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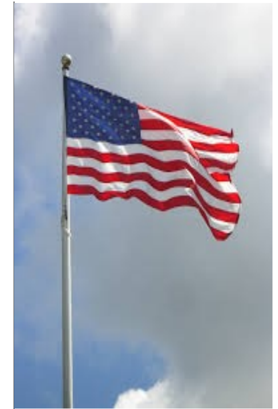


Overview of Summit

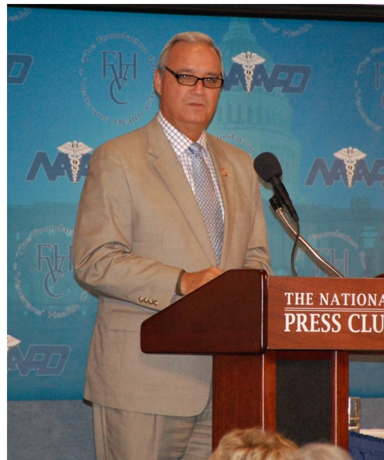
On June 11 **NAVAPD** and the Foundation for Veterans Healthcare hosted the Summit, "Coming Together: The Future of Veterans Health Care" at the National Press Club in Washington, DC. Almost 200 VA clinicians, representatives from the VSOs, Congressional staff and other VA stakeholders came together to discuss healthcare issues facing Veterans.

While the current VA crisis was a hot topic at the Summit, much time was spent discussing clinical topics. Four expert panels discussed:

- PTSD/TBI—How VA Care Must Adapt for the Long Term;
- Continuity of Care: Transitioning from DOD to VA;
- Incidentalomas: A Blessing or a Curse? Including the value, costs and ethics of treating these; and
- VHA's Role in the 21st Century featuring Congressional and other experts.

Detailed summaries of the panels' presentations are included elsewhere in this newsletter.

While planning began in February for the Summit the event grew in significance because of the crisis unfolding at the Veterans Administration. **NAVAPD** reached out to both sides of the political aisle for speakers to address Summit attendees. **NAVAPD** was pleased that Rep. Jeff Miller, Chairman of the House Veterans Affairs Committee and Rep Dan Benishek, MD, Chairman of the House VA Subcommittee on Health agreed to speak at the Summit. Congressman Benishek was our kick-off speaker and Congressman Miller delivered the keynote address at lunch.



Rep. Jeff Miller

Chair, House VA Committee

Rep. Dan Benishek, MD

Chair, Health Sub Committee

Both Congressmen spoke about the issues of delayed care for Veterans, efforts to find those responsible and hold them accountable, and to identify and correct problems within the VA. They also thanked the attendees for the excellent care they provide Veterans despite the issues that have come to light. The House Veterans Affairs Committee has held multiple hearings on the crisis at VA from whistleblower protection (or lack thereof) to coordination between VHA and VA benefits as well as passing legislation on expanding the GI BILL and giving the Secretary authority to fire employees responsible for veterans deaths.

Following their remarks, the Congressmen took questions from attendees. They heard firsthand details of the problems being endured by the clinicians and learned it was a retaliatory culture that prevails throughout VA – not just isolated cases. The topic of protecting physicians against retaliation for raising problems to the leadership was raised by many of the participants. Physicians shared examples of retaliation, operational requirements that keep physicians too busy with clerical work and EHR requirements to properly treat their patients.

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Samuel V. Spagnolo, MD

The President's Corner

Since **NAVAPD** was founded, we've wanted decision makers in Congress and every presidential administration to focus on key issues that would improve veterans' health care. In the past two months, we've had more attention to our issues than perhaps in the entire history of the VA. The initial whistle-blowing in Phoenix and similar catastrophic failings in other centers revealed to America the widespread problems we've long known would come to a head, despite our best efforts to push for change. High-level resignations and personnel changes will likely not make a difference and reform will be slow, if effective at all. That's why it's more important than ever for us to come together as a unified voice and advocate for what VA physicians and dentists need to do their jobs and do them well.

Here in Washington, your **NAVAPD** leadership has been making strong inroads in meetings at VA Central Office and with House Veterans Affairs' Committee leadership, but we need you to add your voice -- and your specific experiences -- to the discussion.

In early June, more than 100 VA physicians and others who work in the veterans' health care arena came together at a Summit in Washington, D.C., hosted by **NAVAPD** and the Foundation for Veterans Health Care. Together, we talked about PTSD and TBI and the long-term needs of our veterans. We talked about the hidden costs of diagnosis and, more specifically, overdiagnosis. We learned about the challenges and missteps that happen when a soldier transitions from Department of Defense health care into the VA system. And, we talked about the future of the Veterans Health Administration, and what the administration and Congress must do -- and not do -- to allow our veterans to receive the health care they deserve. It was an educational give and take with dynamic speakers and panelists and audience members, and everyone walked away feeling less alone and more determined than ever to work on reform together.

Two congressional leaders spoke at the Summit: Congressman Jeff Miller (R-FL), Chairman of the House Committee on Veterans' Affairs; and Congressman Dan Benishek, M.D. (R-MI), Member of the U.S. House Committee on Veterans' Affairs and Chairman of the House Subcommittee on Health (and former VA physician). They offered protection to those who need to expose wrongdoing in their VAMCs. They shared their frustrations with the system, and their desire to do what is right and what is best. They know the system is flawed, and they know there are limitations on what they can do as a legislative body. But, they didn't just speak *to* us, they spoke *with* us, and that is a positive step in the right direction.

The day after the Summit meeting, about 50 VA physicians went to Capitol Hill to attend House and Senate Veterans Affairs briefings taking place that day. It was important to have **NAVAPD** members and colleagues present in the room to see how laws are made, and how Congress does its job. We hope to be able to provide more opportunities like this in the future.

At the Summit, and in the days preceding, I was interviewed by *The Washington Post, The New York Times, Reuters, CNS News,* and others, and we have links to those news stories on our website. Please check out our website -- www.navapd.org -- for more information, and encourage your colleagues to join **NAVAPD**. We need all our voices to be heard.

NAVAPD President Dr. Spagnolo opens the NAVAPD Summit in Washington, DC

It's been a remarkably busy time but all of us at **NAVAPD** hope that as the dust now settles, we can press the administration and Congress for real change, meaningful reform, and a veterans' health care system that works for patients and doctors alike. That means less bureaucracy and paperwork, physician representation in VA Central Office, physician input at all levels on budget and system review, and a strong unified voice on behalf of the thousands of VA physicians and dentists across the country.

That's where **NAVAPD** comes in, and where we hope you can help. Encourage your colleagues to join us in this effort. I thank you, our colleagues thank you, and -- most importantly -- our patients, America's veterans and their families, thank you. ❖

Summary of Panel on PTSD & TBI

Dr. Rubin, Dr. Raskind, Dr. Vogt, Dr. Vasterling, and Dr. Ibson

PTSD and TBI: How VA Care Must Adapt for the Long Term

Panelists and topics were:

- Robert T. Rubin, MD, PhD, VA Greater Los Angeles Healthcare System:
Introduction and DSM-5 Definitions

- Murray Raskind, MD, VISN 20 MIRECC & VA Puget Sound Healthcare System:
Evidence-Based Therapies for PTSD

- Dawne Vogt, PhD, National Center for PTSD, VA Boston Healthcare System:
PTSD in Women: Critical Issues

- Jennifer Vasterling, PhD, Psychology Service and National Center for PTSD, VA Boston Healthcare System:
The Interface Between PTSD and TBI

- Ralph Ibson, JD, Wounded Warrior Project, Washington, DC:
PTSD & TBI: An Advocate's Perspective

Dr. Rubin, panel moderator, introduced the other panelists and indicated that the topics to be discussed represent important aspects of PTSD that have received insufficient attention to date. As background, he showed the DSM-5 criteria for PTSD and noted that the main symptom criteria are subjective; they rely on the statements of the patient as to their presence. There are no objective measures for confirming intrusive symptoms (e.g., memories, dreams, flashbacks), avoidance of stimulus triggers, negative cognitions, or alterations in arousal and reactivity following a traumatic event. This can lead to both minimization of symptoms; e.g., in active duty service personnel who fear the stigma of having psychological issues, and exaggeration of symptoms; e.g., in veterans seeking monetary compensation for PTSD. Dr. Rubin then showed the DSM-5 criteria for TBI, indicating that there are objective criteria for the diagnosis, including demonstration of some degree of cognitive disorder, neuropsychiatric signs of traumatic brain injury, and an immediate temporal relationship between the traumatic injury and neurocognitive impairment.

Next, Dr. Raskind discussed challenges in using evidence-based therapies for combat PTSD in veterans. He reinforced that, as in the treatment of almost all behavioral disorders, individually tailored combinations of pharmacotherapy and psychotherapy produce the best results. Combat PTSD differs from civilian PTSD in that it often follows multiple traumas in an "up tempo" war zone, and hyperarousal symptoms predominate, often with sleep disruption and nightmares. Regarding evidence-based psychotherapies, prolonged exposure has produced a 35% reduction of PTSD symptoms in selected veterans, but there has been a high dropout rate. Therapy aimed at education, problem solving, and developing supportive relationships, however, has been as effective as the more structured prolonged exposure and cognitive behavioral therapies. Regarding evidence-based pharmacotherapies, serotonin-uptake inhibiting antidepressants have been modestly effective for irritability, loss of interest, and comorbid depression, but not for sleep disruption. For sleep disruption and nightmares, prazosin, an alpha-1 adrenoreceptor antagonist that crosses the blood-brain barrier, has been particularly useful, because it reduces excess CNS adrenergic activity, allowing normal sleep and dreaming to resume. It also may be useful to reduce daytime hyperarousal and hypervigilance.

Dr. Vogt highlighted special aspects of PTSD in women veterans. Women are increasing in number and percentage of active duty personnel, are enduring multiple deployments, and more are moving into front-line combat positions. PTSD is the "signature" mental health condition in both female and male service members, but women have different comorbidities: More women than men have cormorbid PTSD and depression, whereas more men than women have comorbid PTSD and alcohol use disorder. Risk factors for PTSD in both female and male active duty personnel include exposure to combat, exposure to other interpersonal traumas (e.g., wounded, dying, and dead comrades), and military sexual trauma. However, reported rates of military sexual trauma are orders of magnitude higher in women than in men (any sexual harassment: 51% vs. 11%; severe sexual harassment: 9.5% vs 0.1%). Additional risk factors for PTSD in military women include a high rate of pre-military physical or sexual abuse (>50% of female veterans), including in childhood (>33% of female veterans), and a high rate of intimate partner violence (about 30% of female veterans). Treatment of PTSD in female veterans is similar to that for

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Summary of PTSD & TBI Panel (continued)

(Continued from page 3)
male veterans, with approximately equal efficacy. The importance of screening for PTSD in female active duty personnel and veterans, offering prompt and effective treatments, and, importantly, eliminating risk factors in the military environment can thus not be overemphasized.

Next, Dr. Vasterling discussed how traumatic brain injury (TBI) and PTSD each may complicate recovery of the other. Military-related mild TBI increased approximately 500% between 2000 and 2011 and declined only about 15% from the 2011 high to 2013. Blast injuries had been the most common source of military TBI over the last several years, but as fewer service members have been exposed to combat conditions more recently, other injuries have surfaced; e.g., motor vehicle and training accidents. In combat, the circumstances leading to blast injury often are psychologically traumatic, putting the service member at risk for both PTSD and TBI. Studies in civilians indicate that mild TBI increases the rate of PTSD about two-fold, and the presence of PTSD symptoms delays recovery from mild TBI, resulting in prolonged post-concussive syndrome. Clinical care is enhanced through the aforementioned evidence-based therapies for PTSD and by psychoeducation for TBI as early as possible following the injury. Cognitive deficits associated with each condition can be addressed through cognitive rehabilitation.

Finally, Mr. Ibson offered an advocate's perspective on the mental-health needs of a generation of warfighters and their too-frequent experience of encountering an understaffed VA health care system. Despite the dedication of VA clinicians and recent improvements in VA mental-health care, the wounded veterans of Iraq and Afghanistan too often describe a VA mental-health system that does not feel patient-centered. The recent, explosive developments arising from the Phoenix VAMC patient-scheduling scandal may have further undermined the trust many members of Congress had in VA administrators. With the likelihood of Congress soon enacting legislation that would strip senior VA administrators of Civil Service protections, Mr. Ibson foresaw the potential for physicians' voices to grow in influence at VA medical facilities—a positive development for veterans' health care. ❖

Summary of Summit Panel on Transition from DoD to VA

Dr. Berger, Col. (Ret.) McLendon, Dr. Cohoon, and Ms. Ilem

Moderator: Tom Berger, Ph.D., Executive Director, Veterans Health Council, Vietnam Veterans of America;

- Barbara Cohoon, Ph.D., MSN, RN, Director, Regional Clinical Services, Southwest Region, United Healthcare;

- Joy Ilem, Deputy National Legislative Director, Disabled American Veterans;

- COL (Ret.) Michael McLendon, former Deputy Assistant Secretary for Policy, Department of Veterans Affairs.

The panel discussed issues that make transition from active military to VA difficult. Many of these have been identified since at least 2003:

- Multiple, duplicative, non-coordinated systems by different branches of the military.
- No alignment of case managers from DoD to VA.
- "Stove-pipe" organizational thinking.
- Lack of easy navigation guidance for the transition.
- Lack of inclusion of the family in the transition planning
- Confusing rules about what benefits are available for the Vet and family based upon discharge type.
- Concern that information revealed in therapy will get back to the DoD and negatively impact Reserve careers.

The GAO has reported that the DoD and VA both recognize the need to reduce barriers to a smooth transition. Both have been unsuccessful in accomplishing this. There was a DoD-VA Transition Working Group to address these and additional issues, but it met infrequently - no significant results were achieved.

There appears to be a lack of Accountability-Responsibility-Authority (ARA) to make the changes needed to remove the barriers. One suggestion is a designated position within the VA that is granted the ARA to find the solutions and assure implementation. ❖

Overview of Summit (continued)

(Continued from page 1)

Summit attendees clearly were heard, because Representatives Miller and Benishek mentioned their participation in the **NAVAPD Summit** and recounted comments made by our participants at the June 12 Congressional Hearing '"Bureaucratic Barriers to Veterans Care" which was attended by nearly 50 attendees from the **Summit.** For many of the attendees it was their first opportunity to see Congress in action.

Clearly much of what was heard at our Summit resonated as Chairman Miller developed some of his questions for then Acting Under Secretary Jesse during the hearing. Input from **NAVAPD** was also mentioned by Congressman Benishek during Dr. Jesse's testimony.

In addition to attending the hearing, **June 12 was NAVAPD Hill Day** and a contingent of **Summit** attendees traveled to Capitol Hill to receive briefings from House and Senate Veterans Affairs Committees' key staffers. The Senate passed the Veterans bill authored by Senators Sanders and McCain on June 11 and the staff provided the participants with details of the legislation.

Comments from those who attended this **Summit** have been extremely positive. Especially positive appeared to be the opportunity to speak directly with Congressmen and congressional staff, and to observe how the hearings on the VA are conducted. Attendees appreciated that Congress clearly is not attacking the care providers at the VA, but rather the lack of effective leadership, administrative barriers and bureaucratic layering. Attendees also expressed their gratitude and support for NAVAPD being their voice in Washington.

The goals of the **Summit** were met and communication with the HIll and VA leadership will continue. Video footage from the Summit will be available soon on the **NAVAPD** website, www.navapd.org. ❖

NAVAPD's Mission and Principles

Mission

NAVAPD is dedicated to the principle that this Nation's Veterans, as a result of their service to our country's Armed Forces, have earned an entitlement to quality health care to meet their needs as they become sick or injured. The Department of Veterans Affairs ("VA") is that agency of government obligated to honor the Nation's contract with its deserved Veterans.

NAVAPD has as its highest priority the preservation and strengthening of the VA Health Care system, so that it stands ever ready to give Veterans quality medical care equal to or better than that which can be obtained elsewhere in our society.

Just as VA doctors care for those who have served, they also stand ready to treat the military and civilian casualties of future conflicts and non-military disasters.

VA Health Care facilities are a principal element in our national security and in our national defense, representing as they do a vast resource to back up the limited capabilities of our military hospitals.

Guiding Principles

NAVAPD shall function as the official professional organization of the VA physicians and dentists at all levels in the VA Health Care system, from the local health care facilities through VISNs to the national level.

NAVAPD shall cooperate to the maximum extent possible with official representatives of the VA, to the end that the best possible health care is provided to Veteran beneficiaries.

NAVAPD shall endeavor to ensure that qualified physicians and dentists are recruited into the VA Health Care system and retained therein.

NAVAPD shall support VA physician research, participate in activities of professional organizations, continuing medical education and participation in equal partnership affiliation with medical schools.

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US House VA Committee Hearing: Bureaucratic Barriers to Care

On June 12, the US House of Representatives Committee on Veterans Affairs held a hearing on "An Examination of Bureaucratic Barriers to Care for Veterans." This hearing had two panels of witnesses.

The first panel included Tim S. McClain, President, Humana Government Business; Dan Collard, COO, The Studer Group; and Betsy McCaughery, advocate and Chair of the Committee to Reduce Infection Deaths.

The witnesses discussed many aspects of current VA operations and procedures. They noted inconsistencies throughout the VA, and how this degree of variability allows inconsistent and unpredictable results. Witnesses McClain and Collard focused on the VA's use of procedural metrics rather than well-defined outcomes metrics, indicating that outcome focused metrics are the more effective approach. Misalignment of incentives was also addressed. Dr. McCaughery expressed her view that VA employee unions are a major part of the problem, that the barriers they present actually protect bad employees and suppress the desire to correct problem personnel.

The second portion of the Hearing, with Dr. Jesse as the sole witness, was tough. This segment can be viewed online at www.ustream.tv/recorded/48697702.

The focus of many questions was lack of accountability of VA leadership, lack of urgency over the current crisis, apparently inaccurate data being provided by the VA, and the perception that the VA was trying to prevent employees from talking to Congress; Dr. Jesse was reminded that such action would be criminal.

Dr. Jesse appeared to have few answers; those he provided seemed not to satisfy most of the Committee. He frequently had to state that he did not know how a statement was released, who approved emails, where wildly incorrect data came from, and what consequences there will be for anyone who knowingly misled Congress or himself. He had no clear answers on correcting past misdeeds or errors other than to apologize and to state, "We will fix it." He appeared to welcome external assistance in resolving the many issues.

This hearing was an emotional insight to the political process and how the VA "functions" at its highest levels. Attending the Hearing was considered a highlight of the Summit. ❖

Summary of Summit Panel on the Role of the VA in the Future

Hon. Cliff Stearns, Ms. Hill, Dr. Martin, Mr. Weidman, Ms. Dolan, Mr. Bowman

The Panel consisted of:
- The Honorable Cliff Stearns, Moderator.
- Christine Hill, Staff Director, House Subcommittee on Veterans Health.
- Dr. James Martin, VA Physician and member of AFGE's National VA Council.
- Rick Weidman, Executive Director for Policy and Government Affairs, of Vietnam Veterans of America.
- Nancy Dolan, Minority Staff Director for House Veterans Affairs Committee.
- Thomas Bowman, Senior Policy Advisor to Senator Richard Burr, Ranking Member of the Senate Veterans Affairs Committee.

The panel was asked to discuss the Role of the VA in the 21st Century and began with a discussion of whether there really is a need for more physicians and dentists at the VA. The consensus was that there likely is a need for additional clinical staff at some, if not all, VA facilities.
However, it was made clear that there is a concurrent problem that is as big as staffing: inefficient and ineffective use of resources. Physicians and dentists are diverted from patient care to carry out clerical and other duties that would be better reassigned to non-physicians. Unfortunately, some facilities are designed in ways that make efficient operations impossible.

The VA has largely been unengaged in efforts to fix these problems of efficiency. Appeals by various groups including NAVAPD have not been fruitful. Concern was expressed that while we look for efficiency we need to ensure that the quality of visits is preserved.

The discussion quickly moved from a discussion of plans for the future to numerous questions or issues voiced by members of the audience to the panel. It was clearly agreed that hiring of new personnel takes far too long and the process needs to be revised and streamlined.

Some issues that will need to be resolved for the VA to fulfill its mission in the 21st Century include:
- How to affectively attract new physicians to the VA; the Veterans Service

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Role of the VA in the Future (continued)

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Organizations have encouraged the VA to recruit physicians at their points of discharge from the military.

- How does the VA eliminate personnel who do not perform adequately?
- How do we make performance pay work as it was intended to aid retention?
- How do we shift clerical duties from physicians to free their time for patient care?
- How do we determine why good physicians are leaving the VA?
- How do we get the VA to understand that their current approach to care is not properly incentivizing personal?

The discussion raised many questions and was an excellent start to an important and necessary dialogue. ❖

Summary of the Summit Panel on Incidentalomas

Dr. Sirovich, Dr. Wruble, Dr. Berlin, and Dr. Michael

The June 11, 2014 NAVAPD Summit in Washington D.C. included an engaging exploration by a panel of physicians on the subject of "Incidentalomas" - the name given primarily to radiological findings of possible tumors and the like that occur incidentally when a medical exam is being conducted for an unrelated purpose. Due to the increasing utilization and capability of advanced imaging equipment, the volume of such findings has increased dramatically, and this fact has created very substantial cost, ethical and relational issues for health professionals -- so serious that the matter was the subject of a December 2013 Presidential Commission report.

The panel's mission was to articulate the scope, gravity and clinical impact of the problem of incidentalomas, and to explore whether the VA, given its unique position and patient population, can and should attempt to advance the guidance regarding incidentalomas. Specifically, can the VA create a consistency of approach and provide more particularized guidelines for use by treating physicians? If so, who should undertake this effort and what can be instituted in the interim to minimize both uncertainty and disparate reporting and management?

The panel included:

- Dr. Brenda Sirovich, M.D., M.S., Associate Professor, The Dartmouth Institute for Health Policy & Clinical Practice, Geisel School of Medicine/VA Medical Center, White River Junction, VT, whose interests include the downstream consequences of diagnostic testing.
- Dr.Nelson L. Michael, M.D., Ph.D., Colonel, US Army Medical Corps; Director, U.S. Military HIV Research Program, Walter Reed Army Institute of Research, and member of the Presidential Commission which issued the report "Incidentalomas: Anticipate and Communicate," in December 2013.
- Dr. Leonard Berlin, M.D., F.A.C.R., Professor of Radiology at Rush University Medical Center and University of Illinois, past chairman of the Ethics Committee of the American College of Radiology and the Professionalism Committee of the Radiological Society of North America, a well-known diagnostic radiologist with broad administrative and policy experience, and the author of incisive presentations on incidental findings.
- Jill Wruble, D.O., moderator, a diagnostic radiologist and former Army physician, serving at the VA Medical Center, West Haven, CT; and an active member of the faculties of both Yale and UCONN medical schools as a clinical assistant professor, who has developed a large body of work on, and lectures on, the subject of incidentalomas, and who serves as member of the NAVAPD Board of Directors.

The panel highlighted key clinical and medical-legal challenges for radiologists and clinicians. Dr. Bill Thornwarth, President of the American College of Radiology (ACR) and his legal counsel, Mr. Tom Hoffman made last minute flight changes to attend this session. The ACR sets the standards for radiologic care in the U.S. In follow-up comments, Dr. Thornwarth complimented the presentation and described ACR's efforts in this area. He expressed interest in the ACR working with the VA. This would include a trial of ACR guidelines to assist clinicians in ordering most appropriate studies, and also working with the VA to refine treatment management guidelines. ❖

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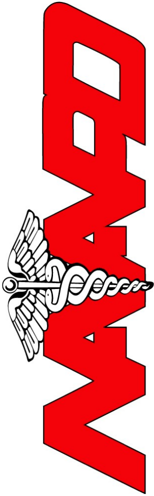

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