STATEMENT

of

NAMI, the National Alliance on Mental Illness

for the Record

U.S. House Committee on Veterans' Affairs

"Legislative Hearing: Draft legislation to establish a permanent Veterans Choice Program & the Department of Veterans Affairs' (VA's) legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act"

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Chairman Roe, Ranking Member Walz, and distinguished members of the Committee, thank you for affording NAMI, the National Alliance on Mental Illness, the opportunity to submit a statement for the record on the Committee's draft legislation to establish a permanent Veterans Choice Program and the Department of Veterans Affairs' (VA's) legislative proposal, the Veteran Coordinated Access and Rewarding Experiences (CARE) Act.

NAMI is the nation's largest grassroots mental health organization, dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has over 900 affiliates and more than 200,000 grassroots leaders and advocates across the United States—all committed to raising awareness and building a community of hope for all of those in need, including our men and women in uniform, veterans, and military families.

Veterans Choice Pilot Program

NAMI applauds Congress, and this Committee specifically, for working swiftly and in a bi-partisan way to implement the original Veterans Choice Program legislation. Veterans were not receiving the timely access to care that America had promised, and Congress worked expeditiously to draft a policy framework with the intent of creating an unmatched system of care. However, there are many lessons learned from the initial three-year Choice pilot program, which presents opportunities for us to work together to develop improvements for a permanent solution.

While increased access should continue to be at the forefront of this discussion, NAMI remains concerned about ensuring high-quality of care standards for mental health care and substance use treatment delivered within the walls of VA and through Choice providers in the community. Additionally, the need for providers to have a satisfactory level of military cultural competency is crucial, especially when delivering mental health care services. If a clinician doesn't establish a positive rapport with a veteran from the initial interaction, or a veteran feels judged by his or her military experiences—we know this often leads to disengaging in treatment. VA must work to ensure this key need is met among all VA and contracted community clinicians.

Draft Legislation to establish a permanent Veterans Choice Program

Title I—Improved Access to Care in the Community

Sec. 101. *Establishment of Veterans Choice Program.*

NAMI agrees that giving the Secretary authority to establish regional networks of providers in Veterans Integrated Service Networks (VISNs) and enter into contractual agreements for the operation of these networks, is a positive step to increase capacity and access to care. The establishment of provider networks would also enable a built-in quality measurement tool to ensure all providers participating in the Choice Program meet a satisfactory level of care and cultural competency.

Additionally, after regional provider networks are established, it could create an opportunity for VA to implement a tiered system and develop incentives, such as the policy outlined in the draft legislation—charging the Secretary to utilize value-based reimbursement models for providers, in order to better meet the specific health care needs of veterans. NAMI suggests the insertion of legislative language in the final bill which would require providers to utilize only evidence-based therapies for treating post-traumatic stress disorder (PTSD) and other mental health conditions as a stipulation for reimbursement.

This will ensure veterans have access to the best treatments, VA is spending Choice program dollars wisely and will begin to make a concerted effort at the reduction of suicides among veterans.

While we understand the positive intent, NAMI strongly disagrees with the proposal which would restrict the Secretary in providing specialty hospital care or medical services, to include mental health care and substance use treatment, unless a referral for these specific services is made by the veteran's primary care provider. Research shows that requiring a referral from a primary care provider only acts as a barrier to care. Concerning behavioral health care specifically, we know that referral patterns illustrate a high number of drop-offs, often resulting in a lack of treatment for the veterans who need this care the most. It is imperative to meet the veteran when he or she has a need for mental health care and develop a system of care which allows veterans to seek a consultation and treatment without navigating an often-burdensome referral process.

NAMI does agree that primary care providers have an integral role in behavioral health care, however would suggest a slightly different approach. Recognizing that earlier intervention and treatment produces better mental health outcomes, coupled with the provider shortage in the behavioral health care field at VA and across America—utilizing primary care providers is necessary. Instead of involving PCPs in the referral process, NAMI suggests VA move towards broad integration of mental health care services in the primary care setting. This could be achieved by providing additional training to PCPs within the Department and in the regional provider networks by the adoption and wide dissemination of a pilot program developed by Dr. Sheila A.M. Rauch, PhD, a clinical psychologist at the Atlanta VA Medical Center (VAMC).

Dr. Rauch's program provides training for PCPs to 1) properly administer a PTSD screening tool to veterans, and 2) deliver 6 sessions of Prolonged Exposure (PE) Therapy, an evidence-based treatment for PTSD, to veterans in the primary care setting. Her data illustrates a significant drop in veterans screening positive for PTSD after receiving this treatment. In the case a veteran still screens positive for PTSD after receiving this treatment, the model had a mechanism in place for a direct referral to a mental health provider to assess and deliver more intensive sessions of Cognitive Behavioral Therapy (CBT).

<u>VA's Legislative Proposal: The Veteran Coordinated Access and Rewarding Experiences (CARE) Act</u>

Title I—Developing an Integrated High-Performance Network

Sec.101. *Improving VA's Partnerships with Community Entities and Providers to Increase Access to Care Through Veterans Care Agreements*

Although VA's proposal utilizes a different approach than the Committee's, NAMI sees benefits and disadvantages to each proposal. Authorizing the Secretary to increase access through Veterans Care Agreements—instead of creating regional provider networks—could be a way in which VA could contract to purchase reliable, high-quality care. However, NAMI believes in this case it would be too restrictive for providing increased access to care. NAMI underscores the importance of only entering into contractual agreements and reimbursing providers, community-based clinics and networks that utilize evidence-based therapies.

Title II—Streamlining Community Care Programs and Eligibility

Sec. 201-221. *Subtitles A, B, C*

NAMI agrees for the need to improve flexibility in the Choice Fund and to consolidate all existing Community Care programs and authorities into one program with a single set of eligibility criteria. One of the primary complaints NAMI receives from veterans on the current programs for accessing care outside of the walls of VA—including Choice, Community Care and Patient-Centered Community Care (PC3)—is the confusion regarding the eligibility and set of restrictions each program contains. Combining all of these programs for accessing care through community providers into one, streamlined program will make great strides in mitigating confusion and will expedite getting veterans into the care they need.

Rural Veterans

The Committee's discussion draft and VA's legislative proposal (CARE) each contain a section on giving the Secretary increased authority to negotiate a higher rate with providers, health care clinics or networks, and hospitals who serve eligible veterans residing in "highly rural areas." The definition that is used in each proposal would define the term "highly rural area" as a specific area in a county that has fewer than seven individuals per square mile in residence. NAMI believes this definition and criteria set-forth is much too specific for many reasons; the primary reason is illustrated by VA's recently released state-by-state report on the suicide rate among U.S. veterans utilizing 2014 as a sample year.[1]

Observing the top 10 rural states by population in the U.S., the suicide rate among veterans ranges between 45.7% (45 per 100,000) to 68.6% (68 per 100,000). Five of the 10 rural states reporting rates of veteran suicide over 50% (50 per 100,000). NAMI would encourage the Committee and VA to expand their definitions of rural veterans to simply "rural areas and states." In many rural areas and states, there are very few mental health professionals for hundreds of miles. Using Montana as a specific example due to the state currently having the highest rate of veteran suicides in the country, when examining the state's most recent *Suicide Mortality Review Report* illustrated that over half of Montana's veteran suicides during the reporting period, occurred in Montana's six most populous counties.[2] VA and Congress needs to ensure all rural veterans are able to receive timely access to high-quality mental health care.

Another solution to serve veterans in rural states that NAMI proposes is for VA to increase their utilization of telemedicine and telepsychiatry. Further, NAMI is supportive of H.R.2123, the *Veterans E-Health and Telemedicine Support Act of 2017* or the *VETS Act of 2017*. We believe this legislation will allow for an increase in high-quality mental health providers to deliver care to veterans in rural settings.

Addressing the unmet Suicide Prevention needs of America's Veterans

In developing a permanent Veterans Choice/CARE Program, it was NAMI's desire to see specific language outlined in each proposal regarding the suicide prevention needs of America's veterans that

[1]Suicide Among Veterans and Other Americans, 2001-2014: Suicide Data by State. *VA Office of Suicide Prevention.* https://www.mentalhealth.va.gov/docs/data-sheets/Suicide-Data-Sheets-VA-States.pdf

[2]2016 Montana Suicide Mortality Review Report. Page 49. http://www.sprc.org/sites/default/files/resource-program/2016%20Montana%20Suicide%20Mortality%20Review%20Report.pdf

are currently not being met. Recognizing that only 6 of the 20 veterans who die by suicide each day are under the care of VA,[3] it is clear that while the Department provides excellent mental health care in most cases, VA cannot go it alone.

VA and Congress must work together with non-profit and advocacy organization partners to 1) better identify the predictive indicators and characteristics of the approximately 14 veterans not engaged in VA care, 2) recognize and detect the gaps in care which currently exist and 3) give the Secretary express guidance and authority to use existing VA Choice funds to contract with community and non-profit mental health networks and clinics to provide expedited access to evidence-based mental health care services. The Secretary should be provided with guidance to expedite the credentialing process for these community-based clinics to ensure they are delivering evidence-based therapies with same-day access to care, and can demonstrate effective clinical outcomes in the veterans they serve.

Conclusion

NAMI is grateful to Secretary Shulkin, Congress and this Committee for the continued focus on improving the access and quality of mental health care and substance use treatment for America's veterans. We wish to express our gratitude to the Committee for the invitation to submit a statement for the record to provide feedback on these legislative proposals, and the opportunity to weigh-in on the future of the Veterans Choice Program—an incredibly important program to veterans with mental health care needs.

It is a devastating tragedy that our nation continues to lose an average of 20 veterans each day to suicide. This is an issue of personal importance to me, the organization I represent and our membership. We continue to commit our organization to working shoulder-to-shoulder with Congress, VA, and our Veterans Service Organization (VSO) partners to achieve our shared goal of the reduction and elimination of suicide among veterans in America.

[3] Suicide Among Veterans and Other Americans, 2001-2014. *VA Office of Suicide Prevention.* https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf