UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

CREATING OPTIONS FOR VETERANS' EXPEDITED RECOVERY (COVER) COMMISSION

OPEN SESSION

TUESDAY
DECEMBER 4, 2018

The Commission met in the Auditorium in the James A. Haley Veterans' Hospital, 13000 Bruce B Downs Boulevard, Tampa, FL 33612, at 9:00 a.m., Jake Leinenkugel, Chair, presiding.

PRESENT:

JAKE LEINENKUGEL, Chair; Senior White House Advisor, Veterans Administration

THOMAS E. BEEMAN, Ph.D., Rear Admiral, U.S. Navy (Ret.), Co-Chair; Executive in Residence, The University of Pennsylvania Health System

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

JAMIL S. KHAN, U.S. Marine Corps (Ret.)

SHIRA MAGUEN, Ph.D., Mental Health Director of the OEF/OIF Integrated Care Clinic, San Francisco VA Medical Center

JOHN M. ROSE, Captain, U.S. Navy (Ret.), Board Member, National Alliance on Mental Illness

MATTHEW KUNTZ, U.S. Army (Ret.), Executive Director for the Montana National Alliance on Mental Illness (NAMI)
TOM HARVEY, U.S. Army (Ret.), Board Member, Milbank Memorial Fund
MICHAEL POTOCZNIAK, Ph.D., Captain, U.S. Army Reserve, Team Lead for Addiction Recovery Treatment Services, Martinez, California

STAFF PRESENT:
CASIN SPERO, Chief Advisor
SHANNON BEATTIE, MPH, Senior Project Analyst, Sigma Health Consulting, LLC
YESSENIA CASTILLO, Senior Consultant, Sigma Health Consulting, LLC
KRISTIANN DICKSON, VA Support Team Project Manager; Alternate DFO
BETH ENGLEES, Senior Manager, Sigma Health Consulting, LLC
LAURA ANN McMAHON, Contracting Officer Representative; Alternate DFO
STACEY POLLACK, Ph.D., Alternate DFO
ALISON WHITEHEAD, Designated Federal Officer
JOHN KLOCEK, Alternate DFO
KENDRA WEAVER, Alternate DFO
NADINE DEDEE LIM, MPH, Senior Consultant, Sigma Health Consulting

ALSO PRESENT:
JOE D. BATTLE, JAHVH Director
DR. MIGUEL LAPUZ, VISN 8 Director
COLLEEN JAKEY, MD, Chief of Staff
MELISSA SUNDIN, Acting Deputy Director
LAUREEN DOLORESCO, Associate Director
ANDREW SUTTON, Acting Associate Director
SUZANNE TATE, Assistant Director
CONGRESSMAN GUS BILIRAKIS, R-FL 12th District
GLENN CATALANO, MD
RONALD GIRONDA, Ph.D.
JACQUELYN PAYKEL, MD
STEVEN SCOTT, DO
JENNIFER MURPHY, Ph.D.
ANGELA DRAKE, MD
NICOLLE ANGELI, Ph.D.
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(9:04 a.m.)

MS. WHITEHEAD:  Good morning, everyone. My name is Alison Whitehead, I'm serving as the Acting Designated Federal Officer for this meeting on December 4th, 2016.

The first day of the meeting of the Commissioners. So, this is the fourth meeting of Creating Options for Veterans' Expedited Recovery Commission. We'll use the acronym COVER in this discussion. And portions are open to the public.

The COVER Commission, as established, is required by Section 931 of the Comprehensive Addiction and Recovery Act, or CARA Legislation, Public Law 114-198, operating under the provisions of the Federal Advisory Committee Act.

Public notice of this meeting was given in the Federal Register on November 26, 2018. Please note, if you didn't already see it, there's a sign-in sheet for members of the public attending this meeting in person.

And we ask all participants that have
called in to the advance lines, to please email
us to record your attendance. So the email box
for that is covercommission@va.gov. So, C-O-V-E-
R-C-O-M-M-I-S-S-I-O-N@-V-A.G-O-V.

This meeting will be chaired by Mr.
Thomas J. Leinenkugel. We ask that you be
courteous and respectful during meetings.
Videotaping or making photos during meetings are
discouraged, as I've instructed for the
Commission, Staff and other audience members.

So, questions and comments from the
public may be submitted, in writing, to the COVER
Commission mail box. There is no open questions
and answers section during this period.

Transcripts of this meeting are being
taken and anything said during this meeting, or
submitted right before, during or immediately
after the meeting, will be available to the
public. This meeting is on the record.

So in close, summarized public notice
for this meeting was published in the Federal
Register. A DFO or ADFO designated federal
officers are present, a quorum of the COVER Commission is present and in person.

An approved agenda for the meeting has been established and will adhere to this agenda. Anything said during this meeting is on the record.

So, before this meeting begins, does anybody have any questions about any of those statements I just made?

All right. So, hearing none, these preliminary statements are concluded. I'll now invite the COVER Chair, Mr. Jake Leinenkugel, to begin and call the meeting to order.

CHAIR LEINENKUGEL: Thank you, Alison. This COVER Commission meeting on December 4th, 2018 is now in session and in order. And with that, I would like everybody to please rise and have Commissioner Khan --

COMMISSIONER KHAN: Please face the National Flag. Hands on your heart.

(Pledge of Allegiance.)

COMMISSIONER KHAN: Please be seated.
CHAIR LEINENKUGEL: Thank you all very much. And in particular, Joe and Miguel, thank you.

This is a wonderful facility. I've heard about it. I've never had the opportunity in my 18 months, while I was in D.C. And now to let people I am back in Wisconsin and Arizona and working on this very necessary COVER Commission.

And I would like to say thank you for opening up Tampa Facility. It's wonderful and we look forward to spending three very interesting and learned days with all of you and your staff. And the accommodation so far is just terrific, so thank you.

I would like to start with brief introductions of the Commissioners. There is one Commissioner who is not in attendance today due to a family emergency. And Dr. Wayne Jonas will be back with us tomorrow morning. And the other nine Commissioners.

I'll start of course with myself. I'm Jake Leinenkugel, I'm a Marine Corps Veteran and
I have served as a Senior White House Advisor for the VA for approximately 18 months. And for the last five months, have had the distinct privilege to head up the COVER Commission.

To my right?

COMMISSIONER HARVEY: My name is Tom Harvey, I am an Army Veteran. I spent two and a half years in Vietnam as an infantry officer.

I've spent much of my career in dealing with the issues revolving around Veterans. I was Staff Director of the Senate Veterans Affairs Committee at one time, I was Deputy Administrator of the VA and I spent three years as Assistant Secretary of the VA for Congressional Relations.

And I just was talking to hospital director and Jonas said that he recalls we met once back early in both of our careers. Thirty some years ago I think. Thank you very much for your hospitality.

COMMISSIONER ROSE: Good morning, all. My name is Jack Rose. I'm a 26 year Navy Veteran
and I have been working with the National
Alliance on Mental Illness for the last 18 years.
And thank you very much for having us here today.

COMMISSIONER KHAN: Jamil Khan, United
States Marine for life. Vietnam through Middle
East. Desert Storm to Desert Shield. I'm a
survivor of the Beirut bombing, and I'm a
recipient of the VA health care but it was
unstable.

At the same time, I'm a very active
faculty for the Veterans. Thank you very kindly
for being here.

COMMISSIONER KUNTZ: My name is Matt
Kuntz, I'm a Army veteran. I came into this work
after losing a family member to PTSD after he
came home from Iraq.

I'm the Executive Director for the
National Alliance on Mental Illness for Montana
and the Director of the Center for Mental Health
Research and Recovery at Montana State. Thank
you for having us and everybody's work.

COMMISSIONER POTOCZNIAK: I am Mike
Potoczniak and I'm a Afghanistan Veteran Army. 
And I'm currently an Army Reservist psychologist
and I work at the VA in San Francisco in the
Santa Rosa CBOC.

COMMISSIONER MAGUEN: Hi, I'm Shira
Maguen, I'm a clinical psychologist by training.
I've been working at the VA since 2001. First
with Boston VA, now with San Francisco as well.
And I wear both a clinical hat as well
as a research hat. Thank you. Thanks for having
me.

COMMISSIONER AMIDON: Good morning,
everybody, thanks for having us. I'm Matt
Amidon, serving as a Marine Corps Reservist for
26 years now.
But in my civilian capacity, I'm the
Director of the Military Service Initiative at
the George W. Bush Institute in Dallas, Texas
where we exist at the intersection of public and
private sectors, ensuring success and transition
for warriors and their families, with a focus on
quality employment for the next career and mental
health delivery as we're a warrior wellness alliance.

But thank you so much for having us here today, I appreciate your time. I know how busy you are.

COMMISSIONER BEEMAN: Again, thank you for your hospitality in inviting us here today. My name is Tom Beeman, I'm Rear Admiral U.S. Navy retired. I have 33 years in the U.S. Navy.

I served as Assistant Deputy Surgeon General for Navy Medicine. In addition to that, I was President and CEO of Lancaster General Health, University Health System in Pennsylvania.

We're thrilled to be here and we're thrilled to do this work on behalf of our veterans.

CHAIR LEINENKUGEL: So, there you have the Commissioners, except for Dr. Wayne Jonas, who as I stated, will be here tomorrow. And I think I am very proud of this Commission and the work that has been done the last five to six months. Really just getting started to get into
the very tough questions.

And we have one of the proponents of the bill, the CARA Legislation, that will be speaking with us shortly. Congressman Bilirakis, thank you so much for being here.

And at this time, I would like to turn it over to Joe and Miguel. And introduce your team.

MR. BATTLE: Well, good morning. I'd like to welcome all the Members of the COVER Commission to the James A. Haley Medical Center here and our clinics in surrounding areas.

I'd also like to welcome Congressman Bilirakis. It's always good to see you, sir, and have you here at the Medical Center.

Also, I'd like to welcome you to VISN 8. And we're very proud of the work that we do in VISN 8. We're proud of what we do here at Haley.

And the whole motion is to improve the well-being of our patients and care givers. And we're very, very excited about that.
I'm just going to take a moment, if I may, and to share some of the great work we've been doing over the, that we've been doing. And you'll see this over the next few days.

Of course, we don't operate in a vacuum. I'd like to introduce our Executive Team, if I might take a second.

Melissa Sundin is our current Deputy Director. And Colleen Jakey is our Chief of Staff. Andrew Sutton is our current Associate Director. Laureen Doloresco is our Associate Director of Patient Care Services. And Suzanne Tate is our Assistant Director.

So, thank you for letting me introduce them.

The VA, in my view, provides world class health care and support services to the men and women who have sacrificed for our nation. But to do this, we rely on evidence-based treatments for patients.

And that includes the care we provide in mental health. In some ways here at Haley
we're a little different than other VAs. We just
have four counties that's our catchment area in
Central Florida.

And we do have two other sister
hospitals. One in St. Petersburg and one in
Orlando.

But those three facilities take care
of approximately five percent of all the veterans
in the country that the VA takes care of. So,
very densely populated with veterans here in
Central Florida.

But, we find that, that our geographic
distribution is not quite as wide but gives us a
lot of opportunity here.

Hillsboro County alone has about
100,000 veterans in it. And that's the largest
number of veterans than any one county in
Florida.

In FY18 here at the hospital, we
treated around 97,000 unique veterans. We did
1.4 million outpatient visits here at the
hospital and had over 11,000 hospital admissions.
So, quite a busy place.

We are in the process of expanding and improving many of our sites of care. In fact, we are upgrading all of them.

In our clinics, we're getting ready to open a new clinic in South Hillsboro County that construction is finishing this month.

And on your way in today you may have seen a sign that said, Mission Modernize. And I'm going to ask you to pardon our dust a little bit, we are in the process of building a new bed tower out in the front parking area. Or what used to be a parking area.

And that will give us 96 additional rooms. And when we're finished, all our patients will be able to have private bedrooms, which is something we've not had here and is well overdue. So, we're very excited about that.

But, it's not just with us. We also partner with the Military. With MacDill Air Force Base, just down the road from us here.

It is home to Special Operations
Command, and also Central Command. And we have a very close relationship with them and our DoD partners. And we also see many active duty military here, on top of the veterans, that we take care of.

We are one of the five polytrauma centers and get referrals from around the world. Between the 100 bed Michael Bilirakis Spinal Cord Injury Center, the 56 polytrauma and rehab beds and ten polytrauma transitional rehabilitation program beds, that makes us the largest federal rehabilitation center in the country.

And at any given time, we have between 15 and 30 active duty military inpatients here at our hospital.

We also have a rapidly growing women's population here. In FY18 we saw more than 9,000 unique women veterans. And enrollment is increasing on the average of five percent for the last seven years.

We see about 37 percent of the eligible women veterans in our catchment area,
which is higher than the national VA average of around 25 percent. Which kind of means once they get here they like it here and they continue to use our services.

In September, we just celebrated the 25th anniversary of our Comprehensive Women's Health Center. It started with eight employees, it's now up to 40. And it's in its third home because it keeps getting bigger and bigger.

It's at our primary care annex, which incidentally, our primary care annex was the first outpatient clinic built around the patient aligned care model, or PAC model as you may know it.

It features a patient center in front of the house, back of the house design. On stage, off stage if you will.

And care teams that treat the whole person. We offer same day services. And mental health is integrated into each interdisciplinary primary care team.

We have a no wrong door approach, so
veterans can enter care at any level and then
move to those levels as their needs and
preferences dictate.

One thing about our primary care
center, it's only considered a model to follow.
We've had over 40 hospitals and private groups
come see what we do at our primary care center.
That also includes foreign countries.

The last big group we had was last
year, was a group from Singapore, came to see
what we do.

We want to provide veterans with the
best possible opportunity to live full and
productive lives. We prioritize evidence-based
practices because we know these treatments work.

It's been based on years of rigorous
scientific study and we believe it's our
obligation to ensure veterans have access to the
best treatment options.

At Haley, and in the VA in general,
we've been embracing complementary and
integrative health care, products and practices
as they're not currently part of the mainstream
or conventional medicine and practice. But we do
embrace those here.

CIH emphasizes patient empowerment,
self-activation, preventative self-care and
wellness. Often in conjunction with traditional
medicine. They go hand-in-hand.

We have many that you'll hear about
over the next three days in some of our key
programs. Some of those key programs it's
chronic pain rehabilitation, creative arts and
music therapy blended by a partnership with
creative forces, a DoD National Endowment of the
Arts Program. We're the only VA hospital
participating in this program.

Our post-employment rehabilitation
evaluation program, or PREP, which helps active
duty service members evaluate and address health
issues, is also an area we use this a lot. PREP
is a one of a kind, holistic program that many
agencies have come to Tampa to study in hopes of
emulating its success.
In fact, over the last three years here at the medical center, we have hosted approximately 34 countries that have come in to look at some of the programming that we're doing. So we're very, very proud of that.

And of course, we're a pilot for the whole health initiative in VISN 8. Dr. LaPuz asked us if we could do that, and I quickly said yes because we feel like we've been working down those roads for many years.

So, we were very excited to do that. Because we want to, while we're a big system, we take care of a lot of people, we still want to take care of every veteran as an individual and give them what they need.

And whole health provides perspective of balance in the mind, the body and the spirit. You need all three. And it's changing the way we're delivering health care across the VA.

At Haley, we also serve as a training site for other VA facilities in whole health.

And Dr. Paykel's Thrive Program has indeed
thrived here and it's now become part of the whole health program nationally. And that was developed by her here.

And whole health builds upon one of our many strengths, community collaboration. Here in Tampa we're lucky to have a large and active duty and veteran community. This is the best community for veterans I've ever seen in my 36 years at the VA.

We have our monthly operation helping hand dinners, we have a MOU partnership with the YMCA, we have our community veteran engagement board, which is Mission United, here locally. We have hundreds of volunteers and donors that support our patients daily, through voluntary services and group therapy, among other whole health programs.

So, a wide gamut of how our community works with us to make sure the veterans get what they need.

We rightfully engage our local state and federal partners and are committed to
building those relationships and affiliate relationships. And we'll be speaking with a few of them over the next few days.

But, just like we use integrated health care teams to treat our patients, an integrated community can also support our veteran population and help achieve what matters most to them and reach their health care goals.

We're very excited about all our programs, but probably enough of me talking, and we can dive into the rest of the agenda. I want to thank you for your time and attention and as we've discussed, comprehensive mental services and the use of CIH.

And at this time, I'd like to turn it over to my boss, Dr. LaPuz, to say a couple things.

DR. LAPUZ: Good morning, Mr. Chairman and Members of the Commission and Congressman Bilirakis. We welcome you all here in Florida.

VISN 8 is actually, it covers South
Georgia, Florida and the Caribbean. We have about, almost 640,000 enrollees in our health care programs across the coverage site. And we have seven health care systems from North Florida, South Georgia, down to the Caribbean in San Juan, Puerto Rico, also covering the U.S. Virgin Islands and anywhere in between.

So I'd like, thank you for giving us this opportunity to share with you what VISN 8 is doing, in particular, to enhance mental health delivery to our veterans.

We are now on our third year of what we have called veterans integrated care team model. So, during our first year we actually focused on primary care for the PAC enhancement.

And there are two components of enhancing the PAC model. First is that we have emphasized on the team base approach and the multi-disciplinary team approach.

Which means to say that we have utilized all of the members of the team in order to provide primary care to our veterans. And the
second component of that is the RN care coordination.

In the RN care coordination, it is actually, what we have done is to reach out to veterans. Among those veterans that are high risk or high utilized with the health care.

And what we have done is that we have provided them health care in a proactive manner. So, before a problem arise, while we were there to support the veteran by providing the RN care coordination.

On our second year we have integrated primary care and mental health. And there are two components of that.

The first is academic detailing. In the academic detailing, we have trained our primary care doctors to utilize the most commonly prescribed mental health drugs. To include antidepressants and anxiolytics.

And by that we have demonstrated that when the primary care docs are more proficient in the utilization of the medications, there is a
high, we have demonstrated there is an
exponential increase in the first-time
prescription that were handed by the primary care
docs.

So, in other words, we have prevented
the delay in care by providing the first drug.
And that is being provided, the prescription is
being provided in primary care.

The second thing is, in the team we
have integrated behaviorists. So, whether that
is social worker or a psychologist, we have
integrated behaviorists so that we have a first
line of therapy that can be offered, even at the
primary care level.

The third component of our veterans
integrated care team is the incorporation of the
whole health. And we are now doing that. We are
now embarking on the incorporation of whole
health.

We are in the process of hiring 117
health coaches across the VISN. And the purpose
of the health coaches is so we will have a
trained individual that will be readily available to the care team that can teach and educate the veterans and provide them with the skills, with emphasis on wellness.

So, we're no longer in the business of just treating physical or mental health, we're in the business of actually providing wellness to prevent physical and mental health condition.

So, in that team, we expect the health coaches to provide our veterans the skills to be able to help themselves stay healthy, both physically and mentally. And we are doing that as a VISN project in all of the seven health care systems across our area of coverage.

So, it is my privilege to actually share with you the VISN projects that we have. And I'm hoping that during your visit that you will be able to, that we may be able to demonstrate the effects, as well as how that is being delivered to veterans.

So, it is my privilege to again welcome you and to thank you for visiting our
VISM. So let me turn this over to our
Congressman. Thank you.

CONGRESSMAN BILIRAKIS: Thank you.

Thank you, Dr. LaPuz, I appreciate it very much.
Thank you, Mr. Chairman. And thank you Joe
Battle, who does an outstanding job. And all the
folks behind me, they're heroes as far as I'm
concerned. They take care of our heroes.

It's truly a privilege and an honor to
join you here this morning. We have a wonderful
community here in the Tampa Bay area that
supports our veterans.

This Commission was born out of the
belief that one size does not fit all.
Especially when it comes to an issue as sensitive
as meeting the mental health needs of our nations
heroes.

I'd like to thank you for your
willingness, again, to serve on the Commission.
This is really a dream of mine. This was my top
priority. The COVER Act and the PROMISE Act. My
top priority, addressing the mental health issue,
particularly PTSD and TBI.

I'm confident that the work you're embarking upon will save lives. That's the goal. And transform the way the VA system, as a whole, approaches behavioral care.

I'd like to tell you a few stories about, that inspire me. One in particular, Jason, who caught me in-between a Homeland Security Meeting, I was walking the corridors of Cannon, I think probably most of you have been to the House buildings, and he caught me and he says, Congressman, I'm not from your District but I know how much you care about our veterans. I know they're your top priority in the United States Congress.

He told me his story where several tours in Afghanistan. And came back and was having a real difficult time. Very difficult time.

Problems in the marriage, connecting with his children, losing job after job after job, going to the VA and getting counseling and
also some medication, but it just wasn't enough. And he was thinking suicide.

And then a non-profit, 501(c)(3), gave him a service dog. And the service dog, as you know, because most of you, thank you for service are veterans, in this case turned his life around. It gave him a sense of purpose.

You know, his wife had taken care of the kids and continued to take care of the kids. He didn't feel like he had a purpose in life to live. And the service dog turned his life around. And with the counseling obviously at the VA. He continued the counseling. You know, it's part of the puzzle.

In any case, he started working for the American Humane Association bringing back service dogs, hero dogs. Hero dogs from Iraq and Afghanistan and reuniting them with their handlers.

So, Jason and others, you know, the best ideas come from our veterans. And I hired Rob, prior to that, Mike Cimino, who works for
the VA now.

Rob used to work with the VA and now he works for me. He's a combat veteran, originated in Santa Rosa.

So, this is where we get our ideas and we know the veterans in the advisory council. And, again, Jason's story is not unique. I've met with countless veterans, as I said, including many in our community who have similar stories of how an alternative or complementary treatment brought their lives back from the brink of ruins.

For some it was a service dog, as I said. Many have found accelerated resolution therapy, and I believe we have that here in Haley. I know we have it at the University of South Florida.

I understand that works for some. Art, there be really art therapy. And Rob is doing art therapy.

Again, it's been transformational. I've, again, I've also heard similar stories about hyperbaric oxygen treatment.
We have a physician who gives it, performs that treatment on veterans in my Congressional district, pro bono. Yoga, acupuncture. I mean, one thing that made a difference in treatment of PTS or TBI.

We want every veteran to have access to whatever treatment works for them, which is why we are assembled here today.

Of course, we want to protect the veteran by making sure that the treatment is evidence-based and effective. I have a heart for the cure are the experts. That's why you are here, again, independently to determine that.

I also want to note that I've seen heartbreak, many heartbreaking stories about young veterans who return home from war struggling with PTS and who are placed on opioids. They develop the reliance on the medication and then have yet another issue that hadn't been addressed. Maybe even not been addressed in some cases.

I'm not saying that medication isn't
part of the solution for our heroes, but it shouldn't be the only option considered. That's why complementary and alternative therapies are so critical.

We even have one veteran, Jason Simcakoski from Wisconsin, I know his family well, communicated with his family while we were working on the legislation. Jason died in a VA hospital from opioid overdose. This can never happen again.

His story inspired the PROMISE Act. Which requires VA doctors to receive training, additional training, and utilize best practicing, prescribing practices, when treating with opioids. These two issues go hand-in-hand, in my opinion.

Substance abuse and mental health issues are often co-occurring. And the treatments the Commission approves for the VA to use will have the impact of treating these issues in a holistic manner, which is very, very critical. And of course, Dr. LaPuz addressed
that.

I believe it is the key component of reducing the suicide rate within the veteran community and helping service members successfully reintegrate into civilian life. Two of our primary objectives.

Again, I'd like to thank all of you for participating. This is a dream of mine and it looks like we've got some great, great Commission Members, highly qualified.

And, again, you were selected by the President and also the Majority Leader in the Senate, Minority Leader in the Senate, Speaker of the House and Minority Leader in the House. And I know that you require the 50 percent of the Commission. I think we're well over that, are veterans. I think it's very important that we engage.

So, thank you very much for participating. Thank you for bringing the COVER Commission to my home area. Tampa had nothing to do with that but I'm very pleased.
(Laughter.)

CONGRESSMAN BILIRAKIS: So, again, God bless you and I'm here to help. But, again, you are the experts and I'm always here to follow the legislation and get it through. So, thank you and God bless you.

CHAIR LEINENKUGEL: Congressman Bilirakis, thank you so much for doing what you're doing and what you have done as far as set this Commission on its path. And we have gotten to know each other quite well in the last few months in getting into the weeds, so to speak.

Because a lot of people don't understand exactly what the Commission is set up for. You just basically defined the principles that we're looking at.

And COVER, plain and simple, stands for Creating Options for Veterans Expedited Recovery. And it's really focusing in on the mental health care of the entire VA system.

And are we living up to the promise to the veterans who do have issues with mental
health, and we're finding out that this is an increasing number as we go forward. It is very complex.

And so, you do have a great group of Commissioners that understand the sense of urgency that you and the rest of Congress have placed on this Commission to come up with the appropriate suggestion and recommendations for the VA to improve in areas. And also look into new areas that veterans can access and expedite their recovery of care for one another.

Also, to Director Joe Battle, thank you so much again. And, Miguel, great to see Dr. LaPuz is back in the saddle on the campus, so to speak, in VISN 8.

And we look forward to now getting into more of the weeds in talking to your doctors, your staff, your clinicians, as to how veterans are cared for here in the greater Tampa area.

I would like to take a couple of minutes to open it up to the other Commissioners,
if there are any questions over the next couple
of minutes. And, we're on a very tight time
frame to either Joe, Miguel or the Congressman.

COMMISSIONER BEEMAN: Just a comment.
And, Congressman, thank you for the clarity that
you've given to the mission of this Commission.

Too often in health care we treat
people with a bundle of symptoms rather than
holistically. And I think what you outlined is
the imperative that we treat our warriors with
what I will call existential or moral wounds
holistically. Not just themselves but in the
context of their family.

So, it's very clear, I think, not only
to the Commission Members but hopefully with the
audience, what our mission is. And I'm really
grateful for that. And we will do our best to
ensure that the law that you put into place is
met, not just the spirit, but holistically as we
try to address these issues.

COMMISSIONER POTOCZNIAK: One
question. You mentioned that you have been
successful in integrating the prescribing of anti-depressants and anxiolytics in primary care, which I see it's a huge hurdle for a lot of other VAs --

CHAIR LEINENKUGEL: Hey, Mike, do me a favor, just put that mic closer to you. Thank you.

COMMISSIONER POTOCZNIK: It's a huge hurdle for a lot of other VAs. I know it is in ours, it isn't a lot that I've seen, I'm wondering how you did that. Maybe if you just say briefly like what barriers you've faced because I've seen a lot of barriers with that.

DR. LAPUZ: Well, one of the more significant barriers is the comfort in prescribing mental health drugs, for example, in primary care. So what we did was, we have an academic detailer, so they're pharmacists, they're PharmDs. And they provide education.

And we have a, sort of like a cheat sheet that was provided to the prescribers so that it made them a lot more comfortable in using
the drugs.

And the second thing that we did was, one of the barriers is that they will feel, the primary care docs, will feel that they are being dumped on because there is another one. So that is important, it is important that we emphasize on a team base provision of care.

That means that we utilize a lot of the nursing protocols in order to unload the burden of the primary care docs. So, we did that in the beginning, in the first year.

So, we did a lot of unloading by utilizing nursing protocols. And by emphasizing that it is not the, it's not the primary care doc that is only the one providing care.

So, instead of the doctor being wrapped around my services and he's the one that is providing care, it's all the members of the team are wrapped around the veteran and they're all providing care.

COMMISSIONER POTOCZNIAK: Thank you very much, I appreciate it.
COMMISSIONER KHAN: Sorry, one question. The clinician that are present, is overloaded with administrative tasks, how can we reduce all of this and we still can help them so they can spend more quality time helping the veteran?

DR. LAPUZ: I know that there are pilots, and in fact, there is a pilot that is mandated by legislation. And that pilot is the use of scribe in the health care setting to unload, for example, the administrative tasks that you are referring to.

Now, in the way we did it in VISN 8 is to unload the task of provision of care by itself. So, in other words, again, like I'm sorry to repeat the description, but what has happened is that we, in the past, we have provided care through the primary care doctor.

So everything will have to be ordered by the primary care doctor. And so, what we did is we unloaded that. So, from the beginning, we recognized the fact that there are things that
nurses can do well, just as well as docs.

So, we have written nursing protocols to allow the nursing staff to do that. And the social worker, there is no, in the event of our primary care integration, there is no requirement for the primary care doc to actively provide a counsel for mental health because there is a behavior that's integrated in the team.

So, there are a lot of things that we have unburdened the primary care doc from the beginning. Now, I am not opposed, and I welcome the pilot regarding scribes because I think that there will be a significant role to further unburden primary care providers in that area.

COMMISSIONER KHAN: Thank you.

COMMISSIONER KUNTZ: Congressman Bilirakis, sir, thank you so much for this legislation and I'm a lawyer who loves congressional intent. And we don't often get to sit down with a Congressman and ask him what they meant when they wrote it.

And I guess one of the things that we
struggled with is the part about conducting a patient centered survey within each VISN. And there's a lot of different bureaucratic hurdles within conducting patient surveys in the VISN and I was just wondering if you would be willing to have one of your staff members guide us and tell us, like, we'll tell you what the challenges are and then you let us know --

CONGRESSMAN BILIRAKIS: Absolutely. I look forward to working with you on this. And yes, definitely --

COMMISSIONER KUNTZ: Thank you.

CONGRESSMAN BILIRAKIS: -- we'll assign a staff member to you. I have one veterans' person up in Washington and several down here. So, maybe Rob probably might be the best person.

COMMISSIONER KUNTZ: Awesome.

CONGRESSMAN BILIRAKIS: But definitely, I understand and we'll help you. And we'll guide you as far as that is concerned. But I think that is essential.
COMMISSIONER KUNTZ: Thank you, sir.

CHAIR LEINENKUGEL: That being said, and we're now 17 minutes over our allotted time to be on schedule, we would like to move forward. But, again, thank you so much Congressman, Miguel and Joe.

And the rest of your staff and the chiefs and doctors that were introduced, thank you for your service to the veterans in Tampa. Thank you.

(Applause.)

MS. WHITEHEAD: All right, so, thank you everyone. We're going to go ahead and get started with our next presentation, an overview of the civilian mental health services.

We have Dr. Catalano and Gironda, who I saw somewhere. Okay.

CHAIR LEINENKUGEL: Doctors, thank you so much and please, take it away.

DR. CATALANO: Well, I'd like to say welcome to Tampa. Commissioners, thank you very much for the opportunity to speak with you and
hopefully we can answer all your questions today.
We appreciate it.

Let's start by giving you the overview of the service. We are happy to say that our mental health services are provided at all James A. Haley Veteran's Hospital primary points of care.

Whenever a patient comes in, we're there. We have full mental staffing, of course at the main hospital, also at our primary care annex, our outpatient mental health building, our psychological rehabilitation recovery center, our domiciliary, which is offsite, and our four, our three community satellite outpatient clinics, which are of course in Zephyrhills, Lakeland and Brooksville.

We also have a large, our outpatient clinic in New Port Richey, all are fully staffed. And it's with subscribers and therapists and PTSD specialists.

Now, we cannot do this alone, okay. So, it's not just mental health in these
facilities, in our service. We also work collaboratively with social work service, chaplain service, nursing service, pharmacy and mental health. Along with being oral, being embedded in other places throughout the facility.

We have tried to build a mental health system of care based on the four primary candidates of course being integrated interdisciplinary, evidence-based and veteran centric. I'll spend a couple of seconds discussing each of those if I can.

First, integrative. Our mental health services staff are embedded throughout the entire James A. Haley veteran system of care. If a veteran comes in on an impatient service, we have a number of consults and consultants who are available for medicine service, spinal cord injury, polytrauma, surgery, wherever they come in.

And, mental service is also internally integrated within the mental health service. Which means that, as a veterans needs change or
as a veterans situation changes, we are able to move them throughout the system of care seamlessly.

We are able to get people moved into the programs they need and based on how they're doing and how they're responding to therapy, making additions and subtractions based on what, on their current situation.

There's usually no wrong door. We want to make sure that when someone comes in, whether it's in New Port Richey or whether it's the domiciliary, we can work with the veteran on a treatment plan for exactly what they need to recover and to get the most out of their lives.

And our continuum of care, it's also called the Step-Care Model. But essentially what we mean there is that we are, and since we offer mental health services throughout the system, the level of service is matched to the veterans needs and preferences.

And as those needs and preference change, they can easily move up and down and
continue over time.

So, interdisciplinary speaking, all of our service programs are interdisciplinary. We have psychiatrists, psychologists, advance practice nurses, RNs, LPNs, pharmacists, social workers, licensed mental health counselors, mental health family therapists, addiction counselors, chaplains and peer support specialists.

Now, there are other services such spinal cord injury and polytrauma, where we have staff that are embedded with, teams with even a broader representation. Whether it's rehabilitation specialists or whether it's internal medicine doctors. As we are embedded in there, we are able to, I think, add to the options available for each of our veterans.

This model does provide a tremendous range. I think when all you have is a hammer, everything looks like a nail. And so, by doing this, by having numerous providers involved in every patient's care, we're able to really have a
large toolbox of options to help our veterans.

And, the whole team works together collaboratively with the veteran towards the shared treatment and recovery goals. We want to make sure that we all work together and we all know what each of us is doing to make sure that our veterans are taken care of.

Evidence-based, we have definitely prioritized the delivery of evidence-based practices. And we've been doing that for at least the last 12 years.

We know these treatments work, there is numerous, there's years of scientific study. And we have, based on these research, we know these work and get people better.

Why? Why the time, because the veterans deserve our best. It's our obligation that veterans have next to the best available treatment, state of the art treatments and whatever they need to get better.

Now, not every evidence-based practice is going to work for every veteran, we know that.
That's why we have numerous evidence-based practices, along with CIH therapies as well.

So, I can guess that essentially every veteran is going to have a different treatment plan. Same diagnoses, but since these treatment plans are all veteran centric and they're all individualized, pretty much no two treatment plans should look alike.

Veteran centric, we're about the recovery model. People can get better. We really want to do everything we can to maximize the veterans functioning and have them do the best they can.

So, we, our treatment plans are driven by the veterans' strengths, needs and preferences. And our change throughout the duration of care.

The treatment is not a static document, it has to change over time. And by allowing, by continually working with the veteran to see what they need and what they want, we want to make sure that we are able to change with the
And the veterans have ownership of their care and they have choice. They can choose, they may not want to be involved in therapy but they may change down the road.

So there is no closing doors either. We want to make sure that they know that they can always come back and be involved in something if they change, if their preferences change.

Outpatient programs. As you can see, we have quite a few. In fact, 95 percent of our patient encounters happen on the outpatient basis.

We have general mental health, you know, just mental health people, but also, we have our three out, three computer based outpatient clinics and our outpatient clinic in New Port Richey.

But we also have specialty care. We have women's mental health, we have a PTSD clinical team, we have a substance use disorder service.
There are some veterans who don't want to come see mental health. I don't want to come. So we even meet them where they are. And that's where our primary care mental health integration comes in.

Everybody needs primary care. And so, instead, we're able to see them as a colleague of their primary care doctor.

We have psychiatrists that are based on the primary care mental health team as well who help the primary care doctors with their medication choices and follow-up there.

Also, we have we offer transcranial magnetic stimulation. We are the busiest TMS program in the VA system.

We have different types of therapy, we have peer support recovery services and we have programs where we see the veterans in their home. Through our mental health intensive case management program and also home-based primary care.

We are also staffed in a number of
other programs in the polytrauma, chronic pain, spinal cord and outpatient medical clinics.

Inpatient. We are fortunate that we only have an inpatient psychiatric unit called the acute recovery center, 40 beds. And that's where our most acute patients go.

We also have, once again, we also have consultation liaison services to all the medical teams and all the other teams. That is the med surge, we have a substance use disorder. That way we can get patients seen immediately and start evidence-based medications for substance use.

We have a geriatric psychiatrist and psychologist specialist in the community living center. They're there full-time. We have a full team embedded in the spinal cord injury and polytrauma. And we have a team involved in the emergency department as well.

Overall, we are embedded throughout the hospital. Also in polytrauma and chronic rehabilitation and pain, and spinal injury in the
community living center. Pretty much wherever the patients, we're there.

And then residentially speaking we have a domiciliary offsite that has 33 beds. Also, we have 20 beds for, especially with our intensive outpatient program and substance use. So, for our veterans who either live far away or are homeless, we can get them in and make sure they come in and complete the outpatient program.

Also, we have complementary beds in the homeless, in the homeless program and in the grant per diem program.

Amongst mental health programs, the CIH that is most utilized are animal-assisted therapy, of course in equine therapy as well is lumped into there, acupuncture art therapy.

By feedback, what is equine therapy? Guided imagery, meditation mindfulness, spiritual care yoga and having outdoor recreation, which happens a lot at our domiciliary.

So, as you see, we've been using CIH for quite a long time and we're excited for the
expansion as we move forward.

A couple mental health measures. Our facilities have over 28,000 veterans and mental health, which is around 27 percent of our patients.

About 11 percent of our outpatient visits are for mental health, which is significant. And we have over 335,000 mental health visits, impatient and outpatient.

We have over 12,000 mental health days of care, which is essentially patients who have stayed on our inpatient services for overnight. So we've had a significant increase there.

And what we're very proud of is our access. The average new patient wait time from create date to patient being seen is 9.8 days. Which, we're happy with but, compared to the community, it's much, much better.

And of course, we also have same day access for veterans who request that. And that's at every site of care.

As Mr. Battle spoke about earlier, we
have a very compact catchment area. And at no point in time, is any veteran more than 25 minutes away from a VA facility that can provide evidence-based care.

But still, some veterans want to be, need to be taken care of at home, and so we have increased our video telehealth encounters since 2016.

And once again, we have over 1,300 TMS encounters last year, which is of course, as you know, a significant number which is probably the most in the VA system.

I'd like to tie it up before I open. I'm sure you have questions.

The VA system allows us to provide care to our veterans in this systematic matter. I'm very appreciative of that.

Our care is in a disciplinary, veteran centric, evidence-based and integrated. But for me, the important thing is, well, one of the important things is the integration.

It's not just mental health that's
integrated it's everything. Mental health speaks with surgery, who talks with internal medicine, who works with whole health, who coordinates with dental, who interacts with neurology. The fact is, we are one family taking care of our veterans.

I'm really proud of our clinicians. Honestly, these are really top-flight people who could work anywhere but they've chosen to work here. And the reason is because of their commitment to our veterans.

They have a dedication to the mission, which is important. And what is the mission, it's to provide compassionate, evidence-based and effective care in a quick manner, in a rapid manner. And they do a great job.

Overall, it's an honor to serve our veterans and work with these people. But, I have to thank the VA for allowing us to work in this system of care because it's, I think, it's one in a million.

And also appreciate the fact that our
hospital leadership has made mental health,
veteran mental health their top priority. And
happy to answer any questions that you have.

COMMISSIONER ROSE: Thank you, Doctor.
A quick question. Two questions actually.

How are your staffing levels? It
sounds like you're doing a great deal of things
here, but it takes professionals, it takes peer
support specialists, it takes a lot of people to
do this, how are your staffing levels?

DR. CATALANO: They're very good.
Actually, we only have a four, I think right now
we have a 4.9 percent vacancy rate. And we have
another individual coming on board it's just we
have, we are fortunate that our hiring is
expedited because of the importance of having
mental health, having boots on the ground. So
it's very good.

COMMISSIONER ROSE: Okay, thank you.
And the second question, you mentioned video
telehealth at home. Can you tell us a little bit
more about that at home?
DR. CATALANO: Certainly. We have a number of providers, a webinar SCI, a spinal cord injury area, and also one of our geropsychiatrist, who are pretty much doing their practice by using the video connect, which is on the cell phone.

COMMISSIONER ROSE: Right.

DR. CATALANO: And also, then they're able to, well, it sort of serves two purposes. One is that if veterans can't get in we're able to see them in their own house, but also, when a veteran is no-show, we're able to call them up and try to, and interact with them, to make sure that there is not something afoot and something going on. So, that way it's not just a phone call it's a face-to-face.

COMMISSIONER ROSE: Thank you. Are you doing this with mental health as well?

DR. CATALANO: Oh yes. We're doing it with, we're doing geriatric psychiatry right now along with the psychologists and the spinal cord injury.
COMMISSIONER ROSE: Thank you, sir.

COMMISSIONER BEEMAN: Two questions for you. When you talk about, on the last page, the 28,000 veterans served in mental health, you're not including the patients that are seen in primary care that are serviced by your health workers that may be embedded in primary care, are you?

My guess is that the percentage of your patients that have mental health issues in primary care are much higher than 28 percent, probably 60, 70 percent of patients that go to primary care practices have some sort of mental health issue or is that everybody?

DR. CATALANO: That's everybody. This is all a 500 series stop code, which would include primary care mental health. Yes.

COMMISSIONER BEEMAN: Thank you. And the second is, you mentioned in the CIH that it's all evidence-based. So, you have the data behind a lot of the therapies and all that you're providing here --
DR. CATALANO: Well --

COMMISSIONER BEEMAN: But that's one of the challenges that we have as a group is to make sure that the evidence is behind integrative and complementary services that we, you know, you can help us out if you've got the research base behind some of this, like equine therapy.

DR. CATALANO: Yes.

COMMISSIONER BEEMAN: We know anecdotally it worked but do we have anything that can demonstrate it because it would really help us.

DR. CATALANO: Well, I think as you know, the nature of CIH is that many of these modalities are experimental. We do have preliminary data, anecdotal some of it. Perhaps not well controlled studies that demonstrate that many of these techniques have promise.

Do we have the level of evidence to suggest that these are, what we would say are evidence-based therapies, by and large I would say no. They have promise. Many of them have
promise.

There's been, in the history of medicine there's all kinds of treatments that over time, show promise but then don't pay out to be useful. And then many go on to be the standard of care.

And so, I would say that the CIH that we have front lined in mental health services are the ones that have higher levels of support. Things like mindfulness and biofeedback, those kinds of things are treatments that we certainly have a lot more confidence in.

Others, we don't know. We have anecdotal data that suggest that they are helpful, and that's why we offer them. But the jury is out on many of these. And we're going to wait to see the data to move those into the categories of evidence-based care.

COMMISSIONER POTOCZNIK: So, a point of clarification. You mentioned about the data, that 500 series stop codes were included in that, the PCMHI data.
DR. GIRONDA: Correct.

COMMISSIONER POTOCZNIK: Correct?

But I'm wondering, are you including the people who are just getting an antidepressant prescribed by their primary care? Because that really wouldn't be coded in that per se.

DR. GIRONDA: That's an excellent point. And many of those would not. Some of them are. We do antidepressant monitoring.

Getting back to one of the Commissioner's questions regarding barriers to primary care prescription of antidepressant medication and other psychotropic medications, one of the things that we have done is to institute antidepressant monitoring.

We have a psychiatrist vetted in primary care as part of our primary care mental health integration team. That individual's job is to assist, consult and assist the primary care providers with the prescription of antidepressant medications.

And he is part of a team that
essentially identifies patients who are getting new scripts for antidepressants, and then monitors them on a routine basis, assessing progress, treatment response, and so forth, providing that information back to the psychiatrist, who then works with the primary care physician to modify the treatment regimen, whether it's to adjust it or to continue the course.

So those individuals would have been included, because they would have been captured in our 500 series stop codes through our BHL or antidepressant monitoring.

But you're right. There's a vast majority of other individuals who would not be captured through a PCMHI contact. Many people do get initial contact in the sense that they will -- there's a warm handoff in primary care from the primary care team to the primary care mental health integration specialist. Suggestions are made.

But if they are kept in primary care,
there's a large percentage of those that are not
going to see any light.

COMMISSIONER POTOCZNIK: So that's
probably the number difference of what we were
talking about, that it's more like 60 or 70
percent, you know, total, because there's a large
bulk of people probably just getting some
Citalopram or some Prozac or whatever it is that
probably are not captured.

One other question I have was, you
talked about the vacancy rate, which is about
four point something percent. But what is the
M.D. psychiatry kind of vacancy rate, because
that's a very -- that's a narrow group, but it is
a very important group that a lot of the VA
struggles with.

DR. CATALANO: We really don't have a
problem with that. I would say it's probably two
to three percent. We have a very strong
relationship with the residency program across
the street at USF. And the only positions we
currently have open from a psychiatry standpoint
are for our new clinic that's opening in April.

(Off-microphone comments.)

CHAIR LEINENKUGEL: Yeah, that is amazing.

COMMISSIONER POTOCZNIK: Well, compared to what we're seeing in California, yeah.

CHAIR LEINENKUGEL: Doctor, out of your 28,000 veterans, again, that are being served for mental health, I would assume that you have a breakdown that would help the Commissioners or one of the subcommittee groups that shows what the diagnoses are for each one of the mental health so we would have a sense of, idea as to what is number one through ten, per se. That's not a question. It's just a comment at this point.

The point I'm trying to make is that, do you also have any outcomes of each one of those categories of mental health that you're currently treating the 28,000 veterans with. So do you know, and can the Commission know, are
these veterans actually improving to get into a normal lifestyle again? Are they being surveyed?

DR. GIRONDA: I think there's a number
of levels of survey, of outcomes, a number of ways in which we assess how we are doing. It's embedded in the system level.

At the national level, we have patient surveys. We have the SHEP survey, which is a survey of inpatient psychiatric, inpatient care. And through that we can get mental health satisfaction data. It's a pretty comprehensive survey of inpatient data.

We have an annual veterans satisfaction survey that we --- that system-wide is administered. It has a number of mental health-specific measures. One of them is the mental health experience of care. We rate very highly on that.

With respect to your specific question, in terms of diagnostic groups, we think about it more programmatically I would say. And certain diagnostic groups tend to be treated in
certain programs. We think about it functionally and programmatically.

So at the service level, we have a number of programs that will have their own outcome measures. I can give you a number of examples of that.

At the domiciliary, we collect outcomes data on a routine basis. We see that one measure that comes to mind is rehospitalization rates. Before domiciliary care, veterans tend to be hospitalized at a rate of about 60 percent. After care, that rate goes down to around 39 percent. Not where we want it, but it's still low.

Also, as a result of doing this, we know that many of those rehospitalizations are based on substance abuse. So, as a result of that information, we've changed practices. We've increased the connection between our domiciliary and our substance use treatment program.

And in fact, we have plans to have a residential substance use program in the future.
We don't have it now. We want to have that. If you ask us one of our barriers, which I assume you will, that's one of the barriers we'd like to see addressed.

Other programs, all of your CARF-accredited programs are required to be accredited to collect outcomes, comprehensive outcomes, functional outcomes, veteran satisfaction, again, holistic approach to assessing the veterans, not just symptom reduction.

Symptom reduction is a piece of it, but it's only a small piece of that. We want to know quality of life. That's important to us. All those CARF programs measure quality of life. I can give you other examples if you'd like, but it's at the programmatic level, and I think really, really, really importantly too, at the individual patient provider level. With evidence-based practice, assessing outcomes is built into what you do.

Evidence-based practice is, the foundation of that is a continual assessment of
what's working for the patient, what's working for the veteran, and modifying the treatment protocol to make sure that what you're doing is working.

And if it's not, because we're veteran-centric and because we have so many treatment options available to us -- we have a number of different evidence-based treatment options. We have a number of CIH options available to us. If it's not working, we'll switch. We will give you something else. We will work with you to pick something else.

And even getting down to how do we know that our providers are doing that, we have a quality of care review process. And part of the quality of care review process is a monthly process where peers review each other's care.

And questions on the quality of care review form address directly that. Are you assessing progress towards treatment goals? Those goals need to be objective and measurable. Are you assessing progress towards those goals?
And if indicated, because they're not making progress, are you changing treatment?

Those are two key questions on our quality of care. So providers are responsible to the patient and they're responsible to their peers.

COMMISSIONER KHAN: Sir, once you capture that quality care, is that data available to us?

DR. GIRONDA: That's internal data. I would be happy to give you a summary of that data if you would like. But it's internal data. It's used for our internal quality of care process.

What happens is you have a -- we have a quality of care committee that every month reviews any fallouts. We call them fallouts if we feel that the care is not what we would like to see. The committee reviews those data, reviews the chart, determines what the shortcomings might have been, and then provides that feedback directly to the provider through
the supervisor.

COMMISSIONER KHAN: I appreciate very much because that will help us to get you more of what you need. The second question, Doctor, so you have a very highly motivated staff. What is the secret of retention? Are they competitive, their salaries, with the private sector?

DR. CATALANO: I honestly feel that it's a special provider that comes to the VA. You're never going to make as much money as in the private practice. But the job satisfaction is a lot higher.

Instead of chasing dollars, essentially what happens is we are, it's a higher calling. And so I think people are, really buy into the mission. And I think for us the important thing is good recruiting. And we've been able to get the best people who see things the way we do. And I think that's been our fortune.

And, but we've tried to make sure that people have the opportunities to get training and
to increase their -- what they can offer, and try
to be, treat them as well as we can.

COMMISSIONER KHAN: Okay. Maybe it's
Tampa's climate that's keeping them here.

DR. CATALANO: I'll take that, too.

(Laughter.)

COMMISSIONER KUNTZ: So, Dr. Catalano,
part of what we're called for is to really figure
out how innovation happens within VA's mental
health or how it should. And I've got to take
the bait that you dangled in front of us twice
about TMS.

DR. CATALANO: Okay.

COMMISSIONER KUNTZ: And, I mean, it
seems like something that you're rightfully proud
of. And it may be fair to say that you're
pushing beyond the bounds of the evidence, you
know, like you're seeing more results. But how
did you guys become the center of excellence in
TMS? It does not seem like it was told to you
from Washington that this was going to happen.
Is that fair?
DR. CATALANO: That's fair. Well, we always had, we've always had electroconvulsive therapy. And when this came out, there was a really, a national expert in TMS who was over at the university who left, and we had the opportunity to grab him.

And when he came here, he -- really we had started the program, but he was able to really put it into the next gear. And he's sort of like the Pied Piper. He's got a number of other faculty, staff here who are helping him out now, which is why we've got, we have two machines running at all times now. And so we're -- it's nice to have it to offer because, you know, some people, that's the only thing they respond to.

So, yeah, we thought it was an opportunity to sort of get a leg up on the private sector. And this, Dr. Kozel, who you'll meet at some point during this, during the next couple days, is, you know, he believes in it. And we believe in it. And he's actually doing the research on TMS and PTSD now. So --
DR. GIRONDA: Can I add a piece to that? It's being done -- we're putting our money where our mouth is. His work is being done in the context of RCTs. And he's going to be telling you about some very, pretty groundbreaking research in the area with methodologically rigorous trials.

So we're asking the question, does it really work. And he's gotten a lot of good data. And so we're following that. We're following that thread.

But he's going to be speaking to you in a closed session. And then you can ask him the hard details about what his results are thus far.

COMMISSIONER KHAN: Sir, I have one more question. Those who are already enrolled in the VA, you're treating them.

DR. GIRONDA: Of course.

COMMISSIONER KHAN: What is the system where -- is there an effort that those who are not enrolled, are reaching out to them?
DR. GIRONDA: Well, we think that every veteran should be enrolled. And so we have a very robust outreach program. Dr. Shiber will speak with you later on today. But we are -- we go to outreach events throughout the area, sometimes, you know, veteran organizations. Sometimes we're at the state fair. Some days we go -- wherever the veteran might be, we are there.

And, but then suicide prevention also does a number of outreaches. And so we try to spread ourselves throughout the catchment area and make sure that if someone's out there that we can sort of bring in onboard, we want to bring them on in.

COMMISSIONER KHAN: So, since you're the pilot program, can you initiate an initiative that can be used at a national level to create a database from the Defense Department, when the military veteran leaves, they track their veterans, where he is, whether he enrolled in the military --- came to VA or not. That's how
you'll reach every veteran. So if you create
that initiative, I'll back you up.

    DR. GIRONDA: You know, we're not
doing that. But it's something that needs to be
done. And I've heard talk about that. It's the
central office level. And there may be others
who can speak to this better than I can.

    But I know that that's something that
has been talked about and thought about. I don't
know. I think the logistics are really
difficult. But that would be something that I
think the COVER Commission should be looking at.

    COMMISSIONER ROSE: Yeah, just a quick
follow-on question, how effective do you see your
community outreach? How many people are you
drawing in to this facility from your community
outreach?

    DR. GIRONDA: So we've been doing this
for a while. The mental health summits have been
our primary mechanism for engaging partners in
the community. And we partner with them to
engage veterans in the community.
So we started doing the summits per the VA mandate back in 2013. We decided very quickly that we wanted to expand what we did with the summits. We saw that as an opportunity to engage in the community. We knew that was the direction of the VA. We knew that having strong community partners was the only way that we were going to be able to do our mission well.

And so we have very aggressively developed a curriculum for the summits that included issues around care coordination with community partners. Many of these are treatment providers and other agencies. Care coordination, providing crisis services, and then also increasing veteran and military cultural confidence among the community partners.

And so then we've used those agencies and those partnerships. We've tried to leverage those agencies and partnerships to increase our reach into the community and to have that be a two-way door. And you're going to hear from a number of those individuals.
We've also -- if you just want straight numbers, the suicide prevention team goes into the community five times a month. Over the past three years, or five years, excuse me, I think they've done 357 outreach events. These are all over the place. These are in churches, coffee shops, vet centers, anywhere we can find veterans.

We know that, and this is an estimate, but we know that an estimated number of veterans attending those events, over the 357 events, is roughly 130,000. So, and again, that's an estimate.

COMMISSIONER ROSE: Right.

DR. GIRONDA: But if you look at each individual and you add the estimated number of attendants, that's what we get. So we know we're reaching a lot of individual veterans.

We have a number of other initiatives. We have the commissioner's challenge. Have you heard about the commissioner's challenge? It's a SAMHSA project designed to bring the community
together to identify veterans, service members, veterans, and their families who are at highest risk for suicide.

This project began in June. We are very much a part of this with some of our other committee partners, the partners, very partners that we have cultivated over the last five years. And you're going to be hearing from them as well during your community session.

But the idea there is that we are helping the community build, identify gaps in services, and to build capacity to provide services to those at risk. And so that's, we're doing that with the community, with the Tampa Bay area, with the Hillsborough County Commission.

COMMISSIONER ROSE: Thank you. Thank you very much.

CHAIR LEINENKUGEL: Shira, we'll end on your question.

COMMISSIONER MAGUEN: Okay, great.

Thank you. You guys did a wonderful job of outlining the CIH modalities that you use here.
I know this is a huge strength of your facility.

And I was wondering, in terms of the patients who are currently receiving mental health care, do you know what percentage of those patients are currently getting one of those CIH modalities?

DR. GIRONDA: The short answer is no.

COMMISSIONER MAGUEN: Okay.

DR. GIRONDA: Yeah, you know, I just don't. I know that they are offered routinely. But we don't track that in particular. The issue is that, again, because we're veteran-centric every patient has a different treatment plan. They're offered an array of treatment options.

(Off-microphone comments.)

DR. GIRONDA: So it's hard to know because they're offered so many different types of treatments. They might get a number of different evidence-based treatments. They might get a number of different pharmacological therapies, pharmacological, evidence-based treatments, different evidence-based
psychotherapies, peer support services, chaplain services, other supportive services, plus CIH. So it's hard to know what any individual is going to get.

COMMISSIONER MAGUEN: So I think, you know, one of the things that is going to be important for us, too, is over time to be able to better attract that so we just know how many people are getting it as well. So it sounds like you're offering it to everybody. But in terms of the numbers, that's not exactly clear.

DR. GIRONDA: We have numbers based on programs in terms of numbers of patients that we, that they're, you know, they're trying to offer it to. So we do know that.

In certain programs it's a lot easier to know. So, for example, with our MHICM program, we know that all of them get the opportunity to participate in equine therapy. We know in our PRC the vast majority of them are participating in art therapy and music therapy.

At our domiciliary, we know that all
of them are offered the opportunity to
participate in things like yoga and therapeutic
outdoor recreation. So it varies by program.
But your point is well taken.

COMMISSIONER MAGUEN: Thank you.

CHAIR LEINENKUGEL: Dr. Catalano and
Dr. Gironda, thank you so much for your
professionalism and your leadership and being
part of this great integrated system, and really
appreciate the time that you spent with us and
being so transparent as well as far as what's
taking place within the Tampa VA and the great
care that you're providing our veterans. Thank
you so much.

DR. CATALANO: Thank you.

DR. GIRONDA: Thank you.

(Applause.)

MS. WHITEHEAD: All right. Thank you
so much. And we'll move right into our next
session. So we'll have Doctors Paykel and Scott
come up to the table now. And they're going to
provide an overview of whole health,
complementary and integrative health, and
recreation therapy modalities in the facilities.
So, thank you, Doctors.

DR. PAYKEL: Thank you.
CHAIR LEINENKUGEL: Go right ahead.

DR. SCOTT: Okay.

CHAIR LEINENKUGEL: There's going to
be some moving and --

DR. SCOTT: Some moving.

CHAIR LEINENKUGEL: We're well
quorumed.

DR. SCOTT: Good morning. My name is
Dr. Steven Scott. I'm the Chief of Physical
Medicine Rehabilitation, as well as the
Polytrauma Director here at Haley. I've been on
staff here since 1990. And I've been also, one
time also the chief of the spinal cord injury
service, too.

I might add I also did, I was also co-
clinical director of an HSR. That's a health
systems research center, as well as a
rehabilitation center, as well as a QUERI center
in the past. And I've also helped develop the
first residency program in physical medicine
rehabilitation in the state of Florida earlier.

I'm going to -- and what we're -- so
I want to welcome the Commission Chair, the whole
Commission, and welcome to Tampa. We have a
great story here. We have a great place. And I
think it's all because we have a compassion and
caring for our veterans and active duty.

And what I'm going to, we're going to
do today -- you can go to the first slide here.
We're going to talk a little bit about timeline
and give you a little bit of an idea of a
timeline and how we basically with this timeline
have grown into the whole health movement.

And I might add, the timeline, I'm
starting just back to 2000 because we can spend
all morning if we went back earlier than that.
And the timeline starts with -- I'm using
different CIH type of activities.

And that's the equine therapy program
that we started back in 2000. Since that time --
and we used an outside community source. And we
continue to use an outside community source to
help us in this equine therapy program.

And these programs are all embedded in
recreational therapy. And many of the times
within our rehabilitation programs they are
interdisciplinary. They are certified by CARF,
which is an accreditation standard for
rehabilitation. And they also have outcomes
based on their programs, not based on the
specific treatments.

The equine therapy program since the
year 2000 has treated over -- almost a thousand
veterans have participated in this program,
including families and other individuals, too.
We've also had an adaptive sailing program. We
actually have our own sailboat here in Tampa.

(Off-microphone comments.)

DR. SCOTT: Yes, we actually have our
lake and our own sailboat. We've had all types
of disabilities that have used this adaptive
sailing program to get them out on the water, to
give them freedom as they use that. And it's a very unique program.

We also partner with MacDill. And together, we actually bought a platoon boat. And we actually have them go out fishing out there in the bay at the same time. And we also do deep sea fishing. But that's also a program we've used since the early 2000s.

In terms of yoga, what we've done is we use a best practices. And we saw a best practice up at Walter Reed. We saw the instructors that would use it. So we basically copied that program, brought it down here. And we have an adapted yoga program. That's for people that have disabilities and that can utilize this or even have PTSD and adapt the yoga aspect to their unique needs.

In terms of golf, this is a big golfing area. Well, we actually have an adapted golf program. We actually took this from the PGA. And we actually, with this program, which meets every Friday morning, we are able to take
even veterans that are blind or all type of
disabilities and give them the opportunity to
play golf.

But it's not recreational. It's also
discipline, it's cognitive thinking, it's
socialization, all those aspects. And so any
disability at all we try to get them back on the
golf range. And that started in 2007.

In terms of our adapted sports
program, we actually started a disabled or
adapted sports program just for the disability,
you know. And the idea was taking all these
different sports -- and you name it, we do it
here, you know, water skiing, you know, whatever
you want to do. If you can't -- we actually do
that type of sports. And we teach them. We
educate them. We get them participating. And we
put them in national events that are hosted
around the country.

I might add that this is sort of an
extension of our rehabilitation program, and our
rehabilitation program and our overall goals.
And I just want to mention this, a mission, is our mission is to provide comprehensive treatment to maximize functional independence, to enhance the quality of life, and to assist the participant to regain his or her role in society as an active and useful person or member. And that's our goal. And that's, in many ways, this adapted aspect, sports allows them to do that.

In 2017 and 2018, we got more involved in music and art. We've always being doing it in rec therapy. We got more formalized with the National Endowment for the Arts. And you'll hear more about this.

This is an exciting area, you know, to mention to you on how we can use seriously disabled people, people that could only maybe move one arm or can't move anything at all and how you can apply music and art to enhance their quality of life, to enhance their rehabilitation, to allow them to become more independent, to allow their family members to interact with them
in that. And we have some exciting stories to
tell on this, as well as benefits of this, of
that program, too.

We also do adapted tai chi. We
actually went and trained, we had 12 people
train. They trained in wheelchairs. Whatever
disability it is we use tai chi to meet whatever
needs they are. And that's the needs on PTSD,
the physical needs, the mental needs, as they go
together.

The virtual reality, which is our last
one there, is sort of an innovative thing. And
it's sort of new. And what we've done on that is
we've partnered with our community, and community
partner was Operation Helping Hand. They
actually donated and allowed us a virtual reality
room.

And with that room, we're able then to
virtual reality different environments, including
those of, say, you're in the Air Force. And we
have a lot of Marines here. So we have guys in
the Marines. We could actually have them fly
over Tampa, you know, and visualize that. And
they could visualize whatever environment they
want to have.

And in that environment, we could then
apply different aspects of their pain management
or their mental aspects and improve that. And
we're in the process now of assessing and
evaluating that, too.

We also use virtual reality in our
head injury population and in other aspects. And
that's a growing area at the same time. Next
slide.

I just want to mention that we have a
whole variety, I think there was listed in the
last presentation, of CIH activities. I don't
have all the research and all the numbers. The
code numbers don't jive, but we'll give you as
much information as we can in this, I wanted to
mention.

But you could see that we have
everything almost A to Z here. You could see
art, music, sports, yoga, golf, deep sea fishing,
equine therapy, animal assistance, aquatic therapy, which you'll see, massage, manual therapy, tai chi, mindfulness, therapeutic gardening, spirituality, biofeedback, acupuncture, guided imaging. And we probably have more than that at the same time.

And I guess when you read that, that's the reason why our retention rate is so high here, because everyone -- we have everything here that you could ever want per se. Next slide.

I just want to give you some numbers. And we're going to give you more as discussions go the next couple days. But in terms of massage and manual therapy, this is used -- these are all in code numbers, CPT codes.

And massage therapy is more of a soft tissue type of treatment. It's usually embedded in other types of therapies that we use, too. But you can see that we used it already on 260 unique patients in '07, in 2007, 289 in 2018.

We also mix that up with manual therapy where they actually move the joints. You
have joint movement and joint activity to enhance
range of motion, to enhance muscle, motor
learning, to basically allow them to function at
a higher rate. And there we used it over 2,000
individuals in '17, and 1,800 in '18, a large
number of people.

When you take those two combined, the
numbers are fairly high when we look at the
actual numbers compared to our overall
population.

If you look at chiropractic care, you
know, over 2,000 unique patients were treated
last year alone and almost close to 10,000
encounters. Two chiropractors did this. We do
send some out in the community. But actually we
had two that saw over 2,000 unique patients,
10,000 encounters. And I might add even last,
the year before that it was 1,600 unique patients
and 8,000 encounters, a fairly large number.

And so, when you look at the magnitude
of that and how many people we've put our hands
on just with the therapies, it's a large
percentage here that's additive to their rehabilitation process. Next slide.

And I'm going to now make the transition over to Dr. Paykel. And she'll introduce herself. And she'll be talking about whole health.

DR. PAYKEL: Thank you very much. And Mr. Chairman, thank you very much for coming to visit us, and all of the Commission members. This is very exciting for all of us.

So I love working here. I'm a veteran myself. I was in the Navy for five years. And this is a fabulous institution to work in. I received wonderful care in the Department of Defense while I was active duty, as did my family members. And I received wonderful care here as well.

So I just wanted to embellish just a little bit the recreational timeline as far as CIH modalities are concerned.

First of all, let me back up for a second. I'm a gynecologist by training, and I'm
also boarded in integrative medicine. And currently, I'm serving as the Chief of Whole Health. And I work very closely with many of the members of the staff here, especially with Dr. Scott. He has been doing CIH and as has mental health for many years in the facility.

I came on board in 2014, started, was very fortunate to be supported to start a holistic shared medical appointment that is now a whole health modality that we offer to our veterans. And we will talk about more of that, about that more later. But in 2015, that was started. And we became a flagship site for the Whole Health Endeavor July 1, 2017. So there has been so much going on.

And if we could move to the next slide, please, I will explain this in a moment. But I just want to give you some of the data that we do have as far as CIH encounters are concerned.

So we saw approximately 28,000 unique patients last year. And that was recorded
through CPT codes that are appropriate for whole health and CIH modalities. 22,600 of those came from PM&R interventions, over 5,000 just from our sleep clinic as far as mental health is concerned, 2,417 from our primary care providers, and then within whole health, over 2,000. So we are very busy.

This graphic that you see before you is our system as far as whole health is concerned within James Haley. The pathway is how our veterans enter into the system. They then go through an introduction or orientation. And then they are referred to either one of -- either Taking Charge of My Life and Health or Whole Health Coaching, or they go right into whatever modality that they choose at that time.

On either side of this diagram, you see two boxes. Both of those are for clinical care. Some of it is inpatient. Some of it is outpatient. Some of it is shared medical appointment. Some of it is one-on-one intervention.
And then down below, the eight circles of self-care that we'll see on the next slide, the eight circles of self-care are down there. And these are courses that we have available for our patients, whether they are didactic in nature, immersive in nature, or a combination thereof as far as modalities are concerned.

Those that are represented in green are up and running at this point. Those that are in purple are in the planning stages but have already significant --- you could build and are planning to be underway within the next three months. So we have a lot of things going on.

I can say that one of the reasons why we are able to recruit wonderful professionals and retain them is because we have exceptionally supportive leadership. That is the key to that situation, I do believe. Okay. Next slide, please.

So this is just another pictorial that can show you the eight different areas of self-care in the whole health circle. We call it the
whole health circle of life, but just some of the modalities that accompany those different aspects of self-care that are available to the veteran. This is within whole health or behavioral healthcare or PM&R. Next slide, please.

And this is Hercules, one of our pets. And I wish he would come for a visit. Is he planning to come for a visit today? He will be here. You will see him eventually.

But what he's doing is he's just demonstrating for you one of our treatment modalities. And he's affected thousands of patients since his inception just over a year ago I would say, right? Yes, so just over a year ago.

So again, 28,000 CIH visits, we've had 3,364 last fiscal year that had at least 10 CIH visits, which is really important because we want them to come back and continue to participate in these endeavors. Once they have their first feel of it, though, we have very good rapport with the veterans and they continue to come back for more.
Just from the whole health service, only in two-month period of time, because we didn't have the consult up and running prior to that, we're a brand new service, we're just getting underway. But in the last two months of last fiscal, we had 473. And then we had over 13,000 patients that had anywhere between 1 and 9 CIH visits.

So this is something that is -- we are an evolving service. We've only been in existence since mid-last year. And I was the only employee of this service until November 15th of last year. And there were four of us in total until middle April.

And so we are now 38 in number and continuing to grow because we have a lot of services that we need to deliver and want to deliver. But we are being supported in that as well. Next slide, please.

And what we are all about is creating community. And this is just a demonstration of that community evolving before you.
Whether it's through Battlefield Acupuncture, even our director joins in the fun, or we have community outreach programs, animal therapy. We have healthy teaching kitchen, fixing nutritious meals in front of the veterans so that they can learn how to do that as well.

Question and answer services up in the right-hand corner, this is THRIVE Immersion. We are now hosting 50 providers throughout the country from different VA sites to come in and learn THRIVE. And so we are expanding that throughout the country. And then up on the left-hand side, you can see art therapy going on.

So there's just a lot of stuff going on. But I'll tell you that the most important thing about what we do is connect people to people. Thank you.

COMMISSIONER KHAN: You should get that President Bush dog because that Labrador reminds me of that.

DR. PAYKEL: Yeah.

CHAIR LEINENKUGEL: Doctors, thank you
so much. And it was great to see you again.

    DR. PAYKEL: Yes, thank you.

    CHAIR LEINENKUGEL: I remember Orlando about a year ago --

    DR. PAYKEL: Yes, that's --

    CHAIR LEINENKUGEL: -- and the great job that you've done then and --

    DR. PAYKEL: Thank you.

    CHAIR LEINENKUGEL: -- love your enthusiasm by all the doctors and the entire staff here. I think we need to bring that nationwide.

    But I do have a question that goes back to what I believe Commissioner Potoczniak asked of Dr. Gironda, if I'm remembering it correctly, Mike, and stop me if I'm wrong.

    But it was about any research that has been going on, or is there any research and data points coming out of CIH type of modality treatments right now, and how you're going about looking at that type of research. Is it mostly anecdotal right now, which I surmise it might be,
hearing from Dr. Gironda.

But is there a plan in place and is somebody leading it? Because I think you have the number one program nationwide under the VA, if not in the entire country. With all the modalities that you're listing here, plus with the experts behind it, plus with the veterans that are receiving it, I worry that, what are the outcomes.

So, until you can tell the Commissioners and the general public and Congress that, boy, these really help or at least rank those, and to start us off, anecdotally, I think it would help the subcommittee number 3 and a little bit on number 5 to really get something out of Tampa here before we leave in the next three days. So it was a question slash comment to see if I was on track with that.

DR. PAYKEL: Yes, I appreciate that because numbers count, and we understand that. We have a very robust relationship with our research department. We have a number of studies
underway just -- and that's on a national scale and on a local scale.

Also, as far as whole health is concerned, the veterans, as far as efficacy and favorability as far as the practices are concerned, that's, at a national level, that is being cared for. So we do not intrude upon that process locally.

I can tell you though, however, at THRIVE we have over 200 veterans that have graduated from that program. And what we have seen in the preliminary data -- we've been keeping metrics since the very beginning. We've seen a 30 percent reduction in depression over the 14-week period of time, a 60 percent reduction in anxiety, a 30 percent improvement in life satisfaction, and we have a 20 percent improvement in neuroplasticity.

One of the basic tenets of THRIVE is acceptance and commitment therapy, also positive psychology. So we move towards happiness, not just neutrality.
And we are seeing a 20 percent improvement in neuroplasticity, which is the ability to think about problems in a different way, including the disease processes that are going on, including the difficult scenarios that you've been presented with during the lifetime.

CHAIR LEINENKUGEL: Is there also some sort of data points as to the decrease of pharmaceutical medication that they're on?

DR. PAYKEL: We do not have that for THRIVE. We are monitoring that with the programs. Dr. Gironda had mentioned that. But I don't know that we have any firm numbers. Okay. I know at a national level, they are looking at that. And there's some preliminary numbers on the horizon.

CHAIR LEINENKUGEL: Any other Commissioners?

COMMISSIONER POTOCZNIK: One question for you, so you're with whole health. Is that right?

DR. PAYKEL: That's correct.
COMMISSIONER POTOCZNIAK: And then you're with recreation therapy?

DR. SCOTT: No, I'm in physical medicine rehabilitation service.

COMMISSIONER POTOCZNIAK: Okay. So I was wondering how, because I know rec therapy is a separate -- is it separate of whole health? Is that --

DR. PAYKEL: We are all one.

COMMISSIONER POTOCZNIAK: You're all one. Well, that's --

DR. PAYKEL: Everybody is one.

COMMISSIONER POTOCZNIAK: Oh, okay.

So that's --

DR. PAYKEL: Yes.

COMMISSIONER POTOCZNIAK: That's actually different. That's what I was asking, because I know in a lot of VAs there's rec therapy and then there's whole health. And so you guys have merged together to be one program.

DR. PAYKEL: This is a very unique situation here. We are the first in the country
to be a service in and of itself as far as whole health is concerned. That was done intentionally so that we could have a broad-reaching effect across the entire facility. We wanted to be able to engage not just in one specific area, but throughout the entirety.

And I'll tell you that Ms. Tate, who was my original partner in crime, she was very crucial in that initial stage when we started this endeavor, because it was she and I that met with each of the chiefs of each of the services. And everybody was on board immediately. And I meet on a regular basis with the chief of staff, too.

So this really, when I say this is one, this is an enterprise-wide endeavor.

COMMISSIONER POTOCZNIK: Well, congrats to you guys.

DR. PAYKEL: Thank you.

COMMISSIONER POTOCZNIK: That's breaking down a lot of barriers --

DR. PAYKEL: Yes, absolutely. Thank
you.

DR. SCOTT: I was just going to make a comment on the Chair, Commissioner's suggestion. And I would highly recommend that this Commission really strongly consider an HSR&D center or a rehabilitation center or a QUERI center for CIH. I think that will be very beneficial. I think it will set the VA on course. And it may be a recommendation you may want to consider as a group.

CHAIR LEINENKUGEL: Matt?

COMMISSIONER KUNTZ: Doctors, I had a broad question about physical exercise and its relationship to mental health wellness. And can you describe how you see that relationship and if there's a connection and maybe how that fits in with your programs?

DR. PAYKEL: There is no disease process ever that has not improved with physical exercise. It fits in very well.

(Off-microphone comments.)

DR. SCOTT: Yes. And we use exercise
and movement. And our philosophy is if you can
move it, we could rehab it. So --

(Laughter.)

DR. SCOTT: And so we use that all the
time. And we believe it's actually our
functional goals is to move.

And I might add that, you know, we've
had the experience here and the fortunate
experience and privilege, you know, myself as a
provider, to treat the most seriously injured
from the war, people that can't move anything.

And we've been able to give them the
opportunity, the hope, and the healing process
here to actually start their lives over again.
And I think that's one of the unique missions
here.

And in order to do that, many of them
are like an N of 1, you know. And I know we talk
about research. We talk about evidence-based.
We talk about all this stuff. But we have so
many what I call Ns of 1. In other words,
there's nobody like this we've ever seen before.
And that's why we have to be creative. The providers have to be not only skilled with evidence-based, but also be innovative and creative in their management and care, as well as the team that they all work together with.

And that's how we got into CIH very early on, because that was the only way that we could approach some of these complex injuries that we see that we've never seen before.

And with that, we've found definitely a positive environment. And it creates the environment of healing, which is so critical and so important for our nation and for the individuals that we treat. I just want to share that with you and, for your thoughts.

COMMISSIONER KUNTZ: Wonderfully helpful.

CHAIR LEINENKUGEL: Doctors, you have a very long list of modalities, the longest that we've seen to date. Are there any others that you're thinking about, that you've heard about, that you've read about that are intriguing to you
and/or other veterans that are struggling with mental health?

DR. PAYKEL: Yes.

CHAIR LEINENKUGEL: Yes?

DR. PAYKEL: There are so many, right?

CHAIR LEINENKUGEL: Would you name --

DR. PAYKEL: Yes.

CHAIR LEINENKUGEL: Give us three that you think may help veterans with mental health issues.

DR. PAYKEL: Sensory deprivation tanks.

CHAIR LEINENKUGEL: Okay.

DR. PAYKEL: Organic farming and urban gardening. Throw out one.

DR. SCOTT: Well, my lifelong dream I guess was started about ten years ago. And actually, the Congressman was working with me on this. And that's sometimes we think that healthcare starts in the health center here. And actually, in many ways, they start in the home and they start outside.
And so I found that mental health, if we can get outside into a more natural healing environment, and so I had a proposal a long time ago on Heroes Ranch, you know. And it's called a whole health heroes ranch where they could actually -- and with some type of partnership with VA and private that we could put together.

And we could actually have that healing type of environment and use evidence-based, as well as use these new, innovative things, as well as use these therapeutic outdoor recreational activities and actually allow them the opportunity to heal, but not only just immediately, but for lifelong, you know, intermittently and lifelong aspect.

And the second thing is we're trying to -- I'm also a believer in the home and how we -- you hear a lot about telemedicine. But let's try to make telemedicine into a connected, healthy home I call it. And that's a concept we're working on here.

We started SMART home technology back
in 2011. And we've been working with that. But how can we make a home and monitor the home with healthcare factors and healing factors and make that the center of healthcare, and --- because I am a believer that the healthy home gives you a healthy community gives us a healthy country.

And so if we could focus on a connected, healthy home by using our telemedicine systems, by using the VA apps, and by using SMART home technology that's out there, we can create an environment that our veterans can connect to our -- to the VA, connect to their work sites, connect to each other, and live a healthy life.

And then we can monitor those things. We can monitor their sleep. We can monitor their activity. We can monitor their medications. We can monitor their behavior, because that's what we actually started to actually do. We could actually manage behavioral changes that really will have an effect in the home and in the community.

COMMISSIONER KHAN: So sir, you're a
proponent of giving every veteran that we are
treating in that category a smart phone so they
can -- with the application of the VA ---

DR. SCOTT: We're heading to that
direction right now. We're heading in a
direction that we want to connect to them, you
know, in a mobile device, not just a stationary
web base, so that we can monitor them.

And actually also just I might add
that we're also in the process right now of
developing an app for the caregiver, because the
caregiver is so critical and important,
especially on our seriously disabled or even our
mental health ones.

And if we could reduce their burden,
reduce their stress, you know, with a mobile
device that could help organize their day and
organize their system, that's another step
forward that we can improve quality of health.

COMMISSIONER KHAN: So, to share with
you, today if Marine Corps puts me in
Afghanistan, there's a technology. They monitor
my movement. If I'm hit, the automatic medevac
comes and picks me up.

My request to you is take this pilot
initiative, ask for that technology. It can be
civilianized. It doesn't have to be the site of
-- I mean, we got all kind of secrets, you know,
in our defense.

But you can use a push button
technology, which is available today. When you
fall on the golf course and you say I can't get
up, they send you somebody to pick you up. That
same technology can be used in what you're trying
to monitor. And I'll ask the Congressman to
support you. Tell him my number, the Marine
asked for it. Thank you, sir.

(Laughter.)

DR. SCOTT: I'll remember that.

COMMISSIONER BEEMAN: Dr. Scott and

Dr. Paykel, just a comment.

CHAIR LEINENKUGEL: We'll end with

your question and comment.

COMMISSIONER BEEMAN: Thank you for
your enthusiasm and what you're doing. Here's a concern that I have. When I was at -- I commanded the NICoE, the National Intrepid Center of Excellence, in Bethesda. And I never met a warrior that came to us that said give me more medicine, you know.

And in fact, they went from being depressed when they got there to being depressed because of their medicine. And so most of the liberation came from, thank god, you know, I'm leaving now, because the complementary medicine that you were doing and the integrative medicine was getting me off a lot of the medication.

In a country that's so devoted to its allopathic sort of roots, we need to somehow demonstrate that we can relieve the pharmacology and take some of it out of the system and replace it with these programmatic sort of lifestyle changes.

And my fear is that if we can't get the data that supports it, that the patients are better off because they've gone through this
program, which just sounds amazing, inertia will
take over and we'll go back to just -- because
there's so many, only so many resources. And
this is pretty resource-intensive.

DR. PAYKEL: That's right.

COMMISSIONER BEEMAN: Pharmacy is less
resource-intensive. It's just more expensive I
think in the long term. We have to somehow get
that balance, I think. And so I just want to
really encourage you.

But also I think your idea of having
a research institute capability that really looks
at this and says, you know, the tradeoff is this.
We just spent $20 billion on pharmacy. This is
going to cost us $10 billion, but we're going to
get, relieve another $10 billion worth of
pharmacy. Unless we can show that, I think we
might slip into or back to where we're at.

DR. PAYKEL: I agree that we need
money, dollars in that effort as far as the
research is concerned.

I can tell you that I've been immersed
in THRIVE for three and a half years. And with that, we did a small cohort of patients, did a retrospective review on their charts and looked at the traditional healthcare resource utilization, and it reduced 50 percent.

COMMISSIONER BEEMAN: That's huge.

DR. PAYKEL: So that -- it is huge, exactly right. So we need to quantify this, and we need to continue to quantify it. But we need the support in order to do that. Thank you.

CHAIR LEINENKUGEL: No, thank you both, Dr. Scott and Dr. Paykel. And it's great to see what has taken place, what is continuing to go on here in Tampa, what needs to go probably nationwide within the VA.

And I'm pretty sure that the Commissioners in charge of 3 and 5 are going to be contacting you. And I think that Doctor -- our director, Battle, would be comfortable with that as long as both of you are, because what you're doing is extremely important and a big part of what the COVER Commission is supposed to
deliver on.

So, again, thank you for your enthusiasm, your dedication, and your commitment to veterans.

DR. PAYKEL: Thank you.

DR. SCOTT: Thank you.

(Applause.)

CHAIR LEINENKUGEL: We will now take a ten-minute stand up, stretch out break maybe led by Alison again for deep breathing exercises, a little bio. So, Alison, do you have any DFO --

MS. WHITEHEAD: Just be back here in ten minutes, at about ten after, we'll resume.

(Whereupon, the above-entitled matter went off the record at 11:00 a.m. and resumed at 11:12 a.m.)

CHAIR LEINENKUGEL: All right. I'll formally bring the COVER Commission back into active open session.

So at this time, Alison, if you'd please introduce these three fine doctors.
MS. WHITEHEAD: Great. Sure. So we will resume our open session with pain management services. So we have Drs. Murphy, Drake and Angeli here to present. So thank you.

DR. MURPHY: Okay. So I am Dr. Murphy. This is Dr. Drake; this is Dr. Angeli. And we are really appreciative today to be here to be able to talk about the pain management services at James A. Haley Hospital, specifically because we really feel like there's great import in terms of the intersection of pain with mental health issues as well as so many other medical comorbidities. And so we're very, very grateful to have the opportunity.

And I'll also just say, kind of the best part of this, some of the other things that have come up. I know I speak for all of us to say it's really a privilege for us to be able to work in the VA and to be able to spend our professional time giving back to the veterans of this country. And so we just wanted to say thank you as well for all of your kind of collective
service. We really appreciate it.

So next slide? So I'm just going to start with sort of an overview and first talk about why are we talking about pain at all in this context? It's a little bit of a divergence from what we've started with here today. That's been a little bit more strictly mental health as well as CIH and supportive mental health. And this is just some of the more overall -- the data that we have around chronic pain and its relationship to the other chronic conditions that we see that are so prevalent across the VA health care system.

What we know is that chronic pain is more common in veterans than in non-veterans and it is not only more common, but also more severe in intensity and it is seen in the context of numerous comorbidities, particularly psychiatric comorbidities. So some data that we have from 2008 to 2015 shows us that while some of those medical comorbidities have remained fairly stable, we've actually seen an increase in the
psychiatric comorbidities that accompany chronic pain. So it really is timely and important to think about how we address all of these issues together.

Some of the other things that of course have already come up today but just to tie it into pain a little specifically is we saw in a behavioral health autopsy report that the VA does in looking at suicides back in 2015 that the most frequently identified risk factor among veterans who died via suicide was pain. So just it's difficult to overstate the importance of asking about pain, evaluating it and treating it in the context of a whole person.

And this morning there's already been a number of things that have come up about integration and I think that we have this kind of intellectual separation of mind and body that doesn't exist. So we're always working with a whole person sitting in front of us and every piece is inextricably tied together. And so that's sort of where we're always coming from
with our pain management services in the VA and
certainly here at this facility specifically.

Next slide? So again in the VA
overall there was officially a Stepped Care model
for pain management that was established back in
2009 in a VA Directive, and that's this sort of
visual aid on the right-hand side of this slide
where we start off with self-management and kind
of core foundational educational services around
effective pain management and then what optimal
pain management looks like across the continuum.

Here at James A. Haley we're sort of
drilling it down to our local services. We
started with primary care. We talked a lot about
our primary care mental health integration, being
available at the most basic primary care level
where in fact most people are treated who have
pain in primary care. And those mental health
specialists are able to really do a lot of the
health, psychology, lifestyle management kinds of
things that they do for a lot of chronic pain
conditions.
We also have some other outstanding resources in primary care. We have an embedded ambulatory pain clinic. So we have expertise in primary care so that those physicians can consult with somebody to get input on treatment planning, specifically medication management decisions, things along that line. We also have a pain workshop which is a multi-disciplinary, multi-week workshop that really addresses all of the different biopsychosocial aspects of pain, the biomedical, all of the psychosocial issues that surround it as well as environment and how different approaches could be helpful.

As we kind of move up the ladder we move into our specialty pain care services, and that -- one of the critical pieces of that is our outpatient pain medicine clinic. We have a variety of services. These are individuals who are really physicians who are boarded in pain medicine. This is their expertise. They're able to provide higher level really expertise on medical management, interventions and procedures.
We also have the chiropractors that were mentioned previously. They're embedded in our pain clinic which is really great. We made that transition when we moved into the building that we're in now, and I think that's really improved the kind of seamless care between chiropractics and our pain services that sort of used to be collocated, which is great.

And then another part of that, the collocation of that in the medical clinic is we also have a group of pain psychologists who are also embedded in that clinic. And so those pain psychologists are able to do the work where -- not only of addressing the psychosocial needs that are related with pain, but also to support the physicians when there is an emergent issue, an issue around suicidal ideation, other things that come up to be able to just go directly to someone's door and get that support for the veteran at the moment it occurs versus there being any delay in that process, which is really wonderful.
Other things we do at the secondary specialty level from a mental health perspective, we have a large pain psychology service here. We're incredibly fortunate to have the largest one in the VA system, and so we're able to offer all of the evidence-based psychological therapies for chronic pain. Those are cognitive behavioral therapy, acceptance and commitment therapy, and mindfulness-based stress reduction. Biofeedback also has a firm evidence base specifically to support headache management, which we offer for that here as well by one of the psychologists in our section.

In addition we have an Integrated Pain Management Team who reviews our high-risk veterans. This includes someone from our Substance Use Disorder Team as well as medical and behavioral, so everyone's in a room together reviewing these individuals who are at highest risk for adverse events including suicide so that we can really take a closer look at those and make appropriate recommendations.
Dr. Scott of course already talked about the wonderful PM&R therapies that are also important when it comes to pain. We have the physical side, and so we need physical therapy, occupational therapy, all of the things that fall under the purview of PM&R.

And then we're going to talk a little bit more about our inpatient and outpatient interdisciplinary rehabilitation options. A couple that we have here: our Chronic Pain Program as well as our Chronic Headache Management Program. That's also the only one in the VA where it offers an interdisciplinary approach to headache management. It can be a particularly challenging pain issue to address and so we're very pleased to have that program growing and developing as well.

Next slide? So in addition to that because we're talking about evidence-based psychotherapies for mental health, cognitive behavioral therapy for chronic pain is one of the VA's evidence-based psychotherapies that's been
rolled out as part of the EBP initiative in VA. And that started back in 2012. I've been a part of that program since its initiation and the lead author for the manual for that treatment as well as the national VA trainer for that.

We have been able to be very effective across this system since we've been doing that, have trained over 500 clinicians in how to use these interventions to help people with chronic pain live their best life, respond to the pain in a more effective way so that there's less detrimental impacts with pain on their lives.

We have a wonderful cohort of people at this VA specifically who also serve as our regional trainers. Dr. Angeli is one of them. We have multiple consultants here that support the program nationally, but again also help us locally here. And CBT for chronic pain, which is the -- a first-line treatment for chronic pain according to the Clinical Practice Guidelines from VA, DoD, from the CDC, basically all of the official recommendations for clinical practice
for pain treatment is to use CBT for chronic pain as a first-line treatment and to offer it to everybody who has pain.

And thankfully we're actually able to do that here because we have the capacity to do it. We offer it individually and in groups as well as in Spanish, which is wonderful. We have one of our staff members who's translated the manual and does a CBT group in Spanish as well.

Next slide? So one thing we also really wanted to highlight here is the Interdisciplinary Pain Program we have here in Tampa. We're really the flagship for the development and maintenance of these types of programs across the VA. Back in 2008 there were two of these programs in the VA. And so I'm specifically referring to CARF, or Commission on Accreditation of Rehabilitation Facilities, CARF-accredited pain rehab programs in the VA. Today there are 20. We have really led the way in helping other VAs to develop these types of programs.
So we hosted over 30 teams from across the VA in trying to demonstrate, train, work with them to tailor what are their resources, how could they have an Interdisciplinary Pain Program at their own VA. We have both an inpatient and outpatient CARF-accredited program. Our inpatient program is the only one in the VA system, so we -- and it was established in 1988, so this is our 30-year anniversary this year. So we've actually been doing this for a very long time.

And we accepted missions from across the country. The majority of those are long-distance admissions. So they are from outside of our catchment area, although we're very happy to be able to offer services to our local veterans as well.

Systematically, since this program started everybody who comes into the program is tapered off of opioid medications during their three-week admission. We have a lot of outcomes that we would be more than happy to share with
you. We collect patient outcomes on everybody who comes into the program.

I did a large-scale study and looked at these outcomes a couple of years ago comparing the pain rehabilitation outcomes for 700 consecutive admissions, comparing those who had tapered from opioids during the program, for those who came in not on opioids and went through -- they go through the same pain rehab program. And what we saw was that not only did everybody improve across domains, but those who were tapered from opioids actually improved even more. And so we see across all pain-related functional outcomes, including pain intensity, that there are positive outcomes across domains.

Okay. Next slide? And this is just a really I think nice example of -- so we are so glad to be of the whole health flagship and have this come on board here. It fits incredibly well with the Chronic Pain Rehabilitation Program because we've always taken a -- very much a whole person approach to pain care because that's the
way that you achieve optimal outcomes. If you are only addressing the biomedical aspects, it's an incredibly important piece, but it's one tire, and so you're not going to get things off the ground if you don't address the rest of what's happening with the individual.

And so this is that whole health wheel, but this is literally just for our Pain Program and everything that we're doing within the context of that program. So as you can see, it not only covers our evidence-based psychotherapy options, but also many of our PM&R options, as well as everybody who participates in these programs does yoga and tai chi and mindfulness and classes with the chaplain and sort of covers again start to finish everything that goes on for a human being who's living with a chronic condition like pain that impacts so many different things.

So we are happy to answer any questions about any of these services. Dr. Angeli is the director of our Inpatient Program.
Dr. Drake is the chair of our Pain Facility Council and one of our pain boarded physicians. And we're happy to answer any questions that you might have about our pain services.

CHAIR LEINENKUGEL: Dr. Murphy, thank you very much. Very extensive and we're going to have questions.

So, Tom, why don't you lead it off?

COMMISSIONER BEEMAN: Well, first of all, I think the director should be very proud of this, all of the teams that have presented today, and you should be issued seat belts because everybody's so excited they're jumping in.

(Laughter.)

COMMISSIONER BEEMAN: -- which is really a tribute to the leadership.

And, Dr. Drake, I assume -- are you an anesthesiologist? Is that what you said?

DR. DRAKE: That is my primary specialty.

COMMISSIONER BEEMAN: I guess a question that I have is why do veterans have more
paine? What, is it that they have physical
injuries or is it their moral injuries create
psychological issues that exacerbate pain? You
said it with such authority. I was just curious
because if we look at this what's creating that
in our population that we're trying to serve?

DR. MURPHY: I think there's a few
important factors: One is just their military
service. So obviously it's a very physical
service that you undertake when you go into that.
And so we certainly have veterans who have
sustained injuries, multiple jumps over time.
Their bodies have essentially been under more
duress and wear and tear than your average
person.

I also think, at least in the VA
system, we do see maybe versus the population in
general, more individuals who also in their --
outside of their military service work in jobs
where there's construction or police officers or
firemen, people that are in jobs in the private
sector that also -- they're not necessarily
sitting behind a desk for a lot of their day. So again, they're kind of -- have more wear and tear to their bodies.

And I think your other point is also really important that we also may see a population that has more vulnerabilities when it comes to the psychological pieces and the physical pieces coming together. We know that trauma is something that is related. There's a correlation between a trauma history and the development of chronic pain. So again, we sort of have a group of things that puts our population at a greater risk for the development of pain problems.

COMMISSIONER BEEMAN: You did a wonderful job in describing how you're addressing pain. Are there things that the Commission should know or that you would like us to know so that if we're looking at our final report we can say in the area of pain we need to address A, B, C?

DR. MURPHY: That's a big question.
And as it sounds like, is evident, I'm very passionate about this work. I think we -- a lot of what's happening, which is really wonderful, right now in the private sector as well as in the VA, who really is leading the charge, is that we do need this cultural transformation where we are talking about a biopsychosocial approach to pain.

So I think that, at least for me, a couple of the most important things are, one, intervening from a biopsychosocial perspective as early as possible. So not waiting until somebody has had pain for 10 years before we mention this concept that all of these pieces are related and important to the pain process and to chronicity. I would say one thing for the future would be if we can focus on, which goes so well with everything that we're talking about here -- but wellness and prevention. How can we stem the chronification?

There's a lot of people that we see in our programs who will say; I know everyone who works in the programs has heard this so many
times, why didn't somebody tell me this 15 years ago? Why didn't somebody talk to me about this a long time ago? And it's -- all you can do is sort of say I'm sorry, but there's a lot of initiatives that I think need to happen around the kind of education that we provide, both in our medical schools, but also there's a shortage of training in the mental health field around what kinds of interventions can lead you as mental health clinicians to help people who have pain.

One, we have to ask about it, but when you're trained, you're less fearful about what to do. You know how you can help someone. So I think that the education is really the beginning of that cultural transformation and getting in there as early as possible is something that we really need to do to help with pain care.

I also would say that certainly something that's a pressing obvious need now is better understanding and treating the intersection of pain and opioid use disorder. So
understanding that population better and what
their needs are so that we can treat them most
effectively would be another area that I would
focus on.

COMMISSIONER ROSE: If I may, just to
follow up on the opioid part, and the program you
have here sounds like it's been very successful,
what is your rate of relapses as the folks go
through this program?

DR. MURPHY: So it's a good question.
Our data, kind of long-term data shows us that
about -- at follow-up say one month, three
months, six months out, we had about 15 percent
return to opioid use.

COMMISSIONER ROSE: Fifteen percent?

DR. MURPHY: But 85 percent don't, at
least from the data that we're getting.

COMMISSIONER ROSE: Right, right,
right.

DR. MURPHY: So we feel like that's
pretty good --

COMMISSIONER ROSE: Yes.
DR. MURPHY: -- numbers there.

COMMISSIONER ROSE: Thank you.

COMMISSIONER POTOCZNIK: So could I have a question about -- to what extent do you guys work with addiction medicine using like buprenorphine or naltrexone or something like that, because -- yes, either during the taper or after the taper how many people stay on it? Do you use methadone at all? So anyway, that's --

DR. MURPHY: So in our chronic pain rehabilitation programs that were in inpatient programs we are focused -- really mainly we're treating individuals who do not have opioid use disorder and are safely tapered off of opioids completely, and therefore are not transitioned to a medically assisted treatment like Suboxone or something along that line.

We do have a lot of individuals on an outpatient basis that we see who do meet the criteria for opioid use disorder and therefore we work very closely with our Substance Use Disorder Team to be able to have those psychiatrists who
specialize in the treatment of OUD assist with transitioning them to a medically assisted treatment that's appropriate for more chronic management. The key is -- which is a complicated one, is figuring out again sort of the intersection of those individuals and also making sure that they get appropriate pain care.

Everybody on MAT doesn't have chronic pain of course, but a proportion of them do. And we would like to -- we feel like if we could adequately address their pain needs, we could certainly help their recovery trajectory overall. And so that's one area we certainly are seeking to improve all the time, that that is one of the goals of that Pain Management Team that's interdisciplinary, that has all of those people, representatives. How can we become more integrated so that we're better able to sort of move people on that continuum, identify people as early as possible and figure out how to optimize their treatment.

COMMISSIONER POTOCZNIAK: So to follow
up to that, because there's -- you mentioned
people with opioid use disorder would work with
your Substance Use Team, but how about the people
that -- you know, we have a lot of veterans; and
I've seen this a lot, that have been taking
opioids for 30-plus years who clearly wouldn't --
you wouldn't characterize as an opioid use
disorder because they've been following it by
prescription --

DR. MURPHY: Yes.

COMMISSIONER POTOCZNIAK: -- but they
are dependent.

DR. MURPHY: Yes.

COMMISSIONER POTOCZNIAK: How do you
handle that because their taper is going to look
different?

DR. MURPHY: Absolutely. Yes, I mean,
I think nationally -- and certainly we're very
much in line with how the VA approaches this
overall here and do a wonderful job of, one,
making it very veteran-centric.

And so, having that conversation about
what are you taking and what does your life look like? I think one of the questions that we often don't focus on enough is that it has to be about functioning, so -- we make all of these decisions independently, so if there's somebody who has been on opioids for a long time and their functioning is great and they're maintained on say a low dose of opioids, I think that a prescriber in our clinic would talk to them about their quality of life, their interest in making any maybe minor reductions in that, and possibly if there is a collaborative treatment plan established to maybe start to make some changes on that. Maybe make a minor reduction very slowly and see if their life changes at all. Does that impact their functioning? If not, maybe just return to exactly what it was before. I think the bigger question is that we certainly work with people who even themselves feel there's a bit of an over-reliance on the medication. Maybe they have been on it for decades and they would actually prefer to maybe
not be on it or be on less. And so is there a
way that we can work with them to talk about what
are some of the other treatments, pharmacological
as well as non-pharmacological, that can be
offered and maybe start to make some of those
changes and see how the person does and really
just evaluate it at every visit and see what the
best plan of care for them is.

CHAIR LEINENKUGEL: Dr. Murphy, who
started the Cognitive Behavior Therapy Program?

DR. MURPHY: So that is part of that
evidence-based psychotherapy initiative out of
the Mental Health Office in VA Central Office.
So back in -- so it's their program. Back in
2012 they got a small group of us together as
subject matter experts and we did a fairly
exhaustive review of the literature of
psychological interventions that can be provided
for chronic pain to decide what was the most
evidence-supported approach. That was cognitive
behavioral therapy.

There are others that are supported by
evidence. It has the biggest stack because it's been around the longest. And so we basically took that evidence and chose those core components and created a protocol that really synthesized those most critical pieces. The manual was born out of that protocol and that's what we've been using since that time.

CHAIR LEINENKUGEL: So No. 1, the VA started it?

DR. MURPHY: Yes, it's one of the VA's large group of evidence-based psychotherapies.

CHAIR LEINENKUGEL: It didn't come from private sector?

DR. MURPHY: Not from the -- oh, no, not -- it's a VA manual.

CHAIR LEINENKUGEL: Answered that question.

DR. MURPHY: Yes. Yes.

CHAIR LEINENKUGEL: No. 2, what is the effectiveness of it?

DR. MURPHY: So we have a couple of studies specifically -- I will -- full
disclosure: one of them that I'm working on submitting right at this moment, that's the largest cohort that we have that looks at effectiveness of CBT for chronic pain, specifically the VA's version. So when you look at the general literature for CBT for chronic pain, there is good evidence for effectiveness with reductions in pain intensity, pain-related disability, reductions in pain catastrophizing etcetera.

The VA's protocol, we have a smaller study that we did a few years ago. It showed improved outcomes across domains again in things like -- pain-related functioning is one of the things that we always look at. Intensity, as well as pain-related catastrophizing, which is really kind of negative thinking related with pain, which is very associated with disability.

The data that we have right now is a much larger sub-set of veterans who have used CBT for chronic pain as part of our training program. So it's close to 600 veterans. And we also see
very positive effects from that. Again, similar
outcomes with reductions in pain intensity,
functional improvement. It's across domains and
they're anywhere from small to moderate effects
on each of those domains.

CHAIR LEINENKUGEL: Thank you for
that. I guess since it started in the VA, and if
my math is correct over six years ago now, how do
you feel about the transference across the
system? Where is it at right now?

DR. MURPHY: I'm really pleased with
how it's all kind of transitioned and generalized
across the system.

CHAIR LEINENKUGEL: Let me back up and
say there's 168 VA Medical Centers. How many are
practicing now?

DR. MURPHY: I can get you the exact
data because I have a very large spreadsheet with
that information, but it is almost every -- I
believe that CBT for chronic pain is available at
every main medical hospital in the VA system. I
can't say for sure like here we have it available
at our CBOCs and our outpatient centers. I can't say that there's a trained person at every single outpatient center, but at every VA Medical Center there are multiple people that have been trained in CBT for chronic pain that are able to use that.

CHAIR LEINENKUGEL: I would hope so, because Admiral Beeman as a Commissioner brought it up right away to you that veterans have a significant higher --

DR. MURPHY: Yes.

CHAIR LEINENKUGEL: -- number inflicted with chronic pain. So if we started this in 2012 and this is one of the a-ha moments that I associate at least; and I don't have enough evidence, that pain definitely has an impact on a person's mental health and well-

So that being said, I would hope that this would be a best practice spread across all the VAs and we'd need to clarify that.

COMMISSIONER BEEMAN: Jake, for the
record though, the VA didn't invent CBT. They
invented their own program, but it was invented I
think by Aaron Beck, right, years and years ago.
He's like a 90 --

CHAIR LEINENKUGEL: Thanks for
clarifying that.

COMMISSIONER BEEMAN: I just wanted to
make sure.

CHAIR LEINENKUGEL: No, I thought it
was started from the VA the way it was described
to me.

COMMISSIONER BEEMAN: Yes. No, no.
It was started by Aaron Beck. He created the
field probably 40 years ago or something like
that.

DR. MURPHY: So cognitive behavioral
therapy is something that initially was really
applied to traditional mental health conditions
such as depression and anxiety. There's a large
amount of longstanding data to support that.
Cognitive behavioral therapy has also been
applied for the treatment of chronic pain very
much again on a longstanding basis outside of the
VA.

When the VA puts together these
evidence-based psychotherapy programs they tailor
them for VA training and distribution, but
they're using evidence that comes from academic
settings and the private sector. So it's well-
supported globally in the literature. And then
we also take a look at our own personal version
as well as its application to veterans and what
it looks like for them.

CHAIR LEINENKUGEL: Thank you for
clarifying that.

DR. MURPHY: Sorry if that was
confusing.

COMMISSIONER KHAN: Dr. Murphy, do you
use acupuncture? I didn't see that on the list.

DR. MURPHY: In terms of like in our
pain programs or something?

COMMISSIONER KHAN: Sure.

DR. MURPHY: So we have a lot of
individuals who we put consults through our pain
clinics to receive acupuncture. Those services
are somewhat limited inside kind of the walls of
our VA, so we do a lot of community-based
acupuncture accessing. It isn't something that
we actually use within our pain program itself,
but we certainly utilize it a great deal in terms
of referrals to outside --

COMMISSIONER KHAN: The CHOICE
Program?

DR. MURPHY: Yes. Yes, in the
community.

COMMISSIONER KUNTZ: Dr. Murphy, I had
I guess one real specific question and then one
more kind of out there for the whole group.
The first one, is CBT for chronic pain
billable by mental health clinicians in the
community generally? So for the veterans not
working with the VA, as they go to their mental
health provider, could they be -- could they bill
for this?

DR. MURPHY: It's one of the more
complicated and problematic issues that we have
as psychologists who are focused on a chronic pain population. In the private sector things are much more restrictive around psychological services as well as the kind of interdisciplinary programs that we're able to offer here, which are really the gold standard of treatment. Those kinds of programs are very limited in the community.

There's a couple of difficulties with accessing a pain psychologist in the community. One is that whereas the VA has this training program and network where we're able to identify who has received this training, in the private sector it's much more difficult. There is not a boarding say in pain psychology. There's not an easy way to Google yourself to a psychologist who has training in chronic pain services. So that piece makes it complicated and there are definitely restrictive billing practices.

Because I am mainly focusing on the VA, I don't know as much about reimbursement, but I'm very active in professional societies and I
know that's one of the limitations of one of the things that is brought up on a regular basis that we need to have more coverage for these kinds of services, which are recommended as first-line treatments, and then we can't get them covered by the payers. And that's a huge obstacle to being able to utilize something that's a first-line treatment if insurance won't pay for it.

CHAIR LEINENKUGEL: So is that a nice way for you to ask the Commission for help?

(Laughter.)

DR. MURPHY: If I was able to play any small part in moving the ball forward towards getting psychological services for chronic pain better covered and accessible to individuals across the country, it would be an amazing accomplishment, honestly, because that is one of the biggest shortcomings that we have is that when we talk about the services that had the best evidence CBT for chronic pain and interdisciplinary pain programs have the strongest evidence and it is incredibly difficult
in the private sector to access them or to even
get these programs built.

    I mean, we were able to be this
beautiful model system here in the VA because we
have -- because we're fortunate enough to be able
to do the work. In the private sectors there's a
handful of them; that's it, in the whole -- in
the country. It's a small network and so we know
each other well and there's not much opportunity
for these kinds of pain programs that are so
incredibly effective or the ancillary
psychological services as well.

    CHAIR LEINENKUGEL: I see.

    COMMISSIONER KUNTZ: And that was what
I was -- I just had a second question. Can you
talk about the relationship between physical pain
and psychological pain, and what the roots are
there or --

    DR. MURPHY: Again, I just -- to me
there's -- when it comes to the experience of
chronic pain, even as the International
Association for the Study of Pain, which is kind
of the big pain academic body -- their definition of pain is that it's a sensory and emotional experience. So as far as I think how we conceptualize pain is it's not a physical experience. It's the way that it's processed is our brain. And it's an emotional process as well as a physical process.

I think the individual differences among everybody in the population, how it impacts their lives, how they respond to pain, the support system that they have or don't have, this is where a lot of our services come into play because it's -- a lot of it is about how do you respond to the pain? What do you do with it? That has so much of an impact on what we see in terms of the outcomes. How does pain actually impact your life.

I don't know if that's a great answer to your question, but --

COMMISSIONER KUNTZ: Thank you.

COMMISSIONER POTOCZNIAK: And just a point of clarification for Jake and for Matt.
When you're talking about billing for these services, we also have to keep in mind that most facilities in the VA are paying Medicare rates to high-performing professionals in the community and they pay late. So you can't really think about expanding into the private sector at all until you fix that problem because a pain psychologist in Tampa, Florida is not going to accept Medicare rates. So even if you get the agreements, they're not going to accept Medicare rates and the fact that they're going to have to wait six months to get paid.

CHAIR LEINENKUGEL: Yes, we're going to find out shortly, Commissioner Potoczniak, if the MISSION Act is going to resolve that issue.

COMMISSIONER HARVEY: May I ask a quick question? The cover article in the DAV magazine this month, which I just happened to read yesterday, talks about medical marijuana in the treatment of pain. And as marijuana is being accepted in medical terms but also recreationally in several states, obviously things are moving
rapidly in that area. Do you do anything with regard to medical marijuana?

DR. MURPHY: I mean, in terms of do anything, I think that the way that we approach medical marijuana is to -- kind of the way that we would do our normal clinical whole-person assessment. So we evaluate for -- is the person using tobacco? Are they using alcohol? Are they using medical marijuana? Are they using other substances? Kind of how are they using them? What are they using them for? What's the impact on their life? What's their functioning? And we just take that as another component of their clinical picture.

Obviously the VA isn't involved directly at this point in time, as you know, with anything related to medical marijuana, but it's certainly increasingly a part of our clinical care and it's something that we're aware of that's a part of what people present with. And so I think for most of us we're -- it's another piece of data that we use in terms of the
person's -- potentially their management of their
disease.

    The one thing I would say just in
terms of again our overall approach, we really
try to encourage as much as possible really
active management of chronic pain. So doing
things like a lot of our movement-based
activities, things that you can impact how you
respond to pain in a certain way. So we seek to
sort of increase those things that are maybe more
actively a part of managing pain and potentially
decrease some of the things that are more passive
as far as the treatment.

    But we would just I think approach
medical marijuana in the same way as we would a
lot of other things as far as the clinical
picture in determining are there any
contraindications with certain medical
prescribing, again in the same way as we might
for alcohol or something else. Does this change
what your medication treatment plan looks like?
And it may.
COMMISSIONER HARVEY: Well, and one of the implications of the article is that there should be research into what does -- that there should be research that would provide evidence or to give -- you know, because medical marijuana is becoming legalized in many places, and recreational marijuana as well in many more places. So it is coming. We ought to know what the implications are when this arrives in the next what, three to five years, whatever? Probably in a relatively short time.

DR. MURPHY: Right. Yes, I mean, obviously the illicit nature of marijuana has made it more challenging to do the kind of empirical data looks that as you're saying are really in order now, and hopefully it would be fast-tracked so we can see a little bit more in terms of impacts and outcomes and things like that because the data is certainly very limited currently.

COMMISSIONER BEEMAN: Well, I guess a question aligned to that is it's not a tool in
your tool kit today because of the federal proscription, but it's starting to be in the tool kit of providers in certain communities where it's been legalized. And I think what I'm hearing you say is we need more studies because clearly if it's an important tool, which I have no alignment either way because I don't know -- but if it's an important tool and you don't have that tool, we need to do research to see if it's a tool that should be added.

DR. DRAKE: I guess I would say just real quick my opinion on it is that it would be treated like any other drug out there is that the research is needed. You don't just want to start using something if someone anecdotally says something is important. Maybe there's really bad side effects for one condition, but then it could be used for another that it would get -- have benefits. You have to know so much more before you could confidently say, yes, let's use it. But if there are benefits, it would be a big benefit to have that out there, the evidence
there to make practitioners comfortable in saying, okay, I know what I'm giving, I know what I'm treating and I know what outcomes possibly there would be.

CHAIR LEINENKUGEL: Any other questions? Any comments from the Commission at this point?

(No audible response.)

CHAIR LEINENKUGEL: Again, very professional, very dedicated, enthusiastic and just doing tremendous work. Thank you, doctor, so much for everything that you continue to do for veterans.

(Applause.)

CHAIR LEINENKUGEL: At this time I would like to formally close the COVER Commission open session on December 4th, 2018. To all participants, the general public, veterans, caregivers, clinicians, Commissioners, thank you very much.

(Whereupon, the above-entitled matter went off the record at 11:56 a.m.)
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In the matter of: Creating Options for Veterans' Expedited Recovery Commission

Before: USDVA

Date: 12-04-18

Place: Tampa, FL

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

[Signature]
Court Reporter

[Signature]
Jake Leinenkugel
Chairman, COVER Commission

[Signature]
Alison Whitehead
Alison Whitehead
Acting Designated Federal Officer
COVER Commission

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UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

CREATING OPTIONS FOR VETERANS' EXPEDITED RECOVERY (COVER) COMMISSION

OPEN SESSION

WEDNESDAY
DECEMBER 5, 2018

The Commission met in the Auditorium in the James A. Haley Veterans' Hospital, 13000 Bruce B. Downs Boulevard, Tampa, Florida, at 8:30 a.m., Jake Leinenkugel, Chair, presiding.

PRESENT

JAKE LEINENKUGEL, Chair; Senior White House Advisor, Veterans Administration

THOMAS E. BEEMAN, Ph.D., Rear Admiral, U.S. Navy (Ret.), Co-Chair; Executive in Residence, The University of Pennsylvania Health System

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

WAYNE JONAS, M.D., Executive Director, Samueli Integrative Health Programs

JAMIL S. KHAN, U.S. Marine Corps (Ret.)

SHIRA MAGUEN, Ph.D., Mental Health Director of the OEF/OIF Integrated Care Clinic, San Francisco VA Medical Center

JOHN M. ROSE, Captain, U.S. Navy (Ret.), Board Member, National Alliance on Mental Illness
MATTHEW KUNTZ, U.S. Army (Ret.), Executive Director for the Montana National Alliance on Mental Illness (NAMI)

TOM HARVEY, U.S. Army (Ret.), Board Member, Milbank Memorial Fund

MICHAEL POTOCZNIK, Ph.D., Captain, U.S. Army Reserve, Team Lead for Addiction Recovery Treatment Services, Martinez, California

STAFF PRESENT

CASIN SPERO, Chief Advisor

SHANNON BEATTIE, MPH, Senior Project Analyst, Sigma Health Consulting, LLC

YESSENIA CASTILLO, Senior Consultant, Sigma Health Consulting, LLC

KRISTIANN DICKSON, VA Support Team Project Manager; Alternate DFO

BETH ENGILES, Senior Manager, Sigma Health Consulting, LLC

LAURA ANN McMAHON, Contracting Officer Representative; Alternate DFO

STACEY POLLACK, Ph.D., Alternate DFO

ALISON WHITEHEAD, Designated Federal Officer

JOHN KLOCEK, Alternate DFO

KENDRA WEAVER, Alternate DFO

NADINE "DEDEE" LIM, MPH, Senior Consultant, Sigma Health Consulting
ALSO PRESENT

COLLEEN JAKEY, MD, Chief of Staff
HERMAN JOSEPH BOHN, Jr., Ph.D., MBA, USF
GLENN CURRIER, MD, MPH, Chair, College of Medicine, Psychiatry and Behavioral Neurosciences, USF
MARK FETTERMAN, Mission United
MANUEL GUEVARA-RUIZ, 211
STEPHANIE KRAGER, Hillsborough County Sheriff's Office
BETH PECORI, NAMI, Central Florida Behavioral Health
EDWIN ORTIZ, Manager, Hillsborough County Veterans Services and Veterans Memorial Park
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8:31 a.m.

MS. WHITEHEAD: All right, good morning, everyone. Everybody, please take your seats, thank you.

Good morning, my name is Alison Whitehead. I'm the Designated Federal Officer for this meeting on December 5th, the second day of the meeting of the COVER. This is the fourth gathering of the Creating Options for Veterans Expedited Recovery Commission, or COVER Commission.

And portions are open to the public.

The COVER Commission was established under Priority Section 931 of the Comprehensive Addiction and Recovery Act of current legislation of 2016, Public Law 114-198.

Public Notice of this meeting was given in the Federal Register on November 26, 2018.

Please note if you didn't already, that there are sign in sheets for members of the
audience attending in person.

    We do ask that all folks who are
dialing in onto the phone to give us your
attendance by email to the COVER Commission email
box which is covercommission@va.gov.

    This meeting will be chaired by Mr.
Thomas Jake Leinenkugel. We ask that you be
courteous and respectful during the meeting.
Videotaping and taking of photos is discouraged
and is disrupted and distracting to the
Commission members and staff and the audience
members.

    Questions and comments from the public
may be submitted using the covercommission@va.gov
email address. There will be no open question
and answer sessions during this open session.

    A transcript of the meeting is being
taken, so anything said during the meeting or
submitted in writing before, during or after the
meeting will be available to the public.

    This meeting is officially on the
record.
So, in closing, to summarize, public notice for this meeting was published in the Federal Register, a DFO is present, a quorum of our Commissioners is here in person.

An approved agenda for this meeting has been established. Anything said during this meeting is on the record.

So, before we officially open, does anybody have any questions of any of the statements I just made?

(No response.)

MS. WHITEHEAD: All right, the meeting statements are now concluded and I'll now invite the COVER Chair Mr. Leinenkugel to begin the meeting.

CHAIR LEINENKUGEL: Thank you, Alison and good morning, everybody and welcome.

I officially announce that the COVER Commission meeting on December 5, 2018 is now formally in open session.

And, I would also like to take this opportunity and time since this is a national day
of mourning as we have lost our 41st President, George Herbert Walker Bush, a World War II Veteran and a great American. We'll take a moment of silence, center yourselves, please.

(Moment of silence.)

CHAIR LEINENKUGEL: We certainly all thank him and his family for his service over a long period of time for our country.

At this time, I would like to call on Commissioner Jamil Khan to lead us in the Pledge of Allegiance.

(Pledge of Allegiance.)

CHAIR LEINENKUGEL: Thank you, Jamil, and participants and Alison.

MS. WHITEHEAD: So, I think everyone can see a great panelist here. We are going to introduce Dr. Colleen Jakey to come up here.

DR. JAKEY: Thank you. Good morning, everyone. Again, I'd like to thank the Commission for this opportunity for us to be able to present to you this morning.

We're going to be introducing some of
our key community partners that we are very fortunate to have. As you've heard, the very Veteran-centric community, and in that, we have wonderful partners that are really integral in the care that we provide.

So, I am going to be introducing them and then asking them to share some with you and then, obviously, there will be plenty of time, and really the majority is really for questions that you might have for them.

If you wouldn't mind, I did want to take one liberty at the beginning. And, I did want to acknowledge, after discussions yesterday, our leadership within our programs and why I feel very fortunate to work here as Chief of Staff, and why I feel very strongly about the success of our programs.

So, first, you met Dr. Paykel yesterday from Whole Health. You know, this is a brand new service. I've never anyone where you start a new service. And, so she's started from the ground up.
We had complimentary integrative health measures, different techniques, but we did not have a service for whole health. So, she developed the structure, the clinics, the providers, new initiatives.

I mean, she's taken some of the national ideas and developed our own local -- we're going to have inpatient whole health nurses and coaches.

And so, I did want to acknowledge that that is a huge task to take on.

There was discussions yesterday as whole health, its own service, is it a separate service? Does it wrap in rec therapy?

The way we envision it is, we have mental health. We have primary care. We have surgery. And, whole health will be a service that will overarch over all of those. So, it really is the true integrated medicine approach.

But, most importantly, I think having it as its own service and having a dedicated service sheet is what really will lead to the
success and the sustainment.

Because, we were talking yesterday about the sustainment and the ability to keep these measures, these initiatives, these programs going on.

And so, having one person who is responsible for making sure of the success of that, but also the cultural transformation of our institutions. So, I feel very strongly that having its own service with its own leader is really what will help to integrate whole health, NCIH and everything we do.

I'd be remiss if I didn't mention Dr. Scott. Clearly, he's an innovator in interdisciplinary care and our physical medics and in rehab. And, is known nationally for that.

He developed some of our earliest implementation of CIH, but also, he's really a thought leader that makes all of us re-examine how we provide healthcare.

And, finally, mental health, there was a discussion yesterday about mental health and
how we are able to not have difficulty in hiring
and maintaining psychiatrists. That really is
all about our mental health leadership.

The ability for Dr. Catalano and Dr.
Gironda to recruit and recruit wonderful people.
And then, once they recruit them, then those
wonderful people are happy and then we recruit
more.

And so, I think that leadership and
recruitment really is the key.

The second part of that is they are
both imbedded in education. And so, we have a
very large psychology training program with 8
interns, 13 post-docs and then I think 12
graduate students.

We are an integral part of the
psychiatry residency at USF and we are actually
the primary teaching site where that's in Tampa,
most -- Tampa General is usually the primary
teaching site. So, for psychiatry, we are.

And so, that educational mission, one,
allows us to meet these people and recruit them
and train them.

It also elevates the level of care we're able to provide.

But, in addition, it allows us to develop the sub-specialties that we need to address these specific populations.

And so, you know, we work on having post-docs in these areas, so trauma and neuropsych, obviously, we have our pain program, substance abuse, we have Suboxone providers.

And so, I think it's the ability to train these sub-specialties and work with them that allows us to provide that level of care.

But, I really do have to say it's the style of leadership from Dr. Catalano that is what has allowed all of this.

You have met with numerous of our leaders under mental health in your small groups. And, as you see, he recruits them, empowers them and then they are engaged and they develop their own programs and grow them.

And so, allowing the leaders under
him, you know, to flourish and develop and think
out of the box really is what has led to the
success of many of these programs.

So, I just wanted to acknowledge that.

Thank you.

All right, so now, our community
partners, thank you all for coming. Again, we
really value our community partners and feel that
they are integral. We -- I will talk a little
about our mental health summit.

But, again, we see it as very much a
two-way street. We are only able to do what we
can do with the help of our community partners.
It really does take a village, we talk about that
all the time.

And, really, two sides. We rely on
them to help us identify and find Veterans that
are not seeking care in the VA, but we also rely
on them to be able to provide comprehensive care
to all of our patients. Because, you know, we
can't do every part of it and so, we rely on
them.
We have some representatives today from our different groups that we work with. One, we have numerous outreach events you've heard, our mental health summit we have in every county, every year. We develop relationships, we work, on education and talk about military culture in those.

And also, brainstorm on ways to coordinate care. So, when Veterans are in and out of the VA system, how do we share all that information back and forth and make sure we are all up to date?

Suicide prevention has numerous outreaches per month on awareness and our resources that we have available.

PTSD clinical team works with local universities, faith-based and does training also of local law enforcement.

As far as our -- some of our broader partners, Veterans Treatment Court, I don't know if you've heard about that and our role with them, but we work with them to provide training,
but also to be a contact so that when -- and, obviously, we host the Veterans Treatment Court in our facilities.

But so that when there is someone who needs to be transitioned into mental health care from the Treatment Court, we facilitate that.

Mission United, as we'll introduce, is really a community of Veterans engagement group that's doing wonderful work in our community and we'll talk a little bit about the crisis center.

So, now, I'd like to introduce each of our panel members just briefly. After I introduce all of them, I've asked them to sort of give us just a brief description of their relationship and role with Veterans in our community and then, obviously, I know that you'll have questions for them.

So, all right, I'm going to start at this end with Manny. So, Manny Guevara-Ruiz is a former Army member. He served in the Army from 1993 until 2006.

He actually served in combat under the
command of the 25th Infantry Division, Tropic Lightning.

He served our community and our Veterans since 2014 in several capacities, including as a case manager, a navigation specialist for support services for Veterans and families program.

He also served our community's homeless Veteran population as the program manager for Circle of Veterans and Families Development of Homeless Shelter initiative and became a part of the inaugural team of the Veteran Peers of the Crisis Tampa Center, the Crisis Center of Tampa Bay and that's really what he's here to speak to today. But, he can give you insight on the community overall.

He served initially as an intervention specialist for this Florida Veterans Support Line and now serves as the program manager.

With that, Manny, welcome.

Next is Beth Pecori. So, Beth is with NAMI Hillsborough and Central Florida Behavioral
Health Network.

She has a BS in elementary education as well as advertising and is certified as a family peer specialist in the State of Florida.

She co-authored her first article, Parents as Colleagues within Local Mental Health System, in Child and Family Journal.

She currently works for the Central Florida Behavioral Health Network as a consumer and family affairs liaison.

Before joining Central Florida, she worked for Success for Kids and Families where she assisted in the development and implementation of Florida's first consumer directed care initiative for children and has worked as a child and family advocate and disability rights Florida.

We work very closely with Central Florida Behavioral Network and they actually hosted our last Hillsborough County mental health summit.

All right, Mr. Ortiz, Edwin Ortiz is
currently the manager of Hillsborough County Veterans Services and Veterans Memorial Park and Leroy Collins, Jr. Veterans Museum.

Mr. Ortiz served as a Major in the U.S. Army for 20 years. He then transitioned to a successful civilian career and began his work assisting the military community as a claims examiner in the Florida Department of Veteran Affairs.

For more than 12 years, Mr. Ortiz has been an advocate for Veterans and answered questions and inquiries from the Governor's Office as well as trained other VSOs in the unique language of benefits and procedures for VA in order to assist with access to care for all those who served.

All right, immediately to my right is Deputy Stephanie Krager with the Hillsborough County Sheriff's Office.

She started with the Clearwater Police Department and then joined as a Deputy with Hillsborough County Sheriff's Office in 1995.
She currently serves as the Crisis Intervention Team Coordinator as well as the Homeless Initiative Coordinator. She helped to actually develop the Crisis Intervention Team in 2004 after she recognized the need for law enforcement training on mental health issues and its importance to the community.

In 2013, she joined the District 3 Homeless Initiative Team and has placed hundreds of chronically homeless individuals into permanent supportive housing and/or reunited them with their families.

Deputy Krager has been honored with over 40 awards and commendations for her work with the homeless population as well as those suffering from mental illness, including recognition from Former President Barack Obama and Congressman Bilirakis who named her the 12th Congressional District First Responder of the Year.

All right, to my left is Dr. Joe Bohn.
Dr. Bohn is an Assistant Professor and Director for Community Engagement for the USF College of Public Health.

Dr. Bohn is a Professor as well as a mentor to students in Doctoral, Masters and undergraduate public health programs focusing on community health intervention planning and systems thinking.

His professional experience is related to six years of civil service with the U.S. Navy in areas of congressional affairs and scenario planning and five years with the Department of Defense in the area of business development.

To his left is Dr. Glenn Currier who is currently the Department Chair for Psychiatry and Professor with the USF Morsani College of Medicine.

Obviously, as I've said, we work very closely with them with our training program and being the primary site.

Prior to USF, Dr. Currier was a research professor at the VISN 2 Center of
Excellence for Suicide Prevention, a candidate of VA Medical Center New York, and he is a health services researcher and expert in emergency care for mentally ill in acute medical settings.

And, last but not least, is Mark Fetterman who is currently the project coordinator and program manager for Mission United. And, he'll speak to you about Mission United way more eloquently than I can.

But, he attended the U.S. Merchant Marine Academy in New York. And, after graduating from Kings Point was commissioned as an Officer in the U.S. Navy.

Mr. Fetterman served as an engineering officer with the Pacific Fleet and the Navy's Far East Command and also served in a joint role supporting Operation Enduring Freedom in Afghanistan with an Army Infantry Platoon.

He developed the Home Front Foundation, a nonprofit organization that teaches Veterans and Servicemembers how to develop their military experiences into compelling stories to
share and connect with their families and communities and then went on to become program manager for Mission United.

So, this is our group. I think, if you don't mind, I'll actually start with Manny from the Crisis Center and we'll sort of work our way down.

MR. GUEVARA-RUIZ: Good morning, all.

At the Crisis Center of Tampa Bay, we are dedicated to connectivity. We understand that, at times, reaching out straight to the VA may seem a bit far off.

So, we connect our callers to community service providers as well as the VA. The main idea is staying connected.

And, we do this through a peer-ship program. Thank you.

MS. PECORI: Good morning and thank you for having us here.

I'm with Central Florida Behavioral Health Network. We are the managing entity here in the Suncoast Region. And, what that means is,
we don't provide direct services, we get dollars from the Department of Children and Families here in Florida and then we subcontract those dollars out to 14 counties here in this region, Hillsborough County is one of them and several of the other counties that the VA serves as well.

We've partnered with the VA for many, many years, reaching out to attend their summits. And this year, having the pleasure to host the summit.

I work in the Consumer and Family Affairs Department and one of the main things that I do working with Veterans and the VA is working with Dr. Shiber and the peer support specialists that she hires. I am one of the state trainers for peer support specialists here in the state along with WRAP, Wellness Recovery Action Planning, which is an evidence-based practice as well through the Copeland Center.

And so, we provide that training to peers including the Veterans here in Hillsborough County.
Also, I work with NAMIs across our region and NAMI Hillsborough is one of -- I'm here representing as well.

Dr. Shiber and her staff have been very involved in NAMI Hillsborough. They just recently had a 5K team that competed in our NAMI walks.

They allow the signature programs that NAMI has to be hosted here so that Veterans and their families can take part in that.

As a person and a consumer of mental health services and the parent of raising a daughter with mental health services, it's also important to me to partner with the VA because my son is an Army psychologist currently stationed at Fort Carson.

So, it's a pleasure to work with the team here and any way that Central Florida can support them and any way that I can personally support them.

So, thank you for hearing from us today.
MR. ORTIZ: Good morning, COVER Commission members.

I work in Hillsborough County as a Veteran Services Manager. And, I'd like to share with you that Hillsborough County has the largest Veteran population in Florida with over 97,000 Veterans.

We have over 33,000 Veterans that we make contact with either through visits to the office or outreach that we conduct.

I would say that our relation with the VA Medical Center, and particularly, mental health services is solid.

We're very fortunate that we just established an MOU, Memorandum of Understanding, which allows us to have a VA full-time healthcare enrollment specialist at one of our main offices which allows Veterans that, upon visiting us for -- applying for VA benefits can also enroll in VA healthcare, so they two for the price of one.

So, that makes a lot of sense and it pays great dividends.
The other thing that we've established is we're fortunate from the Veterans Center, we also have once a week, a full-time mental health counselor right there on site as well. So, that's super. Not only does she see appointments, but allows for walk-ins as the need may arise.

It's important and working with Veterans that we reach out, not only to Veterans per se, but National Guard members, Reserve, active duty, Veteran service organizations, the whole spectrum because it takes a team effort to accomplish everything that we need to do.

Thank you.

DEPUTY KRAGER: Hello, Stephanie Krager from the Sheriff's Office. I'm kind of more boots on the ground. I handle six deputies that run the Homeless Initiative. And, our focus is the ones that need the most care in the community, the ones that have been on the street for 10, 20 years.

And, unfortunately, some of those are Veterans.
So, we're working with a variety of services, HUD VASH to the homeless services here at the VA along with the psychiatry department trying to get those guys help.

I don't know, you know, when you walk in this place, it terrified me. I'm like, oh my gosh, where am I going to find this place?

That's how these guys feel. I mean, when they walk in, they're just terrified of trying to find where to actually enroll. So, we actually kind of handle them into the facility so they can get the services that they need and that they worked for, that they deserve.

We also use the VA psychiatry department. They actually teach a PTSD portion of our 40-hour crisis intervention class. So, basically, it's teaching deputies how to interact with someone that's suffering from mental illness or substance abuse.

So, it's more that de-escalation, how to encounter folks, such as that.

And, we also work on several committee
Meetings together and it's helping Hillsborough to safe and sound Hillsborough, it's all focused on mental health and how to better our community and working together. Thank you.

Dr. Bohn, Jr.: Good morning, Commissioners.

I'll note a couple of points for you. My focus is on outreach with the -- in regards to the Veteran community.

A couple things of note have been with our Tampa Bay street medicine team which Dr. Currier is also been involved with and working on some of the outreach efforts.

There's a focus with the homeless Veterans that are encountered and trying to help get them in touch with the right resources here in the community.

Also, for myself, as a professor, there's been some mentoring with, you know, with some of our Veteran students that need some help in terms of leadership philosophy.

And then, also, another key initiative
has been an effort over the last year working
with faith leaders across the three county region
and Dr. Nicole Shiber here has been involved in
helping with looking at Veterans issues across
two of the counties that we've been involved
with.

DR. CURRIER: Good morning, it's a
pleasure to be here. The USF James Haley VA
relationship is very strong and we take a great
deal of pride in being one of the most Veteran-
friendly public universities in the country.

Not only do we provide most of the
trainees who eventually get hired here as
psychiatrists, but we have a lot of joint
educational efforts.

USF is also a Veterans Choice site, so
we provide direct clinical care. We take a lot
of pride in providing care to the families of
Veterans who come here for poly-trauma and other
things.

And, finally, since MacDill is in our
catchment, we do active duty as well through
TRICARE coverage.

I'm firmly committed to growing this relationship. My son is in field artillery at Fort Lewis Washington and I know what's involved here. So, you know, we want to make things better.

MR. FETTERMAN: Good morning, everyone. My name's Mark Fetterman. I think to really tell you some of what we do, I'd like to tell you a little of why. And, it starts with my story.

In 2010, I was deployed in Afghanistan and there's this one day that really sticks out in my head and it pretty much sticks out in everybody's head is the day we were going home.

So, I was standing on the flight line in Bagram and it's this hot, hot day. And my ruck sack's weighing me down and it was a great day, though, because our whole team had made it, everybody was going home.

So, we load this C-17, this orderly fashion two by two and we drop our ruck sacks
down and we fly into Kuwait and that's really
where we're going to transition and start heading
home and on our separate ways.

   And, that's where that happy feeling
kind of turned into something a little different.

   They came up to me and they said, hey,
sailor, you've got to take that uniform off. I
was going to be flying out of Kuwait
International Airport.

   So, I took the uniform off and I
bought some civilian clothes over at the
exchange. And, when I flew into the airport in
San Diego which was home at the time, that
orderly fashion from the C-17 turned into
absolute chaos for me.

   It was only about 72 hours before I
was in the mountains of Afghanistan. The next
thing I know, I found myself at the baggage
carousel and the alarm had gone off and that was
the same alarm as incoming.

   So, I pushed myself against the wall
and I backed up and I waited for this chaos to
And, finally, I grabbed that ruck sack that was weighing me down on the flight line and I went out and I got in a cab and I sat in a hotel room by myself for about three weeks. And, I think to myself, as an officer, as somebody who's somewhat educated and can start to navigate some of these systems, why is it so hard even for me?

So, this is why we think we -- Mission United is so important. We've actually asked this community, you know, what's missing? What is the gap? What do we have? What are the needs?

And, from there, we establish five areas we want to start to focus on. One, it's a transition, it's a process, not an event. Two is employment. We need to start gainfully and meaningfully employing these individuals into their next role and not viewing them as the victims, but actually as a resilient workforce, somebody who can contribute to our
economy and contribute to their communities.

It's the benefits, accessing benefits is really difficult, but these benefits are earned. The family and caregivers, our military strength starts at home. If we can't support the home, we can't go and fight where we need to go.

And then, finally, and really this one touches me really a lot is, changing the narrative. We see often a Hollywood or this pervasive theme is all heroes are all broken, neither of which is true.

We just need to be able to tell our own story. When we do that, we can start to become part of our community all over again.

So, thanks so much for taking this time to look at this new initiative and how we can partner throughout the community and with the VA. So, thanks for your time.

CHAIR LEINENKUGEL: Let me start by saying, thank you all so much, but in particular, I want to start with Dr. Jakey for your leadership and also for your fantastic, fabulous
five minute recap of what we saw, witnessed and
did yesterday with the team here in Tampa.

You pretty much encapsulated
everything that we saw and did with your fine
team here.

More importantly, thanks to the panel,
in particular, Dr. Bohn, Dr. Currier, Mark,
Manny, Deputy Krager, Beth, Edwin and the Mission
United story is something that, for 18 months I
totally agree after being in Washington, D.C.,
that story needs to be told and we fully support
everything that Mission United is doing.

So, what an excellent panel for the
Commission to interact with this morning.

And, with that, I will open it up to
the rest of the Commissioners.

(No response.)

CHAIR LEINENKUGEL: I will start,
then. I want to add how important this is. With
any time you have government involved in
something in dealing with care, and again, I'm
editorializing, this is Jake Leinenkugel as a
Commission, only my gut feeling.

If you don't connect with the
community, whether it's VA, DoD or state, it
doesn't matter what government entity it is, the
strength of how you're going to operate is how
you connect with the community.

And, here, our community leaders at
our panel today. And, probably the best group of
folks, a diverse section of Hillsborough County
is what I got from your 15 minute introductions,
who deeply care about the mission of the VA in
Tampa.

And, I'm a true believer that comes
from the leadership at the top and it goes all
the way down to the bottom.

And, I think that every Commissioner
would probably say the same thing that I'm going
to say, that this is an exemplary example of how
government should connect and operate with its
local communities.

And, again, I can't thank you all
enough for the hours, the time, the commitment
that you are giving back to Veterans on a daily
basis, whether it's mental health which this
Commission is really charged to cover to make
sure that they're getting the best care possible,
when and where needed.

And, in particular, you all do care
and so, there is something going on here that we
need to encapsulate and bring nationwide and
that's basically my editorial comments and my gut
feelings.

So, other Commissioners would like to
ask some questions. We'll start with Tom.

COMMISSIONER BEEMAN: First of all,
Dr. Jakey, thank you for aggregating this group
of professionals. It's really important and I
think that Mark said something sort of important
is, all of us that have served come out of the
community.

And, then, of course, then we come
back to the community and we set up special
programs and we set up a VA. But, at the end of
the day, we're still part of this community.
And, that you really very well articulated the need to reintegrate. You know, we dis-integrate and we become parts of other communities when we're away. And then, we come back and we have to figure out how to reintegrate.

So, I guess the question I have for all of you is that, this Commission is charged with looking at the services that the VA provides for mental health.

But, you know, this is really the first time I think we've started to talk about what are the community services that are available and how do you integrate those so that we can make sure we reintegrate our warriors into the communities that they not only get the best healthcare that we can provide in the VA, but they also live with their families out in the community?

And so, what can we do to sort of make Congress aware of the work that you're doing and the seamlessness that seems to be here in this
community so that we can really get them to think
about that as they write new legislation to
really encourage the kind of activities that
you're all engaged with that helps the VA, helps
the community meet its mission to really serve
these men and women who have left at our behest,
you know, to really to protect our nation and
then they come back, how do we -- how can we
communicate that?

So, what would you like us to take
back with us so that we can really help you be
successful in your mission?

MR. GUEVARA-RUIZ: VINC-8 had just
recently, the first of October, charged the
Crisis Center of Tampa Bay with providing care
coordination to the Veterans that reach to us via
the 211 system and it's going through the state.

So, this right here, the fact that we
have to have support from VINC-8 shows how, as
the Chairman was saying, the connection that the
federal government has with the local agencies
works.
We are, as service providers for the
community, we are eager to help the VA. Not
every agency has the financials to do so, but
having that support makes an immense change in
what we do and allows us to do such much more to
the point of we are bringing what the VA has,
locally, we are bringing it to the state through
the community service providers.

So, it's another avenue to reach out
to the Veterans, not only the VA but the
community service providers.

And, it is very important that we, as
community service providers, understand that we
need to work together and this is the way to do
it. Thank you.

DEPUTY KRAGER: Can I say something?
I think it's communication, honestly. I've been
working with the Sheriff's Office and mental
health for at least 15 years now.

And, it was very difficult to
penetrate the VA system in the very beginning.

It was a lot of knocking on doors, the VA summit,
I was the biggest screamer at that meeting, just basically saying, listen, we need to talk to somebody, we need to tell them what's wrong in this community.

Because, we were having some serious people come back damaged and it was, you know, dealing with those folks on the street, it's -- they need help, they really do.

We have a quarterly outreach the VA is very involved in. And, basically, we have over 10 VA Veterans service providers, we have not only the VA there, we have the Vet Center, we have someone that can actually do benefits right then and there.

Because, as you know, getting folks out of the woods into a community area is very difficult.

So, when we provide all those services all in one spot, it's great for those folks because they're able to go to, I'll say, Tuesday, we're having one at the American Legion. We have between 200 and 250 homeless folks that arrive at
that location.

    It's all the services are all in one spot. And I think that makes a big difference instead of coming to this big facility where it's hard to get around.

    You know, you go right there, you determine right then and there whether they can get benefits or not, what their DD-214 says, everything is right there on premise.

    So, I would say just communication and going out into the community and being part of those community resources, those fairs, so to speak.

COMMISSIONER KHAN: Deputy, are those stand downs?

DEPUTY KRAGER: We don't call them stand downs.

COMMISSIONER KHAN: But, they're just like a stand down?

DEPUTY KRAGER: Yes, yes, actually, September was supposed to be the VA stand down. They actually came and were part of ours.
COMMISSIONER KHAN: My next question, what about the physical security of the VA facility? Is that provided by the VA or is it provided by the community?

DEPUTY KRAGER: What do you mean the security? The campus?

COMMISSIONER KHAN: Yes.

DEPUTY KRAGER: Oh, it's the VA Police. I mean, we actually respond to different circumstances that happen here. We actually bring our VA patients to assist the mental health. So, we bring patients here to the ER all the time.

We actually have a contract -- the county has a contract for transfer that actually transports patients here.

COMMISSIONER KHAN: Do you have enough security available to do all the stuff required for you to do as security from the VA?

DEPUTY KRAGER: Well, I'm actually not -- I'm the government, I'm the county government.

So, we actually surround the VA. We actually don't do anything on the property unless we're
called to or if we have a Veteran that's in need of services we'll come and, like I said, go through and handle them and try to find eligibility and all the services that they need on campus.

COMMISSIONER KHAN: From the VSO, how do you reach out to those Veterans who are not enrolled in the VA system? Is there a database available to you?

DEPUTY KRAGER: Well, I've developed friendships over the years that will have the Veteran actually get on the phone with someone that has access to those services.

And, we'll have them talk face to face to see if those services can be provided to that Veteran before we even step foot here.

COMMISSIONER KHAN: No, I'm -- my question is, there are Veterans who are not in the VA system.

DEPUTY KRAGER: Absolutely.

COMMISSIONER KHAN: Who have no buddy system. How does the community -- is there a way
for community to reach out to these Veterans? Is there a database available to you to reach out to them?

MR. GUEVARA-RUIZ: We do hear that a lot. Because the Crisis Center of Tampa Bay manages the 211, and I don't know if anybody's aware what the 211 system is.

Our very first question to every caller is, are you a military Veteran? And, right there, the person discloses, yes. And, immediately, a chain reaction starts happening.

Okay, from here, that's when you go through that care coordination piece we offer to every Veteran caller a care coordination piece at our level with the goals of connection with the idea of, if you are a Veteran who for access or why never reached out to the VA, we know --

COMMISSIONER KHAN: Well, that's understood. My question is --

MR. GUEVARA-RUIZ: -- and we connect them.

COMMISSIONER KHAN: -- my question is,
not when he comes into the VA, my question is, do you have a toolkit, something available to you to know where all these Veterans are? That is not available to you?

MR. GUEVARA-RUIZ: No.

COMMISSIONER KHAN: So, my next to leadership is, that there should be an effort to go to the higher -- national level and work with the DoD to create a national data where every reference, once he's enrolled, his life history is followed, whether he's a combat Veteran or he's not a combat Veteran.

So, when Jamil joined the Marine Corps, I'm in the system. When I leave Afghanistan and I come back and I do not go to the VSO, I do not ask for any help, my question is, we promised that Veteran. So --

CHAIR LEINENKUGEL: I think, Jamil, we're getting into a larger concern here at this point as far --

COMMISSIONER KHAN: Thank you, sir.

CHAIR LEINENKUGEL: -- as our outcome.
And, I think that Mark Fetterman probably could provide something through Mission United and you live in this space as well.

So, Mark, do you have something?

MR. FETTERMAN: Yes and I appreciate the, you know, making the connection between the DoD and the VA, it may be essential at some point and we can actually do that in the interim is, what we're trying to establish is a civilian transition assistance program.

So, through the DoD right now, when a military member is going to be separating approximately about a year out, they're required to go through the transition assistance program offered on base.

But, quite often, when they do leave the base, they didn't get all their questions answered or there was just too much information at that one time.

So, what we're trying to do is supplement that with a community-based effort called a Civilian TAP Program. And, the idea
behind that is when you leave the military,
you've got too much information, you had a plan
and regardless, the plan's going to change.

We'd like you to have a place to turn
to get some of those questions answered when
you were not quite answered or asking the right
questions at that time so they can come back to
that.

Because, as it is, there's only about
17 percent of our Veteran population that
actually retire. They're the only ones typically
other than a 100 percent disabled who are allowed
to go back to the base.

Well, how do we supplement the other
83 percent? This is where we think the Civilian
TAP Program can go.

And, I think through the leadership of
this VA here, I think we're really starting to
see that it's not about who gets the credit, but
the outcome.

And, I think when the VA's actually
able to be a part of that as well, I think we're
able to go a whole lot further.

COMMISSIONER KHAN: Are you reaching out to the Vietnam Veterans?

MR. FETTERMAN: Yes, we are. And, actually, there's several ways to communicate. It's, you know, telephone, television or tell a Veteran. Any ideas, this is a grassroots effort, actually.

So, what we actually, we're really trying to do is try to use other Veterans and their success stories to allow other Veterans to know that they have a place to turn.

MS. PECORI: Yes, and that -- oh, I'm sorry -- and that goes to what I wanted to say. Because what I've heard that's very familiar and we talk about in the community is the engagement of the Veteran.

Being engaged to come into services can be challenging if your first encounter is with law enforcement or, like they said, coming into the front door.

But, utilizing Veteran peer
specialists to engage the Veteran, someone who's been there, is crucial. And, we have seen that in the civilian world.

And, the wonderful staff here at the VA have started a peer specialist program. But, I'm going to say, you know, from the bottom of my heart, there's not enough.

I train a lot of those peers but I can only do four trainings a year with 30-something people. Manny's one of my trainees.

And, I know that the VA has a training program, but, for some reason, it's not being utilized.

So, any way we could -- we partner with them to do this, but there's also a Veteran-specific training for peer specialists that you could take back and suggest that is implemented throughout the VA system.

You know, and talking with my own son, when his soldiers come out, you know, when they have had issues and stuff, his key point is how do we engage them once they leave. Mark, very
true what you're saying.

But, those peer support specialists have been on the ground, they know what they're going through and someone will talk to them first a lot of times before they're going to talk to a professional.

Not saying that we don't need the professionals, they are very well needed. But, that lived experience is crucial.

COMMISSIONER KHAN: Thank you.

COMMISSIONER BEEMAN: I want to give Dr. Currier an opportunity to -- then every -- I would like everybody to respond to my first question. I want to make sure that we take back to Washington what --

But, I have a question for you and then maybe you can -- I know you wanted to say something else, and it is, I'm with Penn Medicine. One of the things that we thought was really important for academic healthcare in particular, is to ask questions on your medical record about, have you ever been in the service?
If so, where have you served?

So that you can start building the
database within the academic health system.
Because there's specific and important needs that
are unique to warriors and they may not be part
of the VA. I know they're still working or
something like that.

Do you do that within your electronic
health record?

DR. CURRIER: We absolutely do.

COMMISSIONER BEEMAN: Okay.

DR. CURRIER: We have a whole battery
of question built into ethic around that. Not
only that, but all kinds of trauma, various, you
know, lived experiences. So, yes.

COMMISSIONER BEEMAN: And then, I have
a further question. One of the things we found
very useful is creating a liaison between the
academic center.

We have a full-time nurse practitioner
who helps Veterans move between the academic
health system and the VA.
Do you have a program like that?
Because I'd like to get those things out there
because I think there's opportunity for this partnership.

DR. CURRIER: Yes, we have actually
Dr. Charles Brock who's from the neurology
department is charged with all interface on our
end between the VA, not only Haley, but Bay Pines
as well. And so, he takes very solid interest in
that. Yes, we know who to call to problem solve.

COMMISSIONER BEEMAN: Great.

DR. CURRIER: I wanted to reply a
little bit to your first question. You asked
what you could take to VACO that might be useful.

I love working at USF, it's the most Veteran friendly Veteran focused institution I've been around a little bit.

And, part of it is because, not only do we highlight hiring Veterans, and that's been explicit focus, but we're really proud of the number of discharged soldiers, sailors, Marines,
Coast Guardsmen who come to these duties.
And, I think that the VA could push its academic partners a little bit harder to take that stance. Because it creates a culture of respect for Veterans, an awareness of Veterans issues because of their you're coworkers, they're your students.

And, I've been at other places where there's just that's just like that's a language that's not spoken.

COMMISSIONER BEEMAN: Thank you.

COMMISSIONER POTOCZNIK: So, I had one question for whoever wants to answer or a few of you, if you could.

I'm kind of most interested in maybe one or two kind of barriers that you experienced in working with the VA or that your Veterans have experienced.

You know, there's -- I know sometimes people are hard to reach in the VA, sometimes it's difficult to penetrate the VA like you were talking about.

But, maybe if you could say from your
perspective or your Veterans perspective a

barrier for the VA?

MR. GUEVARA-RUIZ: It has been my

experience personal as well as working with my

brothers and sisters that the one barrier we have

here that's been coming up and up and up and up

again, it's a good one. This VA serves so many

Veterans, they can't find a place to park.

(Laughter.)

MR. GUEVARA-RUIZ: Also, that has been

it.

MR. FETTERMAN: So, one barrier that

I actually experienced, I moved here from San

Diego is VA's don't necessarily speak to each

other. I had to rebuild my profile and actually

had to re-establish with this VA. I think that's

one part that could possibly.

DEPUTY KRAGER: I think just

confirming that they're a Vet and what their

discharge is. That's what's most important for

me. I don't want to have to spend three hours

trying to figure out whether this Vet actually
can get services here or not.

   If I can have one place to call and
just say, hey, could you tell if this guy's a
Vet? If he's honorably discharged? And, if he
can get services at the VA?

   Sometimes, that's difficult. I've
made connections over the years so it makes it a
little bit easier, but for that day to day
person, it's very difficult.

   COMMISSIONER POTOCZNIAK: I feel your
pain, ma'am.

   DEPUTY KRAGER: Yes.

   COMMISSIONER KUNITZ: Mr. Fetterman,
to start out with and then Manny and the rest of
the crew to weigh in, I guess I'd really like to
focus on work that you have. And, I would love
to have you talk a little bit about the
importance of work to mental health recovery.

   And then, maybe the specific question,
do Veterans have concerns about their benefits as
they begin to work? I've seen, you know, it --
is that a balance? And sometimes, the concern
about benefits may weigh in with somebody's work goals?

MR. FETTERMAN: So, the biggest thing that we see that comes from work and being either meaningful or something with a possibility of advancement is the sense of belonging and purpose all over again.

When we leave the uniform, we leave this identity and that comes with a purpose and that comes with a mission.

But, we need to find that somewhere else and sometimes that comes through employment, you know, gainful, meaningful employment.

As far as benefits, quite often, we have to identify the difference between compensation and then, you know, the healthcare, which is, you know, where we are today.

Quite often, I haven't seen it as the largest issue, but compensation comes up a lot. But, I do think when somebody's employed, they often -- they'll use their employer's healthcare benefits just because it's a little easier and
it's part of that culture.

MR. ORTIZ: Thanks, Mark, for your remarks.

As far as employment, you know, you're absolutely right. The Veterans number one concern when they get out is not necessarily enrolling in VA healthcare or seeking VA benefits in general, it's getting a job. That's the bottom line, getting a job, taking care of his family, being able to support them and their needs.

So, how does that influence Veterans not enrolled in VA healthcare? They're too busy working, they don't have time for compensation claim, they just don't have time.

However, as time passes, they've settled in and about after that one year mark or so, they finally realize, hey, I've got VA benefits, geez. And they start talking to other Veterans.

And, as they learn that there is compensation benefits for everything they have endured while in service, then they come to visit
us to do a claim for benefits and so forth.

And, I know we're dealing with the mental health side, but on the claims side, the processing of claims has improved substantially since the implementation of the -- what they call national work queue which is basically where the claims are not paper anymore, they're electronic. So, they can be sent out to any of the seven regional offices for process based on the workload determined by the VBA on a daily basis.

So, that helps expedite the claims, so that's been really good.

But, that's the hard part is how to reach those Veterans that are not enrolled in VA healthcare and insuring that they're informed of what -- word of mouth is, I can tell you, the most effective tool that exists, because that's how I get so many referrals.

They want to see you, they want to do the claim. They bring their discharge Form 214, we're in business. You know, we can get things done and we like to get those done, obviously,
that same visit, that first time.

    So, that's critical. Why? Because it
gives them another source of income apart from
the job. You know, and VA benefits are tax free
so that's huge.

    So, that's the key thing is, you know,
ensuring that we communicate, as it was
mentioned, through outreach that we do a lot, but
mostly, it's like personal contact, handing out
your card, giving a couple extra cards. And,
believe me, they are distributed rather well.

    So, we stay busy, but it's sort of
like the busy that you feel real happy to do and
help Veterans.

    CHAIR LEINENKUGEL: Dr. Jonas, final
question due to time constraints.

    COMMISSIONER JONAS: Sorry, this is
hopefully a short one. I had general one that
builds on yours, and but, on challenges, how to
overcome challenges around integration and happy
to talk to anyone on the panel that we have and
sub-panels that we have coming up around that.
But, actually, Deputy Krager, I have one specific question for you because I know you can answer this question.

How many homeless are there in Hillsborough, on average?

DEPUTY KRAGER: Well, the paperwork says about 2,600, I'm estimating more of like 4,000. I don't think they're counted as appropriately as they should during the annual point in time count.

DR. JONAS: So, the paperwork says 2,600, you think there's more like 4,000?

DEPUTY KRAGER: At least.

DR. JONAS: And, of those, what number really need a lot of hand holding like you talked about? I mean, that area really high risk, just refractory 10, 20 years, out in the woods or --

DEPUTY KRAGER: I would --

DR. JONAS: -- need some other kind of support, getting a job, for instance, those kind of things?

DEPUTY KRAGER: I would say there's
about 20 to 25 Veterans right now that are chronic homeless. They have been on the street for a significant amount of time.

Some of them do have services. I think the barrier is when we finally get someone to get in our car and want the help, we need to do it right then and there.

So, the least path of resistance is what we usually end up with. So, I reach out to Tampa Crossroads, Veterans Helping Veterans. There is so many community-based organizations for Veterans that can help me right then and there.

So, if I need to get somebody in a hotel, that's how I call, you know, just to get them off the street and get them into the system.

DR. JONAS: So, let's assume there's maybe 200 out of that 4,000 that really need a lot of help and services. Is there a registry of who they are, records, names? People assigned to them who say, I know where, you know, Joe is or I can find out where Joe is? Or, this is where he
was last, et cetera, et cetera.

Is there a database of names, actual people with assigned folks available to help?

DEPUTY KRAGER: They're not really assigned. We do have a database that actually has homeless folks that we have encountered day in and day out which I said, they're in the camps. They're -- they don't really seek services, so they're not in the community.

DR. JONAS: Right, I understand.

DEPUTY KRAGER: Yes. So, we do have a database. We also have access to unity, which is out homeless database.

So, because they are Veterans, more than likely, some of them don't go through that side of the service because Veterans Services are much better than homeless services as far as like HUD VASH availability is what I'm talking about.

When I encounter a Veteran on the street, I can get them off the street in a day, if that's what they want.

If it's a regular homeless person, I
say, it takes me a month or two just to get them in the process of getting somewhere.

So, I can say the VA and Veterans Services are awesome in that aspect when they want it, when they're ready to do it.

DR. JONAS: Yes, so if you had your one place to call, what would need to be in that to make sure that that one place to call was going to allow you to help manage and provide what was needed, you know, for the spectrum that you --

DEPUTY KRAGER: For Veterans-specific?

DR. JONAS: Well, I mean, we're talking about Veterans, so, yes, one place to call for Veterans.

Obviously, it'd be nice if it was one place to call for more than that, but for Veterans. What would be in that? You have a place, you dial it, you say, what needs to be part of that so that you can make sure that anybody that you encounter or walk in or reach out to who comes in, you're able to get them what they need?
DEPUTY KRAGER: Someone that would answer the question. You know, I know HIPAA and everything else that's involved in that.

We just need -- a lot of these folks just don't know how to communicate. You know, I had a military Veteran, 78 years old, has no -- medical benefits, but nothing else.

He did not realize, actually, the VA called me and asked me, hey, what can we do with this guy?

I took him down to Social Security one Friday afternoon, got him $14,000 in back pay and $1,400 a month. How easy is that?

And that's what frustrates me, it's like, wait a second, I said, this guy could have gotten, you know, money instead of living on the front porch of that city dump, you know, all this time and been in a nice, warm house.

And, you know, I guess it's just getting the information firsthand and if somebody needs to assist them in any way, getting them in their car, having the ability of someone that is
communicating with the homeless service provider
or VA service provider just to get them down.
Why did they need to call me to get them down to
Social Security?

MR. FETTERMAN: Do you mind if I add
on to that? I think the best thing we can do as
far as the community is understand the role we
play individually. Because, quite often, we're
seeing ourselves as trying to offer all services
to all Veterans and then we fail.

So, what we need to do is start to
realize what role we play in this large holistic
health that we're actually providing.

Where she can reach out to 211, the
Crisis Center, experts and actually talking
someone down, bringing them in, getting them the
services they need.

When we establish what we can do and
focus on our strengths, we can allow others to
focus on our weakness and that's what we call
collaboration and then a collective impact.

DR. CURRIER: I'd just also add that,
Hillsborough County partners, including the big health systems, the VAs, the law enforcement and others, are working right now on a conjoint medical and social services release form so that HIPAA, which has been a real problem is going to be kind of bypassed through this route so that that's under development right now.

DR. JONAS: So, it sounds like the integration and coordination components is a fairly sophisticated way of what's needed to actually gets down to a personal level.

And, I say that because you guys do it probably better than almost anybody that we've actually seen.

CHAIR LEINENKUGEL: Yes, I think it goes back, Wayne to --

DR. JONAS: It takes that persistence --

CHAIR LEINENKUGEL: -- the starting comments of how important the integration of the community is within this type of agency and the fine work that these folks are doing.
I think to your point and question, Wayne, I think that Manny, Edwin and Mark along with Deputy Krager can sidebar maybe five minutes at the closure of the open session and we need to discuss this further because I think there is something there that we need to take a little broader base.

That being said, I want to thank Dr. Jakey. I want to thank all of you for your service to Veterans, service to your community and service to your nation. It means a lot to this Commission for you to take the time to come in.

But, more importantly, to serve those Veterans in need. So, again, Dr. Jakey, Dr. Bohn, Dr. Currier, Mark with Mission United, certainly Manny, Deputy Krager, Edwin, thank you for your services and depth for what you do.

Thank you all.

(Applause.)

(Whereupon, the above-entitled matter went off the record at 9:30 a.m.)
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CERTIFICATE

This is to certify that the foregoing transcript

In the matter of: Creating Options for Veterans' Expedited Recovery Commission

Before: USDVA

Date: 12-05-18

Place: Tampa, FL

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

[Signature]
Court Reporter

[Signature]
Jake Leinenkugel
Chairman, COVER Commission

[Signature]
Alison Whitehead
Alison Whitehead
Acting Designated Officer
COVER Commission

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CREATING OPTIONS FOR VETERANS' EXPEDITED RECOVERY (COVER) COMMISSION

OPEN SESSION

THURSDAY
DECEMBER 6, 2018

The Commission met in the Auditorium in the James A. Haley Veterans' Hospital, 13000 Bruce B. Downs Boulevard, Tampa, Florida, at 8:30 a.m., Jake Leinenkugel, Chair, presiding.

PRESENT

JAKE LEINENKUGEL, Chair; Senior White House Advisor, Veterans Administration

THOMAS E. BEEMAN, Ph.D., Rear Admiral, U.S. Navy (Ret.), Co-Chair; Executive in Residence, The University of Pennsylvania Health System

WAYNE JONAS, M.D., Executive Director, Samueli Integrative Health Programs

JAMIL S. KHAN, U.S. Marine Corps (Ret.)

SHIRA MAGUEN, Ph.D., Mental Health Director of the OEF/OIF Integrated Care Clinic, San Francisco VA Medical Center

JOHN M. ROSE, Captain, U.S. Navy (Ret.), Board Member, National Alliance on Mental Illness
MATTHEW KUNTZ, U.S. Army (Ret.), Executive Director for the Montana National Alliance on Mental Illness (NAMI)
MICHAEL POTOCZNIAK, Ph.D., Captain, U.S. Army Reserve, Team Lead for Addiction Recovery Treatment Services, Martinez, California

STAFF PRESENT
CASIN SPERO, Chief Advisor
SHANNON BEATTIE, MPH, Senior Project Analyst, Sigma Health Consulting, LLC
YESSENIA CASTILLO, Senior Consultant, Sigma Health Consulting, LLC
KRISTIANN DICKSON, VA Support Team Project Manager; Alternate DFO
BETH ENGLEES, Senior Manager, Sigma Health Consulting, LLC
LAURA ANN McMAHON, Contracting Officer Representative; Alternate DFO
STACEY POLLACK, Ph.D., Alternate DFO
ALISON WHITEHEAD, Designated Federal Officer
JOHN KLOCEK, Alternate DFO
KENDRA WEAVER, Alternate DFO
NADINE DEDEE LIM, MPH, Senior Consultant, Sigma Health Consulting

ALSO PRESENT
CLIFF SMITH, Ph.D.
ANDY POMERantz, MD
CARY C. HARBAUGH, Colonel, USA Director, U.S. Special Operations Command Warrior Care Program (Care Coalition) and Director, DoD Warrior Games 2019
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8:33 a.m.

MS. POLLACK: Good morning, everybody.

My name is Stacey Pollack. And I'm serving as the Designated Federal Official for this meeting on December 6, which is the third day of the meeting of the Commissioners.

This is the fourth meeting for Creating Options for Veterans Expedited Recovery Commission. We'll use the acronym COVER in this discussion. And portions of this meeting are open to the government.

The COVER Commission was established as required by Section 931 of the Comprehensive Addiction and Recovery Act of 2016, TARA, which is public law 114.198, and operated under the provisions of the Federal Advisory Act, FACA, as amended.

Public notice of this meeting was given in the Federal Register on November 22 and 26, 2018. Please note that there is a sign in sheet for members of the public attending this
meeting up by the front.

We ask that all participants who have called into the listening line, please email us to record your attendance. The email address is covercommission, all one word, at va.gov.

This meeting will be chaired by Mr. Thomas J. Leinenkugel. We ask that you be courteous and respectful during the meeting.

Videotaping or making photos of the meeting are discouraged as they're disruptive of the Commissioners and the staff and other audience members.

Questions and comments from the public may be submitted in writing using the covercommission@va.gov email address. Again, that's all one word, covercommission@va.gov.

There is no open question and answer period. A transcript of this meeting is being taken. And anything said during the meeting, or submitted in writing during, before, or immediately after the meeting, will be made available to the public.
This meeting is on the record. In closing to summarize, public notice for this meeting was published in the Federal Register.

A DFO is present. A quorum of the COVER is present in person.

An approved agenda for the meeting has been established. And the meeting will adhere to the agenda. Anything said during the meeting is on the record.

Before the meeting begins, does anyone have any questions about what I just said?

(No response.)

MS. POWELL: So these preliminary statements are now concluded. And I now invite the COVER Chair, Mr. Leinenkugel to begin and call the meeting to order.

CHAIR LEINENKUGEL: Thank you Stacey. The December 6, day three meeting of the COVER Commission is now called to order.

And at this time I would like to call upon Commissioner Jamil Khan to lead us in the Pledge of Allegiance.
COMMISSIONER KHAN: Please, right hand on your heart. Join me.

(Pledge of Allegiance.)

COMMISSIONER KHAN: Thank you. Please be seated.

CHAIR LEINENKUGEL: Thank you Jamil. And also once again, thank you to the entire staff, Director Battle, and the entire team here in sunny, cool Tampa.

(Laughter.)

CHAIR LEINENKUGEL: We've had a wonderful experience within this facility. And we look forward to this morning's session as we have two key individuals that are with us today that I believe came in last evening.

And we can't wait to get on with this morning's meeting. So, at this time I would like to turn this over to Dr. Cliff Smith and Dr. Andy Pomerantz, who will be discussing the continuum of care and also SAIL at this point.

Gentlemen?

DR. POMERANTZ: Okay, Thank you.
Having come in from Vermont last night, it's good to be someplace sunny and warm.

(Laughter.)

DR. POMERantz: So, I'm going to give some background, set the context for some of the things Cliff's going to talk about as well.

I'm the National Mental Health Director for Integrated Services. The core of my position has been the integration of mental health into primary care.

And I've been in that position for about years. Previously I had worked in the VA in Vermont where we developed one of the core models of integrated care. Which is probably how I wound up in this job.

So, let's see, I've pushed every button on this thing. But, just a broad overview, not specific to the VA, these are the general problems we face in this country as well.

We know that the mental health conditions are very common in the population. Even more so in veterans then the rest of the
We know that if left untreated or under-treated, which is the norm in our healthcare system, that the consequences are, if not immediately disastrous to the individual, they have profound effects on family and society, as well as on the cost of healthcare and healthcare outcomes in general.

So, what's our solution in the VA?

And this is where we're -- where what we're trying to do. It's not 100 percent perfect.

But this is our goal. This is where we're aiming for. Is to really develop a care system that provides the right amount of care, what kind of care people need.

I think many are aware that typically mental health care begins with a referral to some other place. Sometimes far away, occasionally close by.

And that it often begins with an extensive data gathering visit where individuals are essentially treated as though they had a very
complicated problem that needed a great deal of attention.

As opposed to the way most healthcare works, where most problems are simple and fairly straightforward.

So, what we aim to do is really conserve the resources for those who really need them. And provide the right level of care for people who don't need the traditional care.

This is the description of the framework for our continuum of care. We had a lot of great minds from the field, got together and met and talked for about a year to develop the actual plan, continuum of care.

And really, it's based around both, you know, it's reducing veteran suicide, which is our number one clinical priority. As well as support for a life worth living.

I think that's an important thing to keep in mind. This is a schematic of how we view the -- where we're aiming.

And what's really at the bottom is
self-directed care. Which takes many forms. You know, it may be a veteran awakes in the middle of the night on the internet.

It may be somebody, a veteran looking for other methods of treatment. You know, outside of the traditional medical treatment that we're known for providing.

It may be various community-based groups. A wide variety of things that we all do to take care of ourselves. It could be as simple as a walk in the park.

The next level up is the -- it's doing it by itself.

(Off-microphone comment.)

DR. POMERANTZ: Oh, should I wave at you? Okay. Great.

So this has nothing to do with what I've been doing.

(Laughter.)

DR. POMERANTZ: It's like the same button never worked twice.

(Laughter.)
DR. POMERantz: Very helpful. So anyway, this is our -- this is where we're headed.

And as you can see, you know, the size of the pyramid here is really aimed at really the -- you can think about that as the number of patents or the percent of the patients who really need to go that -- go to that level.

You know, the most severe, acute crisis go into inpatient care. So, next. Next slide.

And this is in a meeting out in VISN 21. This was a schematic that a veteran came up. This is what it looks like from my perspective.

You know, and I as the veteran, is the one who should be holding the key to this whole thing. I'm the one who opens it and gets started.

So, next slide, please. So for our continuum of care, again, this is more detail on the same idea. That it is based on the level of need.
Not everybody starts as though they had a serious complex mental health problem. We aim for effective treatment.

As well as being able to identify when somebody needs a higher level of treatment. And that requires ongoing assessments of the patient's care.

And of course least restrictive care is the general principal. Very different then from one -- when I started in healthcare a long time ago.

And this is that we really want care to be as community-based and veteran-centered as possible. Next slide, please.

This requires measurement-based care. One of -- my initial background was as a family physician many years ago before coming into psychiatry.

And it never occurred to me to not check a patient's blood pressure or their pulse. Or listen to their heart and gather data to know how we were doing.
But this is still an uphill climb throughout this country. And, again, not specific to the VA.

To really measure what we're doing. Look for outcomes. Is this patient getting better with the treatment we're giving?

Gathering a lot of up front self-report information from a patient, is critical to knowing what level of services they need. And then -- and being able also to provide that as feedback to a patient.

Patients feel good when they know their blood pressure is 120/70. Likewise, they often will kind of miss the point that they're actually feeling better until they actually see that their PHQ-9 score, the self-report tool for depression, has dropped from 20 to 14.

So, being able to use this data collaboratively with patients make it possible. As I'm sure you're also aware, the VA shift to more patient-centered care approach begins with what matters to the veteran.
You know, what's important. Many veterans that I've seen over the years are, no doc, it's not. Yeah, I can live with my nightmares, you know. It's just, how do I get along better with my family, has been.

Find out what, you know, what are your goals. And we often change this over the course of treatment as we get to know patients better.

As patients begin to experience perhaps different ways of interacting with others. It may alter the course of treatment along the way. So, next slide, please. Get this out of the way because I keep trying to grab it.

So, other principals here. It's focus on recovery. And recovery too is -- it's been what, probably 15 years since the Substance Abuse and Mental Health Service Administration came up with the principals of mental health recovery.

But, it's still -- we still have a long way to go to move away from seeing individuals with mental health conditions as people with impairments that need to have their
impairment fixed so that they can be okay.

I think any clinician in this room can
tell stories of patients whose symptoms went
away. But their lives were ruined. I'll leave
it at that.

And really to focus on what the
veteran wants. What's the -- because if we're
focused on something else, we're not likely to
have a good outcome. And we're likely to run
into even more problems.

Suicide prevention is a lot more than
just addressing highly suicidal patients. And if
I can make no other point in this discussion
today, the key is that really that a lot of our
work should be focused around preventing people
from becoming suicidal in the first place.

I will try not to say support for a
life worth living too often. But, I will say it
one more time at least.

That really our -- we need to provide
that intensive level of care for highly suicidal
patients. That we cannot afford to lose sight of
those patients who are early on in the course of their adult life.

It's really important. So, next slide, please.

Then medical necessity. So, we, you know, what is we -- what are the reasonable and necessary interventions that we should be providing for this individual patient?

Team based care too, is another kind of evolution over time in VA and elsewhere. And we're still working hard on this in VA to encourage it, to support it.

Mental health care should not be a collection of individuals each doing their own thing in a little office somewhere. Corresponding only by email, if even then.

But really needs to be a group. You probably know some about the patient aligned care team at this point.

I think that's the, you know, patient centered medical home in the VA. Which is very much designed around those principals. Next
slide, please.

Practicing at the top of one's license. And that's, you know, that's hard to do. And not everybody wants to do that all day long.

Sometimes we do need a break from what only we can do. But for the most part, that's what we're aiming for.

So, I as a psychiatrist, doing the things that only a psychiatrist can do, is important. Which also is a big piece of team-based care. Individual clinicians who are used to being very independent and autonomous, to really be able to rely on and trust information provided by other people, and intervention from other people.

And then lots of different ways. What's going to work best? How, you know, is this somebody who's going to come to the facility every day? Is this somebody who we need to reach out to with more innovative solutions such as
videos at home for instance. Next slide, please.

And then, you know, de-implementation and reducing redundancy. You know, what we aim to do is have services, you know, that are being provided to patients, but not having the same thing going on in some other setting.

But really, really focus on evidence-based practices that will be a benefit to this particular patient. Which also means stopping doing things that aren't helpful.

It doesn't mean stopping care. And it means finding alternative methods of care.

So, when I came into the VA, I was handed a caseload, you know, a bunch of patients. Many of whom had been coming to the VA for 30 years. And they didn't know why they were still coming.

Well, because I'm coming because I get to talk to somebody once a month. That's fine. Well, maybe there are other ways.

And so, you know, ending some of those practices are important. And then partnerships
with the vet centers and other non-VA community partnerships.

I think we all know that healthcare is not just the delivery of medical services to people. But it’s many organizations and community-based opportunities that people have. Next slide, please.

So, I think this is -- and I said I wasn’t going to say it again, but I will. Providing support for a life worth living is well beyond.

It’s not the same. It can include what’s on the other side of that scale. Managing diseases, chronic disease management, identifying specific diseases, providing treatment.

But it’s also about shoring up the individual’s existing strengths, their connections with family, community, and society at large. And many things that people don't always associate with healthcare outcomes.

But if we do one side of this and not the other, we're not serving our veterans the way
we need to be. Next slide.

Ah, this is another schematic. You
know, similar to the pyramid you saw earlier
that's a little bit more descriptive. I'm not
going to read it to you. It's really the same
kind of thing. It really just starts at home and
community.

And the upper level is really specific
care provided according to evidence-based
standards. Next slide, please.

So, I'm going to talk -- again I said
DCMHI, primary care/mental health integration is
my target area. So, along with a little bit of
that. Next slide, please.

This is a statement, the AHRQ, Agency
for Healthcare Research and Quality, did a review
of integrated care. As well as one on patient
centered medical home.

And the bottom line is that the
initial review of integrated care, which was done
ten years ago, it's really, let's -- you know,
this is an evolving field. We don't know the
right answer yet. But, there are a lot of good things happening. Let's stay tuned.

Which is a challenge for us in VA, developing policy. To make them broad enough that they can adapt to local environments while at the same time be specific enough to hit the core ingredients. The other is another statement that was commissioned by AHRQ eight years ago. Looking at the patient centered medical home.

That we really need to provide mental healthcare within the patient centered medical home as much as possible. Next slide, please.

Here's one definition, this one I particularly like. It's written by CPT. It's also part of the information that the AHRQ has developed. And it's really just -- it just refers to the mental health providers being a core part of the overall healthcare team. All as one team working with the individual patient. Next slide, please.

So in VA the patient aligned care team is the -- is our patient centered medical home.
We also have PCMHI, the primary care mental health integration program, which was formally rolled out in VA about ten years ago.

And these are the mental health providers, primarily mental health providers, who are working as part of the PACT, the primary care team. Next slide.

So, this is our goal. Our primary focus in this has been there are a couple of key features. You know, one of which is providing same day services within PACT.

There's plenty of -- a good body of research that demonstrates the longer people have to wait for a mental health appointment, the less likely they are to get treated.

Many people are quite ambivalent about getting mental health care for a lot of reasons. But these, that's been our goal since day one.

And we primarily focus on those common, uncomplicated problems that come up in the primary care population. We don't typically treat schizophrenia in this program.
But we are there for the more common things that happen. So that we can stress this early intervention.

Again, to try to help the -- I have a 22 year old veteran, the first ever episode of depression. You think about what happens to that patient if it goes untreated for their lifetime.

Then they wind up in that highly suicidal bunch of people. So, we provide that early intervention to try to address it with a minimum of resources. Next slide, please.

This is a little bit repetitive. So, in the interest of losing redundancy, I'll leave it for reference later. Anybody looking at the slides.

Except to say that the outcomes we do know, we have published papers from many investigators demonstrating that we have since developing this program nationally, we have improved the percentage of the primary care patients who are identified with, and treated for a mental health problem.
And that those who have passed through our treatment and primary care, if they do need a referral to higher level of care, they are much more likely to engage in that care. Next slide, please.

So the core components. One is the co-located collaborative care. That was the model that we had developed in our center in Vermont over the years.

It's often known outside VA as the behavioral health consultant. These are the embedded mental health clinicians that are part of the PACT.

We provide typically some consultative advice. You know, ideally when the PACT is functioning as it should be, there's morning huddle every day.

They talk about the patients coming in. Our providers are there in the huddle to do some troubleshooting ahead of time, make some suggestions, or even offer to see the patient if necessary. Next slide, please.
The other component is known outside the VA is collaborative care model. That has a much more extensive body of evidence than the co-located collaborative care.

When PCMHI was first rolled out in the VA, we already had, you know, 10, 15 years of randomized control trials of the collaborative care model showing effectiveness.

There wasn’t a whole lot of information when the good data on the co-located collaborative care. So, we’ve been generating that data ourselves along with a lot of other non-VA researchers. And developing brief methods of treatment. Doing a lot to move that field forward.

But the care management collaborative care is a cost-effective way of improving outcomes. Initially it was just for depression. A nurse calling a patient on the phone, following a protocol. How are you doing? Looking for side effects of medication. Doing some basic problem solving. And
being a link between the primary care provider
and a consulting psychiatrist.

In this way a, you know, single care
manager can help manage the care for, you know,
one hundred or more patients with mental
disorders with the psychiatrist or psychologist,
whoever is needed, only seeing a very small
percentage of those who really, you know, are
maybe not responding to treatment. Next slide.

Also, outside of mental services are
the health behavior coordinators. This was a
program rolled out through the national center
for prevention a few years after our PCMHI.

The task of the health behavior
coordinators typically has been to help the
primary care providers do a better job of
addressing conditions that are very behaviorally
sensitive.

There are also health promotions,
disease prevention program managers who are there
to -- they may not even be clinicians. But
they're there to help oversee and coordinate
prevention efforts taking place within the PACT.

Next slide.

So these are our outcomes. I think this -- what's really key here, I think, is -- and these are all, you know, outcomes based on research study.

I'm not a researcher. I support researchers. Try to provide some ideas if I can. But these are things other people have done that have helped demonstrate and develop the evidence base for what we're doing here.

Certainly key in here is that both patients and providers like this. They really like this approach.

We see many patients who would never go even 100 feet down the hallway to see a mental health provider, who will see a mental health provider if it's there, right there with the primary care team. Next slide.

So, these are our key metrics.

Percentage of primary care patients who have seen a mental health provider in PCMHI. And the same
day access.

   Same day access, thanks in large part
to some of the things Cliff is doing, you know,
has been improving over the years. We're not
where we need to be, but we're getting there.
Next slide.

   Do I still have some time? I'll keep
going until somebody gives me the high sign.

   So, this is another slide that again,
kind of demonstrates how we, you know, the
patient flows. Not everything that we do is on
here.

   But these are sort of the key within
mental health services. The services we provide
within mental health. Typically, this is how it
works. Too busy with this slide. So we'll just
go onto the next one.

   Again, open access to care is our
goal. Make the process as streamlined, as
seamless for the veteran as possible.

   We don't want any veteran who is being
referred to mental health to go home with a well,
why don't you, you know, just wait, you'll get an
appointment in the mail. It's coming. Check is
in the mail. Just wait.

You know, we know that the traditional
old model of mental healthcare, going back a few
decades, was well, the patient really needs to
call the mental health center to demonstrate that
they really want treatment.

You know, I don't think that's as
pervasive now as it used to be. It's certainly
not in the VA. Next slide.

Referral management is part of our
flow. Setting up agreements whether formal or
not, between primary care and mental health. And
then kind of defining the flow within general
mental health, PCMHI, and specialty mental
health.

As well as the -- how it's going to
work. This is essential with team-based care.
Is that you have your processes in place.
And then we always encourage, you
know, our facilities, the smaller ones to
collaborate with the larger ones for highly specialized care.

That's one of the advantages I think we have in the VA system. I know times over the years when I have been able to bring in somebody from thousands of miles away who happens to be an expert in what's going on with my patient.

And bring that person into this patient's care. Next slide.

This is again, interesting thinking about when is an episode of care over? Is it ever over?

As I mentioned the patients I inherited when I came into the VA, had been coming so long they didn't know why they were coming. But they kept coming because they had appointments.

And really, we need to be constantly aware of and thinking about how to, when has the need been met, and it's time to shift this patient back towards primary care and self-directed care. Next slide, please.
This is just I'm going to close with a discussion of the FLOW Project. Which was a demonstration project that was developed down in Texas, VISN 17 a few years ago.

It was really aimed at identifying when have patients completed their mental health care? And how can we successfully transition them back to primary care? Next slide.

So, they began the project with kind of looking at well, how can we identify these people? We actually know. We have a lot of data in VA.

So how do we use that data in a way that would help us identify from a high level, who's really ready for transition back to primary care. That was the first task. Developing the criteria. Next slide.

So this is -- this says what the group decided was important. And it was really, you know, these are people who have been coming maybe monthly, maybe a couple of times a year with certain, you know, and stable medication regimens
if they were on medications.

    With certain critical exclusions.

These were the criteria thought to be consistent with stability and the end of an episode of care.

Next slide, please.

    Again, a busy slide. This just kind of talks about how it happens. The key part of this though, is that it was left in the end, despite what the data might indicate, it was left for the patients and providers to make the determination of whether this patient could be transitioned out of mental health services. Next slide.

    So, this is an old slide. It's a year old. But the project was being completed then. We're now rolling this out to a number of other facilities, trying to develop national dashboards that will support it.

    But this was a big deal. Four out of 190 patients, the transition was not successful. And I think that suggests that these are pretty conservative criteria if the number's that low,
and that they're an effective way to kind of get started on this process. Next slide, please.

So we did prepare, this group developed, based on the things that I've talked about, a recommendation. A report that was distributed to the field a year ago.

Demonstrating, you know, here's how you set up a continuum of care. It comes with an offer of some of us to help you do it if you'd like. Next slide, please.

You know, as well as a gap analysis that went in it. You know, a series of questions. How do you now you have a continuum of care?

How does it work? And what, you know, how do you organize in your system? Because I -- it's not been the law of the land in mental health anywhere. That there's a coherent continuum of care. So that's what we're attempting to do. Next slide, please.

This is just a sample. Just to see what the gap analysis tool looks like. How
individual services will look at this report and think about it.

Look at their current processes and think about what's working. What could be changed? And how are you going to know? And of course, who's going to make sure it happens? So next slide, please.

These are the steps we're recommended to. We had a couple of national mental health conferences last year. East side of the country and west side of the country.

We had some presentations about the continuum of care as well as then a set of recommended next steps, what people could be doing.

We have since reached out to a couple of facilities that have expressed interest in following up on this. This is not something we can necessarily mandate and say everybody must do this exactly the way we say. That never works. But we're gathering some interested facilities who are interested in leading the way.
And moving on from there. Next slide.

Okay. My voice was about done.

CHAIR LEINENKUGEL: Perfect. Dr. Pomerantz, thank you so much. I think that was something that we expected was a 50-page PowerPoint to start the day.

DR. POMERANTZ: Oh.

CHAIR LEINENKUGEL: But it was absolutely essential for us to see that. Because the continuum of care is very important in the mental health process and what this Commission is exploring.

I'm going to start with a question that I have for you. And I want your honest answer on it.

It's the sufficiency of resources that are available to the Department of the VA to ensure the delivery of quality healthcare for mental health issues among veterans seeking treatment in the Department.

Do you think that we have the sufficient resources throughout this Agency to
properly administer what you just showed us over the last 20 minutes for every veteran that has a mental health issue?

Whether we know it or not, because I think that was slide one. That there's just so many out there that are not being treated.

So, I would like your assessment.

DR. POMERANTZ: We have islands of sufficiency. There aren't a lot. I was in a large meeting a few months ago. And I asked for a show of hands.

I was at a PCMHI meeting and a show of hands of who feels they have sufficient resources in their facility. And one hand went up.

I told her to keep that to herself in the future.

(Laughter.)

DR. POMERANTZ: But it was just guidance and mentoring.

(Laughter.)

DR. POMERANTZ: You know, I think there are areas of inefficiency as well. And I
think that the best way to improve our efficiency and do more with whatever we have, is to implement a continuum of care.

So that you're not throwing a lot of intense resources at people who really do not need them. And probably will only show up for one visit because you haven't given them what they wanted.

So, yeah, I think there are areas where we can be more efficient. But overall as a system, I don't think we have enough.

CHAIR LEINENKUGEL: Thank you for that.

COMMISSIONER POTOCZNIK: So, I have one question. You were talking about the continuum of care, and I'm -- you know the different levels of care, which I'm a big believer in. That's a great way of thinking of it.

As a mental health director in a CBOC, I just noticed that the continuum of care frequently breaks down. Like you talked about
the islands of sufficiency, it -- it almost seems
like they're just little micro-islands of
sufficiency sometimes when you get to the higher
levels of the continuum.

For example, you know, when you get to
the residential levels of care, you know, and
then you go to the inpatient levels of care, I
find that a lot of times if veterans aren't
living right in the center of an urban area,
which is exactly where veterans don't live, a lot
of times, they don't really have access to the
higher levels of the continuum.

Or you get a healthcare system within
a VISN that hoards the resources. And then
starves the other ones in the VISN.

So I've kind of seen that. I see it
-- listening to Tampa during our interviews here,
you know, I've seen that here. But I've also
seen it in VISN 21 where I am.

And so I'm just wondering if you have
-- you know, when you're talking about there
might be islands of sufficiency, you know, there
are people working on that because there are contacts out there.

You know, but I know funding is an issue and that kind of stuff. But it's a huge issue for us on the ground.

DR. POMERANTZ: I like to think of the facilities as you described, Tampa, others, you know, as sort of the places that have the resources to develop the models.

And then the challenge is how to stay true to the principals of those models when you don't have that level of resources.

I think one of the problems we have in our CBOCs recurrently. And I dealt with it when I was leading mental health and services in Vermont, is that you have a CBOC with 15 hundred patients or something like that.

You may have a mental health provider.
You should have a mental health provider. You're supposed to have a mental health provider.
And very often that provider is spending their time doing, you know, intensive,
cognitive processing therapy for PTSD or some other base psychotherapy.

And so the other patients are left not getting care. And I think that, you know, they're at least not being identified.

So I think the key is community partnerships where they can work effectively. Where the community partners are willing to adopt the same standards as we have within VA.

Which was not universal in my experience. Where if they can provide that kind of care, fine.

Otherwise, using other resources within VA, other parts of our own, you know, main facility through either depending on distances, through actually having people go to these CBOCs as needed for the more specialized care.

Or, having those evidence-based therapies provided via tele-mental health. So that the provider onsite can deal with all of the other mental health problems that are not being dealt with.
When you get into some of the more highly specialized programs, you know, it's not likely that if somebody needs a course of electroconvulsive treatment, they're going to get it at a CBOC.

COMMISSIONER POTOCZNIAK: Right.

DR. POMERANTZ: Yeah. So that some things they are going to have to go to the medical center for. But that happens, you know, outside the VA as well.

COMMISSIONER POTOCZNIAK: I guess my point to that was more, so even in -- even when you want to contract out, like I totally understand as -- in a CBOC you definitely can't do the higher level stuff or residential care or anything like that.

But, there are complete lack of contracts, right. Or, if you do want to refer, you know, because some healthcare systems don't even have residential levels of care.

But if you actually want to refer for residential levels of care, there actually isn't
even always contracts for it.

And so that's the -- and so you're
left kind of as a clinician going I want to
elevate this person to a higher level of care,
but I have absolutely no avenue to do that.

And that's the concern, I think, that
I have. If I'm in an urban area experiencing
that, I can only imagine what's going on, you
know, in Montana.

DR. POMERANTZ: Yeah. I agree. I
think it's a real challenge. You know, is there
a suitable program outside of VA that we can
contract with that can provide this care?

And if not, I mean, if I wouldn't send
a family member there, I don't want to send a
veteran there.

COMMISSIONER POTOCZNIK: Right.

DR. POMERANTZ: And I think that's
really critical, and something all, you know,
facilities are having to deal with. I think it's
an issue.

Likewise, if I live in Montana, I
don't want to have to go even to Idaho to be in a residential program, leaving my family and everything I know, you know, behind.

And then suddenly coming back. Hi, I'm cured. What do I do now? I think that's a really critical point.

COMMISSIONER POTOCZNIK: Back to the panel comment.

COMMISSIONER BEEMAN: Where does a CIH fit into the continuum as an adjunct to the primary care or psychiatrist when they're in their practice?

DR. POMERANTZ: I think it fits on both sides of that balance scale.

COMMISSIONER BEEMAN: Okay.

DR. POMERANTZ: Both the support for the life worth living, a lot of CIH interventions really rely on the individual to practice them.

And at the same time, those interventions, I like to think of it as they set the stage for healing. You know, healing doesn't happen in a vacuum.
Which is how we traditionally approach it in healthcare. Healing provide -- you know,
its drawing on the internal strengths of the organism to promote healing.

I think that -- we don't have a lot of hard evidence. And I think where research needs to go is to stop trying to do comparisons of this CIH intervention versus this evidence-based health treatment, and think about the two together compared to either of them.

COMMISSIONER BEEMAN: Have them at least alone.

DR. POMERANTZ: Yeah. I think that. So, I think it's critical, you know, for self-care and for just kind of strength and picking up on existing strengths.

COMMISSIONER BEEMAN: Thank you.

CHAIR LEINENKUGEL: Go ahead.

COMMISSIONER JONAS: I would like to get the 50-page PowerPoint. I mean, possibly if we could get that, then we wouldn't have to really copy that report.
DR. POMERANTZ: Oh, I can give you a thousand pages if you want.

(Laughter.)

DR. POMERANTZ: I mean, I've got, you know --

CHAIR LEINENKUGEL: Wayne would like a thousand page one.

COMMISSIONER BEEMAN: Jake and I would like the executive summary.

DR. POMERANTZ: Yeah. I mean, that's all I have. I put that together for today.

COMMISSIONER JONAS: I noticed, I think the step care approach, the pyramid care model that you have, it's brilliant. It needs to be applied across all of healthcare.

It shouldn't just be mental health. Because this is not a -- mental and physical health are not separate. And yet we separate them.

We have mental health integration. And yet we know that people with mental health can get better if they'd just improve their
nutrition and actually stop their physical thought linking minds.

In fact many of you see the PCMHI people have told us that it really is a PCBHI, behavioral health. And that the ratio of those folks are not there.

I've wondered if the whole health program might facilitate that. I would love just to see the integration between PCMHI and the whole health program.

I'll probably need some design thinking, because I noticed on your slide of this, of the step care model, you said this is future. And this is -- so it sounds like it's aspirational in those areas.

And I'm just wondering again, to get back to the resource question, what do you need to make this happen? And that's really the question we're getting at.

This is sort of the ideal model. And we have these spots of brilliance in which, you know, particular aspects of that long list of
characteristics, each of which is a challenge in itself, to actually implement efficiently and technically, gets a part -- becomes routine.

And it gets easy. What's needed to actually make that happen? If that happens, I would assume that then we would be using less of the top level of the resources.

If we invested more in the lower level resources on a preventative area. And so maybe that's where the cost-effectiveness and the cost investment meet so the resources could be associated.

So I wonder if you could kind of comment a little bit on that? About what is needed here in order to make this sort of aspirational model a reality everywhere.

DR. POMERantz: The easy quick answer is we need leadership with vision and courage.

Those two qualities.

We need leadership to have a vision.

You know, to really go past all they were trained to do and think about what healthcare they should
be.

And have a vision of how that can happen locally. How can we achieve that? But also have the courage and will to lead the people who are working with them.

Because a lot of this flies in the face of a couple of centuries of mental health knowledge. I think you know, we like to say we left Freud behind, but we didn't.

You know, there is still a view among most mental health providers, and I can go out on a limb and say most, not just many, that unless you take a comprehensive intake, just learn everything you could possibly, that the patient is willing to tell you, you are not delivering good care.

And that's why most patients coming into public mental health systems, if they show up, they don't come back. And they don't engage in care. Because they're not getting what they want.

COMMISSIONER JONAS: Yeah, so should
there be more? You know, this is on the
reduction of the redundancy and the de-
implementation component.

Because that's where the courage is
needed, right? Don't do that. Not do this, but
don't do that. I mean, is that -- if we would
focus on that, would that help this become a
widely spread use?

DR. POMERANTZ: Yes. I think it
would. I think it would. I mean, we see
frequently, at least within the PCMHI program,
you know, programs rising to the top and then
slipping when there's a leadership change who
doesn't get it.

So yes, I think getting -- and that's
part of the courage. Is to really look at what
you're doing. How you do it, and reflect on it.

COMMISSIONER JONAS: I assume you two
talk a lot about how to measure the outcomes
here. And the outcomes that I heard here are
primarily process outcomes.

DR. POMERANTZ: Right.
COMMISSIONER JONAS: That doesn't get
at the other up to triple, I would say quadruple.

DR. POMERantz: Right.

COMMISSIONER JONAS: Are needed and
hope we can talk a little bit about that.

DR. POMERantz: Yeah. And --

COMMISSIONER JONAS: That might be a
way of doing that.

DR. POMERantz: And I think something
as simple as measurement-based care everywhere is
what we really need. I can't show you.

I can only show you clinical outcomes
in programs that have looked closely at them.
But that's not a lot of the programs. So that's
what we need.

CHAIR LEINENKUGEL: Go.

COMMISSIONER KUNTZ: Doctor, I would
second the request for the PowerPoint. And if
there's any way to have footnotes for the stuff
that you'd really want to highlight where you got
the research from.

Because we are going to have a report
at the back-end. And every bit of guidance that comes with a footnote is doubly valuable for us.

I have a question I guess since you brought up ECT, and this facility in particular is really well, I guess really does well with treatment resistant depression through TMS.

It makes me wonder, what is the journey of somebody with treatment resistant depression in your system look like? How does it go through that process?

Because working with folks that go through there, at least on the ground, it's pretty difficult. What does that process look like in your system?

DR. POMERANTZ: When you say my system, do you mean the VA? Because I mean, it's, you know, hundreds of different ways it could happen. But, in a logical continuum of care, --

COMMISSIONER KUNTZ: Yes.

DR. POMERANTZ: How it should it look, is it starts with early identification. As you
know, the VA screens for depression yearly in every patient.

And either a positive screen or a -- something the patient says, you know, the screening doesn't pick up everybody. And there are false negatives as well.

False negatives and false positives. That that screening then leads to ideally the primary care team asking a few more questions. Maybe the PCMHI folks getting involved.

And developing a treatment plan with the patient. May or may not include medications. Since we're talking about ECT, we'll assume that there's medications being tried.

A follow up with care management. And the care manager in the collaborative care model, following up with both the consulting psychiatrist and the primary care provider.

And then let's say that patient's PHQ score started at 18, and after a month the score is up to 22. Which is much worse.

At that point the patient -- and said,
I don't think we can really manage what you've got here, in primary care. I'd like you to, you know, I'd like to move things up to another level of care.

They go into general mental health. They get a more specialized team. They may have other providers involved. They may have a few others.

They will obviously have somebody doing very close medication management. Tracking that score. The score goes up.

I would like we were talking about complementary and integrated health a moment ago. I would hope that there would also be some efforts made to go beyond the medications. So again, that's part of the team care.

And look at other things that may be helpful. And then gradually over time, provided this patient is still safe, you know, ECT although it's very safe, it's the most effective treatment we have for depression.

It has, you know, it's resource
intensive. It has a very bad reputation among patients. They're scared of it.

But at that point, I think that's when ECT is going to be indicated. It may be done in that facility. It may be done elsewhere.

I think there are other things that can be done. I think the literature on transcranial magnetic stimulation for depression is still evolving.

I know of some sites where they say well, we want to do that before we go to ETC. Because it's easier. It's cheaper. It's safer.

You know, it looks -- you know, patients are more comfortable with it. But that would be a -- that would be a typical flow.

COMMISSIONER KUNTZ: Okay. Thank you.

CHAIR LEINENKUGEL: Wayne?

COMMISSIONER JONAS: Are there sufficient social workers in the facilities?

With the teams? And what impact might be boosting social workers to have on suicide?

DR. POMERANTZ: Okay, I'll say it
again, support for a life worth living. And I think that's key to what social workers do. And I think, do we have enough? Probably not. I think the key issue in there is that there's a PACT social worker who's a medical social worker.

And the PCMHI mental health provider maybe a licensed independent clinical social worker, who is providing psychotherapy.

So those are the two components of social work. And I don't -- I never think you can get enough social work.

I mean, there are just so many areas where patients often need help. Some pat -- I've seen patients, I won't use the word cured, but certainly, you know, improve just because somebody helped them get food stamps.

Or another patient of mine with severe PTSD, who went through all of our stuff. And he got a dentist and got new teeth. His life changed.

COMMISSIONER JONAS: I'm just reminded
of Emil Durkheim, the original massive study on
the Sociology of Suicide where he said, if you're
embedded in local, family, and community
components, suicide levels are low.

But if you're not in that, suicide
levels are high. And that's the obvious part.

DR. POMERANTZ: Yeah. And I was
reading something the other day about, you know,
globally the suicide rate is dropping.

COMMISSIONER JONAS: Yeah.

DR. POMERANTZ: You know, we're an
outlier.

COMMISSIONER JONAS: Yeah. We're an
outlier.

DR. POMERANTZ: And you know, and
that's because so many more under-developed
places are getting, you know, kind of getting
that end handled a little better.

CHAIR LEINENKUGEL: If I may Andy, let
me as the Commission lead, ask the last question
of you. And take you off the hook.

But this was a fantastic presentation.
And truly met the needs of some of our key questions.

DR. POMERANTZ: Good.

CHAIR LEINENKUGEL: There's something that bothers me, and has been around the VA. You said something your presentation.

When you're building out a great model such as you have, and you know that certain things are really effectively working. And you say mandating something does not usually work.

It's contrarian to my thinking and my knowledge from the private side, when you have a big idea and you take it through your system, whether it's making and selling beer for instance. That was my background and I know every well.

If it's a big idea and a new technique or something new, you do mandate it. And everybody goes immediately, because they know that it's going to be the best for the company.

So when you say that in the context of a big idea for evolving mental health and the
continuum of care, and you say wait now, we don't want to mandate it because we know that does not work. Could you clarify that?

DR. POMERANTZ: I have a colleague in the Department of Defense who goes after me when I say things like that. He's like well, you just tell them to do it. They go to do it. That's how we do it.

What -- I think there are a lot of factors that come into play. And one is, that it's going to be more effective if you have the heart and soul of the people who are doing it.

And telling them do it this way, I mean what worked in my shop in White River Junction, Vermont may not work in Boston. I heard that from the people in Boston a lot.

But, you know, the idea is to be able to mandate this is what we're trying to do, these are the principals. And then say, you've got to do this.

Which gets to a lot of what Cliff is going to talk about, about measuring things.
That people -- I have a conflicted relationship with SAIL and some other things because I think it doesn't often get to the heart and soul.

But, I think that in order for that, and there's been a lot written about successful businesses. And you know, belief, you know, the employees belief in the brand and the company and the product is critical.

And I think a lot of our providers hate, and I've seen recent email chains that I've had to intervene on, you know, about this, you know, VA forcing us to do all these things and use these templates, and losing the human part.

I think that there's a lot of kind of education and motivational interviewing that has to be done with our own people to have that happen.

CHAIR LEINENKUGEL: And I don't disagree with that. But you just said it. I did not see anything on your slides that would deviate from the human part of making that type of transitional change.
And I only say this because I think that everything moves at a snail pace when it comes to veterans healthcare within a large system like this.

And I'm speaking just for myself at this point, on an 18 month experience within the VA. And so I'm on the record as basically saying that sometimes when there's a big idea, we are very slow to implement that big idea that could be helping veterans and their continuum of care.

DR. POMERANTZ: Well, that's the diffusion of innovation. You know, there's a lot written on that topic and the difficulties of doing that.

So, I prefer myself to work with the early adopters. And then have the others be pulled along rather than putting all the efforts to folks that aren't into it.

CHAIR LEINENKUGEL: Doctor, thank you so much for today.

DR. POMERANTZ: Thank you. Thanks for the opportunity.
CHAIR LEINENKUGEL: Appreciate it. At this time we're going to transition to Dr. Cliff Smith, and he's going to be talking about SAIL.

DR. SMITH: Thank you.

Good morning, everyone. I'm Clifford Smith. I am a psychologist by training, a neuropsychologist by specialty. Current title, I'm Director of Field Support and Analytics. Prior to the office merge, I was the Deputy Director of Mental Health Operations. So, my skill set falls on the operational side.

Andy and I have the north covered. I live in Iron Mountain, Michigan. So, Chippewa Falls is still south for me.

I cut my teeth as the Chief of Mental Health there for about six years. So, I understand rural mental health and the challenges when your veterans live six hours from the medical center.

I've also worked as an Associate Director. I understand budgets, the money issues that Directors face, and I've been in operations
for a number of years.

Next slide.

So, we're going to talk about SAIL.

I was thrilled to hear -- it warms one's heart
-- when one does not have to bring up the Triple
Aim and others already are familiar with that
model that was first identified or outlined in
2008 with a focus on improving the health of
populations and enhancing the experience of
individuals, of those patients, and being mindful
of the cost.

That was expanded brilliantly, I
think, in 2014 where the importance of the
healthcare worker was added to the model. Hence,
the Quadruple Aim. And so, we're going to talk
about that and how I in my work try to move the
field into improvement in these four areas.

The challenge, we have there, the last
bullet, nationally accepted quality metrics
specific to mental healthcare are pretty sparse.

Next slide.

You're probably very familiar with, if
you Google "healthcare quality," there's a lot of systems out there measuring hospital quality, CMS, you know, where somebody shows up on The U.S. News & World Report, right; Leapfrog; Healthgrades. The challenge with those is they're typically hospital-based; they are not mental-health-based. And if they are addressing mental health, they're typically mental health related to the hospital. So, HEDIS or ORYX measures, your inpatient hospitalization, length of stay, readmission rates, things like that.

So, there really is no good comparison of quality between VA and non-VA facilities.

Next slide.

So, that got the VA a number of years ago looking at developing its own kind of comparative model; hence, the development of SAIL, Strategic Analytics for Improvement in Learning. This is just kind of a historical slide that's been around for a long time. You're probably very familiar with the rating star system. All facilities receive a score, then are
ranked based upon that score. The problem with a ranking system is what? You may be a very good system, but you may be ranked low. So, that's easy to perceive, oh, my gosh, you're ranking at 100; you must be a poor facility. That doesn't necessarily reflect the truth, right, because we are comparing ourselves to ourselves.

Next slide.

The challenge with the original SAIL metric was mental health was left off. And so, I think there's part of the mental health culture, right? We are a medical healthcare system who accidentally does a little mental health on the side. And so, a group of us, back in 2014, met with the SAIL group and developed a mental health component to be added into the SAIL. So, one could say mental health was an afterthought to SAIL. It would have been better if we were at the table as it was developed, I think, initially, but it was a great thing to add. So, in 2015, Mental Health SAIL came into existence. There is an article that we published on that
process, what the mental health component looks like in SAIL. That is cited there with Lanki, 2017.

Next slide.

So, the approach we took with mental health was, if I give a facility a metric, a single metric, I'll guarantee you they're going to take it, right? People, providers, will bend around backwards in order to make this.

So, we were a little devious on the mental health side. There's not a single metric. Mental Health SAIL is actually three components, and within those components there's multiple metrics. So, it was intentionally designed so you could not push all your resources into a single area and succeed. You had to push resources everywhere to succeed. And that's the system that we intentionally tried to create.

We focused on three critical components of care. Think of them as three doors:

Population access. So, for example,
if I know at a facility there are veterans, there are 10,000 veterans that have a substance use disorder diagnosis, that's my population. And then, I want to be able to look at how well that facility is reaching out to that population. So, if the facility is only seeing one patient out of that 10,000, that's probably not a good thing, right? It's not intended to be 100 percent of the population, but we want to get the sense of how well a facility is set up reaching out to the mental health population.

The second door is the continuity of care. So, once a facility is able to reach out to a veteran, how well can we provide treatment to that veteran. This isn't just seeing them one time. Maybe that's important. But we want the full episode of care provided to that veteran. So, door No. 2 gets at the continuity of care, how well, once we engage them, we can engage them into some kind of treatment.

And then, the third component, going back to the Quadruple Aim, assesses not only the
veteran's satisfaction, but we added the provider's satisfaction, intentionally thinking of the Quadruple Aim; that if our providers are not happy, if our providers are burnt out, we will be decreasing the quality of our care in the long run.

So, with those three doors, those all funnel into the single Mental Health SAIL domain.

Next slide.

So, what that looks like at a facility level, this is Tampa's data from quarter 3. You've probably seen it. Originally, the same picture would have been there, but mental health, which you see up at about three o'clock there, would have been gone. It didn't exist until we added it in 2015.

This is the broad level of mental health. All three of those categories, population health, continuity of care, and experience of care, all are combined into a single overall metric. And Tampa's doing a very good job there, you can see in green.
Next slide.

The second component that facilities have access to is, then, it breaks it down. So, going from that broad mental health domain to now the three components, you can see up at 12 o'clock there experience of care, which although it's at the top, their performance is some of the best in the nation. And then, there on the left, continuity of care and population coverage. So, a facility can see where they rank in relation to other facilities.

Next slide.

There's a dashboard. This starts just teasing it apart. Mental health there is down at the bottom. You can see one, two, and three, again, the three doors and their performance.

Next slide.

So, what is being funneled to those components? The population coverage component, continuity of care component, and experience of care component are a series of metrics. And so, here's an example of our population coverage.
So, you can see we're looking at populations of substance use disorder, PTSD, depression, and seriously mentally ill. Those would be kind of the four big buckets that would be feeding this population metric.

A couple there, the HIAS 21 and 72 there, that gets into our seriously mentally ill population. ICMHR is our MHICM program or our intensive case management. So, here at Florida, you can see, just quickly, there on the third row down, the percent of vets with ICMHR-targeted diagnosis receiving ICMHR. This is intensive case management. You can see Tampa is approaching 5 percent of their population, which is above the national average. So, they're doing a great job reaching out to our most seriously mentally ill veterans with a serious mental illness.

Next slide.

And so, population coverage is actually made up of 15 metrics. Continuity of care has 13 metrics. And experience of care has
six metrics. So, I hope you can see we're trying
to discourage facilities from putting all of
their resources in a single basket.

So, if I made the single focus of
quality care in the VA PTSD care, every medical
center across the U.S. would take all of their
15,000, whatever number we are at, mental health
professionals right now, and say, you're doing
mental healthcare. We would all do great. But,
then, others would suffer, right? Our most
seriously mentally ill, the resources would be
taken away.

So, the Mental Health SAIL was
intentional about that. We took the Uniform
Mental Health Service Handbook, which outlines
the required mental health services at each
facility, and tried to create a system where the
goal wasn't to focus on one thing; the goal is to
focus on all things.

Next slide.

That exists. So, what do facilities
do with it? In my group, I in many cases, and my
staff in many cases, develop and distribute a series of dashboards that are specifically designed to identify those challenge areas and identify the opportunities, and create a process for improvement.

I have a series of monthly webinars. Right now, twice a month I talk about mental health access. Since 2016, I was actually doing that weekly. So, I think I had had over 150 webinars specifically on access. I have a once-a-month business operation call where I take some component of business or SAIL and discuss/outline process improvement activities.

Dr. Klocek and his gang of technical assistant specialists host a once-a-month SAIL process improvement webinar, where, again, we will focus on specific metrics and identify ways and best practices of improvement.

I have quarterly calls with our VISN mental health leads in the facilities to discuss the challenges and opportunities.

I have three Program Evaluation
Centers with a bunch of very bright analytic folk that are available for onsite consultation.

In the last bullet there, probably that which has had the greatest impact is I have seven dedicated staff -- Dr. Klocek is one -- called Technical Assistance Specialists who are improvement specialists. And we do a series of ongoing onsite and virtual improvement training sessions. These may be two to three days. We will go to each facility, either at their request or based upon a review of where they fall in SAIL. If they're in the bottom of the SAIL performance, we're probably going to come visit a site.

We did publish recently in 2018 an article that outlined the site visit collaborative care process, the collaborative process. Back in 2012, we started doing site visits that were very intense and which resulted in a lot of action items. It was in response to Congress. Congress in 2012 required us to visit every VA and to review the compliance with the
Uniform Mental Health Service Handbook. And that resulted in, you know, here's your 30 action items for follow-up.

Our process now, like with our Technical Assistance Specialists, is, unless it's a matter of safety, patient safety, I'm not going to tell somebody what to do. Here's what we would suggest. Here's our plan for process improvement. Here's ways you can get there. But, ultimately, like Andy said, it's up to the facility and local decisions. But that's an ongoing process, and we do a lot of traveling with that. And those could be "for cause" or consultative in nature.

Next slide.

So, the challenge, we know untreated mental health conditions -- Andy talked about this -- lead to increased mortality, worse health outcomes, increased disability, right? There's some challenges with mental health.

Next slide.

To help the facilities, we create
deep-dive tools, and some places we intentionally do not develop deep-dive tools. For example, the example the facility has 10,000 veterans with a substance use disorder diagnosis. I am not going to develop a tool to tell a facility, "Here's your 10,000." I get that asked a lot. They'll give me a call, "My Director wants to know..." And I will refuse, because you're not going to cold call 10,000 veterans saying, "Hey, Pal, don't you want to come into treatment?" That's not how we should be developing mental health. We want to create an environment where those 10,000 feel welcome to come, right? So, some places deep dive doesn't make sense. Other places deep dive does.

For example, the first bullet there, the antidepressant non-adherence, patient dashboard, blah, blah, blah, that's a metric MDD43h and 47h. That one requires, for a new diagnosis of depression, you want good medication coverage. So, that's 84 days' coverage and, then, 120 days' coverage.
We have a deep-dive tool where you can see here's a veteran who has a new diagnosis of depression. And yet, they only had a 15-day prescription of an antidepressant. Maybe we should follow up with that veteran, right? Maybe we want to ensure that, if it was serious enough to diagnose, don't we want to ensure that we've covered it? So, we have tools like that where it does make a lot of sense to understand who we should be reaching out to.

Next slide.

Shifting gears some, I get this asked a lot. Does staffing matter? This is a correlational analysis. I know it's busy, but each quarter is one box. Because I say I've argued, yes, your staffing is important to how you do on SAIL. And no matter what quarter I look at, it's consistently somewhere around a correlation of .5 or 25 percent of the explained variance is attributed to how well a facility is staffed. And staffing here is not the number of staff you have, not the FTE. It's the ratio.
Next slide.

I recently published an article here, "Mental Health Treatment, Access, Quality, and Satisfaction: Optimizing Staffing in an Era of Fiscal Accountability". Myself and group, Dr. Klocek, published this article looking at does staffing make a difference.

There's two ways to approach staffing. One is an efficiency-based model. If you look at their productivity -- and there's a system in the VA called SPARQ, you may have heard of, that balances productivity and wait time. So, if you look at places that have low wait time and low productivity or high wait time and high productivity, you can draw out the quadrant and say, gee, maybe you have too many staff; maybe you need more staff. It's an efficiency-based model, based upon how efficient those providers are with their productivity.

I've argued in the article, and other places, I'm not a fan of an efficiency-based model. For example, the example I use is
evaluating the unemployment rate. The unemployment rate only tells us the rate of unemployment among people who are looking for employment. At some point, people become discouraged of looking for employment. And so, they stop. They're still unemployed; they're just not counted in the rate any longer, right?

And so, my concern about efficiency-based staffing is it only tells us how well we are doing seeing the veterans who are coming. There's in many cases a large population that just stop coming, right? If staffing is poor, they get frustrated; they know don't come. You know, you're not going to be seen anyway. So, they still would benefit from being seen, but they've stopped coming. So, they're not going to show up in an efficiency-based staffing model.

So, we have argued in the VA for a population-based staffing model of 7.72 providers per 1,000 veterans, outpatient veterans. And so, I know how well a site meets that is really well correlated with how well they're going to be
doing on SAIL. So, their quality, their access, their satisfaction, provider and veteran satisfaction, are all going to be related to how well staffed they are.

Next slide.

This is just a real simple graphic to show pictorially how well we do. You can see our Northwest generally is our better-staffed facilities. The Southwest and the Southeast are our challenged facilities.

Next slide.

There is a hiring initiative, right? You may have heard Dr. Shulkin specifically initiated an initiative to add a thousand net new mental health providers. Currently, from the start of his announcement, we are at 866. The VA can hire. There are some challenges with hiring I'd be happy to talk about and have opinions on. But this is our staffing ratio over time. Okay?

And you notice it's not going up. In fact, if I really were to blow this up, we're actually going down. So, how can we be hiring in
the VA, but our staffing ratio is going down?

We're getting more patients. The more we attempt
to hire, the more patients come. It happens
everywhere. If I were to bless any facility with
here's an extra hundred staff, veterans would
come. And so, as a result of that -- next slide
-- our staffing ratio goes down.

So, you can see over time, this last fiscal year, we were up over 1.7 million veterans
served in mental health. You can see we continue
to hire. These numbers are a little old. We are
over 12,000 now in outpatient staffing. And yet,
our ratio is flat. And that's simple math,
right? Our hiring cannot, or at least is not,
outpacing the veterans that are coming in.

Next slide.

So, this is a tool I created to help
facilities understand where their challenges are.
And this is Tampa's SAIL data. So, this is the
population coverage for Tampa. And they have a
couple of metrics there that stand out, PACT15
and Psy38. Those are the places where they are
performing less than the 50th percentile for the
nation in SAIL.

So, if the mental health staff here at
Tampa say, you know, gee, we want to be at the
90th percentile in our SAIL, this will tell them
how many patients that would mean, and those
little yellow dots are what one provider could
account for. So, you can see Tampa's PACT15 or
their PCMHI, they're really doing well. You
know, 300 more patients seen in PCMHI this year,
and they would be at the 50th percent for the
nation. So, maybe they want to be at the 90th
percentile; they want to lead. I can easily
calculate that, and I know what that means for
patient care. And if I know what that means for
patient care, I can calculate that into what that
would mean for staff, right?

In many places, why I created this is
facilities want to do better on SAIL, but the
bottom line is they don't have enough staff to do
better on SAIL. And so, it was a tool to help
medical center directors understand this is what
it would take in staffing if I wanted to get
there.

Next slide.

So, some projects: the Mental Health
Access Initiative, Modeling to Learn Step Care,
Andy talked a little about step care. I'm not
going to talk about that, but will briefly about
Modeling to Learn. But I want to hit next Mental
Health Access Initiative.

Next slide.

I wrote, back in 2018, a memo where I
asked the field in general mental health to
specifically design in general mental health
programs, or your BHIPs, this thing called open
access scheduling. We have same-day services,
same-day care, but that's different than an open
access schedule where, as a psychologist I want a
specific portion of my week to not be scheduled,
so I can tell my patients, "If you have something
that comes up you need to see me, Thursday
afternoons is my free time. I see patients. If
I'm free, I'm happy to see you." You know, it's
a scheduling model.

So, I was writing a memo outlining that "ask," and before I wrote it, I sat down and I wrote a preamble. And it was essentially this, and it was my aspiration for the VA: that we aspire to be the nation's leader in understanding what access is.

And access for me has three components. There's crisis access, engagement access, and sustained access. And I'll explain the three and the differences.

I was involved early on with the Access Initiative on a detail from my position as Associate Director at Iron Mountain, and I didn't like the conversation. Because, usually, when people talk about access in the news, they're talking about access right now for this crisis. That's all it applied to. It would be simple -- I can instantly today create huge access in the VA if I just tell all of my providers, "You no longer do individual psychotherapy." We are an emergency department. We do crisis care. We
have access. It's simple, right?

Or, instead of individual psychotherapy, if I say, "We will only do group psychotherapy," look at that. Instead of one patient per hour, I can now see 10 per hour.
I've increased access, right?

But that was at a detriment to quality, right? So, access to crisis is critical. If there's an immediate need, we have to have an available system to see that veteran.

But, as Dr. Pomerantz talked about, we need engagement access. When a veteran asks for help, we have to be able to see them as rapidly as we can. If my ability to see this veteran who asked me to help today is to schedule them six weeks out, I've lost that veteran. They're not coming back. And then, I wonder why we have a no-show, right?

I sit in my office. I wait with my patient list, and I'm surprised the patient didn't come see me. Of course they're not going to come see you; that was six weeks ago, right?
So, we have to engage them quickly; get them in for that appointment. If it's the same day, like in PCMHI, open access, great. If we have to schedule it for their convenience next week, that's what they wanted, great. But if I have to schedule them out four, five, six weeks from now, I've lost that opportunity. So, we need engagement access.

And finally, we need sustained access. When we get them in, when they come in and ask for help, we have to be able to provide the full course of care that that veteran needs. And if that's weekly psychotherapy, we need to have space or access to schedule weekly psychotherapy. There are many places where psychotherapy consists of one appointment a month. I'm a psychologist. I know I'm a snob sometimes. Once a month is not psychotherapy. It may be good support. It may be important for that veteran. But let's call it what it is, and it's not psychotherapy, right?

We need intensive care for psychiatry
follow-up, for psychological follow-up for therapy. We need space to be able to do that.
So, the Access Initiative for me was about finding this balance, not just focusing on crisis care, care right now, but how well is our system doing in all three, right?

Next slide.

So, I created a bunch of stuff and I've presented hundreds of times on this to facilities, walking them through how they can, at a facility level, understand how they're doing in all three. So, this is just a simple slide. 502 is general mental health. This would be your BHIP. This is our completed appointments in a month. The orange, the biggest ones, those are scheduled. The little red slot is a walk-in appointment, a same-day appointment.

In the VA, there are two ways you have a same-day appointment. One is it can be scheduled. Okay? And it can be scheduled either as a walk-in or unscheduled, or you can call, say, at eight o'clock; you'd like to be seen.
Get an appointment scheduled at two o'clock, later in the afternoon. That's a same-day appointment. It was scheduled, but it's the create date and the appointment date equals the same.

The last component is -- so that purple, that's created through our CPRS system. It's not a scheduled appointment. So, that is, there was a need. A veteran needed an appointment. A provider was free. The provider saw the patient and they wrote a note in CPRS when they created an encounter. It's not an appointment, right? An appointment in the VA is made in VistA. An encounter is just between the patient and the provider. They both have workload, but one is just a formal system in the old computer, right, in VistA, and the other was not.

And so, if you add up all of that, you can see we're a little less than 10 percent scheduled same-day appointments. But when you look at that same-day workload -- so, I know, as
a Chief, I saw patients, but I may be walking
down the hall, and one of my providers sees me.
"Hey, I have a situation here I'm not sure what
to do with. Can you see this patient?" I'm
happy to.

I'd see the patient, put my note in,
right? It wasn't scheduled, but it was a same-
day appointment. And when you look at all of
that in the VA, we are approaching a little less
than 25 percent in BHIP monthly workload that
happens the same day.

Now the question I often get is, so
what's the right amount? I don't know. The
right amount is whatever the amount the veteran
needed, I guess, right? It's not 50 percent. I
don't want to go to 100 percent same-day access.
There's no treatment there, right? But I need
this kind of availability. And I created this so
sites can understand what's happening every day.

Next slide.

This gets to the engagement access.

This is looking at our wait time from a create
date -- somebody asks for help -- to when they were actually seen. This is just looking at change over time, and you can see, roughly, if we look at general mental health or BHIP, we're somewhere around 14 days, which isn't bad, right? You know, two weeks for that first appointment can look pretty good. And this is nationally. If I look at individual facilities, it can be less; it can be more. But, nationally, we're at 14 days.

Next slide.

But the trick with mental health, though, is we're a bunch of different providers. So, at most facilities, it's fairly easy to see a psychologist or a social worker. There's more of them, right? There's fewer psychiatrists, depending on the site you're at. And so, this is that same process, but now I asked, what's the wait time for psychiatry, not just to see a provider? Because to see a psychologist is usually pretty short. To see a psychiatrist nationally, you can see there's a bad trend going
on, right? We are creeping up. If you're familiar with statistical process control charts, the dotted line there, the upper and lower control limits, and now we're one standard deviation over, our wait times for psychiatry nationally are creeping up.

Next slide.

There's another process of the "So what?" So, there's a ton of data out there. What do you do with it? Those are just some things that I've created for facilities to understand locally.

Here's another one, and I'll end with this, and open for questions.

There's a process out there called Modeling to Learn. It takes local data. So, here you can see this is psychiatry data. AUD is alcohol use disorder/depression. OUD, opiate use disorder and other. It takes local data and pulls from that.

Next slide.

And then, we sit down with staff and
we ask them, okay, so what is it exactly you're trying to do? If you're trying to improve your wait times, decrease wait times, if you're trying to improve access to OUD, there's a system out there, and this is just a little snapshot. But this helps sites understand, if you make this little change here -- so, for example, if we can change our no-show rate from 15 percent to 12 percent, the system here, the algorithms will show sites in real time what that would actually mean for their access.

So, this is similar to flow, right? There's not enough mental health providers in the U.S. to see everybody forever, right? My job, as a psychologist, is to work myself out of a job. You know, if you could to see me for care, if you're still seeing me in 30 years, my new house may appreciate that, but I wasn't successful as a provider, right? I don't want you to see me for 30 years, right? We need flow, right? Get the care when you need it. Feel free to come and go. But don't stay forever. This
helps sites understand with their own data, if they make these system changes, here's the real-world impact that it would have on your clinic.

Next slide.

And this is just some early data from that. The first, to the left, those are seven clinics that did the same thing as usual. And you can see nothing really changed. And this example was the site wanted to increase their evidence-based psychotherapy. So, the team, using these principles, helped Clinic 1 and Clinic 2. The seven clinics changed nothing. And you can see they didn't really change how much evidence-based psychotherapy they were providing. Clinic 1 and Clinic 2 did make these changes based upon input from the algorithms. And you can see the significant increase in their goal, how much evidence-based psychotherapy they were actually providing.

Next slide.

I think that is it. So, with flow and that Modeling to Learn, just two models of using
facility-based data to help facilities understand
how they can make system changes to improve
access, quality, and satisfaction.

CHAIR LEINENKUGEL: Thank you, Dr. Smith. Enlightening. And I wish I would have
had that 18 months ago as far as SAIL is
concerned, but also over that 18-month period
you've been doing a lot of fine-tuning and work.
Especially, I did not know that mental health was
not part of it back in 2012 or 2014. So, thank
you for finally initiating that.

This will be helpful, I think, to a
degree for the Commission and Commissioners to
dig a little deeper from a national basis.
Because, you know, our charge is the entire
veteran mental health issue and the entire nation
and community of veterans.

So, when you're speaking of staffing,
to me, I mean, it goes right back to the resource
issue. And we already talked to Dr. Pomerantz
about that as well. It's always the biggest
catch and bugaboo, I think, going on nationally,
and you said it yourself.

    I mean, from a context of what the
Commission has to do, it is to answer the
question about resources, and it's pretty clear
to most of us that, you know, that is going to be
an ongoing challenge. So, when you look at your
flow and you look at how you want to do the
continuum of care, along with what Andy
presented, which I think is absolutely critical,
I'm really worried -- and I think the rest of the
Commissioners are -- about properly staffed and
resources.

    But we would probably like to come
back to you, and we've gone over time for a
reason, because this is, both sections, very,
very important. And I want to give the other
Commissioners time to ping you as well before we
go to break.

    MR. POTOCZNIAK: I guess I could say
there's one question I have. You mentioned in
your slides about how primary care is kind of the
de facto kind of initial mental health care, and
it does serve the largest amount of people.

It seems like there is, though, a block, and I've noticed it kind of throughout some of the VAs, where a lot of primary care providers are not willing to fill that role.

It's a big frustration for general mental health as well as specialty mental health.

Is there anything in the VA that does -- we don't want to say "mandate," right? -- but is there anything that does mandate primary care providers to provide that care? Because there are definitely whole clinics where primary care will ban together and say, "We're not doing this."

DR. SMITH: And I'm sure Andy knows sites like that.

Completely agree. There are many providers uncomfortable with mental health, will outright refuse even a mild, you know, an antidepressant for mild symptoms. No. And this gets to the flow, right? So, they've been very stable on this medication for 25 years in primary
care. There we get into the pockets. We work, Andy's office works a lot with chiefs-of-staff.
I think, for me, that's really where I want -- mental health has to do a better job
supporting, and we have to do a better job, as our overall facility processes, understanding this. We are sharing patients.

In my community, in Iron Mountain, there's one psychiatrist outside of the VA, and he is scheduling 18 months for that first appointment. I know the majority of primary care providers in my community are treating this. They are the ones who are treating mild depression. We have a hard time with that, and some VAs struggle more than others.

The challenge is, I cannot, from a central office perspective, come out with my Smithsonian fiat and mandate it. I have to provide an environment of education and support to try to get the field there, rather than the big hammer.

CHAIR LEINENKUGEL: Matt?
COMMISSIONER KUNTZ: I guess coming from my part of Montana and our part of the country, I just have been so amazed here at the level of like psychologists doing clinical care and master's level social workers doing case management. I mean, it's almost a degree above kind of where you see in some other parts of the country. Montana, you would probably be just as likely to receive clinical therapy from a psychologist as you would from the talking elk. You know what I mean? They're not statistically different. They're just not. Nobody is doing it.

And I guess I wonder, how do you measure staffing when -- like these guys have USF across the street, and they should be using psychotherapists. I mean, whereas, if Montana chased psychologists, that's dumb. You know what I mean? I mean, just do your numbers reflect those different realities in terms of staffing and what's realistic?

DR. SMITH: So, like with the 7.72, we
don't have a specialty breakdown. From Iron Mountain, historically, hiring -- I know when I started, I had five psychologists, and that was it. Most of my providers were social workers because that's what is available there.

And we have to be thinking what resources are there. Sure, there's some things that's a Board-certified neuropsychologist that only I can do. But, in the grand scheme of things, that's just a very limited amount, right?

So, I don't tell any facility, "You need more psychologists." I would advise facilities, "You need more therapists." Now, if that's marriage and family therapy, if that's licensed professional counselor, if that's social worker, hire what is regionally appropriate for you.

There's a few positions that are mandated, but it's not specialty mandated, unless it be like a neuropsychologist kind of thing. But I don't tease it apart to get at that.

Like the challenge with Montana, and
other sites that send work out into the community, community care, it's a challenge, right? I know, as a chief, I would send my veterans out, and I didn't always get notes back. And when I did get notes back, they were often pretty bad notes for VA quality.

But we don't measure that. So now, we get into the whole MISSION Act and that, hopefully, will be changing as we develop our community partnerships. But I can look at, like with Montana, I recently spoke with the chief of staff. Lot of sites will think, "Well, we're doing a lot of community care." I can look up how many you're doing in community care and I can do the math and say, you know, yes, I know you're doing a lot, but, still, there's this bigger population out there. So, what are we doing? It's not all community care.

But, there, we have to get into the partnerships like just there's no psychiatrist in Iron Mountain. You can search all you want, and other than Dr. Van Holla, they aren't going to
exist. So, how do we supplement that in the VA,
tell community care, where appropriate,
partnering with HOMA, partnering with Madison?
Some 10 years ago, I had psychiatrists stationed
in Madison and Milwaukee, and even at home. We
have to think outside of the box, especially like
in our more rural places, even social workers can
be pretty thin.

COMMISSIONER KUNTZ: Thank you.

COMMISSIONER MAGUEN: I have a follow-
up question, because I think you're bringing up a
really important point about in the cases where
we do have to have veterans go outside of the VA.
And what are some of the things that we're
thinking about? Here you're presenting a
beautiful model of how we look at quality inside
the VA. How are we going to make sure we're
holding outside providers to some of the same
standards?

DR. SMITH: That's a very timely
question, especially with the MISSION Act.
There's been lots of conversations, even along
the lines of -- what I appreciated with the MISSION Act is there's specific lines in there of quality. What is quality care?

And as Dr. Pomerantz said, if I wouldn't send my family to this provider in the community -- and I know in my community there are providers I would not send my family to -- how can I send veterans there? What I appreciate with community care and the MISSION Act is I think we're going to be able to define that. The challenge we have, for example, in mental health, we do great evidence-based psychotherapy. There's nobody in the private sector that does evidence-based psychotherapy like we do it. So, from a leadership position, if I say I expect the same thing in the community as I would expect from my providers internal, I've just eliminated care because it doesn't exist.

In a similar fashion, if I hold the community to the same level of training that I have -- I have an APA-accredited internship; I have an accredited post-doctoral fellowship; I
have my Board -- if we set up our standards the
same internally for our community care, we've
just eliminated opportunities for care, right?

   So, that's going to be the interesting
battle, right? We have a set a very high bar.
This is why I love VA mental healthcare. There
is a high bar. The Uniform Mental Health Service
Handbook, published 10 years ago, was way ahead
of its time. Nothing like that is in the
community to have that broad residential. I
mean, we have the system covered. I think that's
going to be the interesting thing, how that works
out.

   Do we lower our standards to be able
to provide somebody? Is a body better than
nothing, right? There's people smarter than me
working on that. I think that's going to be our
challenge.

   COMMISSIONER MAGUEN: Right. It is a
measurement dilemma, though, because the
definitions necessarily are going to be
different, right?
DR. SMITH: Yes.

COMMISSIONER MAGUEN: And then, how do you balance measuring what's going on inside the VA with other places what's going on?

DR. SMITH: Right. I could give examples. Like we have required follow-up post-discharge from an inpatient service, right? The public standard is you can -- if I'm on an inpatient unit and the social worker comes and sees me while I'm on that unit, that would count for seven-day post-discharge. Okay? And I think that's a pretty silly model, but that's the definition. Okay?

And so, there was a lot of concern as we were moving to that private definition of seven-day follow, of post-discharge follow-up, if that was going to be a good thing. From my statisticians, they're like, you know, even with the private sector being able to do that, we still beat the pants off the private sector for our follow-up. So, if they want to see somebody when they're still an inpatient and call it post-
discharge follow-up, let them; we're still going
to beat them.

And that's going to be the challenge
as we measure quality. Nobody else dose
measurement-based care like we do. I mean, we
have the numbers, but we also have the
infrastructure to do it. That will be an
interesting battle.

CHAIR LEINENKUGEL: Wayne?

COMMISSIONER JONAS: Yes, several
questions. I'll try to keep that focused.

You asked, we need to think out of the
box. Could we think out of the box by thinking
of the whole person? I have patients who come
in; they clearly have depression. They've been
on treatment. They're getting quality care. And
then, they join a group. They get their reasons
for living back, their purpose back, and their
depression markedly improves.

There's evidence-based approaches not
delivered by psychologists or mental health, such
as exercise for depression, such as diet and
training in diet, for example, acupuncture. A study just published on depression and PTSD showing acupuncture improves depression as much as standard psychotherapy.

I'm wondering if we have a whole health system we can start thinking whole person, mind and body together. I know that would be maybe even more of a challenge to measure because you're now looking at --

DR. SMITH: Correct.

COMMISSIONER JONAS: -- staffing around mental health. And now, we're talking about a mix of staffing that's much broader than that. It seems to me there would be a way to come up with assessing that if we were looking at -- maybe there's some demo models or something like that, looking to the future. So, that's one question.

And then, I have a second question about SAIL 2.0.

DR. SMITH: Measuring or adding CIH into the measurement system can be a challenge.
I was an NIH-supported researcher. Before I came to the VA, as a medical university, I had probably somewhere around $5 million in my grants. Science, I mean I am a scientist. So, evidence-based is important.

And so, I know, for me, I can struggle with, okay, so where do I want to go? Some interventions may not have the volume of science that I would like behind it. At some point, I have to say, yes, well, so what? There's value to the veteran when they find value in it. It's important to them, and that makes a difference.

I need to set aside my little specialty superiority and nobody can do it like a Board-certified neuropsychologist, and "harrumph," you know, and say, that's okay. It was ultimately a good thing for the veteran and their quality of life improved.

So, where is that balance, and how do we bring that into the fold, and yet, maintain scientific integrity. Evidence base, rigorous placebo double-blinded studies, those are great.
For me, I know, as a chief, that's the struggle.

At Iron Mountain, we have acupuncture.

We have acupuncturists. I sent my chief of anesthesiology to Harvard to get certified in acupuncture. It has value. But that's going to be the challenge of how we weave that into our quality metrics.

COMMISSIONER JONAS: Yes, and I'm not suggesting abandoning evidence. I'm a firm believer in evidence. We're doing a whole evidence assessment of a section in great detail using standard hierarchy models and all that type of stuff.

But there is a clash between person-centered care and evidence-based medicine often, and the provider is often trying to figure out to balance that, right --

DR. SMITH: Yes, yes.

COMMISSIONER JONAS: -- all the needs and the wants.

I'm really asking if it's possible for the VA to even think outside the box by saying,
maybe we ought to get rid of the "M" in the PCMH
or the "B," whatever you call behavior, and just
call it PCHI, or maybe add well-being to it --

DR. SMITH: Uh-hum.

COMMISSIONER JONAS: -- with metrics,
with assessment tools, and call it patient
primary care health and well-being integration,
and come up with a SAIL 2.0 model that actually
allows us to track that, feed it back into these
learning models that you have, in order to get
the drivers and change going in those areas.

And then, maybe even add some other
metrics that don't appear to be in SAIL very
well, but maybe you just didn't present them, and
that's some of the other aspects of the Triple
Aim, which is cost issues and clinical outcomes.

DR. SMITH: Right, right. So, those
components are not in Mental Health SAIL. They
are in SAIL.

COMMISSIONER JONAS: They are in SAIL?

DR. SMITH: So, there is an efficiency
metric there that gets at the costs and staff,
overall staffing, things like that. That is built in and reported on the ultimate SAIL model. I think it's in one of my slides underneath "Mental Health". There was a metric down there on efficiency.

And one place I think we will see our ability as we integrate other aspects of care in our current Mental Health SAIL is veteran satisfaction improves. And you'll see that in the experience of care. It is that there will be an increase in their satisfaction overall with care.

COMMISSIONER JONAS: Is there any discussion or taste in VA of doing a SAIL 2.0 that really fully integrates mental health into it instead of an add-on?

DR. SMITH: Well, depending on probably who you ask, they would say, well, mental health is integrated. We are what, 20 -- we're not 20 percent. Thirteen percent? Twelve. We are 12 percent, right? Twelve percent of the overall SAIL performance is mental health.
That's up from zero percent. So, I'm pretty happy with that.

Mental Health SAIL is not static. So, every year we change the metrics. In the fourth quarter, the metrics can be shifted. For those metrics that are stable, and we know 99 and 100 percent of the sites are doing well, we will drop it and shift new ones in. We do that for a couple of reasons. One, it doesn't do any good to measure something where you're completely successful at it. So, we'll get rid of it. But, then, we add new ones to keep people thinking it's not about doing well on these metrics. It's about doing well overall. How is our mental health program?

So, we actually do have a mechanism. We just, fourth quarter, created our new Mental Health SAIL. So, next fourth quarter, there will be new Mental Health SAIL. And so, there will be opportunities, as we think about --

COMMISSIONER JONAS: And that's going to include costs, resources, and clinical
outcomes as part of that?

DR. SMITH: So, the costs we keep out of mental health, although I would probably have a battle with the RAPID folks if I wanted to put costs which they have outside in big SAIL, if I was going to then put costs internal. But we certainly monitor that. I have other monitors for mental health costs in the cost per clinic, the cost per episode of care.

And then, as we continue to develop measurement-based care, that will, I would hope, eventually be one aspect we will be able to weave in. Right now, nationally, we're doing it. It's still an area of growth. There's some IT challenges with measurement-based care. Some facilities have iPads and they can do the testing, and others can't have iPads. But, as we refine our measurement-based care processes, that would certainly be important to include because that's a critical components of measuring quality.

CHAIR LEINENKUGEL: Thank you, Wayne.
Dr. Smith and Dr. Pomerantz, first of all, thank you so much for what you're doing. And it's great to have such valued folks involved in veteran affairs and the many issues, and your professionalism, and taking the time to come from two states that are in the low teens for temperatures right now, so the snow, ice, which are all good things, by the way.

(Laughter.)

DR. SMITH: Which are all good things, that's right.

CHAIR LEINENKUGEL: To come to the fun and the sun of Tampa. So, hopefully, you're going to be able to enjoy a little bit before you travel back.

But, again, thank you for the great mission that you both have done for our veterans.

Thank you.

DR. SMITH: Thank you.

DR. POMERANTZ: Thank you.

(Appause.)

CHAIR LEINENKUGEL: We're going to
take a 10-minute break at this time, and be back, and we'll have Colonel Cary Harbaugh onboard at that time.

(Whereupon, the above-entitled matter went off the record at 10:31 a.m. and resumed at 10:48 a.m.)

DR. POLLACK: So thank you, everybody, for returning. I just want to take a moment and introduce Colonel Cary Harbaugh who is going to be talking to us now.

Colonel Harbaugh is the USA Director of the U.S. Special Operations Command Warrior Care Program from the Care Coalition and he is the Director of the DoD Warrior Games for 2019.

Colonel Harbaugh does not have a presentation to present to you all today but is rather here to answer any questions that the Commissioners may have.

So at this point I will turn it over to you, Commissioner Leinenkugel, and we'll start working with Colonel Harbaugh.

CHAIR LEINENKUGEL: Thank you very
much. And thank you, Colonel, for coming in and being part of the COVER Commission and also thank you for your service to this nation and we are delighted to have you on board today.

I know that you are prepared to talk and we have not really had the opportunity to integrate and do a lot of work with the DoD that's part of our Commission mandate as well is looking into the alliance and partnerships and relationships between the VA dealing with veterans' mental health and also DoD on the transition of those service members that are now becoming veterans on a full-time status.

So I know that you don't have any particular presentation but I would like to have you just speak from the heart if you would, sir, as to your background, what you are currently doing, and then we'll talk about the transitioning of service members.

COL. HARBAUGH: Yes, sir. No, honored to be with you, honored to be with you all today, and to represent the United States Special
Operations Command and the Warrior Care Program 
that I have been, you know, privileged to be able 
to lead for the past almost five years now. 

And a Warrior Care Program is near and 
dear to my heart because it took care of me and 
that's kind of how Admiral McCraven put me in the 
job back some years ago which was he knew I had, 
he knew my story because he had been around my 
story and lived it. 

My story is not the story to be really 
be talked about, it's really all the stories of 
the many that we serve out of that Warrior Care 
Program. 

The Warrior Care Program for the 
United States Special Operations Command services 
currently about nearly 15,000 wounded and/or 
injured Special Ops service members and their 
families are included in that 14,900 and change, 
which was my last figure a couple of days ago, 
are some family members. 

Our mandate from our Commander is that 
we will also support family members of active
duty service members in health crisis. So
primarily when we are talking about those kind of
cases it's severe illnesses, usually cancers,
that kind of thing, where we are providing
resources to approximately the 80,000 sized SOF
force that is out there.

   The program has both an active duty
component and a veteran component. Our Warrior
Care Programs also continue to assist into the
veteran years.

   We are able to do that within our
charter and without violating, you know, sort of
the colors of money that are out there as
programs are put together by the fact that the
Veterans Administration graciously provides us
embedded personnel into my staff, so I have VA
personnel there to handle the veteran-oriented
issues.

   But in order to maintain a continuity
of care and relationship and a tether to the
Special Operations Force for the Special Ops
veteran, they still have access to their what we
call a recovery care coordinator and formally the advocate that then overwatches them and is that lifeline to call in when they have a need and for us to align them with the resources.

The resources just change as the status changes, and as well there is always as you mentioned, sir, that's the transition phase, we have those components. I will give you a little bit more about that.

I am going a little bit back to me. I have been in the Special Ops community for a very long time. I have been service, I am in my 41st year of service actually. I did ten years as an enlisted service member all in the Airborne and Special Ops world, then moved into officer service in 1988, did 30 years as a commissioned officer in Special Operations primarily.

I am an intelligence officer and I just moved into the Special Operations Intelligence world and served in a variety of levels all the way through commanding an intelligence center for Special Operations as my
O-6 Command.

And, again, in one of those fun, little adventures ended up acquiring some weird thing in the African desert as we chased some bad guys and ended up enrolled in a Warrior Care Program and the Warrior Care Program assisted me through what was kind of a life-threatening challenge for a couple of years, and that, of course, was where the alignment came to the program.

The struggles that we have, the continued challenges we have, first of all one thing I would want all the members of the Commission to understand is that the Warrior Care Programs, there are five that are recognized by Congress and the Department of Defense.

They are the four traditional services as you know them and U.S. SOCOM. Congress brought us to life in 2013 by NDAA and made us a peer-level program and we benefit from that tremendously because as those of you that have served in the military, which I know is most of
this Commission, you know that within the conventional force there is one type of mindset and one type of management of personnel, including their talent and how they are utilized, and the SOF force is unique.

You know, it's one of those things we say it's hard to be humble when "special" is in your names sometimes, but it's Special Operations.

And in order to also have -- and when we were created in 2005 informally, and it took us eight years until we had that formal recognition. It was done so because General Brown, the Commander at the US SOCOM at the time, was noticing that we were bleeding, literally and figuratively, talent from the battlefields.

And what was happening is the hard to train, hard to recruit, hard to select, hard to get through assessment and training in the first place because it's high attrition rates through our training, we were losing these highly talented people to medical ailments,
disabilities, injuries, through a Medical Evaluation Board process that the military has in
place, and, of course, that ultimately flows into the IDES process and ultimately into VA care when it comes to disabilities, we were losing these people at rates that we could not sustain.

And so he wanted to put into place something that allowed us to ensure that rehabilitation -- recovery and rehabilitation, were protracted enough to get the greatest opportunity that if we could retain the service member, even post-injury, that we could do so and, therefore, not then have a hole in our formations, and so that's kind of where we were born from and that attitude.

We have over the years, and I am very proud of the five years that I have been running this program, that we are maintaining a 73 percent retention rate for our wounded.

That is tremendous. And if you compare that to the DoD aggregate average it's 10 percent and that 10 percent is because we are 73
percent. Okay, so most of the services are retaining at about two to three percent.

So the fact is that we are -- and really the secret sauce to our effort is that we slow roll the system, classic SOF -- we ignore orders.

What we do is we allow the maximum recovery time and we have put the call to go to an MEB in the hands of our SOF leadership, and in particular our SOF doctors, so that we can protract that rehab phase as long as possible.

Sometimes it doesn't work out and we end up having to transition the service member. One of those cases is a local wounded Green Beret who we maintained on active duty six years as a quadriplegic.

Much to the service that he belonged to, the Army, is, you know, kind of snarling at us a little bit from time to time, but we wanted to give Chief Camargo every possibility.

Romy Camargo is the man I am speaking of. He actually runs a small benevolent org here
that assists spinal cord injury service members
and veterans with rehabilitation.

It's just down the street here. He is
tethered to this hospital because he has such
great love for this hospital.

And so about six years we retained him
on active duty. We tried everything, stem cell
research, anything we could get that could
potentially get him back to work, to walking,
that's what Romy wanted and that's the way we
fight.

Now that's a rare case. For most of
our guys we kind of max out at about the year,
year and a half mark for maximum rehab time and
then make an assessment as to whether or not
there is going to be a return to duty potentially
in their lives.

But this is resolvent as well that
we've got, you know, guys wearing prosthetics go
out there kicking in doors in our most
specialized units at the highest level and that's
pretty cool.
And I am talking about guys that have lost limbs and have gone six combat tours since limb loss, so we are pretty proud of the fact that we have been able to run a program that retains at that level.

The other thing is that the 27 percent that are not able to be retained don't necessarily reflect just not able to be retained if we wanted to.

What we do is, you know, sometimes you get, and especially in our formations, tend to be older, more experienced, and you get a guy that gets injured and he might be injured at a point in his career where he is already retirement-eligible, he's already maybe had a couple of smaller hits through his career and through deployments and it's kind of like, hey, I'm not going back for, you know, another helping to see if I survive the next one, and so they just make a natural attrition decision and we support them through that process as well.

So just to give you a sense of kind of
how and what our focus is and this has been
driven by, you know, our commanders that have
followed General Brown, from Admiral Olsen, to
Admiral McCraven, to General Joe Votel, to
General Tony Thomas, who I currently work for,
all of them have made a strong commitment to
warrior care and to our program and that we have
been very, very graciously supported by the
Department and then by the Congress itself as we
continue to move forward on our efforts.

And we have grown now to be the
largest warrior care program with the number
still serving on active duty. So a lot of people
think little, old Special Ops -- well little, old
Special Ops has borne a lot of burden of this war
and if I were to just talk to you about the past
ten days and severely wounded, just yesterday
another severely wounded Green Beret who probably
will be in a wheelchair the rest of his life, we
had three instantly killed in an IED last Monday.

We had a fourth die at Landstuhl from
brain swelling due to that same IED. We had
another Ranger killed last Sunday in an accidental, in a raid, green on blue. It was not an intentional green on blue, but we had a Ranger killed and another Ranger buddy of his severely injured.

It's just a gift that keeps on giving right now as coming off the battlefields and in particular where Special Operations serves, so plentiful in that business.

Now the Warrior Care Program has the recover and rehabilitation aspects then it moves into other elements. One of those is adaptive sports, which we use as a tremendous rehabilitative tool. It is necessary to preserve it. It is used in the Veteran's Administration System as well as a continuing rehabilitation and I think also it has tremendous social aspects to it, too, that help preserve the veterans.

And I know that it preserves our veterans because even in our warrior game system and even in our adaptive sports system our veterans continue to participate.
So we have to, you know, control the funding for that. Most of it is funded by benevolent organizations that support the veterans to be continued to be part of our programs for those type of events.

But it's highly successful and I have seen many people blossom out of these things from the deepest and darkest holes where adaptive sports has been, has had a measurable impact and positive impact on the lives and it's something that we really have to fight as a nation to continue to preserve and proliferate out into our communities.

And a few different avenues that that can work, from sport leagues that are oriented on adaptation and disability to just accessibility to them.

Like I was out yesterday with a foundation that does golf and we're trying to --- golf, one of those sports you can play lifelong and you can play almost with any disability, with the exception of just really severe brain damage.
But you can play this game well into your late years and all you have to do is have the right adaptations. U.S. Adaptive Golf has been very, very involved in this as has been the PGA of America, as are a number of entities.

This one in particular that I was meeting with yesterday, the Crossroads Foundation run by LPGA legend and hall of famer Jan Stephenson, and what they are doing they've got a whole facility designed, it's in this Tampa Bay area, designed to help disabled veterans and wounded warriors recover and rehab through the game of golf, and what they are doing in their facility I was absolutely totally impressed with.

So a lot of the active sports world, which also goes on my other, my third job for this year, because I also have another role that I serve the Commander as a special assistant for, my third role is the Director of the Warrior Games.

And the DoD Warrior Games it was SOCOM decided to take its turn. The four services had
already done theirs since DoD took it over with the 2015 games and the Marine Corps were the first to host it, and we are bringing 300 wounded warriors, and that includes a veteran, every one of these games has a veteran component to it and all of teams, and along with six partner nation teams, which, again, are a combination of active duty and veterans that will be there for 300 athletes total along with over 1000 family members coming to the Tampa Bay area.

It's going to a Vegas-style extravaganza I assure you, with Amalie Arena for our opening and closing ceremonies, A-list entertainment acts there, and sports going on for about eight days across the Tampa Bay area.

It's going to be absolutely tremendous. It usually gets a lot of media attention and we use it to showcase the needs of our wounded warriors and to show how they are recovering and also to highlight to the public that, you know, Joe's leg is not going to grow back, okay, and he's not getting out of that
wheelchair, he is going to need help the rest of his life.

So it is more than just this week of patting him on the back and thanking him for his service, it's what you can do, look to see what you can do to support him or to support the organizations that support him and his family through what will be a life of disability.

And that is one of the great things about the Warrior Games is it gives us that opportunity. So adaptive sports is another key component of what we do.

Benevolent support. We can't do everything that we do in warrior care programs, and that's not just mine, it's my brothers in the four other programs, without the support of benevolent organizations that are just weaved across the fabric of this land.

We have got from ones that are specifically oriented on my Special Ops tribes, you know, the Navy SEAL Foundation, the Green Beret Foundation, Ranger Lead the Way, the Marsaw
Foundation, I can go on and on, SOF Warrior

Foundation, one of our biggest.

These organizations, you know, fill

the gaps and seams that the Department and the VA

can't cover for lots of things, to include care,

and that means getting them out to new innovation

that may not be in the Tricare folder, may not be

in the VA constellation of care yet that we can

get somebody out to try, provided that his

primary care provider says that this isn't going

to be harmful.

If we've got something that we want to

experiment with or a therapeutic retreat or what

have you, a lot of those things can't be covered

by Department of Defense funding or VA funding

but are covered by these benevolent orgs and they

do tens of millions of dollars to support all of

us every year.

And it ranges from home builds to, you

know, tricked out adaptive vehicles to all

different sorts of things, to fishing trips and

golf clubs and you name it, but it is
unbelievable what's out there.

And what we do with our program is
make sure that it's delivered fairly, that it is
to people who need it the most and not just are
to people who are vocal about it, which is something I think across
our wounded warrior and disabled veteran
population we have to be fair about and
recognize.

A squeaky wheel doesn't necessarily
need the grease in our business. Sometimes it's
-- in fact I find with my special operators that
the ones that need it the most seem to be the
quietest and most humble and it's sometimes
compelling them to take advantage of an
opportunity, but the benevolent orgs are key to
that.

So I have a whole team, a benevolent
team, as part of our apparatus at the Warrior
Care Program that makes a determination, does the
judgements, finds out and records and tracks as
well as gets the legal and ethical reviews that
are required because when it involves active duty
members there is more scrutiny to make sure that it's done appropriately and, you know, especially who it's coming from.

And then, finally, it's career transition, and we all career transition. They are going to make me take this off, 41 years or not.

I did what is called a retiree recall year at General Thomas's request in my personal desire to be able to run the Warrior Games because I was instrumental in bringing it here.

When the Commander said let's do it I am the one that staffed and because I have been through already six Warrior Games plus four Invictus Games I wanted to be able to lend my experiences and expertise to running this warrior game for us in this area.

So the career transition piece though of this involves unique authority bestowed upon us by the Secretary of Defense that we conduct fellowships as our service members transition.

The fellowship allows them in the
final months of service, up to six months, to get out and sample the high level corporate world, the small business, government agency, to helping them build, you know, build a small business themselves, you know, assisting them of the needs of a new entrepreneur, re-training, re-education.

We've got tremendous accessibility, some just high-end institutions, Stanford, Columbia, just to name a couple, that will support our guys and we've got a great brand.

Again, the Special Operations brand carries a lot of weight in society and so with that we have been able to use that effectively and have over 500 partners and we have executed 380-so fellowships where a service member gets out and is able to be sampled while still drawing their Department of Defense salary.

They are able to be sampled by a business. We have tremendous success with this, a 100 percent job offer rate and a 92 percent job take rate.

And the reason being is that we do
good counseling ahead of time, so we kind of kind
of match the guy up to what they are looking to
do in life next.

          And, again, it's no harm no foul for
the business that they are oriented on because
they may not work out and the business can say,
hey, not the right kind of guy. That's okay. We
have had that done, it's been very, very few
cases.

          But it's done, you know, graciously
and with a lot of respect. It's not done ugly.
But, again, because you can see by the rates,
that's not been the case.

          Typically it's, hey, how can we get
this guy, and not only how can we get this guy,
how can I get more of these guys? And that has
been why we have snowballed to where our rolodex
of opportunities is actually bigger than our
clientele that are transitioning at any given
time. So we have grown over the time that we
have been existing.

          We started off in 2005 with about 600,
I think was where we were and now as I told you 14,900, so, you know, it's the gift that keeps on giving and we just continue to grow with well over 6,000 plus still on active duty plus about 1,000 active duty, a little over that, almost 1,500 active duty family members, and then about the 7,000 and change veterans that we continue to support.

So that's kind of a quick overview of what we do, subject to any questions you may have on the program per se or any other questions that you want to hit me on with regard to how we use this fine facility as well as the VA, because I am located everywhere SOF is.

It's not just here in Tampa. This just happens to be one of our flagship locations and it's serendipitously located close to my headquarters and to my office.

So we've got a great relationship here with the Haley VA and Director Battle and his entire staff have been absolutely fantastic partners for us both for our active duty service.
members' care as well as for our veteran care.

We utilize this hospital and we bring in guys from distance to this hospital for many good reasons, but we also use the VA's, the four, that have poly-trauma total, which, of course, is one of the four, the other three -- we use all of them because of proximity to our footprint.

But our Warrior Care Program I have personnel from Landstuhl to Walter Reed to West Coast to Hawaii, I am covering everywhere that Special Ops is and in every one of our sub-component footprints I have a presence that is under our purview as the Warrior Care program.

Sir?

CHAIR LEINENKUGEL: Dr. Harbaugh, as I said to you earlier thank you so much for coming in, but more importantly thank you for your 41 years of service to this great nation and your continued enthusiasm, and I say that with a capital E because you certainly have it.

COL. HARBAUGH: Thank you, sir.

CHAIR LEINENKUGEL: And on behalf of
the Commission we are delighted to have you
represent our warriors out there and also at the
same time I need to know the dates for the 2019
Warrior Games that you are going to be saying
your farewell at.

It won't be your farewell, sir, but it
will be something that you started and are going
to be highlighted for, so what are those dates?

COL. HARBAUGH: Well the dates of the
Games are the 21st to the 30th of June with the
opening ceremony actually on the 22nd, but the
21st we do some preliminary sports, like a lot of
games like this new Paralympic style, and the
30th closing ceremonies, both opening and closing
at Amalie Arena.

And then we will be all over this
area. We wanted to bring Tampa Bay into it. We
didn't want to do it on a base because we found
that that doesn't give the same accessibility to
public.

The last game was held and hosted by
the Air Force, a beautiful game run in Colorado
Springs, but just that barrier, that natural
barrier, even if you make the gate open to the
public, people won't take the step, and so public
attendance at those games was not what you would
like to hope, you know, would like to see.

And we are really trying to pull in
the population so I have been doing a lot of
media events and talking to people and saying,
look, you know, I want to get a volunteer
support, and I said, look, the best volunteer for
a wounded warrior is a butt in a seat cheering
there for him.

And I'm going to tell you right now
you want to warm a wounded warrior's heart don't
be guarding a cone out in the parking lot, be in
here cheering for him, patting him on the back,
you know, making a lot of noise, and proud of
him.

So we will be Amalie Arena for opening
and closing. We will be at the Tampa Convention
Center and taking over the floor space there that
they are very graciously giving to us at a very
low cost for that eight-day phase playing
everything from wheelchair basketball, wheelchair
rugby, shooting archery, power lifting, indoor
rowing, mini sports, on the courts that we will
set up inside that facility.

We will be doing track and field
across the street here at USF and USF has been
very gracious to include providing the
transportation support here, so giving their bus
service for us so that we can again -- we are
trying, our model for game, General Thomas and I
had a lot of talks about this and what we were
wanting to do was set a model for sustainability
of the games.

The games have been escalating in
cost. We are trying to prove a concept, that has
become the SOCOM model as they are calling it at
DoD.

And my brother that -- Colonel Larry
Miller that runs the Marine Corps program is
embracing that and he is stepping up because he
will be running it in 2020 in San Antonio and
they are following the same kind of format, and
that is looking for a city that wants to host us
Olympic style, so to speak, bring you in, low to
no-cost venues, keep the costs low.

Let's preserve the funding that we
were having to dispense for a warrior game and
preserve that for care because we got 300
athletes and that's the tip of the iceberg. I
call it a flake off the iceberg.

I mean there are 15,000 wounded
enrolled in my program alone. If I start adding
my brothers out there, they've got tons more. We
start to bring these together it's like when we
get 300 athletes they are exemplars of what is
out there but they are not the whole kit, and
what we were doing is we were seeing, you know, a
lot of money spent.

It was alarming to the Secretary of
Defense. He wanted us to look at how we do that
better. We already had a format. We knew what
we wanted to do and we were already stepping
forward on that even before the SECDEF had
expressed his concerns and that was, look for a
community that wants you there, that wants to
embrace you, wants to keep the costs low by
providing you venues at low cost and allowing you
to be able to do this very smartly.

So USF will be out at the Long Aquatic
Center in Clearwater for our swimming event and
the Mayor of Clearwater has graciously donated
his facility.

We have a golf course that is donated.
We added golf to the Warrior Games for the first
time this time and we've got one of the companies
that does seven PGA Tour events every year is
doing the PGA Tour kind of treatment for us.

And I got PGA players and LPGA players
coming out to play the practice round with our
guys and then caddy for them the next day. Can
you think of anything better?

It's like I'm looking at how do you
pull in more and more folks and by doing so --
Jon Stewart, by the way, from the Daily Show fame
is our emcee. He has been the emcee the past
three games. He has graciously signed on to do our game as well.

We've got A-list entertainment acts from Rock-and-Roll Hall of Fame stature to ones that have immediate public appeal that are signing on. The whole idea is, what pulls the public in gets them watching these athletes and supporting these families.

So I think that you'll see this whole area touched by it. It will be a tremendous event and we are hoping to see much of the senior political leadership we know that are already signed on board.

Governor Scott from the outset, General Thomas and I sat down with him in a meeting and he was like what do you need, Florida is on board.

I mean it has been just absolutely tremendous and that's what we expected. And I can tell you that my brother Larry there has been calling, he was in San Antonio the other day and he and I are really best friends, so he's going,
man, I'm already seeing it here, too, so what we expected to see.

So we are, again, trying to set a model for how we preserve these games, keep them under the budget. Right now Congress appropriates for us about $5 million a year to run a warrior game.

We think we can keep it under budget. The games that had the -- the past two games ahead of us had gone much higher than that and that was sort of sad, and as well we were trying to avoid having to sell our souls to corporate sponsors.

We don't want it to be that way. I told the groups that had asked to do that, I said our wounded warriors are not NASCAR, they don't need to be wearing things all over their jerseys.

They need to be honored and respected for the limbs they have lost, the blood they have spilled, and the reason that you have the prosperity you have.

If you are willing to come on board
and support us we will thank you, but we are not looking to have you use them in that regard, so that's the way we're holding the line on that as well.

CHAIR LEINENKUGEL: Thank you, sir.

I would like a follow-up transition, if you would, and this is something that I think all Commissioners need to hear from you, sir, and I know it's going to be very transparent and blunt. Special Operations do multiple deployments and multiple very difficult missions and I have met with a few while I was active within the VA and when I heard that they did six, seven, eight, nine, even up to 13 different deployments, or operations as they called them, I was dumbfounded, so very active.

I am surmising, and I don't know this for a fact, I want you to enlighten us as a Commission, that through all of the actions that you and the other medical staff have your hands full in dealing with some traumatic, what we would call mental health issues either when they
are active or at the point of transitioning.

How is that handled from the military doctor side, sir, and then what happens during the transition?

COL. HARBAUGH: Okay. First I'll come back a little bit on the behavioral health thing. I benefit, we benefit, our Command benefits from very tough, very resilient people and while we have certainly a portion of our force that is dealing with the behavioral health issues, be they, you know, fully-rooted post-traumatic stress or post-traumatic disorder, I loved how, by the way, Bush instituted, and I credit President Bush for making that distinction, it's a positive thing.

We have plenty of guys with post-traumatic stress. We don't everybody with a disorder that is disabling. But I think that the invisible wounds aspect of what we have been experiencing in 17 years of war is the most misunderstood, in particular, in my force.

The most pervasive injury in my force
is traumatic brain injury. Traumatic brain injury manifests itself most times in a behavioral health way.

Traumatic brain injury is physiological damage to the brain and it is being -- and you can't counsel your way out of TBI. Now you need to be able to treat the symptoms that are behavioral health and those manifestations.

You need to be able to do that so you need the behavioral health component to this but it has to be done comprehensively. One of the things that I love about this hospital and the PREP program and the whole poly-trauma kind of perspective is that it understands that it is more than just the behavioral health component here, it's got to be full body.

And I think that any of you that are familiar, and probably many of you are more familiar than I am when it comes to TBI, the fact is that it is still a bit of a mystery science right now and the therapies out there are more in
the realm of test bed and pilot programs.

There is no proven efficacy of any one. We find some that have relief, but we also have some that the relief may be nothing more than placebic.

So it's like -- it's hard to judge that. But I know that this is the injury because when we've gone to and, of course, even more alarmed when we see things like what the research is showing us in astroglia scarring because Special Ops guys, especially when I am talking about our trident wearing long tab, you know, that's the Special Forces' tab, short tab, Ranger tab, you know, the folks that we have that are exposed to blasts routinely through, you know, assessment, selection, training, preparation for deployment, deployment, return cycle, and as you said, sir, repetitively doing that, because each time it's going back out, getting back to the ranges, getting ready to go back out the door, another deployment.

And when you are on breaching ops
every night, and I have been in my particular role as a SOF intel officer, you know, out there building target packets and running the, you know, the SSE afterwards, the site exploitation, to run the next target.

The guys are there popping a door and every time one of those door pops goes, any time that flashbang goes, any time a detonation goes add to that what the enemy is throwing at you, RPGs, high-powered weapons, IEDs, all of that blast exposure, whether it hits you with a single event that brings you to the mid-grade to higher level TBI or it's cumulative that gets you a mild level TBI, the fact is TBI is out there and it's not -- and it can't be treated as a behavioral health condition.

So we have to look at -- we look at our guys holistically and comprehensively and that is where recovery care coordination and advocacy is key.

And I would tell you quite frankly as a guy who had been running a program as long as I
have with so many cases, if I had one authority
that I could get out of the United States
government, and that would be, you know, out of
Congress coupled to how the Department of Defense
and the VA work when it comes to this stuff, is
give the recovery care programs the authority to
operate in the veteran space.

We are not transgressing on Veteran
Affairs activity, but the lead coordinator role
that is in the Veteran Affairs realm, lead
coordinators are overwhelmed by volume and if you
allowed us to aid you in that volume and resource
us, and the reason I say that is I have to play
this game.

I have to, one, I have the embedded VA
guys. I need them, okay, because we got guys
that are going through various levels of
transition, to include their medical transition,
so I need them.

But I don't have outright authority as
a Department of Defense activity to man my force
to cover my 7,000 veterans. Instead I do it
under the auspices of what I call residual
capacity, which is of my own coining.

It was the way that I could
substantiate to my bean-counting masters that I
wasn't abusing what the Department of Defense
funded for me.

And so I was using a model that
because when I transition a veteran he doesn't
need the full crisis care kind of coverage out of
a recovery care coordinator that I was using at
about a three or five to one ratio, that I would
make sure that my caseload, active caseload in
any one of my recovery care coordinators wasn't
so high that I had residual capacity for them to
cover the veteran space.

But this is a workaround and it's not
fair and I think that we could aid if we were
more partnered, I mean, hell, the Veterans
Affairs budget and the, you know, DoD budget come
out of the same national security budget and I
don't understand why they can't get the lines of
money across.
So I am being frank with you, and
probably get shot by the SECDEF after this, but I
am telling you how I really feel because that's
what you are asking me to do, not to mention I am
on retired recall, what are they going to do to
me --

(Laughter.)

COL. HARBAUGH: -- retire me again?

But I am telling you that there is -- We had
working for some time what was called the IC3,
the Interagency Care Coordination Committee.

We were doing this up at DHA on a
quarterly basis. It had a lot of Veterans
Affairs players and all the different subsets of
Veterans Affairs.

We had a lot of DoD players and all
the warrior care programs of the services and
special ops and were all part of this thing. It
was a great coffee klatch where we went around
there and chased our tail around the tree and
never came up with any solutions.

And the problem with it is while it
had the goal of getting solutions nobody could
come down to beating down the barriers and then,
of course, you have changes in Administration and
changes of leadership to Congress and all this
stuff that goes on.

I used to be a legislative affairs
guy, too, by the way, for JSOC, so I had a couple
years on the Hill for experiencing that and the
complexity of that.

But the bottom line is that I know
we've got certainly an Administration willingness
to support us. I know we have congressional
willingness to support us and if we could the two
sides, the VA and the DoD to talk and be
reasonable about how you do this and resource
your warrior care programs so they could
continually serve the veteran space, maintaining
that relationship.

My peers on the other programs have
less capacity than I do to service veterans.
Many of them are very restrictive on it. We do
it because we feel it's a moral obligation and
because once you become SOF, you are SOF for life.

Once you become Special Operations, SOF means Special Operations Forces, we don't -- It's hard to get a guy that's been a Green Beret or a Navy SEAL that identified himself throughout his career from what was really childhood through to retirement now in his middle age as a badass doorkicker as the way he looks at himself in the mirror and then says, okay, it's now time to retire and not think of himself that way still and not wanting to have connection to that.

And as well, if you want them to seek care the benefit of our programs, in my program in particular, is that the guys I've got doing recovery care coordination came from our force, and I call them my crusty sergeant's major, but that's because most of them are retired E-9s.

But I also have some retired O-5s and O-6s as well. But I got seasoned, experienced folks that came out of our formations. Most of us have been, you know, wounded or injured
ourselves, who understand it, went through an MEB, went through it and ultimately made a transition decision and are now retired, but they walk through into these formations, or when they are dealing with these guys over the phone, or face-to-face they speak with credibility that gets the guy to get to care.

So when you are talking about how we get them into care and make that segue into care and preserve it that's where that tether is, it's the buddy.

In this case that buddy is your advocate who says you need to go see Doc Schmuckatelli because he is the best guy for what you got, okay?

You need to get out for this and here is what I got for you and I have a plan for you. Here is how I keep you. And by the way if you start feeling low you got my number, brother, you call my number.

And when he calls, and I have had this recently. Hell, I had a kid -- I believe
somebody was from like north, like Minneapolis or something, or whoever was just in here, we were talking Wisconsin weather, right.

I just had a wounded warrior, TBI, PTSD, combined guy, who for whatever reason he got into dire financial straits, was living in Las Vegas, and for some reason decided to go with no money, homeless, and get on a bus and go visit people, or go visit what he thought might be people that he could see in St. Paul, Minnesota.

He just did this last week and I get a call because he's now got nothing and he arrived, by the way, the night before Thanksgiving.

So trying to find people the night before Thanksgiving that are going to take you in and provide you services, the Veteran Resource Center was closed there that night.

So I get a call. So we immediately send out the troops and because he's SOF, he's a brother because he's Special Ops, and we do it, and I think that by preserving that in the
program and by giving us the authority to do that
that would be the best thing possible to maintain
that relationship and ensure that your guys are
getting to care or getting the nudge to care,
because sometimes it's a kick in the butt.

I heard one of your witnesses here was
speaking to the fact that you can't force them.
That's a fact, we can't force them, but we're
pretty good at cajoling and strong-arming.

And you know what that is effective
when that comes from -- when you are Green Beret
and you are feeling kind of low but you don't
want to go see the psych because you think psychs
are a bunch, you know, a bunch of blarney. Well
when you hear it from a brother who goes, look,
I've worked with Doc Schmuckatelli he's a good
dude, he's really going to help you, I want to
get you there.

When a brother tells you, you go.
You're not going to listen to some sweet social
working kind of background working person.
You're not going to -- it doesn't have the same
impact with our guys.

And so I say that to you as one of those mechanisms and also because I want to make sure that you understood when I go back to my TBI thing that we are dealing with a much bigger problem and I am also worried that the Veterans Administration is prepared, needs to be prepared, it's already working in these realms, but it needs to be prepared with what I think will be a tsunami in neurologic disorders that are coming.

This TBI brain stuff, especially when we start to see what astroglia scarring does long term. And some of the research, like Dr. Pearl's research out of Fort Detrick, out of Walter Reed is showing that many of the pharmaceuticals dispense for behavioral health conditions are actually exacerbating TBI and so what we are doing is we are not necessarily helping even though we think we are and until we really understand TBI fully I don't think we can address the BH side, not at least with pharmaceuticals.

You can still -- there are some other
therapies that are effective, but we have to be aware of that. Also, we need to get ahead when it comes to TBI and behavioral health.

We need to get ahead of the innovations. We need to move faster in the innovations, getting them evaluated, determining efficacy and safety and getting them out into the realm of care.

We have got things like, we have been testing the magnetic resonance therapy, which is essentially EEG-guided frequency modulated transcranial magnetic stimulation, but it's, you know, more fixed.

It's run out of the Brain Treatment Center at Newport, California. Those are the ones that kind of came up with this innovation and we were hearing some positives about it.

We had some guys try it with benevolent org funding. We had some positives out of it, not completely, but we had some positives -- enough that we thought there was enough smoke here that we need to see if there
was fire, and we just need to be able to, you know, just to process with these, you know, blind studies and all the other stuff, you now, you're putting it through.

And I tell people, look, I don't really care if it ends up being much more than acupuncture or massage therapy for your brain. If it turns out that it is effective let's not have it in the realm where we have to pay a lot of money for it.

Let's get it into the VA centers and let's get it into the military clinics and military medicine and make it accessible so that a guy can get in there and, you know, he needs to get a tweaking, maybe it's like teeth whitening, I don't care, you know, zaps him, makes him feel better.

If it makes him feel better for 90 days and they got to go back in that's fine, but if we're having to pay 30k a month for it that isn't the best way to do it, so let's figure out smart ways.
That's just one example but we've got others that are out there. Carrick Brain Center is doing stuff, Brainsake up in the D.C. area, Wake Forest has got one that works in the auditory realm.

There is a lot of stuff out there and all I am is, look, I am a consumer, I am a Special Ops intel officer, I am not a doctor nor do I play one on television, and I am looking for what works and I take the input from my wounded warriors as to what is working for them, that's how I determine efficacy, what's working, comes out of the mouths of those men.

CHAIR LEINENKUGEL: Commissioner Jonas?

COMMISSIONER JONAS: Thank you. And I want to say thank you for your candor and I want to push it a little bit farther in the area of the caregiver in the family.

Kicking doors down is not something you do at home, okay, and there is a huge cadre of family members and caregivers that are out
there and when someone gets a serious injury and comes back and needs the recovery and the support you have is tremendous, but as you know many of them are full-time caregivers afterwards in those areas.

COL. HARBAUGH: Yes, sir.

COMMISSIONER JONAS: How do you address those issues and the resilience of that and not falling out of that family? I know you got your brother family, but falling out of that family in your programs.

COL. HARBAUGH: Yes, sir. Well I can tell you first of all it's comprehensive with us. Frankly, I have more interaction -- or our program folks have more interaction with the caregiver tends to be the spouse than we have often with the service member themself.

They are -- it's part of our process is that we embrace the whole person and whole family concept because we know that's where healing occurs and we also know that they are bearing a tremendous burden.
And most of the resources that we dispense when it comes to whether that is pulled from the benevolent space or from the Department or from the Veterans Administration space is ones that look at the problem through that lens.

So, you know, our caregivers are near and dear to our heart, our care providers, as are, by the way, also, I have the other obligation in my program which is our Gold Stars, so families of the fallen and we provide them because often there is care that is required.

And care is shut off once you have received your SGLI and all the other benefits and now you are dependent on Gold Start activities out there and other organizations to support you.

Thankfully we have an incredibly and benevolent and gracious nation. But if we didn't have that we would struggle. So we take advantage of that but most of our Gold Stars don't know where to withdraw those resources.

But, yes, sir, from the standpoint of caregiver support -- and there are a lot of thing
that are -- a lot of our wellness-oriented therapy activities are full family or couple oriented. We recognize that.

We have one tremendous partner called Operation Healing Forces, it's actually based in this area but it services the entire SOF nation, and it does specifically couples retreats because we have high divorce rates in our formations.

When you've got eight, ten, 13 deployments guess what, it's tough on a marriage and so we really do what we can. We also have -- I think we are also very proud of the fact that we have what we call steel magnolias.

We have absolutely, and I'm saying that because it sounds like it is solely oriented, we also have plenty of women in our SOF formations now, more coming up, so we have also male spouses out there.

But our steel magnolias when it comes to our Green Beret formations, our SEAL formations that are yet to really have women in them where we are talking about our spouses, are
absolutely amazing.

So the support networks we have collectively through the effort that we run out of Special Operations Command called Preservation of the Force and Family.

It's a partner to us. It's a resiliency building activity. I am kind of right of bangs, so after the bangs happen they are part of our resource staff but they are there strengthening the family, strengthening the service member.

We have a physical component to it with human performance, behavioral health performance, spiritual performance, so it's got all the mains.

We build up their strength and their resiliency and, by the way, we've already recruited pretty tough people anyway, so they are there.

You also have to think about the SOF guy. The SOF that guy that gets hurt says how do I get back to the team? To me one of the most
heartwarming things about my job is that when I am visiting a guy laid up in a Walter Reed, and he may be freshly wounded, half the time he's on FaceTime talking to his team back in Afghanistan or Iraq, wherever he came from, going, hey, guys, I'll be back in three months.

I'm looking at the guy thinking it's probably going to be a year, but that's his mindset and that mindset fuels recovery and rehab because it's how do I get back to duty, what does it take to get back to duty.

I've got a guy working for me right now, a hero of the Camp Integrity attack a couple of years ago, Master Sergeant George Vera. He was a Green Beret.

You may have seen, if you saw any coverage of the Invictus Games after he got his gold medal we really showcased that, ESPN picked it up, so did Fox News, because Prince Harry and Meghan gave his medal and congratulating him and his daughter ran out on the floor, it was a very heartwarming thing, and he is stuck in a
wheelchair the rest of his life.

He came off after a long recovery, to include a lot of time in this hospital, and he rolled in, literally rolled into my office and said, sir, I've still got three years on my SF bonus, my last Special Forces bonus that I took, I'm serving them out, man, I want to work.

And so we put him to work as an instructor and now he is on my staff helping me with Warrior Games. But that's the kind of guy that we have.

And so that fuels, and I will tell you that the caregiver support around him is, you know, his wife, his children, it is a comprehensive package of folks that we care for and that have to be cared for with anyone of our warriors.

COMMISSIONER JONAS: And that gets extended to your veterans population, too?

COL. HARBAUGH: Yes, sir. Yes, sir, it gets extended to our veterans population as much as we can. But, again, going back to my
authority things, it's where I am then having to
operate in the benevolent space because there is
not as much out there --- well, that's not true.

There is a lot of out there, but I
can't -- it doesn't come to me as quickly, and so
needs come up. For instance, a couple of days
ago I had a SEAL spouse call me, husband badly
injured, medically retired SEAL O-3, back some
years -- a few years ago at least, and she was
having struggles.

And it was like I heard about it
through an email, I had seen it, that got
forwarded to me, and I called out to her and
said, hey, I am here for you, what do you need,
and I immediately re-invigorated.

And the problem was this, service
member was going I'm good, I'm good. He was
getting his periodic checks by his recovery care
coordinator, who was a retired SEAL, like I was
telling you about my model, retired SEAL Master
Chief, was calling him.

And so we have a tracking system that
we maintain and it's got every interaction with
every wounded warrior or veteran, and I'm
looking, and so I immediately go if I see, hey, I
got this guy's name pop up, bump, bump, bump,
where we at with him?

Okay, well he has been contacted here,
he was contacted here, says he's good to go,
what's going on. And this is exactly it.

Brother recovery care coordinator SEAL calls and
says, hey, man, you need anything? How's it
going? Where are you at with your care right
now? That kind of thing, because it was follow-
on care, and he was giving him all good, brother,
all good, except wife's calling going not good,
help.

Okay? So we immediately respond to
wife, send in the troops, the resources, and, you
know, we're already -- she called me back the
other night just, you know, glowing about how
we're getting James back out to where he needs to
be, it will back the family setting a lot better,
you know, all the things and all the resources
that are already pouring in.

   So it was just a matter of -- now he's
in veteran space and we are getting -- one of the
resources he is taking advantage of is a VA
location, but we're also getting him out to an
innovative care.

   I'm actually trying to get him, I'm
going to try to get him slated for a PREP here
that you guys are going to see later, which we
are big believers in. So that's kind of the
steps we take. Sir?

COMMISSIONER KUNTZ: Colonel Harbaugh,
I guess I just want to say thank you for what you
do and one of my rugby buddies is being patched
up in San Antonio by your crew after a tough
mission.

COL. HARBAUGH: Good to hear.

COMMISSIONER KUNTZ: So especially
thank you for taking care of that one right now.

COL. HARBAUGH: We got a great team in
San Antonio by the way, awesome.

COMMISSIONER KUNTZ: But I guess I
brought this up with you a little bit earlier to make sure that you had some time to think about it.

Just before you got on board, I guess around five years ago, I got a call from a family and they had a Navy SEAL in this area that was -- the military had tried to force him into care. He certainly needed care.

COL. HARBAUGH: Yes.

COMMISSIONER KUNTZ: No question. He walked away from their attempt to take him into care. He was thrown into the brig. Some mid-level person decided he was incredibly dangerous so then they put him in solitary confinement.

And I got involved when the family contacted me and we worked through Congress, we worked through the legal team to help him, because he was just about at retirement anyway, just ten years in Afghanistan had been too much.

COL. HARBAUGH: Yes.

COMMISSIONER KUNTZ: He had pre-existing bi-polar disorder and I, you know, I
think that that -- Admiral McCraven was helpful, you know, but that solitary confinement time severs a lot of those ties to the community and I just -- how has the process of involuntary commitments been changed in the past five years?

COL. HARBAUGH: Well I think, one, well gratefully, the involuntary commitment kind of thing, you know, through Baker Act or what have you is not a high number and I have experienced a handful of cases over my past five years.

There has been, it's been an education process for all of our formations with our leaders, in particular commanders and senior enlisted leaders to make sure that they understood.

Where we are benefitting right now is the guys have grown up now. It's 17 years of war, so guys have grown up. You know, you've got O-5 commander-level folks that grew up all at war so their appreciation for what the stresses are on that force has, you know, changed.
So we had, obviously, a different, you know, if you go back ten years ago you had more guys that had maybe grown up or were already at mid-grade or more senior officer level, that were in command roles that didn't necessarily have the same appreciation.

You get into -- well here's where the difficulty is, as any of you that served in uniform especially as an officer know, that once a guy breaches the UCMJ it complicates what I can do, especially if I am in any kind of adjudicative role, so it complicates what I can do.

And we had this with a case, a Green Beret, that had -- and the Green Beret actually ended up a patient here in this hospital, but the substances became the outlet for dealing with his issues and once the event happened that ultimately injured him, because he was injured in an accident created by the abuse of substances, and that put him into a spinal cord injury setting.
And then it became a legal thing because toxicology was drawn on him when he was injured and he was found to have substances that are very illegal, not just borderline illegal, very illegal, and then that tied into the abuse of him and others and potential sales or resale which then, of course turns this into a huge UCMJ action.

Now the guy needed to be in care, obviously, and there had been attempts to get him into care but they turn it into performance and you turn it into another act when you add those components to it.

COMMISSIONER KUNTZ: Yes.

COL. HARBAUGH: So now for guys that just go off reservation, so to speak, don't mean to be impolite about it, but say we had -- I had a special tactics NCO, a great history of experience, you know, tremendous special operator, Air Force Special Operator, Air Commando, that got to the point where his post-traumatic stress and other behavioral health
disorders had him, you know, all the hyper-
vigilance, all that kind of thing, and he would
go into states where he felt he had E&E, that
included using his skills to steal cars and get
involved in, you know, being chased by police,
endangering lives, obviously, in high speed
chases, I mean those kind of things, and where we
had to get him committed and get him under the
care. Ultimately he was put into care at the
Eisenhower Center up in Michigan, where the
advocacy continued to include senior-level
advocacy to make sure it didn't turn into too
punitive and more therapy oriented.

But we also had to recognize with this
particular individual there had to be some period
of, albeit behavioral health incarceration, there
had to be some period of restricting him from
access to society until you could be comfortable
that he is safe.

And this is where the hard thing comes
in the case you are citing. You've got people
that are trained to hurt people, preferably bad
people that are, you know, opposing the interest 
of the United States or our allies, but they are 
highly skilled at hurting people. 

And so you have to take steps to 
protect society if it's appropriate. It's how 
you do that in a compassionate way that we have 
all kind of learned, and I'm not saying it's 
perfect right now because there still is 
sometimes cases that pop up and I get them from 
time to time where we have to go, okay, I mean we 
obviously we have the veteran court system, we 
have some other things out there that can inform 
fair judgement of care. 

I'm not sure though all the resources 
that are necessary to provide the kind of care 
they need, especially when you are dealing with 
TBI that has as a co-morbidity a post-traumatic 
stress or other behavioral health disorder 
related to it, I don't know that we have the 
apparatus necessarily in place. 

Thankfully it's not too many cases we 
have to deal with, but I think we should at least
address that there is that need from time to
time. Does that answer your question?

COMMISSIONER KUNTZ: Thank you, sir,
that was perfect.

COL. HARBAUGH: All right.

CHAIR LEINENKUGEL: Colonel Harbaugh,
due to the time constraints, I as the Chairman
need to say thank you again, sir, so much.

COL. HARBAUGH: Sure.

CHAIR LEINENKUGEL: A couple of add-
ons as well, the depth, breadth, the insights
that you have brought to this Commission were
exemplary and the candor, as Wayne noted,
fabulous and we hope that that continues with all
of the people that come before the COVER
Commission because it will make our suggestions,
recommendations, and outputs much more clear to
the key components of who are going to be the
participants of making these changes for better
veteran's mental health care.

And I will make a promise to you and
our mutual marine friend Keith Lawless, who I
have not seen in 40 years, to be here in June as
long as my marine buddy will have a rack for me.

COL. HARBAUGH: That I will set up for
you, sir. I have great -- if I could in just
kind of a closing comment to you, I only got to
allude to it a few times.

This VA hospital has been an absolute
fabulous partner for our Special Operations
community. The PREP program that I know they are
going to display to you today, which I am sure
you've already gained some familiarity on, it is
almost exclusively servicing the SOF community,
both veteran and active duty right now.

We rely on it. It needs to grow. It
needs to be out in every VA hospital. Frankly, I
wish it was in every community. It's hard to
find the expertise to populate that I know that
because it requires the providers and the
equipment to do so.

But it is a flagship of care when it
comes to dealing with the traumatic brain injury,
post-traumatic stress disorders, but all factors,
because it's poly-trauma, it's orientation.

   Every SOF service member that I have
sent to this has benefitted from it and raves
about it. We have never had one come out going I
got nothing out of it, it wasn't that good. It
is phenomenal.

   And we were hopeful to see it start to
spread across the Veterans Administration. I
know funding and other things get in the way
sometimes, but we need to have these everywhere.

   I, of course, am going to continue.
I have told them I can fill his classes, he knows
that I can fill his classes every time. I've got
more guys -- I've got guys in the queue, but
whatever could be done through the work of the
Commission to impart or to provide resources to
the Veterans Administration to allow this thing
to proliferate would benefit so many.

   Now it doesn't need to be abused, and
I say that because as I mentioned in my opening
comments about the concern about the degree of
diagnosis or misunderstood on the post-traumatic
stress.

There are a lot of folks are carrying that as a badge of courage and unfairly have it. Now my guys in my population worry about that. You know, if I'm going to get disability for my knee I got to show you how I got my knee injured, okay?

We've got a game being played right now and we got to be aware of that and we got to be respectful of those that truly have post-traumatic stress and post-traumatic stress disorder, but we also have to recognize that some people have anxiety disorders, depressive disorders, other things, and to classify them all in one category, which connotes to the American public and to the rest of us that it means combat service, okay, I have been in combat, it's kind of hard to have PTSD unless you got it, you know, sexual trauma, car accident, something, watched grandma fall down the stairs and die in a grotesque manner.

I don't know, but you got to have
something that was traumatic in your life. We don't force that substantiation. And for the guys in my community that have gone through deployment after deployment watching their buddies die in their arms or get hit or get killed, for them to have somebody call it post-traumatic disorder based on the fact that they just merely put a uniform on is unfair.

And so I think we just have to be reasonable about that. We made a proposal a couple of years that that they reviewed, and it was during the DOLE Commission process, that they do a look at deployment-related stress disorders, service-related stress disorders.

Have a classification so that you can break it out and be fair about it. Hey, what they get ultimately in a disability rating or payment I don't care, we don't care, but it ought to be a little fairer and that way you can't -- we have whole people take advantage of this thing and really when I look at it through the lens of so many of my folks that have got legitimate
post-traumatic stress I worry about that.

So I'm just telling you, again, from the standpoint of being very frank with you that I think that we as a nation got to grasp this because not all of us that served in uniform are dealing with those issues, but those that do could ultimately be robbed of benefits somehow or robbed of care if we dilute that diagnosis and not make that something that is really well understood. So I share that with you as a --

COMMISSIONER KHAN: God Bless SOF brothers everywhere.

COL. HARBAUGH: Thanks.

(Applause.)

DR. POLLACK: So thank you all for coming and this ends the open session.

CHAIR LEINENKUGEL: The open session of Day 3, December 6, 2018, of the COVER Commission is now formally adjourned.

(Whereupon, the above-entitled matter went off the record at 11:49 a.m.)
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In the matter of: Creating Options for Veterans' Expedited Recovery Commission

Before: USDVA

Date: 12-06-18

Place: Tampa, FL

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

[Signature]
Court Reporter

Jake Leinenkugel
Chairman, COVER Commission

[Signature]
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Alternate Designated Federal Officer
COVER Commission

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