

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

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CREATING OPTIONS FOR VETERANS'
EXPEDITED RECOVERY (COVER) COMMISSION

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OPEN SESSION

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TUESDAY
JULY 24, 2018

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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

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

1:17 p.m.

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

1 meeting, and one for participants on the phone.
2 For those on the phone, we will take this
3 information at the scheduled breaks as needed,
4 as people may dial in during the course of the
5 meeting.

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

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

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

18 Minutes of this meeting are being
19 taken, and anything said during the meeting or
20 submitted in writing before, during, or
21 immediately after the meeting will be available
22 to the public. This meeting is on the record.

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1 In closing, to summarize, public
2 notice for this meeting was published in The
3 Federal Register. A DFO is present. A quorum
4 of the COVER is present and in person. An
5 approved agenda for the meeting has been
6 established, and the meeting will adhere to
7 this agenda.

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

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

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

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

20 And with that, I would like to
21 invite Dr. Taylor to join us today. Let me
22 give you a brief background on Dr. Beth Taylor.

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1 She joined the Department of Veterans Affairs
2 in 1996 as an Associate Director for Patient
3 Care Services and Nurses Executive in Saginaw,
4 Michigan. She continued to serve in this
5 executive role in several VA facilities as well
6 as several special-focus detail assignments.
7 In 2013, Dr. Taylor assumed the role of
8 Director, Workforce and Leadership, for the VHA
9 Office of Nursing Services, and became the
10 Deputy Assistant Deputy Under Secretary for
11 Clinical Operations on April 2nd, 2018.

12 Dr. Taylor received a bachelor of
13 science in nursing from Indiana University, a
14 master in business administration from Saginaw
15 Valley State University, and a doctor of health
16 administration from Central Michigan
17 University. In addition, she holds a graduate
18 certificate in international health from
19 Central Michigan University and is Board-
20 certified as a nurse executive advanced. She
21 is a longstanding member of the American
22 Organization of Nurse Executives and Sigma

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1 Theta Tau International.

2 So, let's welcome Dr. Beth Taylor.

3 (Applause.)

4 DR. TAYLOR: Thank you very much.

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

16 Before I get into discussing the top
17 five priorities for the agency, it's important
18 to recognize that the agency consists of three
19 different Administrations: Veterans Benefits
20 Administration, Veterans Cemetery, our National
21 Cemeteries, and, of course, the largest,
22 Veterans Health Administration.

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1 Veterans Benefits, as the name
2 implies, is to identify the eligibility for any
3 veterans relating anywhere from healthcare to
4 home loans, unemployment benefits, and the
5 like.

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

16 VHA's roots also go back to the
17 Civil War. In President Lincoln's second
18 inaugural address in early March of 1865, he
19 spoke very strongly about the need and
20 responsibility to ensure that we take care of
21 our Civil War soldiers. To that end, President
22 Lincoln signed into law to establish a National

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1 Soldiers' and Sailors' Home. The first home
2 was in Augusta, Maine, and it was for the Union
3 troops.

4 Also, in that inaugural address in
5 1865, he challenged us "to care for him who
6 shall have borne the battle and for his widow,
7 and his orphan". In 1959, those words became
8 VA's motto.

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

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

21 A couple of recent Acts over the
22 last four years has assisted us in the funding

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1 of identifying non-VA providers to assist us in
2 providing those choices in care. In 2014, the
3 VA Choice and Accountability Act, VACA, or the
4 Choice Act, was signed into law. That provided
5 funding focused on improving access to care for
6 non-VA providers. In 2018, the VA Mission Act
7 expanded funding for private healthcare options
8 in such areas as caregiver support and the
9 Medical Foster Home. And President Trump
10 signed that into law on June 6th of this year.

11 Modernizing our systems is our
12 second priority. We believe that veterans and
13 the VA employee needs technological systems to
14 help us deliver high-quality care and that we
15 need to stay on top of technological advances.
16 The electronic health record is the cornerstone
17 of VA's modernization efforts. Some of our
18 core goals under modernization include: to
19 stabilize and streamline our core processes and
20 our IT platforms. We want to eliminate our
21 material weaknesses, focusing on cybersecurity
22 and risk management. We want to introduce new

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1 capabilities that drive improved outcomes, such
2 as community care, My HealtheVet, electronic
3 scheduling, and electronic benefits delivery.

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

15 Using a predictive model, which
16 REACH VET is, we analyze existing data from
17 veterans' health records to identify those at
18 statistically-elevated risk for suicide,
19 hospitalization, illness, or other adverse
20 outcomes. This predictive modeling allows VA
21 to provide preemptive care and support veterans
22 even before they get into acute crises.

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1 Our third priority in VA is to focus
2 resources more efficiently. We believe it's
3 essential that veterans and our taxpayers know
4 that we are focusing and have confidence in our
5 focus on resources to ensure that we have the
6 best value for our veterans and that our
7 veterans receive the care that they need; that
8 they receive quality care; that they receive
9 timely care, and at the point of care that is
10 most effective for them. To that end, we've
11 identified core and foundational services,
12 those things that we do very well, that we're
13 best in class in, and those services that are
14 absolutely fundamental to any healthcare
15 system.

16 Timeliness of services. We believe
17 that some veterans are still waiting too long
18 for care or services, but we track that every
19 month and we track that very closely in terms
20 of our access. For as an example, in February,
21 96 percent of appointments occurred within 30
22 days of the clinically-indicated date or the

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1 veteran's preferred date; 84.9 percent were
2 completed within seven days, and 21 percent
3 were completed within the same day.

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

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

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1 in their time of crisis.

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

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

20 For fiscal year 2017, just to give
21 you a few statistics, as evidence of our
22 dedication to this mission, we trained over 800

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1 dental residents and students just in fiscal
2 year 2017, over 43,000 physician residents,
3 25,000 medical residents, 27,000 nursing
4 students, and, in total, nearly 123,000 health
5 professional trainees, including physical
6 therapists, social work, respiratory
7 therapists, registered dieticians, and some
8 healthcare administrator trainees as well.

9 Our third statutory mission is
10 research. VA has a very long and rich history
11 of its contributions to healthcare and the
12 healthcare industry. A few examples of VA's
13 contributions to healthcare include: the first
14 decisive trials for effective treatments of
15 tuberculosis; the demonstration of the
16 lifesaving value of treatment of hypertension;
17 the development of the concept of CT scanning;
18 the discovery and development of
19 radioimmunoassay facilitating measurements of
20 previously impossible precision; cooperative
21 studies proving the efficacy of psychoactive
22 drugs in stabilizing psychiatric disorders; the

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1 demonstration of the relationship between
2 smoking and lung cancer, leading to the initial
3 warnings and the report of the Surgeon General
4 on smoking; development of a practical
5 implantable cardiac pacemaker; development of
6 the LUKE/DEKA advanced prosthetic arm and the
7 powered ankle/foot prostheses; the development
8 of the nicotine patch; the work on liver
9 transplantation, and Dr. DeBakey's work on
10 cardiovascular surgery, just to name a few.

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

22 The VA staff participate in

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1 facility, community, and regional disaster
2 preparation drills, and hundreds of VA staff
3 have been deployed to disaster areas to assist
4 with providing care to individuals, both
5 veterans and community members.

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

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

21 We have Health Care Centers, Multi-
22 Specialty Community-Based Outpatient Clinics,

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

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

18 A few vital statistics for VHA. And
19 again, this is for fiscal year 2017. We have
20 9.12 million enrollees, almost 6.3 million
21 unique veterans. So, you'll notice that not
22 everyone who enrolls in VHA care actually is a

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1 patient in VA. Almost 84.2 million outpatient
2 visits last year, 577,000 hospital discharges,
3 146 million prescriptions that were filled, and
4 727,000 patients receiving care via telehealth.

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

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

20 As I mentioned earlier, we have
21 identified both core services and foundational
22 services. This is a list that is a menu that

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1 you might see at any healthcare system across
2 the country. There's a couple of the services
3 here that are our core services that I just
4 want to mention.

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

14 The other core health service that I
15 want to mention -- and I know that you'll be
16 hearing more about the mental health aspects of
17 our core services in a little bit -- but
18 women's healthcare is another area to
19 highlight. Women currently make up 10 percent
20 of the veteran population in the U.S., and
21 nearly half of that population is of
22 reproductive age. It is the largest or

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1 fastest-growing subgroup of our veteran
2 population, so one that we feel as though we
3 need to pay close attention to, to ensure we
4 meet the needs of that veteran population,
5 particularly when it comes to women veterans
6 who are seeking assistance with fertility
7 issues and maternity care.

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

18 One of which is the Blind Rehab
19 Services. We have a hub-and-spoke approach to
20 providing blind rehabilitation with 13 hub
21 sites nationally. This is a residential
22 program that assists veterans with various

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1 levels of loss of sight and assists them in
2 developing successful strategies to ensure that
3 they are safe in their daily life.

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

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

17 Environmental exposure is another
18 area of work that VA provides that's unique to
19 our healthcare system. Our veterans are
20 exposed to agents depending on when and where
21 they served, from Agent Orange to exposure
22 related to burn pits. The VHA is attuned to

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1 these unique exposures and monitors patients
2 for healthcare issues related to such.

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

14 And finally, I would like to
15 highlight our spinal cord injury and disease
16 program. We have 24 spinal cord injury and
17 disease centers around the country, again, a
18 hub-and-spoke approach to connect veterans with
19 the care and the specialists that they need.
20 We provide them annual physicals. We help
21 veterans with acute injuries as well as chronic
22 injuries, and have very full and detailed

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1 programs, again, to help them navigate with
2 their injury and be as mobile as they wish to
3 be.

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

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

20 Home telehealth actually uses
21 devices that are placed in the home using phone
22 lines or modems. That helps patients and their

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1 care providers monitor chronic conditions such
2 as congestive heart failure and diabetes and
3 supports patients managing those diseases as
4 they stay within the comfort of their home.

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

15 Our tele-mental health leverages the
16 expert mental health providers that may not
17 otherwise be available locally to the veteran.
18 We're doing more in telehealth than any other
19 healthcare system and connecting mental health
20 providers to areas where mental health
21 providers are difficult to recruit or this area
22 of healthcare may not be available. It is a

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1 key priority for our tele-mental health
2 services.

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

13 My HealtheVet is a portal that
14 veterans use to schedule appointments, to fill
15 prescriptions, review their healthcare records,
16 and access their personal health information.
17 In addition, on this portal, they have the
18 ability to perform secure messaging. This
19 allows the veterans at any point in the day,
20 whenever it's convenient to them, to pose
21 questions to their healthcare team, to email
22 about experiences they're having or give

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1 updates to their providers or nurses. They can
2 also receive health educational material
3 through this secure messaging.

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

16 We have found that it decreases the
17 cost of veteran travel and the necessity for
18 veteran travel to a facility for care. It
19 improves access to specialty care. It improves
20 veteran and provider satisfaction, and it
21 increases provider knowledge, competencies, and
22 professional training in those rural areas or

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1 where specialty services are not available.

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

12 And finally, we have VA Point of
13 Service Kiosks. That link allows veterans to
14 check in for their appointments as they come
15 into their clinic. They review and update
16 their addresses, phone numbers, and email
17 addresses. They can update their own next of
18 kin, their insurance information, their copay
19 information, and they can review their
20 prescriptions and allergy information before
21 they go in to meet with their provider. They
22 can also view and print upcoming appointments.

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1 So, we have quite an array of technologies that
2 we're using to connect with our veterans at a
3 point that's convenient to them.

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

10 Thank you so much.

11 (Applause.)

12 CHAIR LEINENKUGEL: Any questions of
13 Beth at this point?

14 DR. KHAN: Jamil Khan.

15 CHAIR LEINENKUGEL: Jamil, use the
16 mic, please.

17 DR. KHAN: My question pertains to
18 the pharmacy. At present, I get 14 medications
19 mailed to me, and sometimes they come in 14
20 different packages. Each package has large
21 documentation attached to it. I've been taking
22 those medications for the last 15 to 20 years.

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1 Why cannot we stop the additional paper that
2 comes with it? And it's too expensive to send
3 14 packages that can be mailed in one package.
4 My recommendation is we should use the
5 Pridecare model and save this extra money being
6 wasted by the VA.

7 Thank you.

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

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

15 Anybody else at this point? Because
16 I have a comment and then a question or two
17 that I think are pertinent. Let me start with
18 the comment. This is something that I
19 think -- Beth, thank you very much for
20 presenting this -- this is just good background
21 information that we all need to have access to,
22 because this is the transformation to the new

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1 VA right now, is the way I look at it. These
2 are the things that have to happen and be
3 implemented in order for us to move from World
4 War II type of veterans service and care to the
5 new future, as we like to term it. And this is
6 really just starting.

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

14 DR. TAYLOR: Thank you for that
15 question.

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

21 Suicide is very complex, and a lot
22 of patients that report that they are not

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1 suicidal do, indeed, commit suicide. We know
2 that there are a lot of life events that are
3 linked to suicide, to veterans committing
4 suicide. It may be the loss of a spouse. It
5 may be the loss of a job. It may be financial
6 crisis.

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

14 Anything, Wendy, you might add to
15 that?

16 DR. TENHULA: I would just add,
17 going with the idea that suicide is always
18 multifactorial, and, oftentimes, I think the
19 majority -- I don't remember the exact numbers,
20 but can get them for you -- the majority of
21 individuals, veterans who die by suicide who
22 are in our healthcare system didn't endorse

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1 suicidality at their last doctor's visit, were
2 not identified as high risk for suicide based
3 on clinical factors.

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

20 As Dr. Taylor said, it's in
21 relatively early implementation stages. We're
22 evaluating the effectiveness of it as we go and

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1 have some early results that I think we could
2 get for you, as far as looking at the
3 effectiveness of the program.

4 CHAIR LEINENKUGEL: Thank you very
5 much.

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

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

14 DR. TAYLOR: The core health
15 services?

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

21 The VA ensures that all eligible
22 veterans have access to all the healthcare

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1 services necessary to promote, preserve, and
2 restore their health. And to me, it
3 was -- Matt and I were walking over for lunch,
4 and I think, Matt, this sort of hit home on the
5 statements that we were bantering back and
6 forth.

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

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

20 We really need to get to, are we
21 restoring them for being productive citizens or
22 productive soldiers once again? So, I think I

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1 just like that headline, and I wanted to bring
2 that to everybody's attention.

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

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

20 And I was given permission to talk
21 to one of them because he agreed. And he said
22 it's made a world of difference. But the first

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1 step that he had to have was a connection with
2 a real person. And I wondered, is that the way
3 it is with everybody that is going through some
4 sort of struggles? And he said there was a
5 definite connection with four visits -- and I
6 think this is key -- with the same doctor,
7 where he felt comfortable in getting into a
8 booth and looking through a screen, talking
9 with that doctor.

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

20 My last point. You have a veteran
21 population -- we talked about it briefly this
22 morning -- but we need to, as a Commission,

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1 have clarification because you brought up
2 something important. There's 9 million
3 enrolled veterans in VA care right now. When
4 you say "uniques," the 6.2 uniques, those are
5 the ones that you is as the VA services, am I
6 correct in that, Beth?

7 DR. TAYLOR: Correct.

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

11 DR. TAYLOR: Yes.

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

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

16 CHAIR LEINENKUGEL: Yes, that's
17 probably the right answer. And it bothers us,
18 I think, as commissioners, that we have that
19 subset that we don't know. And I'm talking
20 about mental health. And then, we have a whole
21 15 million others that we don't know.

22 And part of this Commission, as we

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1 all know now, is we are tasked for trying to
2 find out, if we can, just about every single
3 one of them. Are they at risk? Do they have
4 mental health needs?

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

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

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

22 So, it's important, and I'm saying

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

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

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

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

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

21 Are we going to see some of that?
22 Because that sort of is kind of important for

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1 projecting into the future of how things are
2 managed. I know in the civilian sector it's
3 built around can we get payment, not around
4 patient-centeredness. We know that. The
5 question is, how is this one built?

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

17 And so, you mentioned several times
18 a hub-and-spoke model. That's another model.
19 Is that changing? Are we still maintaining
20 that in the VA? Are we going to a network
21 model? What is the model? And are we going to
22 find out about that?

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1 DR. TAYLOR: Well, I think the short
2 answer is you're probably going to learn more
3 about that over the successive presentations.
4 But I think it also depends on some of the
5 specific programs. The hub-and-spoke model for
6 some of our super-specialized programs, like
7 spinal cord injury and disease like blind
8 rehab, really do work. The folks for blind
9 rehab actually fly into places like Tucson from
10 Salt Lake, from Albuquerque, New Mexico, and
11 spend a few weeks there and get the resources
12 they need, the prosthetic devices they need,
13 and then, go back.

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

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

21 DR. TENHULA: I would agree that
22 probably you're going to learn more there. To

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1 my mind, the model we use needs to be tailored
2 to the individual needs of the veteran, of each
3 veteran. So, how we approach their care,
4 whether it's through a hub-and-spoke model of
5 telehealth or a hub-and-spoke model of blind
6 rehab, will depend on what the individual needs
7 of the veteran are. And I'll talk when I talk
8 a little bit more about some of the approaches
9 we use in mental health, too, that may help
10 start giving you some information that will be
11 helpful.

12 DR. BEEMAN: Dr. Taylor, I know
13 you're not a health economist, but do you how
14 much money the VA is spending on mental health
15 services versus other things? It's my
16 contention that in the civilian sector we
17 underspend. In fact, the insurance companies
18 are set up to minimize the access of patients.
19 And the question I have, how much are we
20 spending vis-a-vis the civilian sector? Two,
21 is that enough? And three, are there other
22 things that we're doing that we don't need to

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1 do that we could stop, so that we could fund
2 properly the mental health services that we
3 want to provide?

4 DR. TAYLOR: Thank you.

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

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

16 Thank you so much for the question.

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

19 Jack?

20 MR. ROSE: Yes. Just a question
21 with respect to mental health. We've had the
22 question about how much funding is coming at

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1 mental health. The area of research which is
2 so critical in mental health, what percentage
3 of research right now is being directed towards
4 mental health and improving it?

5 Thank you.

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

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

15 It is, I can say, having been in the
16 VA system for quite a while, it is a much
17 larger percentage than it used to be, and there
18 is a strong investment in VA research in mental
19 health and in suicide prevention. And we can
20 get you, absolutely can get you more
21 information on that and more details on the
22 priority.

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1 And I hope that you all will be
2 hearing in more detail over the course of your
3 work about VA's research. Dr. Taylor mentioned
4 VA's research efforts, and in mental health
5 it's been so critical to innovations and
6 changes.

7 MR. ROSE: Thank you very much.

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

16 Thank you.

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

19 DR. TAYLOR: Thank you.

20 CHAIR LEINENKUGEL: We'll probably
21 have you back or we'll come and see you at some
22 point in time.

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1 DR. TAYLOR: I'd love it. I'd love
2 it. Thank you.

3 CHAIR LEINENKUGEL: At least as a
4 subgroup.

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

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

12 (Laughter.)

13 CHAIR LEINENKUGEL: I have the
14 privilege to introduce Dr. Wendy Tenhula. Dr.
15 Tenhula is the Director of Innovation and
16 Collaboration in the Office of Mental Health
17 and Suicide Prevention at the VA. She oversees
18 our Mental Health Centers of Excellence,
19 including the National Center for Post-
20 Traumatic Stress Disorder and programs that
21 address women's mental health; also, families
22 and the effects of military sexual trauma. She

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1 also leads coordination with the United States
2 Department of Defense and the Substance Abuse
3 and Mental Health Services Administration on
4 mental health issues and oversees the VA's
5 national award-winning Make the Connection
6 Outreach Campaign.

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

15 She's earned her bachelor's degree
16 in psychology at Vanderbilt University and a
17 doctor of clinical psychology at Northwestern
18 University. She's completed her internship and
19 a postdoctoral fellowship at the Hennepin
20 County Medical Center in Minneapolis, and
21 second fellowship year in the Department of
22 Psychiatry and Behavioral Sciences at Stanford

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1 University School of Medicine. She has been
2 with the Department of Veterans Affairs now for
3 18 years.

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

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

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

14 DR. TENHULA: Okay. Okay.

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

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

20 CHAIR LEINENKUGEL: I will be the
21 hook, yes.

22 (Laughter.)

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1 DR. TENHULA: Thank you. Thanks,
2 Mr. Leinenkugel, and thank you to each of you
3 for agreeing to serve on this Commission. It's
4 really important work and I appreciate the
5 opportunity.

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

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

16 It really is a pleasure to be here.
17 I'm honored to work in VA mental health, as Mr.
18 Leinenkugel said, for the last 18 years in VA
19 and various aspects of our mental healthcare
20 system. Our office, the Office of Mental
21 Health and Suicide Prevention, stands ready to
22 help this Commission do their work, whether

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1 it's providing follow-up information for your
2 questions, providing documents, reports, any
3 work that we've done that we can share to help
4 you all as you are doing your work. We are
5 standing by ready to help.

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

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

15 I'll give you a high-level, sort of
16 general overview, a snapshot of VA mental
17 health. I wanted to try to highlight a few
18 areas where I think there are some unique
19 aspects to VA's mental healthcare system versus
20 the private sector mental healthcare system,
21 and that I thought would be of interest to you
22 as you're sort of launching into your work.

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1 So, I'll touch on each of the areas
2 here on this list, and I hope that will give
3 you sort of a flavor of VA mental health
4 services and some of the things we do, and some
5 of the things we do that are unique.

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

16 As part of that full continuum of
17 care, we have immediate crisis intervention and
18 support available 24/7, 365 days a year,
19 through the Veterans Crisis Line. And that's
20 available by phone, online through the
21 computer, and by texting on your mobile phone,
22 across the healthcare system in different

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1 setting.

2 So, we don't just think about mental
3 health if someone comes to a mental health
4 clinic. We proactively screen for depression
5 and post-traumatic stress disorder and
6 problematic alcohol use in primary care and
7 across our health system.

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

16 And one thing I want to mention
17 that's unique to VA is the use of peer
18 specialist. We have about 11000 peer
19 specialists working in our system right now
20 that really provide unique opportunities to
21 engage veterans in care. So, our peer
22 specialists are veterans themselves who have

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1 themselves experienced mental health challenges
2 and really are wonderful assets to our system.
3 In fact, the mission that Dr. Taylor mentioned
4 offers us the opportunity to expand the use of
5 peer specialists, not just in mental health
6 clinics, but in primary care clinics as well.
7 So, we're excited about that.

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

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1 healthcare system.

2 Along those lines, we have seen
3 demand for VA health services go up. In fiscal
4 year 2017, VA provided mental health treatment
5 to more than 1.7 million veterans, and that
6 increased by 80 percent from FY 2006 to FY
7 2017. And that's an increase that's more than
8 three times the increase that we've seen across
9 all of VA care. So, we're seeing more of an
10 increase in demand for mental healthcare than
11 we are -- we are seeing an overall increase in
12 demand for VA healthcare. We're seeing more of
13 an increase for mental health.

14 And just another way of saying that
15 is, back in 2006, about 20 percent of people
16 who came to VA for their healthcare were
17 receiving mental health services, and last year
18 that was about 28 percent. So, I think, Dr.
19 Beeman, that goes back to your question a
20 little about how much of the care we are
21 providing is mental healthcare. It's a pretty
22 big chunk of what we're doing.

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1 I'm pushing the wrong button. I'm
2 going to push my microphone button instead of
3 my slide button.

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

21 I just want to highlight a couple of
22 things in the access realm. Also, we

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1 intentionally put access to high-quality care
2 because we don't want to just provide access.
3 If we can get someone in the door for an
4 appointment, it's important that we get them in
5 the door for an appointment for good-quality
6 care that's going to be effective and helpful
7 for them, not just that we can check a box and
8 say we got them in for an appointment, right?

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

18 And I will also talk about a little
19 bit more one of the ways that we have improved
20 access to mental healthcare is through
21 integrating mental health providers into our
22 primary care settings. And open access is a

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1 key principle of primary care-mental health
2 integration. That is, if someone is there
3 seeing their primary care physician, and the
4 primary care physician identifies a mental
5 health need, being able to do a warm handoff
6 right away to a mental health provider is part
7 of the model of primary care-mental health
8 integration that is, I think, unique to VA's
9 integrated sort of full continuum of care,
10 being part of the system like we are. So, I
11 wanted to mention that.

12 Two other quick things to highlight
13 is expanding access to those with other than
14 honorable discharges and the recent Executive
15 Order, signed by the President in January, that
16 enhances access for service members who are
17 transitioning from active duty. Those are two
18 populations that we know are in various ways at
19 risk for adverse outcomes, and we want to make
20 sure that we are paying attention to their
21 needs and providing services as appropriate.
22 So, those are two specific populations that we

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1 have been focusing on in terms of access to
2 care.

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

13 So, we have the Strategic Analytics
14 for Improvement and Learning, or SAIL. And the
15 mental health SAIL domain has three components
16 to it: an experience of care -- so, when a
17 veteran comes to VA for mental healthcare, what
18 is their experience of care like and how do we
19 measure that? -- population coverage and
20 continuity of care. So, those are the three
21 sort of subdomains that we look at under SAIL
22 that are related to mental health.

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1 The Veterans' Outcomes Assessment is
2 a phone interview -- going back to your point,
3 Mr. Leinenkugel, about outcomes -- looking at
4 outcomes for individuals who are new to mental
5 healthcare. So, when they initiate mental
6 healthcare, we follow up with them within two
7 weeks after their initial appointment, and
8 then, three months later. And we're looking at
9 mental health outcomes, symptoms and
10 functioning and how are they doing, and whether
11 they've continued. And then, we can crosswalk
12 that with our administrative data and look at
13 their utilization of care, et cetera. So,
14 that's the Veterans' Outcome Assessment.

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

21 And then, we also have an Annual
22 Mental Health Provider Survey where we look at

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1 the experience of the mental health
2 professionals that are working in the VA
3 system.

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

7 I also just want to mention, in
8 terms of ensuring that we're offering high-
9 quality care, we have -- and I mentioned this a
10 little bit already -- specialized programs to
11 address the needs of specific populations, some
12 of which are listed here. We offer training in
13 evidence-based treatments for mental
14 healthcare. As of a couple of months ago, more
15 than 12,700 VA mental health clinicians had
16 been trained in evidence-based psychotherapies,
17 with about 8500 of that in either prolonged
18 exposure or cognitive processing therapy, which
19 are the two treatments for post-traumatic
20 stress disorder that have the strongest
21 evidence base. So, we are really investing in
22 our mental health professionals and their

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1 training, and making sure that what they can
2 offer to veterans is based on the best evidence
3 that we have.

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

14 I also want to mention our Mental
15 Health Centers of Excellence. We have 10
16 MIRECCs they're called, Mental Illness Research
17 Education and Clinical Centers, and six or
18 seven, depending on how you count, other
19 Centers of Excellence in the realm of mental
20 health. They each have a specific and distinct
21 mission. Each of those 16 centers has a
22 specific and distinct mission and are really

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1 hubs of innovation for our system. They all
2 have a combined mission of doing research,
3 providing education, and developing innovative
4 clinical programs, and testing innovative
5 clinical programs. And so, they are a real, I
6 think, jewel in our crown of VA does when it
7 comes to mental health.

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

15 I also want to mention -- it's not
16 just us tooting our own horns -- external
17 reviews of VA's mental healthcare generally
18 find that VA care is equal to or better than
19 care that's available in the community. And I
20 understand that you will be hearing more about
21 the National Academy of Medicine evaluation,
22 which is the most recent thing. So, I'm

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1 thrilled that you're going to be hearing more
2 about that in detail. So, I won't go into
3 detail here, but I think it's always helpful,
4 not just for us to look at ourselves, look at
5 what we're doing, but what do other people
6 think of what we're doing?

7 All right. And so, I promised I
8 would highlight just a few things that I think
9 are more specific, but I think relevant to your
10 work and unique to VA. One is the primary
11 care-mental health integration. VA really is
12 seen as a national leader in this area. What
13 that means, as I mentioned, is that we have
14 mental health providers who are embedded in
15 primary care settings. It allows us to
16 proactively screen. It allows us to identify
17 and address mental health concerns as early on
18 as possible. It allows us to identify and
19 address mental health concerns for people who
20 might not to walk down the hall to the mental
21 health clinic, but might talk to their primary
22 care doctor.

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1 We know that a lot of mental
2 healthcare is provided in primary care, and it
3 better equips our primary care providers to
4 provide that care. It reduces wait times. As
5 I mentioned, one of the principles of our
6 PC-MHI program is to have open access. And it
7 gives us a doorway to engaging people who might
8 need more extensive mental healthcare, to try
9 to get them moving in that direction.

10 And I think it's important, going
11 back to talking about suicide, to note that,
12 according to the CDC, 54 percent of people who
13 died by suicide did not have a known mental
14 health condition. And about 40 percent of our
15 own patients, veterans, who are seen in VA who
16 died by suicide did not have a known mental
17 health diagnosis or mental health treatment in
18 the previous year, but they were being seen in
19 VA. So, it's really important, I think, for us
20 to make sure that our primary care providers
21 are well-equipped to address the full range of
22 challenges that veterans come to them with and

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1 to try to help identify if someone is at risk,
2 because a lot of people who are at risk are not
3 being seen in mental health and don't have an
4 identified mental health condition.

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

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

22 We share those results with the

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1 veteran. So, right there in the session, talk
2 to them, show them, graph their progress, or
3 lack of progress, and then, use that to make
4 changes and make decisions about treatment and
5 make decisions about when someone is ready to
6 move on to less-intensive treatment, might need
7 more intensive treatment, when a treatment is
8 or isn't working. And it really allows us to
9 empower veterans as partners in their care and
10 use data and use information to provide the
11 best care we can. So, it's an exciting
12 initiative that we have underway.

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

17 So, just moving on, I want to just
18 talk briefly about tele-mental health again,
19 amplifying something that Dr. Taylor said about
20 how much we have increased the use of tele-
21 mental health in our system. In fiscal year
22 2017, we provided tele-mental health services

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1 to more than 151,000 veterans, and that was
2 more than 473,000 sessions.

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

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

14 Okay. I'm going to shift gears real
15 quickly and mention our suicide prevention
16 efforts. As we have talked about, this is a
17 major priority for VA to address veteran
18 suicide. We are taking a public health
19 approach to veteran suicide. The idea is that
20 suicide prevention is everybody's business.
21 Suicide is preventable. And we know that the
22 majority of veterans who have died by suicide

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1 haven't come to VA, at least not recently, for
2 care.

3 And so, we need to help reach
4 veterans and their families wherever they are.
5 We need to build community engagement. We need
6 to change the conversation around suicide. We
7 need to continue to develop innovative
8 strategies for prevention and continue the work
9 that we're doing within our VA healthcare
10 system. Because we also know that, while the
11 rates of suicide have been going up in our
12 country overall, and rates for veterans have
13 been going up overall, the rates for veterans
14 who are in VA care are not going up as quickly
15 as the rates for veterans who are not in VA
16 care. They are still going up. It's still
17 happening that there's an increase, but it's
18 not going up as quickly for veterans who are in
19 VA care. So, we need to do all these other
20 things and we need to keep providing good
21 mental healthcare and good care within our
22 system as well.

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1 Just to quickly mention some of the
2 key suicide prevention goals that are directly
3 in line with what I was just saying: the
4 mobilized action nationwide; this idea that
5 suicide prevention is everyone's business;
6 expanding universal prevention initiatives.
7 That means, in a public health model, universal
8 prevention is a prevention strategy that's
9 applied to everyone, not just those who are in
10 specialty treatment and not just those who are
11 identified at risk, but everyone.

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

17 Fostering innovation. Again, a
18 public health research strategy. Educating
19 veteran communities about lethal means safety,
20 and going back to the idea of access to
21 proactive mental health support and treatment,
22 and with a particular focus with partners in

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1 the community on veterans transitioning from
2 service. So, those are some of the key focus
3 areas or key holes related to our suicide
4 prevention efforts.

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

19 And then, the last thing I'll
20 mention, we've talked a little bit about how we
21 need to reach all veterans and how many
22 veterans are not in our care. One way in which

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1 we've worked on doing this within the mental
2 health realm is through outreach.

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

13 The Make the Connection Campaign
14 really highlights the strengths of veterans
15 that have sought support. It features veterans
16 themselves telling their own stories of
17 difficulties they've faced and what has helped
18 them, and what they have done to have healthier
19 and happier lives. They're really incredibly
20 powerful and courageous stories, and it's an
21 online resource. It's through social media.
22 The last data that I looked at, the Make the

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1 Connection website had had about 15 million
2 visitors to the website. About 59 million of
3 the videos had been viewed by visitors to the
4 website.

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

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

22 And I think that was the last thing

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1 that I wanted to mention. So, quick snapshot,
2 45,000 -- did I hit 45,000-ish feet?

3 (Laughter.)

4 CHAIR LEINENKUGEL: I'd say 30,000.

5 (Laughter.)

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

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

10 DR. TENHULA: Great.

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

13 This is going to go Dr. Carroll, who
14 will be coming in next month. But it will be
15 on the record, and I don't expect you to have
16 the answer because I have not heard the correct
17 answer for 18 months. But we need to find out
18 the answer because you have an integrated,
19 connected healthcare system now within VA
20 dealing with mental health along with primary
21 care. And you have a name for it and an
22 acronym.

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1 And I know it does work in certain
2 VAs because I've seen it where the primary care
3 doctor made sure that a patient did not leave
4 until she saw, due to a stress situation that
5 she had, a mental healthcare provider, which
6 was fantastic.

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

13 No. 2 --

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

16 CHAIR LEINENKUGEL: Vacancies,
17 correct.

18 DR. TENHULA: Okay.

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

21 Two, what are the mental health
22 vacancies that are open, both on the clinician

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1 and systemwide shortage?

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

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

15 So, it's on record now for us to
16 find out and get the exact number through this
17 Commission, so that we have clarity going
18 forward to see if there is a true gap and how
19 we are going to resource that gap or repurpose
20 dollars from other programs, as Commissioner
21 Beeman brought up earlier. So, I think these
22 are the right type of things that we, as a

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1 Commission, need to start asking the questions
2 and getting the answers to, so that we can come
3 up with the proper recommendations.

4 But both of your presentations were
5 absolutely spot-on from the 100,000-foot,
6 80,000, down to 35,000. And we're going to get
7 down to ground level. That's where the
8 Commission needs to be.

9 So, next? Wayne, did you have
10 something?

11 DR. JONAS: Yes, I just wanted,
12 actually, to add onto that a bit. I think it's
13 in the same theme. I mean, just simple math.
14 If 80 percent, or three times the service
15 demand has gone up since 1006, as have the
16 resources, given that you have such a good
17 system -- it sounds like you have one of the
18 top mental health systems anywhere -- have
19 those resources gone up proportionately? So,
20 was it one-to-one during that period of time?
21 Or is there a relative deficit now? That's
22 just building on your question here.

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1 DR. TENHULA: So, I can say -- and
2 we can provide more -- I don't have the exact
3 numbers off the top of my head. I can say that
4 mental health staffing during that time has
5 gone up. So, I showed you the demand curve of
6 how many more patients we're seeing and how
7 many more visits. Mental health staffing has
8 gone up during that period, but it has not kept
9 pace.

10 DR. JONAS: It has not kept up?

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

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

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

17 DR. JONAS: Yes.

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

21 DR. TENHULA: The staffing has not,
22 but it has gone up.

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1 DR. JONAS: Have you evaluated the
2 peer-to-peer system? I mean, is there some
3 hard data on how that's impacted quality,
4 access, outreach, mental health, any of the
5 other outcome parameters in some way?

6 That's a model, by the way.

7 DR. TENHULA: Yes.

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

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

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

18 DR. JONAS: Yes. Okay. My last
19 question is, given that you have such a robust
20 mental healthcare system and there is a
21 movement now to try to increase the access into
22 civilian populations, which I presume many of

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1 which will not be as good, is there a problem
2 there? For example, is there a need to kind of
3 map out and create some top examples of what
4 needs to happen if civilian groups get in?

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

10 DR. TENHULA: It was an amazing
11 experience.

12 DR. JONAS: Yes.

13 DR. TENHULA: You're right.

14 So, we've tried to address that.
15 I'm not sure this will fully answer your
16 question. But one of the things that we've
17 tried to do, for example, is create training
18 and education that is available for free and
19 provide free continuing education credits for
20 civilian providers on topics such as military
21 culture competence, military culture training,
22 on various aspects of suicide prevention that

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1 are evidence-based.

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

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

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

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

19 Evidence-based confirms that where
20 the veteran was reached the last minute, there
21 were a large number of successful prevention.
22 And this push-button should not be answered by

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1 a call center. It should be answered by a
2 qualified clinician. It will save lives.

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

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

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

21 Thank you very much.

22 DR. BEEMAN: Dr. Tenhula, I

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1 appreciated your presentation. Just a couple
2 of comments.

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

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

22 This has got a long tail on it.

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1 What worries me, as the private sector gets
2 into the business as well, we're going to
3 create a tremendous shortage. We may not be
4 able in government to meet or compete for the
5 professionals because they have more money to
6 spend perhaps. How are we going to meet that
7 demand? So, we have to be prepared, I think,
8 to answer that question.

9 Thank you.

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

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

21 DR. TENHULA: That's a good point
22 and something that is really important to look

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1 at and be mindful of. The shortage of mental
2 health professionals, the gap demand, between
3 need and professional services available isn't
4 a problem that's unique to VA. It's our mental
5 healthcare system in our country is lacking
6 providers.

7 Thank you.

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

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

18 MR. ROSE: It works?

19 DR. TENHULA: Yes.

20 CHAIR LEINENKUGEL: I don't want you
21 ruining Dr. Carroll's nice vacation in Germany
22 and pinging him immediately with those three

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1 requests from the Commission. But I bet you
2 some staff members can start working on that
3 for him.

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

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

13 (Applause.)

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

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1 forward and move on to the next presentation.

2 We have three very prominent ladies
3 in front of us, and I'm not going to read each
4 of their bios because that would cut in another
5 10 or 12 minutes because they're extensive.

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

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

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

21 DR. GAUDET: Very happy to provide
22 any details you want after the session.

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1 I'm Tracy Gaudet. Very honored to
2 meet all of you, and I'm very excited, we all
3 are, about the Commission and the opportunity
4 before us, the VA and the nation actually.

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

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

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1 I thought maybe we should do this or
2 something, the three of us.

3 (Laughter.)

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

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

20 And everybody knows this is not
21 sustainable. Everyone in the nation is calling
22 for a massive transformation in how we think

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1 about health. We know it's somehow related to
2 helping people take charge of their health and
3 well-being, because 75 percent of costs are due
4 to chronic conditions that are affected by
5 people's choices.

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

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

21 We've been working in the VA to say,
22 how could we do healthcare in a completely

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1 different way? And this I'm passing out
2 because you can see this model in the
3 first -- if you open up that little handout,
4 you can see it a little bit better than on this
5 slide.

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

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

19 Actually, it used to say "you" in
20 that little center. And I was at the
21 Fayetteville, North Carolina, VA, and there was
22 a homeless veteran who was holding this thing

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1 up. And he said, "This put me back in my life
2 again." And I went, oh, why does it say "you"?
3 It should say "me". So, it says "me" now.

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

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

12 DR. KHAN: Jamil.

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

19 So, the concept of mindful awareness
20 is teaching veterans -- and veterans love this
21 and get this -- just to take a moment and tune
22 into the state, whether it's the state of their

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1 depression, whether it's the state of their
2 impulse to end their life, whether it's, oh,
3 something practical like tuning into, oh, I
4 have pain right now; it's at a level 2; I
5 wasn't really noticing it because I don't
6 usually pay attention until it's a 9. But, oh,
7 if I pay attention now, I could be more
8 proactive about my health and well-being.

9 So, that concept of mindfulness and
10 awareness is a skill that we're teaching, and
11 it interfaces with all of those areas of green.
12 And all of the areas of green are self-care.
13 It spans everything from relationships to work,
14 to stress, to nutrition, to surroundings, et
15 cetera. And all of those elements we know are
16 so critical to someone's health and well-being.
17 It's the majority of the model. And yet, our
18 healthcare delivery system is actually focused
19 only on the blue, on the professional care,
20 right? So, how do we begin to shift that? It
21 really requires that we change the
22 conversation.

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1 Two quick stories I wanted to tell
2 to demonstrate what this approach looks like.
3 One is a story that Jeff Milligan, who is now a
4 Network Director, told when he was the facility
5 Director in Dallas. And he tells the story of
6 a gentleman, a veteran, who was a patient, an
7 outpatient veteran in their primary care clinic
8 who committed suicide. And he tells it very
9 eloquently and beautifully.

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

19 And the reality is, they did
20 everything right. They did everything right in
21 our current system. You know, they asked all
22 the questions they were supposed to ask. They

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1 checked all the boxes. But we're asking the
2 wrong questions and missing people's suffering.

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

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

18 I'll give you one other
19 illustration, how teaching people to change the
20 conversation can change everything. And this
21 is a story that a physician in Boston, Jackie
22 Spencer, shared and gave us permission to

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1 share.

2 She was in a busy clinic, seeing her
3 patients. An OEF-OIF veteran comes in who she
4 had seen a couple of times before. She said,
5 this big, burly guy, and he comes in and he's
6 got knee pain. Chief complaint, knee pain.

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

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

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1 because I was doing the knee pain." He came in
2 with knee pain.

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

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

17 So, we said, okay, we're going to
18 focus on this treat bucket. And now, when
19 people come to their visits, and primary care
20 visits in particular, we're going to train
21 clinicians in this approach and we're going to
22 do all of this in the clinic.

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1 So, you guys are looking at me like,
2 "Yeah, I can tell you that wouldn't work."
3 Right?

4 (Laughter.)

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

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

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

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

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1 (Laughter.)

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

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

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

18 And that was really an important
19 breakthrough, that it wasn't just doing it
20 differently in the clinic; it was actually
21 reconfiguring what healthcare is and how we
22 deliver it. And if, in addition to clinical

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1 care, we have well-being programs that are
2 focused on equipping people, that's a big deal.
3 We're going to connect it with their personal
4 health plan.

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

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

16 So now, what we're finding are
17 amazing stories -- and I'm going to let Kavitha
18 tell some of them -- of people discovering what
19 they want to live for and doing that with
20 peers, not with clinicians, doing that with
21 family members, and really bringing that
22 forward to this is what I want my health and

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1 life for. And now, they're empowering. Then,
2 they get the skills they need in the well-being
3 programs and, then, they have clinical care
4 that's aligned, too.

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

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

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

18 So, I just wanted to mention, too, I
19 think in the mail-outs you maybe received the
20 entire CARA legislation, which is huge.
21 Section 931, which is the COVER Commission, is
22 one of those very important pieces.

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1 And then, two other sections that
2 I'll just mention. You can do some nighttime
3 reading of the full legislation. But Sections
4 932 and 933 are also under Subtitle C. And so,
5 what those do, they mandate the expansion of
6 integrative health, education, research, and
7 clinical care.

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

15 And then, also, Section 933 -- and
16 Kavitha will get a little bit more into this on
17 one of our later slides -- was the mandate for
18 no fewer than 15 three-year pilot sites to
19 expand complementary and integrative health.
20 But, just as Dr. Gaudet was talking about, we
21 can't really just plot integrative health into
22 the medical center by itself. We really need

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1 the sort of systems approach of how to do that.
2 And so, those are our whole health system
3 flagship sites, which we'll talk a little bit
4 more about. And also, I think in Tab O in your
5 binders is a whole list of the flagship sites,
6 in case you're curious where those are.

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

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

22 So, as such, while our office has

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1 been working on the different components of
2 whole health and that system, we also have an
3 arm of our team that's solely focused on whole
4 health education. And so, up on this slide I
5 have some of our current and planned practices.

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

20 Also, on top of that, with our
21 flagship sites, we know that we can't just do
22 all of this training nationally. So, we need

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1 folks who are locally at the medical centers.
2 We have identified two whole health flagship
3 site education champions at each of our 18
4 flagship sites. They're there to really help
5 train and deliver local trainings at each of
6 our flagship sites.

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

16 Some of our new whole health
17 education initiatives, which we'll be able to
18 get more information for you as they're being
19 developed, but a Whole Health for Mental Health
20 Course, which I think we're going to be trying
21 to pilot two of those courses in fiscal year
22 '19, in collaboration, of course, with the

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

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

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

18 And then, another exciting program
19 that we're working on right now with some of
20 our subject matter experts is VA CALM. And
21 that's a mindfulness facilitator/instructor
22 training that each of those flagship sites will

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1 be able to send a couple of folks to be
2 trained, so that they can, then, be leading
3 mindfulness meditation at their sites.

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

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

19 In addition, we have a number of
20 online resources as well. So, there is the
21 option for employees to take trainings on their
22 own online. We also have a Whole Health

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1 Library. And so, we can send you the link to
2 that. You can also just Google "VA Whole
3 Health Library". This is open to the public.
4 It's a whole bunch of different educational
5 materials and courses, all the courses I
6 mentioned. If you want to know more about it,
7 a whole lot of information on there for you to
8 take a look at.

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

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

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

21 So, while we have a really strong
22 whole health education program, a couple of

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1 things that we're noticing or getting requests
2 for from the different facilities is the need
3 for more facility-level training for large
4 employee populations. And so, VA medical
5 centers have also asked for the train-the-
6 trainer programs, so that they can not only
7 offer education at a local level, but also
8 train instructors at a local level as well.

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

15 So, some of the recommendations that
16 we are looking at for our plan practice going
17 into the future is, in fiscal year '20, to
18 offer a train-the-trainer course for whole
19 health facilitators and whole health partners.
20 Really continue to work to make national whole
21 health offerings flexible and customizable at
22 the local level. Continue to help standardize

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1 whole health education as well to keep away
2 from slippage. And then, as I mentioned,
3 enhancing integrative health trainings to
4 include additional integrative health
5 approaches beyond just our battlefield
6 acupuncture. So, looking into the practicality
7 of maybe mindfulness training, yoga training,
8 tai chi training, things like that, inside of
9 VA.

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

12 DR. REDDY: Thank you, Alison.

13 I might go to the next slide.

14 So, as Alison mentioned, CARA asked
15 us to greatly expand the delivery of education,
16 but also to look at research of complementary
17 and integrative health, especially as it
18 pertains to our patients with mental health
19 illness, chronic pain, substance use disorder.
20 And so, I really am excited to share with you
21 some of the research that's happening now and
22 some of the planned research going forward.

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1 There's an \$81 million collaborative
2 between DoD, VA, and NIH, actually, and
3 multiple studies being done looking at CIH and
4 pain management. Seven of those are being done
5 within VA.

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

16 We are looking at CHI for PTSD.
17 Recently, in 2016, we had a state-of-the-art
18 meeting where we looked at specifically non-
19 pharmacologic approaches to pain, a very
20 successful meeting, and those recommendations
21 have recently been published as well in The
22 Journal of Internal Medicine.

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1 We have evidence-based synthesis
2 program reports on several CIH reports. These
3 are quite useful in educating our providers and
4 when and where to use these approaches in a
5 personalized health plan with their patients.
6 And we plan to be doing ones on hypnosis,
7 biofeedback, and guided imagery. So, we'll
8 have a really robust library of those reports,
9 and we can share those with you at a future
10 date as well.

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

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1 of those recommendations that came out of that
2 summit.

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

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

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

21 MS. WHITEHEAD: I could talk about
22 this for a full day. So, I'll try to keep it

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1 brief. I'm very passionate about integrative
2 health.

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

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

21 And for those of you who have worked
22 in the healthcare setting outside of VA -- and

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1 with colleagues outside of VA, this is
2 something that is sort of new outside the VA as
3 well. So, I think we've done a lot.

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

10 And then, more recently, a survey of
11 approximately 1200 veterans on the use of, and
12 interest in, complementary and integrative
13 health showed that approximately 52 percent of
14 those veterans had used any type of integrative
15 health approach in the past year, which I
16 thought was very excited. The top two reasons
17 for use, which may not be a surprise, was pain
18 and, then, also, stress reduction and
19 relaxation. And some of the more frequently-
20 used approaches, based on that survey, were
21 massage, chiropractic care, mindfulness, and
22 yoga.

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1 The first bullet up there under
2 current practice, VHA Directive 1137, the
3 Provision of Complementary and Integrative
4 Health, so that's something that our office had
5 been working on for quite a long time.

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

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

21 And so, approaches on our List 1,
22 which I'll name in just a moment, must be

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1 provided through VA onsite via telehealth or in
2 the community as part of the medical benefits
3 package. So, these integrative health
4 approaches have to meet the definition of basic
5 care as described in the medical benefits
6 package, and must be in accordance with
7 generally-accepted standards of medical
8 practice, and as we heard earlier, to promote,
9 preserve, and restore health.

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

18 So, the current List 1 approaches
19 include: acupuncture, biofeedback, clinical
20 hypnosis, guided imagery, massage, meditation,
21 tai chi, and yoga. So, you might think, oh,
22 well, there's all these other approaches. Even

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1 in the legislation, it lists a whole long list
2 of different potential approaches for this
3 group to look at.

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

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

20 So, there's a lot of support and
21 infrastructure that needs to be developed and
22 happen to be able to implement these

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1 integrative health approaches, which are new
2 within the U.S. healthcare system in general,
3 not just VA. So, a lot of what we've been
4 doing currently or recently is building that
5 business infrastructure to put into place a
6 mechanism, for example, to be able to track
7 these approaches.

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

19 At the same time, I had mentioned
20 briefly an internal survey that was done in
21 fiscal year 2015. We're working closely with
22 VA researchers on a complementary and

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1 integrative health environmental scan, sort of
2 an internal survey looking at what integrative
3 health approaches are being done across the
4 board, by what types of providers. And I think
5 that survey is actually closing the end of this
6 month. So, hopefully, in the next few months
7 we'll have some preliminary data that we can
8 share on that as well.

9 Just a few other things that we've
10 been working on related to integrative health
11 approaches. One issue that we had seen was
12 being able to hire integrative health
13 providers. So, the development of
14 qualification standards, minimum proficiencies.
15 For example, in February, we just had published
16 a qualification standard for a Licensed
17 Acupuncturist. So, we can now hire
18 acupuncturists at VA. Developing nationally-
19 classified position descriptions for things
20 like yoga instructors and tai chi instructors,
21 so that those types of providers can also be
22 hired at VA.

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1 So, we have various subject matter
2 experts across the field helping with that.
3 So, with the development of minimum
4 proficiencies, position descriptions,
5 qualifications, standards, et cetera.

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

19 A couple of other things that we're
20 working on, which I wasn't sure whether to put
21 them in the current or planned practice, but
22 expansion of integrative health through tele-

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1 whole health. So, we've heard a lot about
2 telehealth and telemedicine earlier today.
3 We've been working a lot around that with the
4 Office of Telehealth, the Office of Rural
5 Health, and various subject matter experts.

6 To go on to our planned practice,
7 really just continuing to grow each of our List
8 1 approaches due to supporting evidence that
9 we've been being able to collect, and, also,
10 developing new qualification standards as
11 needed to help support the field. For example,
12 we're working on a qualification standard for
13 massage therapy right now. So, that will open
14 up more of an availability for facilities to be
15 able to hire Licensed Massage Therapists.

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

21 And just really continuing to
22 reinforce that integrative health should not be

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1 just a standalone service or program, but
2 really integrated into this whole health system
3 of care.

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

16 And then, also, something else is
17 just the community partnerships, so partnering
18 with groups in the community. For example, we
19 have a national VA-YMCA MOU. You hear space is
20 an issue. So, getting creative. Some of our
21 sites will hold their groups, their peer
22 groups, maybe their health coaching, something

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1 like that, can be held in a different space.
2 So, it's a lot of local MOAs are being
3 developed between VA and YMCA, as an example,
4 but there's other partnerships happening as
5 well.

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

16 And one of our recommendations going
17 forward, I guess for ourselves, is really to
18 align resources to support our VISNs, or our
19 Veteran Integrated Service Networks, and local
20 medical facilities to ensure the appropriate
21 tracking of CIH approaches and, also, the
22 appropriate delivery of approaches.

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1 And now, I'll hand it over to
2 Kavitha, and she'll give you a little bit more
3 of the details of the flagship sites.

4 DR. REDDY: Okay. Thanks, Alison.

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

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

19 Right now, we have those 18 sites
20 launching, and we've had learning
21 collaboratives following the Institute for
22 Healthcare Improvement's Model for

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1 Collaborative Learning, in which we come
2 together for face-to-face meetings. We have
3 action periods of process improvement and
4 performance improvement. We have virtual
5 meetings. But what it does is it gets us all
6 on the same page for implementing, and then, we
7 can evaluate that implementation consistently.

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

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

21 We really want to deploy this model
22 over the next three years -- we're already deep

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1 into FY18, so the next two years after
2 that -- touching at least 30 percent of unique
3 veterans in each flagship hospital, so that we
4 can really see, does this generate the outcomes
5 we're looking for, does it generate a return on
6 investment, and looking at these quality-of-
7 life measures.

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

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

22 So, in my mind, the flagships are

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1 really trying to look at how do we
2 comprehensively look at our patients. And
3 then, that helps treat all these disorders.
4 That helps treat all the illnesses that we're
5 speaking of today.

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

11 We are bringing in more veterans now
12 because we're de-stigmatizing mental health.
13 We're bringing them in saying, we want to focus
14 on your well-being. We want to find out why
15 you want to be healthy. And maybe the
16 gentleman is telling me that he wants to hunt
17 squirrels in the forest. I am in Missouri.
18 So, just keep that in mind. Or the person that
19 says he just wants to get down on the ground to
20 work on his motorcycles. You find what it is
21 that they want to work for and you start to
22 uncover a lot of the backstory, right, things

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1 that they didn't want to share.

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

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

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

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1 us as physical complaints.

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

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

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

19 That's one example. I have another
20 young female who her story is about wanting to
21 jump off the Jefferson Barracks Bridge every
22 time she drives over it going over the

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1 Mississippi. And she somehow came to us and
2 started to work on her pain, her nutrition, her
3 migraines. And slowly, we uncover a military
4 sexual trauma that actually was feeding into a
5 lot of her behavioral choices.

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

14 And if you can't hear it in my
15 voice, what that's also doing is helping the
16 burnout of our employees. Because I was there
17 and I have seen it all around me. You talk
18 about same-day access with staffing shortages.
19 You're seeing burnout. And when that
20 compassion isn't there for patients because
21 you're burned out, you've got a problem again.
22 So, here we're talking about creating a system

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1 where employees are starting to feel incredible
2 about what they're doing now and fulfilled.

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

15 And I think, finally, I just want to
16 say community collaboration is a huge piece of
17 this puzzle, too. We are actively in the
18 YMCAs. We have a community churches reaching
19 out to us. We have vet centers, ESOs. So, I
20 think this is really about getting out into
21 those communities and rebuilding that trust
22 again.

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1 If I could say one thing for the
2 group here about the recommendation, it is I
3 can't say enough about how this feels like the
4 way forward. And if that's the case, then we
5 really have to align resources to develop this.
6 And that needs to come from all levels of
7 leadership, the highest levels to the program
8 offices, to the facilities, to our direct
9 supervisors.

10 So, that's the recommendation.

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

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

22 Just so the people, if there is

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1 anyone on the phone, can follow this:

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

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

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

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

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

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

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

20 Boston, Mass. "VA turns to
21 alternative pain treatments amid opioid
22 crisis."

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1 And I also added that we were very
2 fortunate to have the opportunity recently to
3 present an invited presentation to the Giving
4 Pledge. And the participants of that group
5 included Bill Gates, Warren Buffet, Richard
6 Branson. This was the only healthcare
7 presentation made to that group. Because they,
8 too, understand how huge of a transformation
9 this is, and that the public sector and the
10 nation can learn from what the VA is doing in
11 this. So, it's very exciting.

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

20 And when we think ourselves about
21 how we know what success is, it's so amazing
22 when veterans achieve outcomes that they never

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1 even envisioned possible. And it's not only
2 young, healthy veterans, it's all across the
3 spectrum. It's as pertinent at the end of life
4 as every place in between. And then, oh, guess
5 what? By the way, clinical outcomes improve
6 and costs decrease.

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

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

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

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

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1 death.

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

5 (Laughter.)

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

8 (Laughter.)

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

19 I would say that you have the best
20 momentum -- and I'm making a statement for the
21 record on that right now -- because there is
22 substance behind this. I mean, I could tell

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1 stories like Kavitha has just in my short
2 amount of time. So, I'm excited about this.

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

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

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

22 And one of the things that I've

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

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

18 The reason I mention that is that,
19 in creating that extraordinary experience every
20 time for those really difficult patients, we
21 started to create the extraordinary experience
22 and extrapolate that. And so, as I listen to

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1 you and say, you know, the primary care
2 physicians can't be that navigator. It's got
3 to be somebody else in the continuum. And it
4 sounds like you've got them, but maybe you need
5 to codify more the kind of navigator that
6 you're going to have.

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

15 I hear a lot of us in VA comparing
16 ourselves to the civilian. "We're better at
17 this. We're better at that. We do this really
18 well." No one cares. What you want to do is
19 let's run our own race. Let's be so
20 extraordinary that those 9 million veterans,
21 the 3 million that don't come to us choose us
22 because we're so extraordinary.

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1 And so, there's an awful lot that
2 happens in this private side that's better than
3 we can ever provide. And there's so much more
4 here. Because I think that what we're doing is
5 so noble, and we're ennobled by our patients
6 and the special bond that we have with them,
7 that we don't have to compare ourselves with
8 them. Does that make sense?

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

18 Thank you.

19 DR. GAUDET: Well, and I appreciate
20 those comments very much and agree with that.
21 I'll just quickly respond to your first
22 question about, are we trying to do too much?

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1 I'm an impatient person by nature, but on my
2 team we've coined the phrase "death by
3 enthusiasm."

4 (Laughter.)

5 DR. GAUDET: But I will say, I was
6 hired by the VA to stand up this effort in
7 2011. So, sometimes I look at it and go, "Man,
8 it's taking so long." But not really, because
9 it needs big system transformation.

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

16 But we didn't begin to know how to
17 implement it, and we did not want to do that
18 from the top-down because that fails every
19 time. So, we really, over these years, have
20 resourced innovation in the field, learned,
21 observed, evolved the model, created education
22 to advance what we know. And it has been a

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1 rather strategic evolution, to the point where
2 now we at least have a consistent model, which
3 is done and we'll still learn and grow. But we
4 know enough to say, these we believe are the
5 core elements of this transformational
6 approach, so that we can now look at this
7 consistently.

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

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

19 DR. JONAS: I have four questions,
20 and these aren't all for you, but I want to get
21 them out there because I think we need to hear
22 from somebody about these.

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1 Boy, Tom, I sure wish that we could
2 do that, and I hope you take his advice. Don't
3 listen to me. Do exactly what he said.

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

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

20 So, we've got to figure out how to
21 do that better. And so, that's a methodology
22 issue. We need to figure out how to do that.

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1 Maybe your evidence bubbles, which VA has sort
2 of created, and is doing great, can be expanded
3 and built upon, so you can truly get
4 comparative effectiveness research.

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

18 I would be interested to know if
19 there are any civilian models out there that
20 are doing something comparable and, if so,
21 could we possibly gather some of them and
22 actually look at that within this Commission?

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1 I mean, are there some systems out there that
2 are trying to shift the incentive model and the
3 model of delivery on its head, so it's team
4 care and it is a truly primary care-based
5 model, not that primary care physicians are
6 delivering it, but it's a primary care-based
7 model? And that would be, I think, very
8 helpful for some comparison component.

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

17 And I know that some systems have
18 had to actually redesign the electronic medical
19 record because they could not find or execute
20 on a commercial one that actually wasn't about
21 payment in some way. And so, I hope we can get
22 some information about that in those areas.

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1 Then, finally, I just want to say
2 congratulations. We had some of the top
3 leaders in the VA just before you at our closed
4 meeting, and they all mentioned complementary
5 and integrative medicine, every single one.
6 So, it's like, okay, maybe we're getting there
7 in those areas. So, you've been doing some
8 good communication in those areas. So,
9 congratulations on that.

10 DR. GAUDET: And if I could just add
11 on the record, I am really grateful that you're
12 interested in the electronic health record. We
13 are not the experts, obviously, but I was
14 briefed on that as a part of the Leadership
15 Council last week. And we were told in that
16 briefing that VA will have the opportunity to
17 shift and define the content of that health
18 record, which I think is paramount, because we
19 can do all of this we want, and if it's not in
20 the record -- so, I appreciate that the
21 Commission is interested in that question
22 because I think it would be very critical.

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1 CHAIR LEINENKUGEL: Anybody else on
2 the Commission for any of the doctors at this
3 point? Ladies, I want to thank you so much for
4 your efforts.

5 There is one. Oh, thanks, Shira.

6 DR. MAGUEN: One more quickly.
7 Sorry.

8 CHAIR LEINENKUGEL: Thank you.

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

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

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1 actually get those services.

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

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

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

17 But, second of all, we have looked
18 at what literature does exist to create some
19 national recommendations for frequency and
20 duration of offering those approaches, so that
21 there's at least a standard across the country
22 for that. Of course, we're working with

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1 community care. We don't have a lot of updates
2 on that yet, on ways to be able to provide this
3 in the communities when those resources don't
4 exist.

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

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

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

21 DR. MAGUEN: I will also say that
22 what's been really neat is that some of our

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1 primary care doctors have been trained in
2 battlefield acupuncture. And so, we're
3 actually seeing that they're able to get
4 release time to do it onsite and have seen
5 incredible results, too. So, I think that
6 we're starting to kind of think about how can
7 we work it into some of the staff that we
8 already have there, which has been helpful, but
9 we can't quite get that for whole health within
10 every one of the domains.

11 CHAIR LEINENKUGEL: Thank you so
12 much, Shira. Alison and Kavitha and Tracy,
13 again, great to see all of you, and great,
14 also, to see you making tremendous headway with
15 whole health within the VA system. I
16 personally believe it's the future. I think
17 that you are leading in it right now, without
18 really knowing who the true competitors are.
19 But I think it's something that, when you see
20 it in practice, when we all see it in practice
21 and, then, talk to the veteran after the
22 veteran has been exposed to what you have in

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1 your toolbox, and whether or not it's enough or
2 it's too much, you're figuring that out right
3 now. And that's been just a delight to see.
4 We, as commissioners, will be participating in
5 the next 18 months to see more of it. But
6 thank you all for your efforts.

7 (Applause.)

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

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

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

17 And thank you so much for coming
18 before the Commission, this being our first
19 public session. And it's very important for
20 what you're going to present to us today, for
21 us to get the context into what is taking
22 place.

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1 Dr. Alicia Carriquiry is a
2 distinguished professor of liberal arts and
3 sciences and professor of statistics at Iowa
4 State University. She also holds the
5 president's chair in statistics and is director
6 of the Center of Statistics and Applications in
7 Forensics Evidence, an NIST Center of
8 Excellence.

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

16 (Laughter.)

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

22 Born in Uruguay, where she graduated

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

7 Welcome and thank you so much,
8 Alicia.

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

22 And the hope was that we would

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1 understand why some veterans do not use the
2 VA.

3 And among those that use the VA, what do they
4 think about the services they receive?

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

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

20 So, the committee designed and
21 filled in a survey that is representative of
22 the veteran population of OEF, OIF, and OND.

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1 We ended up interviewing over 3,000 veterans.
2 As I said, this is a representative sample.
3 So, the conclusions we -- or the results we
4 draw from these particular veterans we
5 interviewed can be extended to the population
6 of veterans themselves.

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

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

20 So, as I said before, the approach
21 that we took was to collect all the available
22 information. So, survey of veterans, site

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1 visits, information from -- and during the site
2 visits, I should say, we talked to as many
3 people as possible. We talked to veterans that
4 used the VA. We talked to veterans that didn't
5 use the VA. We talked to family members. We
6 talked to community providers. We talked to VA
7 providers at all levels. And so I think those
8 visits were pretty intense and we got
9 information from all sides.

10 Yes?

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

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

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1 access to them. And it was hard.

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

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

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

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

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1 interesting.

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

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

13 And then the report goes out for a
14 thorough review. So, in this particular case,
15 it went out to something like 16 external
16 reviewers from all areas. The committee
17 doesn't know who the reviewers are, of course.
18 And these reviewers came back with about 90
19 pages of comments and request for changes and
20 so on. We tried to be responsive to the
21 reviewer's comments. And what you see there is
22 the final version of that report.

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1 So, what are some of the key
2 findings? I think we had some interesting
3 findings.

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

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

21 The other finding was that there's
22 several barriers for access. But the number

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1 one, by a mile and a half, barrier to access is
2 the clumsy transition between DoD care and VA
3 care. The transition of veterans from the care
4 they received while on active duty to, you
5 know, entering into the VA system is a huge
6 barrier.

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

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

20 And so that's -- I think it's going
21 to be reflected back in our recommendations.
22 That was our number one recommendation, to try

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1 and, you know, sort of marry those two systems
2 so that there's a seamless transition between
3 DoD care to VA care.

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

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

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

21 For example, we find that many of
22 the veterans that live in rural areas, for

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1 example, sometimes have to dedicate an entire
2 day to come for a visit of the VA. Two hours
3 in a bus from somewhere. Then the visit. Then
4 two hours back in the bus. This is a real
5 deterrent to seek care.

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

12 The ability to own and carry guns is
13 a big concern of veterans. Many veterans do
14 not seek care because they think that might
15 lead to a loss of a permit to carry and own
16 guns, also to loss of contact with or custody
17 of their children, concerns about loss of
18 medical, disability benefits. There's many
19 issues that have very little to do with the
20 quality of care that the VA provides, and a lot
21 to do with the environment in which these
22 veterans operate.

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1 This said, once a veteran is in the
2 VA system, in general the reports are very
3 positive. So, veterans have a very good --
4 well, let me -- many veterans report a very
5 good experience with the VA mental health
6 services. They wish they could get more of it
7 and they could get it faster. But once they
8 get it, they really like it.

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

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

22 There's many complaints, too, of

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1 course. But, overall, that's what the data
2 suggested.

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

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

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

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

21 Like it was noted before, there's
22 burnout and job-related stress among VA staff

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1 at all levels. Medical staff, administrative
2 staff. And that contributes to high turn ver.
3 And part of the issue is that many of these
4 individuals are carrying out tasks that are
5 simply not what they should be doing. So you
6 find clinicians doing a lot of administration.
7 You find administrators doing things that, you
8 know, they were not expecting they would have
9 to do.

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

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

22 It has enormous advantages in that

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1 the VA, of course, is also a teaching
2 institution. So you have the research paired
3 with clinical practice. There is a quick
4 transition from research to practice in many of
5 the different types of care that the veterans
6 receive.

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

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

20 DR. CARRIQUIRY: Yes. And that's
21 the other thing that -- yes, caseload plays
22 into that. Everything plays into that.

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1 The fact that, for example, a
2 clinician doesn't have the facilities to carry
3 out small group sessions. Or doesn't have, you
4 know, the staff to take good records and has to
5 be typing himself or herself while listening to
6 a patient. All of those things contribute to
7 burnout.

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

14 There's a lot of -- there has been a
15 lot of attempts to coordinate activities with
16 other community providers. And there's some
17 formal programs -- for example, the Veterans
18 Choice Programs. This is all good. The
19 committee was all in favor of the VA
20 coordinating services with community providers.
21 But, of course, there's this issue that all
22 community providers are not within the VA.

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1 So, the controls, the quality
2 control that goes on for VA providers, it
3 doesn't really go on for providers outside of
4 the VA. So there's an issue about making sure
5 that the quality of care that veterans receive
6 outside of the VA, but with the blessing of the
7 VA, if you will, is really the type of care
8 that the veterans would have received in the
9 VA.

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

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

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1 some ideas on how that might be carried out.

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

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

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

21 Continue integrating the services of
22 non-mental healthcare providers with the VA

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1 healthcare providers. Again, making sure that
2 quality is maintained even outside of the VA
3 system.

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

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

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

18 Deployment and use of evidence
19 practices. Increasing the use of AVPs through
20 efficient and scalable training procedures.
21 And, of course, identifying and addressing
22 research gaps and other priorities.

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1 The VA needs to eliminate barriers
2 to accessing mental healthcare. Some of those
3 are going to be easy to do. Some of those are
4 going to be very difficult to do.

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

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

22 One should ensure that the diverse

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1 patient population receives accessible, high
2 quality, integrated mental healthcare services.
3 The needs, for example, of women veterans,
4 minority veterans, LGBT veterans, are not the
5 same as the needs for, you know, a straight
6 male veteran.

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

15 The homeless veteran population is
16 another population that sometimes is
17 underserved. So there's a need to -- of
18 course, most of the homeless is Vietnam-era
19 veterans, not necessarily the OIF, OEF, and OND
20 veterans. But, nonetheless, this is a
21 population that is underserved, and agreements
22 such as those that exist between VA and the

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1 housing authority to find housing for these
2 veterans is really important.

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

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

19 And so one recommendation is to
20 explore whether every mental healthcare worker,
21 at all levels, can be brought under this Title
22 38 that alleviates -- that makes the hiring

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1 process much more flexible and easy to get
2 through.

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

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

19 One of the things that the VA is
20 extraordinarily good at is developing new
21 technology and implementing new technology. So
22 the VA should leverage its existing health

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1 technology infrastructure and top of the line
2 expertise in telehealth and virtual care --
3 there's nobody better than the VA in terms of
4 virtual care and telehealth -- to achieve many
5 things.

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

15 So there's a possibility of, you
16 know, making this expertise more uniform
17 through the entire system. Telehealth is also
18 very beneficial for those veterans that really
19 feel uncomfortable in crowded situations, that
20 do not want to visit crowded waiting areas. So
21 there's a lot of promise in terms of expanding
22 the use of telehealth, I think.

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1 And, finally, I think this is the
2 last recommendation. The VA should take this
3 opportunity to lead the nation in terms of
4 advancing quality management in mental
5 healthcare.

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

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

18 And I am not in the business of
19 recommending, you know, bringing business to
20 the National Academies, but I think that a
21 perfect consensus study would be, what are
22 affective outcome indicators? How do you

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1 measure what you want to measure? How do you
2 track? And furthermore, how do you put them
3 into practice to improve the services that the
4 veterans get?

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

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

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

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

20 I get the subset of what I call "the
21 long war" participants, where they're at 17
22 years now from the War on Terror. Or I like to

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1 refer to it as really 27 years, since 1991.

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

8 DR. CARRIQUIRY: In terms of
9 proportions?

10 CHAIR LEINENKUGEL: Proportions.

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

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

19 DR. CARRIQUIRY: I think this group
20 was very important for several reasons. Number
21 one, like you say, this is the longest conflict
22 that the U.S. has been involved in. This was

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1 the first time that women were deployed in
2 large numbers. The all-volunteer Army, what
3 happened was that these poor guys were deployed
4 multiple times for very long periods.

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

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

19 There's a couple of things that were
20 on the recommendations that I think we, as
21 commissioners, will take a look at deeply. And
22 a couple that jumped out at me personally were,

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1 when you say veterans like to be cared by
2 veterans, there's no question about that.

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

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

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

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

21 CHAIR LEINENKUGEL: Yeah. And just
22 from my recollection, I've heard bits and

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1 pieces of this, but not to the clarity that you
2 just presented in a very clear, short amount of
3 time.

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

13 MR. TROJANOWSKI: One hundred
14 percent.

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

21 CHAIR LEINENKUGEL: That's more than
22 fair, Alicia. Two points for the

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1 commissioners. Because it's going to come up
2 before us. Again, it's another ham sandwich
3 that we're sitting on and we're starving to
4 death. They're ICTs. And if you're in the
5 military, you know what an ICT is. It's that
6 medic, corpsman, doc, it's that individual that
7 went down to San Antonio -- I believe that's
8 where they're all trained, if I remember -- and
9 got distinct training, trauma training.

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

18 Do you know how many we have in our
19 ICT program that's been going on for over five
20 years? Seventy-three. And we have what's
21 called a clinician shortage in the VA. So, I
22 bring that up because you brought it up with

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1 your other recommendation on hiring, which was
2 Title 38. And that actually is part of the
3 solution. There's no question.

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

9 Tom, do you have something?

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

18 And then secondly, just anecdotally,
19 I remember in particular, I won't -- I'll cite
20 the service I thought did a great job. The
21 Marine Corps, when we were treating PTSD and
22 TBI patients, were part of the care process.

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1 So, the sergeant and the platoon lieutenant
2 would come to the center and be part of both
3 the admission process, but also the discharge
4 process. In a lot of the other services it
5 seemed as though the warriors were on their
6 own.

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

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

20 And so that's one of -- I'm not
21 saying that this is everywhere, but we have
22 heard reports from veterans that say, "I don't

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1 get support from my superiors to seek mental
2 healthcare."

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

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

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

19 DR. CARRIQUIRY: Yes. So, your son
20 had the benefit of having a supportive family.
21 This is one of the biggest facilitators to
22 seeking and keeping mental healthcare among

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1 veterans.

2 There are a lot of veterans that do
3 receive this type of support from their
4 community, the service, or what have you. But
5 the vast majority of them don't. I shouldn't
6 say the vast majority of them. There's a
7 sizeable proportion of veterans that fall
8 through the cracks between DoD and VA.

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

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

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

21 DR. CARRIQUIRY: Yes. We don't have
22 a list, but the VA does. So, one of the things

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1 that we did as a committee was, after each site
2 visit, we wrote a report. We didn't write a
3 report that said this clinician is a disaster.
4 We wrote a report that said, you know, we have
5 found these issues in this facility and these
6 things could be improved. And so on and so
7 forth.

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

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

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

21 (Off-microphone comments.)

22 CHAIR LEINENKUGEL: Okay. Last

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1 follow-up and then Wayne. What were the main
2 reasons that your group of individuals found
3 that veterans said we're getting great mental
4 healthcare or we're getting adequate mental
5 healthcare? What were the main drivers? Was
6 it the type of therapy? Was it the drug
7 therapy? Was it the counseling?

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

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

21 And so it was a combination. I
22 think that it's a love/hate relationship I

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1 think that the veterans have with the VA.

2 CHAIR LEINENKUGEL: Yeah. That's
3 fair enough.

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

12 DR. CARRIQUIRY: Yes.

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

18 (Simultaneous speaking.)

19 DR. JONAS: So it would be really
20 great to look at that. And I'll look through
21 the report and if there are back reports that
22 get into that.

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1 I'm interested in if you looked at
2 the flip side of stigma. Which is the
3 disability system.

4 DR. CARRIQUIRY: The what, sir?

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

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

22 Can you talk a little bit about

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1 that?

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

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

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

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

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1 DR. CARRIQUIRY: Yeah.

2 DR. JONAS: How many? Fifty
3 thousand?

4 DR. CARRIQUIRY: I have no idea.
5 But --

6 (Off-microphone comments.)

7 DR. JONAS: Forty-five thousand.
8 That's right Okay, sorry. There's a boatload.

9 DR. CARRIQUIRY: There's a boat load
10 of them, yeah.

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

16 DR. CARRIQUIRY: Yeah.

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

22 And I'm just wondering if there's some low-

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1 hanging fruit in that area. Is there a map of
2 how to do it so that these ICTs, once they get
3 in and now are helping, can actually get that?

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

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

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

22 MR. ROSE: I think just another

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1 comment there. Another comment, and that is, I
2 don't care if it's a substance abuse problem or
3 if it's a mental health issue. And you look at
4 the spectrum and how a person goes through
5 that.

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

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

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

22 DR. CARRIQUIRY: That was one of the

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1 striking findings. Right? So, we screened
2 about 8,000 veterans using the usual screeners
3 for substance abuse, PTSD, and depression, and
4 all these other things. And among the ones
5 that we screened and did appear -- this is not
6 a diagnostic, obviously. It's just a screener.

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

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

15 CHAIR LEINENKUGEL: Anything else?

16 (No response.)

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

22 DR. CARRIQUIRY: Thank you so much.

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1 Good luck with your work. And if you need any
2 more information, you know where to find me.

3 CHAIR LEINENKUGEL: We will. Thank
4 you very much.

5 (Applause.)

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

10 (Laughter.)

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

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

20 And also, I think, a larger
21 outcropping of that, seeing that this is now
22 exposed on a national level, nationwide, with

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1 our general population, that once again, we'll
2 be taking the lead, and should be taking the
3 lead, as far as making sure that at least our
4 veteran subset of our general population is
5 living up to the promise that various groups,
6 including our whole health has put up on the
7 screen today, that we have a commitment to our
8 veterans.

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

14 So, I'm just very proud to be part
15 of this Commission. I thank you for being all
16 in on day one. Day two is, again, going to be
17 a very interesting day. We're going to have
18 Fran present a lot tomorrow with the background
19 that she has, and also give us a clearer
20 direction. We're going to spend, then,
21 the entire afternoon talking about our
22 outcomes, how we're going to work together,

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1 what product we're going to actually produce,
2 how we're going to get there and work as, what
3 I call a team, rather than just a generalized
4 commission.

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

14 (Laughter.)

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

19 (Whereupon, the above-entitled
20 matter went off the record at 4:51 p.m.)

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Jake Leinenkugel

Thomas "Jake" Leinenkugel
Chairman, Cover Commission

UNITED STATES DEPARTMENT OF VETERANS AFFAIRS

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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

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Thomas "Jake" Leinenkugel

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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
KRISTIANN DICKSON, VA Support Team Project
Manager; Alternate DFO
BETH ENGILES, Senior Manager, Sigma Health
Consulting, LLC
HEATHER KELLY, Ph.D., American Psychological
Association
LAURA McMAHON, 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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Thomas "Jake" Leinenkugel 4

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

8:05 a.m.

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

1 that we have three sign-in sheets, one for
2 members of the public in attendance at this
3 meeting, and another for those who wish to make
4 a public comment at this meeting, and one for
5 those participants on the phone. We'll also
6 have one that we'll move around for the
7 commissioners to sign also.

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

18 Minutes of the meeting are being
19 taken, and anything said during the meeting or
20 submitted in writing before, during, or
21 immediately after the meeting will be available
22 to the public. This meeting is on the record.

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1 In closing, to summarize, public
2 notice of this meeting was published in the
3 Federal Register; a DFO is present; a quorum of
4 the COVER is present and in person; and an
5 approved agenda for the meeting has been
6 established and the meeting will adhere to this
7 agenda. Anything said during the meeting is on
8 the record.

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

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

16 CHAIR LEINENKUGEL: Thank you,
17 Sheila. Day Two of the COVER Commission is now
18 called to order, and I would like to welcome
19 the commissioners back after a very interesting
20 and getting-to-know-each-other, first-day
21 session, and also the importance of this
22 commission that not only has the eyes of the

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1 White House, the Hill, now VSOs, from a few
2 that have pinged me over the last 24 hours, and
3 also members of the general public.

4 So I think, going forward from what
5 we saw yesterday presented and what our charge
6 is with the COVER Commission, we're going to
7 see a lot more activity and responses back to
8 what our mission is.

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

20 So we certainly started out with why
21 we're all here as commissioners, and the
22 importance of the Comprehensive Addiction and

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1 Recovery Act, which is the CARA Act, signed in
2 2016. Our charge from that act, which is about
3 seven pages towards the end of the CARA
4 legislation, really Sections 931, that
5 everybody went over in detail yesterday, and
6 we'll conclude today with basic sign-offs and
7 workouts of each commissioner being assigned
8 certain sections that the co-Chair, Tom Beeman,
9 and I, will work with to develop with all the
10 commissioners and get actively involved prior
11 to the next month's meeting.

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

18 We also had the VA whole-health
19 system and complementary and integrated health
20 care, that we ended the afternoon with
21 yesterday, along with the presentation on the
22 National Academy of Medicine Study, which we

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1 all found to be very interesting, and also
2 discovered that this was just released, I
3 believe, as of January of this year, and a lot
4 of the findings, I think, will become very
5 relevant to portions of what we're going to be
6 talking about when you're looking at the COVER
7 Act for what we need to really be working into
8 for the next 18 months.

9 So just so the general public knows,
10 this commission began yesterday, and we have an
11 18-month period to complete this. So if you're
12 looking at a calendar, you're going out until
13 about December of 2019, which seems like a long
14 ways away.

15 As the commissioners discussed
16 yesterday, we've been involved in doing some of
17 these things in the past, and we know that
18 that's a very condensed period of time to do
19 all of the items that are requested of us, to
20 uncover and then make suggestions to make sure,
21 again, that the VA has the proper resources,
22 that the VA has the proper tools and mechanisms

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1 in place, has the proper people in place; that
2 the VA possibly needs to reconsider their
3 approaches in mental health care, and we're
4 going to look at what some of those approaches
5 may be to assist in making recommendations and
6 suggestions in that report out December of
7 2019.

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

17 Also, please put the microphone
18 right in front of you, because they are
19 directional, and if you lean back, we're going
20 to lose a little bit of sound, and we want to
21 make sure we capture everything for the
22 transcription of all notes and meeting minutes.

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1 So at this time I'm going to open it
2 to the commissioners. If you have any insights
3 into your point of view as to, number one,
4 reason for being on the COVER Commission;
5 number two, the scope of the COVER Commission
6 and what was covered yesterday, and an overview
7 of the presenters. I think it would give all
8 of us and the general public a feel for the
9 depth of what we did on Day One.

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

22 What I was impressed about yesterday

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

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

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

21 CHAIR LEINENKUGEL: Thank you, Tom.
22 I think that was a great synopsis. Anybody

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1 else at this point?

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

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

19 My question and challenge would then
20 be, how do we distribute what that right looks
21 like to a nation of effort, considering that
22 perhaps the majority of our Veterans are not

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1 partaking of VA health care? Can we be the
2 exemplar, but ensure that that exemplar is
3 distributed to others who can capture those
4 best practices?

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

11 I think the number that we heard
12 yesterday is correct, because I've heard it for
13 18 months now: Out of the 22 million American
14 Veterans alive in America, highest all-time
15 ever, only nine million of them are enrolled,
16 and 6.2 million of them are unique users. So
17 when you're doing the math on that, you're
18 looking at about 70 percent that are not
19 getting or obtaining VA care.

20 Then I want to jump on what you just
21 said, Matt, on top of what Tom just said. From
22 what we've seen -- and I think I've known and

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1 felt for the last 18 months -- when the
2 Veterans get VA care, that subgroup of about 30
3 percent of the total population, really enjoy
4 and like that care in most cases. I think
5 that's a big thing that is missed in today's
6 conversation as a whole.

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

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

19 It's truly something that we need to
20 look at, the whole person, the whole healing
21 process; it's not just medication. It goes
22 beyond that. Therapy is extremely important,

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1 but you need to get into some of the different,
2 holistic types of approaches that have been
3 truly effective.

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

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

21 CHAIR LEINENKUGEL: Thank you very
22 much, Jack.

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1 DR. JONAS: Yes, thanks. It is a
2 great honor to be on this commission and to
3 contribute to try and do right by our Veterans.
4 It is the military and the Veterans that
5 actually allow us to enjoy the freedoms and the
6 great country that we live in here. They sign
7 an obligation when they sign up, and they
8 defend the country. We have an obligation to
9 return that to them, and this is part of
10 fulfilling that obligation.

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

19 Twenty-five percent of our GNP may
20 be spent by 2025 if the current inflation rate
21 occurs. In addition to that, the value is
22 going down. The main outcomes, if you look at

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1 the general outcomes across the population,
2 population health outcomes are declining over
3 the last 30 years. So we're not getting value
4 for what we're paying in health care in
5 general.

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

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

22 So I think this commission has an

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1 opportunity to reset health care in general,
2 and if we do it right for the VA and the
3 community, then we'll do it right for the
4 nation. So it's a great honor to be able to
5 contribute to that.

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

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

19 I also agree that the direction that
20 we're going is so exciting. I really loved the
21 whole-health movement transformations that I
22 have seen, working in the system, and how

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1 that's really made a big impact. I think that
2 this commission really has a chance now to
3 impact how we move forward, and I'm also very
4 confident, from what I've heard from the
5 commissioners so far, that we each bring a
6 really unique piece to this and can contribute
7 in ways, as a whole, that can transform how we
8 move forward.

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

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

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

20 We have to look at the basics. One
21 of the basics in the VA is why the Veterans are
22 not getting in there, and one of the major

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1 difficulties is getting the disability rating.
2 The voices you hear who are saying we are
3 great, the majority of them are those who are
4 100 percent disabled, or 70 percent plus. They
5 are treated like royalty in the VA system.

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

15 CHAIR LEINENKUGEL: Thank you,
16 Jamil. Now that you've got a broad scope from
17 the general public's standpoint as to the
18 commissioners and the various backgrounds and
19 opinions and fact-based upbringing that we've
20 had in various other jobs and commitments,
21 whether it's on a clinician side or a business
22 side, that first and foremost, we do care about

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1 Veterans. In most cases, we are all
2 Veterans, and we have, as Wayne and Tom and
3 everyone has stated, along with Matt, we have a
4 charge to the nation that anybody who has
5 served in uniform for this country, we have the
6 absolute first and foremost reason for making
7 sure they get the best quality care with
8 quality outcomes.

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

17 But more importantly, there's a lot
18 of other things that we need to raise that
19 should be either researched, looked at,
20 debated, or discussed as being holistic or
21 different type of approaches towards care.
22 Because it's not just the mental health of the

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1 Veterans, we're seeing this as a national
2 issue. As Wayne and Tom stated, and Matt
3 again, and certainly Shira from the clinical
4 side -- we know that this has a broader
5 implication, not just to Veterans, but to the
6 health care of the general public.

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

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

21 We have two great people on board
22 today that are going to be presenting, and it's

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1 Eric Rodgers and also Paula Schnurr. Again, we
2 have their bios, but just for the general
3 public's sense, I want to put on record their
4 backgrounds because they have terrific
5 backgrounds. They are great folks, and they
6 are going to give us the overview of evidence-
7 based.

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

20 His past military and civilian
21 positions include chief nurse executive,
22 regional director for a large non-profit health

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1 care system, private practice, research
2 director, company commander, nursing faculty,
3 nursing education director, and staff nurse.
4 He is one heck of a nurse. So thank you, Eric,
5 for being on board.

6 And at this time, Dr. Paula Schnurr
7 as well. Paula is the executive director of
8 the National Center for Post-Traumatic Stress
9 Disorder and previously served as deputy
10 executive director of the Center since 1989.
11 She is a professor of psychiatry at the Geisel
12 School of Medicine at Dartmouth and editor of
13 the Clinician's Trauma Update Online.

14 She received her Ph.D. in
15 experimental psychology at Dartmouth in 1984
16 and then completed a post-doctoral fellowship
17 in the department of psychiatry at Geisel
18 School of Medicine at Dartmouth.

19 She has a lot of other things in
20 this great bio, but the main thing is her most
21 current grants are comparative effectiveness
22 trial of prolonged exposure and cognitive

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1 processing therapy and a validation of the
2 primary care PTS screen for DSM-5.

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

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

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

22 I've been with the Evidence-based

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

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

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

20 My particular interest is in
21 studying the treatment of PTSD, functional
22 outcomes in PTSD, and especially designing

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1 trials for non-pharmacologic interventions such
2 as complementary and integrative health
3 practices.

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

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

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

19 Since the focus of this commission
20 is on mental health, we will also speak to our
21 most recent updates related to mental health
22 practice guidelines, and then some examples for

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1 integrative health recommendations from the
2 PTSD guideline.

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

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

22 So our guidelines are specifically

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1 designed to improve the overall quality of care
2 and health management for both our Veterans
3 health and military health care systems. We
4 have a governing body known as the VA/DoD
5 Evidence-based Practice Work Group that
6 oversees the guideline development process and
7 reports to the Health Executive Council.

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

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

22 So the governing body solicits and

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1 prioritizes the guidelines to be developed as
2 well as to be updated, and the guidelines are
3 updated roughly every five years. And that's
4 consistent with the Institute of Medicine's
5 standards for trustworthy guidelines, which we
6 do follow.

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

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

21 Most of our guideline groups -- it
22 varies, depending on the guideline and the

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1 expertise needed, but usually it's around 20
2 people, 10 from -- we tried for 10 from each
3 side, however that varies a little bit because
4 we want to make sure that we get the correct
5 disciplines represented on our guidelines.

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

18 We do follow very strict conflict of
19 interest disclosure. Every member is asked to
20 fill out a conflict of interest form at
21 multiple times throughout the guideline
22 process. And at many of our meetings, we do a

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1 verbal acknowledgment of conflicts of interest
2 as well. And we do not just go by what they
3 tell us. We -- these are -- we do independent
4 verifications for conflicts of interest on all
5 of our work group members, and we require that
6 our champions be -- have no conflicts of
7 interest.

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

15 Simultaneously, we also conduct
16 Veteran and patient focus groups to get their
17 input into the guideline and what is important
18 to them from a patient perspective, and --
19 because we want to include that to make sure
20 that during the key question development phase,
21 because again, like I said, that's what defines
22 what we're looking for in the evidence. And so

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1 we don't want to miss something that the
2 Veterans feel are important. We want to make
3 sure that that's included in the literature
4 search.

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

14 We use a third-party independent --
15 actually use a contract company to do the
16 guideline development itself, and they use a
17 third-party independent for the evidence
18 review. Currently, that's with ECRI. I don't
19 know how familiar the commissioners are with
20 ECRI, but it's a very large and well-known
21 evidence review company. And actually they
22 were one of -- I believe one of the first to be

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1 identified by the Agency for Healthcare
2 Research and Quality as a quality evidence
3 review organization.

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

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

13 Ultimately, the work group comes
14 together in a face-to-face meeting for three
15 and a half days where they then -- the work
16 group members themselves review that evidence
17 and then apply a second level of rating to the
18 evidence in order to come up with -- ECRI
19 determines the, we'll say, the quality of the
20 studies, individual studies, and then the work
21 group ends up rating the strength of the
22 aggregate of the studies to come up with the

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1 recommendations.

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

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

15 It goes through an iterative draft
16 review process and drafts. Once it's ready, it
17 goes out what we call internally. We send it
18 out on both the VA side and the Department of
19 Defense side to multiple providers. Actually
20 on the VA side we send it out widely to
21 basically all of our providers in our system.
22 But it's -- that's done through the chain to

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1 the VISNs and the medical directors and chiefs
2 of staff to distribute out to their providers.

3 But we have a website that they can
4 go to and provide feedback on the guideline.
5 It's open for varying periods of time. Again,
6 all of that feedback is addressed by the work
7 group members, and any changes made to the
8 recommendations are done so based, again,
9 solely on the evidence.

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

15 Once we have that cleaned up and
16 ready, it then goes out again to the same
17 people internally, but now we also send it
18 externally to various professional
19 organizations, individuals outside of our
20 systems that are clearly recognized as experts
21 in the field. And, again, they have that same
22 opportunity to provide that feedback. And,

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1 again, it is all addressed, and changes made
2 are solely based -- have to be supported by the
3 evidence.

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

15 And then in addition to the clinical
16 practice guideline itself, we develop tools to
17 help with the implementation. The guideline
18 itself is usually 150, 180 pages. We'll come
19 up with a clinician summary that's 30-some
20 pages, a little more manageable, as well as a
21 patient summary so that -- and it's written so
22 that -- for the important components that the

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1 patients value, and have told us this is what
2 they need to know about whatever the disease is
3 that they're dealing with. This is usually
4 two, maybe four pages at the most. And then we
5 also develop a pocket card for quick and easy
6 reference.

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

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

21 And I guess I should have, you know
22 -- we do updates every five years unless the

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1 evidence -- there's significant evidence to
2 warrant an update sooner. Also, to do an
3 update it takes us about 12 months from start
4 to finish on an update, and for a brand-new
5 guideline I'm going to say 18 to 24 months. It
6 used to be 24 months, but we've gotten it down
7 real close to 18 months now, and most of that
8 time is consumed by the evidence reviews. And
9 then related to mental health is our Opioid
10 Therapy for Chronic Pain, which was just
11 updated in 2017.

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

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

20 The PTSD guideline was revised from
21 a prior format in which consensus was used
22 along with evidence. It has become a best

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1 practice around the world in the development of
2 guidelines to base guidelines on evidence, and
3 when there isn't evidence to say that there
4 isn't evidence one way or another.

5 So the PTSD guideline had to get
6 pruned, essentially, from over 200 -- I think
7 220-some recommendations, we came down to 40
8 evidence-based recommendations. This is
9 actually better for all the stakeholders
10 because Vets get better information about the
11 evidence, providers get better information
12 about the evidence, and it's a lot easier to
13 use the guidelines. It's also a lot easier to
14 defend the recommendations because it's based
15 on evidence review and not the opinion of a
16 bunch of people in a room.

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

22 The first bullet that's listed here

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1 is about treatments that are not necessarily
2 complementary, but they're different, such as
3 repetitive transcranial magnetic stimulation.
4 That's actually an FDA-approved treatment for
5 treatment-resistant depression.

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

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

17 And by the way, Eric didn't say
18 this, but the way the guidelines grade evidence
19 is to make a strong recommendation, a
20 recommend, or a weaker recommendation, a
21 suggest, and you can recommend for or against,
22 or suggest for or against. In the PTSD

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1 guideline, because we were aware that there
2 were many treatments that have advocates of
3 people who are using the treatments, we used
4 insufficient evidence ratings for those kind of
5 treatments to ensure that users would know that
6 we don't know one way or the other.

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

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

19 So the practice guidelines are a
20 foundational component of our evidence-based
21 practice program. What we've tried to provide
22 here is a sense of the process and the rigor.

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1 I think we really do stand on an international
2 footing in terms of the quality of our
3 guidelines.

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

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

19 But they are suggestions for how to
20 practice. The guidelines all heavily emphasize
21 the importance of taking patient preferences
22 and values into account, considering resources

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1 and other factors that tailor the care to the
2 individual within the body of evidence.

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

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

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

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

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

20 DR. SCHNURR: Not in any PTSD
21 guideline that exists. I'm not aware of
22 whether there are any for other mental health

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1 conditions, but for -- that are prevalent in
2 Veterans, but the UK guidelines, the Australian
3 guidelines, the American Psychological
4 Association, and the VA guidelines, none of
5 them have found the evidence sufficient yet.

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

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

18 And so there are really good people
19 in the field now, with much more rigorous
20 studies ongoing, but to the best of my
21 knowledge -- and I'm speaking now as a
22 scientist, not a representative for VA -- the

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1 evidence just isn't there yet.

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

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

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

21 DR. BEEMAN: Just to comment for
22 Jack: What I had wanted to get on record

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1 earlier is that I think, because mental illness
2 impacts not just the warrior but the families
3 and by extension, the community, I think it's
4 really important as we talk about our findings
5 over time, that we don't discount the import of
6 family.

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

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

22 There's just excellent ongoing work

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1 that I think will be much more definitive in
2 the coming years. I actually don't believe
3 it's -- it's challenging to study, but it's not
4 impossible to study, and we will have much
5 better evidence.

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

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

17 If you've got every five years that
18 you're looking at this, and it takes about a
19 year to do it -- I know it's a huge process
20 that you have to go through. But this is
21 really critical for mental health, and that's
22 the purpose, that's why we're here.

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1 I don't know. I don't know if you
2 have any comment on that. Thank you.

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

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

20 Just a couple of questions, I know,
21 having been involved in this process for a
22 while, so I know -- is there any training,

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1 especially for the patient input? The fact
2 that you have the patient input on multiple
3 levels is fabulous, but the dynamic, as you
4 know, in many of these groups can be quite
5 touchy. There's a power dynamic, there's an
6 expertise dynamic, there's a personality
7 dynamic, if some people dominate.

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

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

19 Then the other is that under current
20 law, we would have to have no way to cover
21 their reimbursement for traveling to conduct
22 some of the work that we do.

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1 The way that we've addressed this is
2 that we go to them for our focus groups, and
3 while it's not extensive, we do some
4 preliminary kind of education with them in
5 terms of laying out the expectations and the
6 ground work.

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

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

21 So those can help to either raise
22 the level of a rating or actually lower the

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1 level of a rating. That's why it's a yes and a
2 no that we've addressed it.

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

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

19 But there is this sort of tension
20 between the effectiveness and efficacy of
21 research, efficacy usually being counted as
22 more rigorous, because they look at randomized

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1 control trials, theoretical components of a
2 placebo, etc., to try to determine an
3 effectiveness, which don't work out there in a
4 more heterogenous environment in populations.

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

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

18 So we end up with these laundry
19 lists of, this works, that doesn't work, etc.,
20 when in real life, what I do in my practice and
21 what most clinicians and patients do is, they
22 go through a whole process of treatment in

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1 setting guidelines, and that's how process
2 guidelines are often set up. But we're not
3 sure if those will actually work, if those
4 models work, and I know it's a challenge to do
5 that.

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

12 DR. SCHNURR: I think that one's for
13 me. The short answer is yes, we have thought
14 of this, but the work in PTSD has focused
15 primarily on collaborative care in primary care
16 settings. So integrating mental health care
17 into the primary care setting, creating step-
18 care models where lower-intensity care is
19 delivered in primary care if a patient is not
20 too severe, and then moving the patient along
21 the continuum -- that evidence is still mixed.
22 In fact, I did the first randomized trial of

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1 collaborative care for PTSD, and we found it
2 changed the care, but it didn't improve
3 outcomes.

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

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

19 In fact, the guideline recommends
20 these trauma-focused psychotherapies as the
21 first line of treatment over medication and
22 other types of psychotherapies, some of which

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1 are also suggested.

2 DR. JONAS: Thank you. Just one
3 more question, if you will, so surgery is used
4 in interventional studies, injections, surgery,
5 a lot of things were used a lot for chronic
6 pain. Is there sufficient evidence to show
7 that those actually work or reduce pain
8 chronically, or are useful in mitigating the
9 opioid issues, using the criteria that you
10 approach? Has a guideline or evaluation been
11 done on interventional studies like that, that
12 are a key part of chronic pain management?

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

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

22 DR. RODGERS: I do know that when

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1 the opioid guideline was updated, that was
2 among the key questions that was looked at. I
3 apologize. Off the top of my head, I can't
4 necessarily tell you exactly what the ultimate
5 recommendations were that ended up in the
6 guideline, but I do know I remember it being
7 part of the key question development. I can
8 get that answer for you.

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

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

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

22 DR. RODGERS: I do know we had an

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1 interventional surgeon that was one of the
2 champions.

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

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

19 DR. RODGERS: Currently the only way
20 that we have to evaluate that is what I can
21 call indirect measures. We keep striving for
22 that. Electronic health records, where they

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1 are implemented, make it easier to track and
2 monitor and be able to assess the direct
3 outcomes on them.

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

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

18 So when that guideline came out, we
19 saw a significant decrease in the high dose
20 ranges of our statin usage and the coinciding
21 money saved. That was quite significant. So
22 that's an example.

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1 But we're always looking and talking
2 about how else we can get this in front of the
3 provider where it's used. So besides our
4 publication of these, we've tried to be
5 creative, and we've turned to partnering with
6 Epocrates, who is now placing our guidelines on
7 their mobile app platform, which we know a lot
8 of clinicians utilize. It's right in their
9 pocket. We're strongly advertising that with
10 our providers, that that's another place they
11 can go to get it rather than try to pull it off
12 the computer or get a hard copy of it.

13 We also know that our providers look
14 at these other journals, so the Annals of
15 Internal Medicine has committed that they want
16 to publish all of our guidelines, and so every
17 time we do a guideline update, it gets
18 published in the Annals. That way we know our
19 providers, both on the VA and DoD side will
20 look at that, possibly before they'll look at
21 something that comes out from us. So we try to
22 be creative in getting it out there in front of

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1 people.

2 We also have a study that's about to
3 kick off a survey, again, trying to get at that
4 answer, asking the providers, are they using
5 them? How are they using them? What do they
6 want from us that would improve their
7 utilization of it? Hopefully, that will come
8 out in the next couple of months.

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

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

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1 started, and Wayne, and Jack at this point.

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

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

16 That being said, we have a sense of
17 urgency as commissioners to come up with
18 recommendations, and I will tell you that I
19 love the procedures. You have a very
20 disciplined approach. There has to be that,
21 but there also has to be a sense of urgency to
22 some of the things that you stated, and I don't

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1 think there is, and that's my opinion.

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

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

19 If there is a piece of evidence that
20 maybe at a 2.2 pressure over a 40-minute period
21 sustained over seven weeks, there's an 80
22 percent improvement. I don't think they've

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1 gotten there yet, but there's that possibility.

2 Another group -- let's face it -- is
3 medical cannabis, not recreational, but
4 medical. I think we're doing an injustice, I
5 think that our largest VSOs have stated through
6 their membership that over 90 percent of
7 American Legion, which is two million strong,
8 Veterans are advocating that we at least take a
9 look at research within the VA, which I don't
10 think we're doing. To me, that makes no sense.
11 It's a plant, it's an herb. I'm not advocating
12 for recreational use at all.

13 But from this commission, we need to
14 look at every variation of complementary type
15 of care under what we had yesterday, whole
16 health. I know I'm editorializing a little
17 bit, but I want to at least get it on the
18 public record that these are things that I
19 think we need to start taking a look at, along
20 with -- what are a couple of the other ones? I
21 know, Paula, you talked about ECT and
22 repetitive transcranial magnetic stimulation

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1 that had some other groups that said that was
2 really helping me.

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

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

20 My last point is, from an evidence-
21 based practice, and I would think both of you
22 have had these occurrences or situations, just

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1 give us a sense for how Veterans are being
2 treated today. Let me give you two scenarios,
3 because they're both true; they are scenarios
4 that I am aware of.

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

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

20 With guideline-concordant care,
21 there would be shared decision-making, some
22 collaboration between the patient and the

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1 provider or providers that are involved to help
2 determine the best course of action for her.

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

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

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

19 But in psychotherapy, I mentioned
20 the word collaboration. Essentially what
21 you've got is a patient and a therapist talking
22 about the issues that are relevant to the

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1 patient. Now, in good psychotherapy, no matter
2 what kind it is, there's exploration at the
3 outset to understand the person and their
4 context and clarify what they want to get out
5 of the therapy.

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

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

20 There may be exercises; there may be
21 what is called homework, even, in some
22 therapies to go out and do some activities.

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1 Some therapies are just about the talking. But
2 essentially what you're doing through this
3 process is helping the person get back on
4 track.

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

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

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

21 So I think that really laying that
22 groundwork first and working on some basic

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1 skills that can help the person just cope with
2 the day-to-day stresses is really important in
3 a case like that.

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

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

16 It was a VA nurse, during a homeless
17 stand down, who found her and took her in. She
18 went through psychotherapy, went through what I
19 call a partnership and collaboration with the
20 Arizona Coalition, who the VA nurse also
21 brought in. They are very close to the Phoenix
22 VA.

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1 So it was a collaborative effort in
2 getting her re-established for bringing her
3 self-esteem back to where it needed to be, and
4 right now she's part of the Arizona Coalition,
5 working with the Phoenix VA, and it's one of
6 those success stories.

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

19 DR. MAGUEN: This individual just
20 feels disconnected; that sounds like that's a
21 key issue that they're presenting with, this
22 disconnection from many sources, feeling really

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1 alone and isolated. Is that right, just to
2 clarify?

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

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

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

20 So it's not only about getting them
21 into psychotherapy, but this person might not
22 even be ready or willing to engage in that kind

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1 of care. So I think that using the resources
2 that we have available, using the peer support
3 network, I've seen incredible work done with
4 motivational interviewing or the motivation to
5 engage in care, so to speak, where peers can
6 come in and say, Look, I have gone through
7 this. I know what you're going through, and
8 here's what helped me. Lets' talk through
9 this.

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

15 I've also seen incredible work done
16 with -- if we think about the whole-health
17 model, spiritual leaders too, which we have
18 available to us at the VA. For some people,
19 that loss of faith, depending on what that
20 person saw in combat, we want to leverage those
21 resources too. So having the person be
22 able to think about how their spiritual outlook

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1 fit into this, and connecting them not only
2 with one mode, but connecting them with our
3 system of multimodal care to get the person
4 engaged and ready move forward with any care.

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

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

18 What has helped this individual turn
19 off all of his drugs was medical cannabinoid
20 oils. So that actually flipped the switch for
21 him in his case, because he probably never had
22 the opportunity to receive the type of

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1 evidence-based care, and what I would call a
2 little bit of integrated holistic care at the
3 same time, and peer counseling, which we talked
4 about yesterday.

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

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

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

21 We have to have a sense of urgency.
22 To do guidelines and evidence-based takes time.

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1 So I think as commissioners, we need to ask
2 ourselves, are we willing, 18 months from now
3 or even before, to make some bold
4 recommendations prior, to move things along,
5 faster, or evidence-based trials, testing, for
6 our Veterans' toolbox?

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

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

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

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1 thing to diagnose.

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

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

16 We recognize that every patient,
17 every Veteran is an individual. Every provider
18 is an individual, and their expertise and
19 treatments that they might offer vary from
20 provider to provider, as well. So they are
21 guides to follow that are based on the
22 evidence. The evidence says that this is the

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1 best available treatment; however, we allow for
2 that flexibility for the individual.

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

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

17 I can say, at least for the PTSD
18 work group, we talked a lot about this, and we
19 tried to write it into the guideline's DNA so
20 that people would understand the importance of,
21 on the one hand, understanding the best
22 evidence and the recommendations, along with

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1 ensuring that the individual's needs,
2 preferences, and such, were respected.

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

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

22 CHAIR LEINENKUGEL: Dr. Schnurr and

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1 Dr. Rodgers, thank you so much. You're
2 probably going to hear back from us. We're
3 going to corner you, just like we are the other
4 presenters from yesterday, whether it was Dr.
5 Stone, Dr. Clancy, Dr. Meyer; we need you to be
6 actively involved along with this commission.

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

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

16 (Applause.)

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

20 (Whereupon, the above-entitled
21 matter went off the record at 9:34 a.m. and
22 resumed at 9:57 a.m.)

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1 CHAIR LEINENKUGEL: I'm going to add
2 one admin item at this point in time. I will
3 be leaving to head downstairs to get the Acting
4 Secretary, Peter O'Rourke, probably in the next
5 35 minutes.

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

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

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

18 No need? Well, you're going to get
19 it. You've had a distinguished career, Fran,
20 as a health care executive, Board Certified
21 Neurologist, and a United States Air Force
22 Veteran.

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1 Dr. Murphy currently services as
2 President and CEO of Sigma Health Consulting, a
3 woman Veteran owned small business.
4 Congratulations.

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

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

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

17 Dr. Murphy's current work has been
18 focused on evidence-based medicine, patient-
19 centered care, and mental health policy and
20 program evaluations. She published numerous
21 peer reviewed publications, book chapters, and
22 reports.

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1 And has had over a 20-year career
2 working in the Department of Veteran Affairs at
3 VA Medical Centers during neurological care,
4 research, and education, as well as in the VA
5 Central Office as a senior executive.

6 Welcome Dr. Fran Murphy. Fran?

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

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

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

18 Because it's really focusing on what
19 your charge is. And how we can begin to move
20 towards getting you the information that you're
21 going to use to make your decisions and
22 recommendations.

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1 I thank Dr. Rodgers and Dr. Schnurr
2 for providing the great background in the
3 evidence-based practice programs. Because I
4 think that is at least a good model to get you
5 the kinds of information that you can use.

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

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

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

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

22 So, I'd like to discuss with you the

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1 potential scope for your evidence-based review.
2 Some proposed key questions.

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

6 So, this is -- okay. This is part
7 of the charge. But, I thought we had swapped
8 out this slide.

9 So, you are charged to examine the
10 available research on complementary and
11 integrated health treatments for mental health.
12 And identify the potential benefits and
13 including this list of therapies in treatment
14 for Veterans who have mental health diagnosis.

15 So let's talk about how we can
16 potentially address that issue. So, what is a
17 proposed approach to conducting an evidence-
18 based review to make that charge?

19 And I'd like to answer a couple of
20 questions for you. Why, what, when and how?

21 So, why? Well, your charge is to
22 examine evidence-based treatment models used by

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1 VA for treating mental health conditions of
2 Veterans.

3 And then to make decisions about
4 what the potential benefits are of including
5 complementary and integrative health
6 treatments.

7 We've heard from the evidence-based
8 practice folks that they do those analysis
9 about evidence-based practice. And they've
10 included some key questions about complementary
11 and integrative health.

12 But many of the guidelines, the
13 evidence reviews are several years old. And so
14 they need to be updated.

15 We heard yesterday from the Office
16 of Patient Centered Care. And they gave a very
17 inspiring presentation about their passion for
18 whole health and VA's implementation of that.

19 What was missing, in my view, is the
20 fact that so far, neither the state of the art
21 conference or the evidence reviews have really
22 looked at the specific issue of mental health

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1 conditions.

2 And what the effectiveness is of the
3 complementary and integrative health
4 interventions in addressing whether mental
5 health outcomes and patient centered outcomes
6 for those individuals, are improved.

7 And that's really your charge. So,
8 what are we going to do?

9 Well, we're going to do an evidence-
10 based review for you. And the what is, an
11 evidence-based review is a process that allows
12 you to systematically look at the research,
13 which you are tasked to do by the legislation.

14 And to make sure that you're
15 gathering all of the relevant information.
16 We're not going to cherry-pick certain studies.

17 We're going to have an objective
18 systematic process that minimizes the impact of
19 any bias or errors. And to allow us to give
20 you the information about what the evidence is,
21 so that you can make relevant decisions.

22 The decisions are yours. Your

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1 support staff are going to gather the evidence
2 for you.

3 So, what about the question of when?
4 Well, let's look at a potential time line. The
5 star on this -- this Gantt chart or time line,
6 is where we are now.

7 We've been working for several
8 months with the VA staff in trying to structure
9 this meeting. And to help make some early
10 progress on issues like the evidence-based
11 review and the survey, which we'll talk about
12 next.

13 And in order to complete the
14 evidence-based review or the system map review
15 for you to be able to make decisions, we need
16 to begin relatively quickly.

17 And that's why I'd like to get your
18 endorsement for the scope of the review. And
19 the key questions, if possible, sooner rather
20 than later. Today, if that is possible.

21 So, what's the process for the
22 evidence-based review? These are the steps

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1 that were on that time line.

2 As you heard from Dr. Rodgers and
3 Dr. Schnurr, defining the scope of what you're
4 going to look at is the first step. Then you
5 develop key questions.

6 And the key questions are designed
7 to make sure that we have a common
8 understanding of what your priorities are. And
9 what kind of research you want us to gather.

10 And the key questions really give us
11 the opportunity to objectively and clearly
12 define all of the different aspects of a search
13 for the literature.

14 We'll then begin to review the
15 studies that come back from that search.
16 Including an abstract screening, a full tech
17 screening, and then do a report on the evidence
18 for you.

19 So, one proposed scope for the
20 Commission's review is that since you're
21 primarily interested in Veterans, we really
22 should be looking at all adults over the age of

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1 18.

2 So the research we'll be gathering
3 are -- will exclude children. But include all
4 adult patients.

5 Now one of the options you have is
6 to say, well no, I only want to see military
7 and Veteran studies. I would recommend that
8 you not do that.

9 Because I think the literature is
10 relatively small. And I think in this case,
11 the literature on any adult will inform your
12 evidence-based decisions about the
13 effectiveness of the potential interventions.

14 I'd also suggest that your charge
15 says that you're to concentrate on mental
16 health conditions. And to look at VA's
17 evidence-based treatment models, and how they
18 might be incorporated into those models.

19 So the conditions that I think are
20 highest priority for you are post-traumatic
21 stress disorder, major depressive disorder,
22 substance use disorder, including alcohol and

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1 opioid use disorder, and suicidal behaviors.

2 There was some discussion yesterday
3 about pain and stress as interest of the
4 Commission. And I think that one of the slides
5 that was shown on the clinical practice
6 guidelines was the opioid therapy for chronic
7 pain guidelines.

8 And the way the guidelines usually
9 handle issues of associated conditions, or
10 comorbidities, is that we'll focus on the
11 primary condition.

12 And then within the guideline there
13 may be a warm handoff to say, some of the
14 guidelines related to pain is in this guideline
15 and the recommendations reside there.

16 I believe it's outside of your
17 charge to do a primary study of pain. But
18 that's obviously a matter of discussion for
19 this group.

20 At this point I'd like to stop and
21 maybe get your feedback on this proposed scope.
22 And some of your thoughts about what your

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1 priorities are and how we can organize the work
2 going forward.

3 Is that okay Mr. Chairman?

4 CHAIR LEINENKUGEL: Fran, that's
5 perfect. And I think it's an opportunity for
6 us to ask a couple of questions of Fran.

7 Because we are talking scope here.
8 We are talking a compressed amount of time in
9 that 18 months like we started the meeting off
10 with.

11 So please, interject at this point.
12 I think it's critical that all of us have a
13 point of view.

14 DR. MURPHY: So, and if I could,
15 I'll just add that one of the things I should
16 have said when I brought up the time line slide
17 is that the more conditions we include, the
18 more key questions there are, the longer time
19 it takes to actually gather and review that
20 literature.

21 So, if we enlarge the scope, we're
22 likely not to meet your 18-month time line.

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1 CHAIR LEINENKUGEL: Yeah. You and I
2 had this side discussion at the end of
3 yesterday. So, I'll start.

4 And there was the question about
5 pain. And I am a true believer, again, as a lay
6 person, but just from my 18 months of
7 experience in dealing with Veterans throughout
8 the country, that there is a direct correlation
9 with pain, opioid abuse, and potential suicide.

10 So that's where I'm at. I mean,
11 we're going to be looking at opioid use
12 disorder. Me not being a doctor, is smart
13 enough to realize that if you're on opioids,
14 you obviously have some pain.

15 So, if it's a disorder, I just put
16 my lay person mind onto the subject saying that
17 pain must be very much involved in this
18 directly or indirectly.

19 My point of view only.

20 DR. BEEMAN: Jake, I'm not going to
21 disagree with you because I'm not a clinician.
22 On the other hand, I want to agree with Dr.

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1 Murphy on this one.

2 I think that there's a cause and
3 effect. You know, I think that you take
4 opioids because you have the pain.

5 I mean, there's a lot of pain and
6 stress in the overall environment. And I think
7 if we studied all of it, we would be here the
8 rest of our lives.

9 I like the compactness of this.
10 Understanding that, you know, knowing about
11 pain and knowing what are the precipitating
12 factors, why people get suicidal ideation and
13 everything, is a result of some of these other
14 factors.

15 Where -- because I don't -- and I
16 could be wrong, I don't look at alcohol use as
17 exactly the same as pain. I look at alcohol
18 use as a result of pain and stress.

19 CHAIR LEINENKUGEL: My point
20 exactly. I concur.

21 DR. BEEMAN: Okay.

22 DR. MAGUEN: You know, one of the

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1 things that I think has been the elephant in
2 the room is just the tremendous comorbidity
3 that exists. That we see on the ground.

4 And so, I think that, you know, for
5 me some of these complementary and integrative
6 treatments, so for example if someone comes to
7 me and they have PTSD and they also have
8 chronic pain and substance use disorder, I
9 think that all of those things we need to look
10 at together in order to develop the best
11 treatment plan.

12 And so just jumping ahead for
13 example, even if we're evaluating acupuncture
14 for this person. So the evidence for pain and
15 acupuncture is a lot stronger than for PTSD.
16 Which is insufficient evidence as we've just
17 heard.

18 And so, it's -- unless we look at
19 the whole clinical picture, sometimes it's very
20 hard to make those determinations.

21 And so, I'll just -- I don't have a
22 definitive thought about yes or no yet. But I

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1 think -- I just want to put that out there.

2 That it's often times, the rates of
3 comorbidity are so high that even if we're not
4 looking at it, we're looking at it indirectly.

5 DR. JONAS: I want to concur with
6 that. I see patients with chronic pain every
7 week.

8 And the only reason they might not
9 have a comorbidity is because I haven't asked
10 them. Okay.

11 At least in my population. And in
12 those areas. And I think very often, people
13 with things that we're dealing with in mental
14 health will come in with pain as the primary
15 complaint.

16 Especially in primary care. And
17 then we'll go down the path of treating that
18 pain without actually getting at the underlying
19 issues.

20 And then that creates problems. It
21 even causes harm. I guess my question would
22 be, is it redundant?

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1 Hasn't this already been done? And
2 if it's already been done, then why would we
3 repeat it?

4 On the other hand, if it's already
5 been done, we can just build on that. So it
6 shouldn't require a whole lot more work.

7 So, that would be a couple -- and.

8 DR. MURPHY: So maybe, and I haven't
9 practiced clinical neurology for a long time.
10 But I used to run a headache clinic.

11 And a lot of my clinical practice
12 was in the borderlands between, you know,
13 neurology pain and mental health.

14 And I would just say that even
15 though you may have a patient who has a
16 significant pain problem, if the primary
17 diagnosis is one of the four or five conditions
18 listed on the slide, you structure the
19 treatment plan so that you're addressing both
20 the primary and secondary diagnosis.

21 But the treatments are different.
22 And your tasking is to determine whether the

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1 complementary and integrative health treatments
2 are effective in improving the mental health
3 outcomes.

4 That doesn't mean that we can't look
5 at what has been done by VA in the state of the
6 art conference and other information that's
7 been gathered by OP -- by the Office of Patient
8 Centered Care, and incorporate, you know, this
9 holistic model.

10 In fact, I would recommend that you
11 do that. But, that work is, you know, related
12 but preferable to your charge.

13 DR. JONAS: So, I'd say we need --
14 we don't have to repeat that work. But I think
15 we need to make it a core part of what's
16 presented.

17 Because we're going to have to take
18 that into context. So, at least, I mean, if
19 there are major updates that are required, then
20 that's different.

21 But if we at least see what that
22 information is as part of what's presented as

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1 you go into these areas.

2 I will can -- I will make a
3 prediction that you'll go through the entire
4 review for these conditions for complementary
5 and integrative medicine practices, individual
6 practices.

7 And by the way, we're also asked to
8 talk about models. Even more difficult.

9 And we will end up in the
10 insufficient evidence for everything in those
11 areas. That's probably what will happen.

12 So we need to go beyond that to
13 really do the acceleration that Jake and others
14 described about in an earlier conference.

15 DR. MURPHY: And if the Commission
16 wants to deliberate on the issue of pain
17 further, what I can suggest is that if you
18 could give us your decision that at least for
19 mental health conditions, these are the issues
20 that you'd like us to cover, we can begin this
21 portion of the evidence review once we get the
22 key questions set.

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1 And we can always add other issues
2 later after you've had a chance to look at the
3 information gathered on pain by other parts of
4 the VA organization.

5 CHAIR LEINENKUGEL: Fran, I think
6 you're headed right where we need to be going.
7 And number one, thanks for teeing up this
8 slide.

9 Because this does define the scope.
10 And I think that it hits everything that Tom,
11 you agreed when you first saw this, right?

12 And the rest of the Commissioners as
13 well, I think, are pretty good with that at
14 this point.

15 To what Wayne just said, there
16 should be some sort of studies and correlation.
17 Especially out of opioids that you should be
18 able to provide us by next month's meeting.

19 And I would say try it. You're
20 going to have a lot more support from this
21 Administration and from this Acting Secretary
22 then before, Fran.

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1 So, there will be a sense of urgency
2 behind this.

3 DR. MURPHY: Okay. Back up --

4 CHAIR LEINENKUGEL: Fran, if you
5 could, talk more into the microphone a little
6 bit. Thank you.

7 DR. MURPHY: I'm not red. I was
8 off.

9 (Laughter.)

10 DR. MURPHY: So, this is the
11 legislatively mandated group of what they're
12 calling complementary and integrative health
13 interventions.

14 I will tell you that some of these
15 things are really not usually considered in
16 that bucket of integrative health or
17 complementary therapies.

18 And I'll just point out things like
19 the HBOT, hyperbaric oxygen therapy, and trans
20 cran -- transcranial magnetic stimulation.
21 Those are a little bit, you know, different
22 then some of the other integrative health

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1 treatments.

2 And I wonder what your thoughts are?
3 We'll cover all of these. But it also says
4 other therapies that the Commission determines
5 are appropriate for study.

6 Were there other issues that were of
7 particular interest to you? Under yoga, we
8 cover yoga and tai chi.

9 Under meditation, would be
10 meditation and mindfulness and other forms of
11 meditation. But other things that are not on
12 that list that are of very high priority for
13 you?

14 DR. BEEMAN: I had talked to Jake
15 about putting this on the record. So, I just
16 want to just mention something.

17 I think family therapy, which I know
18 is an accepted therapy. But is also part of a
19 holistic treatment system, should be part of
20 this.

21 And I would just make a comment.
22 Nine years ago when the National Intrepid

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1 Center of Excellence was put into place by the
2 DoD, the Fisher Family donated 65 million
3 dollars, or raised 65 million dollars to help
4 the government get this started.

5 For the past nine years, they've
6 been accepting about one or two patients a day.
7 So typically they have about 30 patients at any
8 one time, in what is really basically a 30-day
9 intensive outpatient program.

10 Almost all of these therapies, with
11 the exception of equine and HBOT, is -- are
12 used there. And so they have nine years worth
13 of data.

14 It's populated by neurologists,
15 internists, psychiatrists, podiatrists,
16 radiologists, they have chaplains and a whole
17 host of other folks.

18 And in addition to that too, they do
19 virtual reality. Where they have experts that
20 can recreate the events.

21 I'm not sure nine years into it what
22 the data's suggesting. But they might make --

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1 might have some very helpful information for
2 your research into this for us.

3 To say, yeah, you know what, we've
4 been using this for nine years. This is what
5 we're finding. These are the results.

6 I can say that the patients they
7 took were mild to moderate. They did not take
8 the really intractable kinds of patients.

9 And they've had both men and women
10 in the thing. So, maybe something to look at
11 if you haven't done that already.

12 But, I just wanted to put a word in
13 for the family therapy piece. Because I think
14 all of these treatments are enhanced by the
15 ability to have the shared experience within
16 the context of family.

17 Thank you.

18 CHAIR LEINENKUGEL: Well, I'll make
19 my pitch one more time. Yes, medical cannabis,
20 synthetic cannabinoids needs to be included.

21 And will be included, at least from
22 the Chairman's perspective. But I think Shira

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1 also agreed with me.

2 That there's been some things going
3 on. Even within the VA or with some VA
4 doctors.

5 There are large groups of Veterans
6 across America right now, one group that I will
7 bring in, the Veterans Cannabis Project Group,
8 with five Veteran heroes.

9 They're people that went and served
10 multiple times. And came back and got their
11 doctorates from either Harvard or Yale.

12 I mean, they're -- you would not
13 expect them to be looking at cannabinoids. But
14 they're very much involved. That being one.

15 Hyperbaric oxygen treatment. There
16 are two large groups that have pinged to me for
17 the past 12 to 13 months. They're becoming
18 much more proactive.

19 They're gaining resonance on the
20 Hill and also in states. So, whether or not we
21 think that treatment works or has any evidence
22 based to it at this point in time, it is not

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1 relevant to me.

2 I think it needs to be explored,
3 because I did listen to Veterans that have gone
4 through different pressure treatments over
5 various periods of times at different depth
6 levels, per se, which is pressure.

7 That absolutely swear by it. Got
8 off all of their opioids. Have less pain.
9 Clearer thinking, et cetera.

10 So, it's all anecdotal. But at
11 least it's something that's up there. And it's
12 been put up there for a reason when this law
13 was written two years ago.

14 DR. JONAS: Yeah. I'd like some
15 time to look over this list. Instead of
16 sealing it down right here.

17 I think the big risk, number one, is
18 that we get into the this for that. Everything
19 becomes therapy, a component.

20 And you go down the laundry list
21 like this. And our first charge is actually
22 looking at models of care.

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1 And this won't allow us to look at
2 models of care if we're simply looking at the
3 components.

4 I think you're getting at it with
5 family therapy. I mean, that's a system, a
6 model of care.

7 We've seen several models of care
8 already yesterday. A lot of them were
9 described.

10 The one, I think, that has the
11 greatest interest is this whole person,
12 integrative health model. Which is a very
13 different way of delivering the same kind of
14 care that incorporates some of these and some
15 of the conventional stuff.

16 That's why it's called integrative.
17 And so we should look at those models of care
18 and what evidence do we have for that.

19 Or gaps. What gaps are in those
20 areas? So, I think we -- that would be number
21 one in my opinion. Instead of just adding to
22 this list.

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1 With that said, I would add to the
2 list. And I agree with you completely that
3 cannabis, medical cannabis needs to be up
4 there.

5 I think hyperbaric oxygen needs to
6 be looked at because of the issues that have
7 emerged since the last reviews.

8 I think spiritual care is a key
9 issue. And there's various forms of doing that.
10 Especially for PTSD.

11 There's retreats for example. Some
12 of which have been studied and shown profound
13 changes that occur through a therapeutic
14 treating group.

15 Many of those are run by chaplains
16 outside. So, spiritual care is a key
17 component.

18 I think that -- I don't know if you
19 pulled off the transcranial electromagnetic
20 stuff. But there's a wider category, it's
21 called CES, cranial electrical stimulation.

22 There was a review in the Annals

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1 just a few months ago about that. And I think
2 that ought to be on there.

3 Transcranial is a subset of that.
4 But there are FDA, I don't know if they're
5 approved or not, but you can certainly buy them
6 online.

7 And the FDA has at least partly
8 blessed things like Fisher devices and things
9 like that. That, you know, for depression, for
10 insomnia, for, you know, things like that.

11 So I think those ought to be looked
12 at. If you talk to the nurses, they will
13 describe, and the Hague Report had this on VA
14 use, of things like therapeutic touch, healing
15 touch for example.

16 It's a bioenergy type of practice
17 that nurses deliver. And there are
18 certifications for it.

19 There's been some randomized control
20 trials on that. And we should look at that.
21 And then osteopathic aspect.

22 I know chiropractic is considered

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1 already there. And so is off the list. But
2 osteopathic manipulation, cranial especially
3 and others, is used for these areas. And so
4 should be on the list.

5 And then I'd like to look at it
6 further.

7 DR. MURPHY: Thanks.

8 CHAIR LEINENKUGEL: Thanks Wayne.
9 And I have Sheila taking some notes. And she
10 added those as well. Thank you.

11 DR. MURPHY: And we'll be going back
12 to Sheila with questions about, you know, how
13 far we can go. Because it affects, you know,
14 how many people we need to put on this.

15 DR. JONAS: That's fine.

16 DR. MAGUEN: And just to add to the
17 models, you know, one thing that we should do
18 too, is there are eight modalities that whole
19 health recommends too.

20 So we should look at the list, this
21 list and compare it to that list to make sure
22 we're hitting all of those issues as well.

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1 DR. MURPHY: I'll ask Allison to
2 help us with that.

3 MR. ROSE: Mr. Chairman, I also
4 would recommend what my fellow Commissioners
5 and lady have recommended here. We're at the
6 start.

7 We need to take a little bit of time
8 until we shoot out of the gate. I don't know.

9 And I don't know how it's going to
10 impact. I hope it won't impact, I mean, we
11 have a deadline.

12 That's it. We got to make that
13 deadline. Thank you.

14 COLONEL AMIDON: Mr. Chair as well.
15 I just want to make sure in the search for the
16 perfect we don't forego the effort that could
17 start right now.

18 So given that there's a list right
19 here, I suggest we move forward sufficiently to
20 do so.

21 Secondly, I just wanted to make sure
22 I understand the assumptions and the terms.

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1 You're going to look for formal study output in
2 support of this?

3 DR. MURPHY: We should go over this.

4 COLONEL AMIDON: Okay. Well, then
5 my question being then is, I know within each
6 one of these, as an example, of organizations
7 out there doing the work that are attempting to
8 capture data, but haven't formalized data
9 output yet.

10 And in doing so, I think I know of
11 two cannabis studies ongoing right now. And I
12 would like to recognize one of the public
13 members in attendance today if I could, Mr.
14 Chair.

15 CHAIR LEINENKUGEL: Please.

16 COLONEL AMIDON: Dr. Heather Kelly
17 from the APA. Thank you so much for being
18 here.

19 And I just wanted to say, Dr. Kelly
20 since 1998 has served as a senior lobbyist in
21 APA's Science Government Relations Office.

22 And in addition, her new portfolio

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1 includes advocating for the mental health and
2 well-being of military personnel, Veterans and
3 their families. And communities that have been
4 supporting this, psychologists that serve those
5 who served.

6 So, it's very nice to have a
7 professional organization in attendance today.
8 Thank you so much.

9 DR. MURPHY: So, to answer your
10 question, we're going to be looking to gather
11 the published literature for you.

12 We -- you know, you can certainly
13 look at non-published work from either the
14 NICoE or other organizations.

15 But really to determine whether
16 these treatments are effective, you've got to
17 go through a formal process. And part of that
18 process, after we've developed the scope, is
19 developing the key questions.

20 And those key questions will guide
21 the review process and give all of us an
22 understanding of what your objectives and

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1 priorities are.

2 So I'd like to walk you through that
3 next step. And we've done the --

4 CHAIR LEINENKUGEL: Fran, could I
5 interject for just a minute and give you a ten
6 minute break while I bring in the Acting
7 Secretary?

8 We have him scheduled for 10:30.

9 DR. MURPHY: I assumed that I'm
10 stopping here. He takes over, and I'll finish
11 when he stops.

12 CHAIR LEINENKUGEL: Perfectly. Let
13 me get Mr. Peter O'Rourke.

14 (Whereupon, the above-entitled
15 matter went off the record at 10:31
16 a.m. and resumed at 10:35 a.m.)

17 CHAIR LEINENKUGEL: All right, we
18 are back in session after that five minute
19 break.

20 This is a public session, so we are
21 on the record. There are public observers.

22 And, I have the opportunity at this

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1 point to introduce a friend of mine that we've
2 gotten to know over the last 19 months.

3 Peter O'Rourke brings a highly
4 diverse skill set in transformation, innovation
5 and leadership honed by over 27 years of
6 demanding fields and challenges.

7 He served in the military as a Navy
8 enlisted plane captain, an Air Force officer
9 and logistician.

10 He is a Lean Six Sigma Master Black
11 Belt and has held positions in consulting in
12 government service including service as Senior
13 Policy Advisor, Congressional Staffer and
14 Executive Director for nonprofits focused on
15 generating support for federal government
16 efficiency.

17 Peter has served as the VA Chief of
18 Staff from February 16, 2018 to May 29, 2018.
19 And, in that short period, I can tell you he
20 helped oversee the Department through the
21 appointment of Acting Secretary Robert Wilkie,
22 now to be Secretary Robert Wilkie.

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1 And, was instrumental in finalizing
2 VA's electronic health record modernization
3 contract as well as working with the White
4 House, Congress and Veterans service
5 organizations to secure the passage of the
6 landmark VA Mission Act.

7 Prior to becoming VA Chief of Staff,
8 O'Rourke served as the first Executive Director
9 for the VA's Office of Accountability and
10 Whistleblower Protection.

11 And, in that position, he
12 established and led this new office to which is
13 the first of its kind in federal government.

14 In this role, he quickly became a
15 trusted advisor to many leaders throughout the
16 Department on accountability and culture
17 issues.

18 Mr. O'Rourke is a 1998 graduate from
19 the University of Tennessee and United States
20 Air Force Institute of Technology in 2005.

21 At this time, it's my pleasure to
22 introduce my friend and Acting Secretary, Mr.

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1 Peter O'Rourke to the Commission.

2 (APPLAUSE)

3 CHAIR LEINENKUGEL: You do know that
4 you have to turn this on.

5 MR. O'ROURKE: Is it red now? Okay,
6 good. Red usually means stop, which for me,
7 talking I should stop.

8 No, thanks, Jake, I appreciate that.
9 I bring greetings from the incoming Secretary,
10 Mr. Wilkie who, all indications are, he'll be
11 sworn in on Monday, so that's -- we're all
12 excited about that and especially me.

13 Being an Acting Secretary is a great
14 honor from the President to fill that gap, I
15 guess you could call between the times. But, I
16 can fully appreciate what it means to run an
17 organization with the scale, the geographic
18 scope and everything else that goes along with
19 the serving Veterans.

20 So, it's, like I said, been an
21 honor, but I am very much looking forward to
22 supporting our new Secretary as he transitions

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1 in and continues on the good work that we've
2 started here that I know that you all will --
3 are beginning today and will continue to do.

4 It's an area that we all are
5 familiar with and I think has probably touched
6 us in a lot of different ways.

7 Prior to this -- prior to these
8 jobs, I'm sure throughout our life, I'll tell
9 you one quick story that is pretty recent for
10 me and, for me, is probably going to be a very
11 informative one.

12 I got a chance to speak with folks
13 at DAV at their convention a couple weeks ago
14 and prepared the speech and, you know, go
15 through all that and you're hitting the points
16 about the different DAV's a lot focused on, you
17 know, claims processing and things like that.

18 So it was good to highlight some of
19 the good work that folks at the Veterans'
20 Benefits Administration is doing and highlight
21 that with that with this group and talk through
22 some of those issues.

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1 But, one of the things that I talked
2 about in the speech and I'll the story, I
3 wasn't really prepared, I mean, I knew the
4 issues, I had looked into the suicide
5 statistics and all those things. In fact, I
6 had gotten the full brief on the new CDC stats
7 a couple weeks ago and they're heartbreaking,
8 wrenching.

9 I mean, it's what we would expect
10 being human. But, what I also didn't realize
11 when I became the Acting Secretary was the
12 alert message on suicides that happen on VA
13 campuses. They come direct pretty much the day
14 of. I'll see those and read the initial
15 details and then get the follow up and stuff
16 like that.

17 And, the Thursday prior to -- the
18 speech was Saturday morning, Thursday prior I
19 had gotten the one notice about a 77-year-old
20 Veteran who had attempted suicide and I don't
21 really even want to have to go and do the
22 follow up to find out if he was ultimately

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1 successful.

2 But, he had made a good effort, I
3 guess is the way to put that.

4 And then, Friday, got the second one
5 of an 86-year-old Veteran who was successful in
6 suicide.

7 I remember getting the first one of
8 those roughly a few days into this job and I
9 remember being very engaged in the sense of
10 wanting to know the story, what was going
11 through this person's head.

12 You know, they had just walked out
13 of the VA, walked to the parking lot, took
14 their life. What was going on? What was their
15 diagnosis? Looking for insight, looking for a
16 reason, which I think is probably everybody's
17 reaction when they get into this. Why? You
18 know, answer that question for me.

19 And, so, got those two emails
20 Thursday and Friday and it kind of just weighed
21 on me. And, you know, the speech was good, I
22 had practiced it a few times.

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1 But, I woke up Saturday just
2 thinking, you know, you've got to say something
3 about this.

4 So, I ad libbed a little bit at the
5 end of the speech and really used a friend of
6 mine who's a 86 -- or an 80-year-old Veteran
7 who I've known for quite a long time and talked
8 about Ed.

9 You know, Ed and I talk roughly at
10 least once a week, share a few emails. So,
11 we're in constant contact.

12 He's gone through a couple bouts of
13 prostate cancer, some of other stuff. But,
14 he's still kicking. He's an old Marine so he's
15 not going to get taken out that easy.

16 But, it's always getting with him.
17 And, he's gone through a couple periods where,
18 you know, it's just weighed on him a lot. And,
19 you know, we've had some good conversations,
20 just kind of being a friend kind of thing.

21 And, he's got plenty of folks to
22 talk to, too. But, it was that engagement.

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1 So, I encouraged the folks there not
2 to follow my example but, just, you know, they
3 all know people like that and that are
4 struggling or could be struggling, just
5 reaching out to them and kind of just ended it
6 there. It was kind of clumsy, but it was just
7 ad libbed, but it was what was on my heart at
8 the time.

9 And, Garry Augustine, who's the
10 National Director for them, comes to me at
11 lunch, we had lunch with Chairman Roe and so,
12 he wanted to pass on to me that, evidently,
13 there was a Veteran in the crowd, a mother who
14 was notified that her 32-year-old son had
15 committed suicide.

16 And so, of course, he tells me this
17 story and he said how they, you know, had some
18 mental folks there from the local VMC and took
19 care of her and they were, you know, just
20 concerned about her. But, you know, basically,
21 he was highlighting how she was getting taken
22 care of.

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1 Of course, I felt like absolute
2 crap. You know, I figured, well, tore open a
3 wound that was probably pretty fresh for this
4 lady. You know, I just felt like crap.

5 And, I said, really? I mean, and I
6 told him that, I said, man I feel bad now for
7 even bringing that up.

8 He goes, no, no, she got the call
9 after your speech. Literally about an hour
10 after the speech wrapped up about -- probably
11 about 9:45, 10:00, sometime between 10:00 and
12 12:00, she got a call that her son had
13 committed suicide.

14 Both were deployed -- had been --
15 had deployed to Iraq and Afghanistan, both were
16 Veterans.

17 So, it still felt just as bad, but
18 it was -- it really kind of highlighted that
19 stuff happens and for reasons that we're still
20 struggling to understand.

21 So, that leads into the work that
22 you all are doing both on the therapy side but

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1 also to help us, you know, promote from our
2 perspective, I guess, from the VA on how we can
3 do more, what we can do effectively, how we can
4 get the word out.

5 I don't know how to tell these
6 stories other than just to tell them and
7 encourage folks to do everything they can.

8 I know there are scientific things
9 we can do. We can be smart about things, we
10 can look at data.

11 I guess from the layperson's
12 standpoint, from my perspective, it's just, you
13 know, how do you engage with people on the
14 frequency that you do it and those things.

15 I don't think those are solutions.
16 I think that's just a reaction to it and kind
17 people on emotionally driven human nature
18 stuff.

19 So, anyway, so that was -- that part
20 of it getting into the important work that you
21 all will be doing, I can communicate a few
22 things.

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1 One, you have a 100 percent support
2 from leadership of the VA. Unquestioning,
3 unqualified. I mean, it is whatever you all
4 need to do this work, you're going to get.

5 We all take this -- I know Mr. --
6 I'll speak for Mr. Wilkie and the rest of the
7 leadership team. I mean, this is always top of
8 mind for us and probably the most frustrating
9 thing that's top of mind because this is
10 something that we don't -- that we struggle
11 with, especially after learning that, you know,
12 really suicide rates haven't changed.

13 Mental health struggles across the
14 Department while we invest in it, we work, we
15 try to hire, we do all these things, still, you
16 know, it's a battle that keeps going.

17 So, you have that support.

18 As we, you know, change, which is
19 inevitable in any organization this size, we
20 want to make sure that we're cognizant of what
21 you learn and what your recommendations are.

22 So, I can also tell you that, I

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1 guess, Boomer can attest to this, one of the
2 things that we changed at least when I got here
3 and I'll make the strong recommendation to Mr.
4 Wilkie is that we, as a leadership team, as a
5 Secretary, Deputy Secretary, Chief of Staff,
6 you know, those are a leadership review your
7 findings and, frankly, review them
8 uncoordinated, or whatever you want to call it,
9 unconcurred on.

10 I'd like to know exactly what you
11 guys are saying. I don't need an
12 administration to Vet it for me. So, I'll
13 encourage Mr. Wilkie to do the same thing. I
14 think he'll be right on board with that.

15 So, I want you all to have the
16 assurance that your recommendations, your
17 comments, your feedback, whatever form that
18 takes comes to us directly.

19 We'll still have the concurrence
20 process and all that good stuff, that's
21 appropriate and proper. But, at the end of the
22 day, these are hard decisions that have very

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1 real consequences. So, you all deserve to have
2 those hears unfiltered.

3 So, and participation with these
4 meetings. I mean, I know Jake and I know how
5 aggressive he is, so I will not set myself up
6 to coming to every single one of them, but I
7 promise to be to as many of them as I possibly
8 can. And, I know Mr. Wilkie will feel the same
9 way as well as the rest of the team.

10 So, you will get the support from us
11 that you need. And, if you ever don't just let
12 us know.

13 With that, I would love to hear any
14 questions you all have, anything you want me to
15 pass on to the new Secretary? Any comments?
16 Any feelings? I'm open to listen.

17 CHAIR LEINENKUGEL: Mr. Acting
18 Secretary, if I may, let me start with my Co-
19 Chair, Mr. Tom Beeman. I already introduced
20 him, but, Tom, very briefly, in 30 seconds or
21 less, an overview for Peter, if you will, on
22 your background and why you're part of the

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1 Commission?

2 Then we'll go around the table.
3 There's actually, Mr. Acting Secretary, there
4 are eight out of the ten designated spots
5 filled at this time. We have a quorum.

6 I can tell you from yesterday's
7 meeting, this is a very active, proactive
8 group. It will be stimulating and I was so
9 happy to hear of the approach that you have and
10 that Secretary -- Incoming Secretary Wilkie
11 will have.

12 And, my intent, even though I'm not
13 mandated, only by letter after 60 days of
14 meeting, was to give you a brief overview of
15 whether or not we're receiving the proper
16 support, not only from the VA, but any other
17 agencies or governments departments that need
18 to provide us materials in a quick, responsive
19 way.

20 I told Dr. Stone yesterday that,
21 because of his VHA duties, that I would be
22 giving him a monthly, if not weekly, briefly on

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1 if there are any roadblocks or barriers and if
2 he could deal with those and he immediately
3 said, absolutely. And, I plan to do the same
4 with you and the Secretary.

5 DR. BEEMAN: Tom Beeman, glad to
6 have you here, sir.

7 I'm a 27-year Veteran of health
8 care. I've been a CEO of Health System for the
9 last 27 years or so. I'm with Penn Medicine.

10 I was also the Assistant Deputy
11 Surgeon General for the Navy. So, I'm a
12 retired two star.

13 And, I was the first Commander of
14 the National Intrepid Center of Excellence
15 which really has helped inform my work.

16 DR. MAGUEN: Hi, so glad to have you
17 here. I'm Shira Maguen. I'm working at the
18 San Francisco VA.

19 I am a clinician, a researcher and
20 also do training for our trainees, both
21 psychiatry and psychology.

22 I'm a clinical psychologist by

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1 training and have been in the VA since 2001.
2 So, really glad to be part of this. And, an
3 open invitation to come visit us.

4 (OFF MICROPHONE COMMENTS)

5 MR. ROSE: Good morning, sir. My
6 name's Jack Rose and I'm a 26-year Veteran with
7 the Navy. And, I've been involved -- also from
8 Wisconsin.

9 And, a mental health advocate. And,
10 I've been involved with the National Alliance
11 on Mental Illness here since probably 18 years.

12 And, I look forward to supporting
13 this Commission. And, thank you very much for
14 the opportunity.

15 DR. KHAN: Jamil Khan, United States
16 Marine.

17 (OFF MICROPHONE COMMENTS)

18 COLONEL AMIDON: Good morning, sir,
19 Matt Amidon, U.S. Marine as well.

20 (OFF MICROPHONE COMMENTS)

21 COLONEL AMIDON: I wasn't down in
22 Dallas, no, sir. I was actually out on

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1 military duty and this is why this is near and
2 dear to my heart.

3 On the last drill weekend less than
4 a week ago, we had a memorial service for a
5 young Marine who decided to take his own life
6 in the barracks in Fort Worth.

7 And so, it's deeply meaningful to
8 me. But, you have a chance to hear about what
9 we do at the Military Service Initiative.

10 And, I think we uniquely exist to
11 the benefit of this Commission at the
12 intersection of public and private and provider
13 and consumer. And so, can be an important
14 broker in this effort. And, I'm deeply honored
15 to be here.

16 Thank you.

17 DR. JONAS: I'm starting to feel
18 lonely here, I'm Wayne Jonas, United States
19 Army.

20 (LAUGHTER)

21 DR. JONAS: So, and I think the only
22 physician on the panel actually. I'm a primary

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1 care doc. I still see patients at Fort Belvoir
2 which is a purple suited training program
3 actually up there.

4 And, one of the biggest primary care
5 training programs in the DoD anyway.

6 And, also have a long history of
7 research at Walter Reed, NIH, Uniformed
8 Services University.

9 I now run a foundation that supports
10 Veteran area, DoD areas in the area of whole
11 person and integrative health. And, I practice
12 that in the military hospital near here.

13 And, so, really would like to see --
14 just so supportive of what Jake's doing and the
15 Commission is doing to try to accelerate care,
16 not only for our Veterans, for our nation which
17 deeply needs this.

18 CHAIR LEINENKUGEL: So, I think you
19 can see, Mr. Acting Secretary, that this is
20 just a solid group and we're going to add to
21 this group over the next 30 days as well.

22 There is a person I want to

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1 introduce you to that's in the bullpen right
2 now warning up and not officially vetted. So,
3 when we're walking out the door, I'll bring out
4 this person to introduce him to you.

5 That being said, thank you so much
6 for everything that you have done for your 19
7 months of being within the VA.

8 And, I want to tell the group this.
9 Peter O'Rourke was the quiet one when I first
10 came in in January of 2017. And, found out to
11 be the smartest one and the hardest worker.

12 As he told me, I may not be the
13 smartest person that you brought in, Jake, but
14 I'll be the hardest worker. And, he was that.

15 And, I gave Peter two assignments,
16 and he completed both of them. And, one
17 assignment was to get the Veteran ID card off
18 the ground that was languishing, again, for two
19 and a half years with nobody taking ownership
20 and The Hill demanding for the VA to finally
21 take action.

22 Peter took action and did it within

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1 six months. I have my card. I know Veterans
2 that are receiving their cards. They think
3 it's the best thing since VA health care.

4 Even though it gives them a 10
5 percent discount at various stores, but thank
6 you for that.

7 And also, setting up and watching
8 him set up the Office of Accountability and
9 Whistleblower Protection is a well-kept secret
10 within the 15 mile radius of Washington, D.C.

11 And, the people that he brought in
12 and how he has done a great job at bringing in
13 some of the best and brightest to set this
14 office up. He is fantastic.

15 And, you've got to remember, it's
16 just starting. And, I think it's going to be a
17 best practice in years to come and Peter
18 O'Rourke is the one with the thumb print on
19 that.

20 So, Peter, thanks for your service
21 and thanks for being a fantastic Acting
22 Secretary to calm the waters over this period

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1 and get the VA on the right mission track
2 again.

3 And, this Commission, as the COVER
4 Commission, is very much a part of where we're
5 going to be going in the future with health
6 care.

7 Thank you, sir.

8 MR. O'ROURKE: I don't know if I
9 calmed the waters as Acting Secretary, but I
10 definitely stirred up the waters a little bit.

11 (LAUGHTER)

12 MR. O'ROURKE: But, that needed to
13 be done. So, no, I appreciate that, thanks.

14 Any questions from anybody? I know
15 it's still probably new, but anything you want
16 me to take back? I'm more than happy to do
17 that.

18 DR. JONAS: I'm sorry, I didn't mean
19 to -- I don't mean to jump in here too quickly,
20 but I did have a very specific question, but I
21 need to tell you why I am asking this.

22 So, I was down at the St. Louis VA

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1 about two months ago looking at their whole
2 health program doing a deep dive in there.

3 And, there was a Veteran panel they
4 had set up, using various panels to look at.
5 One of the Veterans, long hair, tattooed,
6 former Marine guy, okay, had -- was coming in
7 for his back pain. And, he had chronic back
8 pain, had multiple interventions and
9 treatments, still had chronic back pain.

10 He met with a peer to peer
11 counselor, okay, and did a personalized health
12 plan which is what they are doing down there,
13 we're interested in.

14 He got a personalized health plan
15 and the peer said, why don't you come over to
16 the yoga class with me? He said, yoga? Are
17 you kidding me? No, just come on over, we'll
18 try it out.

19 He started the yoga class, his pain
20 improved and then he said something that just
21 startled everybody in the room. He said, yoga
22 saved my life.

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1 And, I said, what do you mean? And,
2 he said, I thought about suicide every single
3 day before this class and I would never tell
4 anybody about it because I know what happens
5 when you tell them that. Okay?

6 And, we were just stunned. Okay?
7 We're going to get an evidence review that is
8 likely going to say, yoga does -- there's
9 insufficient evidence to use yoga for PTSD.
10 Okay?

11 So, my question to you is, how are
12 we going to -- how is the VA and the nation
13 going to determine value on investment? And, I
14 use that term specifically over return on
15 investment because we're looking at value which
16 has to hit at something.

17 And, Drew yesterday put me in touch
18 with a great study done in 2007 where they
19 looked at designs of health care around that.

20 And, as someone who's going to be
21 looking at accountability, how are we going to
22 actually measure the accountability issue when

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1 it comes to value on investment for something
2 like that?

3 MR. O'ROURKE: So, there's yoga,
4 there's hyperbaric, there's -- and these are
5 things that I'm new to. I'm not a clinician,
6 obviously, but I've heard those and you see the
7 stories.

8 And, I've talked to Congressmen that
9 -- and women that have their opinions about
10 things with -- that are light on the scientific
11 data side.

12 I think this Commission is going to
13 go very far with providing us the qualified
14 reasons why we should do these, maybe not the
15 quantified.

16 And, I relate that back a little bit
17 to what we're doing in benefits, actually.
18 Because we do the buddy statements and things
19 like that. I mean, when there was no record,
20 when there's those, we've expanded to provide
21 different methods of justification or different
22 methods of validation of those verification of

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1 them.

2 I don't know what the answer is, but
3 I know that getting a group like this together
4 to start advocating for it in an organized way,
5 not an average see from the outside in saying,
6 you know, hey, this is great, it's the only
7 thing that worked, you know, take Vitamin E all
8 day, you'll be fine sort of thing.

9 More recognizing what the effect of
10 long term war is, because we can't quantify
11 that either, by the way. Right? I mean, I
12 haven't seen a study. We see anecdotal type
13 things, things like well, what really happens.

14 I mean, if we want to go back in
15 history and look at the Spartans or we want to
16 go back and, you know, Greek and Roman history,
17 I'm sure we could, you know, come up with
18 stories about the long term effect or go back
19 to World War I, which ever.

20 At the end of the day, it's more of
21 the organizations, plural, so it's us and DoD
22 and by association, the rest of the federal

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1 government saying, let's just be honest about
2 this with ourselves.

3 What is our mission really going to
4 be? What are we truly going to do for Veterans
5 and what are we not? Are we going to encourage
6 them to go do things or are we going to mandate
7 it, i.e., fund it for them?

8 So, I think those are the harder
9 questions that we really have to look at. And,
10 I mean, we have this debate right now with the
11 presumptions and, you know, types of health
12 care, things that we're going to take care of.

13 So, I think those are open questions
14 for good conversation for debate for as much
15 evidence as we can find and then we just really
16 taking our Veterans for who they are, what they
17 are and then just dealing with that and making
18 this really focused.

19 Because, for the one Marine that
20 yoga, you know, he admitted it, we'd probably
21 have ten people that wouldn't admit to that.
22 And, then, a few others say, no, I didn't even

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1 think about that at all.

2 And, half of those like the yoga and
3 half of them say, no, I'd never do that.

4 I mean, there's going to be a lot of
5 variance in that. And, at the end of the day,
6 if it's a personal lifestyle choice kind of
7 thing that's going to help them, I think we
8 should encourage all good type things.

9 I mean, if we can define that it's
10 good, of course, we encourage it. Of course,
11 that's a cop out answer, right, because it's
12 not, okay, yes, but are you going to fund it?
13 Are you going to make it a benefit?

14 And, that's -- then we start
15 crossing lines into other broader conversations
16 of exactly what benefits are we going to
17 provide and is it, you know, earned in that?
18 We'll leave that for later on.

19 I think what work that you guys are
20 doing are going to help us with the validation
21 of, yes, these are things we should do.

22 I mean, I sat with the folks from

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1 Columbia that are developing the equine therapy
2 handbook, you know, the actual observable, you
3 know, responses to that and how should we do
4 it.

5 And, I'm pretty sure they probably
6 just kind of skipped over that. Can we
7 actually say, playing with horses is going to,
8 you know, do X, Y and Z? Or just result in X?

9 And then, kind of just jump to, it's
10 like, hey, it's observable. It's kind of like
11 what we are -- we have puppies now in the lobby
12 every month. I hope it's every month, because
13 that's what we all kind of decided to.

14 Not because we have a scientific
15 study that says playing with puppies is great,
16 but anybody can walk in the lobby on the day
17 that the puppies are in the lobby and realize,
18 oh my gosh, the morale of all of our employees
19 at VA just went through the roof.

20 Now, that may have only lasted for
21 about ten minutes. As soon as they got in the
22 elevator and got stuck there for a few minutes.

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1 But, for that brief moment, those puppies made
2 their day.

3 I think it was the same thing we
4 observed with horses and everything else.

5 I mean, there's things that we just
6 know. Do we need to study them to death and 25
7 years later realize that, yes, this is
8 something we should have been doing for the
9 last 50?

10 I mean, that's for us to provide
11 reasoned arguments and as much qualified or
12 quantified data that we can and then let
13 politicians decide what they're going to fund
14 or not, what we can encourage.

15 Because, I can encourage a Veteran,
16 hey, go play with some puppies, go ride a
17 horse. And then, maybe find a charity that'll
18 help them do that or find other methods for
19 them to get that done.

20 If we know these are good things to
21 do, then that's things we can probably get out
22 through our systems and we can start doing

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1 this.

2 We're a pretty scaled up
3 organization. So, if we just say, hey, this
4 would be a great thing for a Veteran service
5 organization to help us do, I mean, that's
6 where kind of the experience for the Veteran ID
7 card came in is, yes, we had a funding problem
8 with that and that's what was the major
9 roadblock.

10 Because we connected over our own
11 internal roadblocks we set up, whether they
12 were the way we were trained to develop the
13 solution or just the legal part of it. And, it
14 was just -- we just can't do it.

15 And, I said, well, let's just find
16 somebody else to pay for it. And, we did that.

17 And, I had -- I still have attorneys
18 that yell at me because I -- you can't do that,
19 you have to charge the Veteran. Because, it
20 actually says we are supposed to charge the
21 Veteran for that?

22 And, of course, when Jake and I saw

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1 it, I was just like, this is absolutely insane.
2 I'm not going to ask somebody to pay for a 10
3 percent discount. I mean, it was just
4 ridiculous.

5 So, when we had somebody from the
6 private sector who said, yes, sure, we'll pay
7 for that. Okay, let's do that.

8 And, the Secretary has those
9 flexibilities that has that flexibility to
10 accept in kind and in cash to do things for
11 Veterans. There's a process for doing that,
12 let's just do that.

13 So, I think we have more solutions
14 than we give ourselves credit for for some of
15 this that we get stuck on the science
16 sometimes. And, I don't mean to offend anybody
17 that does that.

18 I mean, but, we do, right? We get,
19 you know, the paralysis by analysis kind of
20 thing. It's, you know, funny consultant type
21 thing. But we do that sometimes with solutions
22 is we just don't want to sometimes get there.

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1 We're -- I think what you guys are
2 going to be promoting is let's just get there,
3 let's just do it and we'll figure it out.

4 DR. JONAS: That's wonderful, thank
5 you.

6 If we were to point in the direction
7 of here's some outcomes that everybody wants,
8 you know, something along lines going, could --
9 would that help the VA and sort of build a
10 flexible system that could say, all right,
11 let's innovate. We can look at all kinds of
12 innovative programs that might get at those
13 outcomes as long as you show you're getting
14 those outcomes.

15 Is that something that the VA is --

16 MR. O'ROURKE: I would much rather
17 go to The Hill to advocate for a million
18 dollars to try something that we really think
19 are going to work than hide hundreds of
20 millions dollars under things that I didn't
21 realize we wasted money on.

22 I'd rather be intentional with it

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1 and just say, yes, I'm going to go spend this
2 money on this. I don't know if I'm going to
3 get the exact outcomes, but I think it's going
4 to be good for Veterans. I don't know a
5 politician that wouldn't buy into that.

6 It's good transparency and, frankly,
7 it's a great argument. It's a whole lot more
8 interesting to talk about than some of the
9 other things we have to advocate for for money.
10 It's much more fun than an IT project, I know
11 that.

12 MR. ROSE: Sir, if I may, along with
13 this cross item that had come up, if we can
14 look at it like increasing what we have in our
15 toolbox to help the Vets and in lieu of costs
16 that we might have spent on something else, I
17 don't know, if we could just give it a little
18 bit broader range.

19 MR. O'ROURKE: Yes, when we figure
20 that part out, as narrow as that is, then we
21 have found the Holy Grail of arguments on that.

22 I think the metaphor on the toolbox,

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1 though, what's interesting and what I found in
2 the little bit of traveling around that I have
3 is that our VA folks probably do that to spite
4 us.

5 Because, if they see something that
6 works, they're usually are going to do it.
7 Now, that's the good part about some of the
8 independence of the way we're structured and
9 also there's some negatives to that as well.

10 So, I think if we focus on that as
11 really the drive, the initiative for these
12 things, there's putting more in, some of these
13 we'll want to mandate, right, and that will
14 kind of cross us into that, well, okay, if
15 you're going to mandate it, you better pay for
16 it kind of thing.

17 We have lots of unfunded mandates
18 anyway. So, I don't really usually buy that as
19 an argument.

20 It's going to be compliance and
21 accountability for those things. We can find
22 the money usually to do them. And, usually,

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1 some of this stuff, I mean, yoga, I'm sorry, my
2 wife does like a bar class. It's, you know,
3 \$10 a class. I mean, we're not talking about
4 huge --

5 I mean, I'm -- well, I should back
6 up. I mean, we're the federal government, we
7 can find a way to make yoga really expensive,
8 I'm sure. But --

9 (LAUGHTER)

10 MR. O'ROURKE: -- maybe we can, you
11 know, just farm that out and let the private
12 sector do the yoga stuff and we just encourage
13 them, maybe give a little, you know, way to do
14 that.

15 But, I remember when we had the
16 first chiropractor at Wright-Patterson, it was
17 hilarious just talking to him about how his
18 whole thing was working.

19 Because he was the brand new thing
20 at the time and, you know, you all are more
21 familiar with the history of chiropracting than
22 I am. But, it was just interesting to hear his

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1 travails and just trying to say, hey, I really
2 think this can help people and, you know, and
3 just --

4 And, we was there for six months and
5 they booted him out. I don't know what
6 happened. I'm sure they brought him back at
7 some point. This was a while back. But, it
8 was interesting.

9 DR. BEEMAN: Just a comment, sir.

10 I mentioned this to Jake earlier and
11 I hope it doesn't offend Dr. Jonas at all, but
12 I think we might be on the same wavelength.
13 And, I'm speaking as a person from a major
14 research institution having done my Doctoral
15 work at another one.

16 And so, and that is, is it possible
17 that the skepticism that appropriately
18 characterizes modern medical science has led to
19 cynicism when it comes to complimentary
20 medicine?

21 Because, modern medicine is
22 reductive, modern science is reductive and,

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1 really, what we're talking about is more
2 holistic.

3 So, it's almost impossible to prove
4 some of this stuff except anecdotally. And, I
5 think that that's what you were saying, Dr.
6 Jonas, is that, you know, we see stuff and it
7 works.

8 You know, all you need to do is get
9 on a horse and realize that the worst headache
10 in the whole world is cured within about five
11 minutes because you start riding and you become
12 one with the animal.

13 I do that all the time, that's how I
14 reduce my stress. But, I can't scientifically
15 prove that other than I know that it happens.

16 So, I'm glad to hear that you're
17 open to that because I think there's a lot of
18 things that we can do that treat people as
19 human beings.

20 And, this goes back to one anecdote
21 I have to tell you. I went to see physiatrist
22 and a neurosurgeon about my back pain, my lower

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1 back pain. And, he said, you know what? You
2 don't need surgery, you need yoga.

3 So, I went home, I told my wife.
4 She said, I've been telling you. And, I did
5 yoga for about a month, no back pain. I
6 haven't had back pain in at least five years.

7 And so, no intervention, no real
8 cost to the system, maybe a little personal
9 cost.

10 So, I think there's a lot of
11 opportunity, but we just have to really grab it
12 and put it out there.

13 MR. O'ROURKE: You said something
14 that struck me and it's just for conversation.

15 So, treating the whole person as a
16 human being. When was the last time we did
17 that in DoD? We tend to do the exact opposite.
18 Right?

19 I mean, you're an instrument. So,
20 it is really a huge culture change. And, for
21 the person, right? I mean, they're used to
22 that, that we all grew up in that kind of

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1 culture.

2 And now, we're coming to the VA
3 asking people, you know, treat me as a human
4 being. There's a cultural part of that, the
5 change over.

6 And, what you brought out, and I'll
7 let you guys fight that one out, but the
8 reductive or not. But, it really is that your
9 willingness or your ability to say, oh okay,
10 I'll try that.

11 Or, is that what you even really
12 want? Or do you want somebody just to listen
13 to you? I'm in pain both physically, maybe
14 mentally. I'm frustrated with life.

15 One of the things I have struggled
16 with here, and especially -- and it kind of
17 goes back to the story about the older
18 Veterans, everybody has, and maybe this is just
19 a person that already has this sort of mental
20 image when they hear about a Veteran suicide.
21 And, I guarantee it's not an 86-year-old person
22 unless you're familiar with the statistics.

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1 Usually, you think, oh, it's some,
2 you know, I watched a movie and it's some kid
3 that got back from Iraq and just can't deal
4 with life, comes back and kills himself.
5 That's the --

6 You know, or we've put him on meds
7 and that's the kind of thing.

8 I've thought about this and, okay,
9 somebody serves four years, six years, they get
10 out, they go on with life.

11 They hit 42 and life kind of crashed
12 in. They go through a mid-life crisis,
13 whatever else, financial difficulties, whatever
14 and then they consider suicide.

15 Completely decoupled from their
16 service. I mean, this has nothing to do with -
17 - I say that, maybe it's over simplification,
18 but I mean, there's been enough time that's
19 passed between their, you know, maybe they
20 reflect back on that, but it wasn't enough
21 trauma during that period that they were having
22 those issues right after.

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1 But, there's still one thing about
2 them that makes them unique, at least from our
3 perspective, they're still a Veteran. So, do I
4 care about that person that has -- that Veteran
5 who's mental health issues are not related to
6 necessarily something I can pull a string on
7 back to their service?

8 But, they're still a Veteran,
9 they're still suffering. Do they come to us
10 for -- do they come to us? Do they go to
11 somebody else? Do we not have an equity in
12 that person at that point?

13 You know, that part of it kind of
14 plays into that, you know, somebody offers you
15 -- it's not surgery, it's not drugs, whatever.
16 Hey, go do yoga, go ride a horse, do those
17 things.

18 Maybe that's not what they want to
19 hear right then. I want somebody to listen to
20 me, I want somebody to help me, my life's
21 falling apart.

22 How do we recognize those things?

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1 Or are we just focused on, well, your back
2 pain, okay, you can get surgery, you've got a
3 bulging -- oh you can do this, here's your
4 options and then that's -- we just walk away
5 from that, we just focus on that.

6 Which leads to just like what you
7 said, I mean, I made a decision to go do yoga
8 then a month later, I don't have the pain.
9 Whereas, you could have just -- I'm sure you
10 could have gone to other doctors who would have
11 said, sure, come on we'll do laser surgery,
12 we'll do some kind of surgery, something to
13 you.

14 So, it's that mental state on some
15 of those scenarios that are interesting to
16 think through because, I don't know where all
17 these folks are coming from.

18 And, that maybe the bigger picture
19 is really determining where they're coming from
20 and getting them into the right kind of care
21 that they may need, that kind of stuff.

22 I don't know if even we're, as an

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1 organization, our science, we're flexible
2 enough to do that.

3 Those are some of the things I would
4 love to start having a better understanding on
5 or maybe I'm just, you know, don't read enough
6 journals or something.

7 But, those are the kind of things
8 that I hope we're smarter on through this
9 process.

10 DR. JONAS: Sir, thank you for that
11 answer. I'm totally on board with what you
12 just said, I'd like to talk to you more about
13 that.

14 MR. O'ROURKE: Good thing you're in
15 the same room.

16 DR. JONAS: You know, I want to take
17 a bit of an issue with something you just said
18 about whole person care.

19 So, I practice in the DoD, I've seen
20 folks working in the VA. They are taking care
21 of whole people every single day. We are
22 taking mind, body, spirit care every single

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1 day. Okay?

2 But, we're doing it in a system that
3 makes it really, really hard to do. And,
4 that's the biggest -- that is the reason that
5 the 50 percent of primary care folks, nurses,
6 et cetera, are burning out. Okay?

7 We need to create it so it's easy to
8 do. We need somehow an accountability ruler
9 that says, as long as you hit these milestones
10 in terms of quality, costs and outcomes, you
11 can have the flexibility to do it through any
12 path because we need multiple paths.

13 We need somehow to structure our
14 system in a way that it brings in the evidence,
15 but isn't tied to it as the only thing that's
16 going to get paid for.

17 We need to somehow get an innovative
18 model that allows for the whole person care to
19 work better for what people are trying to do
20 every single day, in my opinion.

21 So, can you bring an accountability
22 ruler?

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1 MR. O'ROURKE: Yes, I mean, I just
2 ask why? I mean, why don't we have that
3 system? If everybody's doing it, right, so
4 here's the part that I just way over simplify,
5 look at it, if that's the -- not if, but that's
6 the case, why has there been no substantive
7 reaction by the rest of the system?

8 The measurement system of that, you
9 know, the payment system, what all those others
10 are? Or, do we really just have two factions
11 fighting against each other so would limit us
12 in some places we don't actually do all that.

13 That's what I would lead to,
14 typically an organization, right, if you're
15 producing something a certain way, the rest of
16 the organization eventually has to be forced
17 into or is forced into some sort of alignment
18 whether it's completely ineffective, whether
19 it's whatever else, I mean, but you'll see
20 something.

21 It's just you can't twist two gears
22 two different ways and not sheer all the nubs

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1 off and finally you just have two things
2 spinning.

3 So, that's what I'm kind of
4 wondering is, you know, what is those actions
5 we can take as this leadership management, you
6 know, our systems to align with that, if that's
7 truly what we're doing, or is there not enough
8 consistency there that we don't see the
9 evidence coming out of that naturally. I mean,
10 just overwhelmingly coming out and seeing it.

11 And, that's probably part of the
12 struggles of all that anyway when you look at
13 something that's hard to quantify, easy to
14 qualify and so you just -- you're always
15 warring between those two types of data.

16 I mean, I can tell you how I feel, I
17 can't measure it for you. Right? I mean,
18 well, one day I say it's my daughter suffers
19 from migraines. Sometimes it's three times,
20 sometimes it's seven. I'm always wondering,
21 you're 16, is there something else going on? I
22 mean, did you friend just call and piss you off

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1 so now you're at a six? But, it's not really
2 due to your pain?

3 I don't know those things so I just
4 sort of usually step back and let it work and
5 just be supportive and kind of try to create a
6 cocoon around it.

7 I don't know if that's sort of the
8 same reaction we're doing as an organization
9 around some of the efforts. I don't know, I'll
10 just -- things, put that in the list of things
11 I don't know.

12 CHAIR LEINENKUGEL: Jamil?

13 DR. KHAN: So, first of all,
14 personal thanks.

15 MR. O'ROURKE: It's good to see you
16 again.

17 DR. KHAN: For getting those cards.

18 No, I have another request to you
19 and this has to do specifically with the
20 suicide prevention.

21 In the system, those that we have
22 flagged that we know who are high risk, we

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1 should be able to issue them a push card, the
2 technology that exists today.

3 It can be procured from the same
4 funding like you did for the cards.

5 (OFF MICROPHONE COMMENTS)

6 DR. KHAN: Yes, sir. Yes, sir.

7 Because, if Jamil has that, and
8 let's say I'm one of those people who are ready
9 to do it. There is a very much possibility
10 that before I do it, I'll push it to say a last
11 word to someone.

12 And, it should be answered not by a
13 call center, it should be answered by a
14 qualified technician who knows I'm ready to
15 jump the San Francisco Bridge.

16 And, he says, Jamil, wait two more
17 minutes. I mean, you're going to jump, and
18 let's talk about it.

19 At present, evidence based has
20 shown, not with this push card, but wherever
21 there was an intervention, they had a high
22 success rate.

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1 So, my request to you is, get the
2 push buttons out.

3 CHAIR LEINENKUGEL: Well, if anybody
4 can get it done, it's going to be this guy
5 right here.

6 MR. O'ROURKE: I mean, I've talked
7 to the Amazon guys that have the -- we've been
8 talking specifically in that context. But, the
9 technology is there, the crisis line, you're
10 right, it's a call center. And, we do track
11 the number of interventions that they do and
12 how many times we call out for register help,
13 those kind of things.

14 My only -- and I agree in principle
15 in all that. It's my concern, at least from
16 this perspective, is having the capability and
17 the resolution -- the capability to do the
18 resolution on that to make sure that we don't
19 get ourselves into where --

20 well, in an area we're already
21 nationwide shortage and can I provide that
22 capability with a reasonable belief that, you

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1 know, within five seconds somebody's going to
2 pick up the call, it's going to be that kind of
3 interaction giving our number?

4 Or is there another way to find that
5 solution that distributes that out to the
6 providers that are out there that do those kind
7 of services?

8 That's kind of the struggle with an
9 organization this size and with a population
10 this size, frankly.

11 DR. KHAN: Sir, you don't do that.
12 The Jamil Khan, the Marine asked for this. He
13 will, I'm sure, make this out.

14 MR. O'ROURKE: This is the forum. I
15 mean, it's part of the recommendations. We can
16 have those conversations. I know we've talked
17 to Mr. Gates about other things.

18 DR. KHAN: So, the second thing I'm
19 thinking of is the Choice Program. In the
20 Choice Program, we started with regionally.
21 The VA handled it itself.

22 Then, it became too big, so went out

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1 and found a contractor that was Health Net.

2 MR. O'ROURKE: Two of the, but yes.

3 DR. KHAN: Yes, sir. The Health Net
4 has done some good, but a lot of bad. The bad
5 stuff gave the VA a bad name to all Veterans
6 who otherwise were coming to the VA.

7 You know, once they get the bad
8 name, unfortunately, it takes a long time to
9 get a good name back.

10 But, recently, there are VA Medical
11 Centers, I'm from Wisconsin, and medical center
12 in Madison, they arrange my choice appointment
13 with a provider and they paid directly to the
14 provider. So, we have no issues.

15 I think it's coming from the ground.
16 Marines like me asking you, don't bring me a
17 third-party in there just let me take --
18 Veterans take care of Veterans.

19 MR. O'ROURKE: So, I mean, it's a
20 broader issue. Yes, that's just a broad issue.
21 I noted there's some things that make that much
22 more complicated than it may seem.

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1 And, success in one area,
2 unfortunately, is not indicative of the whole
3 system.

4 There's work to be done, there's
5 balances to be made between that and where
6 we're going to go. But, I would rather find
7 the best solution in that case.

8 The one that you described for a
9 couple of things, service good, cost very high.
10 And, we would say we'll spend whatever we need
11 to spend, but when it means not being able to
12 do other services because we're going to pay
13 that bill, I think we have to look for the best
14 solution in those and make them work.

15 I mean, you're right. I mean,
16 that's prefaced by that we -- I think we go
17 back, we weren't doing that great before we had
18 a choice. So, we had different places,
19 individual places that did it a little better
20 based on factors.

21 But, overall, we -- there was a
22 reason why we went to the choice thing, there's

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1 a reason why we went to third-parties. And
2 then, there's a reason why we're coming back
3 from that and there's reasons why we're going
4 to go back to it, just doing it the right way,
5 managing it the right way and the cost savings
6 you can get from that don't outweigh any lack
7 of service, but we need to be better competent
8 on how we execute those kind of contracts.

9 Health Net will not be our
10 contractor for very good reasons, although the
11 DoD will be dealing with Health Net because
12 that is now their new contractor, but I'll
13 leave that to them. Maybe they can do a better
14 job managing the contract than we did.

15 So, but that's noted, but I don't --
16 I think we'll just have to continue that
17 conversation for a little while I think.

18 CHAIR LEINENKUGEL: You know, Mr.
19 Secretary, it was nice, not only for you to be
20 here, but we scheduled you for a half an hour
21 and it's been an hour now.

22 MR. O'ROURKE: So, Meredith is

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1 screaming at me right now?

2 CHAIR LEINENKUGEL: And, we could
3 ask questions all day of you. And, we welcome
4 you back at any time.

5 MR. O'ROURKE: Okay.

6 CHAIR LEINENKUGEL: And, whatever
7 high profile role you're going to have in
8 serving Veterans, but Peter, thanks for being a
9 friend. Thanks for taking the time to come in
10 front of the Commissioners of the COVER
11 Commission. And, thanks for always being
12 supportive of our requests and needs.

13 Thank you very much, sir.

14 (APPLAUSE)

15 (Whereupon, the above-entitled
16 matter went off the record at 11:22 a.m. and
17 resumed at 11:35 a.m.)

18 CHAIR LEINENKUGEL: I'm not going to
19 apologize because it's always great to have an
20 Acting Secretary or a VA leader in front of the
21 Commission on the time.

22 DR. MURPHY: No apologies necessary.

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1 I'm sure that that was more valuable to the
2 Commission than --

3 CHAIR LEINENKUGEL: But, you were
4 right in the heart of something that's very
5 necessary and will be an outcome that we will
6 be discussion and doing action on this
7 afternoon as well.

8 So, by closure of the day 2 session,
9 we will have at least key people in alignment
10 as far as how we're going to go about and
11 approach the work effort and then the type of
12 support that we're going to request from you
13 and your staff.

14 DR. MURPHY: Give me the opportunity
15 to take a slight diversion. I just want to
16 respond to something the Commissioners have
17 said.

18 So, to give a low back pain example,
19 and I and my trusty computer while everyone
20 else was talking with the Acting Secretary,
21 pulled up the low back pain guideline. And, I
22 want to tell you what the recommendation is.

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1 It is that they suggest the use of
2 mindfulness-based stress reduction, clinician
3 directed exercise, spinal manipulation and
4 mobilization, acupuncture, pilates, yoga and
5 tai chi for the treatment of chronic low back
6 pain.

7 And, they had a specific key
8 question about models and recommended a team
9 approach including an interdisciplinary rehab
10 team that included a holistic approach with
11 biopsychosocial modeling.

12 So, you know, the guideline process,
13 I think, works pretty well. Now, it's based on
14 what the literature has published. And, some
15 of the important work at places like NICOE may
16 not have gotten into the literature yet.

17 But, where there's literature, I
18 think, you know, VA has tried to pull in a lot
19 of the things that this Commission is
20 interested in.

21 And, that's, you know, one of the
22 pain related guidelines and I think they did a

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1 nice job.

2 DR. MAGUEN: If I can just add to
3 that, I think one of the things you're
4 highlighting is let's not replicate what's
5 already been done. And, I think that that's a
6 really key point.

7 I think that if we think about it
8 that way, you bring to the table, look, I don't
9 need to duplicate this work because we have
10 good evidence here that this was done
11 rigorously. Let's not, you know, waste time
12 and duplicate work.

13 So, I think that that's, from my
14 perspective, really important.

15 DR. JONAS: So, let's start with
16 that recommendation around pain because we
17 don't want to forget about pain. Right? It's
18 a key issue around opioids, but not necessarily
19 request that you replicate it. But, let's make
20 sure we don't lose it.

21 DR. MURPHY: So, after we, you know,
22 really nail down the scope, we're going to

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1 start with what we had. And, once we nail down
2 the scope, the next big piece is determining
3 what your priority key questions are.

4 Because, they really begin to drive
5 the search criteria and the systematic review.

6 So, remember that we said that we
7 would start with PTSD, major depressive
8 disorder, opioid use disorder, alcohol use
9 disorder and suicide prevention. Five mental
10 health conditions.

11 And, each of them needs three key
12 questions. So, for adults with PTSD, are
13 complimentary and integrative health treatments
14 effective as monotherapy for improving mental
15 health outcomes?

16 Meaning, no other therapy, only the
17 complimentary and integrative health.

18 I think we're unlikely to find a lot
19 of studies like that. But, if it works against
20 placebo, then we've got a great recommendation
21 based on the strength of the evidence.

22 The other two questions that I'd

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1 like to propose to you is, for PTSD, are
2 complimentary and integrative health treatments
3 effective as adjunctive therapy?

4 And, we have to look separately at
5 pharmacotherapy and at psychotherapy and
6 psychosocial intervention.

7 So, those are the three questions
8 and we would do the same thing for major
9 depressive disorder, opioid use disorder,
10 alcohol use disorder and suicide prevention.

11 So, that's a proposal. Let's go
12 look at then what you do next in fleshing out
13 some of these issues.

14 So, based on the key questions, we
15 developed statements about the PICO(TS). We
16 defined the population of interest, the
17 intervention, what we're going to compare it
18 to, the outcomes and, if relevant, the timing
19 of the studies and the settings of the studies.

20 So, here is an example of a PICO(TS)
21 table, population intervention. comparator,
22 outcome, timing, setting that fills in all of

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1 that stuff.

2 So, the population of interest, as
3 we said, was adults 18 years or older with a
4 PTSD diagnosis.

5 We've got the list from the
6 legislation which we can potentially add to
7 based on your input as the interventions and
8 the -- since this is the monotherapy question,
9 it's compared against either wait list or
10 placebo.

11 The outcomes are the outcomes that
12 the PTSD Work Group for the guideline
13 determined were their outcomes of interest.

14 And, we'll look at at least a 60-day
15 follow up to see whether the outcome -- the
16 improved outcomes persist and we'll look at
17 overall primary care, specialty care and mental
18 health clinic care.

19 So, that's sort of the way we would
20 fill that in.

21 We can go on, that's just a reminder
22 of our population. Here are the interventions.

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1 So, for monotherapy, we've got a list of
2 interventions.

3 And then, for an adjunct therapy,
4 you're going to look as your primary
5 intervention at pharmacotherapy plus that list
6 above and then psychotherapy plus that list.

7 And, what we did in the
8 pharmacotherapy and the psychotherapy was we
9 pulled out the evidence based-treatments from
10 the guidelines.

11 So, we have the treatments that were
12 determined to be effective in each of those
13 guidelines.

14 When we look at the comparators,
15 they're going to be slightly different,
16 depending on whether we're looking at it
17 adjunctive or at monotherapy.

18 So, for -- as we said, for the
19 monotherapy question, if it's a primary
20 therapy, wait list of placebo, for the
21 comparisons and adjunct, you're going to look
22 at pharmacotherapy alone or psychotherapy

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1 alone.

2 And, here are some of the outcomes
3 that have been determined by a panel of experts
4 to be the important outcomes for each of the
5 conditions that we're tasked by you to study.

6 So, rather than give you a headache
7 looking at this incredible detail, what I would
8 ask is that you, as a Commission, think about
9 whether you want to set up subcommittees to
10 oversee the evidence-based review and some of
11 the other tasks that you want to carry out and
12 we can work specifically to make sure that the
13 PICO(TS) statements are exactly what you want
14 to drive your literature review.

15 And, with that, I'd like to stop and
16 open to questions. I know that I went through
17 that really quickly, but we'll come back and
18 talk about it later.

19 And then, I'd like to move to this
20 survey if we could.

21 So, Mr. Chairman, are there
22 question?

1 CHAIR LEINENKUGEL: Please go back
2 to your PICO(TS) slide, if you would, that
3 initial slide.

4 And, you did condense about eight
5 slides into ten minutes. These are things that
6 I think all of us as Commissioners want. I
7 personally as the Chairman and I know that the
8 Co-Chair would want to see, you know, this in a
9 format.

10 So, again, once MAX is up, it'd be a
11 great MAX entry point for us. But, we need
12 this today because we are going to start to do
13 the segmentation work led by myself and Tom as
14 far as subgrouping, call it subcommittees, but
15 how we're going to work.

16 And then, you know, is this the
17 right model? Well, you've got it set up so I
18 would imagine and assume that it should be.

19 It doesn't necessarily mean we have
20 to stick rigidly to it. But, at least use it
21 as a guideline while we do the subgrouping of
22 our work.

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1 DR. MURPHY: Sorry, we have actually
2 developed the PICO(TS) statements and the
3 tables for each of the conditions and each of
4 the three key questions. So, we can give you
5 that blown out document to give you all of the
6 detail.

7 But, for brevity of presentation, we
8 didn't put all of those into the slides.

9 CHAIR LEINENKUGEL: You did it the
10 right way, Fran.

11 I'm just saying, though, as backup -
12 -

13 DR. MURPHY: Yes.

14 CHAIR LEINENKUGEL: -- give us the
15 rest of the backup --

16 DR. MURPHY: Absolutely.

17 CHAIR LEINENKUGEL: -- with the
18 detail behind it and then we can work off of
19 that from the subgroup or subcommittee basis.

20 And, I think it'll give us a real
21 good start in getting into the meat and the
22 layering of what the Commissioners need to come

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1 up with the solution basis and recommendations
2 at the conclusion of the Commission.

3 But, at the same time, I look at
4 these as working documents going forward. This
5 is where the Commissioners will talk, whether
6 it be telephonically or within subgroups first,
7 which I highly recommend to get clarity.

8 And, also, I would say get consensus
9 if possible from the subcommittees before
10 bringing the work forward to the Committee.

11 So, I know I'm getting ahead of
12 myself, but this is a, I think, a real good
13 template for us to take a hard look at and it's
14 something that is already there from the
15 evidence-based work that you've done, Fran.

16 Everybody else agree to that?

17 (NO AUDIBLE RESPONSE)

18 CHAIR LEINENKUGEL: So, I think --
19 yes, go ahead, Wayne.

20 DR. JONAS: Just ask a couple
21 particular questions, it seemed to be, and I
22 guess if we have a subcommittee, then we can

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1 talk about them.

2 But, I wouldn't -- you did put
3 comparator which is wait list and placebo. I
4 wouldn't exclude those that are comparators to
5 others.

6 There are some studies in which the
7 comparator is another treatment. It's not a
8 wait list or a placebo, it's an actually active
9 treatment and you're trying to do comparators.

10 So, I'd make sure we include those.

11 CHAIR LEINENKUGEL: I see that, yes,
12 because I think I agree with you on that.

13 DR. JONAS: Well, so, there are some
14 of these -- some of -- there are studies where
15 some of these complimentary approaches have
16 been directly compared to another treatment.
17 Okay? Not a wait list or a placebo, but
18 another active treatment like psychotherapy or
19 some other treatment.

20 So, I just want to make sure those
21 are included in the study, but it wasn't as an
22 out on there. I assume you would.

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1 DR. MURPHY: We can make those
2 changes.

3 DR. JONAS: The 60 days, why 60
4 days? I mean, a lot drugs for depression are
5 measured at 30 days. I know that FDA doesn't
6 like that and a lot of people don't like it
7 because people take them for longer.

8 But, that's the usual standard, or
9 at least for depression drugs. So, why 60
10 days?

11 DR. MURPHY: I'd like to see some
12 persistence of the effect. You also, especially
13 for some of these conditions, like to give
14 enough time, for instance, in the major
15 depressive disorder, pharmacotherapy comparison
16 takes a number of weeks for the drugs to become
17 active.

18 DR. JONAS: Yes.

19 DR. MURPHY: But, again, we can --

20 DR. JONAS: I would encourage us to
21 do that.

22 DR. MURPHY: -- open for discussion.

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1 DR. JONAS: Okay.

2 DR. MAGUEN: That was something that
3 stood out to me, too. I think that one of the
4 challenges of the work that we're all about to
5 do together, too, is that a lot of these
6 studies probably, like, for example, evidence
7 based treatment for PTSD is 12 weeks.

8 So, I would just suggest maybe
9 looking to, if there's a pre and post, maybe we
10 can think about time line a little together
11 because I think it's a complex question.

12 I agree with you, what you're
13 saying, we want long enough so that there's an
14 exposure and a pre/post. But, the exact time
15 line, I think, we might rule out studies that
16 we want to look at that have a shorter time
17 line.

18 DR. MURPHY: I think as long as you
19 say at least X, we can always look at a year
20 follow-up. But, you want to set some minimum
21 time.

22 So, if the study is done a week

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1 after and you know that your pharmacotherapy is
2 not going to be active at that time, then it
3 may not be a good study. It will be a very low
4 quality study.

5 So, you're really looking at ways to
6 define your inclusion criteria and your
7 exclusion criteria.

8 But, again, we can work on that
9 together.

10 DR. MAGUEN: Yes, I totally agree
11 with that. I think we might, again, when we're
12 thinking about that, just in thinking about
13 some of the nuance, we might want to be more
14 lenient when we look at just studies that have
15 -- are looking at, you know, a CIH as primary
16 versus CIH as secondary because there -- we
17 might want to get sort of our hands around more
18 studies in that number one category.

19 So, thank you.

20 DR. BEEMAN: Just an observation.
21 We're calling it monotherapy and I think it's
22 instructive. In reality, complimentary and

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1 integrated medicine goes with something else.
2 Right?

3 Complimentary means it compliments
4 something. Integrated means that it integrates
5 with something.

6 So, it may be instructive that in a
7 -- that one of these complimentary therapies
8 actually works on its own, then it might not be
9 called complimentary anymore. Right?

10 It would be just non-
11 pharmacologically based therapy or something.

12 DR. MURPHY: I --

13 DR. BEEMAN: I don't know, I'm just
14 trying to get my head around it because I'm
15 guessing, at the end of the day, this is going
16 to be an easier sell for the VA if we say,
17 these are approved complimentary therapies.
18 They are in no way supposed to, you know, yes,
19 replace, thank you, I'm to think of a more
20 difficult word, but it's replace traditional
21 therapies, you know.

22 But, maybe it's that this

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1 complimentary therapy can help us mitigate the
2 amount of pharmacology that we're using and
3 all. Does that make sense?

4 DR. MURPHY: Yes, I'm with you. So,
5 the reason I thought the three questions were
6 important is that if you only at adjunct, we
7 may get criticized by some of the advocates for
8 transcranial magnetic stimulation and HBOT.

9 So, I think structuring it so that
10 you look at it as -- and, remember, the
11 recommendation from the PTSD guideline that was
12 an example, was, you know, those treatments
13 were not -- had insufficient evidence as a
14 primary therapy. That was their term for
15 monotherapy.

16 DR. JONAS: I think that's right.

17 I'd like to just have a language
18 issue that I think what you described like
19 around the pain assessment, that was very
20 helpful, okay, in terms of framing this.

21 So, something similar to that would
22 be good. That's evidence, that's what I call

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1 evidence informed approach as opposed to what
2 we heard earlier which is the evidence based
3 definition, so evidence informed. Okay?

4 And so, because they have said, even
5 -- we heard in the evidence based that there's
6 insufficient evidence, that's their language,
7 boom, end of story. Okay?

8 But, the recommendations for pain
9 were we recommend you consider these into the
10 guidelines. So, that's a little bit different,
11 that's evidence informed practice. And, that
12 may not go in your review process, but it
13 should go in the contextualization that the
14 Commission puts into this.

15 But, something that may affect your
16 workload here is that it would be great to know
17 the context around this, especially around
18 pain. What are the current effects sizes for
19 established, proven therapies for PTSD,
20 depression, et cetera, the drugs, the
21 psychotherapy?

22 What kind of effect size and

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1 evidence levels do previous reviews, not yours,
2 say you get in that? So that we at least have
3 the context in which we're looking at these
4 other therapies.

5 DR. MURPHY: So, full disclosure, I
6 was the physician facilitator for the
7 guidelines that we're talking about. So, I sat
8 through the entire process, you know, worked --
9 Erica's one of my clients. Dr. Rodgers and
10 Paula was the Chair of the PTSD Committee.

11 They went through, in detail, and
12 they used the same process for both the low
13 back pain guideline and the PTSD guideline.

14 The criteria for grading the
15 recommendations is exactly the same. And so,
16 the difference is based on the quality of the
17 evidence, not on the process.

18 CHAIR LEINENKUGEL: Thank you, Fran.
19 That's stage one of two stages that you have to
20 present today. So, if you don't mind, could
21 you move on to the recommended approaches and
22 considerations to satisfy the patient centered

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1 survey COVER requirement number one?

2 DR. MURPHY: So, while --

3 CHAIR LEINENKUGEL: Or duty to, I'm
4 sorry.

5 DR. MURPHY: While we're waiting for
6 the slides to come up, I'm going to take a
7 similar approach. I'm going to truncate this
8 discussion, but ask you for your advice and
9 decision on the key issue, which is what
10 options should we look at and how the survey
11 should be carried out?

12 So, if we could go to the first
13 slide?

14 Let me first show you what the
15 legislation says about the need to conduct a
16 patient centered survey, and that is their
17 term, patient survey within each VISN.

18 Now, you saw the map of the 18 VISNs
19 that exist across the country. So, we need to
20 collect information from each of those areas.

21 And, we need to collect very
22 specific information about the experience of

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1 Veterans with the Department of Veterans'
2 Affairs when seeking assistance for mental
3 health issues.

4 So, what is the experience of
5 Veterans?

6 Some of that, we can get from doing
7 data analysis. But, VA does a Veteran
8 satisfaction survey that's called the SHEP.
9 And, that is done so that you can get
10 information about patients who have received
11 mental health care in each VISN.

12 And, in some cases, if we collected
13 the information over a long enough period of
14 time, we may even be able to say something
15 about the experience of Veterans and their
16 satisfaction with that care at a medical center
17 level or a health care system level.

18 So, that's one option.

19 The other thing is, we heard
20 yesterday that the National Academy of Medicine
21 did look at experience of Veterans with -- who
22 screened positive for mental health conditions

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1 and they looked at both mental health, VA
2 mental health users and for the second
3 question, they also looked at the experience of
4 OIF/OEF Veterans who had not used VA mental
5 health care.

6 So, that helps us, and their focus
7 groups and qualitative site visit information
8 helps us with those, too, potentially.

9 There are also -- we're also asked
10 to look at the preference of Veterans regarding
11 available mental health treatments. And,
12 that's a little bit more difficult.

13 What do Veterans believe is -- are
14 most effective for them?

15 As well as, what do Veterans feel
16 with respect to complimentary and integrative
17 health therapies?

18 We've looked for existing surveys to
19 help us answer those two questions. And, have
20 not really found adequate data sources at this
21 point.

22 We believe that the prevalence

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1 question about what medication is prescribed to
2 Veterans in mental health is a question that is
3 best answered by querying the pharmacy benefits
4 management database and looking at the clinical
5 data warehouse so we can, with the help of the
6 Office of Mental Health and Suicide Prevention,
7 get access to that data and do that analysis
8 for you.

9 I don't think that that's a survey
10 question, but I'd be happy to discuss that.

11 The other issue is the outreach
12 efforts of the Secretary. Again, if I were
13 designing a study, I would want to collect that
14 information from the VA.

15 We might ask in a survey whether any
16 of the Veterans who are responding have
17 participated in an outreach effort.

18 But, I think we can get a good sense
19 of what VA does to outreach to Veterans with
20 mental health issues including things like
21 attending the transition assistance program,
22 discharge briefings, going to stand downs,

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1 participating in the PDHA and PDHRA activities
2 as people fill out screeners and get, you know,
3 as they redeploy from a combat theater.

4 So, there are a number of things
5 that we know that VA is doing. And, we collect
6 the information about what the outreach efforts
7 consist of.

8 Now, let me go on to the next slide.

9 So, we really have three options, at
10 a minimum. We can utilize exclusively existing
11 qualitative and quantitative data sources to
12 satisfy one or more of the Commission
13 requirements.

14 But, as I've told you, there will be
15 gaps if we do that.

16 We can design and conduct a patient
17 centered web based survey to gather that
18 information.

19 Or, we can use a combination of
20 both, you know, using the existing data sources
21 where they are available and then designing a
22 survey to fill the gaps that are not covered by

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1 the other information that we have.

2 We've talked a little bit about the
3 Paperwork Reduction Act. It is a law, VA must
4 comply. And, if we choose anything other than
5 option one, which is using the existing data
6 sources, we invoke this Act.

7 So, let me say a little bit about
8 that very quickly.

9 The Paperwork Reduction Act triggers
10 -- is triggered when VA wants to conduct any
11 information collection from ten or more members
12 of the public. The Veterans are the public,
13 they're not government employees.

14 So, when you want to obtain that
15 information, either by asking identical
16 questions or identical reporting, record
17 keeping and, if you want to write a report on
18 it, a publication, it triggers this Act, ten or
19 more, total for your entire activity.

20 Now, that process, after you've
21 developed your survey instrument, you submit it
22 to the Office of Management and Budget and they

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1 go through a complex approval process, often
2 coming back and asking a lot of questions and
3 asking you to change some parts of your
4 questionnaire.

5 And that can take six months to a
6 year. So, it really impacts the time line for
7 the Commission.

8 The good news is, that there is an
9 expedited review process. We will have to work
10 with OMB to see if they will let us use that.

11 If that's true, we could get
12 approval, once we have a questionnaire to put
13 before them, we could get concurrence from them
14 within 60 days potentially.

15 Now, I don't think we can say that
16 there will be public harm if they -- we go
17 through the normal clearance process or this is
18 an unanticipated event. But, maybe criteria
19 number three is.

20 Because we will not meet the
21 statutory deadline if we have to do this. So,
22 I'm going to leave that up to all of you.

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1 But, I think we -- what we need to
2 determine together is, which of these options
3 you want to invoke.

4 So, here's some potential
5 challenges. There are information gaps and so,
6 if you decide to use only existing data
7 sources, you will not get experience of
8 Veterans who use non-Department facilities and
9 providers. And, we won't get a good
10 information about the preferences of or
11 experience of Veterans with complimentary and
12 integrated health treatments.

13 If you pursue a new survey, then
14 we've got to deal with the expedited review
15 process or the routine review process.

16 So, the next step is to understand
17 the existing data sources, evaluate what gaps
18 there are, and I've given you my opinion about
19 what the biggest ones are and then, choose an
20 approach to meeting the requirements.

21 And, I'd like to stop there and
22 answer any questions.

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1 If you look at some of the appendix
2 slides, we go through, in detail, each of the
3 charges and tell you where we have found
4 information. And so, that's there for us to
5 look at in more detail at a later time, but I
6 don't want to hold up your lunch going through
7 that detail.

8 CHAIR LEINENKUGEL: Go ahead, Jack.

9 MR. ROSE: Mr. Chairman, just a
10 question on option one. What kind of
11 reliability are we going to get from that
12 option and what percentage of the Veterans will
13 be touched?

14 DR. MURPHY: So, each of the data
15 sources is different. We heard from the
16 National Academy of Medicine that they started
17 with a population of almost 9,000 Veterans
18 across the country covering every VISN. But,
19 it's only OIF/OEF/OND.

20 Now, they did say in their report
21 that there were some Veterans who were from
22 earlier eras that got included in their site

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1 visit reports, but we don't know how many.

2 The Veteran satisfaction survey, the
3 SHEP survey is very reliable. It's the same
4 type of survey that the private sector uses
5 with their HCAHPS survey. They are Veteran --
6 they are patient satisfaction surveys that CMS
7 requires. So, we'll have a comparison with
8 private sector.

9 And, that covers the entire nation
10 and all eras of Veterans that give you -- that
11 have accessed mental health care in VA.

12 So, I think that's a really valuable
13 source of information.

14 So, it depends on the population of
15 interest. Then we have other research studies
16 and I -- Paul Schnurr was instrumental in
17 collecting the surveys and questionnaires that
18 have been done by the National Center for PTSD.
19 So, those would be focused on PTSD.

20 So, we've got these niche issues,
21 some are small surveys, some are large and
22 broad. But, there isn't a single or a

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1 combination of these surveys that actually
2 helps us with each and every one of our
3 charges.

4 DR. MAGUEN: That's really helpful.

5 I have just a quick question that
6 may or may not be possible. But, the VSS
7 survey that's already happening, is it possible
8 to add questions to that? No? Okay, that was
9 one thought. That would have been lovely. So,
10 that would have been an easy way for us to --

11 DR. MURPHY: Well, I don't think so.
12 We can ask that --

13 CHAIR LEINENKUGEL: What is that
14 survey?

15 DR. MURPHY: -- specifically.

16 DR. MAGUEN: So, it's a survey
17 that's already being done by the VA and would
18 reach the people -- a lot of the people that we
19 want to reach and specifically, if we add some
20 CIH questions, that would, you know, prevent us
21 from having to go through the whole Paperwork
22 Act because it's already happening.

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1 DR. MURPHY: So, remember, that OMB
2 -- every time you add a question, they want to
3 re-review it. So, that triggers the Paperwork
4 Reduction Act also.

5 DR. MAGUEN: Oh, it does? Okay.

6 DR. MURPHY: Yes, unfortunately.

7 CHAIR LEINENKUGEL: We're going to -
8 - I'll give you my opinion on all of this.
9 We're going to battle OMB. Okay?

10 This is a very important Commission.
11 Everybody on The Hill realizes that, the
12 President realizes that, SVAC realizes that,
13 HVAC realizes that. Everybody in this room
14 came in as Commissioners realizes that.

15 One of the things that we want to do
16 is streamline and modernize this government.
17 And, if you're going to have hurdles and
18 barriers such as OMB saying that this is a very
19 important Commission, but we are going to delay
20 you for 18 months while you go through the
21 hurdles.

22 We need to stop that, or, at the

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1 very least, as a Commission, make a
2 recommendation that OMB, in this case, should,
3 at the minimum, expedite our requests. That's
4 first and foremost.

5 Secondly, is I think that this is
6 the right approach right here. Before we jump
7 that shark, take a deep breath this afternoon,
8 we'll make some assignments that Tom and I will
9 agree to and, seeing that you have the survey,
10 I will help out with that as well because I
11 have strong opinions on this, as I'm already
12 stating.

13 But, we need to understand what
14 those existing gaps are because we have a
15 charge, as easy as it was when they wrote the
16 bill to put that in, we know how difficult it's
17 going to be to obtain the necessary information
18 as requested.

19 Probably more so for those Veterans
20 that are outside the VA, without question.
21 Right?

22 So, that will be the biggest hurdle

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1 that we will discuss. Because, I and everyone
2 that has spoken as Commissioners, realize that
3 there's a gap that exists with connecting to
4 all Veterans, Right, and obtaining their
5 feedback on their health care and, certainly,
6 mental health care.

7 And, there's the large group of
8 Veterans that don't receive care.

9 I don't have a clue today how to
10 reach all of them, but we need to either source
11 that out. We have the capability and the
12 budget to do that, bring in experts and list
13 consultants to at least help us jump the shark.
14 Right?

15 So, I think that will be, use what
16 Fran is presenting here, let's understand the
17 existing gaps. Let's evaluate those gaps and
18 then choose an approach which may or may not
19 be up there right now. We may build our own
20 approach based on what I just said.

21 And, is it going to impact the
22 scope? No. Will it impact the time line?

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1 Possibly.

2 And, that would have to be one of
3 those immediate call outs which we are charged
4 with after our first 30 days after our first
5 meeting.

6 So, I just spoke to Sheila and said,
7 highlight this one because this is going to be
8 something that we're going to need leverage,
9 whether it's POTUS, SVAC, HVAC to circumvent
10 OMB restrictions.

11 DR. MURPHY: And, I would ask that
12 you maybe think about the survey in broad
13 terms. So, it doesn't have to be a, you know,
14 a web based survey. It could be that you want
15 to meet with groups of Veterans in focus groups
16 while you're out doing your site visits where
17 you might be able to recruit both VA users and
18 non-users.

19 So, it could be either at
20 qualitative face to face information gathering
21 or --

22 CHAIR LEINENKUGEL: Well, Fran, I'll

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1 interject and I'll tell you what we're missing.

2 First of all, we're missing the
3 VSOs, even though they represent 6 million
4 Veterans out of the 22, that's still a
5 significant group.

6 So, we need to activate this
7 afternoon how are we going to bring in the VSOs
8 in to become active partners for the survey?
9 First and foremost.

10 And, also, at some point, inclusion
11 into at least become public participants in the
12 open sessions. So, that's number one.

13 Number two is we always forget to
14 talk about state, county, local Veteran
15 services. We talked about it yesterday for the
16 Veterans Centers. There's a whole resource out
17 there as there is at the VA right now.

18 There are people within OPIA that
19 this is how they should be helping us as maybe
20 inclusion with the subcommittee or as
21 consultants, unpaid consultants because they're
22 already being paid.

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1 But, there's people out there that
2 know how to jump that shark, or at least will
3 have some ideas.

4 And, are we going to get to a 100
5 percent? No. Remember, we all said, I think
6 we agreed to the 80 percent principle or at
7 least I threw that out there, maybe you don't.

8 But, this is the meaty one I think
9 that is going to cause us issues. It's
10 fretting Fran and the SIGNA group because it is
11 a big, big thing that we need to at least
12 respond to within 30 days as a call out that
13 there could be some issues in us getting to a
14 good, what I call solid base sampling of the
15 two Veteran groups, the mental health group
16 within VA and those questions specifically that
17 we need to answer that were on the other pages.

18 And, the same with the other group
19 that are outside the VA, the much larger group.

20 So, I just throw that out there. I
21 think that once we get to this afternoon, and
22 once we start working on this before August

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1 meeting.

2 Another group or another person I
3 did not mention is Lynda Davis, the Veteran
4 Experience Officer at VA, a wonderful resource.
5 Fran knows her. She has Medallia that's up and
6 running now. And Medallia can ping that
7 Veteran once they are days visit at the VA --
8 VHA was completed. How was your care?

9 And, I don't know how specific it
10 is, but Lynda's coming in on August, so maybe
11 we ping her prior to this to get a little more
12 background while we're doing the further survey
13 work as a subgroup.

14 DR. BEEMAN: Jumping this shark is a
15 new one to me.

16 (LAUGHTER)

17 DR. BEEMAN: Skinning the cat is
18 something I'm used to, but jumping the shark
19 sounds a lot more dangerous.

20 (LAUGHTER)

21 DR. BEEMAN: I think --

22 (OFF MICROPHONE COMMENTS)

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1 DR. BEEMAN: I think we need to use
2 the existing data sources as much as possible
3 because there's an awful lot of data out there.
4 It just seems to make sense to me that we would
5 use it, to not ask the same question over
6 again.

7 Having -- and that does identify the
8 gaps.

9 And then, the question that I would
10 have is, I think qualitative sometimes is more
11 effective than quantitative. And, the question
12 might be is, in each VSO could you get nine
13 people and let them run it and basically say,
14 we need you as partners so you guys are going
15 to have to just -- could you identify nine
16 people and ask this question set.

17 But, in addition, ask any other
18 question that you want to find out. Because, I
19 actually this it's sometimes better to hear
20 from a small group of people that has a chance
21 to interact than it does for people on an --
22 answering on a computer, yes, yes, yes, yes.

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1 So, that might get us around the
2 paperwork thing because it would be within, you
3 know, it would be each VSO putting in for nine
4 people.

5 Just a thought.

6 CHAIR LEINENKUGEL: I like your
7 thinking because you own this one.

8 (LAUGHTER)

9 DR. MURPHY: So, we do patient focus
10 groups, as Eric said, with the clinical
11 practice guidelines. And, we went to OMB
12 saying, in general, we want to ask these --
13 this set of questions and then it's only
14 different, depending on what the underlying
15 condition is and they wouldn't give him
16 approval.

17 So, we're stuck doing patient focus
18 groups with nine Veterans for each guideline.

19 PARTICIPANT: We've got to jump that
20 shark now.

21 CHAIR LEINENKUGEL: Shark --

22 PARTICIPANT: It sounds like a whole

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1 shark.

2 (LAUGHTER)

3 MR. ROSE: Mr. Chairman, just on the
4 VSO and back, looking at Kenosha County, small.
5 Okay? Made the call yesterday, right now,
6 we've got 13,500.

7 I had requested how many of the
8 13,500 are getting VA care at this point? Now,
9 I don't know if that's how far you want to, you
10 know, drill down to this or if we already know
11 that answer at a state level. I ask the
12 question, do we know?

13 CHAIR LEINENKUGEL: Jack, what
14 exactly is your question? I mean, do we know
15 what? Do we know the amount of Veterans --

16 MR. ROSE: Yes.

17 CHAIR LEINENKUGEL: -- by county?

18 MR. ROSE: Yes.

19 CHAIR LEINENKUGEL: By -- it all
20 depends on the state from what I know. So, I'm
21 not part of the state, Tribal group of OPIA,
22 but their resources are as in depth as yours.

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1 They know exactly by most counties, and most
2 states --

3 MR. ROSE: Right.

4 CHAIR LEINENKUGEL: -- the
5 population of Veterans. But, it's all over the
6 board.

7 It could be off by 6,000 in Kenosha
8 County because 6,000 of them may have moved to
9 LA and Phoenix since the last time they took a
10 count.

11 And, it is a changing demographic.
12 Arizona's done the best work to date that I'm
13 aware of that has tracked down every Vet and is
14 now paying attention to transitioning Veterans
15 and where they're locating and going.

16 And also, following up with the type
17 of care or non-care that they're receiving.

18 So, I think Drew alluded to Arizona
19 yesterday being his home state with the suicide
20 prevention and what the Arizona coalition has
21 done and how they partnered with the state,
22 with the counties and with the various tribes,

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1 and they've got a dozen tribes out there. And
2 they're very proactive.

3 But, again, it took nine years for
4 them to get there.

5 I would say from what you and I and
6 Jamil know with the State of Wisconsin, the
7 county VSOs and the county executive directors
8 do a fairly good job. But, I'll bet you that
9 their data and their numbers are not up to
10 date, would be my guess.

11 DR. JONAS: I'd just like to support
12 your thought about focus groups. I mean,
13 experience and preference are qualitative
14 issues. Okay?

15 So, they may lend themselves more to
16 qualitative research methods and there are
17 valid ways of doing qualitative research to get
18 to saturation where you've got 80 percent or
19 more of what the issues are.

20 And, in sometimes, collected even
21 better than having a checklist on a survey.

22 CHAIR LEINENKUGEL: A couple of

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1 things I'm just thinking real quick here with
2 working the solution which Commissioners always
3 do and you're trying to get to an answer right
4 away.

5 So, again, let me throw out a couple
6 of other things.

7 This is going to be the challenging
8 one, but I like the direction that Tom stated
9 with qualitative. I like the focus group
10 because I know these can be done because
11 they're being done on an ongoing basis.

12 And, American Legion has the
13 capability to do them quite well.

14 I'm not sure, but I think DVA does,
15 DAV as well.

16 So, I mean, those groups probably
17 can help us out in the next 30 days.

18 And, making a decision based on
19 Fran's next step, maybe that becomes the new
20 approach that we use.

21 And, again, I think we would have to
22 send back and SVAC and HVAC because this law,

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1 it was written by the people on The Hill. I
2 think there was 36 folks that signed on to
3 care.

4 And, we would have to back and
5 actually either make a clarify point saying,
6 this is the reality. And, I don't know what
7 reality is at this, except that there's some
8 barriers. That I do know.

9 The other thing is there it might be
10 cost to get to those other 9 million Veterans
11 not using VA or 14 million Veterans not using
12 VA health care.

13 So, are there other means and
14 methods to do this? The answer is yes, there
15 are.

16 So, I think this will be a very
17 interesting exercise, probably not just for a
18 subgroup but for all of us to collectively
19 think about and then come back by August so
20 this may very well be our first opportunity for
21 a teleconference call prior to the August
22 meeting. So, I'll throw that to Sheila and the

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1 work group as well.

2 Where, by the time we leave this
3 afternoon, we may have three items that we're
4 going to talk about on the teleconference call.
5 So, I'm sort of jumping ahead here.

6 Working this afternoon's project
7 based off of this. But, it's perfect timing, I
8 think, because we do need to leave here going
9 with not only how are we going to work, but
10 what are we going to work on? Then, who's going
11 to be accountable and responsible for the
12 outcomes back to the rest of the Commission? I
13 think that's a fair statement, would all the
14 Commissioners agree?

15 (NO AUDIBLE RESPONSE)

16 CHAIR LEINENKUGEL: That said, thank
17 you very much, Fran, because we could debate
18 with you all day long but we're going to break
19 for lunch and we'll think of more things by the
20 end of this session.

21 So, let me say this has been great.
22 It's been a great day and a half, again, my

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1 perspective.

2 We're going to go into the final
3 phase of our first meeting which will be a
4 closed session. But, I want to make sure we
5 have enough time for everybody to make personal
6 calls, do things and we sort of truncated that
7 yesterday.

8 So, let's give ourselves until 1:30,
9 that's an hour and ten minutes and I'm going to
10 give that because I would like us to work
11 diligently from 1:30 until 4:00.

12 And then, try to conclude everything
13 by 4:00 on how we're going to work. And, then,
14 to see if there's any summation items or any
15 points of contention that need to be raised
16 from a 4:00 until 4:30 time frame.

17 And, it'll give Sheila, as the DFO,
18 time with her group to start to process things
19 of do outs of what we're going to need to do in
20 the next 30 days prior to our August meeting.

21 Then, we'll talk about the August
22 meeting and then, hopefully, we'll all depart

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Thomas "Jake" Leinenkugel

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1 here with smiles on our faces at 4:30 this
2 afternoon.

3 Good plan? Let's see if we can
4 execute it.

5 Thanks.

6 (Whereupon, the above-entitled
7 matter went off the record at 12:22 p.m.)
8
9

X *Jake Leinenkugel*

Thomas (Jake) Leinenkugel
Chairman, COVER Commission

