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NAVAPD

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NEWS

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Honoring All Veterans On Veterans Day

November 11

NAVAPD Hosts Capitol Hill Meeting on Hepatitis C

Samuel V. Spagnolo, M.D.

Rep Ralph Abraham, M.D.

Rep Dan Benishek, M.D.

The Foundation for Veterans' Health Care (FVHC) and National Association of Veterans Administration Physicians & Dentists (NAVAPD) hosted an educational briefing for Members of Congress and their staff on Thursday, September 17 to discuss the impact viral hepatitis and related diseases are having on America's veterans. Dr. Samuel V. Spagnolo, President, FVHC and NAVAPD, opened the briefing by introducing Rep. Ralph Abraham (R-LA), a family physician and Chairman of the House Veterans Affairs Subcommittee on Disability Assistance and Memorial Affairs. Dr. Abraham said he has treated a lot of Hepatitis C patients and recognizes the need to treat them early so they do not develop additional diseases. He thanked VA doctors for their hard work and dedication.

Dr. Spagnolo introduced an Infectious Disease specialist familiar with VA's efforts to treat Hepatitis patients with new drugs. He said VA clinicians know how to treat this disease and thanked the pharmaceutical industry for their hard work in developing a cure that is safer, has cut the viral hepatitis death rate in half and reduced Hepatitis C deaths, specifically, by two-thirds. The specialist also noted that stronger treatments and cures have also saved back-end costs in terms of transplants, liver disease costs, and cirrhosis treatments because they are able to treat Hepatitis before other co-morbidities take effect.

He said that VA needs to do a better job in screening and testing. He believes that within the system, 140,000 identified as treatment candidates and another 40,000 who have not yet been tested also likely carry hepatitis.

Another challenge the VA faces in terms of testing and treating veterans for viral hepatitis is that it is difficult to ensure patients show up for appointments. Veterans are afraid to get tested because they believe a diagnosis is a death sentence. And, many veterans don't have fixed addresses or up-to-date contact information, so it's a challenge to encourage them to be tested or begin treatment.

Rep. Dan Benishek (R-MI) a surgeon formerly with VA and Chairman of the HVAC Health Sub-committee joined the briefing and thanked Veterans Administration physicians for their work in this arena. In his remarks, he shared that he has taken care of hepatitis patients and knows how important recent treatments and cures are for the veterans community. He promised to make sure drugs are available and will continue to support VA physicians. ¤

Inside this issue:

The President's Corner

Samuel V. Spagnolo, MD

The *New England Journal of Medicine* called for a total culture and operational overhaul in the VA health care system in a piece published on September 30. Stemming from the *Veterans Access, Choice, and Accountability Act of 2014* which required a comprehensive, independent assessment of 12 areas of VHA care delivery and management, the panel of independent, blue-ribbon experts made a series of operational recommendations for both the near and long term. They include: more exam rooms to increase physician productivity, increased staff-to-patient ratios, elimination of administrative silos, and greater authority granted to service chiefs for overall management of resources.

The panel also heavily criticized the way VHA goes about handling construction planning and costs, recommending that they cease viewing each issue as an isolated problem to be remediated and, instead, adopt a broader systems-wide approach to solving challenges. More important than the operational recommendations is addressing the root causes for previous reforms from 137 (!) earlier studies not being implemented. The panel called for "strategic vision and dynamic decision making argues for a new VHA governance board that is representative, expert, empowered, and relatively insulated from direct political interactions." We couldn't agree more. We don't need more task forces, more studies, or more bureaucracy. We need to be empowered to improve quality, patient experience, personnel hiring and management, and cost-effectiveness for the work we do.

The panel also observed — which many of us have known for decades — that "the VHA is experiencing a crisis in leadership because of an organizational environment that's perceived as disempowering, frustrating, and occasionally toxic." They also noted that there is a medical staffing crisis looming, as two-thirds of network directors, nurse executives, and chiefs of staff are eligible for retirement, as are nearly half of medical center directors.

What's their solution? They believe we need immediate changes in practice that will result in VHA leadership fostering a ubiquitous patient-centric culture that encourages sharing best practices, encourages and values feedback, and sparks innovation. They also call out the 160% growth in VA Central Office staff as a huge hindrance to progress. The panel's report calls for "a shift in VHA focus from central bureaucracy to supporting clinicians in the field and clearly articulating what decision authority resides at each level of the organization."

Last, the panel supports what we all know is and has been an issue — technology infrastructure for patient care management and other administrative tasks like billing, hiring, data aggregation, and supply chain. Are any of these findings shocking to NAVAPD members? No. Not at all. Have we been asking for these reforms for years, along with our VSO colleagues? Yes. Do we think this study will actually be the catalyst for changes to really take place? It's unclear. With the 2016 elections looming on the horizon, and a few leadership changes pending in Congress before the end of this year, it's yet again another uncertain time for us in terms of making serious and much-needed reforms.

Here in Washington, NAVAPD will continue to advocate for physicians and dentists. We will continue to push for reform in VA Central Office. We will continue to work with Members of Congress to ensure your voices are heard on important reforms. And, most importantly, we will continue to focus on what's at the core of our mission — ensuring safe, reliable, dependable health care for our nation's veterans. ¤

Independent Report Confirms NAVAPD Reports—What Now?

Since the patient scheduling scandal at the Phoenix VA Medical Center erupted in 2014, bringing the issues within the VHA into laser-focus, NAVAPD has been working with Congress to find ways to improve the VHA operations. In fact, NAVAPD had been working with the VA and Congress well before that seminal event. We revealed problems and offered solutions, but those were ignored.

Now, a Congressionally mandated sweeping independent review of the Department of Veterans Affairs healthcare system made public Friday has revealed and confirmed the issues NAVAPD has been describing for years. Will Congress and the VA act this time?

The report shows the multibillion-dollar agency has significant flaws, including a bloated bureaucracy, problems with leadership and a potentially unsustainable capital budget. More than a dozen assessments—from analysts including Mitre Corp., Rand Corp. and McKinsey & Co.— show that the Veterans Health Administration, the health-care arm of the department known as VHA, is still plagued by long-standing issues, including unsustainable costs in the future and a system that veterans find tough to navigate.

The assessments, weighing in at more than 4,000 pages total, were mandated by the Veterans Access, Choice and Accountability Act, commonly known as the Veterans Choice Act, a more than $16 billion emergency funding measure passed last summer in the wake of a systemwide scandal at the VA that led to the resignation of a number of top officials, including then-Secretary Eric Shinseki. They appear to restate, more thoroughly, many issues that have been previously identified. The assessments will be used by the Commission on Care, also mandated by the act, which is tasked with presenting the VA and

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Independent Report Confirms NAVAPD Reports (continued)

(Continued from page 2)
Congress a comprehensive reform plan in early 2016.

"The report bears out collectively what I have seen individually, what I have seen in my role as chairman over the past nine months," said Sen. Johnny Isakson (R., Ga.), chairman of the Senate Committee on Veterans' Affairs. "There is a huge focus on some glaring deficiencies that need to be addressed."

Mr. Isakson said the VA suffers especially from a system saddled with a number of different departments that can't effectively talk with each other, as well as a number of vacancies in leadership positions that need to be filled, though he said the department has been working to correct a number of issues.

"VA is undergoing a radical transformation," the department said in response to the findings, pointing out a number of efforts to address problems highlighted in the assessments. "VA will work with Congress, veterans service organizations, veterans, and other stakeholders on the recommendations outlined in the Independent Assessment Final Report. VA will especially work closely with Congress on those final report recommendations that specify specific congressional action needed to implement."

The assessments found VA care outperformed non-VA care by many measures but also showed a system that needs even more change.

"The independent assessment highlighted systemic, critical problems," the report said. "Solving these problems will demand far-reaching and complex changes that, when taken together, amount to no less than a systemwide reworking of VHA."

With an annual budget of some $60 billion, 1,600 health-care sites and 300,000 employees, the VHA says it is the largest integrated health-care system in the U.S. Last year, nearly 6 million veterans were treated in the system. That's $10,000 per veteran.

The reports portray the VA as a huge operation that has become difficult to steer and permeated by a bureaucratic system plagued by mismanagement and inconsistent care from hospital to hospital.

"It's pretty bad for VHA, it's pretty stinging," said a senior staff member of the Senate Committee on Veterans' Affairs. "There's nothing in here that has surprised me, but seeing it all in one place is probably the hardest thing."

"They'll push out a directive and they won't follow-up to see how it's implemented," the congressional staffer said, adding that a large number of leadership positions in the organization remain unfilled or staffed by interim employees.

NAVAPD has noted frequently that the VA has become more and more top-heavy, even as key positions and clinical positions go unfilled. The report shows that the central office has grown 160% over the past five years, yet key leadership positions down the chain remain empty. More than half of the executives in the organization are eligible for retirement and could leave at any time, which could create even more leadership gaps. With little succession planning in many facilities, delays in replacement of departing personnel result in functional issues.

The lengthy and critical reports come as the VA faces questions over whether it should allow more veterans to go outside of the system to receive private care. Recently, according to the assessments, health care obtained outside of the VA accounts for about 10% of VHA expenditures. The Veterans Choice Act of last year was built in large part around funding this type of care.

Questions about further privatization were highlighted recently when Ben Carson, a leading Republican presidential candidate and physician, suggested the VA make a push toward privatization and elimination of the VHA, its health-care delivery arm.

Earlier this week, a number of major veterans groups sent an open letter to Mr. Carson stressing the need to keep the VHA solvent.

The assessments released Friday unfavorably compared the VA's management style to a number of private health-care providers like Kaiser Permanente.

Sen. Isakson said the Veterans Choice Act, which allows veterans more leeway in seeking care outside the VA, was an emergency measure and not something meant to steer the VA down a privatized path. "The Choice program, contrary to what everyone thought, was not a sinister program to privatize the VA."

Robert McDonald, who took over as VA secretary last summer, has been praised by many in Congress as well as most major veterans groups for his efforts to reform the VA and his willingness to listen to patients and workers. But he has also been criticized for things like moving too slowly in firing underperforming employees and not supporting efforts to create an environment where employees can point out wrongdoing in the department. Mr. McDonald has said multiple times in the past that he is forcing out bad actors as quickly as possible.

"As a general matter, the president has made it a priority to ensure that America's veterans are getting the kind of health care and benefits they have so richly earned," White House press secretary Josh Earnest said Friday, saying he had not seen the substance of the report.

Mr. Earnest said that some of the reforms at the VA have already begun to show progress in improving care. "But the president, Secretary McDonald and other senior officials at the VA are not going to rest until we have accomplished our goal of making sure that all our veterans are getting the kind of care that they deserve, on time," Mr. Earnest said.

On Thursday, the U.S. Office of Special Counsel, an independent federal watchdog tasked with protecting government employees, especially whistleblowers, sent a letter to President Barack Obama criticizing what they said was the VA's reluctance to take disciplinary action against officials responsible for inadequate patient care.

"I have identified recent additional cas-

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Independent Report Confirms NAVAPD Reports (continued)

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es in which the VA confirmed serious misconduct brought to light by whistleblowers, yet failed to appropriately discipline responsible officials," said Carolyn Lerner, the head of the office. Her office criticized the VA for punishing whistleblowers while not punishing those who engaged in misconduct.

"Over the past year, the Department of Veterans Affairs has worked closely and in good faith with the Office of Special Counsel to correct deficiencies in the department's processes and programs to ensure fair treatment for any whistleblower who raises a hand to identify a problem, make a suggestion or report what may be a violation in law," the department said in a statement.
Access to VA care has increased dramatically since the mid-1990s, the report said, as changes in policy opened up the system to include not just combat-wounded veterans but many others who have served. Former Secretary Shinseki pushed to have veterans take advantage of their benefits and increased access to those like Vietnam veterans exposed to Agent Orange.
Although the VA has other departments, including a benefits arm, the VHA accounts for nearly 90% of the department's discretionary budget and employee base. While the total population of veterans in the U.S. peaked around 1980 at 30 million and has declined since then, according to the report, demand for VA care has been steadily increasing as greater numbers of vets take advantage of benefits. The number of enrollees and patients isn't expected to peak until 2019. ¤

House VA Committees Address OIG and GAO Reports

by Kay Bulow

The full House Veterans Affairs Committee (HVAC) held a hearing October 21 to receive testimony on the VA OIG report on inappropriate use of position and misuse of relocation program and incentives in the Veterans Benefits Administration (VBA). The OIG report can be seen at *www.va.gov/oig/pubs/VAOIG-15-02997-526.pdf*. The Committee invited five individuals from VBA to testify. However, VA Deputy Secretary Sloan Gibson, refused to let them testify because it could compromise VA's internal investigation. The Committee voted to issue subpoenas to those employees to testify at a hearing scheduled for 7:30p.m. November 2, 2015.

The HVAC Health Subcommittee held a hearing October 22 to receive testimony from the Government Accountability Office (GAO) about their study "VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care" report issued the same day. Excerpts follow:

"What GAO Found"
GAO found that the Department of Veterans Affairs' (VA) data on primary care panel sizes—that is, the number of patients VA providers and support staff are assigned as part of their patient portfolio—are unreliable across VA's 150 medical facilities and cannot be used to monitor facilities' management of primary care. Specifically, as part of its review, GAO found missing values and other inaccuracies in VA's data. Officials from VA's Primary Care Operations Office confirmed that facilities sometimes record and self-report these data inaccurately or in a manner that does not follow VA's policy and noted that this could result in the data reliability concerns GAO identified. GAO obtained updated data from six of seven selected facilities, corrected these data for inaccuracies, and then calculated the actual panel sizes for the six facilities. GAO found that for these six facilities the actual panel size varied from 23 percent below to 11 percent above the modeled panel size, which is the number of patients for whom a provider and support staff can reasonably deliver primary care as projected by VA. Such wide variation raises questions about whether veterans are receiving access to timely care and the appropriateness of the size of provider workload at these facilities.

Moreover, GAO found that while VA's primary care panel management policy requires facilities to ensure the reliability of their panel size data, it does not assign responsibility to VA Central Office or networks for verifying the reliability of facilities' data or require them to use the data for monitoring purposes. Federal internal control standards call for agencies to clearly define key areas of authority and responsibility, ensure that reliable information is available, and use this information to assess the quality of performance over time. Because VA's panel management policy is inconsistent with federal internal control standards, VA lacks assurance that its facilities' data are reliable and that the facilities are managing primary care panels in a manner that meets VA's goals of providing efficient, timely, and quality care to veterans.
In contrast to VA's panel data, GAO found that primary care encounter and expenditure data reported by all VA medical facilities are reliable, although the data show wide variations across facilities. For example, in fiscal year 2014, expenditures per primary care encounter—that is, a professional contact between a patient and a primary care provider—ranged from a low of $150 to a high of $396 after adjusting to account for geographic differences in labor costs across facilities. Such wide variations may indicate that services are being delivered inefficiently at some facilities with relatively higher per encounter costs compared to other facilities. However, while VA verifies and uses these data for financial purposes, VA's policies governing primary care do not require the use of the data to monitor facilities' management of primary care. Federal internal control standards state that agencies need both operational and financial data to determine whether they are meeting strategic goals and should use such data to assess the quality of performance over time. Using panel size data in conjunction with encounter and expenditure data would allow VA to assess facilities' capacity to provide primary care services and the efficiency of their care delivery. By not using available encounter and expenditure data in this manner, VA is missing an opportunity to potentially improve the efficiency of primary care service delivery."
www.gao.gov/products/GAO-16-114T

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Adam Robinson, Jr., M.D. Named Director of VA Maryland HCS

NAVAPD is extremely happy to learn that a physician, Adam M. Robinson, Jr., M.D., has been named the new Director of the VA Maryland Health Care System (VAMHCS). One of NAVAPD's most consistent messages to the VA leadership has been that there needs to once again be physicians in charge of VA medical centers and VA health care systems. At one time, virtually all medical center directors were physicians but this has dropped to a mere handful across the system.

NAVAPD President Samuel Spagnolo, M.D., has reminded VA leadership and Congress of this fact, and how it demonstrates the disenfranchisement of physicians and dentists in the VA. It has been NAVAPD's belief that physicians can contribute to improving the operations of the VA, if their voices are heard. Physician directors would also better understand the impact of impediments placed on physicians in the current environment.

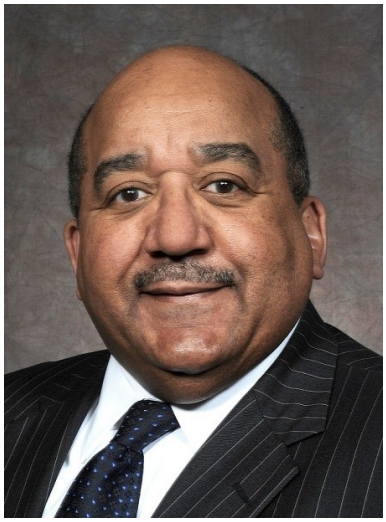
NAVAPD congratulates Dr. Robinson and applauds this appointment in hopes that it represents a recognition that naming more physicians as Directors of VA facilities and Health Care Systems will serve the Veterans and the VA well. The official press release regarding the appointment follows.

PRESS RELEASE
August 14, 2015

The Department of Veterans Affairs (VA) is pleased to announce the appointment of Adam M. Robinson, Jr., M.D. as the new director of the VA Maryland Health Care System (VAMHCS). Dr. Robinson will oversee delivery of health care to more than 55,000 Veterans and an operating budget over $550 million.

"We are excited to bring Dr. Robinson on board as the new director of VAMHCS," said Joseph Williams, Jr., Acting Network Director, Veterans Integrated Service Network (VISN) 5. "His sound leadership qualities and proven experience will be valuable assets for the health care facilities, community clinics, employees and volunteers, and most importantly, for the Veterans we are honored to serve. We anticipate he will assume his new role as head of the health care system within the next 45 to 60 days to begin his official appointment."

Robinson joined VA in February of 2014 as the Chief of Staff for the VAMHCS. Prior to his appointment with VA he served a distinguished 37 years in the United States Navy, most notably holding the position as the 36thSurgeon General of the United States Navy when he retired in 2011. As the Surgeon General, he served as the principle TriCare Health Plan representative for active duty sailors and marines, their families, and Navy and Marine Corps retirees and their families, numbering more than 2.5 million people. He led a team of 63,000 Navy Medicine personnel in over 220 health care facilities located worldwide with an annual budget of $3.5 billion. This included three tertiary care medical centers located in geographically diverse part of the United States that provided the single largest source of



residency trained health care providers for the Navy medical department.

Robinson earned his medical doctorate degree from Indiana University School of Medicine through the Armed Forces Health Professions Scholarship Program. He was commissioned in the Navy following completion of his surgical internship at Southern Illinois University School of Medicine, Springfield. Robinson also holds a Masters of Business Administration from the University of South Florida in Tampa, Fl. After retiring from the Navy as a Vice Admiral, Robinson served as medical director and staff physician of Conmed Healthcare Management in Montgomery County, MD.

The author of numerous publications, Robinson holds fellowships in the American College of Surgeons and the American Society of Colon and Rectal Surgery. He is a member of the Le Societe Internationale de Chirurgie, the Society of Black Academic Surgeons, and the National Business School Scholastic Society, Beta Gamma Sigma. He is also a Certified Physician Executive from the American College of Physician Executives. During his distinguished military career, Robinson earned numerous service awards, including two Distinguished Service Medals, two Legion of Merit awards, two Defense Meritorious Service Medals, three Meritorious Service Medals, a Navy Commendation Medal, a Joint Achievement Medal, a Navy Achievement Medal, and various service and campaign awards.

With more than 3,000 staff, VAMHCS consists of the Baltimore and Perry Point VA Medical Centers and the Loch Raven VA Community Living & Rehabilitation Center.. VAMHCS also has six community based outpatient clinics located in Cambridge, Fort Howard, Fort Meade, Glen Burnie, Loch Raven and Pocomoke City. In addition to health care services for Veterans, VAMHCS has a large research program with a total expenditure for research projects amounting to approximately $28.8 million in FY 2013. ¤

HVAC Considers OIG and GAO Reports (continued)

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Dr. Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations VHA's formal testimony said VA "is appreciative of the Government Accountability Office (GAO) findings in this regard, and agrees that greater oversight and responsibility for the accuracy of data are needed. Through the changes recommended, our processes to identify and manage instances of significant variation will be strengthened."

"The report by GAO found that primary care cost data reported by all VHA facilities were reliable, but varied ranging from a low of $150 to $396 per encounter. GAO further stated that VA is missing an opportunity to potentially improve efficiency in improving primary care service delivery through heightened oversight of encounter use and costs. VA concurs with the findings of this assessment and acknowledges that primary care managers have not fully understood or routinely used encounter and expenditure data to explore the impact of cost, and further recognizes the possibility of incorporating data to guide precision decision making."

During Q&As Dr. Lynch said an improved PCMM (primary care data collection module) is no longer on hold and being implemented. He said VA has awarded contract for new medical scheduling program and will be pilot tested in Boise, Idaho.

Rep. Roe asked how many scribes were being deployed in VAMCs. Dr. Stark replied that formal pilot was being deployed at three sites with 4 or 5 providers. Rep. Abraham added that he has used scribes in his practice for years and can provide VA with performance data to accelerate deployment within VHA.

Mr. Williamson, GAO Health Care Director, said 7 VAMCs were reviewed and found that the initial data provided by VHA was not reliable and GAO worked with the medical centers to get better understanding of their panel sizes. He added that the panel size was flawed because those patients included were dead or had not been seen by VHA for two years. He said neither VHA HQ nor VISNs were performing adequate oversight. ¤

NAVAPD BOD Member Participates In Overdiagnosis Conference

The 2015 Preventing Overdiagnosis Conference held September 1-3 on the campus of the National Institutes of Health in Bethesda, MD, brought together an international group of over 350 scientists, clinicians, consumers, health policy and members of the media to examine the problem of overdiagnosis in medical care around the world and to develop methods to improve the delivery of healthcare to individuals by reducing the harms related to overdiagnosis.

Many individuals from the Department of Veterans Affairs attended and presented work conducted in VA. Nancy Kressin, PhD from the Boston VA led a workshop focused on VA's leading role at improving health of Veterans through implementation of High Value Care. Panel members included Dr. David Aron, who described VA's Diabetes Choosing Wisely Campaign to develop implementation strategies for reducing the harms of overtreatment including the creation of an "out of range" glycemic index to assess quality of care in older adults with diabetes and comorbid conditions; Dr. Timothy Wilt and Professor Melissa Partin from the Minneapolis VA Healthcare System, who described a value framework for cancer screening and research related to improving patient communication about prostate cancer screening; and Dr. Linda Kinsinger, Chief Consultant for Preventive Medicine in the Office of Patient Care Services, who summarized VA's initiative to pilot and evaluate the effects of program for lung cancer screening among potentially eligible veterans prior to initiating a system-wide lung cancer screening program.

Other VHA presenters included Dr. Leonard Pogach, National Program Director for Medicine, Office of Patient Care Services, who presented an abstract on balancing glycemic overtreatment and undertreatment for seniors; Dr. Sarah Lillie, a health services research at the Minneapolis VA Healthcare System, who presented on Veterans' identification of important factors in lung cancer screening decision making; Dr. Tanner Caverly, a general internist and health services researcher at the Ann Arbor VA Healthcare System, who presented on using a single question to facilitate shared decision making for lung cancer screening; Dr. Jeremy Shelton, a urologist and health services researcher at the Greater Los Angeles VA Healthcare System who presented on reducing inappropriate PSA-based prostate cancer screening in men 75 years of age and older; and Dr. Doug Owens, a health services research at the Palo Alto VA Medical Center, who participated in a panel session on the role and limitations of statistical modeling in estimating overdiagnosis in screening programs. In addition, Dr. Kressin also presented two abstracts related to race/ethnicity and over- and under-use of care. All of these projects are examples of VA leadership working collaboratively with researchers, clinicians, health care administrators and Veterans to deliver High Quality care to Veterans by reducing the harms of overdiagnosis and overtreatment.

In addition, Dr. Wilt served an important role on the Scientific Planning Committee for the meeting and facilitated a session of presentations. Drs. Wilt, Kinsinger, and Kressin , along with Dr. Jill Wruble, a radiologist at the VA Connecticut Healthcare System, also participated in an invitation-only workshop on September 4, 2015 to discuss future research directions for the area of overdiagnosis. For more information see:

www.preventingoverdiagnosis.net ¤

Tomah VA Medical Center Temporarily Closes Acute Psych Unit

Due to critical psychiatric staff shortages, the Acute Psychiatry Inpatient Services unit at the Tomah VAMC temporarily closed on August 31. Tomah-area Veterans requiring Acute Psychiatry inpatient services were transferred to VA facilities in Madison or Milwaukee or non-VA facilities if VA care is not available. Area Hospitals will be notified of the change.

The medical center also suspended new admissions to its Community Living Center for Veterans requiring Mental Health Recovery treating specialties until sufficient psychiatric staff is hired.

"Ensuring that Veterans have access to the safe, high-quality care they have earned and deserve is my top concern," said John Rohrer, Acting Director for the Tomah VA Medical Center. "I do not make this decision lightly. We intend to re-open the unit but will only do so when we have the necessary psychiatric staff to do so safely."

"It is an on-going search for psychiatric professionals," said Rohrer. "We have boosted starting salaries, increased our advertising and initiated recruitment bonuses for these critical roles."

VA is taking additional actions:

- Receiving tele-mental health support from other VA facilities.
- Receiving support from the Mental Health Leads at other VA facilities.
- Utilizing Disaster Emergency Medical Personnel System (DEMPS) psychiatrists and psychiatric nurse practitioners to provide in-person or tele-mental health support.
- Expedited recruitment efforts:
  - Increased psychiatrist starting salaries to $240,000.
  - Continued advertising in psychiatry-related periodicals
  - Postcard mailing to psychiatrists.
  - Retention/recruitment bonus for current/prospective on-site or inpatient psychiatrists at Tomah
  - adjusting fee-basis rates commensurate with salary increases. ¤

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 our 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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☐ Payroll 2. Deduction $6.15/PP

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