UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

CREATING OPTIONS FOR VETERANS' EXPEDITED RECOVERY (COVER) COMMISSION

OPEN SESSION

TUESDAY
JULY 24, 2018

The Commission met in the South American A/B Room of the Capital Hilton, 1001 16th Street, Washington, D.C., at 1:15 p.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
ALSO PRESENT

SHEILA HICKMAN, Designated Federal Official
SHANNON BEATTIE, MPH, Senior Project Analyst, Sigma Health Consulting, LLC
LUIS CARRILLO, VHA Administrative Support
FERNANDA CARRION, Junior Project Analyst, Sigma Health Consulting, LLC
ALICIA CARRIQUIRY, Ph.D., National Academy of Medicine; Iowa State University
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
TRACY GAUDET, M.D., Executive Director, National Office of Patient Centered Care and Cultural Transformation, Veterans Health Administration
LAURA McMAHON, Contracting Officer Representative; Alternate DFO
FRANCES MURPHY, M.D., MPH, President and CEO, Sigma Health Consulting, LLC
STACEY POLLACK, Ph.D., Alternate DFO
KAVITHA P. REDDY, M.D., Emergency Medicine/Integrative Medicine Whole Health System Clinical Director, VA STL HealthCare System
BETH TAYLOR, DHA, RN, NEA-BC, Deputy ADUSH for Clinical Operations, Veterans Health Administration
WENDY TENHULA, Ph.D., Director of Innovation and Collaboration, Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs
DREW TROJANOWSKI, Special Assistant to the President for Domestic Policy
ALISON WHITEHEAD, Alternate DFO
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MS. HICKMAN: Good afternoon. My name is Sheila Hickman. Again, I'm serving as the Designated Federal Officer for this meeting today. This is day one of the first meeting of Creating Options for Veterans' Expedited Recovery Commission, or COVER.

The COVER Commission was established as required by Section 931 of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198, and operated under the provisions of the Federal Advisory Committee Act, as amended by 5 USC Appendix 2.

Public notice of this meeting was given in The Federal Register on July 15th, 2018. This session from 12:00 to 4:45 is open to the public.

Please note that we have three sign-in sheets, one for members of the public in attendance at this meeting and another for those who wish to make public comment at this
meeting, and one for participants on the phone. For those on the phone, we will take this information at the scheduled breaks as needed, as people may dial in during the course of the meeting.

In addition to speaking during the public comment period, members of the public may also submit written comments.

This meeting will be chaired by Mr. Thomas Jake Leinenkugel.

While in session and during the meeting of this Committee, members of the public are asked not to make comments during the briefings or during commissioner discussions. Questions and comments from the public must be made during the public comment period.

Minutes of this meeting are being taken, and anything said during the meeting or submitted in writing before, during, or immediately after the meeting will be 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 and in person. An approved agenda for the meeting has been established, and the meeting will adhere to this agenda.

Anything said during the meeting is on the record. During the break, I will ask individuals on the phone to record their names.

Before this meeting begins, does anyone have any questions about what I have just said?

These preliminary statements now concluded, I now invite the COVER chair, Jake Leinenkugel, to call the meeting to order.

CHAIR LEINENKUGEL: This first session of the COVER public meeting is now in order.

And with that, I would like to invite Dr. Taylor to join us today. Let me give you a brief background on Dr. Beth Taylor.
She joined the Department of Veterans Affairs in 1996 as an Associate Director for Patient Care Services and Nurses Executive in Saginaw, Michigan. She continued to serve in this executive role in several VA facilities as well as several special-focus detail assignments. In 2013, Dr. Taylor assumed the role of Director, Workforce and Leadership, for the VHA Office of Nursing Services, and became the Deputy Assistant Deputy Under Secretary for Clinical Operations on April 2nd, 2018.

Dr. Taylor received a bachelor of science in nursing from Indiana University, a master in business administration from Saginaw Valley State University, and a doctor of health administration from Central Michigan University. In addition, she holds a graduate certificate in international health from Central Michigan University and is Board-certified as a nurse executive advanced. She is a longstanding member of the American Organization of Nurse Executives and Sigma
Theta Tau International.

So, let's welcome Dr. Beth Taylor.

(Applause.)

DR. TAYLOR: Thank you very much.

My charge this afternoon was in a short period of time to give a 50,000-foot view of VHA, and I would propose that it's going to be more like a 100,000-foot view of VHA, given the breadth and scope of our agency and the number of great programs that we have for our veterans. So, in this short period of time, I'll give you a little history and give you a little bit of background of some of our core and foundational services, some of the priorities that we have as a Department, and some of our foci as VHA.

Before I get into discussing the top five priorities for the agency, it's important to recognize that the agency consists of three different Administrations: Veterans Benefits Administration, Veterans Cemetery, our National Cemeteries, and, of course, the largest, Veterans Health Administration.
Veterans Benefits, as the name implies, is to identify the eligibility for any veterans relating anywhere from healthcare to home loans, unemployment benefits, and the like.

Veterans Cemetery Administration dates back to 1862. In the middle of the Civil War, President Lincoln determined that we needed to dedicate some ground to the men who had been casualties of the war at that time. We started out with seven cemeteries, seven National Cemeteries for our Civil War soldiers. Today we have 136 cemeteries and greater than 4 million Americans are currently buried in our National Cemeteries.

VHA's roots also go back to the Civil War. In President Lincoln's second inaugural address in early March of 1865, he spoke very strongly about the need and responsibility to ensure that we take care of our Civil War soldiers. To that end, President Lincoln signed into law to establish a National
Soldiers' and Sailors' Home. The first home was in Augusta, Maine, and it was for the Union troops.

Also, in that inaugural address in 1865, he challenged us "to care for him who shall have borne the battle and for his widow, and his orphan". In 1959, those words became VA's motto.

In 1988, President Reagan made VA a Cabinet-level Department, and today VHA operates one of the largest healthcare systems in the world.

In terms of our agency-level priorities, you see five before you, the first of which is to provide greater choice to our veterans for their healthcare. VHA and VA is committed to ensuring that our veterans partner with us as they make decisions for their healthcare and those decisions that work best for them and for their families.

A couple of recent Acts over the last four years has assisted us in the funding...
of identifying non-VA providers to assist us in providing those choices in care. In 2014, the VA Choice and Accountability Act, VACA, or the Choice Act, was signed into law. That provided funding focused on improving access to care for non-VA providers. In 2018, the VA Mission Act expanded funding for private healthcare options in such areas as caregiver support and the Medical Foster Home. And President Trump signed that into law on June 6th of this year.

Modernizing our systems is our second priority. We believe that veterans and the VA employee needs technological systems to help us deliver high-quality care and that we need to stay on top of technological advances. The electronic health record is the cornerstone of VA's modernization efforts. Some of our core goals under modernization include: to stabilize and streamline our core processes and our IT platforms. We want to eliminate our material weaknesses, focusing on cybersecurity and risk management. We want to introduce new
capabilities that drive improved outcomes, such as community care, My HealtheVet, electronic scheduling, and electronic benefits delivery.

And as part of VA's commitment to put resources and services and all technologies available to reduce veterans' suicide, VA has recently launched an innovative program called REACH VET. Recent research, as you will hear much more about this afternoon and in other presentations, recent research suggests that 20 veterans die each day by suicide and veterans are at a greater risk of suicide than the general public, although not all veterans are involved in VA care.

Using a predictive model, which REACH VET is, we analyze existing data from veterans' health records to identify those at statistically-elevated risk for suicide, hospitalization, illness, or other adverse outcomes. This predictive modeling allows VA to provide preemptive care and support veterans even before they get into acute crises.
Our third priority in VA is to focus resources more efficiently. We believe it's essential that veterans and our taxpayers know that we are focusing and have confidence in our focus on resources to ensure that we have the best value for our veterans and that our veterans receive the care that they need; that they receive quality care; that they receive timely care, and at the point of care that is most effective for them. To that end, we've identified core and foundational services, those things that we do very well, that we're best in class in, and those services that are absolutely fundamental to any healthcare system.

Timeliness of services. We believe that some veterans are still waiting too long for care or services, but we track that every month and we track that very closely in terms of our access. For as an example, in February, 96 percent of appointments occurred within 30 days of the clinically-indicated date or the
veteran's preferred date; 84.9 percent were completed within seven days, and 21 percent were completed within the same day.

In a 12-month period this past year, VHA and the Choice contractors created over 3.7 million authorizations for veterans to receive care in the private sector. So, we believe that timeliness of services is not only the services that we provide within our healthcare system, but as we partner with the private sector and other private sector agencies, and our community partners.

Finally, preventing suicide is our topic clinical priority for VA. I said earlier, and you'll hear much more about this this afternoon, 20 veterans die by suicide each day, and, to us, this is unacceptable. Suicide prevention is our highest clinical priority, and we believe it's a national health crisis, that we need to partner with our government and private partnerships to ensure that we create a web and a net that supports veterans and others
in their time of crisis.

Moving on to VHA, our mission is to honor America's veterans by providing exceptional healthcare that improves their health and well-being. We do have four statutory missions. Obviously, healthcare is our primary mission, but I want to touch on the three others.

Education and training is a significant mission that VA has participated in for quite some time. It is our responsibility to focus on preparing the next generation of healthcare professionals to ensure that we have a trained and ever-ready group of clinicians that can provide healthcare not only to our veterans, but to our nation. This mission is accomplished through our coordinated efforts with affiliated academic institutions all across the country.

For fiscal year 2017, just to give you a few statistics, as evidence of our dedication to this mission, we trained over 800
dental residents and students just in fiscal year 2017, over 43,000 physician residents, 25,000 medical residents, 27,000 nursing students, and, in total, nearly 123,000 health professional trainees, including physical therapists, social work, respiratory therapists, registered dieticians, and some healthcare administrator trainees as well.

Our third statutory mission is research. VA has a very long and rich history of its contributions to healthcare and the healthcare industry. A few examples of VA's contributions to healthcare include: the first decisive trials for effective treatments of tuberculosis; the demonstration of the lifesaving value of treatment of hypertension; the development of the concept of CT scanning; the discovery and development of radioimmunoassay facilitating measurements of previously impossible precision; cooperative studies proving the efficacy of psychoactive drugs in stabilizing psychiatric disorders; the
demonstration of the relationship between smoking and lung cancer, leading to the initial warnings and the report of the Surgeon General on smoking; development of a practical implantable cardiac pacemaker; development of the LUKE/DEKA advanced prosthetic arm and the powered ankle/foot prostheses; the development of the nicotine patch; the work on liver transplantation, and Dr. DeBakey's work on cardiovascular surgery, just to name a few.

Our final mission is that of emergency management. The Office of Emergency Management is the program office for the VHA that provides a comprehensive emergency management program. In an emergency or national disaster, this office coordinates essential VA emergency medical responses and support services at the local, regional, and national levels to ensure the health and safety not only of our veterans, but of our communities.

The VA staff participate in
facility, community, and regional disaster preparation drills, and hundreds of VA staff have been deployed to disaster areas to assist with providing care to individuals, both veterans and community members.

This map is a depiction of our 18 Regions. You can see how we're divided across the country and how we organize our care by Regions. We start with Maine and Puerto Rico to the east, and we stretch all the way to Hawaii, the Philippines, Guam, and American Samoa in the west. So, quite a huge geography that we cover.

This is an overview of the VA sites of care. We do have 171 medical centers, but we also have extended care and VA Community Living Centers, or CLCs. These programs provide not only nursing home care, but also provide specialty services such as rehab, hospice, palliative care, and geropsych care.

We have Health Care Centers, Multi-

Specialty Community-Based Outpatient Clinics,
or CBOCs as we call them, Primary Care Community-Based Outpatient Clinics, or CBOCs, Vet Centers, and Mobile Vet Centers. So, all in all, there's 1700 points of contact across the nation for our veterans to connect with VA and to connect for care.

As you may be sensing, we're moving from a hospital-centric system, where we expect the veterans to come to the hospital for care and the hospital clinics for care, to a healthcare system that is actually very veteran-facing. We want to be in the communities. We have to have technologies that connect with veterans where they are, so they can receive the healthcare that's most convenient to them, that's closest to them, and that will meet their needs.

A few vital statistics for VHA. And again, this is for fiscal year 2017. We have 9.12 million enrollees, almost 6.3 million unique veterans. So, you'll notice that not everyone who enrolls in VHA care actually is a
patient in VA. Almost 84.2 million outpatient visits last year, 577,000 hospital discharges, 146 million prescriptions that were filled, and 727,000 patients receiving care via telehealth.

We're very proud of our VA workforce. VA is one of the largest civilian employers in the federal government and one of the largest healthcare employers in the world. As you can see on the screen, we have 327,000-plus total VHA employees, about a third of which, about 30 percent of which are veterans serving veterans.

We are one of the largest employers of physicians in the world with 25,000 employed physicians, and we have over 95,000 employed nursing personnel, Registered Nurses, nurse practitioners, Certified Registered Nurse Anesthetists, LPNs, and Certified Nursing Assistants.

As I mentioned earlier, we have identified both core services and foundational services. This is a list that is a menu that
you might see at any healthcare system across the country. There's a couple of the services here that are our core services that I just want to mention.

Care management has become increasingly important, as our veterans have options for aspects of their care, and as we continue to partner more robustly with our community and other federal agencies. Coordinating that care and ensure we capture every episode of care in a single health record will be a continuing challenge as we move forward with our modernization efforts.

The other core health service that I want to mention -- and I know that you'll be hearing more about the mental health aspects of our core services in a little bit -- but women's healthcare is another area to highlight. Women currently make up 10 percent of the veteran population in the U.S., and nearly half of that population is of reproductive age. It is the largest or
fastest-growing subgroup of our veteran population, so one that we feel as though we need to pay close attention to, to ensure we meet the needs of that veteran population, particularly when it comes to women veterans who are seeking assistance with fertility issues and maternity care.

Our foundational services are services that VA provides that the private sector may not. These are specialized healthcare services that are uniquely related to veterans' healthcare needs and veterans' healthcare experiences. And these are really some of the areas where I think VA really shines and sets our self apart as a national agency. There's a couple that I would like to highlight for you.

One of which is the Blind Rehab Services. We have a hub-and-spoke approach to providing blind rehabilitation with 13 hub sites nationally. This is a residential program that assists veterans with various
levels of loss of sight and assists them in developing successful strategies to ensure that they are safe in their daily life.

Veterans come as residents and they receive coaching in everything from managing money to navigating indoor and outdoor spaces, traveling, cooking, work on the computer, managing a new iPhone, and various arts and crafts, such as woodworking.

And the facility that I most recently worked at, we did have a blind rehab program, and to watch some of the veterans enjoy woodworking and using a circular saw without vision is really something to watch. But this is the type of coaching and services that blind rehab provides.

Environmental exposure is another area of work that VA provides that's unique to our healthcare system. Our veterans are exposed to agents depending on when and where they served, from Agent Orange to exposure related to burn pits. The VHA is attuned to
these unique exposures and monitors patients for healthcare issues related to such.

Our prosthetics and sensory aids is another area in which we really believe that we shine. This is a service that provides everything from service dogs to robotic arms, from low-vision devices, as I just mentioned in the blind rehab programs, to exoskeletons for our spinal cord injury and disease patients; wheelchairs and crutches. Our VHA prosthetic service covers a wide array of devices helping veterans to live full lives that maximize their mobility and their function.

And finally, I would like to highlight our spinal cord injury and disease program. We have 24 spinal cord injury and disease centers around the country, again, a hub-and-spoke approach to connect veterans with the care and the specialists that they need. We provide them annual physicals. We help veterans with acute injuries as well as chronic injuries, and have very full and detailed
programs, again, to help them navigate with their injury and be as mobile as they wish to be.

Finally, connected health. VA is aligning virtual care technologies to create a unified experience for veterans across all VA patient-facing technologies. Again, this links up with the VA priority of modernization, and there's a few of the virtual care technologies that we have listed here.

The clinical video telehealth is a telehealth service that uses health informatics, disease management, and telehealth technologies to target care and case management to improve access to care and improving the health of our veterans. Telehealth changes the location where healthcare services are routinely provided and, again, gets it close to the veterans or in the veteran's home.

Home telehealth actually uses devices that are placed in the home using phone lines or modems. That helps patients and their
care providers monitor chronic conditions such as congestive heart failure and diabetes and supports patients managing those diseases as they stay within the comfort of their home.

Store and forward telehealth is a technology used primarily in dermatology, radiology, and for the treatment of diabetic retinopathy. This telehealth technology involves the acquisition and storing of clinical information, be it data, images, sounds, or videos, that's then forwarded to or retrieved to by another site for clinical comparison and evaluation in the treatment of veterans.

Our tele-mental health leverages the expert mental health providers that may not otherwise be available locally to the veteran. We're doing more in telehealth than any other healthcare system and connecting mental health providers to areas where mental health providers are difficult to recruit or this area of healthcare may not be available. It is a
key priority for our tele-mental health services.

Mobile health. Mobile health aims to improve health of veterans by providing technologies that expand clinical care beyond the traditional office visits. Again, we want to get the healthcare out to where the veterans are in the veteran-facing. VA recognizes that mobile health is an emerging and essential element of healthcare and is dedicated to providing the up-to-date technologies to enhance these veteran experiences.

My HealtheVet is a portal that veterans use to schedule appointments, to fill prescriptions, review their healthcare records, and access their personal health information. In addition, on this portal, they have the ability to perform secure messaging. This allows the veterans at any point in the day, whenever it's convenient to them, to pose questions to their healthcare team, to email about experiences they're having or give
updates to their providers or nurses. They can also receive health educational material through this secure messaging.

We also have SCAN-ECHO. This is an acronym that stands for Specialty Care Access Network-Extension for Community Healthcare Outcomes. SCAN-ECHO uses dedicated video teleconferencing to simultaneously link several primary care providers, many of whom are in the rural areas, with those specialists that are in that same service area. The goals of this technology are to leverage telehealth to allow specialists from tertiary medical centers to support providers in less-complex or rural areas.

We have found that it decreases the cost of veteran travel and the necessity for veteran travel to a facility for care. It improves access to specialty care. It improves veteran and provider satisfaction, and it increases provider knowledge, competencies, and professional training in those rural areas or
where specialty services are not available.

VA now has an app store. You will find access to dozens of apps, including those created specifically for veterans and their healthcare professionals. You can download an app on imaging. You can download an app that assists you in managing your chronic conditions. But this is a whole app store now that we have for some of our veterans that really enjoy being able to manage their care via their own personal devices.

And finally, we have VA Point of Service Kiosks. That link allows veterans to check in for their appointments as they come into their clinic. They review and update their addresses, phone numbers, and email addresses. They can update their own next of kin, their insurance information, their copay information, and they can review their prescriptions and allergy information before they go in to meet with their provider. They can also view and print upcoming appointments.
So, we have quite an array of technologies that we're using to connect with our veterans at a point that's convenient to them.

So, finally, I'd like to thank you for agreeing to serve on this Commission and for the work that you are about to embark on. We know that we, as an agency, will benefit and, most importantly, our veterans will benefit from the work that you all will do.

Thank you so much.

(Applause.)

CHAIR LEINENKUGEL: Any questions of Beth at this point?

DR. KHAN: Jamil Khan.

CHAIR LEINENKUGEL: Jamil, use the mic, please.

DR. KHAN: My question pertains to the pharmacy. At present, I get 14 medications mailed to me, and sometimes they come in 14 different packages. Each package has large documentation attached to it. I've been taking those medications for the last 15 to 20 years.
Why cannot we stop the additional paper that comes with it? And it's too expensive to send 14 packages that can be mailed in one package. My recommendation is we should use the Pridecare model and save this extra money being wasted by the VA.

Thank you.

DR. TAYLOR: Thank you so much. Thank you for that comment. We'll take that back.

CHAIR LEINENKUGEL: It's a good opportunity because we're talking about streamlining and modernization. So, I mean, that fits right into Jamil's question.

Anybody else at this point? Because I have a comment and then a question or two that I think are pertinent. Let me start with the comment. This is something that I think -- Beth, thank you very much for presenting this -- this is just good background information that we all need to have access to, because this is the transformation to the new
VA right now, is the way I look at it. These are the things that have to happen and be implemented in order for us to move from World War II type of veterans service and care to the new future, as we like to term it. And this is really just starting.

You said something, Beth, about REACH VET, unless I did not pick that up right. But it was when you were talking about the predictive modeling of potential suicide. Was I correct in REACH VET? And can you explain a little bit more about REACH VET or what it is and what stage it's in right now?

DR. TAYLOR: Thank you for that question.

It's in a relatively early stage. And some of the folks with Mental Health, you know, from the Mental Health Service may be able to speak more in more detail to this. But it is a predictive modeling.

Suicide is very complex, and a lot of patients that report that they are not
suicidal do, indeed, commit suicide. We know that there are a lot of life events that are linked to suicide, to veterans committing suicide. It may be the loss of a spouse. It may be the loss of a job. It may be financial crisis.

So, how do we use the predictive modeling tools to look at the entire veteran's healthcare and see if we can predict, whether they say they're suicidal or not, whether we can predict people that are at greater risk for suicide? So, it is in a fairly early stage of development.

Anything, Wendy, you might add to that?

DR. TENHULA: I would just add, going with the idea that suicide is always multifactorial, and, oftentimes, I think the majority -- I don't remember the exact numbers, but can get them for you -- the majority of individuals, veterans who die by suicide who are in our healthcare system didn't endorse
suicidality at their last doctor's visit, were not identified as high risk for suicide based on clinical factors.

And so, we knew we needed to look beyond that and look broadly. And so, we took a huge database looking at veterans who had been suicidal and had died by suicide, and used that to develop, to look at which risk factors go into or which factors go into increasing someone's risk, and could we be more proactive about identifying those veterans who are at risk? And if we identify them at risk, be proactive about reaching out to them and intervening, and helping connect them with care, if they need care, but haven't yet sought care, or help them determine if there are other factors that are impacting their lives. Can we jump in and help with services in those arenas as well?

As Dr. Taylor said, it's in relatively early implementation stages. We're evaluating the effectiveness of it as we go and
have some early results that I think we could get for you, as far as looking at the effectiveness of the program.

CHAIR LEINENKUGEL: Thank you very much.

I have a request, and I'm going to drive people crazy with this screen, because I'm going to ask to go back to Beth's slide. I would like us all to take a look at slide 9, I think it was. I should have stopped you at that time, Beth, but you were on a roll. So, I didn't want to break it.

Let's see if that's the right slide.

DR. TAYLOR: The core health services?

CHAIR LEINENKUGEL: Yes. It is. In the headline there is something that I jotted down. Go back to the headline. Because I think it's going to be, it is relevant for this Commission.

The VA ensures that all eligible veterans have access to all the healthcare
services necessary to promote, preserve, and restore their health. And to me, it was -- Matt and I were walking over for lunch, and I think, Matt, this sort of hit home on the statements that we were bantering back and forth.

We need to have outcomes for our veterans to get better. That's the key success that we owe our veterans. If they are damaged, ill, sick, wounded, scarred, how do we get to promote, preserve, and restore their health?

So, I only bring that up as I'm editorializing, I think, a statement that we should use as a charge at some point for all of us to reflect going forward, seeing this is meeting No. 1 for us. I think that's critical for us to remember, especially under mental health, which we are certainly gauged to tackle here.

We really need to get to, are we restoring them for being productive citizens or productive soldiers once again? So, I think I
just like that headline, and I wanted to bring that to everybody's attention.

    I know I'm taking up some time here, but I wanted everybody to have a little bit of clarity to your connected health, because it's going to blend into things where we're going. And again, it's so great to see, and I've been able to sit in for 18 months now, and there's been great progress made on telehealth.

    I saw tele-mental health used for the first time, I want the Commission to know, in my hometown of 15,000 people with a little CBOC in Chippewa Falls, Wisconsin connected to a psychiatrist in Minneapolis. And the three veterans that had appointments that day were all under the age of 40, and that surprised me that they were willing to do, in a private, little room, that they felt comfortable with it.

    And I was given permission to talk to one of them because he agreed. And he said it's made a world of difference. But the first
step that he had to have was a connection with a real person. And I wondered, is that the way it is with everybody that is going through some sort of struggles? And he said there was a definite connection with four visits -- and I think this is key -- with the same doctor, where he felt comfortable in getting into a booth and looking through a screen, talking with that doctor.

But it was the "aha" moment for me, that there’s two things here. Can we get to that comfort level, that touchpoint where they feel they’ve made progress or a connection, as I call it, a true connection? And then, can we do this on an expanded basis in the rural communities, which I think there are some great needs? Whether it's in Arizona, Montana, northern Wisconsin, or Alaska, they're all rural. But we miss so many veterans.

My last point. You have a veteran population -- we talked about it briefly this morning -- but we need to, as a Commission,
have clarification because you brought up something important. There's 9 million enrolled veterans in VA care right now. When you say "uniques," the 6.2 uniques, those are the ones that you is as the VA services, am I correct in that, Beth?

DR. TAYLOR: Correct.

CHAIR LEINENKUGEL: So, there's 2.8 that are either getting their care elsewhere or not getting care.

DR. TAYLOR: Yes.

CHAIR LEINENKUGEL: But do we know if they're getting care or need care?

DR. TAYLOR: I don't think for all of them we know.

CHAIR LEINENKUGEL: Yes, that's probably the right answer. And it bothers us, I think, as commissioners, that we have that subset that we don't know. And I'm talking about mental health. And then, we have a whole 15 million others that we don't know.

And part of this Commission, as we
all know now, is we are tasked for trying to find out, if we can, just about every single one of them. Are they at risk? Do they have mental health needs?

And so, I think just from the VA's standard -- and I would talk to the Secretary about this -- because we struggled for 18 months, when I was actively involved, in getting clear numbers and knowing for certain within plus or minus 1 percent of our veteran population, of what type of care they're getting.

And I know there's a lot of new technology. You've listed it. And it's going to make a difference. It will take some time.

There's also this Medallia application, I believe, that Lynda Davis' group is bringing in that the commissioners should be aware of. And I think at some point Lynda's coming in, or somebody, to talk about that, yes.

So, it's important, and I'm saying
all of this because there's been great strides made. That's No. 1. But No. 2 is we still have gaps, and we're going to be asking from this Commission -- my guess is these commissioners are going to be saying, "Let's narrow the gaps."

DR. TAYLOR: We still have work to do, yes, sir.

DR. JONAS: So, let me just build on that with a couple of specific questions. I understand there's a new EHR joint DoD/VA electronic health record that's supposed to come out next year, is that correct?

DR. TAYLOR: Yes. There is a group that is working on that. I know that my boss has a meeting coming up, I think in two weeks, where they're going to spend the entire week talking with Cerner and talking about the EHR.

DR. JONAS: Yes, it's a Cerner-based thing.

Are we going to see some of that? Because that sort of is kind of important for
projecting into the future of how things are managed. I know in the civilian sector it's built around can we get payment, not around patient-centeredness. We know that. The question is, how is this one built?

So, a related question really is, is there a model? The very first task we were asked to do is to evaluate the efficacy of the evidence-based therapy model. And is there a VA therapy model? I mean, the predictive model is one you just mentioned for suicide. Most chronic disease, to my knowledge, is complex and multifactorial. So, it requires some kind of predictive components of it, if it is really going to be managed in the way that you've just described up there, Jake.

And so, you mentioned several times a hub-and-spoke model. That's another model. Is that changing? Are we still maintaining that in the VA? Are we going to a network model? What is the model? And are we going to find out about that?
DR. TAYLOR: Well, I think the short answer is you're probably going to learn more about that over the successive presentations. But I think it also depends on some of the specific programs. The hub-and-spoke model for some of our super-specialized programs, like spinal cord injury and disease like blind rehab, really do work. The folks for blind rehab actually fly into places like Tucson from Salt Lake, from Albuquerque, New Mexico, and spend a few weeks there and get the resources they need, the prosthetic devices they need, and then, go back.

I think the predictive modeling, though, for issues such as suicide is a very important model that we need to work on.

And I don't know, Wendy, if you have any other comments on the modeling specific to mental health services that may be of value to answer the question.

DR. TENHULA: I would agree that probably you're going to learn more there. To
my mind, the model we use needs to be tailored to the individual needs of the veteran, of each veteran. So, how we approach their care, whether it's through a hub-and-spoke model of telehealth or a hub-and-spoke model of blind rehab, will depend on what the individual needs of the veteran are. And I'll talk when I talk a little bit more about some of the approaches we use in mental health, too, that may help start giving you some information that will be helpful.

DR. BEEMAN: Dr. Taylor, I know you're not a health economist, but do you how much money the VA is spending on mental health services versus other things? It's my contention that in the civilian sector we underspend. In fact, the insurance companies are set up to minimize the access of patients. And the question I have, how much are we spending vis-a-vis the civilian sector? Two, is that enough? And three, are there other things that we're doing that we don't need to
do that we could stop, so that we could fund
properly the mental health services that we
want to provide?

DR. TAYLOR: Thank you.

I think that ties in with the VA
priority of focusing our resources to be most
effective and focusing in our resources on
those things that are going to be most
important for us to address with our veterans.

In terms of the actual cost, I don't
have that data for you, but it's something that
I believe that we can get for this Commission,
if you're interested in such. So, I've made a
note of it here and would be happy to bring
back that information to your group.

Thank you so much for the question.

CHAIR LEINENKUGEL: Anybody else on
the Commission with questions at this time?

Jack?

MR. ROSE: Yes. Just a question
with respect to mental health. We've had the
question about how much funding is coming at
mental health. The area of research which is so critical in mental health, what percentage of research right now is being directed towards mental health and improving it?

Thank you.

DR. TENHULA: That's a great question that we could get for you. I don't know.

I haven't been introduced yet, but I'm Wendy Tenhula from the Office of Mental Health and Suicide Prevention. We work very closely with our Office of Research and Development to help establish the research priorities when it comes to mental health.

It is, I can say, having been in the VA system for quite a while, it is a much larger percentage than it used to be, and there is a strong investment in VA research in mental health and in suicide prevention. And we can get you, absolutely can get you more information on that and more details on the priority.
And I hope that you all will be hearing in more detail over the course of your work about VA's research. Dr. Taylor mentioned VA's research efforts, and in mental health it's been so critical to innovations and changes.

MR. ROSE: Thank you very much.

And another thing, with the different programs that are going on, I think the Commission here will also be interested in the timelines that we're dealing with. You know, it's one thing to say that it's in our top priority, but what is the actual time right now that we expect to achieve those priorities? Okay?

Thank you.

CHAIR LEINENKUGEL: Thank you so much. It's nice having you with us today.

DR. TAYLOR: Thank you.

CHAIR LEINENKUGEL: We'll probably have you back or we'll come and see you at some point in time.
DR. TAYLOR: I'd love it. I'd love it. Thank you.

CHAIR LEINENKUGEL: At least as a subgroup.

And I have the opportunity to present Wendy, who's already commented a few times during this meeting.

Wendy, I'm trying to find your sheet here. So, I'll get to it. Oh, no, I've got it. We're all getting used to these binders, okay, for the first time.

(Laughter.)

CHAIR LEINENKUGEL: I have the privilege to introduce Dr. Wendy Tenhula. Dr. Tenhula is the Director of Innovation and Collaboration in the Office of Mental Health and Suicide Prevention at the VA. She oversees our Mental Health Centers of Excellence, including the National Center for Post-Traumatic Stress Disorder and programs that address women's mental health; also, families and the effects of military sexual trauma. She
also leads coordination with the United States Department of Defense and the Substance Abuse and Mental Health Services Administration on mental health issues and oversees the VA's national award-winning Make the Connection Outreach Campaign.

As a clinical psychologist, Dr. Tenhula has extensive expertise in psychological interventions, the cognitive effects of schizophrenia, vocational rehabilitation, and campaigns to reduce the stigma associated with seeking mental health treatment. Her research has been published in multiple articles and books.

She's earned her bachelor's degree in psychology at Vanderbilt University and a doctor of clinical psychology at Northwestern University. She's completed her internship and a postdoctoral fellowship at the Hennepin County Medical Center in Minneapolis, and second fellowship year in the Department of Psychiatry and Behavioral Sciences at Stanford
Thomas J. Leinenkugel

University School of Medicine. She has been with the Department of Veterans Affairs now for 18 years.

Dr. Tenhula, thank you so much for being with us today.

DR. TENHULA: Thank you. Thank you. Sorry, I'm trying to be practical before I even get started. How long should I plan on? I know we didn't get started on time. I don't want to take --

CHAIR LEINENKUGEL: We're fresh right now. This group needs to hear from you, Dr. Tenhula.

DR. TENHULA: Okay. Okay.

CHAIR LEINENKUGEL: So, I will be the judge if you're starting to go a little long.

DR. TENHULA: Okay. Give me the hook whenever you're ready to give me the hook.

CHAIR LEINENKUGEL: I will be the hook, yes.

(Laughter.)
DR. TENHULA: Thank you. Thanks, Mr. Leinenkugel, and thank you to each of you for agreeing to serve on this Commission. It's really important work and I appreciate the opportunity.

Dr. Taylor said she was going to talk at about 100,000 feet. I'll probably take you down to like 45,000 feet maybe on mental health.

And then, I know that at your next meeting you already have on the agenda Dr. David Carroll to go into even more depth on VA's mental healthcare. So, think of this as just an appetizer, a high-level sort of overview.

It really is a pleasure to be here. I'm honored to work in VA mental health, as Mr. Leinenkugel said, for the last 18 years in VA and various aspects of our mental healthcare system. Our office, the Office of Mental Health and Suicide Prevention, stands ready to help this Commission do their work, whether
it's providing follow-up information for your questions, providing documents, reports, any work that we've done that we can share to help you all as you are doing your work. We are standing by ready to help.

Can I have the clicker? That's good. There we go. Okay.

So, this is what I want to touch on. Like I said, you'll hear more in-depth from Dr. Carroll at the August meeting and have additional discussion, and I'll be happy to take your questions back to him, so that he can be even more prepared to answer them when he comes.

I'll give you a high-level, sort of general overview, a snapshot of VA mental health. I wanted to try to highlight a few areas where I think there are some unique aspects to VA's mental healthcare system versus the private sector mental healthcare system, and that I thought would be of interest to you as you're sort of launching into your work.
So, I'll touch on each of the areas here on this list, and I hope that will give you sort of a flavor of VA mental health services and some of the things we do, and some of the things we do that are unique.

VA provides a full continuum of mental healthcare from outpatient to residential and inpatient mental health services. They are recovery-oriented, going back to that idea of living the fullest life that you can live and the fullest life in ways that you want to live it. Veteran-centered and evidence-based. So, there's a lot packed into that phrase, all of which I think is really important.

As part of that full continuum of care, we have immediate crisis intervention and support available 24/7, 365 days a year, through the Veterans Crisis Line. And that's available by phone, online through the computer, and by texting on your mobile phone, across the healthcare system in different
So, we don't just think about mental health if someone comes to a mental health clinic. We proactively screen for depression and post-traumatic stress disorder and problematic alcohol use in primary care and across our health system.

Dr. Taylor touched a little bit on some of the connected care and uses of technology specific to mental health. We have several web and mobile tools that help connect veterans and their families to mental health resources. I'll talk a little bit about at least one of those later, but there's more; there's a lot there.

And one thing I want to mention that's unique to VA is the use of peer specialist. We have about 11000 peer specialists working in our system right now that really provide unique opportunities to engage veterans in care. So, our peer specialists are veterans themselves who have
themselves experienced mental health challenges and really are wonderful assets to our system. In fact, the mission that Dr. Taylor mentioned offers us the opportunity to expand the use of peer specialists, not just in mental health clinics, but in primary care clinics as well. So, we're excited about that.

I will also, just going back to one of Dr. Taylor's slides, note that, of the 11 foundational services listed on that one slide, four of them are specifically related to mental health. And I'll show you, too, a little bit about what percentage of our care is mental healthcare, but specifically in our foundational services. Military sexual trauma and related care, post-traumatic stress disorder, readjustment counseling, and substance use disorder care, all sort of fall within our mental health realm. So, obviously, it's a big part of what we do. The short way of saying what I'm trying to say is that mental health is a big part of what we do in our VA
healthcare system.

Along those lines, we have seen demand for VA health services go up. In fiscal year 2017, VA provided mental health treatment to more than 1.7 million veterans, and that increased by 80 percent from FY 2006 to FY 2017. And that's an increase that's more than three times the increase that we've seen across all of VA care. So, we're seeing more of an increase in demand for mental healthcare than we are -- we are seeing an overall increase in demand for VA healthcare. We're seeing more of an increase for mental health.

And just another way of saying that is, back in 2006, about 20 percent of people who came to VA for their healthcare were receiving mental health services, and last year that was about 28 percent. So, I think, Dr. Beeman, that goes back to your question a little about how much of the care we are providing is mental healthcare. It's a pretty big chunk of what we're doing.
I'm pushing the wrong button. I'm going to push my microphone button instead of my slide button.

The next thing I just want to touch on, again going back to what Dr. Taylor was saying about access to care, VA has undertaken extensive efforts to improve access to mental healthcare. And that includes access initially. So, when someone realizes that they might need mental healthcare and they want to get in to see somebody for that first appointment, but also we have to think about sustained access to care. So, can someone get a full course of, if what they need is psychotherapy, can they not just get in the door for their first appointment, but can they get in the door for weekly appointments for the period of time that they need that care? And so, we need to think about sort of the whole access picture.

I just want to highlight a couple of things in the access realm. Also, we
intentionally put access to high-quality care because we don't want to just provide access. If we can get someone in the door for an appointment, it's important that we get them in the door for an appointment for good-quality care that's going to be effective and helpful for them, not just that we can check a box and say we got them in for an appointment, right?

And so, a couple of things to point out. By the end of 2016, all VA medical centers attested to being able to provide same-day access for mental healthcare. So, if someone comes in and they have an urgent mental health need, they will receive immediate, same-day attention from a healthcare professional at that medical center or the CBOC, the Community-Based Outpatient Clinic, that they present to.

And I will also talk about a little bit more one of the ways that we have improved access to mental healthcare is through integrating mental health providers into our primary care settings. And open access is a
key principle of primary care-mental health integration. That is, if someone is there seeing their primary care physician, and the primary care physician identifies a mental health need, being able to do a warm handoff right away to a mental health provider is part of the model of primary care-mental health integration that is, I think, unique to VA's integrated sort of full continuum of care, being part of the system like we are. So, I wanted to mention that.

Two other quick things to highlight is expanding access to those with other than honorable discharges and the recent Executive Order, signed by the President in January, that enhances access for service members who are transitioning from active duty. Those are two populations that we know are in various ways at risk for adverse outcomes, and we want to make sure that we are paying attention to their needs and providing services as appropriate. So, those are two specific populations that we
have been focusing on in terms of access to care.

Sort of continuing thinking about access to high-quality care, and thinking about how do we know what the quality is, we have a number of different -- and I wanted to include this specifically because I think you all might be interested in some of the data from these sources. Again, as part of being an integrated system, we are able to tap into a huge amount of data and use that data for quality improvement.

So, we have the Strategic Analytics for Improvement and Learning, or SAIL. And the mental health SAIL domain has three components to it: an experience of care -- so, when a veteran comes to VA for mental healthcare, what is their experience of care like and how do we measure that? -- population coverage and continuity of care. So, those are the three sort of subdomains that we look at under SAIL that are related to mental health.
The Veterans' Outcomes Assessment is a phone interview -- going back to your point, Mr. Leinenkugel, about outcomes -- looking at outcomes for individuals who are new to mental healthcare. So, when they initiate mental healthcare, we follow up with them within two weeks after their initial appointment, and then, three months later. And we're looking at mental health outcomes, symptoms and functioning and how are they doing, and whether they've continued. And then, we can crosswalk that with our administrative data and look at their utilization of care, et cetera. So, that's the Veterans' Outcome Assessment.

The Veteran Satisfaction Survey is more geared towards understanding veterans' experiences of recent mental healthcare, not necessarily when they're just brand-new to care, but across the time that they receive care.

And then, we also have an Annual Mental Health Provider Survey where we look at
the experience of the mental health professionals that are working in the VA system.

So, those are some sources of data that we use for continuous quality improvement in our VA mental healthcare system.

I also just want to mention, in terms of ensuring that we're offering high-quality care, we have -- and I mentioned this a little bit already -- specialized programs to address the needs of specific populations, some of which are listed here. We offer training in evidence-based treatments for mental healthcare. As of a couple of months ago, more than 12,700 VA mental health clinicians had been trained in evidence-based psychotherapies, with about 8500 of that in either prolonged exposure or cognitive processing therapy, which are the two treatments for post-traumatic stress disorder that have the strongest evidence base. So, we are really investing in our mental health professionals and their
training, and making sure that what they can offer to veterans is based on the best evidence that we have.

We have implemented team-based mental healthcare, which really promotes veteran-centered care. It allows us to better coordinate care. It allows teams, interdisciplinary teams, to communicate better with each other. We have found that it improves veterans' engagement in care and also improves things for our staff, like job satisfaction and engagement and communication, as well as increasing access to care.

I also want to mention our Mental Health Centers of Excellence. We have 10 MIRECCs they're called, Mental Illness Research Education and Clinical Centers, and six or seven, depending on how you count, other Centers of Excellence in the realm of mental health. They each have a specific and distinct mission. Each of those 16 centers has a specific and distinct mission and are really
hubs of innovation for our system. They all have a combined mission of doing research, providing education, and developing innovative clinical programs, and testing innovative clinical programs. And so, they are a real, I think, jewel in our crown of VA does when it comes to mental health.

I work closely with them, and I know you guys have already reached out to a couple, the support staff have already reached out to a couple of our centers and gathered some information. So, they are a wealth of information, and I'm sure will continue to be so for your work.

I also want to mention -- it's not just us tooting our own horns -- external reviews of VA's mental healthcare generally find that VA care is equal to or better than care that's available in the community. And I understand that you will be hearing more about the National Academy of Medicine evaluation, which is the most recent thing. So, I'm
thrilled that you're going to be hearing more about that in detail. So, I won't go into detail here, but I think it's always helpful, not just for us to look at ourselves, look at what we're doing, but what do other people think of what we're doing?

All right. And so, I promised I would highlight just a few things that I think are more specific, but I think relevant to your work and unique to VA. One is the primary care-mental health integration. VA really is seen as a national leader in this area. What that means, as I mentioned, is that we have mental health providers who are embedded in primary care settings. It allows us to proactively screen. It allows us to identify and address mental health concerns as early on as possible. It allows us to identify and address mental health concerns for people who might not to walk down the hall to the mental health clinic, but might talk to their primary care doctor.
We know that a lot of mental healthcare is provided in primary care, and it better equips our primary care providers to provide that care. It reduces wait times. As I mentioned, one of the principles of our PC-MHI program is to have open access. And it gives us a doorway to engaging people who might need more extensive mental healthcare, to try to get them moving in that direction.

And I think it's important, going back to talking about suicide, to note that, according to the CDC, 54 percent of people who died by suicide did not have a known mental health condition. And about 40 percent of our own patients, veterans, who are seen in VA who died by suicide did not have a known mental health diagnosis or mental health treatment in the previous year, but they were being seen in VA. So, it's really important, I think, for us to make sure that our primary care providers are well-equipped to address the full range of challenges that veterans come to them with and
to try to help identify if someone is at risk, because a lot of people who are at risk are not being seen in mental health and don't have an identified mental health condition.

All right. I want to also just mention measurement-based care. That's an initiative that we've undertaken over the last couple of years whereby we use veterans' self-reported outcome measures to really individualize and improve mental healthcare. And it's very veteran-centered. It's evidence-based.

The idea is to collect, share, and act. That's our sort of quick and easy way to say it. We collect veterans' self-report measures, both at the beginning of treatment and, then, at regular intervals as part of their treatment. It gives us objective -- we use reliable, validated measures that are relevant to the type of difficulties a person is having.

We share those results with the
veteran. So, right there in the session, talk to them, show them, graph their progress, or lack of progress, and then, use that to make changes and make decisions about treatment and make decisions about when someone is ready to move on to less-intensive treatment, might need more intensive treatment, when a treatment is or isn't working. And it really allows us to empower veterans as partners in their care and use data and use information to provide the best care we can. So, it's an exciting initiative that we have underway.

I keep reaching for the mic button. I will turn off my mic at some point instead of advancing my slides. I need to put the microphone, the thing over here. Okay. Sorry.

So, just moving on, I want to just talk briefly about tele-mental health again, amplifying something that Dr. Taylor said about how much we have increased the use of tele-mental health in our system. In fiscal year 2017, we provided tele-mental health services
to more than 151,000 veterans, and that was more than 473,000 sessions.

Then, the red bar there shows the number of encounters or appointments, and the blue bar shows the number of patients, the number of veterans who received those services.

And the hub-and-spoke model is something we use for tele-mental health as well. We have tele-mental health providers that are located at one place, and they can work with patients who are at various places around the country, including telehealth to the home as well as to other VA locations.

Okay. I'm going to shift gears really quickly and mention our suicide prevention efforts. As we have talked about, this is a major priority for VA to address veteran suicide. We are taking a public health approach to veteran suicide. The idea is that suicide prevention is everybody's business. Suicide is preventable. And we know that the majority of veterans who have died by suicide
havent come to VA, at least not recently, for care.

And so, we need to help reach veterans and their families wherever they are. We need to build community engagement. We need to change the conversation around suicide. We need to continue to develop innovative strategies for prevention and continue the work that we're doing within our VA healthcare system. Because we also know that, while the rates of suicide have been going up in our country overall, and rates for veterans have been going up overall, the rates for veterans who are in VA care are not going up as quickly as the rates for veterans who are not in VA care. They are still going up. It's still happening that there's an increase, but it's not going up as quickly for veterans who are in VA care. So, we need to do all these other things and we need to keep providing good mental healthcare and good care within our system as well.
Just to quickly mention some of the key suicide prevention goals that are directly in line with what I was just saying: the mobilized action nationwide; this idea that suicide prevention is everyone's business; expanding universal prevention initiatives. That means, in a public health model, universal prevention is a prevention strategy that's applied to everyone, not just those who are in specialty treatment and not just those who are identified at risk, but everyone.

Working closely with DoD and working closely on timely data reporting. We need to be able to see if change is happening. If we are making changes in our system, we need to be able to tell if that's making a difference.

Fostering innovation. Again, a public health research strategy. Educating veteran communities about lethal means safety, and going back to the idea of access to proactive mental health support and treatment, and with a particular focus with partners in
the community on veterans transitioning from
service. So, those are some of the key focus
areas or key holes related to our suicide
prevention efforts.

I mentioned before the Veterans
Crisis Line is available 24/7. The Veterans
Crisis Line gets about 2,000 calls a day and,
from a call, can initiate, can make a referral
to -- at every VA medical center there are
Suicide Prevention Coordinators, and the
Veterans Crisis Line can link someone with the
Suicide Prevention Coordinator to get them
linked into care, and in an emergency
situation, can initiate what we call a rescue,
or can contact law enforcement and have someone
immediately go to the person and try to
intervene right away. So, I just wanted to
mention that.

And then, the last thing I'll
mention, we've talked a little bit about how we
need to reach all veterans and how many
veterans are not in our care. One way in which
we've worked on doing this within the mental health realm is through outreach.

The Make the Connection Campaign is VA's mental health public awareness and outreach campaign intended to connect veterans and their friends and family with information -- with each other, first and foremost -- with information and resources and help them identify, if they need help, how can they get in for help. We realize that there is still a stigma that veterans and their families associate with seeking mental healthcare.

The Make the Connection Campaign really highlights the strengths of veterans that have sought support. It features veterans themselves telling their own stories of difficulties they've faced and what has helped them, and what they have done to have healthier and happier lives. They're really incredibly powerful and courageous stories, and it's an online resource. It's through social media. The last data that I looked at, the Make the
Connection website had had about 15 million visitors to the website. About 59 million of the videos had been viewed by visitors to the website.

Our Facebook page for Make the Connection was featured by Facebook as the fastest-growing government or military sector Facebook page, and it has over 3 million likes, I think is the right word. I'm totally technologically not savvy.

And the reach of the public service announcements and things like that, it just goes directly to what you were saying about needing to reach all veterans and encourage those who are having difficulty to help them understand that there are resources available, that there are effective treatments available, if they need treatment, and better understand how and where to reach out for support. So, I just wanted to mention that because I think it is relevant to some of the conversation.

And I think that was the last thing
that I wanted to mention. So, quick snapshot, 45,000 -- did I hit 45,000-ish feet?

(Laughter.)

CHAIR LEINENKUGEL: I'd say 30,000.

(Laughter.)

DR. TENHULA: Thirty? Okay. And have you any questions?

CHAIR LEINENKUGEL: We're going to have a quick questions for you.

DR. TENHULA: Great.

CHAIR LEINENKUGEL: And if I can, I'll start.

This is going to go Dr. Carroll, who will be coming in next month. But it will be on the record, and I don't expect you to have the answer because I have not heard the correct answer for 18 months. But we need to find out the answer because you have an integrated, connected healthcare system now within VA dealing with mental health along with primary care. And you have a name for it and an acronym.
And I know it does work in certain VAs because I've seen it where the primary care doctor made sure that a patient did not leave until she saw, due to a stress situation that she had, a mental healthcare provider, which was fantastic.

Three things. No. 1, what's the true number of clinicians that the VA currently has open? Whether it's doctors, nurses, PAs, it doesn't matter. What is the exact number by table of organization that are not currently filled?

No. 2 --

DR. TENHULA: I'm sorry, that are not currently filled? So, vacancies?

CHAIR LEINENKUGEL: Vacancies, correct.

DR. TENHULA: Okay.

CHAIR LEINENKUGEL: And I'm saying this for a reason.

Two, what are the mental health vacancies that are open, both on the clinician
and systemwide shortage?

And then, three, it should be from the VA leadership -- certainly Dr. Carroll, I would think, would come back with, what is the right number? Because the TO might not be the right number.

So, I would that, by next month, we would be able to have some clarity for that. Because I can't imagine how you have a great primary care-mental health integration if you have 30,000 shortages, as have been bantered around in the press and on the Hill for the last 18 months, without the VA properly responding.

So, it's on record now for us to find out and get the exact number through this Commission, so that we have clarity going forward to see if there is a true gap and how we are going to resource that gap or repurpose dollars from other programs, as Commissioner Beeman brought up earlier. So, I think these are the right type of things that we, as a
Commission, need to start asking the questions and getting the answers to, so that we can come up with the proper recommendations.

But both of your presentations were absolutely spot-on from the 100,000-foot, 80,000, down to 35,000. And we're going to get down to ground level. That's where the Commission needs to be.

So, next? Wayne, did you have something?

DR. JONAS: Yes, I just wanted, actually, to add onto that a bit. I think it's in the same theme. I mean, just simple math. If 80 percent, or three times the service demand has gone up since 1006, as have the resources, given that you have such a good system -- it sounds like you have one of the top mental health systems anywhere -- have those resources gone up proportionately? So, was it one-to-one during that period of time? Or is there a relative deficit now? That's just building on your question here.
DR. TENHULA: So, I can say -- and we can provide more -- I don't have the exact numbers off the top of my head. I can say that mental health staffing during that time has gone up. So, I showed you the demand curve of how many more patients we're seeing and how many more visits. Mental health staffing has gone up during that period, but it has not kept pace.

DR. JONAS: It has not kept up?

DR. TENHULA: It has not gone up one-for-one with how much demand there's been.

DR. JONAS: So, there is a relative deficit?

DR. TENHULA: So, there is a relative --

DR. JONAS: Yes.

DR. TENHULA: It has not gone up at the same rate. DR. JONAS: It doesn't match, right.

DR. TENHULA: The staffing has not, but it has gone up.
DR. JONAS: Have you evaluated the peer-to-peer system? I mean, is there some hard data on how that's impacted quality, access, outreach, mental health, any of the other outcome parameters in some way?

That's a model, by the way.

DR. TENHULA: Yes.

DR. JONAS: I'm interesting in models, as you know.

DR. TENHULA: That is a model. That is one of the models.

There is good evidence to suggest that it does improve engagement and does improve satisfaction with care. And we are in the process of evaluating some of the components of the peer specialist program, but haven't done a comprehensive evaluation.

DR. JONAS: Yes. Okay. My last question is, given that you have such a robust mental healthcare system and there is a movement now to try to increase the access into civilian populations, which I presume many of
which will not be as good, is there a problem there? For example, is there a need to kind of map out and create some top examples of what needs to happen if civilian groups get in?

Many of the mental healthcare is very similar to what goes on in community health centers. And you, having been at one of the best civilian community health centers, Hennepin County, how does that compare to that?

DR. TENHULA: It was an amazing experience.

DR. JONAS: Yes.

DR. TENHULA: You're right.

So, we've tried to address that. I'm not sure this will fully answer your question. But one of the things that we've tried to do, for example, is create training and education that is available for free and provide free continuing education credits for civilian providers on topics such as military culture competence, military culture training, on various aspects of suicide prevention that
are evidence-based.

And so, we've tried to do what we can to make it possible or make it easy for civilian providers to learn as much as they can, if they are going to serve our veteran population. So, it's not a complete answer to your question, but --

DR. JONAS: What I'm trying to get at, is the quality going to go down as the access in the civilian goes up?

DR. TENHULA: I think it's something we need -- we need to be able to look at that for sure. That's a great question.

DR. KHAN: I would like to give you feedback. I don't want to hear another veteran committing suicide. So, one of the quickest solutions within the budget is provide those who are flagged with a push-button technology.

Evidence-based confirms that where the veteran was reached the last minute, there were a large number of successful prevention. And this push-button should not be answered by
a call center. It should be answered by a qualified clinician. It will save lives.

I mean, you know, as a veteran, my heart goes out for the individual who is so far gone. And you can spend millions of dollars for cosmetic changes. It's not going to give you results than the one I'm giving you.

When somebody falls down and says, "I need help," that individual who has so much hopeless -- let's say Jamil, and I'm standing on the San Francisco bridge to jump. But, if I have that technology, there's a point, a 1-percent chance that I may push it. And I hear your voice and you tell me, "Jamil, go ahead and jump, but wait five minutes." And you start talking to me. Last-minute changes have occurred in people's lives.

So, I want to go on the record asking the VA to invest into that technology. It is available now.

Thank you very much.

DR. BEEMAN: Dr. Tenhula, I
Thomas J. Leinenkugel appreciated your presentation. Just a couple of comments.

I have heard it said that 70 percent of those patients presenting themselves at primary care physicians would benefit from mental health services. Clearly, you are seeing more of those patients. But, as we have embedded mental health providers in primary care practices, the number of referrals is just skyrocketing, which creates a tremendous demand on the mental health provider.

I applaud your efforts to train veterans and look at alternative kinds of providers, but I think that that's something we should be prepared to answer. And that is, from an educational standpoint, what do we have to do as a nation to assure that mental health, which is now getting much more of a viewing point, what do we have to do to make sure that we have the right kinds of providers and train the right kinds of providers?

This has got a long tail on it.
What worries me, as the private sector gets into the business as well, we're going to create a tremendous shortage. We may not be able in government to meet or compete for the professionals because they have more money to spend perhaps. How are we going to meet that demand? So, we have to be prepared, I think, to answer that question.

Thank you.

MR. ROSE: If I may, to follow up on that, too, and then, all at once, because I think out in the civilian sector there is a definite shortage in the mental health profession.

And I applaud the VA for having the wherewithal to do what you all do. But, as we start sharing between the VA and the civilian side, the civilian side is not necessarily going to be able to help us out because they're just not there. The resources aren't there.

DR. TENHULA: That's a good point and something that is really important to look
at and be mindful of. The shortage of mental health professionals, the gap demand, between need and professional services available isn't a problem that's unique to VA. It's our mental healthcare system in our country is lacking providers.

Thank you.

MR. ROSE: And if I may, just one more on your family program. I know I have done some work with the National Alliance on Mental Illness, and their family-to-family program has been fantastic. And I believe the VA is going along similar. Is that correct? It works?

DR. TENHULA: Yes. We have an agreement with NAMI to do the family-to-family education program at VA medical centers.

MR. ROSE: It works?

DR. TENHULA: Yes.

CHAIR LEINENKUGEL: I don't want you ruining Dr. Carroll's nice vacation in Germany and pinging him immediately with those three
requests from the Commission. But I bet you some staff members can start working on that for him.

DR. TENHULA: I promise that we will not bother him with it until after he returns from his vacation.

CHAIR LEINENKUGEL: Doctors, thank you both. It's been very beneficial for this Commission to have both of you onboard for our first public session today. And thank you for your time and your efforts with working with veterans in all cases. Thank you.

(Applause.)

CHAIR LEINENKUGEL: Because we got so frisky with the pertinent questions, we're about 30 minutes behind. So, what I'm going to do is make the chairman's statement that there will be no formal break. So, if you need a bio break, we're all educated and old enough to do that by ourselves. And we'll take notes if you're missing for a few minutes or if you have an emergency call. So, we're going to press
forward and move on to the next presentation.

We have three very prominent ladies in front of us, and I'm not going to read each of their bios because that would cut in another 10 or 12 minutes because they're extensive.

But I've gotten to know them and I know the quality of work they do. I have been able to participate in the things that I spoke to some of our commissioners about earlier this morning in our closed session, about Tracy Gaudet, and certainly Alison Whitehead is working with us as well, and also with working with Tracy and the team, and also could be at the ready. So, we're looking forward to this presentation, and the floor is now yours.

DR. GAUDET: Great. Thank you. We appreciate the skipped bios. We're happy to provide details --

CHAIR LEINENKUGEL: Well, they're awesome bios and we have all of them.

DR. GAUDET: Very happy to provide any details you want after the session.
I'm Tracy Gaudet. Very honored to meet all of you, and I'm very excited, we all are, about the Commission and the opportunity before us, the VA and the nation actually.

So, we want to talk to you all about the work we're doing in whole health, and I'll describe what that is. But I just wanted to tee that up by saying what I'm sure you already know. But we have such a tremendous opportunity right now to not only like kind of break through an old way of thinking about sickness and disease, and really get to optimal health and well-being, and do that not only for our veterans, and model it in the VA, but model it for the nation.

And I think your leadership and this Commission can help us do that. So, I just wanted to put that upfront and say we're thrilled and we are at your beck and call in any way, shape, or form across the 18 months, or whatever the timeline is, of your very important work.
I thought maybe we should do this or something, the three of us.

(Laughter.)

DR. GAUDET: But we're going to present to you. I want to start the vision. Because I left academic medicine, a long career in academic medicine, to join the VA because of the opportunity to really catapult VA healthcare in directions that the VA has the vision for.

And I'm not going to spend a lot of time, but I want to ground us in the fact of what we all know, which is our current healthcare paradigm is very broken. There is tremendous data on cost, on outcomes, you name it. You know, we spend so much more in this nation on healthcare, and we get very poor outcomes. We're 37th in life expectancy, as an example.

And everybody knows this is not sustainable. Everyone in the nation is calling for a massive transformation in how we think
about health. We know it's somehow related to helping people take charge of their health and well-being, because 75 percent of costs are due to chronic conditions that are affected by people's choices.

The problem -- and I should say I'm a physician; I'm trained as a physician, an obstetrician/gynecologist. I'm trained in the medical model. And the problem that we have is that the system of care we have is not actually designed to optimize people's health and well-being. It's not what the system is set up for. It's set up to really diagnose and treat disease, and that's important. We're not saying we should throw that out, by any stretch, but we're saying it is not adequate. And it's why we have these huge gaps that we have.

Can you be my like Vanna White and pass those out? Okay.

We've been working in the VA to say, how could we do healthcare in a completely
different way? And this I'm passing out because you can see this model in the first -- if you open up that little handout, you can see it a little bit better than on this slide.

And we have been working with this model -- we call it the whole health approach -- for many years now. We stood up our office in 2011.

And the characteristics at the bottom, the person at the center is really critical. And that comes from the understanding that, you know what, we start in healthcare with the person's chief complaint. We start with their problem. We don't start with who they are. And so, of course, they're not going to be engaged. So, we start with who you are.

Actually, it used to say "you" in that little center. And I was at the Fayetteville, North Carolina, VA, and there was a homeless veteran who was holding this thing
up. And he said, "This put me back in my life again." And I went, oh, why does it say "you"? It should say "me". So, it says "me" now.

The concept of mindful awareness is around the center of that. And I would like to say a word about that, and then, give you a 60-second experience.

The concept is, whether we're talking about the space between, as you so eloquently said, Dr. Kahn -- is it "Doctor"? I don't know everybody's official titles.

DR. KHAN: Jamil.

DR. GAUDET: Jamil. Thank you. The moment between the thought of jumping over the bridge and the action, if we just could put space between the thought and the action, just a moment, there's an opportunity to change the outcome, right?

So, the concept of mindful awareness is teaching veterans -- and veterans love this and get this -- just to take a moment and tune into the state, whether it's the state of their
depression, whether it's the state of their impulse to end their life, whether it's, oh, something practical like tuning into, oh, I have pain right now; it's at a level 2; I wasn't really noticing it because I don't usually pay attention until it's a 9. But, oh, if I pay attention now, I could be more proactive about my health and well-being.

So, that concept of mindfulness and awareness is a skill that we're teaching, and it interfaces with all of those areas of green. And all of the areas of green are self-care. It spans everything from relationships to work, to stress, to nutrition, to surroundings, et cetera. And all of those elements we know are so critical to someone's health and well-being. It's the majority of the model. And yet, our healthcare delivery system is actually focused only on the blue, on the professional care, right? So, how do we begin to shift that? It really requires that we change the conversation.
Two quick stories I wanted to tell to demonstrate what this approach looks like. One is a story that Jeff Milligan, who is now a Network Director, told when he was the facility Director in Dallas. And he tells the story of a gentleman, a veteran, who was a patient, an outpatient veteran in their primary care clinic who committed suicide. And he tells it very eloquently and beautifully.

But he talks about learning about that gentleman and his life and his story. And what was surprising is that he was a diabetic. He was hypertensive. His blood pressure was great. His sugars were great. The primary care team was devastating. They thought they knew this gentleman well. They had no idea that he was suffering. They felt personally responsible and guilty.

And the reality is, they did everything right. They did everything right in our current system. You know, they asked all the questions they were supposed to ask. They
checked all the boxes. But we're asking the wrong questions and missing people's suffering.

   So, one of the things, on the second page of that handout you will see we have these scales now that we're doing. I call them vitality signs, which are simply asking people to say, on a scale of 1 to 5, where 1 is miserable and 5 is great, how are you feeling mentally and emotionally? How are you feeling physically? How is it to live your life, miserable to great?

   And if we were asking those questions, we would be finding suffering in places where we don't even know it exists right now because the system isn't set up to ask those things. And that's really, really important.

   I'll give you one other illustration, how teaching people to change the conversation can change everything. And this is a story that a physician in Boston, Jackie Spencer, shared and gave us permission to
She was in a busy clinic, seeing her patients. An OEF-OIF veteran comes in who she had seen a couple of times before. She said, this big, burly guy, and he comes in and he's got knee pain. Chief complaint, knee pain.

And she said, "I'm doing my thing. I'm going down the list. I'm setting him up with his referrals for his knee pain." Then, she said, "I looked over at his whole health review systems," this thing. And she said, "I noticed when it came to his relationships and his sleep, he scored, like he self-assessed miserable."

She said, "So I stopped what I was doing and I said, 'Hey, you know, I notice miserable on these areas.'" And she said he just broke down, and she said, "He cried like no one I had ever even seen cry before." And this gentleman was suffering with horrible PTSD and his whole life was falling apart. And she said, "I would have missed the whole thing
because I was doing the knee pain." He came in with knee pain.

So, there are a thousand illustrations of, as we're changing the conversation and we're teaching people to do that, and we're teaching veterans to do that, and clinicians to do that, everything can shift. And it's really quite powerful.

So, we went from saying, okay, this is the right construct, but how do we deliver this, right? Because the current system, like I said, is not set up to do this. So, being clinicians -- and I take full responsibility for this error -- we said, "We'll just shove into primary care," right? Because that's what we do.

So, we said, okay, we're going to focus on this treat bucket. And now, when people come to their visits, and primary care visits in particular, we're going to train clinicians in this approach and we're going to do all of this in the clinic.
So, you guys are looking at me like, "Yeah, I can tell you that wouldn't work." Right?

(Laughter.)

I mean, it's not a bad concept, but there's too much to do in the clinic. So, the burden in the clinic got worse. We're like this is not working.

And then, I have to just tell you, really quickly, this one story. Because in the VA people like to mandate things. I am not a fan of mandating, but it's a common thing.

So, one of the networks says, oh, we're supposed to find out what people really -- what really matters to them in their life; we're changing the conversation.

So, he mandated -- do you know this story? -- he mandated that every veteran will be asked this question. So now, this mandate goes out, and there's clerks checking the veterans in for their appointments. "What really matters to you?"
(Laughter.)

DR. GAUDET: And the veteran is like, "What?"

So, you can see this doesn't work. So, we got a little -- not "we," our office -- the field. All of the innovation, all of the great stuff happens in the field. We just observe it, support it, remove the barriers, and help systemize it.

So, we said, ah, the field said, you know, let's co-create in parallel to the clinical entities well-being programs that are designed to equip people to take on these aspects of their well-being, because that doesn't even belong only in the clinic. And you'll hear in a minute how this is actually working.

And that was really an important breakthrough, that it wasn't just doing it differently in the clinic; it was actually reconfiguring what healthcare is and how we deliver it. And if, in addition to clinical
care, we have well-being programs that are focused on equipping people, that's a big deal. We're going to connect it with their personal health plan.

That's really working. It really works when veterans are already engaged. But the majority of us are not particularly engaged in our health and well-being unless we have an event that forces that.

So, we said, ah, there's a third part of this whole health system and it is the empower piece. It is, how do we help people explore what really matters to them in their life and actually link their health and their healthcare to that, right?

So now, what we're finding are amazing stories -- and I'm going to let Kavitha tell some of them -- of people discovering what they want to live for and doing that with peers, not with clinicians, doing that with family members, and really bringing that forward to this is what I want my health and
life for. And now, they're empowering. Then, they get the skills they need in the well-being programs and, then, they have clinical care that's aligned, too.

So, this is a really radical -- if I'm doing what I want to do effectively in these few minutes, it's to help communicate this is a radical redesign of what healthcare this. This is way different than the current dominant paradigm in American medicine, and the VA is putting this into action and leading the way.

And with that, I'm going to let Alison tell you practically what that looks like.

MS. WHITEHEAD: All right. Well, thank you for that nice setup.

So, I just wanted to mention, too, I think in the mail-outs you maybe received the entire CARA legislation, which is huge. Section 931, which is the COVER Commission, is one of those very important pieces.
And then, two other sections that I'll just mention. You can do some nighttime reading of the full legislation. But Sections 932 and 933 are also under Subtitle C. And so, what those do, they mandate the expansion of integrative health, education, research, and clinical care.

So, Section 932 is actually a plan that was to be developed and provided for the VA Secretary on how we would go about doing that, which we've already completed. And I think that may have also been a read-ahead. And if you don't already have it, we can get that for you.

And then, also, Section 933 -- and Kavitha will get a little bit more into this on one of our later slides -- was the mandate for no fewer than 15 three-year pilot sites to expand complementary and integrative health. But, just as Dr. Gaudet was talking about, we can't really just plot integrative health into the medical center by itself. We really need
the sort of systems approach of how to do that. And so, those are our whole health system flagship sites, which we'll talk a little bit more about. And also, I think in Tab 0 in your binders is a whole list of the flagship sites, in case you're curious where those are.

So, the next few slides will go over education, research, complementary and integrative health approach, support, and then, also, the flagship sites.

We've talked a little bit today just about VA's sort of long traditional of education tailored for professional staff to meet the unique needs of our veteran population. And so, as VHA makes this effort towards a whole health systems approach for care, this paradigm shift really requires training and education for our staff, for veterans, for the integration of whole health and integrative health into care and treatment planning.

So, as such, while our office has
been working on the different components of whole health and that system, we also have an arm of our team that's solely focused on whole health education. And so, up on this slide I have some of our current and planned practices.

In fiscal year 2018, we had 58 national whole health education offerings which were delivered to our flagship sites. Some of those include: Whole Health in Your Practice, Whole Health in Your Life, Whole Health for Pain and Suffering, Eating for Whole Health, Whole Health Coaching, Whole Health Facilitated Groups, Taking Charge of My Life and Health, and also, a Whole Health Partner Course, so training of peers. So, there's a whole lot going on with this transformation. And I think in fiscal year '18 alone, we actually had trained about 3500 employees in whole health, which is pretty exciting.

Also, on top of that, with our flagship sites, we know that we can't just do all of this training nationally. So, we need
folks who are locally at the medical centers. We have identified two whole health flagship site education champions at each of our 18 flagship sites. They're there to really help train and deliver local trainings at each of our flagship sites.

So, that is the current practice. For our planned practice coming up in fiscal year '19, we have planned 119 national educational offerings. We also will have 46 offerings at our flagship sites. So, essentially, any of the flagship sites that requested to have these different trainings that I mentioned will be able to host those at those sites.

Some of our new whole health education initiatives, which we'll be able to get more information for you as they're being developed, but a Whole Health for Mental Health Course, which I think we're going to be trying to pilot two of those courses in fiscal year '19, in collaboration, of course, with the
Thomas J. Leinenkugel

Office of Mental Health. And also, our Whole Health Supervisors Course for the supervisors we have onsite for our whole health partners and facilitators.

And then, something else that Mr. Leinenkugel had mentioned earlier today, which is battlefield acupuncture. So, with our Whole Health for Pain and Suffering Courses, we're actually training clinicians to be able to provide battlefield acupuncture or regular acupuncture as a part, sort of an add-on to those trainings.

Our facility education champions are going to be delivering local courses using various curricula from our Whole Health 101, Whole Health in Your Life, and Whole Health in Your Practice.

And then, another exciting program that we're working on right now with some of our subject matter experts is VA CALM. And that's a mindfulness facilitator/instructor training that each of those flagship sites will
be able to send a couple of folks to be trained, so that they can, then, be leading mindfulness meditation at their sites.

And this next year, as I mentioned, we'll have 119 national educational offerings, which is very exciting. So, that's up from 71 previously, 39 in fiscal year '17, 26 offerings in fiscal year '16, and 21 in fiscal year '15.

Some of those will include, for clinical offerings of clinical staff, Whole Health in Your Practice; Whole Health for Pain and Suffering, which I mentioned; Whole Health for Mental Health, so those pilots, and then, also, Employee Whole Health Consultations. Some of our non-clinical offerings include: Whole Health Coaching, the Whole Health Facilitated Groups, and Whole Health Partner trainings.

In addition, we have a number of online resources as well. So, there is the option for employees to take trainings on their own online. We also have a Whole Health
Library. And so, we can send you the link to that. You can also just Google "VA Whole Health Library". This is open to the public. It's a whole bunch of different educational materials and courses, all the courses I mentioned. If you want to know more about it, a whole lot of information on there for you to take a look at.

We've also been developing and updating veteran-facing materials on there as well, so that they can go online and learn a little bit more.

And then, just continued ongoing training and mentoring of our VA education champions.

So, we were asked, in preparation for this briefing, to also talk a little bit about gaps and recommendations. It's always hard to even a take a look at yourself and try to identify gaps in the work that you're doing.

So, while we have a really strong whole health education program, a couple of
things that we're noticing or getting requests for from the different facilities is the need for more facility-level training for large employee populations. And so, VA medical centers have also asked for the train-the-trainer programs, so that they can not only offer education at a local level, but also train instructors at a local level as well.

And also, there's been a request for more integrative health approach provider training. So, like I mentioned with VFA, that's one example, but just taking a look into that in terms of additional types of trainings that we could provide.

So, some of the recommendations that we are looking at for our plan practice going into the future is, in fiscal year '20, to offer a train-the-trainer course for whole health facilitators and whole health partners. Really continue to work to make national whole health offerings flexible and customizable at the local level. Continue to help standardize
whole health education as well to keep away from slippage. And then, as I mentioned, enhancing integrative health trainings to include additional integrative health approaches beyond just our battlefield acupuncture. So, looking into the practicality of maybe mindfulness training, yoga training, tai chi training, things like that, inside of VA.

Then, with that, I'll hand it over to Kavitha to talk about research.

DR. REDDY: Thank you, Alison.

I might go to the next slide.

So, as Alison mentioned, CARA asked us to greatly expand the delivery of education, but also to look at research of complementary and integrative health, especially as it pertains to our patients with mental health illness, chronic pain, substance use disorder. And so, I really am excited to share with you some of the research that's happening now and some of the planned research going forward.
There's an $81 million collaborative between DoD, VA, and NIH, actually, and multiple studies being done looking at CIH and pain management. Seven of those are being done within VA.

Additionally, our HSR&D is looking at how do we use these complementary and integrative approaches. If it's a part of a whole health system where we're really looking at patient engagement and activation, is that going to be far superior than just delivering acupuncture or just delivering chiropractic, where we're asking people to still come into the facility and be rather passive in their approaches? So, that is kicking off now.

We are looking at CHI for PTSD. Recently, in 2016, we had a state-of-the-art meeting where we looked at specifically non-pharmacologic approaches to pain, a very successful meeting, and those recommendations have recently been published as well in The Journal of Internal Medicine.
We have evidence-based synthesis program reports on several CIH reports. These are quite useful in educating our providers and when and where to use these approaches in a personalized health plan with their patients. And we plan to be doing ones on hypnosis, biofeedback, and guided imagery. So, we'll have a really robust library of those reports, and we can share those with you at a future date as well.

And most recently, we brought together over 60 researchers for a two-day summit on CHI -- this was internal and external researchers -- and really were diving into CIH for pain, mental health, and well-being. We have several recommendations that came out of there, and we're working very closely with the Office of Research and Development, who has received all of these recommendations quite well. So, we're excited going forward to really partner further with Mental Health and the Office of Pain Management to look at some
of those recommendations that came out of that summit.

Additionally -- and I'm going to talk a little bit further about this when we actually talk about the flagship sites -- we have an entire evaluation strategy for the flagship sites where we are looking at outcomes. And I heard that come up quite a bit earlier today, and I'll share exactly what those outcomes are. But we are looking at well-being, engagement, activation, and their quality of life.

So, I mean, if asked to look for a gap, honestly, we feel really happy about the direction research is moving, and we will continue to further create stronger collaborations with Mental Health, so we can look at specifically CIH in mental health.

So, I'll hand it back to you to talk about CIH.

MS. WHITEHEAD: I could talk about this for a full day. So, I'll try to keep it
brief. I'm very passionate about integrative health.

And it's really a core component of our whole health system model, and I think we've come a really long way over the past -- even just since I've been with the office the past few years, but definitely since our office had started.

In terms of current practice, the group within our office that I work for is the Integrative Health Coordinating Center. And so, we were stood up within the office in 2014, based out of VA leadership desire for there really to be this coordinated effort around integrative health approaches. In talking to colleagues, I think early 2000s, maybe before that there had been bits and pieces of integrative health happening at different facilities, but really sort of a grassroots approach.

And for those of you who have worked in the healthcare setting outside of VA -- and
with colleagues outside of VA, this is something that is sort of new outside the VA as well. So, I think we've done a lot.

In fiscal year 2015, an internal VA survey showed that about 93 percent of the medical centers offered at least one type of integrative health approach, although that was not necessarily consistent across VA in terms of what was provided.

And then, more recently, a survey of approximately 1200 veterans on the use of, and interest in, complementary and integrative health showed that approximately 52 percent of those veterans had used any type of integrative health approach in the past year, which I thought was very excited. The top two reasons for use, which may not be a surprise, was pain and, then, also, stress reduction and relaxation. And some of the more frequently-used approaches, based on that survey, were massage, chiropractic care, mindfulness, and yoga.
The first bullet up there under current practice, VHA Directive 1137, the Provision of Complementary and Integrative Health, so that's something that our office had been working on for quite a long time.

And also, around the same time, at the direction of the VA Under Secretary for Health, in 2016, we formed an advisory group that would help to evaluate and advise on which integrative health approaches, so evidence-based approaches, should be moved forward in the VHA and in what timeframe.

So, this group is made of subject matter experts from various program offices, including Mental Health, Pain Management, and others. And so, I'm mentioning that group because they're really an instrumental part of which of the integrative health approaches under Directive 1137 are considered part of the VA medical benefits package.

And so, approaches on our List 1, which I'll name in just a moment, must be
provided through VA onsite via telehealth or in the community as part of the medical benefits package. So, these integrative health approaches have to meet the definition of basic care as described in the medical benefits package, and must be in accordance with generally-accepted standards of medical practice, and as we heard earlier, to promote, preserve, and restore health.

So, this group of subject matter experts has really helped us. So, it's not just Kavitha and I sitting in the office deciding what integrative health approaches should be part of the medical benefits package, to make those decisions, and then, take that up to our National Leadership Committee at VA for signoff as well.

So, the current List 1 approaches include: acupuncture, biofeedback, clinical hypnosis, guided imagery, massage, meditation, tai chi, and yoga. So, you might think, oh, well, there's all these other approaches. Even
in the legislation, it lists a whole long list of different potential approaches for this group to look at.

And just one side note on that. Things like chiropractic care have been mandated at VA for a long time. So, we did not need to re-approve them. It doesn't mean that they're not happening or can't happen. They just did not need to be defined in the Complementary and Integrative Health Directive.

I know in August I think we're going to hear a lot more from physical medicine and rehab, recreation therapy, arts therapy, a lot of those other types of services, which are certainly a part of our whole health system. Again, they just did not need to be called out in our Integrative Health Directive because they've already been approved and are already being implemented across VA.

So, there's a lot of support and infrastructure that needs to be developed and happen to be able to implement these
integrative health approaches, which are new within the U.S. healthcare system in general, not just VA. So, a lot of what we've been doing currently or recently is building that business infrastructure to put into place a mechanism, for example, to be able to track these approaches.

I know you're all very interested in data. It's hard to collect data on procedures if the procedure codes and the U.S. healthcare system in general don't exist. So, we're developing sort of our workarounds using the CPT procedure codes that do exist and, then, also, some of our internal VA mechanisms, four-character codes, clinic stop codes, note titles, health factors, to be able to really take a good look at what we're doing related to integrative health and utilization.

At the same time, I had mentioned briefly an internal survey that was done in fiscal year 2015. We're working closely with VA researchers on a complementary and
integrative health environmental scan, sort of an internal survey looking at what integrative health approaches are being done across the board, by what types of providers. And I think that survey is actually closing the end of this month. So, hopefully, in the next few months we'll have some preliminary data that we can share on that as well.

Just a few other things that we've been working on related to integrative health approaches. One issue that we had seen was being able to hire integrative health providers. So, the development of qualification standards, minimum proficiencies. For example, in February, we just had published a qualification standard for a Licensed Acupuncturist. So, we can now hire acupuncturists at VA. Developing nationally-classified position descriptions for things like yoga instructors and tai chi instructors, so that those types of providers can also be hired at VA.
So, we have various subject matter experts across the field helping with that. So, with the development of minimum proficiencies, position descriptions, qualifications, standards, et cetera.

And then, also, something else that we knew was very important was to really work with building a VISN infrastructure for whole health. So, we have a whole health network sponsors. We also have a group -- and this actually came out of the Opioid Safety Initiative -- but we have VISN-level complementary and integrative health points of contact on each of the VISN-level pain management committees. We, our office meets with them on a monthly basis. So, they're sort of part of that infrastructure and liaison to the field.

A couple of other things that we're working on, which I wasn't sure whether to put them in the current or planned practice, but expansion of integrative health through tele-
whole health. So, we've heard a lot about telehealth and telemedicine earlier today. We've been working a lot around that with the Office of Telehealth, the Office of Rural Health, and various subject matter experts.

To go on to our planned practice, really just continuing to grow each of our List approaches due to supporting evidence that we've been being able to collect, and, also, developing new qualification standards as needed to help support the field. For example, we're working on a qualification standard for massage therapy right now. So, that will open up more of an availability for facilities to be able to hire Licensed Massage Therapists.

I had mentioned the potential training of integrative health approaches for current VA staff. So, our VA CALM training, the mindfulness training is one way that we're doing that.

And just really continuing to reinforce that integrative health should not be
just a standalone service or program, but really integrated into this whole health system of care.

And then, again, as I mentioned, the continued expansion of integrated health through tele-whole health; also, through the use of volunteers. So, one of the groups that I work closely with is Voluntary Services. We have 300,000-something VA employees, but I think there is also around 70,000, or some very large number, of volunteers. And we have a lot of folks who provide yoga or tai chi, things like that, that are really interested in providing this at VA on a volunteer basis, which is really exciting.

And then, also, something else is just the community partnerships, so partnering with groups in the community. For example, we have a national VA-YMCA MOU. You hear space is an issue. So, getting creative. Some of our sites will hold their groups, their peer groups, maybe their health coaching, something
like that, can be held in a different space.  
So, it's a lot of local MOAs are being  
developed between VA and YMCA, as an example,  
but there's other partnerships happening as  
well.

Then, again, looking a little bit at  
gaps and recommendations, one thing that we're  
working on, but that continues to be a gap, and  
something that we will continue to work on, I  
think, for a while, is just the consistent use  
of our new integrative health and whole health  
coding and tracking infrastructure. It's  
something that we're continuing to refine and  
revise, and it just takes time for the adoption  
of that.

And one of our recommendations going  
forward, I guess for ourselves, is really to  
align resources to support our VISNs, or our  
Veteran Integrated Service Networks, and local  
medical facilities to ensure the appropriate  
tracking of CIH approaches and, also, the  
appropriate delivery of approaches.
And now, I'll hand it over to Kavitha, and she'll give you a little bit more of the details of the flagship sites.

DR. REDDY: Okay. Thanks, Alison.

I'm really happy to talk about this. I'm quite passionate about it. We are deploying a system that I think really speaks to what we're talking about here today. You cannot treat the mind without looking at the body. You can't treat the body without looking at the mind. And that is what whole health is.

In October of 2017, we launched these 18 flagship sites in each VISN. I work at one of those flagship sites in St. Louis, Missouri. So, I'm going to share some of our higher-level current and planned practice. And then, I just want to share some firsthand testimony to you as well.

Right now, we have those 18 sites launching, and we've had learning collaboratives following the Institute for Healthcare Improvement's Model for
Collaborative Learning, in which we come together for face-to-face meetings. We have action periods of process improvement and performance improvement. We have virtual meetings. But what it does is it gets us all on the same page for implementing, and then, we can evaluate that implementation consistently.

Again, I mentioned that we are looking at outcomes. We are tying those outcomes to the stage of implementation, so we can have a good look at what's actually happening.

Some of those outcomes we're looking at are sense of life meaning and purpose. We're using validated tools to measure this. Engagement in healthcare management, goal setting, perceived improvement in health and well-being, experience of pain, and healing relationships. I'm happy to share all of the tools we're actually using at a later time.

We really want to deploy this model over the next three years -- we're already deep
into FY18, so the next two years after that -- touching at least 30 percent of unique veterans in each flagship hospital, so that we can really see, does this generate the outcomes we're looking for, does it generate a return on investment, and looking at these quality-of-life measures.

But the idea is that we are trying to transform the system where every veteran has a personal health plan and that looks at their social determinants of health. It looks at their meaning and purpose. It catches that suffering that Tracy was talking about.

I mean, I think all of us are recounting stories of patients that we've maybe missed those diagnoses in. I have my own personal ones, and they haunt you. And you also can maybe even think about your own family that's maybe struggled through those kinds of situations and the healthcare system maybe didn't answer to them.

So, in my mind, the flagships are
really trying to look at how do we comprehensively look at our patients. And then, that helps treat all these disorders. That helps treat all the illnesses that we're speaking of today.

Before I get to the gaps and risks, I just want to tell you about what's happening in real time. From this theory and this model, we're talking about what's actually happening at the flagships.

We are bringing in more veterans now because we're de-stigmatizing mental health. We're bringing them in saying, we want to focus on your well-being. We want to find out why you want to be healthy. And maybe the gentleman is telling me that he wants to hunt squirrels in the forest. I am in Missouri. So, just keep that in mind. Or the person that says he just wants to get down on the ground to work on his motorcycles. You find what it is that they want to work for and you start to uncover a lot of the backstory, right, things
that they didn't want to share.

So, a few examples of patients already that we see we're helping. I had a young gentleman that came in that really did not trust the VA system at all. His issue was actually abdominal pain, lot of abdominal pain. CT scans negative. Scopes negative. Labs all fine.

Well, he came in finally to talk to me after talking to a primary care provider, a GI specialist, really going to different people. And he said, "I heard that whole health is happening here. I really want to look for a way to manage my abdominal pain."

Well, after we actually uncovered and went through this personal health inventory and uncovered his story, you find this long history of physical abuse from his father from a young age. Then, alcohol abuse, a sense of perfectionism that created a lot of trouble in the service. And you start to uncover mental health issues that were actually being seen by
us as physical complaints.

And this is where it's missed, right? If he comes into an appointment, it's just seen as the physical complaint. You don't realize that he's struggling with depression and anxiety, a job he can't handle, a family that's overwhelming, and all the while he has to support that, right, as a young father.

So, my point being, there is a generation of folks that want to be seen this way. They want healthcare delivered this way. They want to look at how nutrition helps them. They want to look at non-pharmacologic approaches.

And most importantly, we take the stigma away. People experience anxiety and depression. We have to normalize that it's okay to talk about it.

That's one example. I have another young female who her story is about wanting to jump off the Jefferson Barracks Bridge every time she drives over it going over the
Mississippi. And she somehow came to us and started to work on her pain, her nutrition, her migraines. And slowly, we uncover a military sexual trauma that actually was feeding into a lot of her behavioral choices.

Now here we are a year later, I think you've actually heard from her in different panels, maybe some folks here. She says now she can go days without even thinking about that suicidal tendency. I mean, that's progress she hadn't had in years. Again, I'm just sharing a couple of examples of success we're already seeing.

And if you can't hear it in my voice, what that's also doing is helping the burnout of our employees. Because I was there and I have seen it all around me. You talk about same-day access with staffing shortages. You're seeing burnout. And when that compassion isn't there for patients because you're burned out, you've got a problem again. So, here we're talking about creating a system
where employees are starting to feel incredible about what they're doing now and fulfilled.

And so, I don't want to forget that there is a whole workforce in the whole health system that's built on peers. These are veterans delivering care to their fellow veterans in a group format. That could be peer support specialists as coaches. It could be peers that are volunteering to run groups and let their fellow veterans have space and time to talk about what's important to them. But, either way, this is another part of the workforce that we're creating to support this system.

And I think, finally, I just want to say community collaboration is a huge piece of this puzzle, too. We are actively in the YMCAs. We have a community churches reaching out to us. We have vet centers, ESOs. So, I think this is really about getting out into those communities and rebuilding that trust again.
If I could say one thing for the group here about the recommendation, it is I can't say enough about how this feels like the way forward. And if that's the case, then we really have to align resources to develop this. And that needs to come from all levels of leadership, the highest levels to the program offices, to the facilities, to our direct supervisors.

So, that's the recommendation.

I'll turn it back over to you, Tracy.

DR. GAUDET: Yes. And in closing, before we get to your questions, I did want to draw your attention. These are just a few headlines. Have you ever done one of those exercises where it's like a visioning thing and they say, "Imagine, if you're really successful, like what would the headline be?" Hello? Like I am so blown away by these. These are real headlines, you guys.

Just so the people, if there is
anyone on the phone, can follow this:

Columbia, Missouri. "More than medicine. Veterans hospital takes wellness approach to combat veterans' health problems."

Tomah -- go, Tomah, right, Jake? -- Tomah VA. "Whole health program gives options to veterans."

Tampa, Florida. "VA-YMCA team up to boost veterans' health."

Clarksburg, West Virginia. "Staff/patients embrace Whole Health Initiative at Clarksburg VA."

Iron Mountain, Michigan. "VA hospital/associated clinics offering holistic approach to care."

Insider VA. "VA uses whole health to prevent veteran suicide."

West LA. "Warrior pose: On the front lines of VA's wellness transformation."

Boston, Mass. "VA turns to alternative pain treatments amid opioid crisis."
And I also added that we were very fortunate to have the opportunity recently to present an invited presentation to the Giving Pledge. And the participants of that group included Bill Gates, Warren Buffet, Richard Branson. This was the only healthcare presentation made to that group. Because they, too, understand how huge of a transformation this is, and that the public sector and the nation can learn from what the VA is doing in this. So, it's very exciting.

Our vision is that veterans committed their lives, their health, their well-being -- and I know many of you are veterans -- to mission success in defense of our country. And now, we want to help veterans be mission-ready for their lives, optimizing their health in service of what matters to them.

And when we think ourselves about how we know what success is, it's so amazing when veterans achieve outcomes that they never
even envisioned possible. And it's not only young, healthy veterans, it's all across the spectrum. It's as pertinent at the end of life as every place in between. And then, oh, guess what? By the way, clinical outcomes improve and costs decrease.

So, we are thrilled to be able to share with you the vision and the work that's happening in this.

And we'll turn it back to you, Jake, for questions and conversation.

CHAIR LEINENKUGEL: Well, Doctors, thank you so much.

The first time I met you, Tracy, and you did this presentation over a year ago, it was transformational for me. And then, I watched your approach and the team, whether it was Alison, Kavitha, and then, getting down to work with you in Tampa, it's changed me. So, I have a very biased view of what this is. And I refer to it, as I did earlier in the meeting, of sitting on a ham sandwich and starving to
death.

But I am also one that advocated -- Tracy, you won't be cheering me now -- for mandating this.

(Laughter.)

DR. GAUDET: Oh. Well, I support you mandating it.

(Laughter.)

CHAIR LEINENKUGEL: You hit on something at your end that I know other commissioners are going to, hopefully, raise, but it does come down to resourcing and repurposing dollars and taking the senior leaders at VA to realize that ham sandwich while we are so-called starving to death. And I think that that has come previously. It was an "aha" moment for your entire group this past year.

I would say that you have the best momentum -- and I'm making a statement for the record on that right now -- because there is substance behind this. I mean, I could tell
stories like Kavitha has just in my short amount of time. So, I'm excited about this.

I'm going to defer to the rest of the commissioners for follow-up and let them use their time. But we will all, either together collectively or at least when we do our subgroups, we will all touch whole health and see it in practice, because I think that will be a mandatory statement that I would make to the commissioners, that they definitely see this in reality, live time, and in color.

DR. BEEMAN: First of all, I applaud all of your efforts. And I have a little story and, then, a comment to make. And please don't take the comment the wrong way, because I think there's an opportunity within the comment.

You have an awful lot going on. So, the first thing that I would ask is, is it too much? As I was listening, my mind was just spinning with all of the things you're trying to accomplish.

And one of the things that I've
found out, and here's the story: when I was in Lancaster, we had a Medicaid problem, as we do in most of the states. There wasn't enough money to go around. So, we decided to really focus on what we thought were the most intractable patients, and we picked 400 patients. We found that those 400 patients used 50 percent of the resources.

So, we hired a little extra staff. We created patient navigators that really were the go-to people. And we were able to reduce the emergency department admissions by well over 50 percent and hospital admissions close to 70 or 80 percent, and we saved all of this money, none of which came to us. It all went back to the state. Actually, it went to the managed care payers, which was kind of ironic.

The reason I mention that is that, in creating that extraordinary experience every time for those really difficult patients, we started to create the extraordinary experience and extrapolate that. And so, as I listen to
you and say, you know, the primary care physicians can't be that navigator. It's got to be somebody else in the continuum. And it sounds like you've got them, but maybe you need to codify more the kind of navigator that you're going to have.

And the other thing that I just wanted to share with you -- and this is not a criticism, but just a suggestion -- when I was running track in high school, my coach said, "You know what? Don't look at the person that's running next to you. Every time you do, Tom, you come in second and you watch his butt go over the finish line. Run your own race."

I hear a lot of us in VA comparing ourselves to the civilian. "We're better at this. We're better at that. We do this really well." No one cares. What you want to do is let's run our own race. Let's be so extraordinary that those 9 million veterans, the 3 million that don't come to us choose us because we're so extraordinary.
And so, there's an awful lot that happens in this private side that's better than we can ever provide. And there's so much more here. Because I think that what we're doing is so noble, and we're ennobled by our patients and the special bond that we have with them, that we don't have to compare ourselves with them. Does that make sense?

So, it's not a criticism. It's like I hear it a lot, and I sit on a board with the local VA in Philadelphia, and they're always saying that. And I'm like, "But why? Because we don't need to say that." We need to be so incredibly good at what we do in our unique mission that we don't have to worry about what they're doing. Learn from them, but we don't have to compare ourselves to them.

Thank you.

DR. GAUDET: Well, and I appreciate those comments very much and agree with that. I'll just quickly respond to your first question about, are we trying to do too much?
I'm an impatient person by nature, but on my team we've coined the phrase "death by enthusiasm."

(Laughter.)

DR. GAUDET: But I will say, I was hired by the VA to stand up this effort in 2011. So, sometimes I look at it and go, "Man, it's taking so long." But not really, because it needs big system transformation.

And I will say, we were, I believe, very strategic about how we went about this. In other words, we helped defined a lot of external thought leaders and internal thought leaders. What is that future state? What are the qualities of that future state, et cetera?

But we didn't begin to know how to implement it, and we did not want to do that from the top-down because that fails every time. So, we really, over these years, have resourced innovation in the field, learned, observed, evolved the model, created education to advance what we know. And it has been a
rather strategic evolution, to the point where now we at least have a consistent model, which is done and we'll still learn and grow. But we know enough to say, these we believe are the core elements of this transformational approach, so that we can now look at this consistently.

And I worried about the VA workforce because I know how burned out everyone is, how low morale is. And I thought, oh, my gosh, is this going to be one more damned thing that they have to do and it's going to feel like a drain? And it's the opposite. It is restoring morale and passion and pride.

So, we do need to pay attention to that because we can do the death by enthusiasm thing. And I appreciate the observation. Thank you.

DR. JONAS: I have four questions, and these aren't all for you, but I want to get them out there because I think we need to hear from somebody about these.
Boy, Tom, I sure wish that we could do that, and I hope you take his advice. Don't listen to me. Do exactly what he said.

And you're going to be compared. You're absolutely going to be compared. So, let's figure out how we're doing comparing and what the measuring stick is.

I know that you've built in and you've listed some of those things, but I just throw out a couple of questions about how would you create a good measuring stick for what we're trying to do here. And this is your evaluation component. You've done evidence-based mapping. We need to have evidence-based mapping that looks at what matters to the patient. Otherwise, we get the conflict between evidence-based medicine and person-centered care, veteran-centered care. And they often conflict. Okay.

So, we've got to figure out how to do that better. And so, that's a methodology issue. We need to figure out how to do that.
Maybe your evidence bubbles, which VA has sort of created, and is doing great, can be expanded and built upon, so you can truly get comparative effectiveness research.

I'll give you an example. Pain, pain medicine. Okay. They've said, okay, use non-pharmacological approaches. Okay. Well, how does that compare to using pharmacological approaches? We have no information about that in terms of cost, quality, outcome, et cetera. We have individual silos, but no comparative effectiveness component. Let's get the VA to do that. You're the only one that really has the data that can do that, in my opinion. Well, maybe not the only one; there's a few others that might be able to do it. So, that would be No. 1.

I would be interested to know if there are any civilian models out there that are doing something comparable and, if so, could we possibly gather some of them and actually look at that within this Commission?
I mean, are there some systems out there that are trying to shift the incentive model and the model of delivery on its head, so it's team care and it is a truly primary care-based model, not that primary care physicians are delivering it, but it's a primary care-based model? And that would be, I think, very helpful for some comparison component.

Finally, boy, we hope we learn about the electronic medical record because I've heard it's going to be rolled out in the next two years. I use the one in the DoD now. It's called AHLTA, but everybody in the system calls it "HAHLTA," okay, because it is so cumbersome. It's not friendly to anybody, the patient or the provider, et cetera.

And I know that some systems have had to actually redesign the electronic medical record because they could not find or execute on a commercial one that actually wasn't about payment in some way. And so, I hope we can get some information about that in those areas.
Then, finally, I just want to say congratulations. We had some of the top leaders in the VA just before you at our closed meeting, and they all mentioned complementary and integrative medicine, every single one. So, it's like, okay, maybe we're getting there in those areas. So, you've been doing some good communication in those areas. So, congratulations on that.

DR. GAUDET: And if I could just add on the record, I am really grateful that you're interested in the electronic health record. We are not the experts, obviously, but I was briefed on that as a part of the Leadership Council last week. And we were told in that briefing that VA will have the opportunity to shift and define the content of that health record, which I think is paramount, because we can do all of this we want, and if it's not in the record -- so, I appreciate that the Commission is interested in that question because I think it would be very critical.
CHAIR LEINENKUGEL: Anybody else on the Commission for any of the doctors at this point? Ladies, I want to thank you so much for your efforts.

There is one. Oh, thanks, Shira.

DR. MAGUEN: One more quickly.

Sorry.

CHAIR LEINENKUGEL: Thank you.

DR. MAGUEN: Sorry to get in just under the wire.

But I wanted to just ask about, you know, one of the things that we've really been dealing with a lot at our medical center is people will request certain things and want massage therapy, et cetera, but there is no way to get that approved in the current system under certain -- I guess, when it's requested at certain parts of the medical center, it's not able to be approved. And so, I'm not sure. It seems like there's also a gap between these services being offered and available and the approval process for which veterans can
actually get those services.

So, I would love to hear a little bit more about that and what you guys see for the future.

DR. REDDY: Okay. So, I'll start off by saying, absolutely. And I think when you look at these approaches in isolation, that's what happens when it's just an approach. "I just want chiropractic." "I just want massage therapy."

So, one of the things the flagship sites are really looking at is, how do we offer this as a part of a personal health plan with coaching, with motivational interviewing, so that this is one piece of the plan? I think there's a danger when it is just the approach.

But, second of all, we have looked at what literature does exist to create some national recommendations for frequency and duration of offering those approaches, so that there's at least a standard across the country for that. Of course, we're working with
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community care. We don't have a lot of updates on that yet, on ways to be able to provide this in the communities when those resources don't exist.

And so, I'll start there. And if you want to add to that?

MS. WHITEHEAD: No, that was similar, yes, to what I was going to say. We're still kind of working on that. As Kavitha mentioned, just the duration and frequency guidance for massage, for acupuncture, we know we're going to have to develop this for some of those other approaches that I mentioned as well, as we begin to really start implementing them.

And we do have a national program lead for acupuncture, and we now have one for massage as well. Luckily, it's not just me having to come up with this guidance on my own. So, it's we're continuing to work on it, yes.

DR. MAGUEN: I will also say that what's been really neat is that some of our
primary care doctors have been trained in battlefield acupuncture. And so, we're actually seeing that they're able to get release time to do it onsite and have seen incredible results, too. So, I think that we're starting to kind of think about how can we work it into some of the staff that we already have there, which has been helpful, but we can't quite get that for whole health within every one of the domains.

CHAIR LEINENKUGEL: Thank you so much, Shira. Alison and Kavitha and Tracy, again, great to see all of you, and great, also, to see you making tremendous headway with whole health within the VA system. I personally believe it's the future. I think that you are leading in it right now, without really knowing who the true competitors are. But I think it's something that, when you see it in practice, when we all see it in practice and, then, talk to the veteran after the veteran has been exposed to what you have in
your toolbox, and whether or not it's enough or it's too much, you're figuring that out right now. And that's been just a delight to see.

We, as commissioners, will be participating in the next 18 months to see more of it. But thank you all for your efforts.

(Applause.)

CHAIR LEINENKUGEL: At this time, let's take a 2- or 3-minute stretch.

(Whereupon, the above-entitled matter went off the record at 3:47 p.m. and resumed at 3:57 p.m.)

CHAIR LEINENKUGEL: Alicia, I'm going to begin, because I think that I want to start out with just a couple of the headlines here.

And thank you so much for coming before the Commission, this being our first public session. And it's very important for what you're going to present to us today, for us to get the context into what is taking place.
Dr. Alicia Carriquiry is a distinguished professor of liberal arts and sciences and professor of statistics at Iowa State University. She also holds the president's chair in statistics and is director of the Center of Statistics and Applications in Forensics Evidence, an NIST Center of Excellence.

She was elected member of the National Academy of Medicine and a fellow of AAAS. She is also an elected member of the International Statistical Institute, a fellow of the American Statistical Association, so she is one heck of a statistician, is what Alicia is.

(Laughter.)

CHAIR LEINENKUGEL: But it's all about mathematics, bioinformatics. She's worked on animal genetics and also has done a lot of sponsored research through the Iowa State University.

Born in Uruguay, where she graduated...
as an engineer in 1982. After coming to the United States, she received the M.S. in animal science from the University of Illinois, and also in statistics. Of course you did in statistics. And a Ph.D. in statistics and animal genetics in 1989. Both at Iowa State.

Welcome and thank you so much, Alicia.

DR. CARRIQUIRY: Thank you so much for having me. I am very pleased to tell you about the work we did in the context of this four-year-long study. The committee members and myself became best friends. Sixteen in-person meetings. This was a really important study. We were congressionally mandated to evaluate the Department of Veterans Affairs, and in particular the mental health services, focusing on the quality and quantity of the mental health services the veterans received, but also on the barriers and facilitators to access.

And the hope was that we would
understand why some veterans do not use the VA. And among those that use the VA, what do they think about the services they receive?

So this is the formal statement of task. I've already said several of the things that are there. The focus was on veterans from OEF, OIF, and OND. And the way the committee was tasked to meet its goal was to collect a lot of different evidence.

So we not only reviewed the literature until the committee's -- until 2017, so I think we ended up at the end of 2017. We visited all 31 VISNs, several providers in each one of the VISNs. We obtained a lot of information from the VA itself, many of the surveys they use on their veterans, on their participants. And more importantly, we collected our own data.

So, the committee designed and filled in a survey that is representative of the veteran population of OEF, OIF, and OND.
We ended up interviewing over 3,000 veterans. As I said, this is a representative sample. So, the conclusions we -- or the results we draw from these particular veterans we interviewed can be extended to the population of veterans themselves.

Please stop me if you have any questions along the way.

This was the committee members. I had the honor of chairing this committee, but the rest of the members of the committee was a very distinguished mix of veterans, psychologists, psychiatrists, psychiatric nurses, sociologists, several statisticians, I should say. There was a lot of data that we were dealing with. And I think the diversity in the committee was very beneficial in terms of coming up with a report that I believe has a lot of very good information.

So, as I said before, the approach that we took was to collect all the available information. So, survey of veterans, site
visits, information from -- and during the site visits, I should say, we talked to as many people as possible. We talked to veterans that used the VA. We talked to veterans that didn't use the VA. We talked to family members. We talked to community providers. We talked to VA providers at all levels. And so I think those visits were pretty intense and we got information from all sides.

Yes?

MR. ROSE: Just a quick question. How did you reach the people that were not seeing the VA?

DR. CARRIQUIRY: That is a very good question. And that's a very difficult population to reach. So, we relied a whole lot on VSOs and other community organizations. We did a bit of a -- we contacted many of those organizations ahead of time in each of the places we were going to visit and requested that they communicate with veterans that they know are not using the VA so that we would have
access to them. And it was hard.

And we, of course, managed to interview many more users of the VA than non-users of the VA, but we did have a pretty healthy sample of non-users. So, that was the hard part.

We obtained a lot of information from the VA itself. So, many of the surveys and other information that the committee requested. And, of course, we did a very thorough review of the literature.

All this information was synthesized. Combined where possible. We tried to look at each of the topics in which we were focusing and bring in all the information we had.

So, if you look at the report, for each topic we have what the literature says, what the data suggests, what the VA thinks is happening, and what the site visits revealed. Site visits, of course, are more anecdotal, but some of this anecdotal information is really
interesting.

We developed some findings and conclusions and have a list of recommendations. I don't know how much you know about the National Academy of Sciences process, but these reports are called consensus reports. So, once the report is finalized, the entire committee needs to sign off on the report.

That's a very powerful statement. It means that this very diverse group of professionals agrees with the findings and the recommendations.

And then the report goes out for a thorough review. So, in this particular case, it went out to something like 16 external reviewers from all areas. The committee doesn't know who the reviewers are, of course. And these reviewers came back with about 90 pages of comments and request for changes and so on. We tried to be responsive to the reviewer's comments. And what you see there is the final version of that report.
So, what are some of the key findings? I think we had some interesting findings.

Number one is that there is a substantial unmet need -- but I think that's not news -- for mental health services among the OEF, OIF, and OND population. Interestingly, about half of the veterans that were surveyed by the committee who may have a need for mental care services do not use the VA or any other mental health provider. So, neither the VA nor the private sector. And that's because most of them are not even aware that they have a mental health need.

So we found that among -- you know, those are people that are hard to reach, right? They don't think they need help. And therefore, they're not going to be seeking help. And so that was a very interesting finding.

The other finding was that there's several barriers for access. But the number
one, by a mile and a half, barrier to access is
the clumsy transition between DoD care and VA
care. The transition of veterans from the care
they received while on active duty to, you
know, entering into the VA system is a huge
barrier.

The process is burdensome. The
veterans get lost in the shuffle. You know,
they receive information from the VA before
they separate, but they get this information
when they're about to separate. They don't
want to hear anything. They just want to get
out of there.

And so this information on how to
access care at the VA is probably not provided
at the best of times. And so many of the
veterans that do not use the VA system don't do
so because they simply don't know how to
navigate it.

And so that's -- I think it's going
to be reflected back in our recommendations.
That was our number one recommendation, to try
and, you know, sort of marry those two systems so that there's a seamless transition between DoD care to VA care.

One of the other things that we found that was kind of interesting is that veterans that have support from family members, from friends, tend to do much better than veterans that do not have such support.

So, reaching these, you know, reaching the larger community around the veterans is a good way to ensure that veterans will not only seek services but also stick with the services. So that was one of the big facilitators that we found.

And some of the barriers, aside from the fact that navigating the VA initially is very difficult, are things such as, you know, things that are as mundane as transportation challenges, employment concerns, stigma, the fear of stigma.

For example, we find that many of the veterans that live in rural areas, for
example, sometimes have to dedicate an entire day to come for a visit of the VA. Two hours in a bus from somewhere. Then the visit. Then two hours back in the bus. This is a real deterrent to seek care.

Employment concerns are pretty real. Many of the veterans end up employed in the private sector in security sectors, police. And being diagnosed with a mental health issue for them may mean, or they think it may mean, employment issues, problems.

The ability to own and carry guns is a big concern of veterans. Many veterans do not seek care because they think that might lead to a loss of a permit to carry and own guns, also to loss of contact with or custody of their children, concerns about loss of medical, disability benefits. There's many issues that have very little to do with the quality of care that the VA provides, and a lot to do with the environment in which these veterans operate.
This said, once a veteran is in the VA system, in general the reports are very positive. So, veterans have a very good -- well, let me -- many veterans report a very good experience with the VA mental health services. They wish they could get more of it and they could get it faster. But once they get it, they really like it.

They report the fact that there's a wide variety of services they can access. They trust that their records are going to be private and confidential. They like the fact that it's possible to integrate primary healthcare with mental healthcare at the VA, something that is very difficult to do in the private sector.

There's exceptions, of course. But they are satisfied with the staff's skill and expertise, and oftentimes with the services they get from staff like, you know, schedulers and these kinds of people.

There's many complaints, too, of
course. But, overall, that's what the data suggested.

So some of the other key findings that we report on is that even though many veterans do receive very high quality mental healthcare from the VA, there's a lot of unevenness in the system.

So, not all VA providers are the same quality. There's some underperforming -- there's underperforming facilities within the VA system.

Which is not surprising. Most oftentimes due to staffing challenges, physical infrastructure that in some locations is really subpar.

And, you know, all of this leads to challenges in providing timely care to the veterans, and, in particular, on staying faithful to evidence-based services that require, for example, repeated visits at certain intervals and so on.

Like it was noted before, there's burnout and job-related stress among VA staff
at all levels. Medical staff, administrative staff. And that contributes to high turn ver. And part of the issue is that many of these individuals are carrying out tasks that are simply not what they should be doing. So you find clinicians doing a lot of administration. You find administrators doing things that, you know, they were not expecting they would have to do.

We found, one of our big conclusions in the committee was that the care that veterans received in the VA is generally at least comparable, but typically superior in quality to the mental healthcare that is provided in the public sector and in other non-VA public sectors.

And in fact, the VA has some foci of absolute excellence in the area of mental healthcare. There is really -- this is the largest mental healthcare provider in probably the world; certainly, in the United States.

It has enormous advantages in that
the VA, of course, is also a teaching institution. So you have the research paired with clinical practice. There is a quick transition from research to practice in many of the different types of care that the veterans receive.

There's, like we said before, this ability to integrate primary healthcare with mental healthcare that is very difficult to do in many other places. And of course there's the culture. One of the things that veterans very much appreciate is the fact that in the VA they find themselves, you know, among their tribe. So, there's other veterans. There's a lot of providers that are themselves veterans. And this is something that veterans really appreciate a whole lot.

MR. ROSE: One more quick. Back to burnout. Did caseload play into that?

DR. CARRIQUIRY: Yes. And that's the other thing that -- yes, caseload plays into that. Everything plays into that.
The fact that, for example, a clinician doesn't have the facilities to carry out small group sessions. Or doesn't have, you know, the staff to take good records and has to be typing himself or herself while listening to a patient. All of those things contribute to burnout.

There's a lot of unevenness in the system. There's some providers in the VA, within the VA system that are doing just fantastically well. And there's other providers that are underperforming, for many reasons. Some of it has to do with staffing.

There's a lot of -- there has been a lot of attempts to coordinate activities with other community providers. And there's some formal programs -- for example, the Veterans Choice Programs. This is all good. The committee was all in favor of the VA coordinating services with community providers. But, of course, there's this issue that all community providers are not within the VA.
So, the controls, the quality control that goes on for VA providers, it doesn't really go on for providers outside of the VA. So there's an issue about making sure that the quality of care that veterans receive outside of the VA, but with the blessing of the VA, if you will, is really the type of care that the veterans would have received in the VA.

So, high quality, evidence-based, patient-centered. Though there's this issue with, you know, those things do not necessarily complement each other.

So it's very important to -- so, one of the findings, of course, a conclusion is that there's a lot of opportunities to improve the mental healthcare that's provided by the VA. And perhaps one of the most important recommendations is ensuring consistency and predictability of high quality care across the entire system. And then I have some ideas on how that might be -- I don't, my committee has
some ideas on how that might be carried out.

So the number one recommendation was to encourage the VA to set a very lofty goal of becoming a high reliability provider of high quality mental health services throughout the entire system within three to five years.

In the report, there's many different parts to this one recommendation, but it has to do with removing as many barriers to access as possible; soliciting information systemwide from patients, from providers, from the community, from the staff, about what needs to be done; evaluating service improvement programs such as MyVA. How is that working?

Addressing workforce issues. In particular -- and there's another recommendation about that -- in particular, trying to make the hiring system more agile. It's very difficult sometimes to hire people into the VA.

Continue integrating the services of non-mental healthcare providers with the VA.
healthcare providers. Again, making sure that quality is maintained even outside of the VA system.

Facility and infrastructure needs, things such as parking spaces is important.

The need, for example, to have, sometimes, separated facilities for men and women. Women sometimes feel threatened if they have to be in the same waiting room as men. So this kind of infrastructure improvements are important.

I'll say some more about this, but the use of virtual care technologies, including telehealth and internet-based technologies. This is a very promising activity and is likely to help resolve several problems. And I'll talk a little bit about that in a minute.

Deployment and use of evidence practices. Increasing the use of AVPs through efficient and scalable training procedures. And, of course, identifying and addressing research gaps and other priorities.
The VA needs to eliminate barriers to accessing mental healthcare. Some of those are going to be easy to do. Some of those are going to be very difficult to do.

Engaging the family or the circle of friends of VAs into the care that the veterans receive is clearly something that's beneficial. There's some barriers, like, for example, distance that can be addressed using things such as telemedicine. Staffing problems can also be addressed, perhaps, using virtual care, telemedicine. So, there's many of those barriers that need to be addressed before veterans will participate more fully in the VA.

I talked about this already. So, examine how the facilities interface with community resources. And there's some very many good examples. But the best practices and the quality control needs to be extended to non-VA providers that participate in these agreements.

One should ensure that the diverse
patient population receives accessible, high quality, integrated mental healthcare services. The needs, for example, of women veterans, minority veterans, LGBT veterans, are not the same as the needs for, you know, a straight male veteran.

This, of course, is the first time when a very large proportion of women veterans were deployed. These were mothers of young children. Sometimes you had both mother and father deployed. These stresses are really -- these are new stresses that the veteran population is under, and those stresses require a specific type of care.

The homeless veteran population is another population that sometimes is underserved. So there's a need to -- of course, most of the homeless is Vietnam-era veterans, not necessarily the OIF, OEF, and OND veterans. But, nonetheless, this is a population that is underserved, and agreements such as those that exist between VA and the
housing authority to find housing for these veterans is really important.

As the VA gets additional staff, it would be great if the VA keeps in mind that veterans much prefer to be cared for by fellow veterans who understand the military culture, understand where they've been and where they're coming from. So maintaining a diversity in the provider population is also very important for the veterans.

Hiring is an issue in the VA at some levels. So, one of the recommendations, sometimes the hiring process is very long and convoluted and by the time an offer is made to a professional, the professional has already been working, you know, for six months somewhere else. And so making the system more agile is important.

And so one recommendation is to explore whether every mental healthcare worker, at all levels, can be brought under this Title 38 that alleviates -- that makes the hiring
process much more flexible and easy to get through.

The facilities, again, we talked about the physical plant and the human resources. There's a need for alignment. I'm not saying that more resources are not needed, but the resources that do exist need to be better aligned with the type of outcome the VA wishes to achieve.

And there's a strong need to lessen administrative and clerical burden on clinicians. Improve the quality of fidelity treatment. This has to do with -- you know, whether you can provide the treatment as you should depends on not only staffing but also the availability of facilities. And, of course, more adherence to clinical practice guidelines.

One of the things that the VA is extraordinarily good at is developing new technology and implementing new technology. So the VA should leverage its existing health
technology infrastructure and top of the line expertise in telehealth and virtual care -- there's nobody better than the VA in terms of virtual care and telehealth -- to achieve many things.

Number one, by scaling up the amount of care that is provided at a distance, it would be possible, for example, to alleviate transportation problems for veterans that live in rural areas. It might be possible to alleviate some staffing shortages in other areas. A clinician that is providing care at a distance doesn't have to be sitting in the same VISN as the patient that's receiving that care.

So there's a possibility of, you know, making this expertise more uniform through the entire system. Telehealth is also very beneficial for those veterans that really feel uncomfortable in crowded situations, that do not want to visit crowded waiting areas. So there's a lot of promise in terms of expanding the use of telehealth, I think.
And, finally, I think this is the last recommendation. The VA should take this opportunity to lead the nation in terms of advancing quality management in mental healthcare.

So, the VA collects a lot of information. So, there's many, many, many, things that are measured in the VA, but most of those have to do with process. So the VA has a lot of process indicators, not so many outcome indicators.

And so one of the recommendations is that the VA seriously think about developing a robust portfolio of mental healthcare performance measures, outcome indicators that can be rolled out, can be implemented and maintained.

And I am not in the business of recommending, you know, bringing business to the National Academies, but I think that a perfect consensus study would be, what are affective outcome indicators? How do you
measure what you want to measure? How do you track? And furthermore, how do you put them into practice to improve the services that the veterans get?

So, I just wanted to put that bug in your ear. I think this is a very important topic that deserves some attention. So that's all I had to say.

CHAIR LEINENKUGEL: That was great. Thanks, Alicia. I've got a number of things. But I'll defer while some others ask a couple of questions.

DR. CARRIQUIRY: Sorry, before we do that, I'm at your disposal. So if you have any questions as you do your work -- and so is the committee. Any of the members of the committee would be happy to talk with you.

CHAIR LEINENKUGEL: No one wants to go before me? Really? Okay. I'll go.

I get the subset of what I call "the long war" participants, where they're at 17 years now from the War on Terror. Or I like to
refer to it as really 27 years, since 1991.

So, it's become a long war. I get
that subset. But I also would go back to the
VA and to the people on the study and say, what
does that group really represent within the VA
ecosystem of veterans currently using the VA?
And I wonder if that was ever addressed.

DR. CARRIQUIRY: In terms of
proportions?

CHAIR LEINENKUGEL: Proportions.

DR. CARRIQUIRY: It's definitely not
the majority of the veterans that use the VA.
So the lion's share of VA users is Vietnam
veterans, or Vietnam-era veterans, definitely.

CHAIR LEINENKUGEL: And so, clarify
for us why this group was so important for
reviewing the mental health of the VA system at
that time.

DR. CARRIQUIRY: I think this group
was very important for several reasons. Number
one, like you say, this is the longest conflict
that the U.S. has been involved in. This was
the first time that women were deployed in large numbers. The all-volunteer Army, what happened was that these poor guys were deployed multiple times for very long periods.

And so there were very specific -- you know, there were stressors that were present for this particular generation of veterans that may not have been present for others. And the demand for mental health services just exploded. And so, you know, the VA found itself with an additional two million people seeking mental healthcare coming back from these wars. And so I think that's part of the trigger.

CHAIR LEINENKUGEL: I wanted to hear you clarify that so we all have that distinct understanding as to why that subset group of veterans was used.

There's a couple of things that were on the recommendations that I think we, as commissioners, will take a look at deeply. And a couple that jumped out at me personally were,
when you say veterans like to be cared by veterans, there's no question about that.

You hear that anecdotally. And then when you're out in a center and you see a veteran who served with another veteran, whether they're providing care or just a peer counseling session, is dynamite. It's money in the bank.

And you and your team brought that up. There are things that we're going to talk about as a Commission that should be outcomes of this.

So when did this complete? When did this study complete? And when did the recommendations go to the VA?

DR. CARRIQUIRY: This study completed in December of last year. And the report was published in January of this year. So, I believe towards the end of January. I'm almost sure it was towards the end of January.

CHAIR LEINENKUGEL: Yeah. And just from my recollection, I've heard bits and
pieces of this, but not to the clarity that you just presented in a very clear, short amount of time.

So that's interesting that eight months have gone by. And I would surmise that somebody has this, whether it's one of the doctors that was going to report to us next month, or has already reported, that they're well aware of it. And Drew, as an adviser, sitting in the back room, just came in. And I know that you are aware of this as well. Correct, Drew?

MR. TROJANOWSKI: One hundred percent.

DR. CARRIQUIRY: Let me say, in the VA's defense, this report came out when there was a lot of turnover in the VA. You know, leadership changes and lots of things going on. So it may not have received -- it was probably not --

CHAIR LEINENKUGEL: That's more than fair, Alicia. Two points for the
commissioners. Because it's going to come up before us. Again, it's another ham sandwich that we're sitting on and we're starving to death. They're ICTs. And if you're in the military, you know what an ICT is. It's that medic, corpsman, doc, it's that individual that went down to San Antonio -- I believe that's where they're all trained, if I remember -- and got distinct training, trauma training.

I mean, these men and women can perform battlefield tracheotomies and do a whole bunch of stuff. Yet it's hard as heck for them to get into the VA. In most cases that door is slammed. So, that needs to come to this. Because you know how many are getting out every year? Over 10,500 are being separated from the military every year.

Do you know how many we have in our ICT program that's been going on for over five years? Seventy-three. And we have what's called a clinician shortage in the VA. So, I bring that up because you brought it up with
your other recommendation on hiring, which was Title 38. And that actually is part of the solution. There's no question.

So, I only bring that up for the sense of urgency from this Commission going forward, that we have a couple of big things just on day one that I think we can further explore and make recommendations on as well.

Tom, do you have something?

DR. BEEMAN: I have a question. And I know it's not directly relevant to your study. But I'm curious if you've heard of any studies about resiliency training in the DoD and whether or not any of the services employ it and are effective, then, in mitigating some of the mental health requirements when they get out.

And then secondly, just anecdotally, I remember in particular, I won't -- I'll cite the service I thought did a great job. The Marine Corps, when we were treating PTSD and TBI patients, were part of the care process.
So, the sergeant and the platoon lieutenant would come to the center and be part of both the admission process, but also the discharge process. In a lot of the other services it seemed as though the warriors were on their own.

And I'm curious whether or not there's any data that says, you know, if we could remediate some of this before it becomes a problem by giving proper training, by making sure that it's a holistic thing, maybe the tail-end wouldn't be as big.

DR. CARRIQUIRY: You know, this is another very interesting point. So, talking about the stigma, many of the things, many of the veterans report that they hesitate to seek care because they go to their superior and their superior says, "Man up." You know, "Don't be a wimp."

And so that's one of -- I'm not saying that this is everywhere, but we have heard reports from veterans that say, "I don't
get support from my superiors to seek mental healthcare."

So that's another one. I'm not sure about the resilience training. I don't really know how to answer that question.

DR. KHAN: If I may add, to the Marine Corps side of the house. My son served for five years. He came back from Afghanistan. He was a different individual altogether. And that was about seven years ago.

At that time, prior to discharge, he was in San Diego. For six months he had to go through becoming a civilian. And they pounded on him, pounded on him that you have to seek. On top of it, me being a combat veteran, I made sure that he was prepared to come home. And I knew he was not. However, the system took care of him.

DR. CARRIQUIRY: Yes. So, your son had the benefit of having a supportive family. This is one of the biggest facilitators to seeking and keeping mental healthcare among
There are a lot of veterans that do receive this type of support from their community, the service, or what have you. But the vast majority of them don't. I shouldn't say the vast majority of them. There's a sizeable proportion of veterans that fall through the cracks between DoD and VA.

So they become civilians and they don't know how to reenter, you know, how to get into the VA system. I think that's a big thing to address.

CHAIR LEINENKUGEL: Alicia, real quick. And I'm going turn it over to Wayne. Just so I don't forget Wayne that's a -- I'm on Medicare now.

You talked about underperforming VAs. Is that data available for a who, when, where and why they were underperforming? You must have a list some place.

DR. CARRIQUIRY: Yes. We don't have a list, but the VA does. So, one of the things
that we did as a committee was, after each site visit, we wrote a report. We didn't write a report that said this clinician is a disaster. We wrote a report that said, you know, we have found these issues in this facility and these things could be improved. And so on and so forth.

And so those reports, they were pretty short, three or four pages each, were submitted to VA by the contractor, not by us. Not by the Committee, but by Westat, who was the contractor that worked with the Committee. So they exist.

CHAIR LEINENKUGEL: My question is, I'm looking around at people that support us. Can we find access to that? We need to start building some quantitative data points here.

DR. CARRIQUIRY: So the people that you should contact, my staff, so, Laura and Abby. They would -- yeah.

(Off-microphone comments.)

CHAIR LEINENKUGEL: Okay. Last
follow-up and then Wayne. What were the main reasons that your group of individuals found that veterans said we're getting great mental healthcare or we're getting adequate mental healthcare? What were the main drivers? Was it the type of therapy? Was it the drug therapy? Was it the counseling?

DR. CARRIQUIRY: It was really interesting. They complained about the types of therapy. They complained about the access. They complained about many other things. Yet, they rated the VA care very highly.

I think it was a combination of they felt comfortable in this environment that was sort of familiar with them. They felt that the professionals who were frazzled and overworked were still caring and were very capable. They felt that the quality of the care they received was very high, even though they wanted more of it.

And so it was a combination. I think that it's a love/hate relationship I
think that the veterans have with the VA.

CHAIR LEINENKUGEL: Yeah. That's fair enough.

DR. JONAS: I'll just add one more data access issue. And perhaps this is it. You know, we're going to be asked, and have been asked, to look at preferences and experiences in those areas. And I imagine you have some of that data. So, it might be good to actually see if we can get some of that information.

DR. CARRIQUIRY: Yes.

DR. JONAS: Because that may be a source. I'll just, you know, add onto that. Because that's not easy to get. And it sounds like you did a very thorough assessment of what was going on.

(Simultaneous speaking.)

DR. JONAS: So it would be really great to look at that. And I'll look through the report and if there are back reports that get into that.
I'm interested in if you looked at the flip side of stigma. Which is the disability system.

DR. CARRIQUIRY: The what, sir?

DR. JONAS: Disability system. Because mental health disability is something that is available now. I see patients in the military. Mostly active duty. And many of them are getting ready to get out. And some of them have had a few years. Some of them have had, you know, they're getting up towards retirement age.

And so I have conversations with almost all of them about what their goals are, what their purpose is in coming and in getting therapy. And some of them, even though there's clear evidence-based approaches that could help them get better, don't have those goals, because they're about to get out and they want to make sure that their benefits are not impaired.

Can you talk a little bit about
that?

DR. CARRQUIRY: Oh, yeah. So that was another big reason for veterans maybe to come in the door, but then not continue with the treatment, because they didn't want to be cured. Because if they were cured, you know, or graduate, I don't know how you say this, because of the loss of benefits.

So many of them said, you know, sorry, I cannot continue coming, because if you say that I'm okay, I'm going to be losing this benefit, the other benefit, and the other benefit.

I don't know what the solution for that is, to be honest with you. But, yes, there was a very large number of veterans that said that. Yeah.

DR. JONAS: I guess the other thing, too, I would love to have some assessment of how to better organize. I think there are, what, 20,000 organizations in the country that are here to help veterans.
DR. CARRIQUIRY: Yeah.

DR. JONAS: How many? Fifty thousand?

DR. CARRIQUIRY: I have no idea.

But --

(Off-microphone comments.)


DR. CARRIQUIRY: There's a boatload of them, yeah.

DR. JONAS: Forty-thousand coded. Coded, but nobody really knows. I mean, talk about sitting on a ham sandwich while we're starving. If we could somehow help manage that in a way that assured quality.

DR. CARRIQUIRY: Yeah.

DR. JONAS: They're in the communities. I mean, and this is community access. So you have a whole thing on, you know, how do we get community interface in those areas?

And I'm just wondering if there's some low-
hanging fruit in that area. Is there a map of
how to do it so that these ICTs, once they get
in and now are helping, can actually get that?

DR. CARRIQUIRY: You know, I don't
know if there's a map. But if I was in charge
of doing that, the first thing I would do is go
to the Vet Centers. People forget that the Vet
Centers are part of the VA. They think of the
Vet Centers as something else.

The Vet Centers are the most
effective means to attract veterans to the VA.
They are typically staffed by veterans.
Occasionally they have a clinician, but not
always. There's providers there that know how
to direct the traffic and tell the veterans to
go here or there.

And those are also people that know
the lay of the land in their community. So I
think the Vet Centers is the nucleus. This is
the center from which you then can expand
elsewhere.

MR. ROSE: I think just another
comment there. Another comment, and that is, I don't care if it's a substance abuse problem or if it's a mental health issue. And you look at the spectrum and how a person goes through that.

And you start out with the dark days. I mean, generally a lot of people may have to bottom out before they seek that help.

But the second critical step is acceptance of that problem before they go for treatment. And that, in many cases, is a difficult nut to crack. It really is. For whatever reason. Whether it be stigma, whether it be family, whether it be cultural.

But that's a huge piece. And I think it's very important. Because before you have that acceptance, you're not going to get the treatment. You're not going to go for coping. And you're not going to get on with your life. So I think we all have to be aware of that, too.

DR. CARRIQUIRY: That was one of the
striking findings. Right? So, we screened about 8,000 veterans using the usual screeners for substance abuse, PTSD, and depression, and all these other things. And among the ones that we screened and did appear -- this is not a diagnostic, obviously. It's just a screener.

But those that did appear to have a mental health thing, about half of them didn't even know it. And so, you know, that's about a million veterans if you expand out the numbers.

And that is a population that, you're absolutely correct, is going to be very difficult to reach because they are not seeking care.

CHAIR LEINENKUGEL: Anything else?

(No response.)

CHAIR LEINENKUGEL: Alicia, thank you so much for that. It was very helpful for us. And it gives us another perspective to work off of, and some more data points to collect. So thank you.

DR. CARRIQUIRY: Thank you so much.
Good luck with your work. And if you need any more information, you know where to find me.

CHAIR LEINENKUGEL: We will. Thank you very much.

(Applause.)

CHAIR LEINENKUGEL: With that, commissioners, I'd like to say that we got back on time. Thanks to, I think, Alicia. And no formalized bio-break.

(Laughter.)

CHAIR LEINENKUGEL: Also, this, in my opinion, wrapping up the day, this was a great day. This is an historic day from the seven of us in this U-shaped environment right now.

Our goal 18 months from now is to make historic recommendations for the improvement of veterans' mental healthcare throughout the VA.

And also, I think, a larger outcropping of that, seeing that this is now exposed on a national level, nationwide, with
our general population, that once again, we'll be taking the lead, and should be taking the lead, as far as making sure that at least our veteran subset of our general population is living up to the promise that various groups, including our whole health has put up on the screen today, that we have a commitment to our veterans.

And they also have a commitment back. And that is to, with the healthcare and the great clinical care that we provide them, that they get better. And we provide the tools for them to get better.

So, I'm just very proud to be part of this Commission. I thank you for being all in on day one. Day two is, again, going to be a very interesting day. We're going to have Fran present a lot tomorrow with the background that she has, and also give us a clearer direction. We're going to spend, then, the entire afternoon talking about our outcomes, how we're going to work together,
what product we're going to actually produce,  
how we're going to get there and work as, what  
I call a team, rather than just a generalized  
commission.

So I thank you. And one piece of  
administrative knowledge. We have a great  
place for dinner tonight. It's an historic  
place on a historic day. Why not? It's the  
Old Ebbitt Grill. It's the oldest bar, pub,  
eatery, I think, in D.C. And it's where a lot  
of legislation was either won or lost. And in  
most cases it was won, I think, over a beer or  
a gin martini, depending on the era.

(Laughter.)

CHAIR LEINENKUGEL: But it will be a  
great time there this evening, just to break  
bread with each of you and relax a little bit.  
And then we'll get on with day two tomorrow.  

(Whereupon, the above-entitled  
matter went off the record at 4:51 p.m.)
Thomas “Jake” Leinenkugel
Chairman, Cover Commission

Jake Leinenkugel
UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

CREATING OPTIONS FOR VETERANS' EXPEDITED RECOVERY (COVER) COMMISSION

OPEN SESSION

WEDNESDAY
JULY 25, 2018

The Commission met in the South American A/B Room of the Capital Hilton, 1001 16th Street, N.W., Washington, D.C., at 8:00 a.m., Thomas Jacob Leinenkugel, Chair, presiding.

PRESENT
THOMAS JACOB LEINENKUGEL, Chair; Senior White House Advisor-VA
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
ALSO PRESENT
SHEILA HICKMAN, Designated Federal Official
SHANNON BEATTIE, MPH, Senior Project Analyst, Sigma Health Consulting, LLC
LUIS CARRILLO, VHA Administrative Support
FERNANDA CARRION, Junior Project Analyst, Sigma Health Consulting, LLC
YESSENIA CASTILLO, Senior Consultant, Sigma Health Consulting, LLC
KIRSTIANN DICKSON, VA Support Team Project Manager; Alternate DFO
BETH ENGILES, Senior Manager, Sigma Health Consulting, LLC
HEATHER KELLY, Ph.D., American Psychological Association
LAURA McMahan, Contracting Officer Representative; Alternate DFO
FRANCES MURPHY, M.D., MPH, President and CEO, Sigma Health Consulting, LLC
PETER O'ROURKE, Acting Secretary, Department of Veterans Affairs
STACEY POLLACK, Ph.D., Alternate DFO
ERIC RODGERS, RN, FNP, Ph.D., BC, Director, Evidence Based Practice Program, Office of Quality, Safety & Value, Veterans Health Administration
PAULA SCHNURR, Ph.D., Executive Director, National Center for Posttraumatic Stress Disorder
DREW TROJANOWSKI, Special Assistant to the President for Domestic Policy
ALISON WHITEHEAD, Alternate DFO
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MS. HICKMAN: Okay, good morning and welcome to Day Two of the COVER meeting. I'm going to read the opening statement this morning for the Designated Federal Officer.

Good morning. My name is Sheila Hickman. I am serving as the Designated Federal Officer for this meeting today. This is Day Two of the first meeting of Creating Options for Veterans' Expedited Recovery Commission, or COVER.

The COVER Commission was established as required by Section 931 of the Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198 and operated under the provisions of the Federal Advisory Committee Act, as amended, 5 USC Appendix 2.

Public notice of this meeting was given in the Federal Register on July 15th, 2018. This morning's session from 8:00 a.m. to 12:00 p.m. is open to the public. Please note
that we have three sign-in sheets, one for members of the public in attendance at this meeting, and another for those who wish to make a public comment at this meeting, and one for those participants on the phone. We'll also have one that we'll move around for the commissioners to sign also.

In addition to speaking during the public comment period, members of the public may also submit written comments. This meeting will be chaired by Mr. Jake Leinenkugel while in session, and during the meeting of this committee, members of the public are asked not to make comments during briefings or commissioner discussions. Questions and comments from the public must be made during the public comment period.

Minutes of the meeting are being taken, and anything said during the meeting or submitted in writing before, during, or immediately after the meeting will be available to the public. This meeting is on the record.
In closing, to summarize, public notice of this meeting was published in the Federal Register; a DFO is present; a quorum of the COVER is present and in person; and an approved agenda for the meeting has been established and the meeting will adhere to this agenda. Anything said during the meeting is on the record.

During this break, I will ask individuals on the phone to record their names. Before the meeting begins, does anyone have any questions about what I have just said?

No? The primary statements are now concluded, and I now invite the COVER Chair, Jake Leinenkugel, to call the meeting to order.

CHAIR LEINENKUGEL: Thank you, Sheila. Day Two of the COVER Commission is now called to order, and I would like to welcome the commissioners back after a very interesting and getting-to-know-each-other, first-day session, and also the importance of this commission that not only has the eyes of the
So I think, going forward from what we saw yesterday presented and what our charge is with the COVER Commission, we're going to see a lot more activity and responses back to what our mission is.

So if I may, let's spend a brief time just doing an open review between the commissioners to get up to speed on what was covered yesterday, because it was a jam-packed day, and there are a lot of things we need to get in front of us, get comfortable with, as far as knowing what the VA has done in the past, what they're currently doing, and what the future VA is going to look like as far as caring for the mental health of our Veterans and our Veteran population.

So we certainly started out with why we're all here as commissioners, and the importance of the Comprehensive Addiction and
Recovery Act, which is the CARA Act, signed in 2016. Our charge from that act, which is about seven pages towards the end of the CARA legislation, really Sections 931, that everybody went over in detail yesterday, and we'll conclude today with basic sign-offs and workouts of each commissioner being assigned certain sections that the co-Chair, Tom Beeman, and I, will work with to develop with all the commissioners and get actively involved prior to the next month's meeting.

So we had a lot of great people in yesterday, as far as giving us our charge as far as the background that the VA and the current health care, health care services within VHA, a broad overview of the mental health.

We also had the VA whole-health system and complementary and integrated health care, that we ended the afternoon with yesterday, along with the presentation on the National Academy of Medicine Study, which we
all found to be very interesting, and also
discovered that this was just released, I
believe, as of January of this year, and a lot
of the findings, I think, will become very
relevant to portions of what we're going to be
talking about when you're looking at the COVER
Act for what we need to really be working into
for the next 18 months.

So just so the general public knows,
this commission began yesterday, and we have an
18-month period to complete this. So if you're
looking at a calendar, you're going out until
about December of 2019, which seems like a long
ways away.

As the commissioners discussed
yesterday, we've been involved in doing some of
these things in the past, and we know that
that's a very condensed period of time to do
all of the items that are requested of us, to
uncover and then make suggestions to make sure,
again, that the VA has the proper resources,
that the VA has the proper tools and mechanisms
in place, has the proper people in place; that
the VA possibly needs to reconsider their
approaches in mental health care, and we're
going to look at what some of those approaches
may be to assist in making recommendations and
suggestions in that report out December of
2019.

So I think that basically concludes
the recap of the major subjects that we started
to tackle yesterday, so I wanted to transition
immediately into the commissioners at this
point, with their personal comments. As a
reminder, these directional microphones are
very simple to work; all you have to do is,
like me, I have to remember to press the
button.

Also, please put the microphone
right in front of you, because they are
directional, and if you lean back, we're going
to lose a little bit of sound, and we want to
make sure we capture everything for the
transcription of all notes and meeting minutes.
So at this time I'm going to open it to the commissioners. If you have any insights into your point of view as to, number one, reason for being on the COVER Commission; number two, the scope of the COVER Commission and what was covered yesterday, and an overview of the presenters. I think it would give all of us and the general public a feel for the depth of what we did on Day One.

DR. BEEMAN: Thank you, Mr. Chairman. Tom Beeman, I'm delighted to be a member of the commission. When I was in active duty in the Navy, I had the privilege of being Assistant Deputy Surgeon General in command of the National Intrepid Center of Excellence as it opened. That gave me an opportunity to see some of the challenges we have in treating our warriors and the commitment that we have, and really the moral obligation and the ennobling of our work to serve these incredible women and men.

What I was impressed about yesterday
was not only the scope of the work, which seems daunting when you start, but I was impressed by the level of knowledge that the VA leadership has in this area, and really the many programs that are already extant.

I think the opportunity here is for the largest health care system arguably in the world to help set a standard for the way mental health is done throughout the world, particularly throughout the United States. So I think that this commission has an opportunity to work with the VA to put a stake in the ground and say, This is the way people should be cared for in mental health services.

We know as a nation we've really underserved that community, and now is an opportunity to really double down and to look at it and to really take our resources and marshal them to do the right thing for the people that we serve. Thank you.

CHAIR LEINENKUGEL: Thank you, Tom.

I think that was a great synopsis. Anybody
else at this point?

    COLONEL AMIDON: Mr. Chair, good morning. Matt Amidon from the George W. Bush Institute. I as well am deeply honored to be a part of this. I think I agree with you, Mr. Beeman, that not only is this the moral thing to do, but this is a national security imperative, because as we treat our Veterans, this is a direct plumb line back to the quality of an all-volunteer force.

    Additionally, this is an issue of global competitiveness as we optimize our returning Veterans and their families, we can certainly leverage them as the national assets that they are. So I was very, very impressed with the VA presentations yesterday. I, too, agree that this is a wonderful platform to define and articulate what right can look like.

    My question and challenge would then be, how do we distribute what that right looks like to a nation of effort, considering that perhaps the majority of our Veterans are not
partaking of VA health care? Can we be the exemplar, but ensure that that exemplar is distributed to others who can capture those best practices?

CHAIR LEINENKUGEL: Yes, thank you so much, Matt. I think that, again, the general public needs to know a very important thing that you just said, and that is that the majority of Veterans do not use VA mental care or VA health care in general.

I think the number that we heard yesterday is correct, because I've heard it for 18 months now: Out of the 22 million American Veterans alive in America, highest all-time ever, only nine million of them are enrolled, and 6.2 million of them are unique users. So when you're doing the math on that, you're looking at about 70 percent that are not getting or obtaining VA care.

Then I want to jump on what you just said, Matt, on top of what Tom just said. From what we've seen -- and I think I've known and
felt for the last 18 months -- when the Veterans get VA care, that subgroup of about 30 percent of the total population, really enjoy and like that care in most cases. I think that's a big thing that is missed in today's conversation as a whole.

That being said, I think that both you and Tom gave a real good synopsis of yesterday, but I would like that each commissioner to put themselves on record for their purpose for being, and also, yesterday's sessions.

MR. ROSE: Mr. Chairman, Jack Rose. I think this is a tremendous opportunity and truly an honor to be part of this commission. As a Navy Veteran myself, and as a mental health advocate, we need to go forward in this area.

It's truly something that we need to look at, the whole person, the whole healing process; it's not just medication. It goes beyond that. Therapy is extremely important,
but you need to get into some of the different, holistic types of approaches that have been truly effective.

We have seen examples in the VA right now where this is working. So I think we need to expand on that, and as a commission, I think part of our charter, we need to really look at it, and we need to be true stewards of the resources that we have. Truly, as we go forward, the VA can lead the charge on this; they really can.

They have a huge amount of assets, resources, truly professionals. They have a real base of mental health professionals, and they have a source for those professionals. These need to be used really for the benefit of our Veterans. We owe it to our Veterans for their entire lives, and I think it's just a tremendous opportunity to make this happen. Thank you.

CHAIR LEINENKUGEL: Thank you very much, Jack.
DR. JONAS: Yes, thanks. It is a great honor to be on this commission and to contribute to try and do right by our Veterans. It is the military and the Veterans that actually allow us to enjoy the freedoms and the great country that we live in here. They sign an obligation when they sign up, and they defend the country. We have an obligation to return that to them, and this is part of fulfilling that obligation.

I think in addition to that -- it's been stated -- I think we have an opportunity here to reset health care in the U.S. in general, and I think we need to do that. We know, for example, that in the United States, we spend over twice as much as any other country on health care, and the costs are going up to where they're unsustainable.

Twenty-five percent of our GNP may be spent by 2025 if the current inflation rate occurs. In addition to that, the value is going down. The main outcomes, if you look at
the general outcomes across the population, population health outcomes are declining over the last 30 years. So we're not getting value for what we're paying in health care in general.

So to simply say that we need to cover more of what we're doing is not the answer. We have to do it differently, and I think that some of the examples that we saw yesterday illustrate the direction that we need to go in order to do it differently.

As Jack said, we need to have a more whole-person model. Most of health comes from outside the health care, so we have to have a system that reaches out into that community and changes people's lives, and then links that back with prevention, chronic disease management. Only that type of thing will be able to sufficiently address mental health issues, pain and opioid epidemic issues that we have today.

So I think this commission has an
opportunity to reset health care in general, and if we do it right for the VA and the community, then we'll do it right for the nation. So it's a great honor to be able to contribute to that.

CHAIR LEINENKUGEL: Thank you, Wayne. Very good point. Shira?

DR. MAGUEN: Thank you. First of all, it's an absolute honor to be a part of this. As someone who has worn both a clinical hat, a research hat, and a training hat in the VA system for many years now, I'm very honored to be part of this. I also feel that the VA has really been a leader in leading the mental health charge for our Veterans and have been so impressed with what I have seen. I'm excited to bring that to the commission and kind of dig into the details.

I also agree that the direction that we're going is so exciting. I really loved the whole-health movement transformations that I have seen, working in the system, and how
that's really made a big impact. I think that this commission really has a chance now to impact how we move forward, and I'm also very confident, from what I've heard from the commissioners so far, that we each bring a really unique piece to this and can contribute in ways, as a whole, that can transform how we move forward.

So I'm thrilled to be a part of this and look forward to working with all of you on this really important work.

CHAIR LEINENKUGEL: Thank you so much, Shira, very well stated. Jamil?

DR. KHAN: Mr. Chairman and fellow commissioners, as a user of the VA, I've been, as we call it in our language, in the foxholes. One of the things that I have so far missed from any briefers, and I would like to stress it, is the Keep it Simple, Sir principle.

We have to look at the basics. One of the basics in the VA is why the Veterans are not getting in there, and one of the major
difficulties is getting the disability rating. The voices you hear who are saying we are
great, the majority of them are those who are
100 percent disabled, or 70 percent plus. They
are treated like royalty in the VA system.

But those 70 percent who are not
coming in, they are rated 10 or less than 10
percent. That rating system needs to be fixed,
and I think this is a venue where we can decide
on things we are going to do to bring those
Veterans back into our holy ground. We need to
give them the opportunity to do it. So that
rating system needs to be fixed. That's the
biggest flaw within the VA. Thank you, sir.

CHAIR LEINENKUGEL: Thank you, Jamil. Now that you've got a broad scope from
the general public's standpoint as to the
commissioners and the various backgrounds and
opinions and fact-based upbringing that we've
had in various other jobs and commitments,
whether it's on a clinician side or a business
side, that first and foremost, we do care about
In most cases, we are all Veterans, and we have, as Wayne and Tom and everyone has stated, along with Matt, we have a charge to the nation that anybody who has served in uniform for this country, we have the absolute first and foremost reason for making sure they get the best quality care with quality outcomes.

This commission is really focusing on the mental health, and when you look at the broad-based and evidence-based things that the Veterans are being treated with now, as Jack brought up, there is a whole host of alternative therapies that are being explored, in some cases by the VA right now, ahead of the general public in a health-care basis.

But more importantly, there's a lot of other things that we need to raise that should be either researched, looked at, debated, or discussed as being holistic or different type of approaches towards care. Because it's not just the mental health of the
Veterans, we're seeing this as a national issue. As Wayne and Tom stated, and Matt again, and certainly Shira from the clinical side -- we know that this has a broader implication, not just to Veterans, but to the health care of the general public.

So that being said, I think we had a real good overview of what happened yesterday, the perspectives from the commissioners, giving everybody a sense for who we are and how serious we take our duties and the charge of the COVER Commission.

So we are going to move on to the first presentation today, which is extremely relevant because it's really charge one of the COVER Commission, taking a hard look at what is the current integrated -- or, I'm sorry, the current evidence-based approaches that are used and implemented within the VA for Veterans' mental health care.

We have two great people on board today that are going to be presenting, and it's
Eric Rodgers and also Paula Schnurr. Again, we have their bios, but just for the general public's sense, I want to put on record their backgrounds because they have terrific backgrounds. They are great folks, and they are going to give us the overview of evidence-based.

That being said, let me introduce Eric Rodgers first, who has over 40 years of experience in nursing. He is currently the director of the VHA Evidence-based Practice Program, Office of Quality, Safety, and Value. In this position, he is responsible for the policy, program planning, and carrying out of the VA and DoD evidence-based clinical practice guideline program for both VHA and DoD facilities. He is also a VA primary-care provider and a University of Colorado faculty practice provider.

His past military and civilian positions include chief nurse executive, regional director for a large non-profit health
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care system, private practice, research
director, company commander, nursing faculty,
nursing education director, and staff nurse.
He is one heck of a nurse. So thank you, Eric,
for being on board.

And at this time, Dr. Paula Schnurr
as well. Paula is the executive director of
the National Center for Post-Traumatic Stress
Disorder and previously served as deputy
executive director of the Center since 1989.
She is a professor of psychiatry at the Geisel
School of Medicine at Dartmouth and editor of
the Clinician's Trauma Update Online.
She received her Ph.D. in
experimental psychology at Dartmouth in 1984
and then completed a post-doctoral fellowship
in the department of psychiatry at Geisel
School of Medicine at Dartmouth.
She has a lot of other things in
this great bio, but the main thing is her most
current grants are comparative effectiveness
trial of prolonged exposure and cognitive
processing therapy and a validation of the primary care PTS screen for DSM-5.

So nice to have the balance between Dr. Eric Rodgers and Dr. Paula Schnurr with us today.

DR. RODGERS: Well, good morning, and thank you, Mr. Chairman and commissioners. I do appreciate this opportunity to give you the overview about the VA and DoD evidence-based practice, clinical practice guideline development program. Great introduction, I appreciate that.

A little bit more, I've been with the VA system now -- this is my 21st year as of this month, and as you can tell from my bio, I'm an Army Veteran myself, having served enlisted as a combat medic and eventually switching sides and becoming a Nurse Corps officer. So I always keep that perspective in my daily work that it's the Veterans that we are caring for, and I understand that.

I've been with the Evidence-based
Practice Program under Quality, Safety, and Value for the last seven years, so I'm going to proceed with the presentation. I am not an expert in mental health services, which is why we have the expertise of Dr. Schnurr.

DR. SCHNURR: Well, that was a terrific introduction. I wish my mother had heard it. Just a little bit of extra background, the National Center for PTSD is a center of excellence in research, education, consultation, in the Department of Veterans Affairs. We are congressionally mandated, and we are celebrating our 29th birthday this month.

I want to say that Dr. McGuinn is one of our graduates. She trained with us, and I'm very proud of the impact that we've had on the system, and I'm also grateful for the opportunity to be here today.

My particular interest is in studying the treatment of PTSD, functional outcomes in PTSD, and especially designing
trials for non-pharmacologic interventions such as complementary and integrative health practices.

So Dr. Rodgers will give you an overview of the Evidence-based Practice Program, and then I'll talk about the PTSD guideline because I was one of the VA champions for that guideline.

DR. RODGERS: Thank you. I have to figure out the control. Thank you.

As we mentioned, I'm going to provide the overview for our Evidence-based Practice Program, speak about how we got our start and our partnership with Department of Defense, give you an overview of how the -- what our process is and development and the rigor that we undertake in the evidence reviews.

Since the focus of this commission is on mental health, we will also speak to our most recent updates related to mental health practice guidelines, and then some examples for
integrative health recommendations from the PTSD guideline.

The joint VA and Department of Defense clinical practice guideline program was stood up in 1998, and we've had a very meaningful partnership with DoD ever since then. The first clinical practice guidelines were actually developed in the VA in 1996, and it was a cardiology/congestive heart failure guideline, and it was so well received nationally that the VA decided that it would do more in terms of guidelines, and by 1998 had entered into a partnership with the Department of Defense.

Our goal with clinical practice guidelines is to improve the overall health of our beneficiaries by using evidence-based practices, and it has been shown since -- studies since -- in the 1990s that evidence-based practice does reduce variations in care and does optimize outcomes.

So our guidelines are specifically
designed to improve the overall quality of care and health management for both our Veterans health and military health care systems. We have a governing body known as the VA/DoD Evidence-based Practice Work Group that oversees the guideline development process and reports to the Health Executive Council.

As I mentioned, our governing body is the Evidence-based Practice Work Group. I'm going to put up a slide here that represents the work group members. But, you know, they're -- it's comprised of experts in their field from both the VA and the Department of Defense. On the VA side, they are appointed by the Under Secretary for Health, and on the DoD side of the house by the Assistant Secretary of Defense for Health Affairs.

I won't read the names that you can see there, but the types of offices that are represented kind of covers the gamut of what you would expect within health care.

So the governing body solicits and
prioritizes the guidelines to be developed as well as to be updated, and the guidelines are updated roughly every five years. And that's consistent with the Institute of Medicine's standards for trustworthy guidelines, which we do follow.

Our guidelines do have oversight and peer review process in place, and I'll go into more detail with that, and as I mentioned, we do report to the Health Executive Committee.

So to speak more to the actual development process, once a guideline has been identified either for new development or for update, we identify what we call champions and other professional organizations. We refer to them as chairs, guideline chairs, but we call them champions. But we have champions from both the VA and from the Department of Defense, and our interdisciplinary teams are fairly evenly distributed between VA and DoD.

Most of our guideline groups -- it varies, depending on the guideline and the
expertise needed, but usually it's around 20
people, 10 from -- we tried for 10 from each
side, however that varies a little bit because
we want to make sure that we get the correct
disciplines represented on our guidelines.

   All of our guidelines, as I said, are interdisciplinary. We always have primary
care; we always have nursing; we always have
pharmacy; we always have social work. And then
the additional team members, it depends on what
the guideline is. We often will have
chaplains, chiropractors, we've had
chiropractors on some of our guidelines. We've
had acupuncturists on some of our guidelines. Of course, for mental health we have
psychiatrists and psychologists, so we make
sure that it's well represented.

   We do follow very strict conflict of
interest disclosure. Every member is asked to
fill out a conflict of interest form at
multiple times throughout the guideline
process. And at many of our meetings, we do a
verbal acknowledgment of conflicts of interest as well. And we do not just go by what they tell us. We -- these are -- we do independent verifications for conflicts of interest on all of our work group members, and we require that our champions be -- have no conflicts of interest.

The work group itself, once it's formed, defines what the scope of the clinical practice guideline should be, and they develop the key questions. The key questions are very important because they define the parameters of the evidence review that will be undertaken for the evidence.

Simultaneously, we also conduct Veteran and patient focus groups to get their input into the guideline and what is important to them from a patient perspective, and -- because we want to include that to make sure that during the key question development phase, because again, like I said, that's what defines what we're looking for in the evidence. And so
we don't want to miss something that the
Veterans feel are important. We want to make
sure that that's included in the literature
search.

Once we have a focus group, they
stay involved in the process. They provide
that input during the key question development
process, but then later on when we get to the
draft process, they are sent the draft for
review and for input back to us. And primarily
their focus is did we address the items that
they had identified that were important to
them.

We use a third-party independent --
actually use a contract company to do the
guideline development itself, and they use a
third-party independent for the evidence
review. Currently, that's with ECRI. I don't
know how familiar the commissioners are with
ECRI, but it's a very large and well-known
evidence review company. And actually they
were one of -- I believe one of the first to be
identified by the Agency for Healthcare Research and Quality as a quality evidence review organization.

They've been around about 50 years and actually do a lot of work with Health and Human Services, CMS, NIH, so they've got a good reputation.

It takes several months to do the evidence review. They apply the U.S. Preventive Services Task Force criteria in looking at the quality of the studies for the review and give a rating to that.

Ultimately, the work group comes together in a face-to-face meeting for three and a half days where they then -- the work group members themselves review that evidence and then apply a second level of rating to the evidence in order to come up with -- ECRI determines the, we'll say, the quality of the studies, individual studies, and then the work group ends up rating the strength of the aggregate of the studies to come up with the
recommendations.

Obviously, it goes through several draft components before we have a final product. One of the things that we're proud of is that the VA/DoD guidelines, when they started back in 1998, included an algorithm in all of their guidelines, and that had not been done previously.

Now you see more and more of that happening, but that was sort of a first for the guideline community. And all of our providers' feedback that we get is that they really appreciate the algorithms. It makes it much easier for them to follow.

It goes through an iterative draft review process and drafts. Once it's ready, it goes out what we call internally. We send it out on both the VA side and the Department of Defense side to multiple providers. Actually on the VA side we send it out widely to basically all of our providers in our system. But it's -- that's done through the chain to
the VISNs and the medical directors and chiefs of staff to distribute out to their providers. But we have a website that they can go to and provide feedback on the guideline. It's open for varying periods of time. Again, all of that feedback is addressed by the work group members, and any changes made to the recommendations are done so based, again, solely on the evidence.

We may get feedback that, oh, I always do it this way. But if the current evidence doesn't support doing it that way, we're going to say so. But all the feedback is addressed.

Once we have that cleaned up and ready, it then goes out again to the same people internally, but now we also send it externally to various professional organizations, individuals outside of our systems that are clearly recognized as experts in the field. And, again, they have that same opportunity to provide that feedback. And,
again, it is all addressed, and changes made
are solely based -- have to be supported by the
evidence.

Once the work group feels that they
have a final product, then it is presented to
the VA/DoD Evidence-Based Practice Work Group,
that governing body for review, and it does get
presented and hopefully approved. And I say
hopefully because it is not an automatic.
Oftentimes, the governing body work group will
have additional comments that they feel need to
be addressed. We've actually had instances
where a guideline was not approved. So it's
not an automatic.

And then in addition to the clinical
practice guideline itself, we develop tools to
help with the implementation. The guideline
itself is usually 150, 180 pages. We'll come
up with a clinician summary that's 30-some
pages, a little more manageable, as well as a
patient summary so that -- and it's written so
that -- for the important components that the
patients value, and have told us this is what
they need to know about whatever the disease is
that they're dealing with. This is usually
two, maybe four pages at the most. And then we
also develop a pocket card for quick and easy
reference.

This is just to let you know of our
recent updates related to mental health. The
Major Depressive Disorder guideline was updated
and released in 2016, the Substance Use
Disorder in 2015, and, most recently, the PTSD
guideline in 2017.

Then the Patients at Risk for
Suicide was originally published in 2013, and
we currently have a work group in progress
right now doing the update. In fact, they had
their face-to-face where they looked at -- went
over all the evidence just last week. So like
I said, it's in progress. It's anticipated to
be completed in January of 2019.

And I guess I should have, you know
-- we do updates every five years unless the
evidence -- there's significant evidence to warrant an update sooner. Also, to do an update it takes us about 12 months from start to finish on an update, and for a brand-new guideline I'm going to say 18 to 24 months. It used to be 24 months, but we've gotten it down real close to 18 months now, and most of that time is consumed by the evidence reviews. And then related to mental health is our Opioid Therapy for Chronic Pain, which was just updated in 2017.

And now I'm going to turn it over to Dr. Schnurr.

DR. SCHNURR: Thank you, Eric. So as I mentioned earlier, I was one of the co-champions for the PTSD guideline. I'm also a member of the Evidence-Based Practice Work Group, so it's given me additional insight into the process.

The PTSD guideline was revised from a prior format in which consensus was used along with evidence. It has become a best
practice around the world in the development of
guidelines to base guidelines on evidence, and
when there isn't evidence to say that there
isn't evidence one way or another.

So the PTSD guideline had to get pruned, essentially, from over 200 -- I think
220-some recommendations, we came down to 40
evidence-based recommendations. This is actually better for all the stakeholders
because Vets get better information about the evidence, providers get better information
about the evidence, and it's a lot easier to use the guidelines. It's also a lot easier to defend the recommendations because it's based
on evidence review and not the opinion of a bunch of people in a room.

So because of the commission's focus on complementary and integrative health, I just wanted to mention a few things that are particular to the guideline. I'm glad to take questions about broader details.

The first bullet that's listed here
is about treatments that are not necessarily complementary, but they're different, such as repetitive transcranial magnetic stimulation. That's actually an FDA-approved treatment for treatment-resistant depression.

ECT, again, an approved treatment; hyperbaric oxygen therapy, which is actually quite a controversial treatment; stellate ganglion block, likewise, and vagal nerve stimulation. The evidence for treating PTSD for all of these is insufficient right now.

Also the evidence is insufficient for acupuncture. There's been some work, but the body of evidence is quite small, and the quality of the evidence is not sufficient to make a recommendation yes or no.

And by the way, Eric didn't say this, but the way the guidelines grade evidence is to make a strong recommendation, a recommend, or a weaker recommendation, a suggest, and you can recommend for or against, or suggest for or against. In the PTSD
guideline, because we were aware that there were many treatments that have advocates of people who are using the treatments, we used insufficient evidence ratings for those kind of treatments to ensure that users would know that we don't know one way or the other.

So going on and looking at the complementary and integrative health practices, we found the evidence was also insufficient for meditation, including mindfulness, which happens to be the most widely practiced type of meditation for PTSD in VA. Yoga and mantra meditation -- there's a new study published on mantra that was favorable, and so it's possible in the next guideline that we would see that evidence differently.

So, Eric, do you want me to sum it up?

So the practice guidelines are a foundational component of our evidence-based practice program. What we've tried to provide here is a sense of the process and the rigor.
I think we really do stand on an international footing in terms of the quality of our guidelines.

Our recent diabetes guideline was rated in a JAMA article as one of the top guidelines. There's some controversy about the guidelines for managing diabetes, and the VA/DoD guideline has been receiving very good press. That's produced by the same process as the other guidelines.

The hope of the guidelines is that evidence -- that mental health treatment is improved by using evidence-based practices and reducing unwarranted variation in care, as well as optimizing patient-centered outcomes. So guidelines are not mandates. It's important to understand that these are not thou shalt kind of recommendations.

But they are suggestions for how to practice. The guidelines all heavily emphasize the importance of taking patient preferences and values into account, considering resources...
and other factors that tailor the care to the individual within the body of evidence.

And so we suggest that you may want to review the recent CPG recommendations on PTSD and depression and other mental health disorders to inform the commission's work.

Thank you, and now I guess we'll take questions.

CHAIR LEINENKUGEL: Thank you so much, doctors. That was an excellent overview and gives us a lot of follow up.

I've got a couple of pages, so I don't want to be the lead on this because it's going to lead into, I think, directionally where we need to go as the COVER Commission.

DR. BEEMAN: Doctors, just two quick questions. Are there any complementary treatments that have met the rigorous criteria of the clinical practice guidelines?

DR. SCHNURR: Not in any PTSD guideline that exists. I'm not aware of whether there are any for other mental health
conditions, but for -- that are prevalent in Veterans, but the UK guidelines, the Australian guidelines, the American Psychological Association, and the VA guidelines, none of them have found the evidence sufficient yet.

Can I just say it's also challenging, and much of this work is not as rigorous as it needs to be because it's hard to study something for which you essentially can't have a placebo.

Drugs are easier to study. They have their own challenges. This happens to be a particular passion of mine. I love the challenge of trying to figure this out, but the problem is that often this work is threatened by the possibility that placebo effects can account for the findings.

And so there are really good people in the field now, with much more rigorous studies ongoing, but to the best of my knowledge -- and I'm speaking now as a scientist, not a representative for VA -- the
evidence just isn't there yet.

DR. BEEMAN: Sure. I had one other question: Nowhere yet have we mentioned the fact that mental illness impacts families as well, so it's not just the warrior who has the mental health issue, it's the family. Is family therapy any part of the guideline of treatments for PTSD that you've seen?

DR. SCHNURR: We do have a recommendation around couples therapy. We recognize the importance of this, because PTSD affects everyone in the life of a person who has PTSD. But the evidence is also insufficient for couples therapy or family therapy at this time.

DR. RODGERS: And I would just like to clarify, it's not related to therapy, but when we do the focus groups, we do include family members as well. So we do take that into consideration.

DR. BEEMAN: Just to comment for Jack: What I had wanted to get on record
earlier is that I think, because mental illness impacts not just the warrior but the families and by extension, the community, I think it's really important as we talk about our findings over time, that we don't discount the import of family.

I think, Dr. Schnurr, your answer that it doesn't have evidence yet. We anecdotally know that including the family, that this helps the family. There are certain things about complementary medicine that may not be able to be scientifically proven, but may have anecdotal evidence that helps us. Otherwise, it's going to be hard for us to talk about any complementary medicine if it can't be proven. Thank you.

DR. SCHNURR: May I comment, because I actually believe that we can prove a lot. Even for the challenging complementary treatments that the commission is studying, it just hasn't been done to a great extent yet.

There's just excellent ongoing work
that I think will be much more definitive in
the coming years. I actually don't believe
it's -- it's challenging to study, but it's not
impossible to study, and we will have much
better evidence.

MR. ROSE: Thank you. To whoever
would like to answer this: As far as a mental
health advocate, the mental illness is very
difficult, one, to diagnose. So you're dealing
with one here with PTSD, and there's not enough
evidence base to qualify some of these
complementary treatments.

Is there any way you can try to
fast-track some of these? They have proven --
I don't know, maybe it's anecdotally, but some
of this stuff really works.

If you've got every five years that
you're looking at this, and it takes about a
year to do it -- I know it's a huge process
that you have to go through. But this is
really critical for mental health, and that's
the purpose, that's why we're here.
I don't know. I don't know if you have any comment on that. Thank you.

DR. SCHNURR: I think I would say that I'm not the right person to answer a question about fast-tracking. That would be a question that would fall more into the VA or DoD research spheres. But I can say to the best that I know, there's a lot activity going on now, and the next few years should have, as I was saying before, much more definitive information.

DR. JONAS: Thank you very much for that great overview and the system you've built, which I think is fabulous. I've seen it from the inside and the outside, and I think you've applied the National Academy of Medicine's principles for guidelines even better than they have, in my opinion, so it's really great.

Just a couple of questions, I know, having been involved in this process for a while, so I know -- is there any training,
especially for the patient input? The fact
that you have the patient input on multiple
levels is fabulous, but the dynamic, as you
know, in many of these groups can be quite
touchy. There's a power dynamic, there's an
expertise dynamic, there's a personality
dynamic, if some people dominate.

Any work on trying to create a
process that sort of enhances the patient input
a little bit better to balance those issues?

DR. RODGERS: Good question, thank
you. Yes and no, is the answer. Yes, we have
thought about that. At the moment, we haven't
figured out a way to actually make that work,
from multiple standpoints. One is that in
order to do that, you kind of have to maintain
a cadre of patients, and that becomes quite
expensive.

Then the other is that under current
law, we would have to have no way to cover
their reimbursement for traveling to conduct
some of the work that we do.
The way that we've addressed this is that we go to them for our focus groups, and while it's not extensive, we do some preliminary kind of education with them in terms of laying out the expectations and the groundwork.

We explain to them what a clinical practice guideline is and what it isn't before we start, and we do have interview guides that we follow to get at the important points from a scientific standpoint, but at the same time obtaining their perspectives in what they value as important.

I didn't go into great detail, but that second phase is called a grade methodology process, and significantly incorporated is both the patient preference and the provider preference. Those have significant value, and they are weighted within the grading of the system for the evidence.

So those can help to either raise the level of a rating or actually lower the
level of a rating. That's why it's a yes and a no that we've addressed it.

DR. JONAS: Thank you very much, and I encourage you to keep working on that. It's a great challenge. I think the grade is a great advance in what used to be done in these areas, which is just like, Well, if it's not at the top of the hierarchy in a random, double-blind, placebo, multi-center, clinical trial, then it's insufficient, and that still tends to be the approach.

The levels of sufficient, insufficient -- I'm glad that you're putting things into sort of insufficient evidence, even though one could say, gee, hyperbaric oxygen, for example, in my opinion, there's plenty of evidence that shows that it does not work, so you put it in the insufficient evidence.

But there is this sort of tension between the effectiveness and efficacy of research, efficacy usually being counted as more rigorous, because they look at randomized
control trials, theoretical components of a placebo, etc., to try to determine an effectiveness, which don't work out there in a more heterogenous environment in populations.

So working on coming up with models that can incorporate those assessments, I think, is important, especially when we now know that two-thirds of what has been proven in top randomized control trials can't be replicated, even when it's published in top journals in those areas.

I'm wondering if you've applied this approach to -- what we've been charged with here is to look at models of care. It's so much of what is provided in these guidelines are individual treatments, because it's easy to do the research on that.

So we end up with these laundry lists of, this works, that doesn't work, etc., when in real life, what I do in my practice and what most clinicians and patients do is, they go through a whole process of treatment in
setting guidelines, and that's how process
guidelines are often set up. But we're not
sure if those will actually work, if those
models work, and I know it's a challenge to do
that.

Have you thought of maybe coming up
with some creative ways to evaluate models of
care and visualizing all of the treatments on
sort of a similar map to allow decision-making
within practice, looking at evidence-based
grounding?

DR. SCHNURR: I think that one's for
me. The short answer is yes, we have thought
of this, but the work in PTSD has focused
primarily on collaborative care in primary care
settings. So integrating mental health care
into the primary care setting, creating step-
care models where lower-intensity care is
delivered in primary care if a patient is not
too severe, and then moving the patient along
the continuum -- that evidence is still mixed.
In fact, I did the first randomized trial of
collaborative care for PTSD, and we found it changed the care, but it didn't improve outcomes.

A study that was done in the DoD found more modest improvements in outcomes, and I think the challenge we're seeing by studying models of care is that the effectiveness of the models depends on the care that's provided within that model. Right now the most effective treatments we have in our toolbox for treating PTSD are selected psychotherapies.

There's a number of them, patients have a choice of things that they do. Essentially, psychotherapies that focus on processing the traumatic event in some way seem to be the most effective. So a model of care that ultimately doesn't lead to that as an option is less likely to have a large effect.

In fact, the guideline recommends these trauma-focused psychotherapies as the first line of treatment over medication and other types of psychotherapies, some of which
DR. JONAS: Thank you. Just one more question, if you will, so surgery is used in interventional studies, injections, surgery, a lot of things were used a lot for chronic pain. Is there sufficient evidence to show that those actually work or reduce pain chronically, or are useful in mitigating the opioid issues, using the criteria that you approach? Has a guideline or evaluation been done on interventional studies like that, that are a key part of chronic pain management?

DR. SCHNURR: I think that is something I can't comment on, given my expertise. I don't know your process for finding parking lot questions, but that would go beyond my knowledge.

DR. JONAS: It's opioids also, so it often comes into opioid management. It's a non-pharmacological approach. I didn't see it on the list. I'm just wondering.

DR. RODGERS: I do know that when
the opioid guideline was updated, that was among the key questions that was looked at. I apologize. Off the top of my head, I can't necessarily tell you exactly what the ultimate recommendations were that ended up in the guideline, but I do know I remember it being part of the key question development. I can get that answer for you.

DR. MURPHY: One of the examples we took at were interventions for low back pain.

DR. RODGERS: What she was saying, if you didn't hear her, our low back pain guideline did include that in interventional and looked at complementary medicine treatments as well. So I'd just have to look at the guideline to let you know.

DR. JONAS: I don't think they included surgery in that. I would consider it a non-pharmacological approach, and just wondered where it fits into your evaluation approach for these areas.

DR. RODGERS: I do know we had an
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interventional surgeon that was one of the champions.

DR. JONAS: And I wondered, was there a CAM person on the surgery one? A non-pharm person? There must have been.

Just one final question is the application of the guidelines -- so often, it's difficult to get the application of the guidelines. Clinicians don't necessarily use them, patients don't sometimes understand them or care about them, and the appropriateness of applying them is another whole discipline, and I'm just wondering if that's something that you've looked at in the VA, in terms of the appropriateness of the use of the guidelines. Are they out there being used? Are they benefitting people if they are used? Is there any evaluation of that?

DR. RODGERS: Currently the only way that we have to evaluate that is what I can call indirect measures. We keep striving for that. Electronic health records, where they
are implemented, make it easier to track and 
monitor and be able to assess the direct 
outcomes on them.

Right now they look at indirect 
measures. Pharmacy is a good example where, 
every guideline that comes out and we're 
recommendation alternative therapies instead, 
then we should be seeing a decrease in the use 
of whatever that particular medication might 
be.

Our hyperlipidemia guideline is a 
good example of that. We still recommend the 
use of statins, but the practice at the time 
was that everyone was going on high-dose 
statins, yet the evidence showed that you 
received no better benefit at high doses than 
you did at a moderate dose.

So when that guideline came out, we 
saw a significant decrease in the high dose 
ranges of our statin usage and the coinciding 
money saved. That was quite significant. So 
that's an example.
But we're always looking and talking about how else we can get this in front of the provider where it's used. So besides our publication of these, we've tried to be creative, and we've turned to partnering with Epocrates, who is now placing our guidelines on their mobile app platform, which we know a lot of clinicians utilize. It's right in their pocket. We're strongly advertising that with our providers, that that's another place they can go to get it rather than try to pull it off the computer or get a hard copy of it.

We also know that our providers look at these other journals, so the Annals of Internal Medicine has committed that they want to publish all of our guidelines, and so every time we do a guideline update, it gets published in the Annals. That way we know our providers, both on the VA and DoD side will look at that, possibly before they'll look at something that comes out from us. So we try to be creative in getting it out there in front of
We also have a study that's about to kick off a survey, again, trying to get at that answer, asking the providers, are they using them? How are they using them? What do they want from us that would improve their utilization of it? Hopefully, that will come out in the next couple of months.

DR. JONAS: I just want to commend you on this work. This is the heart and soul of determining what works and what doesn't work, which is what we all want to make decisions about. So you're doing fabulous work. Keep it up, and I just want to make sure the commission realizes that this is a thing that we should clearly focus on in terms of that. So thank you very much for your efforts.

CHAIR LEINENKUGEL: There's no question that you bring a lot to the excitement of the commissioners at this point, and this is going to continue for the next 18 months. It's a good opportunity to be on record as Tom
started, and Wayne, and Jack at this point.

So I want to go on record with two things: number one, what Tom stated, I'm more in that camp. I think we're moving too slow. This commission was put together and was asked to be part of a law two years ago, and it took us two years to get to this portion. That's way too slow, because we are losing 20 Veterans a day.

And to what Jack said, I firmly believe, because I've dealt with two families now that have had Veterans commit suicide. It impacts the family, and in many cases, the community, especially if it's a small community.

That being said, we have a sense of urgency as commissioners to come up with recommendations, and I will tell you that I love the procedures. You have a very disciplined approach. There has to be that, but there also has to be a sense of urgency to some of the things that you stated, and I don't
think there is, and that's my opinion.

Whether they're complementary, whether we think they work or not, there's a group of Veterans and a group of advocates that believe they do, and I'll give you two instances.

HBOT: There are two large groups in the United States right now trying to prove that it does help, even if it is a select group of Veterans. I have heard their stories, I've seen them in person. We will bring those up in front of the commissioners. Does it work on a whole? I don't know. I don't know anything about except what they told me. There's different levels of pressure, there's different variations to the treatment, so there is no what you're trying to do here, set guidelines and standards.

If there is a piece of evidence that maybe at a 2.2 pressure over a 40-minute period sustained over seven weeks, there's an 80 percent improvement. I don't think they've
gotten there yet, but there's that possibility. Another group -- let's face it -- is medical cannabis, not recreational, but medical. I think we're doing an injustice, I think that our largest VSOs have stated through their membership that over 90 percent of American Legion, which is two million strong, Veterans are advocating that we at least take a look at research within the VA, which I don't think we're doing. To me, that makes no sense. It's a plant, it's an herb. I'm not advocating for recreational use at all.

But from this commission, we need to look at every variation of complementary type of care under what we had yesterday, whole health. I know I'm editorializing a little bit, but I want to at least get it on the public record that these are things that I think we need to start taking a look at, along with -- what are a couple of the other ones? I know, Paula, you talked about ECT and repetitive transcranial magnetic stimulation
that had some other groups that said that was really helping me.

So when I look at it in the context, I look at it as a toolbox and a toolkit. Are we going to at least give the opportunity for Veterans, in our subset of what COVER Commission is, to have an expanded toolbox to do evidence-based studies, to see if it does work, rather than doing incremental one-offs, whether it's done by the Army in conjunction with a broader DoD, and maybe VA being brought in at some point?

I think that you need to, since you're on this guidelines approach, to maybe be some advocates, or maybe it needs to come from the top, from the Secretary of the VA and the Secretary of DoD to make some of these statements. We'll take that as a next step from out group as well.

My last point is, from an evidence-based practice, and I would think both of you have had these occurrences or situations, just
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1 give us a sense for how Veterans are being
treated today. Let me give you two scenarios,
because they're both true; they are scenarios
that I am aware of.

5 A woman Veteran, after two years,
discloses that she's had major ongoing sexual
trauma during her four-year enlistment. She is
now homeless. She has a child, and she has
nowhere to go. A VA person actually approached
her during a homeless stand down. How, under
your guidelines, would she be treated today,

10 once she came into the VA?

13 DR. SCHNURR: Well, if she were
receiving guideline-concordant care, she would
have a comprehensive evaluation that would go
beyond just the diagnosis of PTSD, but that
would look at the whole person, her social
circumstances, and help determine the hierarchy
of needs that she has.

19 With guideline-concordant care,
there would be shared decision-making, some
collaboration between the patient and the
provider or providers that are involved to help
determine the best course of action for her.

We would be recommending, as I
mentioned, if PTSD is the primary thing to
treat at that time, we'd be recommending,
according to the guideline, some kind of
trauma-focused psychotherapy. If that's not
what she wanted, we -- sorry?

CHAIR LEINENKUGEL: If you would,
please, just describe psychotherapy and a
psychotherapy session. I have no idea what
that means.

DR. SCHNURR: Okay. So I'm also,
for the record, not a clinician. I was trained
as an experimental psychologist. But I've been
hanging around with very smart clinicians, and
I'll look to Shira to correct me with anything
that I say.

But in psychotherapy, I mentioned
the word collaboration. Essentially what
you've got is a patient and a therapist talking
about the issues that are relevant to the
patient. Now, in good psychotherapy, no matter what kind it is, there's exploration at the outset to understand the person and their context and clarify what they want to get out of the therapy.

In the most effective therapies, people typically would learn skills and tools for understanding their thoughts and their feelings. To me psychotherapy is one of the most natural treatments around, because all you're doing is helping a person learn some skills to heal themselves.

So in the case of PTSD, I think what we're doing is treating a person who is stuck, whose natural recovery has failed and helping that person get back on their feet. The different theoretical approaches ultimately come down to enabling the person to change how they think and feel.

There may be exercises; there may be what is called homework, even, in some therapies to go out and do some activities.
Some therapies are just about the talking. But essentially what you're doing through this process is helping the person get back on track.

Now, that's my non-clinician view of what psychotherapy is, and Shira, if you want to add anything to I've said, I welcome that.

DR. MAGUEN: And I'm also very happy to work with the commissioners to do a presentation on the different types of evidence-based therapies in a very concise way, if we decide that's what we want to do.

I agree; in particular, when someone is homeless, we would really focus on the primary needs first, to really make sure that the person is in a stable environment. Sometimes it's very hard for people who are moving from place to place or don't have a stable base to do the kind of work that is needed for recovery.

So I think that really laying that groundwork first and working on some basic
skills that can help the person just cope with
the day-to-day stresses is really important in
a case like that.

From there I think that some trauma-
processing work can happen over time. But I
think, in terms of the nitty-gritty, again, I
can go over that with the commissioners later
about what those therapies would be.

CHAIR LEINENKUGEL: Let me provide
the outcome. This individual lives in Phoenix,
Arizona, and this lady went from being homeless
with a child on the streets, had no family to
turn to, because she did not want to actually
bring it to the attention of her family or
friends.

It was a VA nurse, during a homeless
stand down, who found her and took her in. She
went through psychotherapy, went through what I
call a partnership and collaboration with the
Arizona Coalition, who the VA nurse also
brought in. They are very close to the Phoenix
VA.
So it was a collaborative effort in getting her re-established for bringing her self-esteem back to where it needed to be, and right now she's part of the Arizona Coalition, working with the Phoenix VA, and it's one of those success stories.

Let me bring up number two now, and then I'll be finished. A male Veteran who comes in finally discloses that he has not slept well for the last 18 months. He has night sweats, tremors, temper. He has lost his family, and is by himself, because his friends can't stand being with him, and he can't relate to family and friends. He walks into a northern Wisconsin VA. How is that person -- I think I can ask you, Shira. How are they handled in a situation like that, using our evidence-based practices?

DR. MAGUEN: This individual just feels disconnected; that sounds like that's a key issue that they're presenting with, this disconnection from many sources, feeling really
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alone and isolated. Is that right, just to clarify?

CHAIR LEINENKUGEL: Yes, and also he could not get out of the trauma that he witnessed in combat.

DR. MAGUEN: I think, in addition to our evidence-based treatments, psychotherapies in particular, cognitive processing therapy, prolonged exposure therapy, I think that what we now have in our VA system is peers who can really assist with that isolation.

I think for a lot of people who come in with that perspective, really feeling disconnected, feeling hopeless, feeling like they are really struggling with even wanting to move forward in a lot of cases -- we've talked about suicide here, as well. I think that the key is that we use a multimodal approach with a person like this.

So it's not only about getting them into psychotherapy, but this person might not even be ready or willing to engage in that kind
of care. So I think that using the resources that we have available, using the peer support network, I've seen incredible work done with motivational interviewing or the motivation to engage in care, so to speak, where peers can come in and say, Look, I have gone through this. I know what you're going through, and here's what helped me. Let's talk through this.

I think that's something that we really want to leverage with those types of Veterans. Again, when we're talking about and thinking about systems of care, we have to use all of the resources available.

I've also seen incredible work done with -- if we think about the whole-health model, spiritual leaders too, which we have available to us at the VA. For some people, that loss of faith, depending on what that person saw in combat, we want to leverage those resources too. So having the person be able to think about how their spiritual outlook
fit into this, and connecting them not only
with one mode, but connecting them with our
system of multimodal care to get the person
engaged and ready move forward with any care.

CHAIR LEINENKUGEL: I did this
exercise for a reason. What a great response,
and I think what you just described is the new
type of care. This happened in 2010, eight
years ago, and the person was given two
different doses of drugs to include an opioid,
because he did have pain, and a benzo to help
anxiety and sleep.

So he became a wreck, and so he
disconnected from the VA, and was found by the
local police, and actually went into treatment.
But you have to remember, this was eight years
ago.

What has helped this individual turn
off all of his drugs was medical cannabinoid
oils. So that actually flipped the switch for
him in his case, because he probably never had
the opportunity to receive the type of
evidence-based care, and what I would call a little bit of integrated holistic care at the same time, and peer counseling, which we talked about yesterday.

So I sort of tricked it up here just to get a response, to let you know that I think the VA has come a long way in eight years. That's number one; that's the news flash.

But there are people still out there from a consistency basis, and you talk about guidelines that we may be missing, that aren't getting the same consistent type of approach on a medical-based, evidence-care background.

So I bring that up only for consideration from commissioners and experiencing this in the last 18 months again, my time within the VA, and some of the anecdotal stories that I pull from that; those were sort of the a-ha moments of how we need to do things differently, quicker, faster.

We have to have a sense of urgency. To do guidelines and evidence-based takes time.
So I think as commissioners, we need to ask ourselves, are we willing, 18 months from now or even before, to make some bold recommendations prior, to move things along, faster, or evidence-based trials, testing, for our Veterans' toolbox?

So I just wanted to give you my sense of where I'm at, and Jack, you probably want to add something.

MR. ROSE: Thank you, sir. One thing: Everybody in this room is different. Each Veteran is different, so I think the approach -- and maybe it's not all going to be evidence-based -- but you have a basic starting point.

And then as the individual comes in, will it be possible to provide that individual with something that works? What works for Matt may not work for Wayne. They're both Veterans, they've both got PTSD, and I think we can all agree, when you're talking about mental illness, behavioral health, it's not an easy
thing to diagnose.

I'm not a clinician, I'm not a therapist or a psychologist, but just as a family member, it's very difficult. So if we can have our folks who are in the field who are treating the follow who is coming or the woman who is coming in with a few more things to be able to help her out, I think that goes a long way. I don't know how it can fit into the system, but I believe it works.

DR. RODGERS: Thank you, and we totally agree with that, and that's why our guidelines say that that's what they are; they're guidelines. As Dr. Schnurr eloquently said earlier, they are not Thou Shall.

We recognize that every patient, every Veteran is an individual. Every provider is an individual, and their expertise and treatments that they might offer vary from provider to provider, as well. So they are guides to follow that are based on the evidence. The evidence says that this is the
best available treatment; however, we allow for
that flexibility for the individual.

We recognize that the best treatment
for them may not work at all, and that you may
have to do something different, and the
guidelines allow for that flexibility so that
we don't come along and say you're a bad person
because you didn't do the letter of the
guideline. It was never intended to be the
letter.

DR. SCHNURR: If I could just
emphasize that the best guidelines clearly
indicate that one size does not fit all, and
that the individual patient with mental health
disorder, physical disorder, needs to be
evaluated.

I can say, at least for the PTSD
work group, we talked a lot about this, and we
tried to write it into the guideline's DNA so
that people would understand the importance of,
on the one hand, understanding the best
evidence and the recommendations, along with
ensuring that the individual's needs, preferences, and such, were respected.

DR. JONAS: I think in the spirit of urgency and the fact that we have a system that is very rigid and structured, appropriately so -- developed over many, many years because of problems that have occurred by not applying evidence-based practice or not applying research -- that maybe a new paradigm and even how we do evidence to delivery needs to be accelerated, such as evidence-informed patient-centered care that maybe is defined a little differently than evidence-based guidelines in those areas.

I urge the VA to see if they can't accelerate the application of the kind of person-centered care we've talked about, because I daresay spiritual care and cannabis oil probably isn't in the guidelines, but it helped these people. So how do we do that without abandoning evidence?

CHAIR LEINENKUGEL: Dr. Schnurr and
Dr. Rodgers, thank you so much. You're probably going to hear back from us. We're going to corner you, just like we are the other presenters from yesterday, whether it was Dr. Stone, Dr. Clancy, Dr. Meyer; we need you to be actively involved along with this commission.

We look at this as a partnership for Veterans and for the VA going forward, so we're all in this together. It's not adversarial; you're providing the knowledge-based, what's happening today, and your future outlook as well. So thank you so much for taking the time to be with us today.

DR. SCHNURR: And I'll say thank you. We're very glad to assist the commission.

(Appause.)

CHAIR LEINENKUGEL: Commissioners, we have a 15-minute break, so please use it, and I'll see you back in 14 minutes.

(Whereupon, the above-entitled matter went off the record at 9:34 a.m. and resumed at 9:57 a.m.)
CHAIR LEINENKUGEL: I'm going to add one admin item at this point in time. I will be leaving to head downstairs to get the Acting Secretary, Peter O'Rourke, probably in the next 35 minutes.

Security will give me a call. So, during Fran's presentation, when you see me leave, I'll be right back with the Acting Secretary.

But at this time we have Frances Murphy, Dr. Frances Murphy. Who was in the background yesterday, because she has a significant role as far as support as well.

But she also has had a distinguished career and terrific background. So, if I may, let me read a little bit about Dr. Frances Murphy.

No need? Well, you're going to get it. You've had a distinguished career, Fran, as a health care executive, Board Certified Neurologist, and a United States Air Force Veteran.
Dr. Murphy currently services as President and CEO of Sigma Health Consulting, a woman Veteran owned small business. Congratulations.

Dr. Murphy is a senior health care executive with extensive experience in managing, operating, and transforming large programs in health care organizations.

Her experience is diverse. And covers the wide range of activities encompassed by the federal health care market.

This experience results in a unique ability to understand the global picture while being expert and knowledgeable about technical and scientific methodology in a rapidly evolving environment, which we're certainly in.

Dr. Murphy's current work has been focused on evidence-based medicine, patient-centered care, and mental health policy and program evaluations. She published numerous peer reviewed publications, book chapters, and reports.
And has had over a 20-year career working in the Department of Veteran Affairs at VA Medical Centers during neurological care, research, and education, as well as in the VA Central Office as a senior executive.

Welcome Dr. Fran Murphy. Fran?

DR. MURPHY: Well, thank you. Okay. I'm technologically challenged on a good day. So, having red to me means it's off.

But, anyway, so thank you very much. I'm delighted that Sigma was chosen as the Veteran owned small business to support your activities.

And we have a great staff who you've met this week. This presentation is going to be a little bit different then some of the ones you've had so far.

Because it's really focusing on what your charge is. And how we can begin to move towards getting you the information that you're going to use to make your decisions and recommendations.
I thank Dr. Rodgers and Dr. Schnurr for providing the great background in the evidence-based practice programs. Because I think that is at least a good model to get you the kinds of information that you can use.

And to begin deciding what the evidence is that complementary and integrative health treatments are effective.

So, with that, the aims of this session are to really review the part of your charge that is related to conducting an evidence-based review. To describe the proposed time line and the process for doing an evidence-based review for you.

And to tee up a couple of decisions that we need to make sooner rather than later. You've got an 18-month period to complete your charge.

And in order to get there, we're going to have to begin relatively quickly in addressing some of the issues.

So, I'd like to discuss with you the
potential scope for your evidence-based review. Some proposed key questions.

And hopefully, get your endorsement of some of those issues. So that we can move forward and begin the work.

So, this is -- okay. This is part of the charge. But, I thought we had swapped out this slide.

So, you are charged to examine the available research on complementary and integrated health treatments for mental health. And identify the potential benefits and including this list of therapies in treatment for Veterans who have mental health diagnosis.

So let's talk about how we can potentially address that issue. So, what is a proposed approach to conducting an evidence-based review to make that charge?

And I'd like to answer a couple of questions for you. Why, what, when and how?

So, why? Well, your charge is to examine evidence-based treatment models used by
VA for treating mental health conditions of Veterans.

And then to make decisions about what the potential benefits are of including complementary and integrative health treatments.

We've heard from the evidence-based practice folks that they do those analysis about evidence-based practice. And they've included some key questions about complementary and integrative health.

But many of the guidelines, the evidence reviews are several years old. And so they need to be updated.

We heard yesterday from the Office of Patient Centered Care. And they gave a very inspiring presentation about their passion for whole health and VA's implementation of that.

What was missing, in my view, is the fact that so far, neither the state of the art conference or the evidence reviews have really looked at the specific issue of mental health
And what the effectiveness is of the complementary and integrative health interventions in addressing whether mental health outcomes and patient centered outcomes for those individuals, are improved.

And that's really your charge. So, what are we going to do?

Well, we're going to do an evidence-based review for you. And the what is, an evidence-based review is a process that allows you to systematically look at the research, which you are tasked to do by the legislation.

And to make sure that you're gathering all of the relevant information. We're not going to cherry-pick certain studies. We're going to have an objective systematic process that minimizes the impact of any bias or errors. And to allow us to give you the information about what the evidence is, so that you can make relevant decisions.

The decisions are yours. Your
support staff are going to gather the evidence for you.

So, what about the question of when? Well, let's look at a potential time line. The star on this — this Gantt chart or time line, is where we are now.

We've been working for several months with the VA staff in trying to structure this meeting. And to help make some early progress on issues like the evidence-based review and the survey, which we'll talk about next.

And in order to complete the evidence-based review or the system map review for you to be able to make decisions, we need to begin relatively quickly.

And that's why I'd like to get your endorsement for the scope of the review. And the key questions, if possible, sooner rather than later. Today, if that is possible.

So, what's the process for the evidence-based review? These are the steps
that were on that time line.

As you heard from Dr. Rodgers and Dr. Schnurr, defining the scope of what you're going to look at is the first step. Then you develop key questions.

And the key questions are designed to make sure that we have a common understanding of what your priorities are. And what kind of research you want us to gather.

And the key questions really give us the opportunity to objectively and clearly define all of the different aspects of a search for the literature.

We'll then begin to review the studies that come back from that search. Including an abstract screening, a full tech screening, and then do a report on the evidence for you.

So, one proposed scope for the Commission's review is that since you're primarily interested in Veterans, we really should be looking at all adults over the age of
So the research we'll be gathering are -- will exclude children. But include all adult patients.

Now one of the options you have is to say, well no, I only want to see military and Veteran studies. I would recommend that you not do that.

Because I think the literature is relatively small. And I think in this case, the literature on any adult will inform your evidence-based decisions about the effectiveness of the potential interventions.

I'd also suggest that your charge says that you're to concentrate on mental health conditions. And to look at VA's evidence-based treatment models, and how they might be incorporated into those models.

So the conditions that I think are highest priority for you are post-traumatic stress disorder, major depressive disorder, substance use disorder, including alcohol and...
opioid use disorder, and suicidal behaviors.

There was some discussion yesterday about pain and stress as interest of the Commission. And I think that one of the slides that was shown on the clinical practice guidelines was the opioid therapy for chronic pain guidelines.

And the way the guidelines usually handle issues of associated conditions, or comorbidities, is that we'll focus on the primary condition.

And then within the guideline there may be a warm handoff to say, some of the guidelines related to pain is in this guideline and the recommendations reside there.

I believe it's outside of your charge to do a primary study of pain. But that's obviously a matter of discussion for this group.

At this point I'd like to stop and maybe get your feedback on this proposed scope. And some of your thoughts about what your
priorities are and how we can organize the work going forward.

Is that okay Mr. Chairman?

CHAIR LEINENKUGEL: Fran, that's perfect. And I think it's an opportunity for us to ask a couple of questions of Fran.

Because we are talking scope here. We are talking a compressed amount of time in that 18 months like we started the meeting off with.

So please, interject at this point. I think it's critical that all of us have a point of view.

DR. MURPHY: So, and if I could, I'll just add that one of the things I should have said when I brought up the time line slide is that the more conditions we include, the more key questions there are, the longer time it takes to actually gather and review that literature.

So, if we enlarge the scope, we're likely not to meet your 18-month time line.
CHAIR LEINENKUGEL: Yeah. You and I had this side discussion at the end of yesterday. So, I'll start.

And there was the question about pain. And I am a true believer, again, as a lay person, but just from my 18 months of experience in dealing with Veterans throughout the country, that there is a direct correlation with pain, opioid abuse, and potential suicide.

So that's where I'm at. I mean, we're going to be looking at opioid use disorder. Me not being a doctor, is smart enough to realize that if you're on opioids, you obviously have some pain.

So, if it's a disorder, I just put my lay person mind onto the subject saying that pain must be very much involved in this directly or indirectly.

My point of view only.

DR. BEEMAN: Jake, I'm not going to disagree with you because I'm not a clinician. On the other hand, I want to agree with Dr.
Murphy on this one.

I think that there's a cause and effect. You know, I think that you take opioids because you have the pain.

I mean, there's a lot of pain and stress in the overall environment. And I think if we studied all of it, we would be here the rest of our lives.

I like the compactness of this. Understanding that, you know, knowing about pain and knowing what are the precipitating factors, why people get suicidal ideation and everything, is a result of some of these other factors.

Where -- because I don't -- and I could be wrong, I don't look at alcohol use as exactly the same as pain. I look at alcohol use as a result of pain and stress.

CHAIR LEINENKUGEL: My point exactly. I concur.

DR. BEEMAN: Okay.

DR. MAGUEN: You know, one of the
things that I think has been the elephant in
the room is just the tremendous comorbidity
that exists. That we see on the ground.

And so, I think that, you know, for
me some of these complementary and integrative
treatments, so for example if someone comes to
me and they have PTSD and they also have
chronic pain and substance use disorder, I
think that all of those things we need to look
at together in order to develop the best
treatment plan.

And so just jumping ahead for
example, even if we're evaluating acupuncture
for this person. So the evidence for pain and
acupuncture is a lot stronger than for PTSD.
Which is insufficient evidence as we've just
heard.

And so, it's -- unless we look at
the whole clinical picture, sometimes it's very
hard to make those determinations.

And so, I'll just -- I don't have a
definitive thought about yes or no yet. But I
think -- I just want to put that out there.

That it's often times, the rates of comorbidity are so high that even if we're not looking at it, we're looking at it indirectly.

DR. JONAS: I want to concur with that. I see patients with chronic pain every week.

And the only reason they might not have a comorbidity is because I haven't asked them. Okay.

At least in my population. And in those areas. And I think very often, people with things that we're dealing with in mental health will come in with pain as the primary complaint.

Especially in primary care. And then we'll go down the path of treating that pain without actually getting at the underlying issues.

And then that creates problems. It even causes harm. I guess my question would be, is it redundant?
Hasn't this already been done? And if it's already been done, then why would we repeat it? On the other hand, if it's already been done, we can just build on that. So it shouldn't require a whole lot more work. So, that would be a couple -- and.

DR. MURPHY: So maybe, and I haven't practiced clinical neurology for a long time. But I used to run a headache clinic.

And a lot of my clinical practice was in the borderlands between, you know, neurology pain and mental health.

And I would just say that even though you may have a patient who has a significant pain problem, if the primary diagnosis is one of the four or five conditions listed on the slide, you structure the treatment plan so that you're addressing both the primary and secondary diagnosis.

But the treatments are different.

And your tasking is to determine whether the
complementary and integrative health treatments are effective in improving the mental health outcomes.

That doesn't mean that we can't look at what has been done by VA in the state of the art conference and other information that's been gathered by OP -- by the Office of Patient Centered Care, and incorporate, you know, this holistic model.

In fact, I would recommend that you do that. But, that work is, you know, related but preferable to your charge.

DR. JONAS: So, I'd say we need -- we don't have to repeat that work. But I think we need to make it a core part of what's presented.

Because we're going to have to take that into context. So, at least, I mean, if there are major updates that are required, then that's different.

But if we at least see what that information is as part of what's presented as
you go into these areas.

I will can -- I will make a prediction that you'll go through the entire review for these conditions for complementary and integrative medicine practices, individual practices.

And by the way, we're also asked to talk about models. Even more difficult. And we will end up in the insufficient evidence for everything in those areas. That's probably what will happen.

So we need to go beyond that to really do the acceleration that Jake and others described about in an earlier conference.

DR. MURPHY: And if the Commission wants to deliberate on the issue of pain further, what I can suggest is that if you could give us your decision that at least for mental health conditions, these are the issues that you'd like us to cover, we can begin this portion of the evidence review once we get the key questions set.
And we can always add other issues later after you've had a chance to look at the information gathered on pain by other parts of the VA organization.

CHAIR LEINENKUGEL: Fran, I think you're headed right where we need to be going. And number one, thanks for teeing up this slide.

Because this does define the scope. And I think that it hits everything that Tom, you agreed when you first saw this, right?

And the rest of the Commissioners as well, I think, are pretty good with that at this point.

To what Wayne just said, there should be some sort of studies and correlation. Especially out of opioids that you should be able to provide us by next month's meeting.

And I would say try it. You're going to have a lot more support from this Administration and from this Acting Secretary then before, Fran.
So, there will be a sense of urgency behind this.

DR. MURPHY: Okay. Back up --

CHAIR LEINENKUGEL: Fran, if you could, talk more into the microphone a little bit. Thank you.

DR. MURPHY: I'm not red. I was off.

(Laughter.)

DR. MURPHY: So, this is the legislatively mandated group of what they're calling complementary and integrative health interventions.

I will tell you that some of these things are really not usually considered in that bucket of integrative health or complementary therapies.

And I'll just point out things like the HBOT, hyperbaric oxygen therapy, and transcran -- transcranial magnetic stimulation. Those are a little bit, you know, different then some of the other integrative health
And I wonder what your thoughts are? We'll cover all of these. But it also says other therapies that the Commission determines are appropriate for study.

Were there other issues that were of particular interest to you? Under yoga, we cover yoga and tai chi.

Under meditation, would be meditation and mindfulness and other forms of meditation. But other things that are not on that list that are of very high priority for you?

DR. BEEMAN: I had talked to Jake about putting this on the record. So, I just want to just mention something.

I think family therapy, which I know is an accepted therapy. But is also part of a holistic treatment system, should be part of this.

And I would just make a comment. Nine years ago when the National Intrepid
Center of Excellence was put into place by the DoD, the Fisher Family donated 65 million dollars, or raised 65 million dollars to help the government get this started. For the past nine years, they've been accepting about one or two patients a day. So typically they have about 30 patients at any one time, in what is really basically a 30-day intensive outpatient program.

Almost all of these therapies, with the exception of equine and HBOT, is -- are used there. And so they have nine years worth of data.

It's populated by neurologists, internists, psychiatrists, podiatrists, radiologists, they have chaplains and a whole host of other folks.

And in addition to that too, they do virtual reality. Where they have experts that can recreate the events.

I'm not sure nine years into it what the data's suggesting. But they might make --
might have some very helpful information for your research into this for us.

To say, yeah, you know what, we've been using this for nine years. This is what we're finding. These are the results.

I can say that the patients they took were mild to moderate. They did not take the really intractable kinds of patients.

And they've had both men and women in the thing. So, maybe something to look at if you haven't done that already.

But, I just wanted to put a word in for the family therapy piece. Because I think all of these treatments are enhanced by the ability to have the shared experience within the context of family.

Thank you.

CHAIR LEINENKUGEL: Well, I'll make my pitch one more time. Yes, medical cannabis, synthetic cannabinoids needs to be included.

And will be included, at least from the Chairman's perspective. But I think Shira
also agreed with me.

That there's been some things going on. Even within the VA or with some VA doctors.

There are large groups of Veterans across America right now, one group that I will bring in, the Veterans Cannabis Project Group, with five Veteran heroes.

They're people that went and served multiple times. And came back and got their doctorates from either Harvard or Yale.

I mean, they're -- you would not expect them to be looking at cannabinoids. But they're very much involved. That being one.

Hyperbaric oxygen treatment. There are two large groups that have pinged to me for the past 12 to 13 months. They're becoming much more proactive.

They're gaining resonance on the Hill and also in states. So, whether or not we think that treatment works or has any evidence based to it at this point in time, it is not
relevant to me.

I think it needs to be explored, because I did listen to Veterans that have gone through different pressure treatments over various periods of times at different depth levels, per se, which is pressure.

That absolutely swear by it. Got off all of their opioids. Have less pain. Clearer thinking, et cetera.

So, it's all anecdotal. But at least it's something that's up there. And it's been put up there for a reason when this law was written two years ago.

DR. JONAS: Yeah. I'd like some time to look over this list. Instead of sealing it down right here.

I think the big risk, number one, is that we get into the this for that. Everything becomes therapy, a component.

And you go down the laundry list like this. And our first charge is actually looking at models of care.
And this won't allow us to look at models of care if we're simply looking at the components.

I think you're getting at it with family therapy. I mean, that's a system, a model of care.

We've seen several models of care already yesterday. A lot of them were described.

The one, I think, that has the greatest interest is this whole person, integrative health model. Which is a very different way of delivering the same kind of care that incorporates some of these and some of the conventional stuff.

That's why it's called integrative. And so we should look at those models of care and what evidence do we have for that.

Or gaps. What gaps are in those areas? So, I think we -- that would be number one in my opinion. Instead of just adding to this list.
With that said, I would add to the list. And I agree with you completely that cannabis, medical cannabis needs to be up there.

I think hyperbaric oxygen needs to be looked at because of the issues that have emerged since the last reviews.

I think spiritual care is a key issue. And there's various forms of doing that. Especially for PTSD.

There's retreats for example. Some of which have been studied and shown profound changes that occur through a therapeutic treating group.

Many of those are run by chaplains outside. So, spiritual care is a key component.

I think that -- I don't know if you pulled off the transcranial electromagnetic stuff. But there's a wider category, it's called CES, cranial electrical stimulation.

There was a review in the Annals
just a few months ago about that. And I think that ought to be on there.

Transcranial is a subset of that. But there are FDA, I don't know if they're approved or not, but you can certainly buy them online.

And the FDA has at least partly blessed things like Fisher devices and things like that. That, you know, for depression, for insomnia, for, you know, things like that.

So I think those ought to be looked at. If you talk to the nurses, they will describe, and the Hague Report had this on VA use, of things like therapeutic touch, healing touch for example.

It's a bioenergy type of practice that nurses deliver. And there are certifications for it.

There's been some randomized control trials on that. And we should look at that. And then osteopathic aspect.

I know chiropractic is considered
already there. And so is off the list. But osteopathic manipulation, cranial especially and others, is used for these areas. And so should be on the list.

And then I'd like to look at it further.

DR. MURPHY: Thanks.

CHAIR LEINENKUGEL: Thanks Wayne. And I have Sheila taking some notes. And she added those as well. Thank you.

DR. MURPHY: And we'll be going back to Sheila with questions about, you know, how far we can go. Because it affects, you know, how many people we need to put on this.

DR. JONAS: That's fine.

DR. MAGUEN: And just to add to the models, you know, one thing that we should do too, is there are eight modalities that whole health recommends too.

So we should look at the list, this list and compare it to that list to make sure we're hitting all of those issues as well.
DR. MURPHY: I'll ask Allison to help us with that.

MR. ROSE: Mr. Chairman, I also would recommend what my fellow Commissioners and lady have recommended here. We're at the start.

We need to take a little bit of time until we shoot out of the gate. I don't know. And I don't know how it's going to impact. I hope it won't impact, I mean, we have a deadline.

That's it. We got to make that deadline. Thank you.

COLONEL AMIDON: Mr. Chair as well. I just want to make sure in the search for the perfect we don't forego the effort that could start right now.

So given that there's a list right here, I suggest we move forward sufficiently to do so.

Secondly, I just wanted to make sure I understand the assumptions and the terms.
You're going to look for formal study output in support of this?

DR. MURPHY: We should go over this.

COLONEL AMIDON: Okay. Well, then my question being then is, I know within each one of these, as an example, of organizations out there doing the work that are attempting to capture data, but haven't formalized data output yet.

And in doing so, I think I know of two cannabis studies ongoing right now. And I would like to recognize one of the public members in attendance today if I could, Mr. Chair.

CHAIR LEINENKUGEL: Please.

COLONEL AMIDON: Dr. Heather Kelly from the APA. Thank you so much for being here.

And I just wanted to say, Dr. Kelly since 1998 has served as a senior lobbyist in APA's Science Government Relations Office.

And in addition, her new portfolio
includes advocating for the mental health and
well-being of military personnel, Veterans and
their families. And communities that have been
supporting this, psychologists that serve those
who served.

So, it's very nice to have a
professional organization in attendance today.
Thank you so much.

DR. MURPHY: So, to answer your
question, we're going to be looking to gather
the published literature for you.

We -- you know, you can certainly
look at non-published work from either the
NICoE or other organizations.

But really to determine whether
these treatments are effective, you've got to
go through a formal process. And part of that
process, after we've developed the scope, is
developing the key questions.

And those key questions will guide
the review process and give all of us an
understanding of what your objectives and
priorities are.

So I'd like to walk you through that next step. And we've done the --

CHAIR LEINENKUGEL: Fran, could I interject for just a minute and give you a ten minute break while I bring in the Acting Secretary?

We have him scheduled for 10:30.

DR. MURPHY: I assumed that I'm stopping here. He takes over, and I'll finish when he stops.

CHAIR LEINENKUGEL: Perfectly. Let me get Mr. Peter O'Rourke.

(Whereupon, the above-entitled matter went off the record at 10:31 a.m. and resumed at 10:35 a.m.)

CHAIR LEINENKUGEL: All right, we are back in session after that five minute break.

This is a public session, so we are on the record. There are public observers.

And, I have the opportunity at this
point to introduce a friend of mine that we've gotten to know over the last 19 months.

Peter O'Rourke brings a highly diverse skill set in transformation, innovation and leadership honed by over 27 years of demanding fields and challenges.

He served in the military as a Navy enlisted plane captain, an Air Force officer and logistician.

He is a Lean Six Sigma Master Black Belt and has held positions in consulting in government service including service as Senior Policy Advisor, Congressional Staffer and Executive Director for nonprofits focused on generating support for federal government efficiency.

Peter has served as the VA Chief of Staff from February 16, 2018 to May 29, 2018. And, in that short period, I can tell you he helped oversee the Department through the appointment of Acting Secretary Robert Wilkie, now to be Secretary Robert Wilkie.
And, was instrumental in finalizing VA's electronic health record modernization contract as well as working with the White House, Congress and Veterans service organizations to secure the passage of the landmark VA Mission Act.

Prior to becoming VA Chief of Staff, O'Rourke served as the first Executive Director for the VA's Office of Accountability and Whistleblower Protection.

And, in that position, he established and led this new office to which is the first of its kind in federal government.

In this role, he quickly became a trusted advisor to many leaders throughout the Department on accountability and culture issues.

Mr. O'Rourke is a 1998 graduate from the University of Tennessee and United States Air Force Institute of Technology in 2005.

At this time, it's my pleasure to introduce my friend and Acting Secretary, Mr.
Peter O'Rourke to the Commission.

(APPLAUSE)

CHAIR LEINENKUGEL: You do know that you have to turn this on.

MR. O'ROURKE: Is it red now? Okay, good. Red usually means stop, which for me, talking I should stop.

No, thanks, Jake, I appreciate that. I bring greetings from the incoming Secretary, Mr. Wilkie who, all indications are, he'll be sworn in on Monday, so that's -- we're all excited about that and especially me.

Being an Acting Secretary is a great honor from the President to fill that gap, I guess you could call between the times. But, I can fully appreciate what it means to run an organization with the scale, the geographic scope and everything else that goes along with the serving Veterans.

So, it's, like I said, been an honor, but I am very much looking forward to supporting our new Secretary as he transitions
in and continues on the good work that we've started here that I know that you all will -- are beginning today and will continue to do. It's an area that we all are familiar with and I think has probably touched us in a lot of different ways.

Prior to this -- prior to these jobs, I'm sure throughout our life, I'll tell you one quick story that is pretty recent for me and, for me, is probably going to be a very informative one.

I got a chance to speak with folks at DAV at their convention a couple weeks ago and prepared the speech and, you know, go through all that and you're hitting the points about the different DAV's a lot focused on, you know, claims processing and things like that.

So it was good to highlight some of the good work that folks at the Veterans' Benefits Administration is doing and highlight that with that with this group and talk through some of those issues.
But, one of the things that I talked about in the speech and I'll the story, I wasn't really prepared, I mean, I knew the issues, I had looked into the suicide statistics and all those things. In fact, I had gotten the full brief on the new CDC stats a couple weeks ago and they're heartbreaking, wrenching.

I mean, it's what we would expect being human. But, what I also didn't realize when I became the Acting Secretary was the alert message on suicides that happen on VA campuses. They come direct pretty much the day of. I'll see those and read the initial details and then get the follow up and stuff like that.

And, the Thursday prior to -- the speech was Saturday morning, Thursday prior I had gotten the one notice about a 77-year-old Veteran who had attempted suicide and I don't really even want to have to go and do the follow up to find out if he was ultimately
Thomas “Jake” Leinenkugel

successful.

But, he had made a good effort, I guess is the way to put that.

And then, Friday, got the second one of an 86-year-old Veteran who was successful in suicide.

I remember getting the first one of those roughly a few days into this job and I remember being very engaged in the sense of wanting to know the story, what was going through this person's head.

You know, they had just walked out of the VA, walked to the parking lot, took their life. What was going on? What was their diagnosis? Looking for insight, looking for a reason, which I think is probably everybody's reaction when they get into this. Why? You know, answer that question for me.

And, so, got those two emails Thursday and Friday and it kind of just weighed on me. And, you know, the speech was good, I had practiced it a few times.
But, I woke up Saturday just thinking, you know, you've got to say something about this.

So, I ad libbed a little bit at the end of the speech and really used a friend of mine who's a 86 -- or an 80-year-old Veteran who I've known for quite a long time and talked about Ed.

You know, Ed and I talk roughly at least once a week, share a few emails. So, we're in constant contact.

He's gone through a couple bouts of prostate cancer, some of other stuff. But, he's still kicking. He's an old Marine so he's not going to get taken out that easy.

But, it's always getting with him. And, he's gone through a couple periods where, you know, it's just weighed on him a lot. And, you know, we've had some good conversations, just kind of being a friend kind of thing.

And, he's got plenty of folks to talk to, too. But, it was that engagement.
So, I encouraged the folks there not to follow my example but, just, you know, they all know people like that and that are struggling or could be struggling, just reaching out to them and kind of just ended it there. It was kind of clumsy, but it was just ad libbed, but it was what was on my heart at the time.

And, Garry Augustine, who's the National Director for them, comes to me at lunch, we had lunch with Chairman Roe and so, he wanted to pass on to me that, evidently, there was a Veteran in the crowd, a mother who was notified that her 32-year-old son had committed suicide.

And so, of course, he tells me this story and he said how they, you know, had some mental folks there from the local VMC and took care of her and they were, you know, just concerned about her. But, you know, basically, he was highlighting how she was getting taken care of.
Of course, I felt like absolute crap. You know, I figured, well, tore open a wound that was probably pretty fresh for this lady. You know, I just felt like crap.

And, I said, really? I mean, and I told him that, I said, man I feel bad now for even bringing that up.

He goes, no, no, she got the call after your speech. Literally about an hour after the speech wrapped up about -- probably about 9:45, 10:00, sometime between 10:00 and 12:00, she got a call that her son had committed suicide.

Both were deployed -- had been -- had deployed to Iraq and Afghanistan, both were Veterans.

So, it still felt just as bad, but it was -- it really kind of highlighted that stuff happens and for reasons that we're still struggling to understand.

So, that leads into the work that you all are doing both on the therapy side but
also to help us, you know, promote from our perspective, I guess, from the VA on how we can do more, what we can do effectively, how we can get the word out.

I don't know how to tell these stories other than just to tell them and encourage folks to do everything they can.

I know there are scientific things we can do. We can be smart about things, we can look at data.

I guess from the layperson's standpoint, from my perspective, it's just, you know, how do you engage with people on the frequency that you do it and those things.

I don't think those are solutions. I think that's just a reaction to it and kind people on emotionally driven human nature stuff.

So, anyway, so that was -- that part of it getting into the important work that you all will be doing, I can communicate a few things.
One, you have a 100 percent support from leadership of the VA. Unquestioning, unqualified. I mean, it is whatever you all need to do this work, you're going to get.

We all take this -- I know Mr. -- I'll speak for Mr. Wilkie and the rest of the leadership team. I mean, this is always top of mind for us and probably the most frustrating thing that's top of mind because this is something that we don't -- that we struggle with, especially after learning that, you know, really suicide rates haven't changed.

Mental health struggles across the Department while we invest in it, we work, we try to hire, we do all these things, still, you know, it's a battle that keeps going.

So, you have that support.

As we, you know, change, which is inevitable in any organization this size, we want to make sure that we're cognizant of what you learn and what your recommendations are.

So, I can also tell you that, I
guess, Boomer can attest to this, one of the things that we changed at least when I got here and I'll make the strong recommendation to Mr. Wilkie is that we, as a leadership team, as a Secretary, Deputy Secretary, Chief of Staff, you know, those are a leadership review your findings and, frankly, review them uncoordinated, or whatever you want to call it, unconcurred on.

I'd like to know exactly what you guys are saying. I don't need an administration to Vet it for me. So, I'll encourage Mr. Wilkie to do the same thing. I think he'll be right on board with that.

So, I want you all to have the assurance that your recommendations, your comments, your feedback, whatever form that takes comes to us directly.

We'll still have the concurrence process and all that good stuff, that's appropriate and proper. But, at the end of the day, these are hard decisions that have very
real consequences. So, you all deserve to have those hears unfiltered.

So, and participation with these meetings. I mean, I know Jake and I know how aggressive he is, so I will not set myself up to coming to every single one of them, but I promise to be to as many of them as I possibly can. And, I know Mr. Wilkie will feel the same way as well as the rest of the team.

So, you will get the support from us that you need. And, if you ever don't just let us know.

With that, I would love to hear any questions you all have, anything you want me to pass on to the new Secretary? Any comments? Any feelings? I'm open to listen.

CHAIR LEINENKUGEL: Mr. Acting Secretary, if I may, let me start with my Co-Chair, Mr. Tom Beeman. I already introduced him, but, Tom, very briefly, in 30 seconds or less, an overview for Peter, if you will, on your background and why you're part of the
Commission?

Then we'll go around the table. There's actually, Mr. Acting Secretary, there are eight out of the ten designated spots filled at this time. We have a quorum.

I can tell you from yesterday's meeting, this is a very active, proactive group. It will be stimulating and I was so happy to hear of the approach that you have and that Secretary -- Incoming Secretary Wilkie will have.

And, my intent, even though I'm not mandated, only by letter after 60 days of meeting, was to give you a brief overview of whether or not we're receiving the proper support, not only from the VA, but any other agencies or governments departments that need to provide us materials in a quick, responsive way.

I told Dr. Stone yesterday that, because of his VHA duties, that I would be giving him a monthly, if not weekly, briefly on
if there are any roadblocks or barriers and if
he could deal with those and he immediately
said, absolutely. And, I plan to do the same
with you and the Secretary.

DR. BEEMAN: Tom Beeman, glad to
have you here, sir.

I'm a 27-year Veteran of health
care. I've been a CEO of Health System for the
last 27 years or so. I'm with Penn Medicine.

I was also the Assistant Deputy
Surgeon General for the Navy. So, I'm a
retired two star.

And, I was the first Commander of
the National Intrepid Center of Excellence
which really has helped inform my work.

DR. MAGUEN: Hi, so glad to have you
here. I'm Shira Maguen. I'm working at the
San Francisco VA.

I am a clinician, a researcher and
also do training for our trainees, both
psychiatry and psychology.

I'm a clinical psychologist by
training and have been in the VA since 2001. So, really glad to be part of this. And, an open invitation to come visit us.

(OFF MICROPHONE COMMENTS)

MR. ROSE:  Good morning, sir. My name's Jack Rose and I'm a 26-year Veteran with the Navy. And, I've been involved -- also from Wisconsin.

And, a mental health advocate. And, I've been involved with the National Alliance on Mental Illness here since probably 18 years. And, I look forward to supporting this Commission. And, thank you very much for the opportunity.

DR. KHAN: Jamil Khan, United States Marine.

(OFF MICROPHONE COMMENTS)

COLONEL AMIDON:  Good morning, sir, Matt Amidon, U.S. Marine as well.

(OFF MICROPHONE COMMENTS)

COLONEL AMIDON:  I wasn't down in Dallas, no, sir. I was actually out on
military duty and this is why this is near and
dear to my heart.

On the last drill weekend less than
a week ago, we had a memorial service for a
young Marine who decided to take his own life
in the barracks in Fort Worth.

And so, it's deeply meaningful to
me. But, you have a chance to hear about what
we do at the Military Service Initiative.

And, I think we uniquely exist to
the benefit of this Commission at the
intersection of public and private and provider
and consumer. And so, can be an important
broker in this effort. And, I'm deeply honored
to be here.

Thank you.

DR. JONAS: I'm starting to feel
lonely here, I'm Wayne Jonas, United States
Army.

(LAUGHTER)

DR. JONAS: So, and I think the only
physician on the panel actually. I'm a primary
care doc. I still see patients at Fort Belvoir which is a purple suited training program actually up there.

And, one of the biggest primary care training programs in the DoD anyway.

And, also have a long history of research at Walter Reed, NIH, Uniformed Services University.

I now run a foundation that supports Veteran area, DoD areas in the area of whole person and integrative health. And, I practice that in the military hospital near here.

And, so, really would like to see -- just so supportive of what Jake's doing and the Commission is doing to try to accelerate care, not only for our Veterans, for our nation which deeply needs this.

CHAIR LEINENKUGEL: So, I think you can see, Mr. Acting Secretary, that this is just a solid group and we're going to add to this group over the next 30 days as well.

There is a person I want to
introduce you to that's in the bullpen right now warming up and not officially vetted. So, when we're walking out the door, I'll bring out this person to introduce him to you.

That being said, thank you so much for everything that you have done for your 19 months of being within the VA.

And, I want to tell the group this. Peter O'Rourke was the quiet one when I first came in in January of 2017. And, found out to be the smartest one and the hardest worker.

As he told me, I may not be the smartest person that you brought in, Jake, but I'll be the hardest worker. And, he was that.

And, I gave Peter two assignments, and he completed both of them. And, one assignment was to get the Veteran ID card off the ground that was languishing, again, for two and a half years with nobody taking ownership and the Hill demanding for the VA to finally take action.

Peter took action and did it within
six months. I have my card. I know Veterans that are receiving their cards. They think it's the best thing since VA health care.

   Even though it gives them a 10 percent discount at various stores, but thank you for that.

   And also, setting up and watching him set up the Office of Accountability and Whistleblower Protection is a well-kept secret within the 15 mile radius of Washington, D.C.

   And, the people that he brought in and how he has done a great job at bringing in some of the best and brightest to set this office up. He is fantastic.

   And, you've got to remember, it's just starting. And, I think it's going to be a best practice in years to come and Peter O'Rourke is the one with the thumb print on that.

   So, Peter, thanks for your service and thanks for being a fantastic Acting Secretary to calm the waters over this period.
and get the VA on the right mission track again.

And, this Commission, as the COVER Commission, is very much a part of where we're going to be going in the future with health care.

Thank you, sir.

MR. O'ROURKE: I don't know if I calmed the waters as Acting Secretary, but I definitely stirred up the waters a little bit.

(LAUGHTER)

MR. O'ROURKE: But, that needed to be done. So, no, I appreciate that, thanks.

Any questions from anybody? I know it's still probably new, but anything you want me to take back? I'm more than happy to do that.

DR. JONAS: I'm sorry, I didn't mean to -- I don't mean to jump in here too quickly, but I did have a very specific question, but I need to tell you why I am asking this.

So, I was down at the St. Louis VA
about two months ago looking at their whole
health program doing a deep dive in there.

And, there was a Veteran panel they
had set up, using varies panels to look at.
One of the Veterans, long hair, tattooed,
former Marine guy, okay, had -- was coming in
for his back pain. And, he had chronic back
pain, had multiple interventions and
treatments, still had chronic back pain.

He met with a peer to peer
counselor, okay, and did a personalized health
plan which is what they are doing down there,
we're interested in.

He got a personalized health plan
and the peer said, why don't you come over to
the yoga class with me? He said, yoga? Are
you kidding me? No, just come on over, we'll
try it out.

He started the yoga class, his pain
improved and then he said something that just
startled everybody in the room. He said, yoga
saved my life.
And, I said, what do you mean? And, he said, I thought about suicide every single day before this class and I would never tell anybody about it because I know what happens when you tell them that. Okay?

And, we were just stunned. Okay? We're going to get an evidence review that is likely going to say, yoga does -- there's insufficient evidence to use yoga for PTSD. Okay?

So, my question to you is, how are we going to -- how is the VA and the nation going to determine value on investment? And, I use that term specifically over return on investment because we're looking at value which has to hit at something.

And, Drew yesterday put me in touch with a great study done in 2007 where they looked at designs of health care around that.

And, as someone who's going to be looking at accountability, how are we going to actually measure the accountability issue when
it comes to value on investment for something like that?

MR. O'ROURKE: So, there's yoga, there's hyperbaric, there's -- and these are things that I'm new to. I'm not a clinician, obviously, but I've heard those and you see the stories.

And, I've talked to Congressmen that -- and women that have their opinions about things with -- that are light on the scientific data side.

I think this Commission is going to go very far with providing us the qualified reasons why we should do these, maybe not the quantified.

And, I relate that back a little bit to what we're doing in benefits, actually. Because we do the buddy statements and things like that. I mean, when there was no record, when there's those, we've expanded to provide different methods of justification or different methods of validation of those verification of
I don't know what the answer is, but I know that getting a group like this together to start advocating for it in an organized way, not an average see from the outside in saying, you know, hey, this is great, it's the only thing that worked, you know, take Vitamin E all day, you'll be fine sort of thing.

More recognizing what the effect of long term war is, because we can't quantify that either, by the way. Right? I mean, I haven't seen a study. We see anecdotal type things, things like well, what really happens.

I mean, if we want to go back in history and look at the Spartans or we want to go back and, you know, Greek and Roman history, I'm sure we could, you know, come up with stories about the long term effect or go back to World War I, which ever.

At the end of the day, it's more of the organizations, plural, so it's us and DoD and by association, the rest of the federal
government saying, let's just be honest about this with ourselves.

What is our mission really going to be? What are we truly going to do for Veterans and what are we not? Are we going to encourage them to go do things or are we going to mandate it, i.e., fund it for them?

So, I think those are the harder questions that we really have to look at. And, I mean, we have this debate right now with the presumptions and, you know, types of health care, things that we're going to take care of.

So, I think those are open questions for good conversation for debate for as much evidence as we can find and then we just really taking our Veterans for who they are, what they are and then just dealing with that and making this really focused.

Because, for the one Marine that yoga, you know, he admitted it, we'd probably have ten people that wouldn't admit to that. And, then, a few others say, no, I didn't even
think about that at all.

And, half of those like the yoga and half of them say, no, I'd never do that.

I mean, there's going to be a lot of variance in that. And, at the end of the day, if it's a personal lifestyle choice kind of thing that's going to help them, I think we should encourage all good type things.

I mean, if we can define that it's good, of course, we encourage it. Of course, that's a cop out answer, right, because it's not, okay, yes, but are you going to fund it?

Are you going to make it a benefit?

And, that's -- then we start crossing lines into other broader conversations of exactly what benefits are we going to provide and is it, you know, earned in that?

We'll leave that for later on.

I think what work that you guys are doing are going to help us with the validation of, yes, these are things we should do.

I mean, I sat with the folks from
Columbia that are developing the equine therapy handbook, you know, the actual observable, you know, responses to that and how should we do it.

And, I'm pretty sure they probably just kind of skipped over that. Can we actually say, playing with horses is going to, you know, do X, Y and Z? Or just result in X?

And then, kind of just jump to, it's like, hey, it's observable. It's kind of like what we are -- we have puppies now in the lobby every month. I hope it's every month, because that's what we all kind of decided to.

Not because we have a scientific study that says playing with puppies is great, but anybody can walk in the lobby on the day that the puppies are in the lobby and realize, oh my gosh, the morale of all of our employees at VA just went through the roof.

Now, that may have only lasted for about ten minutes. As soon as they got in the elevator and got stuck there for a few minutes.
But, for that brief moment, those puppies made their day.

I think it was the same thing we observed with horses and everything else.

I mean, there's things that we just know. Do we need to study them to death and 25 years later realize that, yes, this is something we should have been doing for the last 50?

I mean, that's for us to provide reasoned arguments and as much qualified or quantified data that we can and then let politicians decide what they're going to fund or not, what we can encourage.

Because, I can encourage a Veteran, hey, go play with some puppies, go ride a horse. And then, maybe find a charity that'll help them do that or find other methods for them to get that done.

If we know these are good things to do, then that's things we can probably get out through our systems and we can start doing...
We're a pretty scaled up organization. So, if we just say, hey, this would be a great thing for a Veteran service organization to help us do, I mean, that's where kind of the experience for the Veteran ID card came in is, yes, we had a funding problem with that and that's what was the major roadblock.

Because we connected over our own internal roadblocks we set up, whether they were the way we were trained to develop the solution or just the legal part of it. And, it was just -- we just can't do it.

And, I said, well, let's just find somebody else to pay for it. And, we did that.

And, I had -- I still have attorneys that yell at me because I -- you can't do that, you have to charge the Veteran. Because, it actually says we are supposed to charge the Veteran for that?

And, of course, when Jake and I saw
it, I was just like, this is absolutely insane. I'm not going to ask somebody to pay for a 10 percent discount. I mean, it was just ridiculous.

So, when we had somebody from the private sector who said, yes, sure, we'll pay for that. Okay, let's do that.

And, the Secretary has those flexibilities that has that flexibility to accept in kind and in cash to do things for Veterans. There's a process for doing that, let's just do that.

So, I think we have more solutions than we give ourselves credit for for some of this that we get stuck on the science sometimes. And, I don't mean to offend anybody that does that.

I mean, but, we do, right? We get, you know, the paralysis by analysis kind of thing. It's, you know, funny consultant type thing. But we do that sometimes with solutions is we just don't want to sometimes get there.
We're -- I think what you guys are going to be promoting is let's just get there, let's just do it and we'll figure it out.

DR. JONAS: That's wonderful, thank you.

If we were to point in the direction of here's some outcomes that everybody wants, you know, something along lines going, could -- would that help the VA and sort of build a flexible system that could say, all right, let's innovate. We can look at all kinds of innovative programs that might get at those outcomes as long as you show you're getting those outcomes.

Is that something that the VA is --

MR. O'ROURKE: I would much rather go to The Hill to advocate for a million dollars to try something that we really think are going to work than hide hundreds of millions dollars under things that I didn't realize we wasted money on.

I'd rather be intentional with it.
and just say, yes, I'm going to go spend this money on this. I don't know if I'm going to get the exact outcomes, but I think it's going to be good for Veterans. I don't know a politician that wouldn't buy into that.

It's good transparency and, frankly, it's a great argument. It's a whole lot more interesting to talk about than some of the other things we have to advocate for for money. It's much more fun than an IT project, I know that.

MR. ROSE: Sir, if I may, along with this cross item that had come up, if we can look at it like increasing what we have in our toolbox to help the Vets and in lieu of costs that we might have spent on something else, I don't know, if we could just give it a little bit broader range.

MR. O'ROURKE: Yes, when we figure that part out, as narrow as that is, then we have found the Holy Grail of arguments on that.

I think the metaphor on the toolbox,
though, what's interesting and what I found in the little bit of traveling around that I have is that our VA folks probably do that to spite us.

Because, if they see something that works, they're usually are going to do it. Now, that's the good part about some of the independence of the way we're structured and also there's some negatives to that as well.

So, I think if we focus on that as really the drive, the initiative for these things, there's putting more in, some of these we'll want to mandate, right, and that will kind of cross us into that, well, okay, if you're going to mandate it, you better pay for it kind of thing.

We have lots of unfunded mandates anyway. So, I don't really usually buy that as an argument.

It's going to be compliance and accountability for those things. We can find the money usually to do them. And, usually,
some of this stuff, I mean, yoga, I'm sorry, my wife does like a bar class. It's, you know, $10 a class. I mean, we're not talking about huge --

I mean, I'm -- well, I should back up. I mean, we're the federal government, we can find a way to make yoga really expensive, I'm sure. But --

(LAUGHTER)

MR. O'ROURKE: -- maybe we can, you know, just farm that out and let the private sector do the yoga stuff and we just encourage them, maybe give a little, you know, way to do that.

But, I remember when we had the first chiropractor at Wright-Patterson, it was hilarious just talking to him about how his whole thing was working.

Because he was the brand new thing at the time and, you know, you all are more familiar with the history of chiropracting than I am. But, it was just interesting to hear his
travails and just trying to say, hey, I really think this can help people and, you know, and just --

And, we was there for six months and they booted him out. I don't know what happened. I'm sure they brought him back at some point. This was a while back. But, it was interesting.

DR. BEEMAN: Just a comment, sir.

I mentioned this to Jake earlier and I hope it doesn't offend Dr. Jonas at all, but I think we might be on the same wavelength. And, I'm speaking as a person from a major research institution having done my Doctoral work at another one.

And so, and that is, is it possible that the skepticism that appropriately characterizes modern medical science has led to cynicism when it comes to complimentary medicine?

Because, modern medicine is reductive, modern science is reductive and,
really, what we're talking about is more holistic.

So, it's almost impossible to prove some of this stuff except anecdotally. And, I think that that's what you were saying, Dr. Jonas, is that, you know, we see stuff and it works.

You know, all you need to do is get on a horse and realize that the worst headache in the whole world is cured within about five minutes because you start riding and you become one with the animal.

I do that all the time, that's how I reduce my stress. But, I can't scientifically prove that other than I know that it happens.

So, I'm glad to hear that you're open to that because I think there's a lot of things that we can do that treat people as human beings.

And, this goes back to one anecdote I have to tell you. I went to see physiatrist and a neurosurgeon about my back pain, my lower
back pain. And, he said, you know what? You
don't need surgery, you need yoga.

    So, I went home, I told my wife.
She said, I've been telling you. And, I did
yoga for about a month, no back pain. I
haven't had back pain in at least five years.

    And so, no intervention, no real
cost to the system, maybe a little personal
cost.

    So, I think there's a lot of
opportunity, but we just have to really grab it
and put it out there.

    MR. O'ROURKE: You said something
that struck me and it's just for conversation.

    So, treating the whole person as a
human being. When was the last time we did
that in DoD? We tend to do the exact opposite.
Right?

    I mean, you're an instrument. So,
it is really a huge culture change. And, for
the person, right? I mean, they're used to
that, that we all grew up in that kind of
culture.

And now, we're coming to the VA asking people, you know, treat me as a human being. There's a cultural part of that, the change over.

And, what you brought out, and I'll let you guys fight that one out, but the reductive or not. But, it really is that your willingness or your ability to say, oh okay, I'll try that.

Or, is that what you even really want? Or do you want somebody just to listen to you? I'm in pain both physically, maybe mentally. I'm frustrated with life.

One of the things I have struggled with here, and especially -- and it kind of goes back to the story about the older Veterans, everybody has, and maybe this is just a person that already has this sort of mental image when they hear about a Veteran suicide.
And, I guarantee it's not an 86-year-old person unless you're familiar with the statistics.
Usually, you think, oh, it's some, you know, I watched a movie and it's some kid that got back from Iraq and just can't deal with life, comes back and kills himself. That's the --

You know, or we've put him on meds and that's the kind of thing.

I've thought about this and, okay, somebody serves four years, six years, they get out, they go on with life.

They hit 42 and life kind of crashed in. They go through a mid-life crisis, whatever else, financial difficulties, whatever and then they consider suicide.

Completely decoupled from their service. I mean, this has nothing to do with -- I say that, maybe it's over simplification, but I mean, there's been enough time that's passed between their, you know, maybe they reflect back on that, but it wasn't enough trauma during that period that they were having those issues right after.
But, there's still one thing about them that makes them unique, at least from our perspective, they're still a Veteran. So, do I care about that person that has -- that Veteran who's mental health issues are not related to necessarily something I can pull a string on back to their service?

But, they're still a Veteran, they're still suffering. Do they come to us for -- do they come to us? Do they go to somebody else? Do we not have an equity in that person at that point?

You know, that part of it kind of plays into that, you know, somebody offers you -- it's not surgery, it's not drugs, whatever. Hey, go do yoga, go ride a horse, do those things.

Maybe that's not what they want to hear right then. I want somebody to listen to me, I want somebody to help me, my life's falling apart.

How do we recognize those things?
Or are we just focused on, well, your back pain, okay, you can get surgery, you've got a bulging -- oh you can do this, here's your options and then that's -- we just walk away from that, we just focus on that.

Which leads to just like what you said, I mean, I made a decision to go do yoga then a month later, I don't have the pain. Whereas, you could have just -- I'm sure you could have gone to other doctors who would have said, sure, come on we'll do laser surgery, we'll do some kind of surgery, something to you.

So, it's that mental state on some of those scenarios that are interesting to think through because, I don't know where all these folks are coming from.

And, that maybe the bigger picture is really determining where they're coming from and getting them into the right kind of care that they may need, that kind of stuff.

I don't know if even we're, as an
organization, our science, we're flexible enough to do that.

Those are some of the things I would love to start having a better understanding on or maybe I'm just, you know, don't read enough journals or something.

But, those are the kind of things that I hope we're smarter on through this process.

DR. JONAS: Sir, thank you for that answer. I'm totally on board with what you just said, I'd like to talk to you more about that.

MR. O'ROURKE: Good thing you're in the same room.

DR. JONAS: You know, I want to take a bit of an issue with something you just said about whole person care.

So, I practice in the DoD, I've seen folks working in the VA. They are taking care of whole people every single day. We are taking mind, body, spirit care every single
day. Okay?

But, we're doing it in a system that makes it really, really hard to do. And, that's the biggest -- that is the reason that the 50 percent of primary care folks, nurses, et cetera, are burning out. Okay?

We need to create it so it's easy to do. We need somehow an accountability ruler that says, as long as you hit these milestones in terms of quality, costs and outcomes, you can have the flexibility to do it through any path because we need multiple paths.

We need somehow to structure our system in a way that it brings in the evidence, but isn't tied to it as the only thing that's going to get paid for.

We need to somehow get an innovative model that allows for the whole person care to work better for what people are trying to do every single day, in my opinion.

So, can you bring an accountability ruler?
MR. O'ROURKE: Yes, I mean, I just ask why? I mean, why don't we have that system? If everybody's doing it, right, so here's the part that I just way over simplify, look at it, if that's the -- not if, but that's the case, why has there been no substantive reaction by the rest of the system?

The measurement system of that, you know, the payment system, what all those others are? Or, do we really just have two factions fighting against each other so would limit us in some places we don't actually do all that.

That's what I would lead to, typically an organization, right, if you're producing something a certain way, the rest of the organization eventually has to be forced into or is forced into some sort of alignment whether it's completely ineffective, whether it's whatever else, I mean, but you'll see something.

It's just you can't twist two gears two different ways and not sheer all the nubs
off and finally you just have two things spinning.

So, that's what I'm kind of wondering is, you know, what is those actions we can take as this leadership management, you know, our systems to align with that, if that's truly what we're doing, or is there not enough consistency there that we don't see the evidence coming out of that naturally. I mean, just overwhelmingly coming out and seeing it.

And, that's probably part of the struggles of all that anyway when you look at something that's hard to quantify, easy to qualify and so you just -- you're always warring between those two types of data.

I mean, I can tell you how I feel, I can't measure it for you. Right? I mean, well, one day I say it's my daughter suffers from migraines. Sometimes it's three times, sometimes it's seven. I'm always wondering, you're 16, is there something else going on? I mean, did you friend just call and piss you off
so now you're at a six? But, it's not really
due to your pain?

    I don't know those things so I just
sort of usually step back and let it work and
just be supportive and kind of try to create a
cocoon around it.

    I don't know if that's sort of the
same reaction we're doing as an organization
around some of the efforts. I don't know, I'll
just -- things, put that in the list of things
I don't know.

    CHAIR LEINENKUGEL: Jamil?

    DR. KHAN: So, first of all,
personal thanks.

    MR. O'ROURKE: It's good to see you
again.

    DR. KHAN: For getting those cards.

    No, I have another request to you
and this has to do specifically with the
suicide prevention.

    In the system, those that we have
flagged that we know who are high risk, we
should be able to issue them a push card, the technology that exists today.

It can be procured from the same funding like you did for the cards.

(OFF MICROPHONE COMMENTS)

DR. KHAN: Yes, sir. Yes, sir.

Because, if Jamil has that, and let's say I'm one of those people who are ready to do it. There is a very much possibility that before I do it, I'll push it to say a last word to someone.

And, it should be answered not by a call center, it should be answered by a qualified technician who knows I'm ready to jump the San Francisco Bridge.

And, he says, Jamil, wait two more minutes. I mean, you're going to jump, and let's talk about it.

At present, evidence based has shown, not with this push card, but wherever there was an intervention, they had a high success rate.
So, my request to you is, get the push buttons out.

CHAIR LEINENKUGEL: Well, if anybody can get it done, it's going to be this guy right here.

MR. O'ROURKE: I mean, I've talked to the Amazon guys that have the -- we've been talking specifically in that context. But, the technology is there, the crisis line, you're right, it's a call center. And, we do track the number of interventions that they do and how many times we call out for register help, those kind of things.

My only -- and I agree in principle in all that. It's my concern, at least from this perspective, is having the capability and the resolution -- the capability to do the resolution on that to make sure that we don't get ourselves into where --

well, in an area we're already nationwide shortage and can I provide that capability with a reasonable belief that, you
know, within five seconds somebody's going to
pick up the call, it's going to be that kind of
interaction giving our number?

Or is there another way to find that
solution that distributes that out to the
providers that are out there that do those kind
of services?

That's kind of the struggle with an
organization this size and with a population
this size, frankly.

DR. KHAN: Sir, you don't do that.
The Jamil Khan, the Marine asked for this. He
will, I'm sure, make this out.

MR. O'ROURKE: This is the forum. I
mean, it's part of the recommendations. We can
have those conversations. I know we've talked
to Mr. Gates about other things.

DR. KHAN: So, the second thing I'm
thinking of is the Choice Program. In the
Choice Program, we started with regionally.
The VA handled it itself.

Then, it became too big, so went out
and found a contractor that was Health Net.

    MR. O'ROURKE: Two of the, but yes.

    DR. KHAN: Yes, sir. The Health Net has done some good, but a lot of bad. The bad stuff gave the VA a bad name to all Veterans who otherwise were coming to the VA.

    You know, once they get the bad name, unfortunately, it takes a long time to get a good name back.

    But, recently, there are VA Medical Centers, I'm from Wisconsin, and medical center in Madison, they arrange my choice appointment with a provider and they paid directly to the provider. So, we have no issues.

    I think it's coming from the ground. Marines like me asking you, don't bring me a third-party in there just let me take -- Veterans take care of Veterans.

    MR. O'ROURKE: So, I mean, it's a broader issue. Yes, that's just a broad issue. I noted there's some things that make that much more complicated than it may seem.
And, success in one area, unfortunately, is not indicative of the whole system.

There's work to be done, there's balances to be made between that and where we're going to go. But, I would rather find the best solution in that case.

The one that you described for a couple of things, service good, cost very high. And, we would say we'll spend whatever we need to spend, but when it means not being able to do other services because we're going to pay that bill, I think we have to look for the best solution in those and make them work.

I mean, you're right. I mean, that's prefaced by that we -- I think we go back, we weren't doing that great before we had a choice. So, we had different places, individual places that did it a little better based on factors.

But, overall, we -- there was a reason why we went to the choice thing, there's...
a reason why we went to third-parties. And then, there's a reason why we're coming back from that and there's reasons why we're going to go back to it, just doing it the right way, managing it the right way and the cost savings you can get from that don't outweigh any lack of service, but we need to be better competent on how we execute those kind of contracts.

Health Net will not be our contractor for very good reasons, although the DoD will be dealing with Health Net because that is now their new contractor, but I'll leave that to them. Maybe they can do a better job managing the contract than we did.

So, but that's noted, but I don't -- I think we'll just have to continue that conversation for a little while I think.

CHAIR LEINENKUGEL: You know, Mr. Secretary, it was nice, not only for you to be here, but we scheduled you for a half an hour and it's been an hour now.

MR. O'ROURKE: So, Meredith is
screaming at me right now?

CHAIR LEINENKUGEL: And, we could ask questions all day of you. And, we welcome you back at any time.

MR. O'ROURKE: Okay.

CHAIR LEINENKUGEL: And, whatever high profile role you're going to have in serving Veterans, but Peter, thanks for being a friend. Thanks for taking the time to come in front of the Commissioners of the COVER Commission. And, thanks for always being supportive of our requests and needs.

Thank you very much, sir.

(APPLAUSE)

(Whereupon, the above-entitled matter went off the record at 11:22 a.m. and resumed at 11:35 a.m.)

CHAIR LEINENKUGEL: I'm not going to apologize because it's always great to have an Acting Secretary or a VA leader in front of the Commission on the time.

DR. MURPHY: No apologies necessary.
I'm sure that that was more valuable to the Commission than --

CHAIR LEINENKUGEL: But, you were right in the heart of something that's very necessary and will be an outcome that we will be discussion and doing action on this afternoon as well.

So, by closure of the day 2 session, we will have at least key people in alignment as far as how we're going to go about and approach the work effort and then the type of support that we're going to request from you and your staff.

DR. MURPHY: Give me the opportunity to take a slight diversion. I just want to respond to something the Commissioners have said.

So, to give a low back pain example, and I and my trusty computer while everyone else was talking with the Acting Secretary, pulled up the low back pain guideline. And, I want to tell you what the recommendation is.
It is that they suggest the use of mindfulness-based stress reduction, clinician directed exercise, spinal manipulation and mobilization, acupuncture, pilates, yoga and tai chi for the treatment of chronic low back pain.

And, they had a specific key question about models and recommended a team approach including an interdisciplinary rehab team that included a holistic approach with biopsychosocial modeling.

So, you know, the guideline process, I think, works pretty well. Now, it's based on what the literature has published. And, some of the important work at places like NICoE may not have gotten into the literature yet.

But, where there's literature, I think, you know, VA has tried to pull in a lot of the things that this Commission is interested in.

And, that's, you know, one of the pain related guidelines and I think they did a
nice job.

DR. MAGUEN: If I can just add to that, I think one of the things you're highlighting is let's not replicate what's already been done. And, I think that that's a really key point.

I think that if we think about it that way, you bring to the table, look, I don't need to duplicate this work because we have good evidence here that this was done rigorously. Let's not, you know, waste time and duplicate work.

So, I think that that's, from my perspective, really important.

DR. JONAS: So, let's start with that recommendation around pain because we don't want to forget about pain. Right? It's a key issue around opioids, but not necessarily request that you replicate it. But, let's make sure we don't lose it.

DR. MURPHY: So, after we, you know, really nail down the scope, we're going to
start with what we had. And, once we nail down the scope, the next big piece is determining what your priority key questions are.

Because, they really begin to drive the search criteria and the systematic review.

So, remember that we said that we would start with PTSD, major depressive disorder, opioid use disorder, alcohol use disorder and suicide prevention. Five mental health conditions.

And, each of them needs three key questions. So, for adults with PTSD, are complimentary and integrative health treatments effective as monotherapy for improving mental health outcomes?

Meaning, no other therapy, only the complimentary and integrative health.

I think we're unlikely to find a lot of studies like that. But, if it works against placebo, then we've got a great recommendation based on the strength of the evidence.

The other two questions that I'd
like to propose to you is, for PTSD, are
complimentary and integrative health treatments
effective as adjunctive therapy?

And, we have to look separately at
pharmacotherapy and at psychotherapy and
psychosocial intervention.

So, those are the three questions
and we would do the same thing for major
depressive disorder, opioid use disorder,
alcohol use disorder and suicide prevention.

So, that's a proposal. Let's go
look at then what you do next in fleshing out
some of these issues.

So, based on the key questions, we
developed statements about the PICO(TS). We
defined the population of interest, the
intervention, what we're going to compare it
to, the outcomes and, if relevant, the timing
of the studies and the settings of the studies.

So, here is an example of a PICO(TS)
table, population intervention. comparator,
outcome, timing, setting that fills in all of
that stuff.

So, the population of interest, as we said, was adults 18 years or older with a PTSD diagnosis.

We've got the list from the legislation which we can potentially add to based on your input as the interventions and the -- since this is the monotherapy question, it's compared against either wait list or placebo.

The outcomes are the outcomes that the PTSD Work Group for the guideline determined were their outcomes of interest.

And, we'll look at at least a 60-day follow up to see whether the outcome -- the improved outcomes persist and we'll look at overall primary care, specialty care and mental health clinic care.

So, that's sort of the way we would fill that in.

We can go on, that's just a reminder of our population. Here are the interventions.
So, for monotherapy, we've got a list of interventions.

And then, for an adjunct therapy, you're going to look as your primary intervention at pharmacotherapy plus that list above and then psychotherapy plus that list.

And, what we did in the pharmacotherapy and the psychotherapy was we pulled out the evidence based-treatments from the guidelines.

So, we have the treatments that were determined to be effective in each of those guidelines.

When we look at the comparators, they're going to be slightly different, depending on whether we're looking at it adjunctive or at monotherapy.

So, for -- as we said, for the monotherapy question, if it's a primary therapy, wait list of placebo, for the comparisons and adjunct, you're going to look at pharmacotherapy alone or psychotherapy.
alone.

And, here are some of the outcomes that have been determined by a panel of experts to be the important outcomes for each of the conditions that we're tasked by you to study.

So, rather than give you a headache looking at this incredible detail, what I would ask is that you, as a Commission, think about whether you want to set up subcommittees to oversee the evidence-based review and some of the other tasks that you want to carry out and we can work specifically to make sure that the PICO(TS) statements are exactly what you want to drive your literature review.

And, with that, I'd like to stop and open to questions. I know that I went through that really quickly, but we'll come back and talk about it later.

And then, I'd like to move to this survey if we could.

So, Mr. Chairman, are there question?
CHAIR LEINENKUGEL: Please go back to your PICO(TS) slide, if you would, that initial slide.

And, you did condense about eight slides into ten minutes. These are things that I think all of us as Commissioners want. I personally as the Chairman and I know that the Co-Chair would want to see, you know, this in a format.

So, again, once MAX is up, it'd be a great MAX entry point for us. But, we need this today because we are going to start to do the segmentation work led by myself and Tom as far as subgrouping, call it subcommittees, but how we're going to work.

And then, you know, is this the right model? Well, you've got it set up so I would imagine and assume that it should be.

It doesn't necessarily mean we have to stick rigidly to it. But, at least use it as a guideline while we do the subgrouping of our work.
DR. MURPHY: Sorry, we have actually developed the PICO(TS) statements and the tables for each of the conditions and each of the three key questions. So, we can give you that blown out document to give you all of the detail.

But, for brevity of presentation, we didn't put all of those into the slides.

CHAIR LEINENKUGEL: You did it the right way, Fran.

I'm just saying, though, as backup --

DR. MURPHY: Yes.

CHAIR LEINENKUGEL: -- give us the rest of the backup --

DR. MURPHY: Absolutely.

CHAIR LEINENKUGEL: -- with the detail behind it and then we can work off of that from the subgroup or subcommittee basis.

And, I think it'll give us a real good start in getting into the meat and the layering of what the Commissioners need to come
up with the solution basis and recommendations at the conclusion of the Commission.

But, at the same time, I look at these as working documents going forward. This is where the Commissioners will talk, whether it be telephonically or within subgroups first, which I highly recommend to get clarity.

And, also, I would say get consensus if possible from the subcommittees before bringing the work forward to the Committee.

So, I know I'm getting ahead of myself, but this is a, I think, a real good template for us to take a hard look at and it's something that is already there from the evidence-based work that you've done, Fran.

Everybody else agree to that?

(NO AUDIBLE RESPONSE)

CHAIR LEIENKUGEL: So, I think --

yes, go ahead, Wayne.

DR. JONAS: Just ask a couple particular questions, it seemed to be, and I guess if we have a subcommittee, then we can
talk about them.

But, I wouldn't -- you did put comparator which is wait list and placebo. I wouldn't exclude those that are comparators to others.

There are some studies in which the comparator is another treatment. It's not a wait list or a placebo, it's an actually active treatment and you're trying to do comparators.

So, I'd make sure we include those.

CHAIR LEINENKUGEL: I see that, yes, because I think I agree with you on that.

DR. JONAS: Well, so, there are some of these -- some of -- there are studies where some of these complimentary approaches have been directly compared to another treatment. Okay? Not a wait list or a placebo, but another active treatment like psychotherapy or some other treatment.

So, I just want to make sure those are included in the study, but it wasn't as an out on there. I assume you would.
DR. MURPHY: We can make those changes.

DR. JONAS: The 60 days, why 60 days? I mean, a lot drugs for depression are measured at 30 days. I know that FDA doesn't like that and a lot of people don't like it because people take them for longer.

But, that's the usual standard, or at least for depression drugs. So, why 60 days?

DR. MURPHY: I'd like to see some persistence of the effect. You also, especially for some of these conditions, like to give enough time, for instance, in the major depressive disorder, pharmacotherapy comparison takes a number of weeks for the drugs to become active.

DR. JONAS: Yes.

DR. MURPHY: But, again, we can --

DR. JONAS: I would encourage us to do that.

DR. MURPHY: -- open for discussion.
DR. JONAS: Okay.

DR. MAGUEN: That was something that stood out to me, too. I think that one of the challenges of the work that we're all about to do together, too, is that a lot of these studies probably, like, for example, evidence based treatment for PTSD is 12 weeks.

So, I would just suggest maybe looking to, if there's a pre and post, maybe we can think about time line a little together because I think it's a complex question.

I agree with you, what you're saying, we want long enough so that there's an exposure and a pre/post. But, the exact time line, I think, we might rule out studies that we want to look at that have a shorter time line.

DR. MURPHY: I think as long as you say at least X, we can always look at a year follow-up. But, you want to set some minimum time.

So, if the study is done a week
after and you know that your pharmacotherapy is not going to be active at that time, then it may not be a good study. It will be a very low quality study.

So, you're really looking at ways to define your inclusion criteria and your exclusion criteria.

But, again, we can work on that together.

DR. MAGUEN: Yes, I totally agree with that. I think we might, again, when we're thinking about that, just in thinking about some of the nuance, we might want to be more lenient when we look at just studies that have -- are looking at, you know, a CIH as primary versus CIH as secondary because there -- we might want to get sort of our hands around more studies in that number one category.

So, thank you.

DR. BEEMAN: Just an observation. We're calling it monotherapy and I think it's instructive. In reality, complimentary and
integrated medicine goes with something else. Right?

Complimentary means it compliments something. Integrated means that it integrates with something.

So, it may be instructive that in a -- that one of these complimentary therapies actually works on its own, then it might not be called complimentary anymore. Right?

It would be just non-pharmacologically based therapy or something.

DR. MURPHY: I --

DR. BEEMAN: I don't know, I'm just trying to get my head around it because I'm guessing, at the end of the day, this is going to be an easier sell for the VA if we say, these are approved complimentary therapies. They are in no way supposed to, you know, yes, replace, thank you, I'm to think of a more difficult word, but it's replace traditional therapies, you know.

But, maybe it's that this
complimentary therapy can help us mitigate the amount of pharmacology that we're using and all. Does that make sense?

DR. MURPHY: Yes, I'm with you. So, the reason I thought the three questions were important is that if you only at adjunct, we may get criticized by some of the advocates for transcranial magnetic stimulation and HBOT.

So, I think structuring it so that you look at it as -- and, remember, the recommendation from the PTSD guideline that was an example, was, you know, those treatments were not -- had insufficient evidence as a primary therapy. That was their term for monotherapy.

DR. JONAS: I think that's right.

I'd like to just have a language issue that I think what you described like around the pain assessment, that was very helpful, okay, in terms of framing this.

So, something similar to that would be good. That's evidence, that's what I call
evidence informed approach as opposed to what we heard earlier which is the evidence based definition, so evidence informed. Okay?

And so, because they have said, even -- we heard in the evidence based that there's insufficient evidence, that's their language, boom, end of story. Okay?

But, the recommendations for pain were we recommend you consider these into the guidelines. So, that's a little bit different, that's evidence informed practice. And, that may not go in your review process, but it should go in the contextualization that the Commission puts into this.

But, something that may affect your workload here is that it would be great to know the context around this, especially around pain. What are the current effects sizes for established, proven therapies for PTSD, depression, et cetera, the drugs, the psychotherapy?

What kind of effect size and
evidence levels do previous reviews, not yours, say you get in that? So that we at least have the context in which we're looking at these other therapies.

DR. MURPHY: So, full disclosure, I was the physician facilitator for the guidelines that we're talking about. So, I sat through the entire process, you know, worked -- Erica's one of my clients. Dr. Rodgers and Paula was the Chair of the PTSD Committee.

They went through, in detail, and they used the same process for both the low back pain guideline and the PTSD guideline.

The criteria for grading the recommendations is exactly the same. And so, the difference is based on the quality of the evidence, not on the process.

CHAIR LEINENKUGEL: Thank you, Fran. That's stage one of two stages that you have to present today. So, if you don't mind, could you move on to the recommended approaches and considerations to satisfy the patient centered
survey COVER requirement number one?

DR. MURPHY: So, while --

CHAIR LEINENKUGEL: Or duty to, I'm sorry.

DR. MURPHY: While we're waiting for the slides to come up, I'm going to take a similar approach. I'm going to truncate this discussion, but ask you for your advice and decision on the key issue, which is what options should we look at and how the survey should be carried out?

So, if we could go to the first slide?

Let me first show you what the legislation says about the need to conduct a patient centered survey, and that is their term, patient survey within each VISN.

Now, you saw the map of the 18 VISNs that exist across the country. So, we need to collect information from each of those areas.

And, we need to collect very specific information about the experience of
Veterans with the Department of Veterans' Affairs when seeking assistance for mental health issues.

So, what is the experience of Veterans?

Some of that, we can get from doing data analysis. But, VA does a Veteran satisfaction survey that's called the SHEP. And, that is done so that you can get information about patients who have received mental health care in each VISN.

And, in some cases, if we collected the information over a long enough period of time, we may even be able to say something about the experience of Veterans and their satisfaction with that care at a medical center level or a health care system level.

So, that's one option.

The other thing is, we heard yesterday that the National Academy of Medicine did look at experience of Veterans with -- who screened positive for mental health conditions
and they looked at both mental health, VA mental health users and for the second question, they also looked at the experience of OIF/OEF Veterans who had not used VA mental health care.

So, that helps us, and their focus groups and qualitative site visit information helps us with those, too, potentially.

There are also -- we're also asked to look at the preference of Veterans regarding available mental health treatments. And, that's a little bit more difficult.

What do Veterans believe is -- are most effective for them?

As well as, what do Veterans feel with respect to complimentary and integrative health therapies?

We've looked for existing surveys to help us answer those two questions. And, have not really found adequate data sources at this point.

We believe that the prevalence
question about what medication is prescribed to
Veterans in mental health is a question that is
best answered by querying the pharmacy benefits
management database and looking at the clinical
data warehouse so we can, with the help of the
Office of Mental Health and Suicide Prevention,
get access to that data and do that analysis
for you.

I don't think that that's a survey
question, but I'd be happy to discuss that.

The other issue is the outreach
efforts of the Secretary. Again, if I were
designing a study, I would want to collect that
information from the VA.

We might ask in a survey whether any
of the Veterans who are responding have
participated in an outreach effort.

But, I think we can get a good sense
of what VA does to outreach to Veterans with
mental health issues including things like
attending the transition assistance program,
discharge briefings, going to stand downs,
participating in the PDHA and PDHRA activities as people fill out screeners and get, you know, as they redeploy from a combat theater.

So, there are a number of things that we know that VA is doing. And, we collect the information about what the outreach efforts consist of.

Now, let me go on to the next slide.

So, we really have three options, at a minimum. We can utilize exclusively existing qualitative and quantitative data sources to satisfy one or more of the Commission requirements.

But, as I've told you, there will be gaps if we do that.

We can design and conduct a patient centered web based survey to gather that information.

Or, we can use a combination of both, you know, using the existing data sources where they are available and then designing a survey to fill the gaps that are not covered by
the other information that we have.

We've talked a little bit about the Paperwork Reduction Act. It is a law, VA must comply. And, if we choose anything other than option one, which is using the existing data sources, we invoke this Act.

So, let me say a little bit about that very quickly.

The Paperwork Reduction Act triggers -- is triggered when VA wants to conduct any information collection from ten or more members of the public. The Veterans are the public, they're not government employees.

So, when you want to obtain that information, either by asking identical questions or identical reporting, record keeping and, if you want to write a report on it, a publication, it triggers this Act, ten or more, total for your entire activity.

Now, that process, after you've developed your survey instrument, you submit it to the Office of Management and Budget and they
go through a complex approval process, often
coming back and asking a lot of questions and
asking you to change some parts of your
questionnaire.

And that can take six months to a
year. So, it really impacts the time line for
the Commission.

The good news is, that there is an
expedited review process. We will have to work
with OMB to see if they will let us use that.

If that's true, we could get
approval, once we have a questionnaire to put
before them, we could get concurrence from them
within 60 days potentially.

Now, I don't think we can say that
there will be public harm if they -- we go
through the normal clearance process or this is
an unanticipated event. But, maybe criteria
number three is.

Because we will not meet the
statutory deadline if we have to do this. So,
I'm going to leave that up to all of you.
But, I think we -- what we need to determine together is, which of these options you want to invoke.

So, here's some potential challenges. There are information gaps and so, if you decide to use only existing data sources, you will not get experience of Veterans who use non-Department facilities and providers. And, we won't get a good information about the preferences of or experience of Veterans with complimentary and integrated health treatments.

If you pursue a new survey, then we've got to deal with the expedited review process or the routine review process.

So, the next step is to understand the existing data sources, evaluate what gaps there are, and I've given you my opinion about what the biggest ones are and then, choose an approach to meeting the requirements.

And, I'd like to stop there and answer any questions.
If you look at some of the appendix slides, we go through, in detail, each of the charges and tell you where we have found information. And so, that's there for us to look at in more detail at a later time, but I don't want to hold up your lunch going through that detail.

CHAIR LEINENKUGEL: Go ahead, Jack.

MR. ROSE: Mr. Chairman, just a question on option one. What kind of reliability are we going to get from that option and what percentage of the Veterans will be touched?

DR. MURPHY: So, each of the data sources is different. We heard from the National Academy of Medicine that they started with a population of almost 9,000 Veterans across the country covering every VISN. But, it's only OIF/OEF/OND.

Now, they did say in their report that there were some Veterans who were from earlier eras that got included in their site
visit reports, but we don't know how many.

The Veteran satisfaction survey, the SHEP survey is very reliable. It's the same type of survey that the private sector uses with their HCAHPS survey. They are Veteran -- they are patient satisfaction surveys that CMS requires. So, we'll have a comparison with private sector.

And, that covers the entire nation and all eras of Veterans that give you -- that have accessed mental health care in VA.

So, I think that's a really valuable source of information.

So, it depends on the population of interest. Then we have other research studies and I -- Paul Schnurr was instrumental in collecting the surveys and questionnaires that have been done by the National Center for PTSD. So, those would be focused on PTSD.

So, we've got these niche issues, some are small surveys, some are large and broad. But, there isn't a single or a
combination of these surveys that actually helps us with each and every one of our charges.

DR. MAGUEN: That's really helpful.

I have just a quick question that may or may not be possible. But, the VSS survey that's already happening, is it possible to add questions to that? No? Okay, that was one thought. That would have been lovely. So, that would have been an easy way for us to --

DR. MURPHY: Well, I don't think so.

We can ask that --

CHAIR LEINENKUGEL: What is that survey?

DR. MURPHY: -- specifically.

DR. MAGUEN: So, it's a survey that's already being done by the VA and would reach the people -- a lot of the people that we want to reach and specifically, if we add some CIH questions, that would, you know, prevent us from having to go through the whole Paperwork Act because it's already happening.
DR. MURPHY: So, remember, that OMB -- every time you add a question, they want to re-review it. So, that triggers the Paperwork Reduction Act also.

DR. MAGUEN: Oh, it does? Okay.

DR. MURPHY: Yes, unfortunately.

CHAIR LEINENKUGEL: We're going to - - I'll give you my opinion on all of this. We're going to battle OMB. Okay?

This is a very important Commission. Everybody on The Hill realizes that, the President realizes that, SVAC realizes that, HVAC realizes that. Everybody in this room came in as Commissioners realizes that.

One of the things that we want to do is streamline and modernize this government. And, if you're going to have hurdles and barriers such as OMB saying that this is a very important Commission, but we are going to delay you for 18 months while you go through the hurdles.

We need to stop that, or, at the
very least, as a Commission, make a recommendation that OMB, in this case, should, at the minimum, expedite our requests. That's first and foremost.

Secondly, is I think that this is the right approach right here. Before we jump that shark, take a deep breath this afternoon, we'll make some assignments that Tom and I will agree to and, seeing that you have the survey, I will help out with that as well because I have strong opinions on this, as I'm already stating.

But, we need to understand what those existing gaps are because we have a charge, as easy as it was when they wrote the bill to put that in, we know how difficult it's going to be to obtain the necessary information as requested.

Probably more so for those Veterans that are outside the VA, without question. Right?

So, that will be the biggest hurdle.
that we will discuss. Because, I and everyone that has spoken as Commissioners, realize that there's a gap that exists with connecting to all Veterans, Right, and obtaining their feedback on their health care and, certainly, mental health care.

And, there's the large group of Veterans that don't receive care.

I don't have a clue today how to reach all of them, but we need to either source that out. We have the capability and the budget to do that, bring in experts and list consultants to at least help us jump the shark. Right?

So, I think that will be, use what Fran is presenting here, let's understand the existing gaps. Let's evaluate those gaps and then choose and approach which may or may not be up there right now. We may build our own approach based on what I just said.

And, is it going to impact the scope? No. Will it impact the time line?
Possibly.

And, that would have to be one of those immediate call outs which we are charged with after our first 30 days after our first meeting.

So, I just spoke to Sheila and said, highlight this one because this is going to be something that we're going to need leverage, whether it's POTUS, SVAC, HVAC to circumvent OMB restrictions.

DR. MURPHY: And, I would ask that you maybe think about the survey in broad terms. So, it doesn't have to be a, you know, a web based survey. It could be that you want to meet with groups of Veterans in focus groups while you're out doing your site visits where you might be able to recruit both VA users and non-users.

So, it could be either at qualitative face to face information gathering or --

CHAIR LEINENKUGEL: Well, Fran, I'll
interject and I'll tell you what we're missing.

First of all, we're missing the VSOs, even though they represent 6 million Veterans out of the 22, that's still a significant group.

So, we need to activate this afternoon how are we going to bring in the VSOs in to become active partners for the survey? First and foremost.

And, also, at some point, inclusion into at least become public participants in the open sessions. So, that's number one.

Number two is we always forget to talk about state, county, local Veteran services. We talked about it yesterday for the Veterans Centers. There's a whole resource out there as there is at the VA right now.

There are people within OPIA that this is how they should be helping us as maybe inclusion with the subcommittee or as consultants, unpaid consultants because they're already being paid.
But, there's people out there that know how to jump that shark, or at least will have some ideas.

And, are we going to get to a 100 percent? No. Remember, we all said, I think we agreed to the 80 percent principle or at least I threw that out there, maybe you don't.

But, this is the meaty one I think that is going to cause us issues. It's fretting Fran and the SIGNA group because it is a big, big thing that we need to at least respond to within 30 days as a call out that there could be some issues in us getting to a good, what I call solid base sampling of the two Veteran groups, the mental health group within VA and those questions specifically that we need to answer that were on the other pages.

And, the same with the other group that are outside the VA, the much larger group.

So, I just throw that out there. I think that once we get to this afternoon, and once we start working on this before August
Another group or another person I did not mention is Lynda Davis, the Veteran Experience Officer at VA, a wonderful resource. Fran knows her. She has Medallia that's up and running now. And Medallia can ping that Veteran once they are days visit at the VA -- VHA was completed. How was your care? And, I don't know how specific it is, but Lynda's coming in on August, so maybe we ping her prior to this to get a little more background while we're doing the further survey work as a subgroup.

DR. BEEMAN: Jumping this shark is a new one to me.

(LAUGHTER)

DR. BEEMAN: Skinning the cat is something I'm used to, but jumping the shark sounds a lot more dangerous.

(LAUGHTER)

DR. BEEMAN: I think --

(OFF MICROPHONE COMMENTS)
DR. BEEMAN: I think we need to use the existing data sources as much as possible because there's an awful lot of data out there. It just seems to make sense to me that we would use it, to not ask the same question over again.

Having -- and that does identify the gaps.

And then, the question that I would have is, I think qualitative sometimes is more effective than quantitative. And, the question might be is, in each VSO could you get nine people and let them run it and basically say, we need you as partners so you guys are going to have to just -- could you identify nine people and ask this question set.

But, in addition, ask any other question that you want to find out. Because, I actually this it's sometimes better to hear from a small group of people that has a chance to interact than it does for people on an -- answering on a computer, yes, yes, yes, yes.
So, that might get us around the paperwork thing because it would be within, you know, it would be each VSO putting in for nine people.

Just a thought.

CHAIR LEINENKUGEL: I like your thinking because you own this one.

(LAUGHTER)

DR. MURPHY: So, we do patient focus groups, as Eric said, with the clinical practice guidelines. And, we went to OMB saying, in general, we want to ask these -- this set of questions and then it's only different, depending on what the underlying condition is and they wouldn't give him approval.

So, we're stuck doing patient focus groups with nine Veterans for each guideline.

PARTICIPANT: We've got to jump that shark now.

CHAIR LEINENKUGEL: Shark --

PARTICIPANT: It sounds like a whole
MR. ROSE: Mr. Chairman, just on the VSO and back, looking at Kenosha County, small. Okay? Made the call yesterday, right now, we've got 13,500.

I had requested how many of the 13,500 are getting VA care at this point? Now, I don't know if that's how far you want to, you know, drill down to this or if we already know that answer at a state level. I ask the question, do we know?

CHAIR LEINENKUGEL: Jack, what exactly is your question? I mean, do we know what? Do we know the amount of Veterans --

MR. ROSE: Yes.

CHAIR LEINENKUGEL: -- by county?

MR. ROSE: Yes.

CHAIR LEINENKUGEL: By -- it all depends on the state from what I know. So, I'm not part of the state, Tribal group of OPIA, but their resources are as in depth as yours.
They know exactly by most counties, and most states --

MR. ROSE: Right.

CHAIR LEINENKUGEL: -- the population of Veterans. But, it's all over the board.

It could be off by 6,000 in Kenosha County because 6,000 of them may have moved to LA and Phoenix since the last time they took a count.

And, it is a changing demographic. Arizona's done the best work to date that I'm aware of that has tracked down every Vet and is now paying attention to transitioning Veterans and where they're locating and going.

And also, following up with the type of care or non-care that they're receiving.

So, I think Drew alluded to Arizona yesterday being his home state with the suicide prevention and what the Arizona coalition has done and how they partnered with the state, with the counties and with the various tribes,
and they've got a dozen tribes out there. And they're very proactive.

But, again, it took nine years for them to get there.

I would say from what you and I and Jamil know with the State of Wisconsin, the county VSOs and the county executive directors do a fairly good job. But, I'll bet you that their data and their numbers are not up to date, would be my guess.

DR. JONAS: I'd just like to support your thought about focus groups. I mean, experience and preference are qualitative issues. Okay?

So, they may lend themselves more to qualitative research methods and there are valid ways of doing qualitative research to get to saturation where you've got 80 percent or more of what the issues are.

And, in sometimes, collected even better than having a checklist on a survey.

CHAIR LEINENKUGEL: A couple of
things I'm just thinking real quick here with working the solution which Commissioners always do and you're trying to get to an answer right away.

So, again, let me throw out a couple of other things.

This is going to be the challenging one, but I like the direction that Tom stated with qualitative. I like the focus group because I know these can be done because they're being done on an ongoing basis.

And, American Legion has the capability to do them quite well.

I'm not sure, but I think DVA does, DAV as well.

So, I mean, those groups probably can help us out in the next 30 days.

And, making a decision based on Fran's next step, maybe that becomes the new approach that we use.

And, again, I think we would have to send back and SVAC and HVAC because this law,
it was written by the people on The Hill. I think there was 36 folks that signed on to care.

And, we would have to back and actually either make a clarify point saying, this is the reality. And, I don't know what reality is at this, except that there's some barriers. That I do know.

The other thing is there it might be cost to get to those other 9 million Veterans not using VA or 14 million Veterans not using VA health care.

So, are there other means and methods to do this? The answer is yes, there are.

So, I think this will be a very interesting exercise, probably not just for a subgroup but for all of us to collectively think about and then come back by August so this may very well be our first opportunity for a teleconference call prior to the August meeting. So, I'll throw that to Sheila and the
work group as well.

Where, by the time we leave this afternoon, we may have three items that we're going to talk about on the teleconference call. So, I'm sort of jumping ahead here.

Working this afternoon's project based off of this. But, it's perfect timing, I think, because we do need to leave here going with not only how are we going to work, but what are we going to work on? Then, who's going to be accountable and responsible for the outcomes back to the rest of the Commission? I think that's a fair statement, would all the Commissioners agree?

(NO AUDIBLE RESPONSE)

CHAIR LEINENKUGEL: That said, thank you very much, Fran, because we could debate with you all day long but we're going to break for lunch and we'll think of more things by the end of this session.

So, let me say this has been great. It's been a great day and a half, again, my
perspective.

We're going to go into the final phase of our first meeting which will be a closed session. But, I want to make sure we have enough time for everybody to make personal calls, do things and we sort of truncated that yesterday.

So, let's give ourselves until 1:30, that's an hour and ten minutes and I'm going to give that because I would like us to work diligently from 1:30 until 4:00.

And then, try to conclude everything by 4:00 on how we're going to work. And, then, to see if there's any summation items or any points of contention that need to be raised from a 4:00 until 4:30 time frame.

And, it'll give Sheila, as the DFO, time with her group to start to process things of do outs of what we're going to need to do in the next 30 days prior to our August meeting.

Then, we'll talk about the August meeting and then, hopefully, we'll all depart.
here with smiles on our faces at 4:30 this afternoon.

Good plan? Let's see if we can execute it.

Thanks.

(Whereupon, the above-entitled matter went off the record at 12:22 p.m.)