but they're really living in a hotel right across the street. Their success rate has been extremely high, and talking to the people that are actually making it happen, very positive. So, I think that that part was very key.

And I think another point was the Veterans' Call Center, of how they started and where they are right now. The number of people that they have there, I think the morale of the people that are working there is extremely high. And I think that that's key because you look at what they deal with every day and talk to how they can help people and examples of how they have helped people.

And I don't know if it's a decision point at this time, something to maybe think
about, but could there be a role of artificial intelligence in how you do things at a call center? Just for different strides that are currently being made, we talk about the areas of research. Is that one? And it may go well beyond the Call Center.

But I think, overall, it was a very successful trip. And as the Chairman says, it was not the type of facility that we have been looking at from the get-go. I think, in all fairness, that that's important. I mean, if you keep looking at the facilities right at the top, you get one impression. And I think one of the things that we talk about, it's comparing the different facilities and the different leadership that makes that particular facility go. So, I think, all in all, it was time well spent.

CHAIR LEINENKUGEL: That was a great synopsis, Commissioner Rose.

I also want to add that we spent a lot of time in small groups, so we did a lot of dividing and conquering because it is such a
large campus area, and there were three or four
different facets that we wanted to cover in 36
hours. So, I think that it was still a very
controlled, small-group situation of
Commissioners piecing off, being able to work
amongst various veteran staff groups internally
within Atlanta and at the same time getting Emory
and the Call Center in, which were enlightening.

MR. ROSE: And I think one other
point, if I may make, it's another example that
we have seen throughout our travels about the
role of a Veteran Peer Support Specialist.

DR. POTOCZNIAK: I think the visit to
Atlanta, you know, there were some really good
highs and some really low lows. To go and see
the Call Center was inspiring, all that are
coming to work day-in and day-out, listening to
people at their kind of most acute -- people that
are probably the backbone of the VA mental health
system that are GS-7s and -9s, taking some of the
most intense work and doing audio phone calls
with veterans who are on the edge of suicide. It
has got to be some of the most stressful work within the system, I would say. Watching them and how they dealt with internally, and seeing the camaraderie amongst them was heartwarming.

And the Emory program, I mean, I will totally refer patients to it. It has a really good -- it seems very well-organized and great.

I think the concerning parts of the trip were probably the total almost decimated ELT at that facility. Well, they didn't have an ELT, right? I mean, they have one Director of a massive, expanding health care system. I think it was incredibly concerning to see how little experience they had on the executive level and, also, some of the negative attitudes that I heard about mental health from that executive leadership, which was basically everything in the rural areas onto telehealth, which I thought flies in the face of what we would want the VA to be, which is a community that a veteran can engage with. Especially with veterans expanding into the rural areas, increasingly kind of taking
it and making it something that you're going to always get one kind of care further out and a higher level of care further in. I think that's the opposite direction of where we're supposed to be headed.

So, that was what I got from Atlanta.

CHAIR LEINENKUGEL: Commissioner Potoczniak, I congratulate you on being brave and forthright, because I would absolutely agree with you. And I think that most other Commissioners that saw or noticed what you did in regards to what was taking place in Atlanta, as you noted, is right on. And it is concerning. Also, it made me wonder how many other VA leaders or leadership roles are that type of capacity at this point in time.

Also, directionally, where they were going, to your rural comments, was contrary to what we saw with some of the discussions in Montana, which seemed to be making a larger effort with a much larger space to do a little bit more.
And we also saw the tribal, and we also saw, not to conflate the two, but they were different, to say the least.

But thank you for that.

DR. POTOCZNIAK: Yes.

CHAIR LEINENKUGEL: Any other Commissioner comments?

COLONEL AMIDON: I'll just echo what you said. It takes a special person to be a part of any call center. It takes an incredibly special human being to be at the VCL. I was very taken with those folks and the way they managed their own wellness. They deliver to the extreme on a daily basis.

DR. MAGUEN: Yes, I want to echo that as well. I think that's one of the things that stood out to me, aside from the camaraderie and the incredibly hard work that they do, and how thoughtful they are in the process, just how they think about burnout, taking care of each other.

There was a whole wellness component to how they do self-care of themselves as
providers. And as we know, that's part of what we're looking at in this Commission, too, not only in order to sort of serve the veterans in crisis, you have to take care of yourself. And I thought that was a really nice model of how they do that. So, I want to echo that.

CHAIR LEINENKUGEL: I think we saw the highest of the highs of leadership out at that Veteran Crisis Line Center. If you look at who is in charge and the personality of that person that established that camaraderie and connection to the entire group, of doing something that, quite frankly, he noted -- and I told him later -- he said he could not do what they're doing. And I said to him, "There's no way I could do that, what they're doing."

Yet, we all touched and saw the people that are doing it, and they all had smiles on their faces while they were discussing their challenges with us, which absolutely amazed me, that they do this day-in and day-out, and make a difference to saving veterans' lives.
DR. KHAN: Of all the places I visited, that Call Center was at home to me. I mean, you could see veterans; I mean, it was a home to me, that place.

DR. POTOCZNIK: It's also led by a veteran. That's important. Matt Miller was a psychologist in the Navy, I think, and worked with a lot of pilots, and then, transferred over to the VA afterwards. So, it's really like having veteran leadership up top can be a really good thing.

COLONEL AMIDON: The functional interactions, too, were important, as evidenced by the Emory Veteran Center, where Sheila Rauch, she's sort of dual-hatted as it be, a person and a key component to Emory. You can see that just sort of breaks down the functional stovepipes

CHAIR LEINENKÜGEL: Matt, expand on that because that came up yesterday in the Congressionals, too, about that dual-hatted role.

COLONEL AMIDON: I think it just supports your point, easy and seamless referrals
between the two both ways. It seems like they
had a very good relationship between the two
enterprises in delivery.

    DR. JONAS: That's all peer-to-peer,
    isn't it?

    MR. ROSE: It works.

    CHAIR LEINENKUGEL: Any other
    Commissioners with any other insight?

    MR. ROSE: I made a comment, and it
came up in the discussion the second day at the
Care Center, when the question was asked, "Why
does it work? Why does it work where something
else does not work?" And I think that the
general said, "Access, stigma, and impact, when
you compare that Care Center with what may occur
at a VA."

    CHAIR LEINENKUGEL: You're talking
about Emory, right?

    MR. ROSE: Yes, Emory.

    COLONEL AMIDON: But to hear from you
guys about the relevance of the two-week IOP, and
sort of having that concentrated delivery, it
would be interesting to hear your observations of measurement outcomes upon intake and exit, and then, three, six, and nine months. It certainly doesn't assume that you're finished. It would, then, assume that you need some frequency of follow-on.

MR. ROSE: Recovery, it's part of the recovery, right.

COLONEL AMIDON: But, also, there's streamlined process.

DR. POTOCZNIAK: It truly is. It brought up a couple of issues. And one was that they were still funding it, even though we have VA community care. It highlighted an emerging problem in the VA, which is you've got an excellent program that really could be getting paid by the VA to get funding, and they can't logistically make it happen, even though they've got great lines there. And that's how we lose so many really great programs with the VA, is just the bureaucratic nature of what happens around community care.
Then, the other thing about Emory that they highlighted, which I'm glad you brought up, is we've seen other PTSD-related programs through the VA, some of which have had three-, four-, five-, six-month waits to get into them; whereas, Emory does not have that issue. And so, I think that's an important point because access is the key to success in a lot of cases. People will go almost anywhere if they can get in. So, getting in is the big issue.

COLONEL AMIDON: I think the rolling cohort model for them is unique in the Warrior Care Network. The other ones are fixed cohort. And I don't know that. I can't remember.

DR. JONAS: I was talking to Tom about this, and it's very similar to what the Intrepid Center does here. It's even a bigger program at the Intrepid Center, and it's four weeks and even more resources. This is sort of a mini one.

And we saw another model -- I think there's a variety of ways to go about doing this -- in the VA in Atlanta, and that was the EVP
program that Michael Saenger ran. It was a 10-week, group-based program that, from the data he reported, it looked to be very similar in terms of outcomes from what Emory was doing, but it's very different. They have to come every single week, okay, for 10 weeks, a long time, but probably about the same amount of total time, if you think about it in those areas.

And so, there was an example of one leader who put together an excellent program that was having an impact. And to one of the points you just made, Shira, about, hey, we need to evaluate these things, how do you evaluate, the VA needs to think about how do we evaluate that. Because, you know, when I asked folks at Emory, "Are you going to do a randomized control trial," they said no.

(Laughter.)

And so, if it comes down to paying dollars and cents, the question will be, well, is there an optimal model that could be done? And one could do an RCT of that kind of an intensive
two-week program versus a longer-term thing like
what Michael Saenger's was. So, there would be a
way of doing that, if you wanted to do that.

   DR. MAGUEN: I mean, there are newly-
published studies of massed treatment, so for
evidence-based psychotherapy.

   DR. JONAS: Yes.

   DR. MAGUEN: So, you do it in kind of
   a chunked way.

   DR. JONAS: Right.

   DR. MAGUEN: So, rather than having
   people come back weekly, they come back for
   massed EVP. And so, those studies are published,
   are recently published. And there's, I think, a
   lot of talk in the community about thinking about
delivery and models of delivery. Those studies
   are obviously expensive to do, right, and there
   is some evidence showing that that is helpful for
   people.

   DR. JONAS: Right. And if you wanted
to expand the Emory program to make it more
generalizable, because it is a very select
population that they get there, then the question
of how would you make this expandable, you have
to ask, you have to evaluate that in some way.
Is that effective for 5 percent of the
population, 10 percent? Which ones, and that
type of thing. So, all the questions we were
just asking about that.

DR. MAGUEN: Yes.

DR. JONAS: And they need to be asked
around those questions. But what I liked about
that is that you could do those without going
through every little modality that they have and
say, okay, we want RCT on this one and this one
and this one. You could actually look at the
integrated program for complex, multi-modality,
and for lots of comorbidities. I mean, the
people they had there had -- nobody had one
thing, right? And then, look at, well, does this
impact? What is the impact of it? What does it
cost?

CHAIR LEINENKUGEL: Any other
Commissioner at this point in time?
I think, as a Commission, on behalf of the entire COVER Commission, to the general public, to our constituents on the line, to our support staff in the room, and the general public, thank you for a great day today. I hope you have a sense that this Commission is highly engaged, that we do have a working plan in place, and also an end plan in place, in order to get to all of the actions of each five Workgroups.

Today, you heard from Workgroups 1 and 3, in particular, Dr. Shira Maguen and, also, Dr. Wayne Jonas, an update of the status where they are, some of the gaps, very few gaps in research, some more data collection still coming in on both parts probably over the next couple of weeks, but also a sense of urgency of changing gears from going from the research analysis stage to the recommendation, and then, deliberation and writing stage. And that's where we will pick up in offline Workgroups the rest of this afternoon.

And also, tomorrow we will be hearing in the open session, starting at 9:00 a.m.,
Workgroups 2, 4, and 5 will present during the morning, a very similar status update on their outputs and recommendations, and any constraints and barriers that they may have before we come to a conclusion of next month's meeting in October with more solid recommendations.

Any other further comments or additives from the rest of the Commission at this point?

If not, ordered that this session of the COVER Commission be terminated.

(Whereupon, the above-entitled matter went off the record at 3:00 p.m.)
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In the matter of: COVER Meeting

Before: US DVA

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John Goodrich  
Designated Federal Officer

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Jake Leinenkugel  
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UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

CREATING OPTIONS FOR VETERANS' EXPEDITED RECOVERY (COVER) COMMISSION

OPEN SESSION

FRIDAY
SEPTEMBER 13, 2019

The Commission met in Suite 150A at the VHA National Conference Center, 2011 Crystal Drive, Crystal City, Virginia, at 9:00 a.m., Jake Leinenkugel, Chair, presiding.

PRESENT

JA**K LEINEN**KUGEL, Chair; Senior White House Advisor, Veterans Administration

COLONEL MATTHEW F. AMIDON, USMCR, Director, Military Service Initiative, George W. Bush Institute

WAYNE JONAS, M.D., 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 POTOCZNIAK, 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 (NAMI)

STAFF PRESENT

JOHN GOODRICH, Designated Federal Official (DFO)
CASIN SPERO, Executive Director
YESSENIA CASTILLO, Senior Consultant, Sigma Health Consulting, LLC

KATHRYN FAUSTMANN, Support Staff

JOHN KLOCEK, Subject Matter Expert; Alternate DFO

WENDY LARUE, Alternate DFO; Writer

NICK MAJIE, Senior Consultant, Sigma Health Consulting, LLC

LAURA McMAHON, Contracting Officer Representative; Alternate DFO

HANIFAH MOHAMED, Project Analyst, Sigma Health Consulting, LLC

STACEY POLLACK, Ph.D., Subject Matter Expert; Alternate DFO

SALMAN SHAMSI, Program Manager, Sigma Health Consulting, LLC

TRACY SHEWMAKE, Support Staff
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MR. GOODRICH: Good morning, ladies and gentlemen and welcome to the September 13th meeting of the COVER Commission. My name is John Goodrich. I am the designated federal officer for the Commission.

If you are attending our meeting remotely via phone, we would ask that you notify us of your attendance by emailing us at covercommission@va.gov. Again, covercommission@va.gov.

And I will now turn it over to our chairman, Mr. Jake Leinenkugel.

CHAIR LEINENKUGEL: Thank you, John.

And good morning everybody and welcome participants and all the commissioners on this Friday, September 13th. At this time, I would like to have Commissioner Jamil Khan lead us in the Pledge of Allegiance.

DR. KHAN: Please join me.

(Pledge of Allegiance.)
DR. KHAN: Thank you.

CHAIR LEINENKUGEL: I would also like to take a minute for everybody to briefly have a statement from each commissioner that is in attendance today, with a brief background note as well, so that if there's any questions about anything during this time you can email those to what the DFO, John Goodrich, said under the COVER Commission.

I'm Jake Leinenkugel. I'm the chairman of the COVER Commission. I'm a Marine Corps vet and also a veteran advocate.

MR. ROSE: Jack Rose, a 26-year Navy veteran. I also spent the last 19 years affiliated with the National Alliance on Mental Illness, both at the local and State level, and we have two adult children who live with mental illness. And it is truly an honor to be on this Commission.

DR. POTOCZNIAK: I'm Mike Potoczniak. I'm a psychologist and the Mental Health Director at the Santa Rose Clinic in the San Francisco VA.
I am also an Army Reservist major.

DR. MAGUEN: Shira Maguen. I am a clinical psychologist at the San Francisco VA, Mental Health Director of our Post-9/11 Integrated Care Clinic and PTSD researcher and clinician as well.

COLONEL AMIDON: Matt Amidon, Marine Corps Reservist and Director of the Military Service Initiative at the George W. Bush Institute in Dallas, Texas. Thank you, Mr. Chair.

DR. KHAN: Good morning. Jamil Khan, United States Marine. It's an honor to be part of this Commission. Thank you.

DR. JONAS: Wayne Jonas, Army veteran, 24 years, family physician. I still see patients in the military.

MR. KUNTZ: Matt Kuntz. I'm an Army veteran. I also come from a family that lost a servicemember to post-traumatic stress. And I am Executive Director for NAMI Montana and the Director of the Center for Mental Health Research
and Recovery at Montana State.

CHAIR LEINENKUGEL: And this is Commissioner Leinenkugel again noting that two commissioners have excused absence from this session today, Tom Harvey and Admiral Thomas Beeman. And they both have been involved on weekly calls, and were project leads, and are very up to speed as far as all the content and subject matter as to what the Commission is working on.

And on that note, I think it would be a good idea to give a brief recap for some of those that may have not been on the call yesterday as to actually what a select group of commissioners did 48 hours ago, our first dynamic Hill visit to both SVAC, HVAC staff members, and also to select Congressionals. And it was a very productive day, so productive that we think this will be an ongoing practice.

So for meetings, certainly for next month in October, we will select another group of five commissioners to do about the same thing
that we did to keep the key constituents, such as SVAC, HVAC, White House, and the Secretary of the VA up to date with the progress of the Commission and our work agendas.

We also spoke yesterday at length about milestones for completing the Commission. The completion date has been set for December of this year, with the writing of the report due in late January of 2020. And so we had discussion, debate, and analysis of how to go about reaching the milestone and addressing gaps in research and data collection from each of the workgroups. And we also realized a sense of urgency that it was time to change gears and get to the recommendation stage, which we are currently vigorously working on at this point in time.

All the Commissioners onboard believe that we can make the date. We're putting a lot of stress on the writing end, with final recommendations and then deliberations, debate, and discussion by the full Commission. And that will be upcoming October-November with the final
write-up in December.

So that being said, and this being Day 2 of the COVER Commission's September meeting, we have been going through the workgroups one by one. And yesterday, we heard from Dr. Wayne Jonas on his Workgroup 1 update, and also other needs and requested site visits that he wanted to do. The commissioners thought it was viable and necessary and so he will be doing those within the next 30 days.

Also, Dr. Shira Maguen on a Workgroup 3 update, which was very complete and had numerous recommendations for the commissioners to consider at that point in time as well.

So today, we are looking at, in the morning session, of going through Workgroups 2, 4, and 5 in similar format and style as we did yesterday.

So at this time, I would like to turn to Commissioner Mike Potocznia, who is the lead for Workgroup 2 and his current update.

Commissioner Potocznia.
DR. POTOCZNIAK: Thank you, Jake. So
first let me start, for the benefit of the people
that are on the phone, what are the duties of
Workgroup 2. Workgroup -- so next slide, please.

Workgroup 2 is patient-centered -- is
to conduct a patient-centered survey within each
of the VISNs, which is kind of like regions of
the VA, to examine the experience of veterans
with the Department of Veterans Affairs when
seeking medical assistance for mental health
issues through the healthcare system of the
department.

B is to look at the experience of
veterans with non-department facilities and
health professionals for treating mental health
issues.

C is the preference of veterans
regarding available treatment for mental health
issues and which issues the veterans believe to
be most effective.

D is the experience, if any, of
veterans with respect to the complementary and
integrative health treatment therapies.

And E is the prevalence of prescribing medication -- prescription medication among veterans seeking treatment through the healthcare system.

F is to look at the outreach efforts of the Secretary. And I can go further into that but we're going to focus mostly on A through D today because that's where most of the activity is happening.

And so I want to go into kind of an update -- next slide -- an update on the current activities. So the focus groups that are underway: We have done Cleveland; Baltimore; Chicago; Atlanta; New Orleans we did but nobody showed for that; Nashville; Miami; Philadelphia; White River Junction, Vermont; Denver, Colorado; Canandaigua was canceled -- or are we still going there?

PARTICIPANT: We're going to try to reschedule Canandaigua and Richmond.

DR. POTOCZNIAK: And Richmond also,
which was also canceled. The Northern California VA, which is in Sacramento, is scheduled for this upcoming week, as well as the Puget Sound VA in Seattle.

We've had three virtual focus groups to cover a wider area of more rural veterans that are kind of scattered throughout the VISNs. So we've kind of done some outreach in that direction. We had good participation in that with some good results.

Go to the next -- okay. Emerging themes of Part A. So what I wanted to do is just talk a little bit about what's coming out of the focus groups. These are not so -- these are just emerging themes. We haven't done the coding for it yet but these are kind of what's coming out, what we're hearing from the focus groups thus far, noting that we have at least two or three more focus groups to do. But we are, as Wendy LaRue had said, we're reaching data saturation so some of the same themes are coming up with the veterans.
And so Part A, just to remind you, is to look at the experience of veterans within the Department of VA when seeking medical assistance for mental health issues.

So some of the themes that have come out, veterans have reported generally favorable experiences with VA providers and that they really enjoy that they are specially-trained to understand their military experience. So veterans tend to enjoy the fact that they don't have to explain themselves and what military culture is to their providers.

We've heard some themes of Vietnam-era veterans tending to report feeling stigma from VA employees when seeking mental health treatment. So that was something that we did hear.

Veterans also reported experiencing difficulties with frequent changes in providers due to recruitment and retention. So they didn't like having to tell their story over and over again. There were people that had multiple providers over a short period of time, whether
that's because they were students or whatnot, these were themes that came out.

Veterans appreciated the coordination of care between providers at VA. They liked you know knowing that other providers had read the notes of the other providers and they didn't have to explain some of the things that were going on. So that was a benefit that they had.

Veterans reported the importance of being your own advocate in seeking VA care. So in needing to kind of advocate for yourself within the system is something that they felt was very important.

So family involvement was also important to veterans. A lot of -- there were some themes of veterans saying that they wouldn't have sought treatment if their spouse or family member did not initiate the care.

So this is all within seeking treatment in the VA. These are some of the themes that came out.

And then also, veterans reported
difficulty in initiating care as a new patient in VA mental health but, once they began, they believed it was good quality. So it depends on the facility. There’s different experiences that people have you know when initiating care. Some people it was, obviously you know okay, and then other people reported that they had difficulty getting in for that first appointment.

So and then they also reported variability based on their VA, which VA they were in, with getting appointments that complemented their work schedule. So some veterans that you know work, had trouble getting weekend, night appointments, or just an appointment that would match whatever work schedule they have.

So in seeking care, these were some of the things that came out for veterans.

I just want to pause for a second if anybody has any questions about some of the emergent themes from seeking care in the VA for mental health issues.

MR. KUNZ: Dr. Potoczniak, was there
anything that surprised you?

DR. POTOCZNIAK: No. I think all of this was stuff that I have heard before and experienced either as a veteran or working with veterans in the VA. So I've seen people -- there are definitely people that you know always bring their family members in. I think that family involvement is a little bit unique to the VA. I know that other people in other settings bring family members but I think -- and I'll get to that a little bit later but I think the family involvement can't be underscored enough as being important because of the importance I think of family in Military culture. So that was a good thing.

CHAIR LEINENKUGEL: Commissioner Potoczniak, could you elaborate a little more on the veterans -- it's in the middle there -- the veterans reported the importance of being your own advocate in seeking VA care --

DR. POTOCZNIAK: Yes.

CHAIR LEINENKUGEL: -- any explanation
as to what that means?

     DR. POTOCZNIAK: So knowing how to --
     whether it's knowing how to navigate the system
     or when things aren't going well, who do you talk
     to, how do you elevate a problem. So if there's
     an issue that you're experiencing, you want to
     change a provider, you want better appointment
     times, or whatever it is, how do you go about
     doing that?

     And so some of it is a skill that I
     think a lot of people in private healthcare learn
     that you know you have to talk to the person in
     charge in order to get what you want but veterans
     aren't necessarily always skilled in knowing --
     they kind of take what they get a lot of times
     and don't advocate on their own behalf.

     So whether it's from their experience
     in the Military health care, or whatever, that
     you just kind of take what you get and you don't
     complain, I don't know whether it's because of
     that kind of background but learning how to
     actually be, as one commissioner said, a
healthcare consumer, is very important and learning how to navigate, how do you deal with complaints, and that kind of stuff.

Does that make sense?

CHAIR LEINENKUGEL: It does. And I'd like one more follow-up to your second to the last bullet point. If you could put a little more clarity under the aspect of those veterans that report difficulty, and you just mentioned it as well, in initiating care as a new patient for VA mental health.

DR. POTOCZNIAK: Right.

CHAIR LEINENKUGEL: Why is that?

DR. POTOCZNIAK: I think there's a lack of uniformity throughout the system and how you begin that. There's you know different clinics have walk-in hours. Some of them really don't have the capacity to do walk-in hours. Some of them don't know how. Who do you ask to get a mental health appointment? Do I feel comfortable asking the front desk to connect me to mental health, especially if it's a smaller
VA, a small town, et cetera? But just knowing
the process by which you do it, you know a lot of
mental health clinics are locked behind different
doors and it's not easy enough just to walk up
and say hey, I need an appointment.

So I don't think they know how to ask
for it. Sometimes its embarrassment in doing it
or stigma but then also, just how do you get the
referral. Where is it? I know you know it's
like for example -- I always use this as an
example. Palo Alto, one of my favorite
healthcare systems in the VA has a big building
on campus with a big sign in front of it that
says Mental Health Building. There's not
outpatient mental health care in that building.

(Laughter.)

DR. POTOCZNIAK: So, in fact it's on
another campus about 20 minutes away.

So that's an example of kind of what
-- so I'd always have veterans walking up to that
building saying can I get an appointment. And
I'd say well, you have to get on the shuttle and
go to Menlo Park and they're just, by the time
you say that, they're just like oh, I'm good.
Thanks. I'll figure it out.
So that's the kind of example of kind
of, whether it's signage or it's such a big
system, it's hard to know who to go to first and
how to get there.

CHAIR LEINENKUGEL: Thanks for that.

DR. POTOCZNIAK: Okay.

MR. ROSE: Just a question, if I may.
Just with respect to mental health in general and
the stigma associated with it, I think anywhere
you go, inside or outside, many times the mental
health system is very difficult to navigate. And
whether you have what I'll talk about later, a
veteran peer support specialist, somebody that
can help bring you. You need some kind of
connection, especially if there's difficulty in
where am I really supposed to go. And that's an
issue.

DR. POTOCZNIAK: Yes.

CHAIR LEINENKUGEL: But isn't there
one thing that we did learn on many of our site
visits is the PAC Team makeup? Actually, we
heard consistently that it's up to that primary
care doc and the list of questions in that first
examination or scheduled appointment to make
that, they use the term, warm handoff
consistently. Whether it's done consistently is
something for us to decide but isn't that part of
it, though, Mike? Shouldn't it start there?

DR. POTOCZNIAK: So where it can start
is in primary care but it also can start when
veterans first come out of DoD and they go into
the VA for their healthcare you know they're
usually assigned or directed to a transition care
manager. And that's another place where it
frequently gets brought up. That program is
unevenly kind of distributed, depending upon
which VA you walk in to.

So if you're walking into a small
clinic in Montana versus a large VA in Palo Alto,
you're going to have a very different experience
whether you get in touch with one of those
people. Clearly, it doesn't happen. As we
talked to people on the reservation, they've
never talked to a transition care manager and so
they don't know all the different things that are
available to them.

It does get explained to a lot of
people when they get out of the Military but they
don't absorb that.

CHAIR LEINENKUGEL: You used the term
lack of uniformity --

DR. POTOCZNIAK: Yes.

CHAIR LEINENKUGEL: -- also, lack of
consistency.

DR. POTOCZNIAK: Right. Good
resources that work but they are unevenly
applied.

CHAIR LEINENKUGEL: Thank you.

DR. POTOCZNIAK: Any other questions
on Part A, seeking out treatment?

So emergent themes of B, which is the
experience of veterans in non-VA facilities, and
so there's not -- there was difficulty in
recruiting veterans that sought treatment outside VA. There was some representation of that.

Non-VA veterans reported, in the focus groups, some difficulty with lack of knowledge related to -- or difficulty or lack of knowledge related to VA eligibility. So that's definitely a theme that you hear a lot of in VAs is difficulty in knowing what you're eligible for, whether you're eligible at all, and how many veterans believe that they're not eligible when really, they get five free years of care post-combat. You know it's like but they're not eligible for it.

So recently this year, I saw a guy from my unit that was on his fourth year post-combat that we finally got enrolled. I said you know you are eligible for this and he had absolutely no idea. And the amount of people that I've run into over my career that have that issue -- I'm sure Shira probably knows a lot of stories like that -- you know that there's a lot of people that don't know the eligibility and it
is so complex. And that's part of the confusion
of the VA is knowing what you're eligible for and
what you have to do to get it. So that came out
in this theme here.

Vietnam-era veterans had reported some
trust issues with VA, so they had sought care
outside.

And veterans who split their care
between VA and community had some difficulty
coordinating their care between community and VA.
So people that were getting care in non-VA and VA
felt it was disjointed, which makes sense because
it's a closed system and a lot of their records
don't get put into the VA system. Whether the VA
is paying for it or not, it doesn't matter. A
lot of times it doesn't get in.

Any questions on Part B?

COLONEL AMIDON: Just one -- two.

Just for the record, that five-year eligibility
is for the full expanse of VHA healthcare
delivery or is it just for mental health?

DR. POTOCZNIAK: So there's a weird --
and this is what makes it even more complicated. There's a weird thing that says that service-related issues but that is never true in my experience.

COLONEL AMIDON: Right.

DR. POTOCZNIAK: Like, I've never seen anybody come in in the five-year span that doesn't get -- you have to start with a primary care appointment. And so there's no way to know what is service-connected, at that point, or not. So pretty much everything that then results from that primary care appointment is covered, so regardless of whether it really happened during your service or not. And a lot of people don't know that. They see that for service-related injuries and they think well, if I have to go for my ankle, I'll go the VA but they really need to go a primary care appointment to start off with --

COLONEL AMIDON: To get in the system.

DR. POTOCZNIAK: -- and then they get treated for everything else. So --
COLONEL AMIDON: Can you share some of -- I mean when you read the legislative mandate for what you're tasked to do, we should appreciate the scope and scale in difficulty in finding those who are not partaking of VA health care.

CHAIR LEINENKUGEL: Matt, can you do us a favor? Speak up a little bit because I think --

COLONEL AMIDON: Yes.

CHAIR LEINENKUGEL: -- this is critically important.

COLONEL AMIDON: No, I just I applaud your efforts and I know that, even at the national level, it's very difficult. You know Pew Research has difficulty finding vets. That's an over-simplification but I just -- if you could take a minute to talk about the difficulty of scope and scale of finding those people. I certainly applaud your efforts in getting them into focus groups.

DR. POTOCZNIAK: Well actually, I
think I'd like Casin to talk a little bit about
that because we advertised on social media to
kind of pull people in. And that's where I think
a lot of those people came from.

COLONEL AMIDON: Yes.

MR. SPERO: Yes --

CHAIR LEINENKUGEL: Casin, do us a
favor and introduce yourself and your role, as
well.

MR. SPERO: I'm Casin Spero. I'm the
Staff Director for the Commission. And I'll ask
if Wendy LaRue, our Chief Content Development
person wants to jump in. She assisted a lot in
the recruitment as well.

I would say that you know we did a few
different things. There were some emails that
went out from the VA. Social media went out from
the COVER Commission social media post that went
out from the department. We asked facilities to
share posts. There was fliers. There was
handouts. There was -- at all the facilities
where these were conducted.
DR. POTOCZNIAK: And outreach to the VSOs, too, I think.

MR. SPERO: We did outreach to the VSOs but most of them were -- I had some success at the local level contacting the Baltimore American Legion Office and they shared some posts, sent some stuff out on their listservs. But the national VSOs, it didn't seem to be a priority for them to really participate in sharing that. It went out to the Secretary of the VSO Communicators Group. So that's the communications lead for the national VSOs. Pretty minimal participation in that.

But even with that you know all those groups also had trouble touching those 14 veterans you know who don't engage through VA. And if you think about coming to a VA facility or a focus group in the middle of the day on a weekday, or even if it was a night or a weekend, coming to a VA facility when you've never been to one you know it's just a lot to ask.

And I think if we had five years, we
would still see you know pretty low numbers in this, based on what we've had.

Where we did have some success is we did have some veterans who had started in the VA system left because they had an issue and sought care elsewhere and then, as their issues have gotten better, they had come back to the VA and were learning to trust again, or using it for other things, or --

DR. LaRUE: And so people who started in private sector care and then realized that they were eligible for VA care and then moved over.

MR. SPERO: And also some people who used a mix of service, you know wanted to do this in the private sector and do this in the VA.

But yes, the recruiting thing was definitely a challenge. And given the amount of time between the time we received -- you know going back a year, the time we had, you know 18 months to develop the survey, test everything through the pilot, get approval from OMB with the
Government shutdown mixed in, develop a plan for execution once we had approval, and execute it, it's a very tight window.

DR. LaRUE: And frankly, an impediment to recruiting people, it's two hours for a focus group, is our inability to compensate them you know, when you can't even give them cookies.

You know we had a number of veterans who contacted us, asked about compensation, and then didn't participate because there wasn't any. And just as a point of reference, somebody that I knew personally who was participating in a non-government focus group this week was paid $125 for an hour of time.

So people kind of know that and it does inhibit the quality of research that we can do just by virtue of that.

COLONEL AMIDON: Yes, all that to commend you, and the support staff, and the team for, in a short amount of time, extracting the themes that you're talking about today.

DR. LaRUE: We did have one
participant, that was in one of the focus groups I had run, who had not received any care at all in VA and he found out about the focus group through social media. And interestingly, he was getting ready to move. And after sitting, hearing about the care that the others in the room received, said when he moved he was going to check out the VA in the new city where he was going. He had to start from scratch on providers anyhow. So he was going to go to the VA.

DR. POTOCZNIAK: Thank you.

MR. ROSE: Mike, if I may, just another possible source of veterans who are not in the VA can possibly come from Federally Qualified Health Centers. And we've had some contact with those folks. We've had some numbers and we probably need to maybe look a little bit closer at those numbers but that may be another source.

DR. POTOCZNIAK: That's a really -- we've got to learn that in Montana where they've had veterans in their catchment. So, yes, thank
you.

MR. ROSE: Yes.

DR. POTOCZNIK: Go to the next slide, please.

So emerging themes of Part C, which is the preference of veterans regarding available treatment for mental health issues and which methods veterans believe to be most effective.

So one of the big themes that came about was veterans reported that walk-in appointments, walk-in appointment availability was important to them. It's something that the A has rolled out under -- it's under the title Same Day Appointments, but being able to walk in and be seen that day was something that was -- that they talked about as being key for them.

And veterans also reported satisfaction with being able to contact their providers with secure messaging in-between sessions. So that was something that's part of what we used to call My HealtheVet. I think it's called something else now but there's still
secure messaging on it. And so veterans being able to contact providers is a big thing.

A majority of veterans in the focus groups reported satisfaction with the care they received in mental health. So that was good to hear. Veterans reported satisfaction with cognitive behavioral therapy and some dissatisfaction with prolonged exposure. I think Yessie had that. And that makes sense because prolonged exposure is -- it's not -- I mean it's not a feel good therapy in a lot of ways. It's kind of a rougher experience but it does -- it is very effective. So I would be surprised if people said that they enjoyed the prolonged exposure experience. It's kind of really not enjoyable but it does work.

So there was a mixed response from veterans regarding their preference for group versus individual therapy. So that, to me, just talks about probably personalities. Some people are introverts, people are extraverted.

Veterans who did enjoy groups
commented about the importance of comradery with other veterans. And from what I recall, that was typically a lot of Vietnam-era and older veterans. There wasn't as many 9/11 veterans saying that.

DR. LaRUE: We actually did have some younger veterans in smaller groups.


So the comradery was important. There was significant variability between VA focus groups in the types of treatments available and their overall satisfactions. So some people did have bad experiences. Some people had different kinds of treatments. So there's some variability there.

Peer support specialists were considered helpful, although many veterans did not always understand their role or be able to really identify them. So they didn't understand what their purpose was but wow, that person was helpful.

I don't know if any of you guys want
to say any more about that but, Yessie, I think you had that also.

MR. SPERO: I think that like they would identify someone who helped them get enrolled in care but it was unclear whether that was just another veteran sometimes or if that was -- I don't think they knew to call maybe their peer support specialist, a peer support specialist, the formal title that the VA gives them.

DR. POTOCZNIAK: Yes.

MR. SPERO: So it was tough to I think identify when there was a formal I'm a peer support specialist helping Shira get enrolled in care or you know get this researched. You know what is my battle buddy, you know just saying hey, in case you needed to go in and see what they can do.

DR. LaRUE: In some cases, veterans within the facility had, like in one situation, created their own sort of local DSO. And they had a network that does many of those roles.
At one facility --

DR. POTOCZNIAK: We saw that in Montana.

DR. LaRUE: -- participants created a program called Vet to Vet, which he maintains was the basis of starting the peer support specialist program. So they still do some things through that nonprofit in that area.

So there's some gray area but when they knew that they had peer support specialists, they seemed to really like that person who gets them, helping them navigate things.

MS. CASTILLO: And I would just add that even for those veterans that have a lack of awareness of the peer support program that was available, there was still agreement across the board that something like that would be very valuable and wanted. And they definitely you know saw the value in a program like that.

DR. KHAN: If I may ask, we are using the term VSO. Is that a Veterans Service Organization or is it a Veterans Service Officer?
MR. SPERO: I was using it as organization.

DR. POTOCZNIAK: Yes, I think we're almost always saying organization but I know the counties have Veterans Service Officers, which makes it even more complicated. I always got confused with that.

So the veterans did report a lack of mental health providers available. So they didn't -- the lack of staffing was present I guess to some veterans.

And then Telehealth was an important intervention for veterans, especially in rural locations. However, they reported in some cases that it was not as maybe satisfying as an in-person treatment. So being able to come in in person was still important to some veterans.

Would you want to say anything more about that? No, okay.

And so I think a current theme in mental health treatment I think is important to mention is that Telehealth is being really pushed
as kind of the answer to rural -- to address the
needs of rural people who are veterans. However,
I think it's still important to mention that it's
still good to staff some of those locations with
actual providers because they are part of a
community. And so I know the larger, a lot in
the VA they are kind of saying yes, this is just
as effective and whatever but, kind of time and
time again, what we're hearing is yes, but it is
good to still have a person there sometimes.

MS. CASTILLO: Commissioner

Potoczniak, if I may add, in addition to the lack
of mental health providers available, it was also
staff, as well, where the veterans felt that they
could always use more nurses or social workers
because they were sometimes their liaison in
navigating through the process, and how to get
the care, and also the ones that kept more in
contact with them as far as their appointments
and answering their questions. So it was across
the board needing more staff, as well.

DR. POTOCZNIAK: So you have mental
health --

CHAIR LEINENKUGEL: Excuse me, Commissioner, if I could. Yessie, would you please introduce yourself --

MS. CASTILLO: I'm sorry.

CHAIR LEINENKUGEL: -- to the folks on the phone, and also Wendy, and also your roles, please.

MS. CASTILLO: So my name is Yessenia Castillo. I go by Yessie. I am an epidemiologist by training and part of the contracting staff, helping with the analytic task for Workgroups 2, 4, and 5.

DR. LaRUE: Wendy LaRue. I'm the Chief Content Development Officer for the Commission. My main role is getting the report completed by January and then, also, I have been conducting many of the focus groups for the Commission.

DR. POTOCZNIAK: Yes and I want to just take a moment real quick to thank everybody who has been out. Wendy has been out, I think,
probably on the road -- I don't even want to know how many places you've been to. And Casin Spero has been out. And I know, Yessie, you did some of the virtual focus groups, right? And Salman also did virtual or in-person?

MS. CASTILLO: Assisted.

DR. POTOCZNIAK: Yes, okay.

DR. LaRUE: He's been making sure we have transcriptions of them all as well.

DR. POTOCZNIAK: Was there anybody else that was helping out?

MS. CASTILLO: Doctor --

MR. SPERO: Jennifer, Katie, and Tracy have been out supporting as well.

DR. POTOCZNIAK: That's a crew.

MR. SPERO: Yes, it's --

MS. CASTILLO: Truly a team effort.

DR. POTOCZNIAK: It's been a herculean task and I just want to say how appreciative I am that everybody's been out there you know talking to veterans and listening to them, and getting all the data that we really need to move forward.
MS. CASTILLO: Well, sorry, with that point -- sorry. One thing that was unanimous in at least all the virtual ones that I assisted with, all the veterans were really grateful in having the opportunity to express their opinions, and coming together not only hearing each other's experience but having the opportunity to express and provide their opinions. So they really liked the platform and being heard.

DR. POTOCZNIAK: Yes and you know I think that goes to Jake's point you know that this should be more of an ongoing process.

So you know but I think the thing that -- part of the reason I think in the very beginning I think a lot of people didn't understand why I did want to do this in a qualitative fashion, which was because I did want to have that interaction between veterans, which is what Yessie is talking about, because veterans hear things.

And also, it has an additional benefit for the veteran to participate. So they're not
getting paid but they do learn about things that
maybe save them thousands of dollars in the
future because you know veterans trade
information at these things.

So I think there's some benefit to
that, even if it's not immediately monetary.

DR. MAGUEN: I have a quick question
about the Telehealth not being -- saying it's not
as satisfying as in-person treatment. I'm
curious because, obviously, we're thinking a lot
about preferences and I'm wondering if specific
reasons were given for the satisfaction versus
nonsatisfaction.

MS. CASTILLO: So I can tell you, at
least first for the vets that some veterans have
reported that. They were specific. It depended
on the mental health condition and the reason for
the Telehealth service being provided. That for
some of them, for example, those that suffer with
PTSD, they didn't always like the impersonal
nature of speaking through technology and they
missed the eye contact being there in person, and
just feeling they just missed that.

So it wasn't the same experience for them. They didn't feel as comfortable sharing something so personal to a TV screen versus an actual person. And along with that, they also were really clear that even when they are in person, then now with the use of technology and having the electronic records, there's a difference in providers looking at their computer typing all their notes and they miss the old -- the old method of just pen and paper and having more of a discussion. So they also want that eye contact. Even when they are in person, they don't always get that experience as well now.

DR. MAGUEN: Thank you.

CHAIR LEINENKUGEL: I have an interesting anecdote that might be timely and worth to be put on the record as well, just from the Chippewa Falls CBOC, which is relatively small but growing nicely, located 100 miles away from the Minneapolis VAMC, which is an excellent facility.
I talked to, over the last four months, really since May of this year, to three different veterans -- young, 30s and 40s -- that have gotten into the Telehealth with mental health. And their comments to me were similar I think to what Yessie was saying but it changed.

Once they got comfortable with the face-to-face with the mental health provider that they were working with, they had no issues because it saved them approximately six hours a day to do that Telehealth out of the CBOC in a very private, comfortable, wonderful setting, which I was able to witness but not see during one of their sessions, of course, but they felt very comfortable after about a six-month period.

So I mean that's just anecdotal but it was from three veterans that I thought would be relevant to this discussion.

MS. CASTILLO: I'm sorry. To add to your point, Chairman, they were also still really clear they still preferred Telehealth than not getting the services, that it was still a really
great way to provide those type of services, especially in the resource-lacking areas like rural areas.

CHAIR LEINENKUGEL: Thank you.

MR. ROSE: If I may just also follow on to that. I mean as far as Telehealth, in light of the lack of psychiatrists that we are faced with throughout the United States, whether it's in the VA or out of the VA, it's an opportunity to get access to treatment. And I think a lot of it has to do, if it's in a facility like a CBOC, we're talking some where it may be in the individual's home, with respect, if they have the right kind of technology.

But it's still, I think even in CBOC, I think it's the handle that gets that person into the setting where, all of a sudden, the provider is on the other side of the screen. And I think there are some people, both inside and outside, that really it helps them.

And I would be interested how many folks in the focus group said well, it was --
they weren't appreciative or they didn't like the Telehealth. Do we know?

DR. LaRUE: I don't know that we have a set number or anything.

MR. ROSE: Yes, okay.

DR. LaRUE: I will say a factor in why we're hearing that may be the -- I think that the average age probably skews older and just by virtue of doing focus groups during the day. And if we had more younger vets talking to us, we may not hear that as much because they're accustom to FaceTime and other sorts of video chats.

So I think younger vets would probably give us a little bit different answer.

DR. KHAN: If I may add, Telehealth is a very good concept administered by and in a simplicity form. But in actually, from technical side of the house, it's a big giant.

The contract is given to Apple. Apple has created applications, the majority of them you only use on Apple machines. Within the VA, there is an ongoing effort to provide those iPads
to veterans who are in remote conditions on one of them. And since last January, the system is still working on writing that machine. So there is another difficulty is to -- but it's a very good concept you know to help.

DR. POTOCZNIAK: Yes, I think that's a huge effort by the VA is to provide a lot of veterans with iPads. I know San Francisco does that quite a bit.

And another thin that San Francisco does which I think is an interesting add-on to people that have difficulty, especially the older kind of Vietnam-era and older kind of group of people, is that we have a Telehealth -- he's not a coordinator but he's like a tech support person and he's their age. Like he's around -- he's probably 70 or -- I don't know if I want to say but he's an older guy.

And so he's able to break it down really simply and kind of say do this. And he's patient you know and conducts all the test phone calls and events so that veterans feel
comfortable.

And honestly, we've gotten more veterans on Telehealth for that reason because they're able to sit with him and explain it. And it's kind of peer-to-peer. So that's been a very effective method of getting people on.

Go to the next slide, please.

So emerging themes of Part D, which is the last part. It's experience, if any, of veterans with respect to complementary and integrative health treatments. So we have a few points on this.

Veterans had some lack of knowledge of the types of CIH treatments that were available. So they were learning in the group about all the different kinds that were available but they didn't know the full array of what was available.

They reported variability about whether CIH was discussed as an option by their mental health provider. So it depended. A lot of them, I guess, had said that their mental health providers had never brought it up --
you're shaking your head -- and some people were using it. So there's variability with that.

There's some variability between VAs of the treatments available to them and how they were discussed.

Veterans that used CIH treatments reported they learned of the availability through word of mouth or within a network of veterans. And so that was a theme that came out. So maybe they didn't hear about it from their provider but they heard about it from another veteran that maybe was doing the treatment or something like that. So it spread kind of informally a lot of times.

M.S. CASTILLO: That's a great example in a group therapy session, if a veteran said they were doing yoga and they were doing it at their facility, then that's how the other veterans participating would find out.

And so just to add one more point I forgot to tell yesterday, actually I should have told you then, that for some of the veterans that
did report utilizing CIH treatments, it wasn't always through the VA. They sometimes did it on their own in the community but not with the VA referral because they were not aware that VA also provided it.

COLONEL AMIDON: Was that under the -- I mean I know that the sample size was low but was it under the context of the CIH being a monotherapy or additive to evidence-based care? Did you hear them say I'm only doing yoga?

MS. CASTILLO: No.

COLONEL AMIDON: Okay.

DR. LaRUE: Everybody that I saw was getting other treatment.

MR. SPERO: Or had been.

DR. LaRUE: At some point.

MR. SPERO: There was traditional treatment sprinkled in.

DR. LaRUE: Right.

DR. MAGUEN: And if I can ask you something.

DR. LaRUE: I can think of one case
where the person did not want medication and so forth, just wanted to other things.

   DR. MAGUEN: Can I ask a follow-up about -- up here it says it was not always discussed with their mental health provider.

What about a primary care provider, or peer support specialist, or other providers?

   DR. LaRUE: I would say primarily people talked about receiving newsletters that had information about art therapy, recreation therapy, and so forth. So that was the source of going to something and then talking to -- you know like I go on a hiking trip and then somebody says oh, I go to art therapy; you should come too.

   The networking was huge. I didn't hear very much about providers, although you know I think more with acupuncture, chiropractic.

   MR. SPERO: They asked a provider for a referral --

   DR. LaRUE: Right.

   MR. SPERO: -- after hearing a
positive experience from a friend veteran, family member, something like that.

DR. LaRUE: And a number of participants talked about literally going to the -- they're having a bad day. They go hang out at the VAMC and they know there are other vets there that get those kind of bad days. And then you know those become networking opportunities, where they find out about oh, I can go learn how to meditate to do on my bad day.

MS. CASTILLO: A two-part answer to your question. For some veterans, they did go back to their provider and the provider was unaware, whether it's primary care or a mental health provider.

But then the second answer to that: It depends on the facility as well because we know from, at least for the virtual sessions, some of the veterans were attending care at a Whole Health Flagship Site. So those providers were more well-informed of the treatments that were available related to CIH.
So it goes back to the variable experience among facilities and providers.

DR. POTOCZNIAK: Yes, it's very different, I think, between the CBOCs and the Medical Centers. It's like you're going to hear a lot more in the Medical Centers versus even 30 miles away in a CBOC. So I think that's -- that's I think an experience I've seen throughout the VA is just that there's two different levels of knowledge. And if you're further away from a flagpole, you're just going to miss some of that stuff.

DR. LaRUE: I think that an important side note is that, beyond what's happening in the CBOCs and VAMCs, veterans talked about care that they got at the Vet Centers. And at least in one case in a rural area, that was how a participant was able to get flexibility in therapy times, for example. The Medical Center standard business hours, 8:30 to 4:00 or something and because he needed to work, that was not a good schedule.

But the Vet Center provided extra opportunities
and lots of CIH opportunities.

MS. CASTILLO: And to piggyback off of Wendy, on her comment, for some of the veterans I met or spoke to, they also said the Vet Center was their entry point to getting care at a major medical center for VA, where they had more trust with the Vet Center. They also sometimes felt more welcomed at a Vet Center than a Medical Center but that was one of their entry points to building that trust back with VA, especially if they were older.

And then, sorry, going back to CIH, the veterans also said, even with the lack of awareness related to treatments, I think it was pretty unanimous or at least the majority still wanted to know more about it. So there was a strong interest in using CIH treatments and learning more about it.

And then they also stated some recommendations of just better communication related to all of the available services, not just CIH, but in general, like a missed
opportunity of bulletin boards within the Medical Centers not being updated. They don't always read the newsletters but they do log into the My HealtheVet -- sorry if I'm getting that wrong. But even advertisements through that portal is you know something that they would recommend as well.

And then also related to more positive media coverage or advertisement with the VA, they can be advertising all these services that are available to their veterans. So they will -- you know the majority agree just these things could be done better, too.

So VA in better light, as well, the positive things they are doing for their veterans that are already available and just the better communication related to it.

DR. POTOCZNIAK: So I'm going to go into the next slide but I want to be really clear that we haven't even coded the data yet. So I'm going to talk about what potential, kind of spit balling some recommendations for Part A through
D. I'm just going to talk briefly about them because I don't want to spend too much time on them because it's premature but I want to give an idea of what we're thinking about.

So why don't we go to the next -- there we go.

Okay, so additional focus groups are going to be conducted in the next week. Kind of a coding of the data is going to go into the themes -- or the coding of the data into themes will follow.

But potential recommendations for Part A could include addressing the frequent changing of providers related to retention. So that does seem to be a theme throughout the VA and there's reasons for that, some of which are kind of outside of our scope but there are things that can be addressed related to that.

Training veterans in skills to assist them with advocating for their own healthcare. So I think that there's definitely a lack of skill in that way that veterans are -- they think
they have to kind of take whatever is given to them and they don't really know how to ask the questions. They don't really know how to advocate without getting angry sometimes.

So I think if veterans were trained in some skills to assist them with that, it might be helpful. So that's an idea.

Examining the process of initiating mental health care and identifying issues. So different VAs have different issues. And I think the lack of uniformity around how you seek care throughout the different VAs is part of the problem.

And that does kind of dovetail into eligibility issues, which I won't get into, but there could be a potential recommendation around that because it does stand in the way of accessing mental health.

Examining compliance of night and weekend appointment availability. So there is a mandate that's out there around night and weekends but very typical of Government agencies,
sometimes, there's been a lot of solutions to
that that basically make the -- that kind of
touch on the mandate or gently meet the mandate
but don't actually -- but I personally don't
consider a 5:00 p.m. appointment to be a night
appointment. I kind of still consider that to be
a day appointment, even though it is outside the
Government workday.

So a lot of VAs don't go past 6:00.

Vet Centers do and some VAs do. Some VAs do a
great job of that, a lot of VAs don't.

So what is kind of slightly meeting
the mandate? Who is robustly meeting the
mandate? How can we get those things closer
together?

Because that is an issue. Our weekend
-- our night and weekend appointments, especially
in the plight that I'm in, are gobbled up really
quickly. So there's clearly demand around that.

It's just how do we get it to be uniform.

MR. ROSE: Mike, if I may, is that a
staffing issue did you say or not necessarily?
DR. POTOCZNIAK: It's not -- it can be a staffing issue. It can be that it's hard to get people who are already feeling underpaid to stay late.

MR. ROSE: Okay. Well, it's like a staffing issue.

DR. POTOCZNIAK: You know so I take a job in the Government because I want a certain quality of life and you're telling me now I'm going to work late. Maybe I'll go work for Stanford, or Kaiser, or whatever.

MR. ROSE: Yes.

DR. KHAN: But I think the complement there, you have a triage system within the -- throughout all the -- even otherwise, your quality, it's a matter of information. How does a veteran know what to do for his or her own health?

DR. POTOCZNIAK: Are you talking about the nurse -- the advisors?

DR. KHAN: You call in your -- you call in your 911 and you say I'm a veteran.
DR. POTOCZNIAK: Yes.

DR. KHAN: And you say I'm a veteran.

They'll transfer you to a triage. In the triage, you have a mental health psychologist on station. They will take those calls.

So the system is available but the difficulty for the veteran is not knowing it, how to navigate through this. We always have a shortfall of expert people you know and they will not be available on duty 24 hours a day the same person but within the system there are resources available. The lack of information, how to get to those resources is the biggest hurdle.

DR. POTOCZNIAK: So thank you.

So conducting training on the importance of family involvement in veteran care for VA providers and review clinically appropriate ways of involving family. So I think there is some variability around how VA providers feel about involving family. It's a difficult issue in mental health around involvement of family because there's a lot of times in the
private industry family is seen as -- you know if
family were to show up at a session at a private
practice, it would be considered intrusive and
that's the culture with which a lot of
psychologists are raised in. Some are raised
differently but a lot of times you wouldn't just
automatically involve a family member. But in
the VA, you are expected or at least informally
expected I think, if somebody brings their spouse
in and they're sitting in the waiting room and
they want to come in you're probably not going to
turn them away. But a lot of veteran -- a lot of
providers feel very differently about it and
there's an unevenness into how families are
involved in talking and training providers more
kind of uniformly on how do you involve family,
how do you deal with the privacy issues that are
involved effectively so that it's not a surprise,
especially for trainees and young providers that
are coming out of a training program that may not
have any background involving family in
individual therapy, or group therapy, or
whatever. So I don't know.

MR. ROSE: Just, if I may, say

something on that Mike. I mean with respect to family, and it may not be right in session with the provider, but you know putting on the NAMI hat, I mean we have been very successful in family-to-family training, something that is maybe outside the office hours, if you may, because the families need that. They really do. They probably need as much help as the veteran, in many instances.

DR. POTOCZNIAK: At a lot of the veteran town halls that I've been to, you hear more from the family of the veteran, frequently, than you hear from the veteran themselves. You know and so you hear about what they're happy about or what they're not happy about.

And so the thing is is that you'll get a lot of new providers, as well as even some established providers, when a family member calls to say I don't release information to talk to you so I'm not blah, blah, blah. But the reality is
is what they don't know. You know you can listen
to anybody talk about anything and you just can't
promise to keep it a secret. You know it's like
so you know but there are ways to effectively
work with family that can help the care of the
veteran and the care of the family, which is
sometimes the whole -- the patient is the family
sometimes.

So that's an important point, I think.

And doing work, concentrated training on that
across the system might be very beneficial. So
that's just some potential recommendations for
Part A.

Any questions? Any more questions on
that?

Okay, then Part B, I don't have a lot
for Part B because there wasn't a ton of
participants with this but potential
recommendations for Part B could include
addressing barriers that contribute to a lack of
knowledge related to eligibility.

So I think the complexity -- the
complexity of the eligibility system does not allow for the veteran to advocate for themselves in a lot of situations because there's so many different rules and subparts to those rules and you can't effectively advocate for yourself with it -- usually the help of a VSO or something like that. So and that's where a lot of veterans kind of boil over is in the eligibility process.

So dealing with eligibility issues and making it streamlined, less complex, so they better know what they're entitled to when they walk in, would be a lot -- a lot better.

And then improvement of coordination of care between community care contracted providers and VA treatment teams. I think it's harder to coordinate the care. So I don't know if there's a recommendation coming on care that veterans privately paid for. It's easier if -- but we could improve -- I mean we could improve that but I think that's a bigger leap but we can improve at least the community care that we pay for and improve how we coordinate that.
And I think with the rollout of the MISSION Act, the problems only become a little bit more acute. It hasn't really gotten better because now we have a lot more records coming in and that's being unevenly kind of dealt with, depending upon the system that you're in.

So I think there could be a good recommendation around how to coordinate the care between community providers. And right now you know if a veteran has a suicide flag, or if they have a behavioral flag, or if they have any of these things, the community providers are in the dark with that stuff. So they don't know really what's walking into their office and that can be a big issue in the coordination of care, as well as if they discover something.

Like we have veterans that get hospitalized but we're get notified but the provider won't get notified. So how do they know in their next session?

These are all important gaps that exist under the current MISSION Act rollout and I
think it's important to kind of address some of that. Potentially you know there could be a recommendation on that.

Any questions around that?

Part C is to address lack of uniformity between VAs related to the same day access and walk-in processes. So I know that the VA I think has done a great job with rolling out same day access and providing models that VAs can implement. That doesn't mean that they always implement it in the same way. And so addressing lack of uniformity between the VAs because that lack of uniformity, in some ways -- you know I don't mean to make it overly simplistic but I know that when I go to McDonald's in Washington, D.C. or if I go to McDonald's in San Francisco, I'm getting the same chicken sandwich. You know it's like and I go about ordering that chicken sandwich in about the same.

So VA is a chain, like any other, you know in some senses but it doesn't behave that way. You order a chicken sandwich in Sacramento,
it's going to be different than that chicken
sandwich in Dallas. So changing that and trying
to come up with better uniformity around a lot of
processes, especially same day access and walk-
in, that's important to veterans.

COLONEL AMIDON: Can you describe,
just for those of us -- is the variability in the
delivery of that contingent upon staffing
variance you know per VISN?

So I understand the chicken sandwich
example but McDonald's doesn't have staffing
shortages the same way VA you know in that way.
And I get the complexity differences but there's
a universal policy that was in some over-
simplistically mandated to say same day access
but in some ways it cannot be delivered. So in
order to address the lack of uniformity, is it
accepting that there will be some variance in
that uniformity?

DR. POTOCZNIAK: There has to be some
variance but I think that different VAs have
their ELTs, their Executive Leadership Teams,
have different priorities. And so VAs are
staffed -- so mental health is staffed in a
certain way, based on staffing ratio. But
whether VA meets that staffing ratio or not and
whether the ELT wants to save some money that
year for other things, that's up to the ELT,
right?

And so staffing-wise, that ratio, if
applied, would allow you to meet the same day
access.

COLONEL AMIDON: Okay.

DR. POTOCZNIAK: But if ELT, like in
Atlanta or whatever, decides we're just not doing
that, we don't -- we have bigger priorities right
now. And there are sometimes bigger priorities
if you have dermatology, and ortho, and all those
different services, probably think they're very
important also to the care of veterans. And they
are. So who do we meet? How do we meet all
these different needs? And I think ELT picks and
chooses how it deals with that.

So you know if it was staffed
correctly, same day access shouldn't be as much of an issue.

The smaller CBOCs are always going to struggle, I think, with this because their ratio, they may only be staffed with one or two people. That's a problem, right? But how do you meet that problem?

And I think the Mental Health Uniform Handbook, which was rolled out, you know it was rolled out so long ago it doesn't address any of these things because it's like 2013 or so.

PARTICIPANT: That's optimistic.

DR. POTOCZNIAK: Yes. So it doesn't address, I think, a lot of the -- a lot of these different things. And so I think that there's ways of dealing with it in different environments and I think the VA should address in smaller environments, this is how we handle this, as opposed to one policy that covers the whole Medical Center that can't possibly be applied on lower levels. If they just spelled it out, it would be a little bit better.
DR. MAGUEN: And one point that I'll just add to that, if you have a set number of providers and you allocate their time to the front door, now they're not able to do as much of the ongoing therapy, right? And so I think it's a constant balance in terms of how many people you allocate to the front door versus ongoing care.

And no matter -- right, there's only so much of the pie you can slice to one direction and have the other be left for the other piece of it.

COLONEL AMIDON: And I agree. It reveals sort of the tension of the unfunded mandate, where you set a universal policy that you know they are just now getting behind it. I guess in some simple way where you then now have to try to abide by the mandate without the resources to do so or you have to manage your resources in such a way.

DR. MAGUEN: Right.

MR. SPERO: To clarify something on
the same day access, is that -- so if I get an
appointment but I'm not going to be seen for two
and a half weeks because that's when the next
appointment is, if I don't like that, I just show
up because I have same day access and the mandate
is to care for me then.

DR. POTOCZNIAK: That's exactly it.

MR. SPERO: So to the point of the
front door.

DR. POTOCZNIAK: But so there's
different ways of applying same day access. John
could probably talk our ears off about it but I
won't put him in that position.

So but same day access can be applied
in the sense that okay, instead of having like in
my size CBOC, which is like a large CBOC, the way
that we apply it is we just allow for certain --
like, Matt, today you have an 11:00 same day
appointment and a 1:00. So you're not sitting
around all day just waiting for someone to come
in. And Wendy, you're going to do 9:00 and 1:00.
You can see patients the rest of the day but
between 9:00 and 1:00, you've got to leave those
open in case someone comes in.

So that's generally how we deal with
it on a lower -- on a smaller level but then you
still have crises that walk in. So it is hard to
balance.

The larger VAMCs sometimes have like
an Access Center, where someone just comes in and
here I am. And that's the benefit of the larger
center.

DR. MAGUEN: And oftentimes the people
who will go into the same day clinic, they need
their medications refilled urgently or you know
they're having suicidal ideation or homicidal
ideation. So I think it also varies tremendously
who you get walking into the same day clinic, who
can't wait for two weeks.

MR. ROSE: How -- can you talk a
little bit about the no-shows? Is that an issue,
no-shows for the appointment, or not so?

DR. POTOCZNIAK: Well, for same day,
no.
MR. ROSE: No, no, no but I'm talking just appointments, for mental health appointments.

DR. POTOCZNIAK: I think that is highly variable also. I don't see as many no-shows. I know that, John, there's a certain percentage, right? Is it a 15 percent?

DR. KLOCEK: Nationally, that's about where it stands, yes.

DR. POTOCZNIAK: Yes, so I think that when they look at like labor mapping, and RVUs, and all that stuff, there's a given like 15 percent no-show rate.

Now, depending on your VA -- would you say that some VAs are a lot higher than others, John?

DR. KLOCEK: It's variable. I'm not sure of the range overall.

DR. POTOCZNIAK: Okay. So there is -- I mean personally, anecdotally, I've experienced a range. I just -- I've seen it low in the clinic but I mean I think we're smaller. But the
larger Medical Centers --

MR. ROSE: Okay, thank you.

DR. POTOCZNIAK: Yes, but 15 percent is the -- is what we're allotted for no-show rates.

MR. ROSE: Thank you.

DR. KHAN: If I may add to the same day, for example, I have a primary care appointment and I go to my primary care team and they observe something in me. They refer me to the mental health. In that concept, it's quite a bit practiced because it's a primary care and that team sees me and they said oh, he's dangerous, he shouldn't walk out of the hospital. He needs to see someone. So with that, the PAC Team comes into contact. So that is very much being practiced.

DR. MAGUEN: Right and that is a little bit separate than the same day clinic. So within the PAC Team, there is that integrated care where you might see your primary care doctor and they can do a warm handoff to a mental health
provider that's within the Mental Health Team.

But the same day clinic is also for people who

can just walk in without even having touched

their primary care provider, too.

But you're absolutely right. That's

another way in which people can be seen same day

for mental health with a warm handoff in a
different context. So I'm glad you brought that

up.

DR. POTOCZNIAK: Yes. So, gosh, where

am I on this now? We've been talking about --

MR. KUNTZ: Probably the peer

supports.

DR. POTOCZNIAK: Yes, yes.

Yes, so the other piece is to I think

there are peer support specialists that are
everywhere. And that's also -- I guess I

wouldn't say everywhere, because they are

unevenly rolled out. But peer support

specialists is a growing thing in the VA system

and it's been highly effective.

But enhancing the identification of
the peer support specialist so that veterans actually can point out and see this is the peer support specialist. You know right now, they're kind of within mental health staff. Sometimes they are in primary care. Sometimes it depends on where they are. But in some ways, you should be always able to pick out that's the peer -- like if that person walked down the hall, that's the peer support specialist, whether it's something they're wearing, or a tag, or something like that so that veterans can easily identify that person and know the person that helped them was the peer support specialist, rather than guess.

And I don't want them wearing big name tags but something that easily identifies them as the person, the peer veteran that you can talk to about what's going on.

MR. ROSE: About how many times, though, is the exchange where the veteran peer support specialist will make that initial contact? Not so? I don't know. I'm just
asking.

DR. POTOCZNIAK: How many times --
what was this?

MR. ROSE: You know if the veteran
peer support with no name tag approaches Mike and
whether it's in the waiting room or whether it's
out --

DR. POTOCZNIAK: Yes, that happens a
lot.

MR. ROSE: -- anywhere, I mean that is
a link right there, to kind of bring somebody in.

DR. POTOCZNIAK: Yes, it's what they
do.

MR. ROSE: Yes.

DR. POTOCZNIAK: But the person that
walks up to them, they may not know what to call
that person.

MR. ROSE: Well --

DR. POTOCZNIAK: Or I mean but they
might not know whether that is a person that can
be -- like they don't know the -- like if I go up
to a psychologist, I know what a psychologist is
going to do.

MR. ROSE: Yes.

DR. POTOCZNIAK: A social worker, I know what a social worker is going to do, psychiatrist. That person that walks up to me is just a helpful vet.

MR. ROSE: Okay.

DR. POTOCZNIAK: That's great but there's a lot more that they can do for. And it's helpful to know that I can go back to that person when I have another question.

MR. ROSE: True, true. Okay.

DR. POTOCZNIAK: So right now, they're there but are they just a helpful person? Are they an MSA? Are they -- what are they?

CHAIR LEINENKUGEL: That's a great point, Mike. I think what you're really getting to here is better branding of the role.

DR. POTOCZNIAK: Yes but it's something the VA is very proud of. So they should be happy to brand it.

CHAIR LEINENKUGEL: Yes.
DR. POTOCZNIAK: Is there any efforts around that, John?

DR. KLOCEK: Not that I'm aware of.

DR. POTOCZNIAK: Okay.

And so also it's to utilize peer support specialists to increase knowledge within the network of veterans about various treatment options available.

So I think you know if what veterans are saying is they're finding out about CIH treatments -- I didn't say CIH in this because they can be used for any kind of treatment but a lot of times peer support specialists will show you how to navigate certain things. But I think if they could broadly increase knowledge using the network of veterans because Vet to Vet is a very strong thing within the VA.

If I am sitting in the waiting room talking to Jake, you know I'll tell Jake oh, yes, that was a really good doctor, blah, blah, blah. And peer support specialists do that but they also can enhance like did you know we've got
these things. And you've got that problem about all these things. You know are you using those? And just making that a little bit more uniformly part of the peer support role.

And so I think the last piece of this presentation is Yessenia is going to talk a little bit about, just if you could for a little bit, about the -- go to the slide -- there you go, 13.

MS. CASTILLO: Sure. So thank you, Commissioner Potoczniak.

DR. KHAN: Would you speak a little louder?

MS. CASTILLO: Oh, sure. Sorry.

And just to go back to one of the recommendations related to A, as you know, I can't help myself --

DR. POTOCZNIAK: Go ahead.

MS. CASTILLO: -- but related to the family aspect and this pertains more to Duty 5 but also speaks to the synergy across the workgroups.
The families are usually also the first people to recognize signs of suicidal behavior or ideation. So it's more reason and importance that it should be provided to the family and caregivers of these veterans as well. So I just wanted to make that point known.

DR. MAGUEN: Well, can I just add to that? I think that one of the things that we should really be thinking about and talking about, too, is those -- the veterans we're not reaching. And I think not only the suicidal veterans but the veterans we don't even have hands on and how to involve the family more and just getting them into care.

We saw from the slides that veterans are saying most of the reason that they come in is because family members say to them you know you have a problem or please go get help. And sometimes it's sort of the last resort for the veterans.

So I think if the family is so involved and we're hearing that, then it has to
be at the front end, too, where that's how we're
getting to those veterans we can't touch is
through the families.

MS. CASTILLO: Absolutely. And just
one more thing to add, there's also caregiver
burnout. You know we talk about provider burnout
but there is also the other side of it for those
dealing with helping these veterans at home.
There is such a thing as caregiver burnout as
well, so providing you know greater assistance to
those helping veterans at home is just also
another reason why I strongly agree with the
recommendation put forth by Commissioner
Potoczniak.

DR. JONAS: Just before we get off
here, sort of recommendation draft here --

DR. POTOCZNIAK: Very rough draft.

DR. JONAS: A very rough draft, yes.
I think it would be great for the group, your
group to think about sort of the more meta
recommendation or a general recommendation that
might help with this, sort of like what Shira and
the evidence-based group.

You know we've gone through specific, okay, more of this research for that. And then we said you know what, there's some research system issues that need to be addressed here. And that goes to the point under our general recommendation. It would be really helpful in this scenario.

You know we hear over, and over, and over again that there are coordination problems, that we have a system with multiple factors, lots of different service members based on episodic models of I see you, I see you, then I go there, et cetera, and it's chaotic for people.

And so a company that would normally want to solve those problems that they do routinely every single day would sit down and they would design you know a coordination matrix and actually address those issues. They would go through the flow to see what are the routine needs that occur and how can I design the team to deliver that. And would probably improve the
resource -- I mean would actually access more resources. It would be better spent. You'd actually probably save money on those types of things because it would be more efficient.

And so I mean we have peer support people coordinating. We have navigators. We have health coaches. We have, in the stepped care model, you know they keep talking about okay, all these different levels of care and self-care being down there, and then across then we are trying to get people to flow this way, and all that, that's all a coordination challenge.

And so one of the meta recommendations could be, very draft, is that you know the VA really needs to do some systematic -- and also then because they're standards -- because we don't have that, there's lack of standards, or there's in applicability or there's poor applicability of things that are standards.

So some design issues around simplifying connectivity and coordination or integration around mental health care I think
would be something to consider as a meta.

We saw several examples of how this was done --

MR. ROSE: Iora.

DR. JONAS: Iora was an example outside the VA but we saw several examples inside the VA where they did a really good job of it.

You know when I walk into my hospital where I see patients every day, there is a greeter at the front door. And they're friendly. They're knowledgeable. And you know if I ever -- I use them. I work in the hospital and I'll say you know where do I get this and that. And they will know exactly, and they will show you, and they'll take you there. And that was set in because there was a design problem, in terms of navigation, when you walked into the hospital. That's just one of the design issues.

So anyway, that general design coordination around that to increase the efficiency of the integration across the services I think might be something to think about.
MS. CASTILLO: I would just add to that if you also include then the whole health model with that and looking at the social relationship, it goes back to the family. They should be considered part of that coordination.

DR. JONAS: Well, there's whole community services that are huge, okay, and yet those don't get coordinated very well either, except in certain places.

I mean we saw down in Phoenix you know around the community around the homelessness, and the food, and everything. They had a tremendous coordination system and community support. I'm talking the community was embedded in it and they were providing it. So there are some great examples even within the VA.

MR. ROSE: And you even had -- we had examples of law enforcement that were included in that.

DR. JONAS: Exactly.

MR. ROSE: And they have access and they can really be a contact for maybe some
people that aren't even in the VA. They are a veteran but they get to know them and they may be another source.

MS. CASTILLO: Well and we know that the veterans that have a strong social support network also adhere to the treatment better. They have better health outcomes, better adherence rates. So it's just -- I'll get off my soapbox now.

But related to the data source for Duty 2, the spreadsheet in front of you lists the different data sources on the left-hand side, they type of analyses associated with it --

CHAIR LEINENKUGEL: Just -- I apologize but just because of time, we're 25 minutes over and this was extremely important. It's very valuable. Mike, just a terrific job.

But rather than go through the whole list, as chairman, I'm going to note that there are some items on every one of these that the VA or other folks owe us.

MS. CASTILLO: Yes.
CHAIR LEINENKUGEL: Okay. What I am recommending is that the support staff that owns this and the VA person, if there's not an assigned person to each one of these asks, I want an assigned person by Monday. Okay, today is Friday. So by close of business -- and I'll throw that to John and to Casin to work with our partners in here to assign who is going to be held accountable for getting this information and when are they going to get to Mike, and his team, and to you to complete this.

MS. CASTILLO: Thank you. That is a great summary of --

CHAIR LEINENKUGEL: So I just rather want to speed things up because there's a lot of things on this eye chart that --

MS. CASTILLO: Yes, that's the perfect summary, Chairman. Thank you.

CHAIR LEINENKUGEL: -- would be -- they're all nice to have. There's a couple of things in here that I think that Mike and his team feel are essential at this point in time.
And so let's do it that way.

Casin, while you are walking back, I just assigned you and John a major task in the next 72 hours.

Everybody good with that, as far as the commissioners, with that direction?

DR. POTOCZNIAK: Thank you, everybody.

CHAIR LEINENKUGEL: And, Mike, that was -- compared to 30 days ago, where you were at --

DR. POTOCZNIAK: Compared to last night.

(Laughter.)

CHAIR LEINENKUGEL: It's an unbelievable amount of really good synopsis, condensation of some of the hot topics with what we thought was going to be something that was going to be very difficult to do, if not impossible.

And you came up with an alternative method. I think that the methodology used, and the support team, and the people that you
recognized, just did a terrific job in a very short amount of time to get to what I think are going to be some great recommendations coming forward. So thank you.

DR. POTOCZNIAK: Thank you. Thank you to everybody that's doing -- that's out there in the field doing it. They're doing all the work.

CHAIR LEINENKUGEL: Thank you.

DR. POTOCZNIAK: Yes.

CHAIR LEINENKUGEL: With that, we will take a 15-minute break. It is 10:25. So let's restart at 10:40. So those on the phone, we'll go to mute and just stand by. We'll be back on live at 10:40. Thank you.

(Whereupon the above-entitled matter went off the record at 10:26 a.m. and resumed at 10:40 a.m.)

CHAIR LEINENKUGEL: Okay, 10:40 a.m. Eastern Time and we are back on the COVER Commission open session. We just finished with Mike Potoczniak and his workgroup to update.

And at this time, we're going to
transition to Commissioner John Rose with

MR. ROSE: Thank you very much, Mr. Chairman. Welcome all those that are onboard
today and thank you for the team that makes up
Group 4 here for our Commission.

The Duty 4 is to study the sufficiency
of the resources of the VA Department to ensure
that delivery of quality health care, health
issues among veterans seeking treatment within
the department. And our workgroup membership
includes Matt Amidon, Jake Leinenkugel, Jamil
Khan, Thomas Harvey. And I serve in the capacity
of leader.

At this time, before I get started, I
will ask Matt if he would like to say anything,
since he is in charge of both 4 and 5. Let’s go
to you.

COLONEL AMIDON: Thank you, Jack. No,
I appreciate that. I think what's interesting
about Workgroup 4 is how the
definition/identification capture of data
supporting our sufficiency is sort of universal
to a lot of the other workgroup objectives as
well. I know we've had some good intellectual
collaborations on how to define sufficiency and
interested also to hear on the data capture and
support of that definition, sort of how each VISN
is organizing and managing the demand signal and
supply of resources relevant to the demand signal
but I appreciate the hard work.

MR. ROSE: Okay. Well, we've got a
great crew that's doing it, getting it done, and
I appreciate the support staff.

So for the public out there, we're
using the Quadruple Aim model. And so what does
that mean? And so there are basically four parts
of that and the first one being the experience of
the veteran.

And so I think we've heard different
members of the Commission talk to that, that as
we go forth with respect to mental health and any
related issues, we should be focusing on the
effect on the veteran. And Dr. Jonas talked
about that, as far as the style of treatment, in
his presentation but we really need to focus on
the veteran and we need to listen to the veteran.

And I think, as we go through dealing
with mental health, we are all individuals and I
think we are getting to a point in our mental
health care that, instead of a medical mandate,
we are listening to how the prescribed treatment
is working out.

So if you look at treatment in laymen
terms, I think of it as a three-part process.
You have a medication part and that is in
different levels, depending upon the individual.
I think you also have a therapy part that can be
key, depending upon what that mental illness is.
And then the third part, which we've talked about
quite a bit is the whole person, the CIH model.
And as we go forward, we are going to see a role
for CIH in the treatment of our veterans and it's
key. And I think as Dr. Maguen pointed out, it's
maybe not so much as a CIH, complementary and
integrative health, the models that you have gone
through, the modularity, and with respect to how it may be coordinated with another type of treatment. And it may not always go into each's but a combination. And I think the effort that has been taken with looking at the research and just seeing what's available out there and is it an evidence-based practice or not. But that's just -- it's been key to the task that we've had here.

I think the health of the defined population, that's the second part of the Quadruple Aim, we have a cohort that is not so well, maybe, for various reasons. They are veterans. They have given the ultimate sacrifice in going on deployments as different members of our military services. And we actually owe it to these people for the rest of their lives for the duty that they've paid for our country.

The third part of the Quadruple Aim is the per capita cost of the population and again, looking at the veterans. And we've talked to Dr. Klocek and there are some opportunities to check
and see what these numbers are.

And I think with respect to cost, Team 4, the whole Commission is really looking forward to getting results from our ask to the VA as far as how is the $9 billion that they have in the budget for this year for mental health, how is that going to be utilized. And I think that is extremely important. I think it can help us get a benchmark for what we're doing now with respect to the budget and mental health. And also part of that ask, but let's take it one step at a time, it would be good to look back five years and just see what has happened with that budget and what are the results that we're getting. How is this helping out our veteran? I think that's a very important part.

The fourth part is the impact on providers. And I think we've had different mention. Mike has talked about it and it's the potential burnout rate for our providers. And it's a very serious business. It's a very demanding business. And I think anytime that
you're dealing with mental health, you're dealing
with people that are potential suicide folks,
it's very, very demanding.

I think the way that the different
facilities approach this and recognizing the
potential burnout rate, I think this is important
because in the visits that we've made, a lot of
times you'll go in the VA, the people seem to be
very passionate in what they do. This is
important and we just need to take care of the
people that are providing the care to our
veterans.

Some of the things that we've done so
far, we have had different speakers that have
come and talked to us. We've had a
representative from the National Director of the
VA Office on Rural Health. We've heard a lot
about rural health. We've heard a lot about
Telehealth and how it becomes very difficult to
deal with our veterans that are seeking care in a
rural setting.

We also had Dr. Mike Schoenbaum, who
is the Senior Advisor for Mental Health Services
come in and talk about some of the research that
is being done by the National Institute of
Health. Very, very informative. And I think one
of the good things, and it's been I think a cost-
effective effort, that as we bring in speakers,
we, as a group, will go back, initially start off
with questions that we're looking for. Depending
on how the call goes, we will go ahead and even
ask more questions to that same individual and
it's really kind of built our body of knowledge.

We've had Ms. Ellen Bradley, Director
of Information Reporting for the Allocation
Resource Center. We've had this on a couple of
occasions. And we've also had Ms. Tonya Bowers,
who is the Acting Administrator for Primary
Health Care and Health Resources Service
Administration.

And we've talked about this and we've
talked about community resources, outside
resources that can help the VA. And one of
those, we've found out, is the Federally
Qualified Health Centers. And you'll see, as we get to the recommendations, this is something that really should be investigated because we're seeing evidence that the VA may not be able to do everything for that veteran. And I know it's a huge organization but there are members in the community out there that can help the veteran. And we've got the MISSION Act that's coming out and we're trying to I think do a better job with our community partners out there. And we've seen things in our travels that we have an outside resource, maybe it deals with CIH, and we have a contract with them but sometimes payment of the invoice to that person that's providing the care out in the community is not there. We need to do a better job of it. And it can be a valuable resource but we need to really recognize that resource and pay for that resource.

Aside from the calls that we've done, we've also made some trips. We've gone out either the entire Group 4 or parts of it. And we had an opportunity in June to go to the Captain
James Lovell Federal Health Center. Now this is the first Federal Health Center VA and DoD. And so it's been an opportunity to see how the DoD and the VA can work together.

I think that's one of the issues we have seen in our time on the Commission, and that is the ability of somebody coming out of the DoD, coming out of the Service and going into the VA. I think we need to do a better job of that and you can see how this large facility at -- in Chicago at Lovell, how they deal with some of this stuff. And so there'll be more to follow on that.

DR. POTOCZNIAK: Is that a DoD-VA facility?

MR. ROSE: Yes.

DR. POTOCZNIAK: Okay.

MR. ROSE: Yes, that's the first one and for everybody's benefit.

DR. POTOCZNIAK: There's a couple more now I think out there.

MR. ROSE: That was the first ever.
DR. POTOCZNIAK: That was the first ever?

MR. ROSE: Yes.

DR. POTOCZNIAK: So they're in Hawaii.

MR. SPERO: So Lovell is the first actually integrated system where they actually have the Director is a VA employee, the Deputy Director is a Naval Officer.

MR. ROSE: Right.

MR. SPERO: There's ones that are very close together and linked but they have a completely separate funding stream. They have a completely -- they are one of a kind. I think it's a ten-year implementation --

MR. ROSE: Yes.

MR. SPERO: -- and that they're not all the way through yet.

MR. ROSE: Right.

MR. SPERO: So Hawaii is --

DR. JONAS: Same building but separate operational.

MR. SPERO: Right, so they have
separate budgets, separate everything. So they
actually you know for example, they converted
positions from DoD civilians to VA civilians and
things like that. So it is still unique in that
way.

DR. POTOCZNIAK: And Monterey is --
it's DoD-VA also.

MR. SPERO: But they have separate
operational structures.

MR. ROSE: Yes. It's the first one
ever. And as you mentioned, or as John had, it's
like a ten-year deployment plan.

DR. JONAS: There's a VA Clinic at
Fort Belvoir, it's a VA operated by the VA. It's
again, operated by the VA, it sounds like.

MR. ROSE: A little bit different.

Okay. We also, part of the group went
to Great Falls, Montana and you had an
opportunity. And one of our commissioners here
was the host and went out there to see Great
Falls. And that's a huge area and it's just how
they have to conduct business in Great Falls.
I don't know. Matt, do you want to add anything on that? I mean it was a pretty unique visit.

MR. KUNTZ: Yes, I was really grateful to the commissioners for coming. Part of what I -- I know when I was appointed to this, this was part of the goal was to help the Commission really think about those rural veterans. And then some of that means really, really, really rural and just what that geographic scope means, what that means for the clinicians and the care system. So I was very grateful to everyone that came out and also for the communities that hosted us and Fort Harrison VA, as a Montanan, I was very proud of how our people hosted us.

COLONEL AMIDON: I wanted to say thank you for that. That was a wonderful learning experience. And you know rural is rural and then there's the frontier aspect of rural, certainly. And it certainly reveals the tension of the word access and realistic expectations of access,
But I think what was also very educational was how, in terms of like your previous comment on healthcare consumers, how you can be a consumer of two different healthcare systems in the same location that don't talk to one another, sort of you know the IHS and the VHA interactions. Some of the folks living up on the reservation who can partake of IHS in some ways but not VHA.

Maybe you can allude to some of that but it was very --

MR. KUNTZ: And that hospital was funded as a Critical Access Hospital, which is an entirely different pot of federal money. So I mean it is difficult for a lot of different folks.

And I think it was nice to see from the VA staff that they were very clear that, what, 25 percent of our care is in the community and it's not realistic to ever try to bring that in. It's just something that we have to work with the community partners to make sure that
it's done in the best way possible and to make sure that the interface is as easy as possible for the veterans to navigate.

DR. POTOCZNIK: But at the same time, what -- I think what we learned is that there's a lot of times when people say well, we can't. It's so remote or it's so whatever, we can't possibly provide X or Y. And what we learned, I think, by going to the reservation, which was the remotest place I've been in a long time, is that really what was lacking was not the desire by the veterans to receive care at the VA but the information and relationships necessary to connect them.

There were simple things like $2 solutions, you know what I mean, that would have changed their lives and that was lacking. And despite, I mean Montana is -- Montana has -- I think it was an amazing VA. There were some simple solutions that would have made a world of difference, like if they had rolled out -- this speaks to the lack of uniformity, which I don't
want to highjack with, but the lack of uniformity.

Had they employed the Peer Support Program effectively in that VISN, because they don't. It's funny that was the birthplace, I think, of the Peer Support Program and yet, in Montana, like if you have two peer support specialists sitting up in Havre, like that would have made all the difference in the world to those veterans. They would have had probably adequate care from the VA.

But it's those little solutions that we're lacking and that's not Montana's fault.

You know that's --

MR. KUNTZ: Well, and I think it shows that you know if you're in a resource-poor environment, the ability for management to take on -- you know it's just they end up dealing with today's problems instead of taking care of things that may be a long-term fix.

MR. ROSE: Right. It's just you have limited -- you have to put the fires out before
you can really do this other stuff.

MR. KUNTZ: Instead of taking care of the forest.

MR. ROSE: Right, the forest and the trees.

That brings up an interesting point, though, about the peer support or it sounds like kind of a lack in Montana. But I think we, as a Commission, have seen the importance of peer support specialists throughout all our calls, throughout all our visits. And I think, as we get into the recommendations, I think it really needs to be a point that, as Wendy says, we need a verb at the beginning of that recommendation but we need an implementation, a continued implementation of the veteran peer support specialist.

And I think if you look back historically, there was a huge movement towards veteran peers support specialists a while back. And when that occurred, the road block, and I think the guides might have been well, we need a
thousand peer support specialists. And to this
day I think, I don't know, we have 800. John,
you may know a better number than that, ballpark.

DR. KLOCEK: I don't know the number
offhand but the original hire was 800 --

MR. ROSE: Eight hundred.

DR. KLOCEK: -- and it's gone up since
then.

MR. ROSE: Yes, but the initial
problems with that is they didn't have the proper
certifications for the veteran peer support
specialists. And this was not unlike what was in
the civilian side, too.

Peer support specialists are really a
tremendous link to the glue that can hold us
together but there was a problem outside and
inside with respect to the certification. And I
think that that has been corrected.

So I think, once again, we need that
veteran peer support specialist in many, many
different roles. We really do.

CHAIR LEINENKUGEL: Jack, if I may.
It's a great opportunity to go on the record. And some people that know me from a couple of years ago know that I became very excited about learning that we are discharging 10,500 Medic Corpsman docs every year and we're capturing less than one percent of them into a VA healthcare network.

So there has been a joint VA-DoD partnership to try to correct that. I don't know where it sits right now but again, John, you may.

But I think it's a huge opportunity to utilize that stream on an ongoing basis, not just for ICT, intermediate care technicians in a clinical sense, but also peer support. You know whether or not they've had issues dealing with their time in service, to me, is something you know a clinician could answer with a peer support role.

I think having a Navy Corpsman doctor, Army doc, somebody like that come into the system, be trained up, certified, and have the opportunity to continue their education and
training to further develop their career using the GI bill at the same time because the majority of them are still young and they're looking for something. And if we want to really aggressively make a new recommendation, I think that this Commission has the opportunity to explore that avenue as well.

DR. POTOCZNIK: Well, let me go one step further on that because we do have, I would say, like probably in the thousands range of behavioral health -- behavioral health -- they're kind of like behavioral health medics, essentially, that are Army, Navy -- I don't think the Coast Guard has one but there's tons of them and they're all enlisted techs. They are the behavioral health side of the medic kind of role.

And so they're all trained and certified through the Army or the AIT but the problem you know similar to bringing medics in from the DoD side to the VA, where there is a certification problem and a licensure problem, you have a problem where they -- and it's self-
imposed. The peer support specialist has to have
had a mental health experience and have recovered
to be in that role.

And so I just go on the record to say
you know that seems to be -- I'm not sure if
having that experience is as important as the
training that some of these veterans have had,
which is deploying as a behavioral health
specialist to Afghanistan, Iraq, and be trained
in AIT for six months, which is bigger and much
longer than the VA certification.

CHAIR LEINENKUGEL: Thanks for
responding to my concern.

DR. POTOCZNIAK: Yes.

CHAIR LEINENKUGEL: I asked for a
clinician's take on it. So, thank you.

And Shira, would you agree with that
as well, in that context?

DR. MAGUEN: Yes.

CHAIR LEINENKUGEL: I mean would that
type of person be able to get into that peer
support role without the way we currently
classify the requirements?

DR. MAGUEN: Yes, I think that there's no question that those folks are being underutilized and can be a very effective part of the system.

And not only -- you know not all of them want to necessarily serve in that role but there are other roles that they could potentially serve in. They have you know a larger view of the system.

So in addition to this role, I think we need to think creatively about what are the other roles we can utilize them in as well.

MR. KUNTZ: And I guess, from my perspective, would NAMI have been, you know part of helping build peer support in Montana as a type of care?

And I also served as a mental health tech. That was one of my first jobs out of the Army at a residential treatment center. And I do think both of you are spot on that those are needed and they may be different roles. One may
be a care, you know just be able to serve.
Anything to make that clinician's life easier and
make them want to stay in the VA and have those
patients get the access.

   I mean critically essential and peer
support is critically essential. We're not
talking about the highest paid employees. You
know I mean I do think we have room for both
tracks.

   MR. ROSE: I think one thing to go
with Matt, I mean if you look at a veteran peer
support who is in recovery, I think that goes a
long way with somebody that you're trying to get
into recovery because I think they bring their
experience to the table. And I think it can be
very effective because -- for many reasons.

   You can show that individual how to
navigate the system. We've talked about that
this morning. It can be an issue. We can
improve that. But I think it also shows the
person that -- the veteran that they're bringing
through, what a recovery can do. And it can
happen.

And I don't care if it's a mental health. Many times now you see a dual diagnosis, a co-occurring. You've got some type of addiction plus you have the mental illness. Chicken or egg, what came first, whether it's self-medication. But I think you can show that veteran that recovery is possible.

And I think the recovery piece of this, I think it's very important. And you talk about the CIH and you talk about helping the individual get a better quality of life, that veteran get a better quality of life. And it's extremely important to do that because he or she may be on a recovery that may be the rest of their life. But if you can show them and give them some hope that they will be able to have a full life, I think that it just really goes extremely far.

CHAIR LEINENKUGEL: Any other comments on that?

DR. JONAS: I just had a question.
You said, Jack, that we need and your draft recommendation here is increase the number of veteran peer support. And that's sort of assuming that the current roles are adequate. We just need more of them, increase the number.

But you said -- you made a comment saying in many roles. And we've talked about many roles. And so I'm wondering if there needs to be -- the VA needs to reexamine what is the role of peer support specialists, especially if we're trying to transition to a different model, which is not the current model where we've got all these different roles. We have that one, now you need to hire somebody else, and a mental health person has to have these qualifications.

MR. ROSE: Right.

DR. JONAS: And so I mean redefining what is the role. What actually does the peer support person do and what kind of qualifications, page, training, experience that they need may be something that should be a component in there. It's more than just say
increase the number.

MR. ROSE: Right.

DR. JONAS: It's saying define it in a way that can provide a better access, better integration, you know more maximum components.

I mean a lot of the medics that I have worked with are highly trained in the DoD. And when they're deployed, they're doing tons of stuff. They come back and they go in the clinic over here and they're taking blood pressures and they're going what the hell is this. Okay? They don't want to do that anymore.

MR. ROSE: Yes.

DR. JONAS: And I think if they were in the -- if they were then asked by the VA well, why don't you come be a peer support person, they would look at the current role that we see and many of them would say no, I can help do navigation. I can be a coach. I can actually you know do some treatments.

So I guess the question is what is sort of the role, given that we're trying to
increase the integration components across the system.

MR. ROSE: Matt.

MR. KUNTZ: One challenge is trying to make sure that we line up with what the licensing is at the state level and what the certification because if you create a weird niche that doesn't fit in, that person doesn't have a track for promotion. That person can't switch systems.

The nice thing about peer support, as it is now in the VA, is they can walk across the street and work somewhere else. And I think there's room for doing that with the medics and there's room for doing that with the behavioral health folks.

But if we walk too far away from state licensing, we're creating a dead end position that only works in the VA.

DR. JONAS: Yes, and if we're also going to provide care in community centers and we want them to have the same quality of care, then maybe the state thinks they can figure out how to
provide a better quality of care, if they want to
take care of veterans. I mean so you know --

DR. POTOCZNIAK: I think the thing

that --

DR. JONAS: I hear you. For the

individual, that may be a problem.

DR. POTOCZNIAK: Right. I think the

thing that I would just caution you guys about

with the recommendation is increasing the number

of veterans' peer support specialists without

uniformity and clear identification is kind of a

-- it's a road to failure at the VA because VA

knows how to throw resources at something but not

uniformly.

And so if you go to different VAs --

well I mean we've been to different VAs. But if

you go to a variety of them, I mean Wendy's

probably been to the most, you're going to see

peer support specialists doing admin work because

they're understaffed. And so you know so

frequently, and this happens in DoD all the time,
is they take the behavioral health person, you
know the tech or the peer support person, and because they have a lack of resources, they say well, you do this. And then more tasks get added on to them that they're actually now not doing peer support anymore. They're just an admin person.

And so you grow more resources. For the VAs that are using it in an inefficient way, you're just adding more --

MR. ROSE: Inefficiency.

DR. POTOCZNIAK: -- inefficiency but you have to get them uniform on how they're using them and make sure that that's actually happening. Otherwise, you're just going to contribute to a broken system and you'll have VAs with a flourishing peer support program next to a VA that has front desk people.

MR. ROSE: Good point.

CHAIR LEINENKUGEL: You know to that point, I think that we've seen at least two very effective VA systems in our travels in site visits, where peer support, I don't know if it's
properly defined as far as their role but it
appeared to be but we never saw the job
description and the actual day-to-day duties. So
maybe that's a pull out going back to Palo Alto
area, Tampa area for you to do, Jack, and your
team.

MR. KUNTZ: Tampa didn't use a lot of
internal peer support. The interesting part of
them was they relied on the community to provide
the peer support. So it was a slightly different
model.

DR. POTOCZNIAK: Whereas, like San
Francisco has like one of the most robust, I
would say, peer support programs that I've ever
seen. Even I think their goal is to have two in
each CBOC by the end of whatever period, which is
pretty intense. That's much more than most
places.

Palo Alto has got them and there's a
lot of places that do. Denver had a ton and then
all of a sudden now they don't.

So it's interesting to see like why is
there a change. Why does Montana only have two?
We didn't even meet them. So and yet, they could
be doing such great things. So how are they
being utilized that we didn't even meet them?

DR. MAGUEN: And I just want to add
one more thing to add on to Mike's point about
cautions, I think, in adding more peer support
specialists. So these are individuals who are,
in many cases, doing very intensive work. So the
support structure has to be there. So if you add
more peer support specialists to make sure that
they're getting you know adequate supervision,
that their needs are being met, too. They have
their own lived experience and can get triggered
and there are other issues, too.

So I think we have to be aware of the
net that is there to support them and if you know
the supervisors are already being stretched thin
and you add more and more peer support
specialists, now they're not able to take care of
the people who are taking care of the veteran.

So I think that that's a critical
piece that we can't lose sight of. If you create
more peer supports, you have to --

MR. ROSE: Create the whole system.

DR. MAGUEN: Absolutely. You have to
fill in the whole system behind them as well.

DR. KHAN: If I may add to it.

MR. ROSE: Hang on just a second.

Are you through?

DR. MAGUEN: Yes.

MR. ROSE: That's it?

DR. KHAN: The target is mental

health. So our target is within mental health.

We want to improve the veteran who is coming into
that building. And at present, the peer support
specialist is a bridge between that veteran and
the higher staff. That's why wherever we used
it, those peer support specialists were in mental
health clinics. They had like two peer support
specialists taking care of some 1800 veterans.

So given that side, that peer support
specialist is very much defined. Their job is
defined. Their role is defined. And within
mental health, that peer support specialist is not doing admin job. They work with the veteran. They work with the family. They even work with Vet Centers. They go across the board.

So what I'm sharing with you is I'm the one who wrote the recommendation and their role should be -- at present I think they go as a V and G7 or something like that.

DR. POTOCZNIAK: GS-9 is the highest.

DR. KHAN: The highest. My recommendation was that they should be given management within the mental health higher than nine, so there is more motivation for them to stay in.

DR. POTOCZNIAK: I think they're working on that, actually, Jamil. I think that's actually already a thing that's happening is they're trying to get a GS-11 supervisor for peer support. So I think that's already happening.

One other piece -- I don't mean to pull wrenches for you.

MR. ROSE: No, go ahead.
DR. POTOCZNIAK: Another -- because I really strongly believe in peer support and I think we should increase the numbers. I want to be really clear about that.

MR. ROSE: Yes.

DR. POTOCZNIAK: But I can't echo what you're saying enough about having infrastructure in place. But also, the peer support specialists serve in an outreach role.

Now in a clinic, where you have a two- or three-month wait for therapy, if you throw more outreach into the community, guess what you're going to have?

MR. ROSE: You're going to have --

DR. POTOCZNIAK: You're going to have a system that's going to fail you know in the sense that you're going to be pulling people in, only to find out that we can't actually accommodate you.

So while peer support can serve as a bridge and they actually can provide a holding place while patients are waiting, they can
provide peer-to-peer support, which is what they
do best but there has to be something on the
other end.

And so in thinking about that
recommendation, you might think about these
aspects of it. And those other aspects may be
covered in other slides.

MR. ROSE: Well I think you know in
the discussion and some of the recommendations
we're seeing, I think that's the process we're
going through right now.

DR. POTOCZNIAK: Yes.

MR. ROSE: And you're getting a pot of
recommendations and we need to go ahead and sort
through these and see what fits and what doesn't
fit. But I think that -- I truly believe that
the veteran peer support specialist has a role
and maybe we really need a better definition of
what that person is doing but -- I don't know.
More to follow on that, really, and I appreciate
your input.

Wendy, yes.
DR. LaRUE: The sorts of things that you were talking about would potentially be the implementation for a broadly stated recommendation like that. The implementation could say and they must have adequate supervision and so forth.

MR. ROSE: Right.

DR. LaRUE: So just keep that in mind as you're thinking -- moving forward to that deadline next week.

MR. ROSE: Okay. We will not forget. We will not forget, Wendy.

CHAIR LEINENKUGEL: Also, it would be very helpful to remember what Wayne said as well. I think that there has to be uniformity. It goes back to, Mike, your issue that you brought up earlier this morning is uniformity, so that that role actually has a standard uniform model and is guided that way throughout the system.

MR. SPERO: And I was just looking at my site visits for Chicago the other day and I think that the mental health leadership there
echoes Mike's point, where he said I love my peer support specialists but if you give me any salary for one employee and tell me I can hire a mental health care provider or peer support specialist, because of the staffing reality of his facility, right now, he's always going to go with that mental health care provider.

So that I mean says something there, where he said I love the program but, at the end of the day, I have to get appointments done.

MR. ROSE: Right, the bureau dollars come from the appointments and peer support specialist provide counters but they don't provide our views.

DR. JONAS: And that's the problem with the way the system is designed.

MR. ROSE: Okay.

CHAIR LEINENKUGEL: I think that adds to your recommendation. Wendy, if there's a chance to flag that as an implementation part for -- I know that that had come up before for VERA dollars for peer support specialist.
MR. ROSE: So be it, right?

Okay, anybody else on peer support specialist?

COLONEL AMIDON: Well and I think it's important that as we describe these recommendations, we tie back to our observation of how this recommendation can impact our definition of sufficiency.

MR. ROSE: Right. Okay.

One other thing, as we go through this and I think it sure has been a big help to our analytical plan and shortly, we'll get -- Yessie's going to go through that. We'll go through the bullets and it's quite detailed. But I mean you helped with getting us the questions. But before we get to that, we'll go through the working list of recommendations that we will be improving as we go forth.

But we've talked at length about increasing the number of veteran peer support specialists employed in the VA. We're trying to mandate a VA suicide prevention protocol and I
just have a comment there.

As we made our different visits and had our different calls, that this particular thing about VA suicide prevention, there was one point that was brought out that the VA developed a safety plan and it was based on a Barbara Brown from Columbia University. And it should be a requirement. We have the plan right now and it's been set up as a recommendation only.

And so as Matt gets into more on the suicide piece, I mean you have a prevention plan that's based on science, that works and it just needs to be made a requirement within the VA.

DR. MAGUEN: Can I ask just a quick follow-up?

MR. ROSE: Yes.

DR. MAGUEN: So we do have a suicide prevention protocol. And so that exactly is based on the Columbia screener that is done with every patient that comes in.

MR. ROSE: Right.

DR. MAGUEN: And then a number of the
safety plans. So there's a number of documents
that every clinician -- it's a cascade.

   DR. POTOCZNIK: And a certain amount
   of visits.

   MR. ROSE: And so a follow-on?

   DR. POTOCZNIK: Yes, so there's like
four visits in a week, six visits, I don't know.

   DR. KLOCEK: When the client is
activated, it's four visits within 30 days but
the flag is sustained. It's one visit every 30
days.

   DR. POTOCZNIK: Yes.

   DR. KLOCEK: A safety plan has to be
in place after seven days, either before or after
the activation.

   DR. MAGUEN: And usually, I mean if a
clinician can do the safety plan in that moment
with a Columbia's positive, generally they will
do that. They don't want to let a patient leave,
oftentimes, without a plan in place.

   So I think -- I don't know if you're
thinking about specific things that might be
missing from the protocol that already exists.

MR. ROSE: Is it being utilized throughout the VA?

DR. POTOCZNIAK: It is.

DR. MAGUEN: So yes, we had to do -- it was mandated every provider had to do a training, actually quite recently, because they shifted to doing the Columbia and it had a bit of a different protocol. There was a prior protocol before but it was shifted more recently. Every provider had to do a mandated training and knows -- prove that they have to know how to do the protocol if they are seeing patients.

DR. POTOCZNIAK: So in every VA, if there is one thing that the VA is, I would say one of the most uniform things about the VA is the suicide prevention protocol --

DR. MAGUEN: I agree.

DR. POTOCZNIAK: -- because there are social workers and psychologists who their job is -- in most cases their job is not clinical but their job is to literally review charts and flags
every day and then people that are having issues, as they emerge, they are in the clinic, even some of the smaller clinics, and they will highlight that person and say now you need to -- they will literally come into your office. It's always a bad morning when Anne's in my office but you know she's like you have to do the suicide plan.

And I've seen this very uniformly. Like I haven't seen a VA where this is not done. And that specialist will come into your office and just hey, you have got to do the safety plan; make sure you get that in today.

DR. MAGUEN: And I would add, in addition to that, we've talked a little bit about this here, but there is a whole protocol that is done on the other end of things called a REACH VET, which is the analytics. And if your vet is identified as a high-risk vet, you have to inform that vet about that and have a conversation as well.

So there's multiple things in place that are both at the clinician end and the back
end that kind of speak to this point here. So I
would say if you think that there are things that
need to be modified or changed, I would call them
out specifically and you know I think that would
be the way to go if you're going to go with that
kind of recommendation.

MR. ROSE: And the follow-on, is that
a problem with that?

DR. MAGUEN: It's a very clear
mandate.

MR. ROSE: Okay.

DR. MAGUEN: And they're flagged. So
their charts are flagged, as John was mentioning.
So until that flag is taken off -- once that flag
is taken off, then it goes back to a different
protocol. But the minute that the person is
flagged for high risk --

DR. POTOCZNIAK: They are being
monitored.

DR. MAGUEN: -- monitored --

DR. POTOCZNIAK: Okay, like heavily.

DR. MAGUEN: -- by the suicide
prevention coordinators as well. So there are
eyes on that chart. There are eyes on that
treatment from multiple levels, both at the
clinician and as well as the suicide prevention
 coordinators.

DR. POTOCZNIAK: Yes, and there's, you
know as far as there's a protocol that if a
veteran doesn't show up for a scheduled
appointment, for one of the four scheduled
appointments, there is a welfare check done at --
basically within a certain amount of hours. It's
very prescribed --

DR. MAGUEN: Yes.

DR. POTOCZNIAK: -- and pretty rigid
but it is one of the things the VA, I would say,
is most uniform on, of all of the things that
they roll out.

DR. MAGUEN: Agree.

MR. ROSE: Thank you. Any other --
yes, Wayne.

DR. JONAS: Does it work? Is it
reducing suicides?
DR. POTOCZNIAK: That I would leave to
John Klocek.

DR. KLOCEK: In terms of?

DR. JONAS: So is the suicide
prevention program, which sounds like is
standard, and uniform, and mandated, is it
reducing suicides? Is it preventing suicides?

MR. KUNTZ: So that is Duty 5A.

DR. KLOCEK: We won't know that for a
couple of years because of how -- essentially how
that data is collected and then produced. We'll
be able to look for those kinds of numbers.

You had John McCarthy on at one point
from SMITREC. He may have some early indicators
with regard to that. That may be in our previous
testimony in some of those areas.

MR. KUNTZ: Well, we were briefing
that in Duty 5A. That's exactly what Duty 5A.

DR. KLOCEK: And that's also something
that is monitored in a performance metric on an
ongoing basis.

COLONEL AMIDON: And to highlight some
of sort of lead over from generalities of Workgroup 4 on sort of the context of sufficiencies that relates to some of the other precise.

DR. JONAS: And this protocol is in the mental -- it's primarily a mental health function.

DR. KLOCEK: It's considered to be across the board. Regardless of where this is indicated, there are mandated questions throughout the healthcare system, not just mental health providers. And if those questions are answered positively, there is a mandated protocol that is followed in terms of screening an individual for risk of suicide at that point and active engagement of mental health professionals as a result.

DR. POTOCZNIAK: Where it can fall down is in primary care. I think mental health has a lot of focus on it but does the LVN, or LPN, or the RN actually do the screener that triggers the response? That part I think can
fall down because if they don't do the screener

--

DR. JONAS: So the screener is
required for everybody that walks into a clinic?

DR. POTOCZNIAK: Yes.

DR. JONAS: Any clinic, primary care, specialist, pain clinic?

DR. POTOCZNIAK: Primary care, a specialist. There is a primary care reminder and there is a mental health reminder. So it gets done.

DR. MAGUEN: Right, so there's several layers of where --

DR. JONAS: And it's not just are you -- have you ever thought of suicide?

DR. POTOCZNIAK: No.

DR. MAGUEN: No, no. So if the LVN misses it, the primary care doc. The primary care doc does a warm handoff to the mental health specialist. The mental health specialist can take care of it. So there's layers of protection built in.
But when a person comes into the system, they are screened for depression. If they screen positive for depression, you have to follow that up with a suicide screen or the Columbia. And then there's a whole chain that comes from there.

DR. JONAS: Right but we know that a good chunk of them won't screen positive for depression and then another big chunk of them never see mental health or --

DR. POTOCZNIAK: Or they decline, which they are allowed to do. And I would say that if there is one issue with it is that you know a lot of veterans will screen positive and decline any further contact.

DR. JONAS: Yes.

DR. MAGUEN: I will say, though, that's precisely why, for example, in the post-9/11 clinic what we do is that three-part visit. So they -- we just tell them that mental health is a routine part of their care. They get that three-part visit. It's normalized. And so they
have to say I absolutely don't want that and very few people do, once you set it up that way as a one-stop shop that everyone gets. So there's ways in the system to make sure that that doesn't happen.

DR. JONAS: I know on their active duty side, getting flagged is a no-go. You know, if there's a possibility of getting flagged, then you just don't even touch that place. You don't go there.

On the veteran side, it's different.

MR. ROSE: Okay, good. Let's move on here. Thank you. Good discussion.

The third one there is adopt a recovery-oriented approach to all mental health treatment in the VA and this is something we've talked about. And if you look at mental health, it is a recovery process. As it stands right now, there is not a cure.

So you help an individual get so far along. The follow-on treatment is important. I think you're bringing out CIH modalities that can
help that individual go through the mental health
treatment.

Anybody have any comments on this? I
know you've talked about it a little bit.

DR. JONAS: Yes, I mean a recovery
model is very different than a treatment model,
although they overlap quite a bit. And so we've
had discussions in the models thing, even in the
evidence case thing about what's the difference
between a pathogenic disease-oriented model and a
healing-oriented model or a recovery-oriented
model.

It links back to the processes that
build resilience, that enhance wellness, the same
kind of thing. So I think that recommendation, I
think, has touched across a lot of areas.

MR. ROSE: Okay. Any other comments
on that?

Okay, create a robust Telehealth
system that takes mental health care to veterans.
We've talked about this, too. We can increase
it, utilize the technology that's out there, make
it as user-friendly as possible. And I think as long as we have the shortage of the prescriber, which is an important part, a piece of the treatment process, we need to do it. We have rural communities. We have rural settings and it has been effective.

We talked about it today as far as who may get the most benefits out of it. I think it's how it's presented to the veteran and the utility of the technology that is being utilized.

Anything on --

COLONEL AMIDON: Just to be clear.

MR. ROSE: Yes.

COLONEL AMIDON: As it relates to sufficiency, I think the thesis is we know that Telehealth and Telemedicine impacts and enhances sufficiency by our definition. So, therefore, clearly VA has invested in this as an opportunity.

MR. ROSE: Right.

COLONEL AMIDON: It's how do we enhance it. What are the barriers to enhancement
of that as it relates to sufficiency?

MR. ROSE: Thank you.

All right, and the last one there is to ensure rural veterans have painless interface to receive care through entities such as Federally Qualified Health Centers -- we've talked about that -- Critical Access Hospitals, Rural Health Centers, Tribal Health Centers, Indian Health Centers for Mental Health, mitigation management, lab testing, dental care, and other services.

And I think this is kind of a broad brush but I think what we're saying, and it needs to be refined, but there are other entities out there that can help the VA do their job. And we've talked about community outreach. These are some of the agencies that are out there that can be brought into the fold, utilized better, and just further investigated as far as their potential help in taking care of the sufficiency of the mental health care provided to our veterans.
DR. MAGUEN: I would add, in addition to -- sorry.

MR. ROSE: Yes.

DR. MAGUEN: About the painless interface, I would add ongoing communication between the systems because it was part of what we brought up that there can be an interface but not a feedback loop.

MR. ROSE: Right.

DR. MAGUEN: And that's not going to be the best thing for the veteran.

MR. ROSE: Okay.

DR. JONAS: Just one thing that might help facilitate this, and I'm just thinking specifically about the Federally Qualified Health Centers, we had a really nice presentation on that from HRSA Bureau of Health Director. And I had a follow-up call with her to get -- since they actually have a VA-HRSA Committee that meets -- I don't know how often it meets but they meet regularly to discuss these areas. And they were interested in figuring out how they could make
that more robust, how they could make it operate 
better in mental health areas, and whole health 
areas, et cetera.

So I put her in touch with the VAN, at 
the time, and you know thought there may be -- 
with that there may be a need. You know we've 
talked about you know enhancing development of 
oversight boards that increase interagency work 
across these areas and this may be one that we'd 
want to recommend robustly because --

CHAIR LEINENKUGEL: Thanks for 
bringing that up because it's a reminder also, 
Jack, that we were owed on one of our calls the 
number, first of all, of Federally Qualified 
Health Centers and where they are located. I 
remember I asked where could I go in Wisconsin to 
view one of these. Oh, we have many of them in 
Northern Wisconsin. I'm still waiting for that 
data. So it would be a good opportunity to get 
that to plug in.

DR. JONAS: Yes, follow-up. I mean 
it's a huge system and HRSA has had, I don't know
about in mental health areas, but in other areas
they have had some very effective ways of looking
at developing innovations and then rolling that
out across their system. Diabetes is the one
that they're the most famous for.

They created a diabetes management
program. It was very effective in a couple of
these systems. And then they set up an education
training and implementation process that spread
it quite uniformly across the Federally Qualified
Community Health Centers. And so that's -- those
are the kind of things that the VA would need in
general. It has an infrastructure and is doing
it but I think you know, again, something that a
joint effort could combine.

I don't know if the community care
groups, when they're going out and looking for
folks to get certified in providing community
care are specifically going out to Federally
Qualified Health Centers or HRSA and saying, hey,
let's set up a process to get them certified so
that they can provide appropriate care in those
areas.

MR. ROSE: Yes.

DR. JONAS: That would rapidly widen the access points that were available.

MR. ROSE: Yes, one of the questions we had, too, and we really haven't got an answer yet, was just how many veterans were seen by the Federally Qualified Health Centers. And so that's another thing we need to follow up on.

CHAIR LEINENKUGEL: I love your word painless because there's nothing painless in dealing with access to any health care or any system.

DR. MAGUEN: It's an aspirational goal.

CHAIR LEINENKUGEL: Yes, that's why I loved it.

DR. JONAS: I'm glad that you asked that, actually. There's a new metric that's been evolving, mostly in primary care but they're starting to look at it in other areas, that is a patient assessment of quality. And it's called
the Person-Centered Primary Care Metric. It was
developed by an anthropologist out of the
University of Virginia and it's now being tested.
It's being tested internationally. It's looked
at some large and small systems and they've
started to correlate it with other quality
assessment majors.

And what happens so much in the way we
currently do, as John and others know quite
extensively, is that the burden of the quality
assessment then becomes part of a system and
everybody's got what they want to have. Right?
They want to have their disease condition. And
then they want to have their delivery metrics and
they want to have their cost metrics. And it's a
huge complicated thing.

Very little is actually -- other than
patient satisfaction, which is very easy to game,
you know there's very little actual input from
the actual person or the patient. And if we're
interested in a model in which the veteran is in
the center, then we should probably look at
metrics that examine things like painless and
other kinds of things from the veterans'
perspective. Easy, they help me, they move it
along.

MR. ROSE: Yes.

DR. JONAS: And that metric has those
questions and has been correlated with all the
other major quality aspects within the Quadruple
Aim, actually. But it's simply, the patients
just answer it. It's an 11-point thing.

So those kinds of things get at this
and they flip the quality assessment from a
system, a medical-centric approach with all these
things that everybody wants to know, to okay, is
this something that the patient does. You read
the questions and they're just intuitively right.
They're just like yes, does my -- and it asks
things like painless. You know does my provider
or does my system help me get the care I need?
Have I been through a lot with them together?
Can I trust them? And I know that you know I
would go there in a heartbeat to take care of me.
Those kinds of questions, which I think, again, gets at the patient-centric sort of assessment tool in those areas.

DR. MAGUEN: Can I ask has that -- was that developed for primary care, for mental health, or just system-wide?

DR. JONAS: So it was developed originally for primary care to try to measure what is high quality. How do you determine from a patient perspective if you're delivering high quality primary care?

But they've now started to look at it in a variety of models of care delivery.

DR. MAGUEN: Including mental health?

DR. JONAS: I don't know. That's a good question. I can ask Rebecca Etz, who is the developer of it has it been looked at specifically in a mental health population around that.

DR. MAGUEN: Right because those questions seem like they would also apply to mental health but, until it's been tested in
mental health, we would want that information before we recommend that.

DR. JONAS: Correct. Yes, I'll ask her if it's been tested in mental health. I don't know.

DR. MAGUEN: Perfect.

MR. ROSE: Yes, thank you.

DR. MAGUEN: Yes, that would be very helpful.

MR. ROSE: Any other comments or questions? Anything, anybody?

Thank you all very much.

CHAIR LEINENKUGEL: Jack, thank you. Well, it is a good start. I want to make sure that everybody in the room, including those on the phone know these are all just first stage, very preliminary overviews of working. The key item and the key word on all the slides that you saw yesterday and today, these are working lists of recommendation.

There's a lot of meat that needs to be put on these bones and also definitive
delineations need to be made that all of us, as commissioners, will be deliberating, discussing, and then voting on beginning in five weeks. And then at that same time -- I know that Wendy is smiling back there because the writing piece, we still owe you that by the close of this business as well, a definitive time for each workgroup. And we will get there, as well.

So that being said, it is now 11:42. I think that because of the time of where we're at, which don't we take a quick seven to ten-minute -- seven-minute break? Be back in the room at 11:50 so that we can get on with Commissioner Kuntz and Workgroup 5.

Is that agreeable for the commissioners?

So we'll break for about eight minutes. Stay on the line. We'll mute you.

(Whereupon the above-entitled matter went off the record at 11:42 a.m. and resumed at 11:53 a.m.)

CHAIR LEINENKUGEL: Welcome back.
This is Chairman Leinenkugel, and, at this time, thanks for holding on. We are going on to Duty 5 with Commissioner Matt Kuntz at this time.

Commissioner Kuntz.

MR. KUNTZ: All right. Thank you, Chairman Leinenkugel. I really appreciate this opportunity to brief on this duty, very thankful for the commissioners on the team and the staff. We've been hitting it hard, and I'm really excited about some of the things that we've dug into.

Duty 5 is a little bit more kind of broken into categories, and they're very different categories, so I will go through them. One is to study the current treatments and resources available and see the effectiveness of such treatment and resources in decreasing the number of suicides per day by veterans, to analyze the number of veterans who have been diagnosed with mental health issues, the percentage of veterans using the resources of the Department who have been diagnosed with mental
health issues, and then the percentage of veterans who have completed counseling sessions offered by the VA, and then, finally, the efforts of the Department to expand complementary and integrative health treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments operated by the Department.

So I know it's my legal background, but trying to really answer what we've been asked is the goal. And it's hard because it's really broad. It goes from suicide prevention all the way in to how is the VA implementing CAM and then a bunch of data pools in the middle, which Dr. John Klocek has been remarkable on.

It's important to start out, I think, with who we met with. Sigma is working on a broad analytical plan that we've improved or have approved, but the other piece is who are we meeting with? Outside of just the regularly-scheduled meetings, we have our weekly
group and we try to bring in some of the nation's leading experts. And the list only goes to March 12th, but I want to highlight one from February 26th because it's going to come up, and that's Dr. Alan Teo of the Oregon VA, and he wrote the systematic review that we'll be talking about later.

After that, we had Dr. Shana Bakken, the National Director of the VA Compensated Work Therapy and Supportive Employment Program. It was very interesting to hear her describe the importance of work for suicide prevention. It's a critical part of recovery, and it tied directly into suicide prevention in her eyes and just overall mental health wellness. She also described how the fear of losing veterans or losing benefits is a barrier to employment for her population. So it was interesting to pull that out of there.

We talked to Dr. John McCarthy and he presented to us on REACH VET, the predictive modeling program to enhance suicide risk
assessment. We talked to Dr. Stephanie Gamble. She presented on the VA's behavioral autopsy program to understand kind of that after-evaluation of completed suicides.

We talked to Command Sergeant Major Tom and Jen Satterly, the founders of the All Secure Foundation. It was a command sergeant major of Delta Force, and they've really worked very hard to bring in veterans from across the country. And one of the things that we heard loud and clear from Command Sergeant Major Satterly is we need to continue to improve our system. We need to continue to get better and better and better. That's what they do in Delta Force, and that's what they expect from their veterans' mental health system.

We visited Columbia Psychiatry, which is one of the leading suicide prevention centers in the world. It was very nice to get their take, as well. We weren't able to meet with Dr. John Mann while we were there. He did present to us, and he is one of the nation's leading suicide
prevention experts. He leads the Conte Center on Suicide Prevention that's well funded by the National Institute of Mental Health.

We talked to Dr. Helen Lavretsky, kind of moving towards complementary integrative care, and she works on researching those types of care for the UCLA and did a really cool analysis of mental health and complementary integrative care.

We talked to Dr. Madhukar Trivedi from the University of Texas Southwestern. He is one of the nation's leading depression experts and probably the preeminent researcher on exercise and depression. Incredibly well funded out of the National Institute of Mental Health to figure out how exercise is involved with helping certain types of depression.

We talked to Dr. Donna Ames, and I think she was a real highlight for a number of the commissioners. She is a researcher at UCLA and also a staff psychiatrist at VA and the Greater Los Angeles Healthcare System. And she had complementary integrative care as the
recovery model, really how to implement these things in the VA while still having a strong research background, so she could speak to both sides.

One of the things that I think really came out loud and clear from everyone that we talked to was these complementary integrative care treatments can be measured through science. You know, like the standard methodology that Dr. Maguen and her team are working on to analyze these things, that is how they said that they should be described. And they said that international groups are moving in that direction. It was a nice way to check our methods and have all of these researchers say we're going about this in the right path.

So we had a number of different other visits, but I will move in to our recommendations and what we found. And I'll stand up for that because at West Point and then in the Army and they yelled at me for briefing while sitting down, and I still hear that in my ear. So I
apologize to anybody on the phone if you can hear me worse.

But the main thing that jumps out to me in Duty 5 is very similar to Dr. Maguen. I think it's going to be one of the more potentially controversial elements of our commission is what we do we have high data on and what do we have low data on? There are practices that we are working in a low-data environment. There are practices, such as cognitive behavioral therapy, that have been studied in-depth and detail where we have a high-data environment. We're trying to compare these two systems where we have very different levels of data, and we have to bring that forward in a very honest way but it doesn't mean that things are ineffective because they haven't been studied. You could not do research on whether or not it's good to drop refrigerators on people, but that doesn't mean we don't know what happens and that it's a negative health consequence.

You know, there are some of these
things that we haven't proven. There's some of these things that are going to be, like, veteran suicide prevention, addressed on a national level regardless of the level of data that's out there. So we need to realize that part of what Duty 5 is trying to do was to say, you know, we are in a low-data environment. That does not mean that anybody's time is wasted. That does not mean that we should stop trying to save veterans' lives from suicide or stop CAM. But whether or not we're in a high-data environment or a low-data environment is important in every field, just as it is in the military. The amount of intelligence that you have affects what you do and how you operate. It doesn't stop your mission, but it affects how you go after it.

So starting out with the first part of our duty, there was a big systematic review done by Dr. Alan Teo and his associates within the Portland VA about suicide prevention and risk assessment. This was a very important systematic review for us. We got an in-depth presentation,
and the results were effectively, for these interventions, we're dealing in a low-data environment.

And I can say, as the PI of a suicide prevention project myself, it's hard to do these studies. It's expensive to do these studies right. We brought over an intervention from Europe, and the amount of money that they had to spend just to get a base level of research is hard. This is not the VA's fault; this is not NIMH's fault. It's hard.

So next slide, please. This is what they basically said. Their conclusions were these assessment methods have been shown to be sensitive predictors of suicide and suicide attempts, but the frequency of false positives limits our clinical utility. Research to refine these methods and examine clinical applications is necessary.

The second finding was studies of suicide prevention interventions are inconclusive. Trials of population-level health
interventions and promising therapies are required to support their clinical use. And this was the same thing that we heard at Columbia. Not the VA's fault, not anyone's fault, but we are dealing in a low-data environment. Being a veteran that lives with suicidality myself, having lost a family member to suicidality, we will continue to fight for these levels of care, but we have to honestly acknowledge we're in a low-data environment on how well they work.

Next slide, please. Okay. One of the things that did come out when we were briefed by Dr. Keita Franklin, the prior head of suicide prevention from the VA, is there were so many different ways that the VA was looking at suicide prevention that there seemed to even be some confusion about environmental stressors and mental health and a lot of different angles to look at it. And from the outside, that can be very confusing. From the inside, that can be very confusing.

And when we talked to Dr. Mann of
Columbia, he has been a multi-decade proponent of
the stress-diathesis model, which is really
simple and it says that, you know, suicide is the
result of an interaction between environmental
stressors and susceptibility to suicidal
behavior, which fits in to how the VA deals with
suicide. The nice part about this is we do send
people to psychologists to get better. You know,
if you call the veterans' care line, this is what
we're trying to deal with. We are trying to get
people employment. We are trying to build
community connections which can limit their
environmental stressors or reduce their
susceptibility.

So what we liked about this model or
what I really liked about this model is it fits
into what we're doing. And as a family member
and as an individual who struggles with this
stuff, it makes sense and it makes sense to what
we're doing. Find a model and run with it.
There's an argument that Dr. Thomas Joyner's
model may tweak this a little bit. But at that
level of complexity, it's pretty hard to understand for the person on the ground being briefed by the VA about why suicide happens.

So next slide, please. So we've got into veterans' suicide. We'll spin out a couple of recommendations at the end. Again, there's a giant analytical plan under works to add more data, but that was kind of the big pieces was that effectiveness, we have a massive systematic review that helped guide us and then from leading researchers in the field.

The next few were more data pools. Duty 5B, find out the number of veterans who have been diagnosed with mental health issues. And this was from 2017 pooled by Dr. John Klocek and his team.

Percentage of service users in the VA system in fiscal year 2017 roughly the same number that we've seen throughout. So no surprises to this commission.

All right. Duty 5C, the percentage of veterans using the resources of the Department
who have been diagnosed with mental health
issues. Again, very similar to what we've looked
at before. The Commission has been briefed by
this. John is digging deeper to provide some
nuance to those numbers. From a legal
standpoint, relatively clear, asked and answered
based upon existing data.

And this was where he got the
confirmed mental illness diagnosis or definition
from the last slide. Same definition that we've
looked at before when we first started working.

Next slide, please. Okay. So Duty 5B
was a little bit more complicated. That's the
percentage of veterans who have completed
counseling sessions offered by the Department.
And as commissioners may remember, this was up
for debate. You know, what this means and what
this looks like is up for debate, and what we
decided to do was not to settle the debate, but
just give the data on all of the different
interpretations that this could be, you know.
Does this mean crisis or same day? Let's get the
numbers on that. Does this mean completed
counseling one session? Get the numbers on that.
Completed counseling multiple sessions, get the
number on that.

And Dr. Maguen made a great
recommendation to us, I think it was in our March
report-out, that the data that the VA pooled or
normally pools doesn't go out far enough to
suggest whether or not they completed enough
sessions to fit in to the standard of
evidence-based practice.

So we had our basic data pool. We got
that guidance from Dr. Maguen, and I will refer
to our subject matter expert, Dr. John Klocek to
explain the results in a little bit more detail.

DR. KLOCEK: I'll come over and stand
a little closer so you can hear me more clearly.
So Dr. Maguen had suggested that we look for what
would be sort of a minimal dose of an
evidence-based protocol or evidence-based
treatment, which is eight sessions as usually
understood. We looked at it as eight sessions
within 16 weeks of initiation of psychotherapy,
so that was the request that we made for the data
pool.

We also specified it to be eight
sessions for the same diagnosis over the course
of those 16 weeks, rather than multiple diagnoses
being indicated over those eight sessions. So
those were the numbers that we pooled for the
completed counseling sessions at that point.

MR. KUNTZ: And we do have an in-depth
handout that Dr. Klocek developed for everyone
that goes into this in more detail. If there's a
request for another data pool, let us know at the
end of the day if there's a reason. We are
running up against the shot clock, so right now
is very happy about how we handled this because
we didn't want to tell Congress what they meant
but just give them all of their relevant data and
we'll let the policymakers work from that.

Next slide, please. So we missed Duty
5E, and we do have white papers or a white paper
on Duty 5E that we're waiting for. And this was
an in-depth two-page white paper, and it was
assigned back in December or January. We had our
first take on it in June, and now we're waiting
for a second take. Wendy LaRue has been working
on it. She was overwhelmed by the focus group,
so we had a delay in completing it. We don't
have to all blame Dr. Potoczniak for that, but --

DR POTOCZNIAK: You can.

MR. KUNZ: -- but we can.

But the way that we did it was to try
to wrap our heads around, you know, how is the VA
implementing these complementary and alternative
treatments? Like, how is it going out there?
And such a giant question. A lot of that will be
answered in the analytical plan, but we wanted to
start out with what could we capture beforehand
and thought that the ways to limit that search
would be in to outpatient treatment. The
majority of the VA's care is provided through
outpatient treatment, so let's focus on the
interventions that are provided on an outpatient
basis. And then let's focus on the interventions
that are paid for, that either in VA staff time
or in dollars to outside community providers.

I love the folks that are doing
different things on a voluntary basis, but we
were working off the premise that if you value
something you're willing to pay for it. And if
you are not willing to pay for it, that is a
statement that you don't value it.

A little bit controversial there, but
I do think that there's also a point where some
of these things prove themselves on a voluntary
basis on the community level and then work
themselves into the VA for the long term.

We're still working out those white
papers. We started out with exercise and thought
that, you know, that was one of the most
standardized, complementary, and integrated
interventions. Let's look at that first, and
then we'll go towards some of the more niche
ones. And what we found out with exercise was
the VA has a rule against providing gym
memberships. There's an administrative rule
against providing gym memberships. What's interesting about that is Medicare Advantage plans, gym memberships is exactly how they solved this problem. So we will be talking to UnitedHealth later to figure out how they worked through that problem and, as that doctor in Palo Alto said, I like the idea of incentivizing veterans' exercise, I don't want to pay for people that don't go to the gym. You know, a very real point for all of those of us who have been in busy gyms in January and February and entirely empty in December. We'll work the issue. UnitedHealth serves millions of people. How did they solve it? How do they look at it? And from a cost standpoint, does it make sense to them? Is this actually making their population healthier?

And one of the reasons why this is important regardless of the data and how it comes back is, again, with these alternative treatments, we're working in a low-data environment and we have more desire and need than
data to back these things up. Why did UnitedHealthcare think it was worth it? Why did they feel like they had enough data for their Medicare Advantage plans when the VA chose the alternative?

DR. POTOCZNIAK: How did they deal with people who don't use it?

MR. KUNTZ: That's exactly what we, as a group, will grill them on when they present with us because that's a big issue.

DR. POTOCZNIAK: Some of the VA programs that do provide subsidized gym memberships is under contract with the YMCA. But the veterans have to go to a variety of, like, recreation therapy appointments or classes would have to take place within the YMCA to qualify to do that.

DR. MAGUEN: Yes, I think there's, you know, for some kinds, there's a six-month trial period, you know, where they can get a free membership for a period of time and then, you know, they have to pay for it --
MR. KUNTZ: And that was, there is a rule that says the VA can't pay for it. They can go and ask for free gym memberships. The YMCA in my town spoke to or the VA said that they send folks from inpatient to the YMCA but they don't pay for it. We have an administrative rule that prevents that.

So we'll suss that out a little bit more, but I think it's an example of why we did the white paper process. We're excited to find out more in the analytical plan, but it will be a nice way for us to compare what does a million-plus person system do for this?

MR. ROSE: Is there still an MOU between the VA and the YMCA?

DR. MAGUEN: I believe so, yes. I believe so, I mean, on the national level.

DR. POTOCZNIK: There is because I had to, you know, we have YMCA stuff that goes on in our VISN. So, yes, for sure.

MR. KUNTZ: And, again, I think that with this white paper, it's what are you willing
to pay for? And if you're not willing to pay for
the veterans to get gym memberships, if you have
an administrative rule that says you can't, you
are treating this different than Prozac, you are
treating this different than a back stint. I
mean, like, at some level, if you've chosen not
to pay for it, that's a decision. Maybe you
might have some small programs here or there, but
you do have an administrative rule. And I think
that we'll see in the white papers what the
numbers look like, and they reflect that there's
a rule saying that they can't do it.

So we are still waiting on the next
phase of the white paper, but I do think that it
will give us a little bit more nuance in how
these play out.

I'll move on to the working list of
recommendations. For the folks on the phone or
in the room, again, these are rough drafts of
rough drafts, just something to bring up from the
commissioners in our group.

Based upon that systematic review, it
does seem that there needs to be more funding to
the VA and the National Mental Health to develop
research-proven suicide prevention initiatives.
We have a lot of great research on other things.
Suicide prevention in particular is a low-data
environment.

    Eliminate the possibility of benefit
reduction for disabled veterans who pursue
careers. This is especially important for mental
health, as was mentioned by the VA workforce.
Vocations are a critical part of your wellness,
and we did talk to one veteran at Fort Belknap
that described exactly this issue and he did get
employment, only to have his benefits take away.
And it was solved through working with Buck
Richardson, a VA employee. But it was testified
exactly that this happened. This was something
that came up very loud and clear in the workforce
presentation.

    Develop a telehealth resource to
deliver suicide assessment and follow-up
engagement, veteran emergency treatment, which is
labeled as SAFE VET, to veterans in emergency rooms throughout the country. When I went to Columbia and talked to Dr. Barbara Stanley, she was the developer of this, one of the nation's leading suicide prevention experts. The VA helped develop this model. The VA tested it out in emergency rooms. The results were very positive on delivering a safety contract in those emergency rooms and basically having four follow-up phone calls to help prod the veteran into care. You know, it was very well proven. There was the challenge of the emergency rooms not being willing to have someone in there delivering safety plans, scheduling follow-ups. That was the infrastructure stick that they had, so this came out of that, that there's a lot of data and research on safety plans through SAFE VET that I provided to Dr. LaRue.

Develop a grant program to help incentivize community partners to develop firearm safe storage capacity that can be used by veterans as part of their mental healthcare plan.
Not all communities have safe storage plans. The VA has adopted safe storage and has adopted those conversations, but not all communities have a place to actually keep those guns. And how do you interface with that?

Incentivize exercise among disabled veterans at least to the same level as Medicare Advantage plans, such as the Silver Sneakers program.

Ensure that all veterans in the VHA system have access to effective care for treatment-resistant depression. In one of our data pools that we did, Dr. Klocek looked into the number of veterans that have received care through TMS or ECT. Both of these are on the clinical practice guidelines that the VA has endorsed. The numbers of veterans in 2018 that actually received them were low enough to justify a recommendation on that. If we believe in those clinical practice guidelines, the VA believes in those clinical practice guidelines, it should be available to veterans everywhere. For example,
in Montana, an entire state, we have no access to TMS or ECT for our veterans, as discussed at Fort Harrison.

Next slide, please. All right.

DR. KLOCEK: So there's no community providers that do ECT?

MR. KUNTZ: The VA in Montana has chosen not to offer or not to work with community providers for ECT or TMS. They just don't offer it.

DR. POTOCZNIAK: Can they do that, John?

MR. KUNTZ: That's what this recommendation -- when you see the numbers of how many veterans got these services nationwide, the question of whether or not they can do it --

DR. POTOCZNIAK: I mean, but that almost seems like, I mean, like withholding care --

MR. KUNTZ: The data will speak to it.

DR. POTOCZNIAK: So is it the providers saying that they won't do it or is it the system
saying they won't do it?

MR. KUNTZ: The system does not send people for ECT or TMS. But what we saw at a national level will show you, and I don't know if that's been cleared.

DR. KLOCEK: It has.

MR. KUNTZ: Okay. So we can send those numbers out, but it was not what it should be, in my opinion as a single commissioner.

DR. MAGUEN: Can I ask a question? Are some of those numbers also, it's the number of veterans that are utilized, but does it also reflect the percentage of places it's available at all? I don't know if there's information on that. You know, it's one thing to say X number of veterans received it, but I think, along with that, if we don't know where it's actually offered, it's hard to make sense of that, right?

MR. KUNTZ: We did ask for both, and I believe that that Excel spreadsheet shows both.

DR. POTOCZNIAK: I believe the survey is to assess what they call somatic treatments at
any facility. So the facilities that responded
extensively have those treatments available.
That's my best understanding of it.

    DR. MAGUEN: Got it.

    DR. POTOCZNIAK: And I get
clarification.

    DR. MAGUEN: So TMS falls under
somatic?

    DR. POTOCZNIAK: Yes, as does ECT.

    DR. MAGUEN: Got it. Thanks.

    DR. POTOCZNIAK: So how does that work
when veterans request, these four providers
thinks ECT is good for a veteran, under the
MISSION Act, if the facility decides it doesn't
provide it, that doesn't, they can't stand in the
way of the community care referral. I'm just
trying to think this through because it's one
thing for the facility to say I'm not providing
this, for whatever reason they're saying that
they're not providing it. Their psychiatrists or
whatever get an idea, and they don't want to do
something and --
DR. MAGUEN: Or they're not trained to
do it.

DR. POTOCZNIAK: Or they're not
trained to do it. But it's another -- but if
they're not willing to work with community
providers, it goes a little further than that,
right? Because then it's like I'm not trained to
do it and I don't want you to have it. But
under, like, the MISSION Act, they really can't
say we're not doing this because they're not
national VA.

MR. KUNTZ: And I guess that, having
been someone who's lost a veteran to
treatment-resistant depression that couldn't
access that level of care, you know, I'm probably
a little bit, a little bit too tied to it to dig
into it. I do want to let the data speak to, you
know, this is not one commissioner's
interpretation. We asked the VA, are you
providing this, and this is the data that we got
back. From an individual advocacy level in
Montana, the idea that our VA refuses to provide
those two services in our state, despite them
being on a clinical practice guideline, despite
having practitioners in town that they could do
it with or in a number of other communities
across these state, BlueCross BlueShield pays for
it, you know. It is an issue in states, but I do
think that we have the data to support that
recommendation that the VA follows its clinical
practice guidelines in regards to
treatment-resistant depression. If you have a
veteran that needs it, if you can't do it
internally, go get help externally.

DR. POTOCZNIAK: And this is an
example -- sorry to go further. But this is an
example of the lack of uniformity because in
other places, you know, a similar kind of
hot-button issue is suboxone treatments and
referrals for methadone and that kind of stuff,
that there are psychiatrists that kind of make it
their personal mission that I'm not doing this,
yet it's something that's in the practice
guidelines.
So, you know, they kind of, in one clinic that I saw, you know, all psychiatrists got together and agreed we're not doing this. But how can -- so that it's a hot-button topic for me also because it's just like really? You can't hold the system hostage essentially, but they do. And so I don't know, just putting it out there that it's not exclusive to this. There are places where people deviate. I just don't understand why they can't be held accountable for doing that.

MR. KUNTZ: So that's kind of what that recommendation is about. And we saw the same thing, very interestingly, with EMDR between Lovell and Jesse Brown. At Lovell, I believe it was EMDR was hailed as being an evidence-based practice that was critical to veterans' healthcare. At Jesse Brown, they chose not to offer it. You know, and this was 30 minutes away from each other. So that lack of uniformity again, but I think the root of that one is if it's on the clinical practice guidelines, you
know, if we believe in evidence-based medicine, 
if we're following evidence-based medicine --

DR. POTOCZNIK: Well, it's like a pharmacy that has a formulary and an individual pharmacist saying we're just not going to carry that because I don't like it, you know. It just irks me. But anyway --

MR. KUNTZ: Exactly. Let me keep going because I know that we got to keep digging. Exclude the Veterans Healthcare Administration from compliance with the Paperwork Reduction Act to facilitate data collection to improve the quality of care provided by veterans. We had a lot of pain with the Paperwork Reduction Act in my meetings with veterans' healthcare providers on the national level. It does not sound like it's only an issue for the COVER Commission.

This one was briefed in Duty 4, increased pay and the number of veterans peer support specialists for all the healthcare facilities. Increased pay and the number of VA police force members present at all VA healthcare
facilities. And that has become very big in the
news with the suicides on campus, and in the
community it is police officers that deal with
people suicidal on campus. I will say that
during one of our site visits, we were there
while there was an assault committed at a
facility and the person, I mean, I watched
someone trying to go find a police officer to
report it. So it was something that we saw but
also in Georgia and a number of other areas,
completed suicides on VA campuses.

DR. POTOCZNIAK: Well, it's, when you
think about it, it's really a good
recommendation, the VA police part, because they
were just demoted down to a level lower. I
didn't know this, but they were demoted below
scheduling assistants. So the people that
schedule your appointments are paid more than the
people that protect the clinic. They're GS-5s, I
think, or something like that. So at least in
San Francisco, it means that we're always
operating at half-staff police-wise because you
can't pay $40,000 to somebody to live in San Francisco. It just doesn't work. And they can be pulled, and I think this is via police wire, they can be pulled from facilities that are in outlying areas to come in to VAMCs, but they don't get the extra pay for being in a metropolitan area. So they can be like in a rural system and expected to come down on a regular basis to the main system if they're understaffed and not get paid for it.

So there's all these different negatives to the VA police that go on and on and on. But GS-5s for police officers but GS-6s for MSAs.

DR. KHAN: Additionally it takes 18 months to train their police officer in the pipeline. And after two years, their contract finishes with VA, so the outside company hires them with three times more salary.

DR. POTOCZNIAK: And other federal agencies, the biggest problem that we have is we do train them for 18 months to be a federal
police officer, and then they get sucked up by another federal agency that's willing to pay them what they're worth, you know. So I don't know why they demoted them recently, but they recently changed them from 6s or 7s to 5s.

MR. KUNTZ: Thank you for that in-depth analysis. It had come from one of the commissioners. I mean, it makes sense to have that insight from the ground on why that's needed.

So the next one that we have is hire professional drivers to drive DA vans used to transport veterans to VA healthcare facilities.

DR. KHAN: At present, those van drivers are all volunteers like Jamil. And they're getting old, so the vans are given by the DAV to the VA as a gift. VA manages those vans, but the VA does not provide the drivers. So given a driver every day is 18 hours of driving because wherever they live, they go to pick up the van, they pick up the veterans from different places, they take them from the facility. They
stay there all day until the last appointment is
done. Then they drive back home. So there's a
burnout there.

On the other side, there is a VA
transportation system in place. But the effort
is to use, let the VA have its own drivers to
drive these other vans also.

DR. POTOCZNIAK: What would stop, you
know, what would stop us from just doing what
BlueCross BlueShield does with its rural patients
and just using Uber or Lyft? It's going to be a
lot cheaper, I guarantee you, than hiring drivers
with the federal government system.

MR. SPERO: So Uber actually tried to
create a partnership with the VA, and they're
trying to do this with Medicare and Medicaid, as
well, and they have been for a couple of years
now, where a facility will actually be able to
task an Uber to a patient's home, and the patient
will get just a text, you know, so you can even
get it on a flip phone, saying the driver for
your healthcare appointment is Casin and he's
going to be in a blue Toyota, here's his license number, he'll pick you up. And then the Ubers would bill. It would become part of their, you know, what the insurance or Medicare, Medicaid pay for, the appointment.

So there's some cool pilots out there but a lot of red tape.

MR. KUNTZ: And I think that that's exactly the kind of debate that we can have with that one, you know. Is it just pay for, you know, find better ways to pay for transportation for veterans or, you know. So we'll dig into that in October and in between.

The last one that we had was just as part of my team duty lead, trying to navigate how you manage your team. And as part of that, I realize that federal commissions are currently not covered by Title V of the Rehabilitation Act of 1973, which, in comparison to the community, it is considered best practices to have disabled people on the committees that are there to represent them. And the way that you do that is
through the ADA or through the Federal Compliance Act. I mean, that group of case law and it allows you to have standardized practices that work between the private sector and the federal sector. So if we want veterans long-term wise that live with suicidality, depression, anxiety, some of these disabilities to be able to be active in guiding the VA on how to provide their care, that recommendation would help us.

MR. SPERO: Just a couple of other things. The VA police officer training is only ten weeks. It's not 18 months. And I think that's a specific problem because they're advertising for that GS-6 and GS-7.

DR. POTOCZNIAK: I know our whole force was just demoted.

DR. KHAN: But before they're going through ten-weeks training, they go through other law enforcement training.

MR. SPERO: That's not required by the VA, though.

DR. KHAN: I was given that figure by
the police chief of VA Medicine Hospital. He
told me, he said, if today one of my police
officer leaves for whatever reason, to fill that
vacancy, I have 18 months to wait until the
qualified person can come in and replace him. In
addition to 18 months, the system creates a
vacancy after 18 months, then they would delay in
filling up the vacancy.

MR. KUNTZ: I guess what I would ask
is kind of the Duty 5 is, Casin, if you can
assign a subject matter expert to run down kind
of the brass tacks of what it takes. And I agree
with Jamil that it may take state-level training
first just to be able to do it in that state and
then a second -- I mean, there would be nothing
surprising about that. But if you can add a
subject matter expert to expand on that a little
bit for us.

Next slide. Awesome. That was what
I hoped. Thank you.

CHAIR LEINENKUGEL: Casin, can you
keep that up and go back to the previous slide?
I just have a couple of comments. The second to
the last one. Let's see. It's the one with
research. There it is.

We've heard that a couple of times,
certainly from Commissioner Maguen and now from
Commissioner Kuntz, and I think that everybody
has a little bit of play with a little more
research. I wonder if it's appropriate for us to
talk amongst commissioners over the next couple
of weeks about really going after who we should
find the money from or where we're going to
access and be consistent because we're looking at
this holistically across the United States for
veterans' healthcare, mental health care.

So if we're going to provide more
funding to VA and NIMH, develop research-proven
suicide prevention initiatives, I think there's
an ongoing initiative at least being talked about
right now that is going on concurrently with this
commission that we need to have some linkage with
and what they're trying to do cross-agency so
that at least we should be taking the lead but,
at the same time, being bold enough to bring in everybody and make it much more inclusive.

And when we talk about more funding, I don't necessarily, from my position, that's my position only, think that it has to be additional funding. And I would like to go on record to state that I think that the budget that we've requested after the Secretary told us he was getting $9 billion additional for 2020 mental health and we're still waiting to see how that is going to be appropriated within the structure of the VA, it's timely for us to maybe be much more poignant as to what will it take? And I expect you, from your affiliation, with NAMI, you're doing a lot of research work and certainly Dr. Jonas, as well. What is the amount that we should be requesting or asking for? I'd like to be specific or bold in this case.

And also I would like to challenge the VA itself, as a department, to look again holistically at its entire budget of VHA. And I'm pretty sure this has never been done, to look
and systematically review ongoing programs to see what is actually pointing in the direction of veterans healthcare/mental healthcare and programs that may not or might just be nice to have and get much more pragmatic and definitive about using taxpayer money to really go after mental health in this case and then certainly primary care.

So I think there's an opportunity here, Commissioner Kuntz, for all of us to consider tightening this up in a way that might be bolder. And you may disagree with me, and that's fine. Maybe I just take that out. But I think it's an opportunity that gets a further discussion going within the entire, I call it the corporate entity of the Veteran Affairs Department.

MR. KUNTZ: I love the concept, Chairman. I guess what I would ask is I found through my dealings with the Senate Veterans Affairs Committee in comparison to what we do in the outside world is the VA does say that the
numbers are different when they do research than when NIMH. So we are having Dr. Gordon present to us hopefully, and I would love to hear him weigh in on that. But I think it would be valuable to have Dr. Ramoni and her staff look, I mean, it feels to me like that might be best, that number, if we can make a very specific request for both alternative care or, I'm sorry, complementary and suicide prevention, what that would look like, because I do think that would be very hard for me or Dr. Maguen to be able to say that, not knowing exactly what the VA's research costs are and how they compare.

    CHAIR LEINENKUGEL: Well, it's interesting. I also want to add for the record that we get numerous requests from commissioners that our group leads here for the total amount of research dollars that the VA currently has.

    DR. JONAS: If we knew that, then we could have --

    CHAIR LEINENKUGEL: And we could have that for months, right, Wayne? So that still is
undefined and unrepresented to this commission, as well as the usage of the $9 billion. So, hopefully, by next week, and I know that Casin has been diligently partnering with someone within the VA structure, that we'll get a report back on that.

I had one last thought, but I want somebody else to go first before I bring that up. Did anybody else have additionals for Matt?

DR. JONAS: I just want to support this effort. I think that if we got a good baseline as to what's currently going on and we're saying here's resources that need to go in there, it would be really good if we could have an estimate where we could make specific recommendations that it should be, you know, just like Shira said, hey, 20 percent of the research on MST or on mental health should include women. I mean, we've got a number there. That's a target. They can think about it. You know, it may be off by a few percentages here to there, it doesn't matter. But if we could do something
like that in this area and say X percent of these dollars need to go into, you know, suicide, whole health, mental health things, you know, it would be a lot more than is going in there now probably. And then with the guidance, you know, in terms of what kind of impact and cost offset do we think this would have if the models shift over, you know, to actually produce health and induce recovery. Then that should be an extremely well placed investment. It should lower costs.

MR. KUNTZ: And Yessie had brought up to my attention we have one more handout for Duty 5, and that was we had talked earlier about the Commander John Scott Hannon Act, which has both suicide prevention and alternative care and some sufficiency stuff. So there's a small handout there to give you an idea and the full bill is online. It's a bipartisan bill from Senator Moran and Senator Tester, and it's really easy to Google.

CHAIR LEINENKUGEL: Another thought,
Commissioner Kuntz, and this is really well done and, you know, well developed at the bare bones level at this point with a lot of additives over the next five weeks or some shifts and very well let Matt, as well, from your end. But a thought came to me when I was talking to Commissioner Amidon a couple of days ago, that it popped because you're incentivizing, and we talked about an incentive I'm going to get to in a minute, but you're incentivizing exercise amongst disabled veterans at least to the same level as Medicare Advantage plans. I think that's great. But why don't we think bigger? Why don't we think, and I'm going to use very simple terms here, how do we incentivize veterans to get well?

So it goes back to your number two: eliminate the possibility of benefit reduction for disabled veterans who pursue careers. Personally, I would never want that veteran who got a specific benefit who actually did get better lose that benefit because, in my opinion, he or she deserved that benefit. And if they got
better, good for them. Keep getting paid, okay? That's my position only. But at the same time, I think we do a horrible job and I bet you there's another country that maybe some of our subject matter experts, and nobody has the amount of veterans we do, but somebody, maybe it's Israel, does things differently with their veterans. I don't know. Maybe Canada. But why aren't we looking at the wellness factor and the outcome of giving something back to that veteran? And it could be monetary. To me, I think incentivizing them to get better is so much stronger than, jeez, we're going to take your money away from you.

So can we at least throw that out there for consideration?

MR. KUNTZ: Absolutely. Wendy, will you work with the Chairman on that one to make sure that you get the wording right? All my words are --

CHAIR LEINENKUGEL: I think Matt would help me out, as well. I mean, we talked about
this. You know, it's one thing that we don't do
and we never thought of doing and maybe we should
start. And the more I thought about it the last
48 hours, it makes perfect sense to me
personally, but everybody is going to say find me
the money. Well, I can tell you we're good CFOs,
we can find the money within this current system.

DR. POTOCZNIAK: Well, it's not really
a lot of money in the sense that they don't
adjust people's benefits anyway. I mean, like it
happens in one, two, three percent of the cases,
but it doesn't happen that often. But the fear
of it happening spreads mythical --

CHAIR LEINENKUGEL: And that's why the
strong word eliminate the possibility is so
critical.

MR. KUNTZ: Well, thanks to everybody.
I'm going to sit down.

CHAIR LEINENKUGEL: Any other
questions or comments back to Commissioner Kuntz?
Really well presented, Matt, and really well laid
out and a lot of good information on there. So
congratulations to you and your group.

At this point in time, is there anything else for the good of the order from the commissioners? I know, Casin, you're pointing. We will close with that. Any other pending concerns or business items, except for the whiteboard?

And we'll go to the whiteboard right behind Jamil and Dr. Jonas. It's the time line consideration for what we discussed yesterday in open session, which was really getting to the work screen and finalization of what's next.

So Wendy laid out a September 20th date, which is a week from today, which is a week from today, about getting some more refined recommendations. And what you saw today, Wendy, was that within the ballpark of what your expectations were or --

DR. LaRUE: Absolutely. Based on all the recommendations that have been presented over the last two days, we have a good starting point. I would say if any of the workgroups have
additional recommendations beyond what they
presented today that they should send them.

And I have a suggestion for addressing
the concern that Commissioner Jonas raised
yesterday with the workgroup not having the
opportunity to meet. And that would be if you
were able to send me what you have in mind and
I'll just kind of label those as tentative right
now but can start that process of seeing how
things group up and so forth. And then after the
workgroup meets, you can just let me know remove
these or, oh, we have these to add. That would
allow me to move forward with my process and
accommodate your need to have a meeting if that's
agreeable.

DR. JONAS: I mean, it's okay with me,
but it's up to everybody else.

DR. MAGUEN: I was going to say, too,
we're going to meet today before we go to the
airport, as well. So that --

DR. JONAS: Yes, and I sent around
some high-level ones last night for people to
look at them today, and I think Nick has printed
them out, right? So we can sit down and look at
them and if I can get feedback from that, given
the time line, I can incorporate that feedback
and send you one that has had some feedback in
it.

CHAIR LEINENKUGEL: Well, I think
you're a lot further along --

DR. LaRUE: It sounds like we're going
to be way ahead of the party deadline, but if
things occur to anyone between now and then that
isn't already in my hands or a part of what Mr.
Jonas just mentioned, just feel free to send
them. They'll go to me, John, Casin.

CHAIR LEINENKUGEL: And as chair, I'm
going to give Dr. Jonas and his group a little
bit of leeway here just because, as we noted,
they all have day jobs and night jobs. There's
going to be a lot of travel involved even after
we disperse, especially with Wayne as the lead.
So I would go much more meat on the bone type of
thing, Wayne. Maybe it's October 4th, tentative
day, I'm trying to give them two additional
weeks.

DR. JONAS: The Commission members and
especially my duty group will give me, after we
have our discussion this afternoon for the ones
that are here because there are some that are not
here, you know, if they'll give me and I'll ask
if they'll give me forgiveness rather than
permission. Then I'll go ahead and write out,
you know, as much detail as I think, more detail
than you probably even want. But realizing that
it's not all been vetted with folks --

CHAIR LEINENKUGEL: Fine.

MR. KUNTZ: Can I make a request that
Admiral Beeman be given the same time line?

CHAIR LEINENKUGEL: Yes.

MR. SPERO: What if we just said that
if your workgroup wouldn't have a recommendation
related to workgroup one that you've come up with
to do that work, if you don't have time to vet it
through Wayne before next Friday, can we just
send them all to Wendy then? Can we just say
that --

    DR. JONAS: Yes, we sent five out at
a very high level, and we just need to talk a
little bit more concrete. I'll send them to you
by next Tuesday because I'm going to be gone, so
I don't want to have to be worried about it, and
I got other stuff going on after that.

    DR. POTOCZNIAK: I don't really have
all my data yet. We were conducting the last
focus group on Friday, so I don't know that I can
get you guys, like I can neaten up the
recommendations I got, but I can't get you --

    DR. JONAS: Like pretend it's
supported by data?

    DR. LaRUE: I think what you presented
today is a good starting point for looking for
where there were overlaps and so forth. And it
is going to be an iterative process. In October,
all of that will get discussed anyhow, so I think
that will be perfectly fine.

    CHAIR LEINENKUGEL: On behalf of the
COVER Commission, I want to thank all the
commissioners. This was a terrific, in my case and a couple of us, three days, but exceptional two days as far as the COVER Commission on open session and also the amount of work that has taken place. And as the people on the phone and the people in the room know, it's been well supported by the subject matter experts at the VA and also by Sigma and I want to thank them for their continued work, and there's still a lot of work to go. And you just heard from Wendy as far as some diligent writing and drafting that will begin.

So I really look forward to five weeks from now when we're all back together again and getting to the points of debate, deliberations, and then final recommendations in that October session.

There will also, as a reminder, be some of you commissioners will be pinged by John and Casin and Dan who will put another day on the Hill. And also I requested that there be a VSO type of summit request go out to the VSOs so that
we can download and interact with them over that October period, as well, which gives them a good 90 days out prior to the final submission.

Are all commissioners good with that? Any other concerns or items for the good of the order from the COVER Commission? If not, thank you so much and this is not terminated. This session is closed. Thanks, all.

(Whereupon, the above-entitled matter went off the record at 1:00 p.m.)
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This is to certify that the foregoing transcript

In the matter of: COVER Meeting

Before: US DVA

Date: 09-13-19

Place: Crystal City, VA

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