



reimagine Medicine Episode 1: Advancing Veterans' Health

Dr. Lifshitz: Welcome to the reimagine Medicine podcast for veteran's health episode. I'm Dr. Johnny Lifshitz.

Dr. Brite: And I'm Dr. Katie Brite.

Dr. Lifshitz: We're faculty members at the University of Arizona College of Medicine – Phoenix. We look forward to delving into topics that are shaping clinical care, medical research, medical education and challenging us to reimagine medicine. Each month, we bring together clinicians, researchers, educators, health care thought leaders and medical students to share the experiences and ideas that are fueling their efforts. We're glad you're with us.

Dr. Brite: In this episode, we will discuss several issues affecting veterans' health care, the timeliness of health care delivery, early diagnosis and intervention disease prevention and healthy lifestyles, as well as evidence-based medicine approaches and process Improvement. This content is not just for the VA, but we hope will be applicable across health care and in the community.

Dr. Peterson (narrator): The opinions expressed in this podcast are those of the host and their guests and do not represent the opinions of the University of Arizona College of Medicine – Phoenix or Banner Health. Do not use this podcast for medical advice; instead, consult your personal family physician for medical care.

Dr. Lifshitz: Joining us today are Dr. Michelle Dorsey and Dr. Clement Singarajah from the Phoenix VA Healthcare System, the Veterans Affairs Healthcare System. Dorsey is the chief of radiology and a clinical assistant professor in the Department of Radiology. Dr. Dorsey was recently selected as one of the first physicians to represent the Department of Veterans Affairs as a White House fellow with the White House Leadership Development Program. Dr. Singaraja is an internist and leads the Intensive Care Unit division at the Phoenix VA Healthcare System; he is also a prominent leader in medical and resident education and has been positively impacting the training of future Physicians of Arizona throughout his career.

Dr. Brite: Thank you so much for joining us. Let's start with the timeliness of health care delivery and/or early diagnosis and intervention. First, a question for you, Dr. Dorsey: Customer service in health care — what is expected and what can be consistently delivered?

Dr. Dorsey: Well, thank you and thank you for inviting us here to speak today. I think really the most important thing is that we listen to the voice of our customer — in that case, the veteran. We really can't assume we know what the veteran wants without actually talking to them, and we've really made that a priority at our Radiology Department through a number of surveys, so that we can get direct feedback from the veteran — something called Truth Point. It's like a tablet-based survey they take, as well as actual in-person rounding to talk to the veterans to see what they need; and, you know, we had a lot of preconceived notions about changes that we needed to make to improve our access to services in



radiology, but until we actually heard what the veterans had to say, we really didn't know what changes we needed to make. So we made just a variety of changes based on their feedback, including extended hours of operation — until 10:00 p.m. in the evening and on weekends, so that our working veterans can come in. We also completely revamped our scheduling processes, our phone tree — as far as calling to get an appointment — setting up a call center and even just the simple things like parking instructions — we have really, kind of a big parking problem on our campus — and letting the veterans know how to get to us and where to park when they came was really just reassuring for them. So, you know, I found that you don't really need to have a fancy facility; we don't need a waterfall or a piano in our lobby, but we do need to take the time to actually make each veteran feel special and feel cared for. If we really take that chance to own the moment with the veteran in all of our interactions, I found that no matter, sort of, what their situation is as far as access goes — and we've had some variable times, certainly in Phoenix, where we've had more difficult wait times — but, uh, the veterans really know that they're cared for here; and even sometimes when we are booked out over 30 days, they'll still choose to stay at our VA because they know that we care about them.

Dr. Brite: Wonderful. Thank you. Those are some wonderful patient process improvements. Next, I have a question for you, Dr. Singarajah. What hurdles exist in health care delivery to prevent achieving customer satisfaction or improving patient outcomes?

Dr. Singarajah: Thank you very much for inviting me here for this podcast. I'm very honored and pleased to be here. We have a variety of barriers to improving access, and one of these is, of course, timeliness. One of the problems we're wrestling with is how to prioritize the variety of patients who are referred to our clinics. For example, referring to the pulmonary operation clinic and as everyone who is listening to this will understand, lung cancer is really a high priority among veterans, for obvious reasons. So, we also get patients who don't have lung cancer, who, as a clinician, we would potentially prioritize a little less. So, we have to find a way to balance the needs of those who, to us, aren't as acute, but obviously still need to be seen versus those patients with lung cancer who need to be seen first. So, one of the ways we used to do this incorrectly was every new patient was referred to our clinic basically got scheduled as first come, first served. What we've done the last couple of years is assign a physician, or group of physicians taking turns to look at each new request to see us and try to prioritize which ones need to be seen sooner versus later. So, if it's something like a really obviously looking bad lung cancer, we would try and prioritize them in quickly. Basically, in the process in lung medicine trying to reorganize our old process for lung cancer. When I was in med school, lung cancer screening was basically deemed a complete waste of time and money, but now, it's quite obviously, been shown to be a useful thing with something called low dose CAT scans. And the VA is leading the country in both research protocol and process to screen patients with the appropriate risk; and screening doesn't just mean screening everybody with a lung mass. You have to talk to them first and find out, "Do you understand what this means?" If it's positive, do you want to further; and some patients will choose not to be screened. But once they're screened, with the help of our screening coordinators, some of these patients are funneled into our clinic and expedited that way. Another factor that we're doing fairly well with, especially with the radiology department here, is coordinating the various studies that need to be done to help these patients. It's not just one x-ray; they often need a variety of tests done before. Some of them are radiological; some of them belong to my department in the form of biopsies. We still have an access problem -- lack of physicians, lack of space -- so we have a fairly robust system of working with community clinicians, private clinicians in Phoenix who



we refer out to. In general, probably a good reflection of once they get to see us, they generally like it -- once they get into our clinic.

Dr. Lifshitz: I'm so glad you brought up the fact that things have changed since you've been in medical school because here at the College of Medicine – Phoenix, we exert our effort to train the best physicians with a customer in mind. What we want to know or what we want you to continue to expand upon is how does everything that you do in terms of quality improvement and focusing on the customer change how we prepare future physicians.

Dr. Dorsey: Well, the best advice that I can give to a future physician is to really put the patients at the center of everything that you do. I found that when I have made those decisions, either in my clinical work or in my administrative role, that I have never regretted a decision that I have made. Really try to treat your patients as you would treat a family member. And in my experience, actually, with our medical students here at the University of Arizona, I really don't feel that's a problem. I think they really have a good grasp of this. In fact, I wonder sometimes when I'm doing the multiple mini-interviews with our medical students if I would even be admitted to this school anymore because we really just have a fantastic group of really dedicated and altruistic men and women that are interested in joining our medical school; so I do feel like they have a good grasp of that already, but I think reinforcing is always good. I think actually our practicing physicians maybe are the ones that sometimes need a reminder. We get sort of bogged down in the busyness of our schedule — you know, the access, trying to see more patients in less time — and we kind of forget that that's really at the center of everything we do is the patient or the veteran, in our case.

Dr. Singarajah: I'm pretty sure I would not get into the University of Arizona medical school based on the threshold I've seen as part of the interviews, but that's a tribute to the quality of the students we're getting. One thing I would notice is that many of us as doctors would focus on the medical issues and the jargon, and sometimes, we have to remember as physicians or clinicians of others that these are people who don't know what we're talking about; and we have to put ourselves in their perspective, so I often tell my fellows and residents, "We always tend to fall into jargon when we're talking to patients, and we always tend to talk too much when we're talking to patients. The hardest thing I found to do myself and to show other people and families is sometimes, the residents, you have to stop talking and wait for the patient or the family to tell you what their perspective is. And that is really quite difficult to shut up and keep quiet for even 15 seconds. We like to fill that silence. One of the particular examples I use a lot is unfortunately in the ICU, a lot of our patients are close to death and we're discussing pretty rough issues — your father is going to die, this is what's going to happen — or you're giving them bad news — that you've got stage IV lung cancer. The habit is for most young people and most young physicians, like I was, is to fill that space with too much information. Sometimes just saying what you need to say very basically. Call it death, don't call it moving on, avoid euphemisms. Sometimes saying it straight and then being quiet. It's not easy to keep quiet because we want ... I feel uncomfortable with it. Most physicians feel uncomfortable with silence, but that actually can be quite helpful

Dr. Brite: Thank you for that. For the wonderful advice for our training students and for everyone training in medicine. I'm going to shift gears a little bit here. Dr. Dorsey, tell us about your exciting new role. How do you see your role as a White House Fellow affecting veterans' health care?



Dr. Dorsey: Yes, well, it was certainly an honor and a bit of a surprise. Since I'm going to be the first physician, as you mentioned earlier, from the Department of Veterans Affairs that was chosen for this White House Leadership Fellowship, I will be placed, actually, at the Office of Management and Budget within the Executive Office of the President; and I'll have programmatic leadership of the customer experience, cross agency priority goal. So, kind of the point of fellowship is to work on the President's management agenda, and within the agenda, there are large, overarching, kind of, whole of government problems, goals that we need to work on, and they're called the "Cap Goals" or the "Cross Agency Priority Goals." And they're kind of, again, big whole of government problems. Things like modernizing our workforce, building a workforce for the 21st Century, modernizing our IT, and mine happens to be customer experience; and so, the work that I'll be doing will be trying to more broadly improve the experience of the delivery of services by federal agencies; and it's really not just about health care. Although, actually, the VA is one of the big partners; it's the co-leader in this goal, so I'll be working quite closely with the VA central office while I'm there. But Medicare would certainly be one, but just about anything you can think of; so TSA when you go through, you know, airport security; when you get a federal student loan; when you need emergency help from FEMA. Anyways that we can look at to sort of standardize and deliver better on customers' needs and desires. So, I really think that's eminently transferable to health care. It's really kind of easy to forget the patients sometimes when we're caring for them. We sort of just say, "Hey, take this pill; you need to exercise more; you need to quit smoking;" but really the patient should be at the center of what we do. It's really their body, and it's ultimately their care. So we need to be better about engaging patients in their own delivery of care, and I think the lessons that I'm going to learn this next year in regulating the customer experience will be transferable to my work back here at the VA when I return next year.

Dr. Brite: That is awesome. You're so capable, and Phoenix is proud. Dr. Singarajah, the name of the podcast is reimagine Medicine. How have you seen the evolution of medicine, and what will be the next chapter?

Dr. Singarajah: Medicine has changed hugely since I ... long time ago in a different century when I graduated. It's embarrassing; it was a different century, but when I graduated, it was fairly paternalistic. Physicians were telling patients what to do; we were the God figures, kind of were. And over the last 10 to 15 years, the appropriate change has taken place, where we are more partners with the patients. We are not telling them necessarily what to do; we are working with them as a team, so the model has changed from fairly paternalistic to more team approach for more situations. And technology has changed radically in the last 15, 20 years. Bedside ultrasound, information technology, access to information. It's very interesting watching the newer generation. When you ask them a question, of a group of students or residents, the person who's answering may not answer it, but you see their colleagues rapidly going to Google or Bing. We never use Bing; we use Google primarily. Or finding out information that in my day, we would've spent five hours trying to find in a book. So the information is very easy to gather. What we do need to work on as clinicians is synthesizing that information into something more coherent for the patient. Information for the sake of information won't help the patient. We have to put it together in a plan that they will understand.



Dr. Lifshitz: Thank you so much for highlighting the relationship between the doctors and the patients and how that has become a conversation. We thank you for sharing your insights. It has been a pleasure talking and especially listening with you. Right now, we have to take a break, but we will continue the discussion in just a minute.

Narrator: The reimagine Medicine Podcast is brought to you by the University of Arizona College of Medicine – Phoenix. Dr. Johnny Lifshitz serves as the director of the Translational Neurotrauma Research Program, which is a joint venture through Barrow Neurological Institute at Phoenix Children’s Hospital, the Department of Child Health at the University of Arizona College of Medicine – Phoenix and the Phoenix Veterans Affairs Health Care System. Dr. Katie Brite is the chair of the curriculum committee and co-director of the Family, Community and Preventive Medicine clerkship at the University of Arizona College of Medicine – Phoenix, placing students with community clinical partners all across the state. She is a family physician and the vice president of primary care services at Bayless Integrated Healthcare.

Dr. Brite: Welcome back to the reimagine Medicine Podcast. We are pleased to have Dr. Collan Kennelly and Aaron Kisana as our guests. Dr. Kennelly is a primary care physician at the Phoenix Veterans Affairs Health Care System. Aaron Kisana is a second-year medical student, an MD candidate from the Class of 2021, and a member of the curriculum committee.

Dr. Lifshitz: The health economics of prevention prevail over disease treatment. Per patient prevention is more cost effective than disease treatment. Dr. Kennelly, how do we convey long-term benefits of prevention? How do we sustain the motivation on the part of the patients and their allies in supporting their patients?

Dr. Kennelly: I think the best way to convey it to our patients is to just put things in plain language terms and explain to them that our emphasis is keeping them out of the hospital. We want to keep people living longer, happier, healthier lives, so explaining the purpose behind the medications we’re giving them, instead of just throwing more pills at them. But even more so than that, addressing the non-pharmacologic interventions. The Phoenix VA, for example, has fitness clinics, allowing exercise classes and access to exercise equipment for those who can’t afford it. Nutrition classes, so trying to improve things like cholesterol, blood sugars, blood pressure through lifestyle interventions, rather than just, again, simply more medications. And I think a lot of patients see those benefits when they come in and the scale has come down a few pounds or their blood pressure has improved without adding more medications. I think that provides that motivation to keep them going and make those positive changes.

Dr. Brite: That’s great. And I know that you are actually, Dr. Kennelly, combating preventive health on a daily basis in your job; so can you share with us and our listeners a little bit more about the successes and challenges you’re experiencing with your patients?

Dr. Kennelly: We’ve had a lot of success implementing new interventions and delivering health care in new settings. A lot of the VA Health Care System is oriented toward primary prevention and providing services at the time the patient is there, instead of having them come back multiple times for multiple visits. So, for example, in my clinic, they have access to mental health services, same day handoffs if they



need any sort of counseling or medication adjustments on the mental health side of things. I work hand-in-hand with both psychiatry and psychology in my clinic. We have same day nutritional appointments, same day social work appointments for people who need assistance with housing or job placement. And then, the VA has been trying to remove a lot of barriers in terms of scheduling and arranging more specialty type services. Example being self-scheduled mammograms. Women no longer have to ask their doctor to get a mammogram ordered before they can have it done. They can just call up radiology directly for scheduling. They can also schedule themselves for things like eye exams, including diabetic eye exams, diabetic foot checks and, like I mentioned before, nutrition services, fitness services, job placement, housing and anything that they might need.

Dr. Lifshitz: So exciting to hear the ways in which the VA is breaking down walls in order to improve the delivery of health care, especially for patients and our veterans. What are the barriers today that are inhibiting further improvement in health care?

Dr. Kennelly: I think the biggest obstacle within the VA system — and probably within health care as a whole, not just in the VA — is staffing, in particular primary care physicians. There's a significant shortage of primary care providers relative to the number of patients that we need to serve, and I think the biggest benefit we would see is recruiting more primary care physicians, again, within both the VA, but within the American health care system as a whole.

Dr. Brite: Thank you so much for sharing. Those are really great points. I had one question. You caught my ears' attention when you mentioned your mammogram screening; and I think that maybe some of our listeners may not realize what the VA can offer as far as women's health goes for the veterans and their families. Can you expand upon that a little bit? So what preventive services and what women's health services could you expect to be able to obtain at the VA?

Dr. Kennelly: Yeah, that's one of the areas that I have a particular interest in. I'm the Women's Health medical director there, and one of the things we're trying to do at the moment is increase awareness of services for female veterans. I've heard from a lot of my female patients that they don't consider the VA for their preventive services, so the VA provides a comprehensive female health care package, so to speak. We offer basically all services, short of labor and delivery, which we do outsource to local hospitals; but the VA has an advanced breast imaging center. They provide routine women's health services, pap and pelvic exams. We even do more advanced things like genetic counseling for women who may be at higher risk for breast cancer and the standard services — osteoporosis screening, colon cancer screening. We're making a big push for providing assistance with things like intimate partner violence and other obstacles that female veterans might be facing.

Dr. Lifshitz: So exciting to hear all the different services that are provided under one roof and are hidden from so many of our patient populations that can be served better here in Phoenix. The UA College of Medicine – Phoenix is one of the handful of medical schools that requires all of our MD students to design and complete a hypothesis-driven scholarly project. This four-year project is similar to a master's degree that the students undertake while completing their medical degree. Aaron, you chose



to do a project with faculty at the VA. Can you introduce us to your project? And how has this project expanded your view of health care?

Kisana: So my project is titled, “Using Virtual Transition Tele-Health to Reduce Readmission in High-Risk Patients at the Phoenix VA.” And basically what this project does is it identifies high-risk patients that might have to be readmitted to the hospital, and then as they’re being discharged, we send them an email with a link, so that three days after their stay, they can have a virtual appointment through Skype or Facetime with their physician and see how they’re doing. And, again, the hope of this is to avoid a readmission into the hospital and so we hope to have a better health outcome for the patient. While we’re doing this, we hope to save money, as well. And so this has the potential to not only to improve health care for veterans, but for all Americans in general.

Dr. Brite: Aaron, this is so interesting. Would you share with us and our listeners how you became interested in doing a research project with the VA?

Kisana: Yes. So there’s a few reasons why I chose the VA. I’m a huge fan of it, actually, and I started volunteering there when I was 14 years old on and off. And I continued volunteering there right before starting medical school. Additionally, I have a master’s degree in health care delivery and a green belt certification in Lean Six Sigma, and, so, I think with these past experiences and my interest in quality improvement and patient safety, I was led to start a project here. Additionally, my mentor helped play a role — Dr. Hamed Abbaszadegan, who works at the VA and is the chief health innovation officer.

Dr. Lifshitz: I’m always so impressed our students that we have here at the College of Medicine – Phoenix because in the classroom, they are learning about ... they are learning about how to deliver medicine and how to practice medicine, but in addition to their rotations, their scholarly project allows them to dive into the interworkings of health care and be part of that change that improves what we’re doing. So thank you for all the work that you’re doing. We look forward to the final outcomes.

Kisana: Thank you.

Dr. Brite: Thank you so much, Dr. Kennelly and Aaron, for sharing your experiences. It’s been a pleasure having you join our conversation, and we really appreciate you taking the time to be with us.

Dr. Lifshitz: So I’ve been listening, Katie, along with our listeners to all the great knowledge that Dr. Dorsey, Dr. Singarajah, Dr. Kennelly and Aaron Kisana have imparted on us today, primarily using the Veterans Administration and their health care system to educate us about how Phoenix is challenging the norms of health care. The first thing that I took away was this concept of active listening — that we really have to disengage the mind, so that we can listen actively and then process that information.

Dr. Brite: I couldn’t agree more, and that resonated with me, as well. I was actually thinking during that segment that as we’re trained to be physicians, we want to fix people. We’re constantly thinking about what’s the next step. What’s our next treatment? How are we going to intervene? And sometimes,



especially in the context that Dr. Singarajah was referring to — when someone is maybe in end of life care — really active listening with the absence of thought and just giving the patient that time is all that there needs to be. And that was a great pearl.

Dr. Lifshitz: Yeah, without a doubt. I remember a phrase along the same lines that was “Treat people the way they want to be treated.” And how are we supposed to treat them in a specific way if we don’t first listen to them?

Dr. Brite: Absolutely.

Dr. Lifshitz: And sometimes, if we’re responding too quickly to them, we’re using language that is easy for us, but may not be easy for them.

Dr. Brite: Absolutely. I think avoiding those euphemisms and jargon like we discussed with our guests is really important, as well. And another thing that resonated with me was when both Dr. Kennelly and Dr. Singarajah mentioned just talking to them like you just alluded to, Johnny, in simple terms that they understand, but also as more of a partnership. I mean, we’re educating them on options — a little bit less paternalistic and more involvement from the patient’s perspective, as well.

Dr. Lifshitz: Without a doubt. This idea of health care being a partnership, and the way that I think about my own health care is that I’m my own best advocate. I need to be able to convey my needs to my health care provider, so that we can attack the issues that are on my mind.

Dr. Brite: Absolutely. And empowering you to do that, you know when Dr. Kennelly let us know about the idea that a woman could just schedule her mammogram without needing me to do an order, great. I mean, eliminate barriers. Let them get that done. It’s important, and I will give the patient a call with those results; and it eliminates a barrier and lets us get that important screening test done for the patient, so...

Dr. Lifshitz: Yeah.

Dr. Brite: ...couldn’t agree more.

Dr. Lifshitz: We heard from Dr. Singarajah about how they ask their patients, “What are the barriers?” They identified those barriers and worked through some of those barriers to improve the process; and that was quite remarkable to hear how the VA is constantly changing...

Dr. Brite: Yes.

Dr. Lifshitz: ...and Phoenix is constantly changing. With all the partnerships that the College of Medicine – Phoenix has, we are able to gain new insights from different methods of running hospitals...



Dr. Brite: Absolutely.

Dr. Lifshitz: ...and I can't wait to continue learning from all of our future guests.

Dr. Brite: I am so proud that Dr. Dorsey will be a Phoenician and the first physician to represent the Department of Veterans Affairs as a White House Fellow with the White House Leadership Development Program; and just seeing what has been accomplished at the VA, I can't wait for her to continue to innovate and help change the health care landscape.

Dr. Lifshitz: Without a doubt. She's one of those shining examples of lifelong learning that our students undergo through their scholarly projects, that our physicians undergo when they engage with students and everybody learning from each other about the best, most efficient processes to deliver the highest quality health care.

Dr. Brite: Absolutely. And how about Aaron Kisana also making sure that his amazing research is in line with something he has been patient about since he was 14 years old?

Dr. Lifshitz: Right.

Dr. Brite: I mean, that's a really cool example of lifelong learning, as well.

Dr. Lifshitz: And I'm sure he's going to continue that well after he graduates. Unfortunately, at this time, we have to say goodbye to our listeners because we are out of time.

Dr. Brite: Yep. Thank you all for joining us. We look forward to continuing reimagining medicine.

Dr. Lifshitz: Lifshitz out like a well-functioning GI system.

Dr. Brite: Brite out like a good night's sleep.

Narrator: The reimagine Medicine Podcast is brought to you by the University of Arizona College of Medicine – Phoenix. Join us again as we highlight aspects of clinical care, education and research in an ongoing endeavor to reimagine Medicine. Our podcast team is Dr. Katie Brite, Dr. Jonny Lifshitz, Beth Smith and the media production team at the UA College of Medicine – Phoenix. Our theme song, Dungeon of Return Days, was written and recorded by Mid Air Machine. The song is accessible on freemusicarchive.org and used under the CCBOSA 4.0 license.