GOVERNMENT SERVICE NEUROLOGISTS SECTION STRATEGIC PLAN

I. Introduction

A. Purpose of Document: To provide a reference for other Sections of the Academy whose members are providing care for Military or VA beneficiaries on issues important to Government Services neurologists engaged in patient care and research, as well as professional advancement.

B. Who we are: The Government Services Section (GSS) is comprised of those members of the American Academy of Neurology who are full or part time Federal Employees. This includes commissioned officers of the Uniformed Services who are on Active Duty, members of the Reserves or National Guard, members who serve in the Veterans’ Administration (VA), members who are both commissioned and civil servants in the United States Public Health Service (USPHS) or within one of its agencies (e.g. National Institutes of Health, Centers for Disease Control, Food and Drug Administration) and their retirees. The members of this section come from very different practice settings from rural environments to large federal hospitals and research facilities. Our members participate in a wide range of professional activities including clinical practice and research. Many are adept at caring for neurosurgical emergencies in both rural areas and the battlefield. The VA is the single largest employer of neurologists in the United States.

C. The GSS addresses special concerns of Federal Government Employees. It provides a forum for exchange of information between agencies. Since Federal Employees are not permitted to lobby the Federal Government, it provides access to the Government through Academy channels. It provides a channel for proposing courses to the Academy of special interest to its members.

D. Most members of the GSS belong to one or more subspecialty section. They collaborate with other sections to ensure that clinical guidelines are pertinent and can be applied to the unique populations that we serve.

E. The Strategic Plan will provide a means of informing the AAN of the needs of Government Service Neurologists and how the GSS is helping the Academy to meet the needs of this diverse group of members.

F. Overall Mission statement: The section exists to further the professional needs, both scientific and practice related, of Neurologists employed by the Federal Government.

   1. Serve as a repository for national experts on trauma, rural practice, and global health
   2. Advise the academy of potential neurological needs of the patient populations we serve
   3. Increase awareness of unique needs and talents of government services neurologists
   4. Foster federal collaboration, communication, and support among each other and identify shared common concerns
   5. Enhance patient care, education, and research among the members of the Section. Serve as the initial contact for initiatives for patient care in our service population
   6. Serve as mentors for other government neurologists, especially within NIH/NINDS
   7. Honor neurologists who have served on the battlefield or have been deployed to represent the United States
   8. Report research with emphasis on neurologic problems common to veterans and active duty military personnel such as traumatic brain injury
II. Background/History of Section

A. Landmark early works/milestones: The section is an outgrowth of the Federal Affairs Committee first formed in 1951. During the following changes in Academy structure it was renamed Neurology in the Governments Services Committee from 1967 to 1983, Neurology in Government Service from 1983-1987, and the Uniformed Services Committee from 1987-1995. In 1995 it was expanded again to the Government Services Section when the previously separate VA section was joined with the Uniformed Services.

B. Since then, the Section has sought a more active role in the scientific program of the Academy proposing several short courses of specific interest to its membership.
   1. 2008 Diagnosis and Treatment of Traumatic Brain Injury
   2. 2008 Spinal Cord Injury (co-sponsored with the Spine Section)
   3. 2006 Rehabilitation of Traumatic Brain Injury
   4. 2003 Bioterrorism and Neurology

C. Growth of Section – The number of potential members increased when this section merged with the section on VA neurologists. We have initiated a quarterly newsletter and are taking it online in an effort to recruit additional members from the Academy membership. The Section is limited by the number authorized Government employees and their retirees.

D. We have been instrumental in getting laws passed on a number of issues including:
   1. Retirement and disability benefits
   2. Establishment of multiple sclerosis and Parkinson centers

E. Current Board certification: Most members of our section are required to be board certified to practice at their location. There is not a subspecialty board for military or government practice.

F. Other professional and disease related organizations relevant to the subspecialty.
   1. The Uniformed Services Organization of Neurologists (USON).
   3. Association of VA Neurologists (AVAN) established in the 1990s by Dr. John Kurtzke under the direction of Dr. John Booss to address VA issues. AVAN met at the annual AAN meeting. The last meeting was held at the 2005 AAN Meeting in Miami. The AVAN was asked by the academy to join the GSS.
   4. Because of the nature of the section, its members relate to all of the other Sections of the Academy and most are members of at least one other Section.

III. Current State of the Government Services Section (GSS)

A. Patient care/practice – GSS members are all neurologists in government service, whether full-time or part-time (many VA neurologists and military reservists). However, our duties and work environments are remarkably diverse.
   1. The majority of our section members are employed within the Department of Veterans Affairs. Their principle responsibilities are, like that of many of our colleagues, patient care and/or research. Another segment of our membership is employed by the Department of Defense either as active duty officers or as civilian or contract employees. Another segment is engaged in neither patient care nor research but occupy positions that directly affect patient care or research through administrative, regulatory, evaluative, or advisory roles. Our past chair worked within the Department of Health and Human Services serving as an advisor to the Vaccine Injury Compensation Program. We have members who implement public health measures, respond to disasters, perform neuroepidemiology, respond to the neurological threats of bioterrorism, and advise on evolving infectious diseases affecting the nervous system.
2. As GSS neurologists we affect patient care immediately through direct care for individuals and care provided to populations, as well as indirectly in a variety of ways such as: clinically relevant research, FDA oversight of drugs vaccines and food (BSE), health care administration, and planning.

3. We work at desks, research benches, and a variety of other settings both within and outside the US including: rural areas, inner cities, the truly remote, battlefields, and detention facilities.

4. We serve all ages as well as special populations with special needs and circumstances, e.g., Native Americans, Pacific Islanders, the incarcerated, migrants, and immigrants.

5. Together we are known as a well qualified group of neurologists who provide high quality patient care, perform research and teach at some of the nation's top institutes, and oversee the administration policies that protect the nation's neurological health.

B. Research

1. GSS members serve within the National Institutes of Health in both the intramural and the extramural program. Members have been involved in the coordination of large multi-center clinical trials and have had leadership positions within the National Institute for Neurological Disorders. A recent chair of our section, Dr. Audrey Penn, served as the deputy director for NINDS. Currently, many members of the GSS are actively involved in research on traumatic brain injury, post traumatic stress disorder, and other conditions resulting from the Iraq War. The Federal government is the largest funding source for research in the United States. A great deal of that funding is channeled through government agencies including the NIH, the VA, the Uniformed Services, and the Uniformed Services University of the Health Sciences.

2. The Centers for Disease Control has funded neuroepidemiology and other neurologically relevant research through their divisions associated with neurological disorders.

3. The VA has its own research service, which functions similar to the intramural program of NIH. The VA currently devotes as much money to rehabilitation research as does NIH. The funding rate for VA merit review is now about 18%. The VA has the unique ability for researchers to obtain data from all VA medical centers as all VAs use the same electronic medical record with central collection. Both the VA and military afford opportunities for longitudinal studies not always possible or practical to do in civilian populations.

4. A number of federally funded research initiatives are channeled through the Uniformed Services University of the Health Sciences which also conducts its own robust research program. Additional projects are funded directly through the Military Hospitals and the United States Army Medical Research and Development Command. The Henry M. Jackson Foundation has sponsored research within neurology. Research is also conducted on long term effects of military service such as the risks of acquiring ALS and the long term prognosis of PSD and blast injury. Special research interests of the military enable opportunities within both the military and the VA to studied neurological disease and problems that would be unlikely to be funded elsewhere.

5. Each of the Uniformed Services has its own medical research budget. Military neurologists are especially qualified to perform research in areas affecting active duty personnel since they are the physicians who first contact with these patients. Especially with medical problems related to deployment, military neurologists who have also been deployed have special knowledge of the environmental factors that might have contributed to the patient’s illness.
C. Education

1. The Uniformed Services operates the only federally chartered medical school the F. Edward Hébert School of Medicine of the Uniformed Services University of the Health Sciences. The Uniformed Services also conduct a number of residencies including Neurology, Child Neurology, Clinical Neurophysiology and Clinical Neurology.

2. Many Veterans Hospitals are associated with medical schools. The VA funds about one quarter of all US neurology residency slots outside of the military residencies.

3. The GSS has sponsored at least one course at the annual meeting for the past several years and will continue to do so. In 2008 our courses were "The Diagnosis and Treatment of Traumatic Brain Injury" as well as a jointly sponsored course on "Spinal Cord Injury".

4. NIH trains neurologists as clinicians and researchers.

5. Government service is part of the career development path of many neurologists. The Uniformed Services University, the armed forces residencies and fellowships, the VA, and NIH are not closed systems that retain all those they train for the duration of their careers. A large percentage of US neurologists have received some of their neurology education and training within the government services.

D. Medical Economics Issues

1. The pay for federal physicians is usually lower than the pay for the same physician in an academic center but the pay disparities are diminishing. The pay differential has been an interest of the GSS, and our section did a survey to gather relevant data.

2. The VA and the Military direct care system is clearly the closest thing to "universal health care" in the US. The VA, military service, and public health service are not fee-for-service operations; they are geared to longer term management. Clinical practice in this arena is being evaluated as studies indicate that VA patients may receive better and less expensive care than other sources. The VA has been at the forefront of electronic medical records and currently utilizes teleneurology to deliver care to its recipients who do not live close to a neurologist.

E. Legislative Issues

1. Government employees are prohibited from contacting congress or directly lobbying on their behalf. They can speak as neurologists or individuals, but not as government neurologists. The AAN is the major means that government neurologists have to make their voices heard. Because of this, we have asked for representation in the AAN Legislative Affairs Committee by either an executive committee member or our COSEC representative.

2. The AAN has been very supportive of Veterans, working with groups like the National Multiple Sclerosis Society and Paralyzed Veterans of America to get the Congress and the President to put into law permanent authorization for the Parkinson’s Disease Research, Education and Clinical Centers (PADRECCs) and the Multiple Sclerosis Centers of Excellence. Currently the AAN has spearheaded legislation with the Epilepsy Foundation which established a national VA care system for epilepsy, including Epilepsy Centers of Excellence. The AAN has been very supportive of Veterans and should be supportive of the Government Services Section neurologists who attend to their needs as well as the, the military and others entitled to government care. Our section would like the opportunity to provide direct input into the AAN legislative agenda.
IV. SWOT Analysis of the Subspecialty

A. Current Strengths

1. Patient Care - Because of electronic records, many government health care systems are giving some of the best health care that can be obtained in the United States. The government systems encourage longitudinal care. Most government health centers have well trained physicians who provide excellent care.

2. Research -The Veteran Administration and Department of Defense support research grants as well as the education of neurologists who are interested in research. The availability of an additional line of research funding has long been a recruitment incentive for VA neurologists. The unique ability for researchers to obtain date from all VA Medical Centers and the central collection of VA data provide additional opportunities.

3. Education –Many Veterans Hospitals are associated with medical schools and thus have opportunities to help with the education of medical students, residents, fellows and other professionals. VA supports about 20% of resident slots including neurology. All three Armed Forces as well as the NIH maintain Gradate Medical Education opportunities. The Department of Defense operates the only Federally Funded Medical School (USUHS) open to members of all 4 Uniformed Services.

4. Economics -Although neurologists working for Government agencies do not make as much in salary and immediate benefits as their peers in private practice, remuneration has improved and now is close to that made by members of many academic medical faculties. Military neurologists are largely recruited by the educational benefits provided by the USUHS and by the Health Professions Scholarship Program (HPSP). Those graduating from the USUHS have a 7 year commitment after residency and most will remain on active duty until at least their first possible retirement date. Most HPSP acquisitions usually resign after completion of their 2-4 year payback requirement.

5. Legislation - Government employees are forbidden from contacting congress or directly lobbying on their behalf. This section provides a means for members to have our voices heard. We are dependent upon AAN for legislative representation.

B. Current Weaknesses

1. Patient Care – The esprit de corps among military neurologists is lacking among VA neurologists largely because there is nothing unifying about the practices of government neurologists.

   a. There are specific care issues to the veteran population that need to be addressed

      1) There has been a recent push in VA Medical Centers to have all neurology outpatients seen within 30 day from the time of consultation. Increasing demand without providing resources may adversely influence medical care.

      2) Like the general population, the veteran population is aging, and living longer. Neurology services are seeing more patients with degenerative diseases. Caring for these patients often takes subspecialty skills unavailable in many health centers. Centers like the PADRECCs, are often far away from patients' homes and depriving many patients of the care they need.
for degenerative diseases such as minimal cognitive impairment and Alzheimer’s disease. Early intervention might delay disability and screening methods must be developed and implemented.

4) Many VA hospitals not associated with a medical school might be giving less than optimal neurological care.

5) There is an identity problem among VA Neurologists. Most identify themselves by the type of practice they have – neuromuscular, rehab, stroke, epilepsy etc rather than as VA neurologists.

6) Although our members often have critical practice experience for current neurology topics like traumatic brain injury, post-traumatic epilepsy, and EEG monitoring in unresponsive post-traumatic states, our members in clinical practice are often not in research settings and spend all of their time in clinical practice and are often not asked for their input in their fields of expertise.

b. Issues specific to the Military Services
1) The unpopularity of the War in Iraq has hampered recruiting, especially for the HPSP program, although not significantly for USUHS. Similarly, multiple deployments have increased the resignation rate although morale among service Neurologist remains high.

2) The BRAC closings will present new challenges. The consolidation of Walter Reed Army Medical Center with the National Naval Medical Center will require substantial revisions of the USUHS Neurology Clerkship. It will have less impact on the Residency Program since that has already been integrated under the National Capitol Consortium. Similar challenges will be faced in San Antonio when Willford Hall Air Force Medical Center and Brooke Army Medical Center are consolidated into the San Antonio Military Medical Center (SAMMC). The Willford Hall Neurology Program will move across town to BAMC (SAMMC South under the sponsorship of a local military graduate medical education consortium.

2. Research – Our VA members have a significant impact on research in neurological diseases. However:
   a. The funding rate for merit review is now about 18%. Although is a little better than NIH, it is lower than it has ever been. More money is needed to fund VA research as well as entice excellent clinicians to work with the VA.

   b. The VA and Military facilities take care of many retirees. Often these patients suffer from chronic disabling conditions including memory and cognitive disorders induced by traumatic brain injury, post-traumatic seizures, amputation with phantom limb pain, and post traumatic stress disorder. Only a limited amount of money has been allocated to both prevention and treatment research.

   c. There are many administrative road blocks to research. The VA IRB system has to be made more efficient.
d. Neurology needs a part of the VA’s administrative authority for the TBI program, beyond the ECoEs, as is the case in DOD.
e. A weakness of the VA system is the predominance of male patients without the opportunity to work with women or children.
f. Many VA Neurologists are part time and see themselves more aligned with their university department than the VA. This interferes with communication and collaboration between VA Medical Centers.

3. Education - Although our educational efforts are currently robust, they are entirely at the mercy of the budget process. In the present economic environment, it may happen that funding will be to a greater extent limited to patient care.

4. Economics – Remuneration for government neurologists must remain a priority issue. Although advantages of government medicine such as the relative security of the retirement system and the ability to take leave for recreation and rehabilitation will remain enticements, they will not serve to maintain the force if pay becomes inadequate.

5. Legislation - Both military medicine and the VA are sometimes chosen as political scapegoats.

C. Opportunities for growth in each area –

1. Patient Care: The huge number of injured veterans returning from Iraq and Afghanistan will provide a need for expanding the number of VA neurologists.

2. Research: The VA has an enormous capability for multicenter research that is underutilized. The process should be streamlined. This might be done by providing the Neurologic Director with the budget to accomplish thee studies. It might be hoped to foster the sense of identity among VA neurologists. This might be done with NIH collaboration and in association with the Military hospitals and the USUHS

3. Education: Many of our Military members are not able to make annual meetings due to deployments or difficulty traveling when they are "mission critical" or serving as the only neurologist for an area. It would be helpful if we could find a way to this leadership opportunity and meeting to them.

4. Economics: Federal funds will have to be found to continue the level of care for Neurologic casualties.

5. Economics: Government neurologists must not be lost in the current economic crisis.

D. Threats to achieving goals in each area.

1. Patient Care - VA physicians and some in the Military services are concerned that changes in the health care system could negatively impact on the care provided for veterans through their systems.

2. Research – VA and Military physicians share the general concern that in a time of tight budgets and economic uncertainty the value of research might be undervalued. Without good access to private and state funding, we are far more dependent on the federal purse.

3. Education – Decreased funding for resident training through the VA would have a serious impact on Graduate Education nationally as well as for VA recruitment. The military hospitals might have similar concerns. In times of budget constrain, the USUHS has been threatened with closure.

4. Economics – and Legislation: A recurrent concern in this section has been the federal budget and its potential for working good or ill for our ability to treat our patients, perform our research, and educate future generations of Neurologists. Although the
forthcoming budget and health care policies affect all physicians, members of our section are uniquely vulnerable. 
  
a. Current status of AAN input to each area. The AAN has the most helpful in providing legislative representation.

V. Specific Vision, Goals and Objectives for the Subspecialty/Section
A. Short Term (over next 5 years) Specific defined goals and targets Goal –
   1. Goals:
      a. Ensure section has place to voice its issues
      b. Educate military service about appropriate and unique role of neurologists on the battlefield.
      c. Define rural neurology practice standards, work with other sections on cultural competence and global health
      d. Support members when deployed or isolated who often do not have internet, library or colleagues with network of specialty consultation,
      e. Protect the communities that are served by uniformed neurologists so that when those neurologists are deployed the population can be served by backfilled neurologists (either VA or non-federal under a MOU).
      f. Give AAN input for legislative report
      g. Recognized unique contribution and use of our section members as experts
      h. Guidelines dealing with the care of patients with traumatic brain injury and post traumatic epilepsy
      i. Increase involvement of government service neurologists with this section
         Target – have 20% of government service neurologists become members of the section.

2. Operational strategies to achieve goals – These are yet to be determined
3. Specific action items for each goal – These are yet to be determined
4. Role of AAN in achieving goals -
   b. Increase participation of our members in Expert Panels
   c. Other roles to be determined
5. Benefit to AAN and sub-specialty in achieving goals – These are to be identified
6. How will sub-specialty assess and address success/failure for each goal/area?
   a. Through evaluating the enrollment and activity of neurologists in this section.
   b. Effects on other sections to be determined.

B. Long Term (over the next 5-10 years)
1. Specific defined goals and targets
   a. Develop common grounds for exchange of information gained from providing care within a single payer medicine system that can be used to help improve health care delivery in the US.
   b. Develop and implement national VA and military protocols for management of neurologic diseases seen in our patients.
   c. Develop national networks for clinical practice and research including guidelines and performance measures.
d. Strengthen ties between various governmental institutions for the conduct of research leveraging on the strengths of the military, VA, NIH and other governmental organizations

2. Operational strategies to achieve goals
   a. Goal a-d: Develop forums to consider how neurology is practiced and how practice can be improved in a manner that is economically sustainable. Such forums would consider input from different care systems including government service.
   b. Additional strategies to be determined.

3. Specific action items for each goal
   a. Establish care delivery forums indicated above.
   b. Additional action items to be developed

4. Role of AAN in achieving goals: Support our efforts

5. Benefit to AAN and sub-specialty in achieving goals –
   a. The AAN could become a leader in molding the course of future neurology care delivery.
   b. Other benefits to be determined

6. How will sub-specialty assess and address success/failure for each goal/area? To be determined.

VI. Summary/Concluding Statement

A. Summary of mission/vision/values for specialty: The mission of this Section is to support and represent neurologists employed by the federal government.

B. Global conclusion and assessment of sub-specialty’s place within the larger scope of AAN, other specialties, neurology in general and related fields (e.g. neurosurgery).
   1. This section represents a group of neurologists who are involved in large national (US) health care systems that operates differently from that in the public sector.
   2. The care systems are focused on long-term healthcare management, as well as acute management.
   3. Learning what works well and what does not can provide useful information that can be used to help improve care delivery in the private sector.
   4. To ignore the experience of the Neurologists in this section would reduce the models that can be considered in remodeling health care in the United States.