DRAFT LEGISLATION INCLUDING H.R. 100, H.R. 712, H.R. 1647, H.R. 2191

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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Tuesday, April 30, 2019

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 2253, Rayburn House Office Building, Hon. Julia Brownley [Chairman of the Subcommittee] presiding.

Present: Representatives Lamb, Brindisi, Rose, Cisneros, Peterson, Dunn, Radewagen, Barr, Meuser, and Steube.

OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN

Ms. BROWNLEY. Good morning. Thank you all for being here, and welcome to the Subcommittee on Health's first hearing of the 116th Congress.

First, I would like to thank all of you who were present at our suicide prevention hearing yesterday, last night. I appreciate everyone's commitment to tackling the issue. And today's hearing is another important step in our efforts to end the epidemic of veteran suicide. I believe we had productive dialogue on the subject yesterday and I look forward to our continued discussion today.

In the 116th Congress, the Health Subcommittee's key focus is ensuring equitable access to high quality health care for our Nation's heroes. The Veterans Health Administration is the largest integrated health care system in our country, serving over 9 million enrolled veterans annually at over 170 medical centers nationwide. It is vital that we ensure VHA is meeting the health care needs of these deserving veterans.

I am also committed to ensuring rigorous oversight of the VA's implementation of community care under the Mission Act, enacted in the 115th Congress. As VA rolls out this program, it is crucial that it is well implemented to ensure that veterans have access to the care they need, while also preserving the unparalleled services that only the VA can provide.

Chairman Takano has given our Committee an important goal with his VA 2030 vision, and it will be the duty of this Subcommittee to identify and carry out the objectives within our jurisdiction. I intend to make this Subcommittee a bipartisan and collaborative body and I encourage my colleagues on both sides of the aisle to share with me their thoughts and concerns.

That brings me to the work before us. Today, we are holding the first Health Subcommittee legislative hearing of the 116th Congress. We will consider eight pieces of legislation, including discus-

sion on three important areas: suicide prevention and mental health, cannabis, and whole health programs.

Each year, roughly 6,000 veterans commit suicide. Each and every one of these lives lost represents a heartbreaking tragedy. Many of these veterans were not enrolled in VA health care. We must ask how VA can better assist those currently enrolled and how it can better reach those not enrolled, and how can VA partner with different government agencies and community partners to expand its public health approach model for suicide prevention.

As we discussed last night, the tragedy of veteran suicide is not just a VA problem, but rather a topic that needs to be addressed through partnerships across agencies and community resources to provide the best possible services to our veterans. To that end, we will be discussing four bills today to enhance VA suicide prevention and mental health programming.

In addition to these four bills, we will discuss three proposed bills on cannabis. Thirty-three states, to include my home state of California, have now legalized medicinal cannabis. The bills being discussed today will help VA, a national leader in health research, conduct research on health care benefits of cannabis for veterans and ensure health care providers and veterans can have informed conversations about the use of cannabis, while abiding by state level cannabis programs so that veterans in these 33 states have access to the same health care treatment that their civilian counterparts have access to.

Last, but surely not least, the final bill for discussion today will be centered around VA's whole health program. In May 2018, VA designated 18 whole health flagship sites and 13 additional whole health design sites, which promote a whole veteran approach to health and centered around what the veteran finds important to his or her—

The whole health bill introduced by Vice-Chairman Lamb will ask the VA to generate a report to Congress on the implementation, utilization, and efficacy of VA's whole health program. As chair of this Health Subcommittee, I am truly proud of the work we are doing here today, and I am especially proud of the way we are doing it in a bipartisan manner.

In closing, I would like to thank our witnesses for appearing and I look forward to your testimony. With that, I would like to recognize Mr. Meuser, who is standing in for Ranking Member Dunn, who I understand will be arriving here shortly for opening remarks he may wish to make.

Mr. MEUSER. Thank you.

Ms. BROWNLEY. You are recognized.

OPENING STATEMENT OF MEUSER, RANKING MEMBER

Mr. MEUSER. Thank you, Chairwoman Brownley, very much. Yes. Ranking Member Dr. Dunn is on his way. It is a pleasure to be here with you at our vest first Subcommittee on Health hearing of the 116th Congress. I hope that we will have a productive 2 years and that our work will continue to represent the spirit of patriotism and bipartisanship that veterans embody.

On that note, we do want to note that our disappointment—we do have disappointment that the agenda for today's legislative

hearing was developed without any input from the minority. There are a number of worthy proposals from our colleagues on both sides of the aisle that Ranking Member Roe and I would like to see considered this morning.

However, our request to include them in today's hearing were, in fact, denied. One of them is Dr. Roe's bill, H.R. 1812, that would expand eligibility to Department of Veterans Affairs vet centers to members of the National Guard, Coast Guard, and Reserves. As was discussed in detail at last night's Full Committee hearing, approximately 20 servicemembers and veterans die by suicide every day. Approximately four of those suicide deaths occur among members of the National Guard or Reserve who were never deployed and are not eligible for VA care. Ensuring that those individuals are able to access readjustment counseling services could literally be lifesaving.

Given that, and that four of the eight bills we will be discussing this morning are similarly aimed at preventing suicide among our military and veteran populations, a priority we all share, it is a shame that Dr. Roe's proposal is also—is not also up for discussion today. I certainly hope that this was a one-time oversight and that we can return to a more collaborative working relationship moving forward.

That said, I am grateful to all of our witnesses for being here this morning and we look forward to receiving input on the proposals before us. With that, I yield back.

Ms. BROWNLEY. Thank you, Mr. Meuser, and I just will add that we have several Republican bills before us today, and Dr. Roe's bill or any other bills for that matter, doesn't mean that they have been rejected. We are just not hearing them today. So I appreciate your comments.

And we have two great panels joining us today. And I thank each of you for joining us in what we hope to be a fruitful discussion on these eight bills. For the first panel, we have Representative Blumenauer from Oregon; next, we have Representative Brindisi from New York; next, we have Representative Correa from California; next, we have Representative Lamb from Pennsylvania; Representative Rose is from New York; and last, but surely not least, we have Representative Steube from Florida.

With that, I now recognize Representative Blumenauer for 5 minutes.

STATEMENT OF HONORABLE EARL BLUMENAUER

Mr. BLUMENAUER. Thank you very much, Madam Chair. And it is a pleasure to be here. I wanted to focus in particularly as it relates to the issue of cannabis and our veterans. You have rightly identified truly a tragedy in terms of what has happened to our veterans in terms of suicide, pain management, a series of things.

We are convinced that there is an opportunity in the area of medical cannabis to make a difference. I am pleased that in the past, we have been able to move things along, advancing, demonstrating majority support on the—this is the first time we have had a hearing like this with a substantive Committee, the authorizing Committee, not just appropriations.

One of the great tragedies of our time is the failure to adequately address the needs of veterans returning home from Iraq and Afghanistan. We sent more than two million brave men and women to fight under very difficult circumstances, to say the very least. And while there continue to be debate about the wisdom of entering these wars, we can all agree on the need to provide the care to those veterans as they return home with wounds that are most visible and in some cases unseen.

And it is no secret that our VA facilities have struggled to absorb these returning veterans, which coincided with a national opioid epidemic. And of course, it is not just veterans. Opioids steal the lives of 115 Americans every day, more than 30,000 were killed last year.

As veterans with PTSD, chronic pain, and any number of ailments are looking for relief, lethal opioid overdoses among VA patients are almost twice the national average. We are doing something wrong. This is a time when an overwhelming number of veterans tell me that cannabis has reduced PTSD symptoms, their dependency on addictive opioids.

We have seen evidence that medical cannabis can be a less addictive way to manage pain and other symptoms currently treated with opioids. The National Academy of Science and Medicine recently confirmed the efficacy of medical cannabis for chronic pain in adults. Another study in the journal "Pain" found no evidence of serious side effects among medical cannabis users after a year of treatment. A study published in "JAMA, the Internal Medicine" found states with medical cannabis saw a 24 percent reduction in opioid overdose deaths. Currently, 47 states, the District of Columbia, and most territories have passed some laws that provide for legal access to medical cannabis in some form.

Well over one million patients across the country, including many veterans, now use cannabis on the recommendation of their physicians to treat conditions ranging from seizures, glaucoma, anxiety, chronic pain, nausea, and PTSD. Yet, the VA official policy prevents the doctors who know the veterans best from recommending medical cannabis to our veterans, even in states where it is legal.

As a result, veterans are forced outside the VA system to seek a simple recommendation for treatment for these conditions, or any eligible conditions granted to them by state law, or even consult with them about it. The Veterans Equal Access Act that I have introduced would reverse this policy and allow VA health care providers to provide recommendations and opinions regarding treatment that is legal in their—the veteran in a state where medical cannabis program is authorized.

Veterans should not be forced outside the VA system to seek a treatment that is legal in their state. VA physicians should not be denied the ability to offer recommendations they think may meet the needs of their patients. And I hope my colleagues will join me in supporting this effort.

It is no secret I have been working on this issue for a number of years. I have talked literally to thousands of people about medical cannabis, including veterans, who tell me some of the most heartwarming stories. I appreciate the Subcommittee's attention to

this. This is something that is overwhelmingly supported by the American public. Survey research suggests in the range of 90 percent. In your home state of California, you had a very visible example at the polls. In Florida, it was over 70 percent that approved it.

It is time for the Federal government and the VA to keep pace with what the American public wants and an opportunity to make the lives of our veterans better. Thank you very much.

Ms. BROWNLEY. Thank you, Mr. Blumenauer. And this is an important bill. Thank you for bringing it forward and as you said, as you hear from your veterans, I hear from mine as well. So thank you very, very much for your bill.

I don't see Mr. Brindisi, so we will move Representative Correa from California. Mr. Correa.

STATEMENT OF HONORABLE LOU CORREA

Mr. CORREA. Thank you, Madam Chair and Ranking Member Dr. Dunn. It is good to see both of you. I want to start off by thanking our veterans for your service to our country and for your sacrifice, not only of you and your families. Thank you again, Ms. Brownley and Mr. Dunn, for your invitation to appear before you today. I appreciate the opportunity to testify about this bipartisan legislation written by myself and Mr. Higgins, H.R. 712, The VA Medical Cannabis Research Act.

As you know, veterans experience physical and psychological injuries at a higher rate than their civilian counterparts as a result of their military service to our country. Unfortunately, the current treatment of prescription opioids to address PTSD and chronic pain has, at times, been ineffective. And this had dangerous results, such as addiction or even death.

In response to this crisis, Congress correctly and the VA have joined other national organizations trying to figure out how to reduce veterans' addiction of opioids. Twenty veterans a day commit suicide. We have got to find better ways of addressing the needs of our veterans.

Solution. Over the years, when I was in California sitting on the Veterans' Affairs Committee, chairing Veterans' Affairs, I used to get a stream of veterans coming to me and quietly and privately asking, "Can we use cannabis? Can the VA prescribe cannabis for us? Can we talk to our doctor at the VA about cannabis without losing our VA benefits?" And of course, the answer is, "Yes, you can talk to your cannabis—about cannabis with your doctor at the VA, but the problem is, there is nobody at the VA that can give you information about how cannabis can benefit you."

Time went on. We recently had two polls, one by the Afghanistan Veterans of America, 80 percent of those veteran's support cannabis research, support looking at the cannabis for veterans. The American Legion did another poll, 92 percent of those veteran's support research and the cannabis treatment of veterans and their invisible wounds.

Solution. This bill. This bill requires the VA to conduct double digit blind clinical test trials on the impact of different forms of cannabis and delivery methods of cannabis on specific health conditions of eligible veterans with PTSD and chronic pain.

Madam Chair, Members of this Committee, a few years ago after the veterans came to me in my district and said, "Lou, we want you to talk to us about cannabis," I started visiting different cannabis groups in my district. One of them was a cannabis shop. Legal, medical cannabis shop in my district. I went and I asked the lady at the counter, I said, "Tell me what it is that you do to talk to folks that come to you to ask for medical cannabis. How do you prescribe different cannabis strengths for them?"

She started telling me what she did, and I said, "Ma'am, what are your qualifications? What is it that got you qualified to talk to patients about cannabis?" And she said, "I have been using cannabis for 20 years." Those were her qualifications. And I say to all of you here, it is time to move on. It is time to do research. It is time to make sure that our veterans get to know what cannabis is good for and what cannabis is not good for. We need medical research.

And that is why I brought this legislation forth to simply tell our veterans what cannabis is good for. We owe our veterans a tremendous amount, the least we can do is make sure we are giving them their proper treatment for those invisible wounds that they brought back from the battlefield. Thank you very much.

[THE PREPARED STATEMENT OF LOU CORREA APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Correa, and we miss you on the Committee, but very happy that you are continuing to persevere and one of your priorities that I know has been a priority for you and so thank you for continuing on and I agree, we need to push the VA forward on this issue.

Mr. CORREA. Madam Chairperson, I miss being on this Committee. I think it is that one place in Congress that both Democrats and Republicans come together to do what is right for all veterans.

Ms. BROWNLEY. Thank you very much. I now recognize Mr. Lamb for 5 minutes.

STATEMENT OF HONORABLE CONOR LAMB

Mr. LAMB. Thank you, Madam Chairwoman. And before I get to my bill, I just want to thank Representative Blumenauer and Representative Correa for their efforts and for really leading the way on this issue. You know, we say all the time that veterans deserve the best when it comes to health care and medical treatment. And I think part of what that means is that we have to look at the VA as an institution that can lead, that can break new grounds, that can cross these frontiers. And when there is innovation and reform in health care, we need to be at the front, not behind, not entrenched in the old way of doing things. And I think these are some great efforts to try to help us move forward on an issue that can get veterans better treatment, that can attract a better workforce, that actually wants to be able to prescribe these treatments that they know work. And so I thank you for your efforts.

The whole health bill that I am introducing is really in the same vein. In a lot of areas of American health care right now, we are seeing experimentation with a wider array of traditional and nontraditional treatments. Anything from incorporating chiropractic

services, massage, acupuncture, to just whole health coaching, in diet, in nutrition, and sleep, acupuncture, meditation, yoga. I mean, tai chi. There are all of these things out there and different practices work for different people.

So the idea of this bill is that we would like the VA to look at the places where their whole health program is in effect right now. Tell us how it is doing, but more importantly, tell us what the availability in access is across the VA system for veterans and where there is no access in availability and help us figure out how we can expand it.

I had the opportunity last year to visit the whole health program at Washington, D.C., which is one of, I believe, about 18 or so places that they have the whole health program in place. And what you saw there were patients who were happy, and successful, and felt like they had some measure of control over their own health care. And that is the biggest thing.

We talk about the practices themselves, you know, the way that yoga can help someone who is dealing with chronic pain. That is good. But what struck me as even better is that we were giving veterans an array of options, and the ability to try a few different ones and see what works. And when I—I remember asking an older Vietnam veteran that was there, "Do you like this program?" "Yes, of course, I do." "Why do you like it?" And he was like, "Because I get to pick. I get to pick which classes I come to, and how often, and it doesn't cost me anything. And if I like one of the instructors, and I like the other people who come to the class, I can keep coming back." And they get to know each other.

And there is plenty of research that shows why that is a better way to do health care, when someone feels like they have control over it, it is just going to work better, but I think we all know that. It is common sense.

So that is what is behind this bill, the Whole Veteran Act introduced by myself and my colleague, Mr. Ryan, from Ohio. So I appreciate everybody's support that can get behind it, and I think we can do some great things to help veterans and push the frontier of how we are doing health care going forward. Thank you, Madam Chairwoman. I yield back.

[THE PREPARED STATEMENT OF CONOR LAMB APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Lamb, and again thank you for bringing this important bill forward. And I now recognize Mr. Rose for 5 minutes.

STATEMENT OF HONORABLE MAX ROSE

Mr. ROSE. Thank you, Madam Chairwoman, and thank you Ranking Member Dunn, and just to reiterate my friend Conor's statements, I know Representative Blumenauer left, but Rep. Correa, thank you for your leadership on this issue as well.

As a more recent vet, and someone who still serves in the Guard, we need to utilize all tools available to us to deal with folks as they are still encountering the wounds of combat and of service. So thank you again.

I, like many veterans, as I am, the issue under discussion, that of veteran suicide, is personal. Based on recent events, it is clear that this mental health crisis requires action, both on the part of Members of Congress, and certainly on the part of the VA.

The rising rate of veteran suicide is beyond a tragedy. Every veteran who struggles with mental health issues, physical scars of war, and who dies by suicide is another casualty of combat. And they are a casualty of combat, and of war, and of their service irrespective of whether they deployed to war or not. And we are noticing a truly jarring phenomenon: veterans attempting or completing suicide on VA campuses, four veterans just this month alone lost their lives to suicide within a VA facility or on VA grounds.

Something must be done about this and we need to do it now. A thorough, multi-faceted approach is required to not only assess whether the services these veterans received were adequate, but to make sure that the VA has the framework to provide the necessary data to Congress and to other appropriate entities.

That is why my legislation, I am proposing the Fostering Intergovernmental Health Transparency and Veteran Suicide Act, or Fight Veteran Suicides Act is a key first step. This bill would make sure the VA reports critical information to Congress when these events occur and requires these metrics quickly.

Having these data points would help Congress fully understand the scope of this crisis. You know, as I have said time and time again, we need all of the information necessary so we can better serve our fellow veterans in need, while ensuring the VA has the necessary tools and resources to tackle this trend properly. I would like to thank AMVets, Paralyzed Veterans of America, the Reserve Officers Association, the Military Order of the Purple Heart, as well as the Disabled American Veterans here with us today for their support of this bipartisan legislation. And I strongly urge my colleagues to support it as well. Thank you for addressing this and I yield back the balance of my time, Madam Chairwoman.

[THE PREPARED STATEMENT OF MAX ROSE APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Rose. And thank you also for bringing this bill forward. I think the suicides that we have all witnessed on VA campuses, in my mind, is a cry for help. And I think that is what last night was about. And I think your bill, in terms of reporting, is extraordinarily important. So thank you for bringing it forward.

And I will say thank you to the first panel, and we will have a little transition period here where we set up the second panel. And when that happens, I will introduce the second panel. Thank you very much.

Ms. BROWNLEY. I now recognize the second panel. And we have Dr. Keita Franklin, national director of suicide prevention from the Department of Veteran Affairs. Dr. Franklin is accompanied by Dr. Tracy Gaudet, director of patient centered care and Dr. Larry Mole, chief consultant population health. Next, we have Joy Ilem, national legislative director of Disabled American Veterans. And also here is Carlos Fuentes, national legislative director at Veterans of Foreign Wars. Last but not least, we have Jeremy Butler, chief ex-

ecutive officer at Iraq and Afghanistan Veterans of America. Wrong person. I am sorry. We have Stephanie Mullen. I apologize. It is a good reason to look up, as opposed to—we have Stephanie Mullen, chief—from the Iraq and Afghanistan Veterans of America.

With that, I now recognize Dr. Keita Franklin for 5 minutes. Dr. Franklin.

STATEMENT OF DR. KEITA FRANKLIN

Ms. FRANKLIN. Good morning, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. Thank you for inviting us here today to discuss a number of important bills about mental health and suicide prevention, as well as VA policy on veteran participation in state approved marijuana programs, and cannabis research, and whole health.

Madam Chair, before turning to the specific bills, I want to emphasize that suicide prevention is a top priority in the Department. I think you heard that last night. Suicide is complex. It is a serious national public health issue that affects people from all walks of life, not just veterans, and for a variety of reasons. And while there is much to learn, we know that it is preventable. We know that treatment works, and that there is hope. And I want to thank you for your leadership on this issue.

Although VA is creating the path forward, we know that one agency alone cannot solve the issue. Preventing suicide requires bundled approaches, working across multiple sectors. And our work is guided by the national strategy for preventing veteran suicide. This strategy published in 2018 expands beyond crisis intervention and provides a framework for identifying the priorities, organizing efforts, and focusing resources through a broad public health approach, with an emphasis on comprehensive community level engagement. It is a plan for what we can all do to work together to prevent veteran suicide across the entire Nation, not just within the four walls of the VA.

Legislatures play an important role in this integrated approach, not only because of the importance of policy interventions, but also in your ability to reach out across the Nation. For example, as you may know, this month we started working with you and other Members of Congress to spread awareness about this important topic through a PSA drive on Capitol Hill. Again, we want to thank all of you that have already developed your PSAs, and for your continued support and concern for this important issue of veteran suicide.

So just turning right to the bills that are presented today. These are complex issues. They call for multi-layered solutions that require a rigorous level of review and analysis. And we provided some of our views in our written statements and we are prepared to continue that conversation today. And I will jump right in with the Veteran Overmedication and Suicide Prevention Act of 2019.

This bill calls for the VA to partner with the national academies and to conduct in-depth, post mortem data analysis. Data and surveillance are at the core of our comprehensive public health approach and they inform our suicide prevention efforts and our partnerships with agencies like the National Academy are an essential piece to what we do.

We appreciate Congress' interest in advancing those partnerships and in furthering how suicide data is collected, analyzed, and reported. VA was one of the first institutions to implement a comprehensive suicide surveillance and has continuously improved data and surveillance related to veteran suicide.

Part of this bill reflects a specific requirement to further that analysis that we already do. Other pieces in the bill involve outside organizations and authorities that we don't directly own. And therefore, it will make full compliance with a proposed bill in its existing form very difficult to implement. Yet we know there is room to improve, and this is why we are eager to work with the national academies and to further study this issue. And I do stand ready to work through any and all details and barriers with this Committee.

Moving to the next piece of legislation related to the draft suicide notification bill, this would require VA to submit notification of veteran suicide deaths or suicide attempts that occur on VA facilities to Congress within 7 days of the event. The VA supports this legislation. There are few details that need to be worked out in terms of technical issues, ensuring that we preserve surviving family members' privacy and dignity with regard to deaths that occur. But regardless, we are pleased to work with the Subcommittee on this initiative.

The two remaining suicide related bills call for GAO review of suicide prevention, MOAs, and our memorandums of agreement and understanding, and a review of the role of our suicide prevention coordinators. VA would defer to the GAO on these bills. We defer to the GAO on these proposed bills. I would let the Committee know that we are already in the midst of an in-depth analysis on both of these issues and I am happy to turn over and share any of that information with this Committee.

Third, I am moving from the suicide prevention bills to the piece on cannabis. The VA Medical Cannabis Research Act of 2019 would require VA to conduct a clinical trial to examine a multitude of health outcomes among veterans with varying medical diagnoses and would involve multiple strains of cannabis compositions and routes of administration.

Typically, a smaller early phase trial designs would be used to advance our knowledge of benefits and risks regarding cannabis, before moving to a type of more expansive approach, as described in this proposed legislation. VA is currently supporting a clinical trial of cannabis for the treatment of post-traumatic stress disorder. Any trial with human subjects must include an evaluation of the risks and the safety and include the smallest number of participants to avoid putting subjects at increased risk unnecessarily. So and for these reasons, we don't support this proposed legislation. I do have Dr. Larry Mole here to talk to you more about that during the remaining of the hearing.

And then moving to the Veteran Equal Access Act and the Veteran Cannabis Use for Safe Healing Act. This would authorize physicians and other health care providers in VA to provide recommendations, opinions, and for H.R. 1647, the completion of forms regarding participation in state marijuana programs.

VHA's current policy prohibits VA providers from recommending and making referrals to or completing paperwork for veteran participation in state marijuana programs. This prohibition is the result of the Drug Enforcement Agency, guidance that is pushed out from that agency, which advised VA that no provision of controlled—of the Controlled Substance Act would be exempt from criminal sanctions as a VA physician who acts with intent to provide a patient with means to obtain marijuana.

In addition, this proposal would authorize VA providers to discuss marijuana use with their patients, record that use in the patient's medical record, and prevent VA from denying a veteran any benefit for participating in a state approved marijuana program. Please know that our existing policy in VHA already permits discussion and documentation, and clearly states that veterans will not be denied benefits by discussing this information with a VHA provider. Thus, VA does not support this bill.

The draft VA Whole Health Bill would require VA to submit to Congress a report on the implementation of VA's February 1st, 2019 memorandum on the subject of advancing whole health transformation across VHA. Specifically, this report would include an analysis of the deployment of whole health services at 36 facilities. VA supports this draft bill, but notes that Congress may wish to consider extending the draft bill's requirement to a VHA-wide enterprise update. In addition, a thorough research report on veteran outcomes, cost, utilization, workforce engagement, burnout, and implementation will be provided to Congress on the 18 facilities currently deploying all aspects of whole health in March 2021 as required by the CARA legislation.

Madam Chairwoman, in conclusion, I cannot emphasize enough the commitment of the secretary and all of the VA to use every effort to prevent veteran suicide and continue to equip and empower all veterans with the resources and care that they need to thrive. We appreciate the Committee's attention to this issue. We pledge to work hand in hand with the Congress on innovative and evidence-based approaches to this problem.

This concludes my statement and I am happy to answer any questions. Myself, my colleagues are here to answer any questions that any Member of the Committee may have.

[THE PREPARED STATEMENT OF KEITA FRANKLIN APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Dr. Franklin. And I now recognize Joy Ilem for 5 minutes.

STATEMENT OF JOY ILEM

Ms. ILEM. Chairman Brownley, thank you for inviting—and Members of the Subcommittee, thank you for inviting DAV to testify at this legislative hearing.

We are pleased to offer our views today on the bills under consideration by the Subcommittee. In accordance with DAV resolution number 023, we are pleased to support H.R. 712, the VA Medicinal Cannabis Research Act of 2019. This bill would direct the VA to perform clinical research to determine whether cannabis is able to reduce symptoms associated with chronic pain, and how it may af-

fect alcohol use or dosage of certain medications for veterans with PTSD.

We concur that research is necessary to help clinicians better understand the safety and efficacy of cannabis use for specific conditions that often co-occur in the veteran population, such as chronic pain and post-traumatic stress.

DAV also supports the draft measure being considered that requires GAO to conduct an assessment of the role of VA suicide prevention coordinators and their responsibilities within the VA health care system. The study would assess associated workload, vacancy rates, adequacy and appropriateness of training, and oversight of these positions and how these factors may vary across the system.

VHA guidance for delivery of mental health services allows for local variation and programs and thus, training and oversight of the suicide prevention coordinator position could differ somewhat from site to site. Because of these ambiguities and the importance of the coordinator's responsibilities, DAV agrees this study could yield important information and thus we support the draft bill.

The draft measure focused on advanced—VA's whole health transformation model would require the VA to report on access and availability on each of several complimentary and integrative medicine practices. In accordance with DAV resolution 277, we support veterans' access to a full continuum of care, including alternative and complimentary care, such as yoga, massage, acupuncture, chiropractic care, and other non-traditional therapies.

DAV is aware that some facilities may not offer a full complement of these types of services or may have to limit the number of visits for massage therapy or other popular integrative treatments. The report would help to determine to what extent these services are available across the system for veterans that prefer them over more traditional types of care.

To provide a more complete picture, DAV recommends and suggests that the study also include complementary and alternative services the VA provides to its veteran's community care program.

We need to ensure these—DAV supports the draft bill that would require GAO to report on the effectiveness of VA memorandum of agreement and memorandum of understanding with non-VA providers to carry out suicide prevention activities and mental health case management services.

We need to ensure these agreements hold community partners accountable for delivering evidence based high quality mental health services to veterans who need them. Therefore, community partners or network providers, should be held to the same competency, training, and quality standards that VA mental health providers are required to meet.

The draft bill would provide needed oversight of agreements with non-department entities, providing mental health services to veterans to determine regional variances and the extent to which VA tracks health outcomes of such entities.

H.R. 100, the Veterans Overmedication and Suicide Prevention Act of 2019 calls for a study aimed at identifying suicides among veterans that may be attributed to overmedicating patients or inappropriate prescribing patterns in the VA. DAV supports the intent

of the bill and certainly agrees that research and proper oversight of VA clinical practices are necessary. But it is difficult to assess if appropriate treatment protocols were followed without looking at individual case studies, especially in cases of medically complex patients with co-occurring physical and mental health conditions.

For these reasons, we are urge the Subcommittee to consider working with VA subject matter experts to revise certain provisions in the bill related to data collection so that it can better advance the important goals of improving patient safety, improve poly-pharmacy management, and reducing suicides among veteran patients.

Finally, DAV has no objection to favorable consideration of the draft measure requiring VA to notify Congress about any suicide or attempted suicide of a veteran that occurs on the grounds or in a VA facility.

Madam Chairwoman, this concludes my testimony. I would be pleased to respond to any questions from you or other Members of the Committee. Thank you.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Ilem. And I now recognize Mr. Fuentes for 5 minutes.

STATEMENT OF CARLOS FUENTES

Mr. FUENTES. Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, thank you for allowing the VFW to represent our views on legislation pending before the Committee. The VFW is proud to support the VA Medicinal Cannabis Research Act 2019. The VA's reliance on opioids to treat chronic pain and other conditions has unfortunately led to addiction, and even death, such as Jason Simcakoski, who died from an overdose of medications he was prescribed by his doctors at the Tomah VA Medical Center.

The VFW is proud to have stood next to Jason's family, and many Members of the Subcommittee, to champion the Jason Simcakoski Memorial and Promise Act, which required VA reduce the use of high dose opioids. To its credit, the VA has made concerted efforts to ensure it properly uses pharmaceutical treatments under the opioid safety initiative. VA has reduced the number of patients to whom it prescribes opioids by more than 22 percent. Now, VA must expand research on the efficacy of non-traditional alternatives to opioids, such as medicinal cannabis and other holistic approaches.

VFW members tells us medicinal cannabis works and it is a more suitable option than the drug cocktails VA prescribes. VA must research how medicinal cannabis can help veterans cope with PTSD and other conditions, such as chronic pain. The VFW and Student Veterans of America fellow, Christopher Lamy, an Army veteran and LSU law school student, focused his semester long research project and advocacy efforts on the VA Medicinal Cannabis Research Act of 2019.

Chris' research discovered that veterans experienced chronic pain at 40 percent higher rates than non-veterans and if not properly treated, such chronic pain often leads to depression, anxiety, and

decreased quality of life. Chris also found that veterans who discuss use of medicinal cannabis with their doctors are often—often have their medications changed or discontinued. The fear of reprisal for medicinal cannabis use prevents veterans from discussing and disclosing information to their VA health care providers, which can also lead to drug interaction issues.

This legislation would prohibit VA from denying benefits based on participation in the study. To ensure participants of the study do not have their VA health care impacted, the VFW recommends prohibiting VA doctors from denying or altering treatment for participants without consultation or concurrence with such veterans.

The VFW agrees with the intent of the Veterans Equal Access Act, but cannot offer it support at this time. The VFW agrees that veterans who rely on the VA health care system must have access to medicinal cannabis if such therapies are proven to assist—proven to be effective in assisting and treating certain health conditions. Without such evidence, the VA would not have the ability to prescribe or provide medicinal cannabis to veterans.

It is unacceptable for VA providers to recommend a treatment that is unavailable to veterans at their VA medical facilities, which forces those patients to pay the full cost of such care or rely on other means for those treatments. The VFW strongly supports the provisions of the Veterans Cannabis Use for Safe Healing Act that protect veterans from having their earned benefits eroded or denied simply because they participate in a state approved marijuana program.

Veterans who participate in such programs must not fear that VA will take away benefits they have earned and deserve. However, we cannot support VA providers recommending participation in state approved marijuana programs if VA is unable to provide such recommended course of treatment. The VFW supports the Veteran Overmedication and Suicide Prevention Act of 2019 and they support for Suicide Prevention Coordinators Act.

These two bills would make strides to reduce veteran suicide. Suicide is a serious issue. We must do whatever it takes to save the 20 veterans who take their own lives every day. Madam Chairwoman, this concludes my statement. I am happy to answer any questions you or the Members of the Committee may have.

[THE PREPARED STATEMENT OF CARLOS FUENTES PPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Fuentes. And I now recognize Stephanie Mullen, who is the research director for the Iraq and Afghanistan Veterans of America. Thank you for being here.

STATEMENT OF STEPHANIE MULLEN

Ms. MULLEN. Thank you. Thank you, Chairwoman Brownley, Ranking Member Dunn, and distinguished Members of the Subcommittee. On behalf of IAVA, and our more than 425,000 members worldwide, I would like to thank you for the opportunity to testify here today.

As research director for IAVA, I use the collective experiences and views of IAVA members to support our policy and pro-

grammatic work, giving numbers to the narratives of IAVA members every day.

This work is personal for me. I come from a military family, with a mother that served 20 years for this country while raising a family. Many of the issues IAVA tirelessly advocates for directly impacts the people I love most, and it drives my work to ensure that all veterans are receiving the best care and treatment possible.

Support for veteran medicinal cannabis use is an important part of our work. And it is why it is one of IAVA's big six priorities for 2019. For years, IAVA members have been supportive of medical cannabis. In our latest member survey, 83 percent agree that cannabis should be legal for medical purposes, and a resounding 90 percent believe cannabis should be researched for medicinal uses.

IAVA members are calling for cannabis research and it is past time for the Department of Veterans Affairs to catch up. This is why IAVA is proud to support the VA Medicinal Cannabis Research Act, which will advance research and understanding around the safety and effectiveness of cannabis to treat the signature injuries of war.

However, research takes time. Years, in fact. And veterans are suffering from their injuries today. With over 30 states legalizing medical cannabis, if veterans are unable to go through VA to get medical cannabis, they will go around it. The veterans shouldn't feel that they have to hide and circumvent VA to access a standard of care their civilian counterparts can access easily.

We know this is already occurring from IAVA members nationwide. In just the last month, over 100 IAVA members have shared stories of their cannabis use, with dozens sharing how VA retaliated against them or mishandled their information. And dozens more sharing that they flat out refuse to tell VA about their cannabis use.

While current VA policy allows for clinicians to talk to their veteran patients about cannabis, VA clinicians are unable to recommend cannabis to their patients, fill out state cannabis medical forms, or recommend the best programs and options for their patients. These limitations have negative impacts on the overall care of veterans at VA. For these reasons, IAVA is proud to support the Veterans Equal Access Act, the Veterans Cannabis Use for Safe Healing Act, and the Whole Veterans Act.

Though cannabis reform is an important pillar in our advocacy efforts, the top priority for IAVA and among our membership is suicide prevention among troops and veterans. In 2016, the latest numbers available, an average of 20 servicemembers and veterans died by suicide each day, accounting for over 7,000 deaths each year. Each one of these deaths impacts an entire community, a family, a friend group, a military unit, and the lives of each and every person that veteran or servicemember touched.

IAVA members know this well. Fifty-nine percent of our membership knows a post 9/11 veteran that has died by suicide. That is a rise of almost 20 percent since just 2014. IAVA thanks the Subcommittee for highlighting this public health crisis and we are pleased to support the Veteran Overmedication and Suicide Prevention Act, the Veterans' Care Quality Transparency Act, and the Support for Suicide Prevention Coordinators Act.

Increasing our understanding of veteran suicide, the risk and protective factors surrounding it, and the effectiveness of suicide prevention programs at VA are all essential to tackling this issue.

While we recognize and appreciate the intent regarding veteran suicides on VA property behind the FIGHT Veteran Suicide Act, IAVA has some concerns regarding this legislation.

When a veteran dies by suicide on VA property, to include the tragic veteran suicide just yesterday at the VA in Cleveland, it indicates that the foundation of trust between the public and VA has be catastrophically undercut. These tragic events should be a call to action to ensure that all VA policies and procedures surrounding VA emergency mental health care, facility security, and personnel training are up to date, acceptable, and being implemented correctly. A failure in the system should and must be addressed.

IAVA recommends that the proposed legislation focused on these procedures and policies at VA facilities that may be able to intervene in a moment of crisis, rather than the individual factors surrounding the tragic event itself.

Members of the Subcommittee, thank you again for the opportunity to share IAVA's views on the issues today. I look forward to answering any questions you may have and working with you in the future.

[THE PREPARED STATEMENT OF STEPHANIE MULLEN APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Mullen, for your testimony and thank all of the witnesses as well for your testimony today. And so we will now begin the question portion of the hearing. And I will recognize myself for 5 minutes.

I think the first issue I really wanted to address is the cannabis issue. We have got a couple of bills before us, which I think are good bills, and the VA doesn't support those bills. We have the VSOs all speaking in favor of these bills. This is—you know, this seems to be an issue that has been going on now for a while, this schism between what the VA believes and what the VSOs want. And this is a big frustration for me because I think it is overwhelmingly clear amongst the American people, and amongst our veterans across the country, that this is an issue that they are keenly interested in and want to have access to.

And so I guess my question is, you know, how are we going to reconcile this? You give particular reasons for why you don't support this legislation. You know, I can't speak whether these issues are valid or not, but if they are, how are you working with the VSOs to kind of work through, not I mean these two bills, but there are going to be more because of the interest of our veterans and the interest of the American people.

So Dr. Franklin, if you could just respond to that.

Ms. FRANKLIN. Sure. I would actually ask Dr. Larry Mole, our lead in this area, to respond.

Mr. MOLE. Good morning, and thanks for the opportunity to speak today.

I think for VA, the—and we have seen legislation come in over the last few years and our kind of rate limiting step is the authority related to being able to recommend or prescribe is related to the

Controlled Substance Act. And as long as cannabis or marijuana remains a schedule 1 drug, then we are going to look to the DEA and the Department of Justice to give us their opinion on what our prescribers are able to do.

And that is kind of, I think, a short summary of where that process is at. And so I think this Committee can make strong proposals to us to move forward with recommendations, filling out forms and such, but at the end, we will need to go back to DEA and Department of Justice for their opinion. And I have not seen anything myself that suggests their opinion will change.

Ms. BROWNLEY. And so what role does the VA play in terms of working with DOJ and DEA? I mean, what kinds of meetings are you having? What kind of conversations are you having to try to push the envelope in support of our veterans?

Mr. MOLE. I would say there are very few meetings that occur, and it is because the—and I am not an attorney, so I can't speak from an attorney's opinion—

Ms. BROWNLEY. Understood.

Mr. MOLE [continued]. —but I think they are waiting to see that something changes from a regulation perspective that then they would respond to. And that is, I think, the best way I can summarize it. I mean, we can go to DEA, and Department of Justice, but they are going to continue to point to the Controlled Substance Act until there is a change in that act.

Ms. BROWNLEY. And so you can't even do the research on efficacy because of this?

Mr. MOLE. Research is a whole different question. I mean, and we can get to that. But in terms of the recommending, prescribing, that is where the Controlled Substance Act is the authority of what we do.

Ms. BROWNLEY. Okay, thank you. I would like to hear from the other witnesses in terms of the—your perspective on these issues.

Mr. FUENTES. Ma'am, thank you very much for bringing these issues and consider them by the Committee. They are very important and have the support of the overwhelming majority of the veterans' community.

I would have to say that I agree—the VFW agrees with the VA in terms of prescribing something VA can't provide through its pharmacies, but VA should conduct research on medical cannabis. The claim and previous testimony has also said that they have the authority but still haven't done it. CBD is not medical cannabis, and I encourage VA—the VFW encourages VA to continue CBD research and do more of it, but it is not exactly what we are looking for here with this legislation.

Ms. BROWNLEY. Thank you. Any other comments? Ms. Mullen?

Ms. ILEM. I would say, as well, research is the key. Everyone wants to make sure that these—this medicinal cannabis would be beneficial to veterans. We want to make sure that there is no harm done. So the research is the first step to doing that. And that is essential. But I think even more importantly, as Stephanie, and we have mentioned, is that veterans are using this as a medication to try to stem their symptoms, whether that be from chronic pain, PTSD symptoms, and others.

So we know that they are doing that, and we have heard some of repercussions for that happening. And we want to make sure veterans are safe and have access to all treatments that may be beneficial to them. So this is a critical piece to move forward and I hope VA will be able to address on the research side. I know they mentioned some of that in their testimony about how things like that are conducted. So that type of research.

Ms. BROWNLEY. Ms. Mullen?

Ms. MULLEN. I think that you described the attention between Federal and state policy well and that tends to be the biggest factor when we are talking about VA and recommending cannabis, and allowing it in pharmacies. I do think it is within the purview of this Committee within Congress to close some of those loopholes and ensure that VA clinicians, while maybe not able to recommend it directly, can at least advise what—where to go for it. What state medical places they should be looking at, because right now, it is going completely under the radar.

And again, with the VA policy that is currently in place, right now, veterans are supposed to be able to talk to their providers about their cannabis use and it shouldn't be used against them. I think in practice, that doesn't always occur. And so having some sort of legislation that would actually protect veterans would be very helpful.

Ms. BROWNLEY. Dr. Dunn.

Mr. DUNN. Thank you, Madam Chair. So I think the H.R. 712 has engendered a lot of interest here. I would like to address it. Mr. Mole, you went right to the heart of the problem. I think that the physicians feel, and that is so there is a Federal law that makes it illegal, and there are multiple state laws that make cannabis legal to prescribe and discuss. And yet the physicians and all the clinicians can be prosecuted under either state or Federal law. So there is—we are not, I think, in a position here to actually protect the VA physicians who want to disburse or prescribe cannabis unless we change that law.

So we might be looking at the wrong leverage point when we address these laws without addressing the schedule of the drug and the actual punitive actions on it. I could not agree with you more that we ought to be research on this. I think we ought to change the schedule to schedule 2. It seems like every Committee I go in, we have another discussion about cannabis.

I was in banking not too long ago. Can we bank people who sell cannabis? No, we can't. Yes, we can. It depends on if it is Federal or state law, right? And so the poor person who gets involved in actually helping patients with this substance, potentially helping them, you know, can go to jail in any one of a number of venues.

So thank you for bringing out that what we need to do is move it from schedule 1 to a schedule 2. And that is the major objection, right, on the VA's part of that? But let's take a look at 712, the research very quickly here. You have expressed reservations on the design of the study, as well as the fact that it is not a schedule 2 drug. Would you help us redesign this bill in such a way that the protocol would suit the VA? Dr. Franklin?

Ms. FRANKLIN. Absolutely. I am sure we would. Yes, sir.

Mr. DUNN. Okay. So you could see a way forward doing cannabis research, on tetrahydrocannabinol, as well as cannabidiols, and all those things, as long as we made it legal for your researchers to do that?

Mr. MOLE. Yeah. I would just add that it is legal for our researchers to research cannabis, cannabidiols, marijuana, whichever label we want to use and whatever product it is. And so they are able to do that. That is a folklore that has kind of been around, unfortunately.

Mr. DUNN. But it is difficult?

Mr. MOLE. There are some extra—

Mr. DUNN. It is very controlled drug.

Mr. MOLE. There are some extra steps you have to do. But as Dr. Franklin said, we have one investigator who is funded by VA right now, down in San Diego.

Mr. DUNN. One.

Mr. MOLE. So far.

Mr. DUNN. Busy investigator.

Mr. MOLE. Well, I can tell you, she has a lot of great ideas. But if you look also at some of the state programs, so Colorado and California, they have supported a number of clinical trials. And in fact, Colorado has a clinical trial looking specifically at PTSD and they are funding a VA to do that work.

So I believe this is beginning to expand in the direction it needs to go so we get more knowledge, we get some more experience to do the more comprehensive study that you have proposed.

Mr. DUNN. Thank you. Also Dr. Franklin, you expressed concern about the reporting time. I am now on H.R. 100. Are there timelines that do make sense to you for the reporting on the—this is the Veteran Over-medication Suicide Prevention Act, 100.

Ms. FRANKLIN. I don't think timeline is the issue. The issue, and we spoke about this last night with regard to this proposal, definitely in spirit, and intent, there is a need to do this type of data and surveillance. The issue is when you look at 20 veterans a day and their life by suicide and 14 not touching the VHA health care system. The way the proposal is laid out, it would call for VA to capture medication, issue, and the like from potential deaths that happened outside of our system, not only from veterans that might be accessing care through our choice program, but veterans access care through other entities as well. So if it—

Mr. DUNN. You are saying difficult, then, to get the data. Is that what I understand you—

Ms. FRANKLIN. For those veterans that don't receive health care in our health care system.

Mr. DUNN. Right.

Ms. FRANKLIN. If it were strictly VHA health care system proposal, provide thus and such as written in the proposal with those that get health care through our organization, it would be a thumbs up.

Mr. DUNN. Okay, good. That is exactly what I wanted to underscore. With the 30 seconds left, Ms. Ilem, you said that DAV could support certain sections of H.R. 100, it is the same bill the suicide is reporting. Is there—what part of it do you oppose? What part do you favor?

Ms. ILEM. I think what Dr. Franklin has mentioned, we were concerned about the types of data collection and then how—you know, it might be misleading in terms of how that is interpreted. But you know, certainly, looking at VA data and what they have available, we want to see oversight, obviously, of black box medications and prescribing practices. So I think just making sure that VA's experts in this have looked at it and feel that it is going to benefit.

Mr. DUNN. Thank you, very much. And I want to say, Madam Chair, that it comes up again and again, and across all of the Committees. We need to get this drug into a schedule 2 status. It makes everything so much easier to do. Thank you. I yield back.

Ms. BROWNLEY. Excuse me. Mr. Lamb, 5 minutes.

Mr. LAMB. Thank you, Madam Chairwoman. Dr. Franklin, we talked a little bit about whole health at last night's hearing and you heard some of my comments about it today. And I appreciate your suggestion on maybe even widening the scope of our bill now or in the future. Could you go into a little bit more detail about that, about the planned expansion from 18 to 36, and then also what you think we could learn from the wider VHA experience, you know, if we looked beyond those 36 sites? And as relevant to suicide prevention, of course, but just really in any manner that is effective for veterans.

Ms. FRANKLIN. Absolutely. I am pleased that we have Dr. Gaudet here to talk about it. But I am also, too, happy to engage as well.

Mr. LAMB. Either of you, fine. Yeah. Thank you.

Ms. FRANKLIN. I will ask her to take the lead.

Dr. GAUDET. Yeah, thank you. It is an important question. And the reason we were hoping to actually expand that report is that we do have an intention to do a national deployment of whole health. And I am sure you are aware, but other members may not be, that whole health includes complimentary integrative approaches, but is actually way broader than that. It is really redesigning how health care works to start with what matters to the veteran, to help them explore a sense of meaning and purpose in their life. And that is primarily done through trained peers.

So while we have the 18 flagship sites that are fully funded to implement the entire whole health system 140 health care systems are doing aspects of whole health. So we would love the opportunity to report back to you on the national deployment and where those strategies are, along with the next 36 sites.

Mr. LAMB. Great. Thank you very much. Can you talk a little bit more about—they told me about this when I visited the D.C. site, but I presume that the expansion that has happened beyond those 18 sites, does it have to do with the trainings that VA has made available for peer and other health coaches to then go back? I mean, that was kind of the way they explained it to me—

Dr. GAUDET. Right.

Mr. LAMB. —that there was a voluntary program where you could come and learn some of the practices, even if your site didn't—

Dr. GAUDET. Right. So there are three core elements in this redesign of health care. Of course, clinical care is critical and that is in place. The two newer elements are peer piece, which is designed

around empowering. And I honestly believe, and as it relates to suicide prevention, that this is the most powerful piece of this entire approach. Trained peers to work with other peers around regaining a sense of meaning and purpose in their life. Then from that point, and there are peers trained at every facility now. So that is offered whether they are a flagship site or what other aspects you are doing.

In addition to that, the real goal of the peer piece is empowerment and engagement in your life. But now veterans need support in new ways to approach their life. So the well-being programs, which you described in D.C., places where veterans can drop in, have experiences in yoga, or mindfulness, or nutrition, or battlefield acupuncture, a whole myriad of self-care strategies that empowers them is the second element.

So different facilities are doing different elements. The 18 are doing all of those three components and every facility has trained peers.

Mr. LAMB. That is great. Thank you. Has VA already decided what the new sites are going to be from the 18 to 36? Has that been—

Dr. GAUDET. Yeah, we have—so each network has proposed two sites, thus 36, and those haven't been announced yet, but we have those 36 and that collaborative will start this summer.

Mr. LAMB. Okay. Excellent. Thank you. I will be hoping beyond hope that one of Pittsburgh sites might be included, but if not, we will certainly work hard to get our share of the—

Dr. GAUDET. Absolutely.

Mr. LAMB [continued]. —program underway. Maybe I could become a peer something. You know what I mean.

Dr. GAUDET. That would be fabulous.

Mr. LAMB. Yeah. They tried to put one of the acupuncture ear things on me when I was there at D.C. It didn't quite work out, I don't think, but—

Dr. GAUDET. We can arrange for that.

Mr. LAMB. Yeah. I applaud your thinking and your expansion efforts on this. You guys are ahead of the game, I think, and I do think it is a big part of the future of health care more generally, not just for veterans.

And I guess one last thought, if you have anything, Dr. Franklin, on it is I also see a program like this as a way to appeal to veterans who are not really using the VA system right now because it just—I think it just matches a little bit more about what younger people in particular think health care should be like.

Do you think it is a way that we can find to reach these 13 veterans of the 20 everyday who are not coming to the VA for services?

Ms. FRANKLIN. Yes, absolutely. I have been in close collaboration with Dr. Gaudet on this very issue, particularly within the first 12 months of time when they leave active duty service. We have a project together where we are working on trying to help transitioning servicemembers, right when they leave the DoD roll right into the whole health program and start their VA experience that way.

Mr. LAMB. Thank you very much for your efforts. Madam Chairwoman, I yield back.

Ms. BROWNLEY. Thank you, Mr. Lamb. And Ms. Radewagen, you have 5 minutes.

Ms. RADEWAGEN. Thank you, Madam Chairwoman. I want to thank the panel for appearing today. My question is for Dr. Franklin.

Ms. FRANKLIN. Yes, ma'am.

Ms. RADEWAGEN. In your testimony, you referenced the development of a new suicide prevention coordinator program guidebook and a suicide prevention program directive. When will these be approved and released to the field?

Ms. FRANKLIN. I don't have the exact dates with me, but I can definitely get those back to the Committee in very short order.

Ms. RADEWAGEN. So in your opinion, is the suicide prevention program and the coordinators who are responsible for its execution, are they consistently trained and monitored throughout the VA system?

Ms. FRANKLIN. Yes, they are consistently trained and monitored. They are trained through a number of different portals and avenues that I can run through with you if you are interested. And then there are a number of oversight processes and protocols in place at the VISN level and at the VACO level through a number of bodies.

Ms. RADEWAGEN. Thank you.

Ms. FRANKLIN. I am happy to get into more details with you. I am also cognizant of the fact that you might have more questions. So—

Ms. RADEWAGEN. Yes.

Ms. FRANKLIN. Okay.

Ms. RADEWAGEN. So Dr. Franklin, I think a study such as the one outlined in H.R. 2372 could be useful in helping to define the prior scope of VA cooperation with non-profit and community entities in its suicide prevention work. Do you have an estimate as to how many such agreements currently exist and give us an example of one or two and how they are working?

Ms. FRANKLIN. Sure. Absolutely. So within my program in suicide prevention, we have a total right now of 68 partners and this is just my little program. This does not—little I shouldn't say, but this does not count for the choice program and all the partners in other entities across the VA. But we have 68. Of those, 34 are signed MOAs or MOUs. And others are just informal, and they agreed to partner with us, and we do good work together, but we have not solidified it on pen and paper.

And I will give you an example of one with Walgreens. So we have an MOA with Walgreens recognizing—reference the 14 veterans that there may be some veterans that might pick up their prescription at Walgreens. And they might touch a Walgreens facility. So this MOA has—calls for us to train Walgreens pharmacist on veteran culture, cultural competence, what it means to where the uniform, and how to ask the question, "Have you served?" And "Have you worn the"—"What is that like?" And to really join with our veterans. And then it teaches them also about suicide prevention risk.

So I actually train all of the pharmacists in Walgreens on suicide prevention, myself. I get on a webinar, and I train them, and I go through a series of Q and A with them to bring them up to speed on everything from our veteran crisis line, our campaign around be there, #be there for veterans, around how to ask the question, "Are you thinking of ending your life?" "How many prescriptions are you on?"

And then Walgreens also takes our veteran crisis number and pushes it out to all of their employees at the pharmacy. They give it also to veterans and veterans' family members. And those are just a few examples. But all of that is written into stone on the official MOA and we stay true to it. It is not a legally binding document, but it does go through legal review, and we track the metrics according to it.

So for example, how many pharmacists have we trained? How much engagement have we had with Walgreens? So that is one. We also have an agreement with a non-profit called the Independence Fund, which is a VSO that works with us on reunions. And this is a brand new one, so I will give you sort of the other side of the coin because Walgreens is sort of well established.

The Independent Fund, recognizing the role of social support in preventing veteran suicide and peer support has partnered with the VA to reconstitute military units of veterans to bring them back together for a reunion. And we partner with them. The VA's role in that is to provide the education, the psycho-educational content, classroom instruction, and design the evaluation protocol.

They are in the pilot stage, so we have got to grow the evidence on this. It is small pilots. We have had one so far. The second one is coming up the first week of May where we will continue to test this model of bringing units back together.

Ms. BROWNLEY. You are running short on time.

Ms. RADEWAGEN. Thank you. Thank you, Dr. Franklin.

Ms. FRANKLIN. Yes, ma'am.

Ms. RADEWAGEN. But looking ahead to the implementation of the president's prevents executive order that would provide for grants to communities to increase collaboration, how do you envision these grantees coordinating with your other partners?

Ms. FRANKLIN. Yes, this is an important thing that we have been talking about in the building as well, so I appreciate the question because there is a number of existing partners that are going to be able to bring capabilities to the table. And so we are planning on hosting a series of webinars and informational instructions to share best practices across the new and innovative community partners that will likely come to the table from Prevents, with the existing infrastructure, in such a way that we can leverage—force multipliers in that equation.

Ms. RADEWAGEN. Thank you so much. Madam Chair, I yield back my—

Ms. FRANKLIN. Thank you.

Ms. RADEWAGEN [continued]. —time.

Ms. BROWNLEY. Thank you, Ms. Radewagen. Now, we have Mr. Cisneros for 5 minutes.

Mr. CISNEROS. Thank you, Madam Chair. Thank you all for being here today. First, I have got a question for the VSOs. I am getting like an echo.

I heard repercussions for—you know, that was—somebody said that veterans that are going, and they are afraid of repercussions if they talk to the VA doctor about marijuana use, or they have had repercussions for bringing it up to their VA doctors. Can you give me an example of any veteran—what type of repercussions have they had, you know, for bringing that up to their doctor?

Ms. MULLEN. Yeah, I will start. So I won't use names to protect our IAVA members, but we have had several tell us that they will talk to their VA clinician about their cannabis use, and suddenly in their charts, it will say that they have a substance use disorder. And once that happens, it means they have to go through certain procedures to get their benefits back, to get medications back, or in other instances, they will be taken off certain medications because of their cannabis use, where there is no interaction.

For example, perhaps they are on some sort of opioid for chronic pain and they talk about using cannabis as another factor that helps with that, and there is research to suggest that using both in tandem actually does help that. And then all of a sudden, that prescription is taken away from them. So that is just two examples.

Mr. CISNEROS. And Dr.—

Ms. FRANKLIN. I also offer that I am happy to take it back to the organization to double down on our efforts to educated providers and nurses and physicians on this issue to make sure that there are no repercussions. And if there are individual case studies, I know Dr. Mole and I are happy to chase those down and ensure that there are not ramifications or negative consequences for veterans.

Mr. CISNEROS. Well, that was my question, you know, to you, is you said that patients are allowed to discuss this with their doctors. But is there a VA policy in place, is there a directive in place that says they are allowed to bring this and there won't be any repercussions, or that they won't be listed as a substance abuse? What are those policies? What is—

Mr. MOLE. So the policy isn't as prescriptive as you won't do A, B, C, D, E. But it says that you will not be denied benefits. We encourage you to have a conversation. We encourage the providers to document that so that other providers know and are aware. And to use that information as part of the treatment plan, and how you develop what is appropriate for that individual veteran. That is what we ask for the providers to do.

And I second what you are saying is we want to take a look at providers who are deviating from that policy. Absolutely.

Ms. FRANKLIN. Double down on this.

Mr. CISNEROS. Yeah. No, I would appreciate that. And Representative Steube, his bill right now that I am happy to co-sponsor with him, I think has done a great deal that will go and make sure that these veterans don't have to face repercussions and that they can feel comfortable talking about their plans with their doctors. And I am glad that he brought forth that legislation. I am glad he came up to me and asked me to be a co-sponsor of that.

Just another question going in a different direction, as far as the study that you said the VA wasn't in support of H.R. 712. Now, you had mentioned that one of the reasons was that there should be a smaller study first. But you know, this is a crisis situation. A lot of these veterans are using this to—because of chronic pain to deal with PTSD. You know, why not do the big study first, to go out there and to do this to kind of find the problem and do the research that needs to be done so that we can get to that point to where hopefully the VA can one day can start prescribing cannabis to help treat these conditions that our veterans are dealing with.

Ms. FRANKLIN. Yeah, there are a number of study protocols when you are designing a research study and just a number of processes and reviews when you are looking for evidence and typically you have got to be safe, and do no harm, and start small, and grow evidence over time. But certainly we can work with the best academics in this space and make sure that we are designing it at the right size that both gets after the evidence that you are after and protects human subjects at the same time, without a doubt.

Mr. CISNEROS. Yeah, no. Like I said, I think we are in a situation right now where we can't be taking baby steps. We have got to start running to get there. And if it takes a bigger study to help us do that, then that is what we need to do. So I am also very supportive of H.R. 712. But I yield back my time. I just want to thank you very much for being here today. Thank you.

Ms. BROWNLEY. Thank you, Mr. Cisneros. Next is Mr. Steube.

Mr. STEUBE. Thank you, Madam Chair. First, I just want to thank you for bringing up H.R. 2191, Veterans Cannabis Use for Safe Healing Act. I represent Florida and Florida recently has gone through a medicinal marijuana ballot initiative. There was—I was actually involved in the state legislature where there was legislation and then it became a ballot initiative. And I will say, Dr. Franklin, you had stated that the VA is not denying benefits to veterans. That is not what I am hearing from people in Florida.

Just Google my district and I just went on a local newspaper and there is like 10 different articles, interviews on local stations. So at the very least, I think there is an incredible amount of confusion as to whether veterans who have gotten a—the way it works in Florida is you have to get a prescription by two independent physicians to then get medicinal cannabis. And I think there is definitely some confusion, and I have heard from veterans directly who have said they have been denied benefits from the VA because they have tested positive for marijuana and THC.

So I think—that is why I did the bill, because at least in Florida, I have seen some real challenges in Florida as the application of state medicinal cannabis bills and veterans who are using VA benefits. So I think it is important that the law is clear. You said that there is a directive. The Administrative Directive 1315, but isn't it true if a new administration came along, or a new secretary came along, can't a directive change or be cancelled out?

Ms. FRANKLIN. Typically, at the bottom of the directive, they will have a statement that says something like, and this is generally. I haven't looked at this exact one. But it will say, "This remains in effect until," and it will have a date and time, or it will say, "Upon the change of leadership, this must be updated." So without

seeing it, although it sounds—it looks like maybe Dr. Mole might have a copy of it, but I hear your underlying message, which is confusion and need to do proper education and outreach to veterans and communities across the Nation on what the parameters are and making sure folks know about this policy and that it is not taken in a negative way for veterans.

Mr. STEUBE. Well, but you guys are stating that you are against the bill that we are working on that would codify this. And that is my question in saying can't directives change? I mean, if a new secretary comes in and changes this specific directive that allows veterans to utilize medicinal cannabis, if we have a law in place that says legally under the 10th amendment to the Constitution and the Federal government has recognized that if states have legalize medicinal cannabis, that the VA shall not deny veterans benefits. I think that would go a long way to assuring that there isn't confusion within states that have authorized medicinal cannabis.

So I understand from the DEA perspective why you are against part of the bill, but you have a directive that basically states what we are trying to make law. And so that it is not confusion to people in states that have legalized it.

So I mean, I would be happy to work with the VA on this issue. I am very passionate about this issue because it is a big issue for Floridians. I didn't even vote for the ballot initiative that passed, but it has passed. And I believe under the 10th amendment of the Constitution, that is the law in Florida and veterans should not be denied benefits that they are due and owed for their service to our country just because they now have a prescription for medicinal cannabis.

I think it needs to be very, very clear that that is not going to happen to them.

Mr. MOLE. Yeah. And I think we will take this back. And we are happy to work with you and others on that language.

Mr. STEUBE. And if there is other—you had mentioned several things on that specific bill that I am working on that you have issues with, but I am happy to work with you moving forward. I think this is—it is certainly an important issue to a state like Florida that has—and it is new in Florida. This has only been around a couple of years. So they are going kind of through their legal growing pains as well. But I think it is important that our veteran community in states that have authorized it, those veterans know that they are not going to—and if you Google what I told you to Google and you watch some of the interviews, veterans are actually afraid to go to the VA to use services that they are accredited to do because if they test positive for THC or marijuana, they are afraid that they are going to lose their benefits.

So it is certainly—like there definitely needs to be some messaging to the veterans in states like Florida that you are not going to lose your benefits if you legally are using a state sanctioned medicinal cannabis act. So thank you. And that is—I would be happy to work with you on that.

Ms. FRANKLIN. Appreciate it.

Mr. STEUBE. I will yield back the balance of my time.

Ms. BROWNLEY. Thank you, Mr. Steube. Mr. Rose, 5 minutes.

Mr. ROSE. Thank you, Madam Chairwoman. I just wanted to address something quickly with the VA to clear up some confusion. We have heard concerns regarding potential HIPAA violations in regards to the bill. I, along with several others on this Committee, are introducing FIGHT Veteran Suicide Act, requiring the VA to notify Congress of certain information regarding veterans that died by suicide on VA campuses. Particularly, it asked for the enrollment status of the veteran with respect to the patient enrollment system of the department.

The most recent encounter between the veteran and the—of Veterans Health Administration whether the veteran had private medical insurance, the armed force, and time period in which the veteran served, the age, employment, marital status, housing status to the veteran, and confirmation to the secretary of Veterans Affairs has provided notice to the immediate family members.

To your knowledge, does the requested notification require the release of any protected health information and is thus subject to HIPAA protection?

Ms. FRANKLIN. I would need to put that through a full HIPAA review with our attorneys. I don't have the law memorized and I am not sure. But I will tell you that one of the things that is concerning that we are trying to balance, although you heard in my testimony that we absolutely approve—we recommend and we give this a thumb's up in terms of full support for this report to Congress, is just making sure that we are careful around notifying people in general about suicides that occur in districts, perhaps, where there is just a very small number. And if that got released out to the media in a way that were reported and a mother, or grandmother, or wife of a veteran that ended his or her life by suicide saw that swirl out in the media in a negative way that impacted their family.

So it is just a matter of observing the dignity there. But in terms of HIPAA, we can run it through the HIPAA legal review and tell you what the outcome is.

Mr. ROSE. But you are not seeing any glaring red flags right now? Or else—I mean, the VA just endorsed the bill. You would—

Ms. FRANKLIN. So likely the attorneys looked at the—

Mr. ROSE. Sure.

Ms. FRANKLIN. Looking at it from a social science perspective, I don't.

Mr. ROSE. Okay. All right. No, that is very helpful. I have—I just wanted to really ask you all a quick question. Speaking to the VA folks last night, raised certain facts and figures that show that multiple deployments that are packed together with minimum dwell time, as well as minimum training time prior to an initial deployment, then a second deployment, do substantially increase the risk of suicide. Have you seen these stats bear out amongst your membership?

Ms. MULLEN. The short answer is absolutely. You can see from our members that 75 percent have served in Iraq, 39 percent have served in Afghanistan. Quick math shows you that is more than 100 percent. And we know—we ask about deployments as well. And most do at least one OIF and at least one OEF.

Mr. ROSE. Sure.

Ms. MULLEN. So we deal with a population that has multiple deployments, most of which are while they are doing Guard or Reserve duty, which was another topic of conversation and something that IAVA is concerned about, especially when we are talking about the suicide rates when it comes to Guard and Reservists.

Mr. ROSE. No, absolutely. No, look, as a Guardsman presently, as a vet who has too many friends who deployed five, six, seven times, I think it is our responsibility as well to make recommendations to the DoD as to what is responsible and what is not. And so we are here today considering veterans' suicide. We are here today considering overall veterans' health; all present servicemembers are future veterans.

So what, if any, specifically, recommendations would you make to the DoD, as you are concerned about Iraq and Afghanistan veterans as to dwell time, as to op tempo, as to minimum training prior to deployment?

Ms. MULLEN. That is a great question. When it comes to specific timelines, IAVA does not have specific recommendations to that, but we do hold very high the health and well-being of servicemembers and their families. Coming into that is not only the health of the servicemember, but the experiences transitioning back from deployments, moves within military families, how many moves they are doing, the impact on their children and wives, spouses, husbands, whatever it may be.

So of upmost concern, but I don't have specific recommendations for the—

Mr. ROSE. And do you think in your estimation the VA should be in the business of making recommendations to the DoD about op tempo and dwell time?

Ms. MULLEN. I would say I don't have the background to make that recommendation. I know that VA is doing a lot to support transitioning servicemembers, especially in their last 18 months and as they transition out. I think that is a key timeframe where VA should be engaging with servicemembers as they are going through the TAP program, and ensuring that they are making a smooth transition. Especially because we know that is a height in time for suicidality among that age group and among that transition service—

Mr. ROSE. Yeah. And look, I am just going to close out with this, though. The message I got from the VA yesterday, and we all did, was that there are certain things out of their control. There are certain things out of their control, one of which is op tempo, one of which is the intensity of modern-day combat.

And what I still do not yet understand if there are certain things out of the VA's control, why would the VA then not make recommendations to the entity unto which that is under their purview?

Ms. FRANKLIN. Look, I will share with you that I worked for the DoD and have only come over to the VA in the last year. And we can and will make recommendations to everybody and anybody in this enterprise when it comes to saving lives. And so whether or not DoD will embrace those recommendations is likely to be determined. But when you are talking about dwell time, there is not

only the issue of multiple deployments, but it is also the issue of length of deployment. And so—

Mr. ROSE. Totally agree.

Ms. FRANKLIN [continued]. —there are some studies that show that troops can deploy out 3 months, 7 or 8 times and be fine, and then there are other studies that show they will deploy out 1 time for 18 months, and that particular type of combat and/or deployment will crush them for months to come.

And particularly when it applies to coming in and out of roles with regard to being a spouse and a parent. And so all of that is quite complicated. And to the extent that that has been studied or can be looked at longitudinally, and we can give those recommendations to the DA—the DoD, I am sorry, we can and will.

Mr. ROSE. So, you know, as I think of my friends who have done 15-month deployments, and I never did, but that is two Christmases, two birthdays, two anniversaries.

Ms. FRANKLIN. Yes, sir. Yes, sir. I—

Mr. ROSE. You know, you deploy when your kid is 6 months old for 15 months, you come back and your child doesn't recognize you, doesn't know who you are.

Ms. FRANKLIN. Yes.

Mr. ROSE. So what I am hearing is that you are now—the VA is comfortable making recommendations to the DoD as to what is acceptable or non-risky op tempo, and what are the types of op tempos and the lengths of deployments that do present potentially undue risk for future suicide?

Ms. FRANKLIN. We will tell them what we are learning about suicide, up, down, and all around. What we won't do is get into the business of war fighting with them.

Mr. ROSE. Of course. And no one—

Ms. FRANKLIN. Very well.

Mr. ROSE. I mean, I understand that. I wouldn't want you in that business.

Ms. FRANKLIN. Yes.

Mr. ROSE. But I do want you—

Ms. BROWNLEY. Mr. Rose, your line of questioning is very good, but your time has—

Mr. ROSE. Understood. Thank you.

Ms. BROWNLEY. Yes.

Ms. FRANKLIN. Thank you.

Mr. BARR. Thank you, Madam Chairwoman, and I agree, great line of questioning there. So I was enjoying listening to the dialogue.

Let me shift gears, Dr. Franklin and Dr. Gaudet. Earlier this year, Dr. Stone with the VA—stated that the VA had 60 active equine programs across the VA system and concurred that they are very effective in benefitting veterans.

Last night, we heard from the National Institute of Mental Health, similarly that equine assisted therapy programs have some benefits in terms of mindfulness and other benefits, especially for returning veterans who are struggling with post-traumatic stress and other issues.

I was very encouraged by Dr. Stone's statement that the VA is actively looking to expand equine assisted therapy, as well as all

of the VA's adaptive sports programs. Is equine assisted therapy included in the services offered through the VA's whole health initiative?

Dr. GAUDET. I can probably take that. Thank you. The concept of the whole health initiative is a broad umbrella. So while technically that doesn't fall under my office really doesn't matter for this conversation. What matters is that the concept of supporting people's health and well-being and resilience through any means that is of effect and benefit for that veteran is a part of that approach.

Mr. BARR. Well, this is Kentucky Derby week and horses are on my mind as a Kentuckian.

Dr. GAUDET. Yes, of course.

Mr. BARR. But I can tell you on a more serious note that throughout the calendar year, I have witnessed some really transformational things, positive things happened with veteran constituents of mine who have the benefit of access to equine assisted therapy that may not exist in places outside of Kentucky, for example, and I encourage you to look at that.

In legislation offered by my colleague, Mr. Lamb, there is a provision that allows the VA to report on the accessibility and availability of any other service the secretary determines appropriate. If passed, Dr. Franklin, would you be willing to include equine assisted therapy as part of this report?

Ms. FRANKLIN. Yes, sir.

Mr. BARR. Thank you. Let me shift gears to some of the cannabis related legislation on the docket here today. Back to you, Dr. Franklin and Dr. Gaudet. As you may know, the 2008 Pharm Bill took steps to deschedule industrial hemp derived CBD products. And a lot of people don't fully appreciate the distinction that was made in the Pharm bill related to low THC CBD cannabis versus the high THC marijuana that remains prohibited under Federal law.

Given the passage of this legislation, has the VA, given some concerns about the existing marijuana legislation on the docket today, has the VA changed their approach into researching CBD—low THC CBD treatments for veterans?

Ms. FRANKLIN. I will defer to Dr. Mole.

Mr. MOLE. I am not sure if that bill would have shifted people, but I think clearly investigators are interested in CBD oils. They are interested in low THC or no THC if that is possible. So I know that work is ongoing and there is investigators interested in working on those types of products.

The Pharm bill, I was having to run through some papers because we had some struggles with how to interpret the Pharm bill versus a schedule one substance. And so—

Mr. BARR. Well, if I could, to the extent the VA has concerns about the psychoactive impact and some of the studies relating to schizophrenia with marijuana, let me assure you that hemp with low THC doesn't present those potential risks, whereas CBD, which is now legal under Federal law, may present an opportunity for the VA to take those incremental steps that you all were talking about in your testimony before. And the Pharm bill, just for informational purposes does authorize the FDA and USDA to complete regula-

tions. Those are ongoing. And once that is completed, I would encourage the VA to look at CBD as an initial step on this road to cannabis as a potential medicinal opportunity.

Mr. MOLE. So just very quickly, I don't want to use your time. So what Dr. Franklin said earlier in the testimony was that our current study under way in San Diego is using CBD.

Mr. BARR. Okay. Great. Thank you very much. And finally just to the VSOs, Ms. Mullen, Mr. Fuentes, and Ms. Ilem, have you all had an opportunity to play a role in suicide prevention to the extent that I know your organizations can we—we know from the testimony last night that there are too many veterans who are committing suicide are not accessing, at least recently, the VHA system.

Are you all—do you feel like you all are able to reach those veterans?

Ms. ILEM. I would say for DAV, we just did—recently did a—had VA come over and do a save program with us, training, making sure that our headquarters staff understands how everybody can participate in suicide prevention.

And then we also included that now in our training for our national service officers, who are located throughout the country and see veterans every day, assisting them with their claims. So we know and subscribe to VA's premise that suicide is everyone's business. We all have to play our part. We have to include this information in our magazines, our brochures, we have to talk to veterans, make sure that we are all taking care to watch out for each other.

So I think, you know, we are doing what we can as an organization to spread that.

Mr. FUENTES. Same thing for the VFW. We have one of those unofficial MOUs with VA. Part of our mental wellness campaign to essentially help veterans, and their caregivers and family members, the community identify the five signs. Emotional distress is a partnership with given our Elizabeth Dole Foundation and Walgreens as well to bring people into our 6,500 posts around the world, and train them, part of the day—so we are going it. We are going to continue doing. And VA is being a good partner.

Ms. MULLEN. Yeah, from IAVA's perspective, we operate a bit differently than the legacy VSOs over here and we build online communities to engage our members in suicide prevention and mental health care. And we do that effectively and efficiently.

I will also say that our rapid response referral program has an MOU with the VA as well. They are master's level social workers that work one on one with veterans to do warm hand-offs. So when a veteran calls our rapid response referral program in crisis, they are able to connect them to the VCL immediately. Last year we had over 100 saves through that program.

So it is an amazing program. We also have about 25 percent of our members that don't access VA health care. They do private health insurance only. So I can tell you that the VA members, the IAVA members are definitely outside the VA program and we are connecting with them with suicide prevention and mental health care.

Mr. BARR. Thank you. I yield back.

Ms. BROWNLEY. Thank you, Mr. Barr. And last but not least, Mr. Brindisi.

Mr. BRINDISI. Thank you, Madam Chair. Sorry for being late. Juggling a couple different Committees today, but thank you for allowing me to be here and giving me an opportunity to ask a few questions about our bill, H.R. 233, the Support of Suicide Prevention Coordinators Act.

And I just want to ask just a couple brief questions because I think that coordinators are really the face of the VA's efforts to address the veteran's suicide epidemic and many report being overworked or unable to keep up with some of their responsibilities.

So essentially what this act would do is give our prevention coordinators the resources they need to be able to do an effective job. And specifically, the bill would require the comptroller general to conduct an assessment of the responsibilities, workload, and vacancy rates of the Department of Veterans Affairs suicide prevention coordinators and submit it to Congress within one year.

So I know that the VA hasn't taken an official position on the bill, but I assume that you would welcome an outside assessment by the comptroller general to conduct an assessment and report back to Congress.

Ms. FRANKLIN. Yes. And I also shared with the Committee earlier that we have an assessment well underway where we are looking not only at just the role of the suicide prevention coordinators, but more broadly in the role of other capabilities that we might need to bring to the table. As part of our new strategy, we are trying to work with veterans and get after suicide where they work, live, and thrive, which is outside of our four walls.

The role of the SPCs has largely been focused on clinical work with very limited outreach events, five a month. And so we are not only looking at their role, but we have a study underway and an analysis where we are looking at other capabilities as well that might need to get brought to the table.

Mr. BRINDISI. Can you talk a little bit about, because I represent a very rural district, some of the outreach efforts that are being done in more rural areas where you may not be close to a CBOC or a hospital, and where public transportation options are pretty poor; how do you conduct outreach in those areas?

Ms. FRANKLIN. Yeah, it is a difficult issue, just as you describe. And we try to tackle it through a multi-pronged approach, whether that is our SPCs, which that alone would not solve it because as you describe, it is rural, and they have to go long and far to get across the span. Using online technology helps, but again alone will not solve it because not all of these areas have broadband and the width to do it. And then we have our mobile vet centers that will go out. I don't know if you have ever interacted with his capability, but it is actually like a vet center on wheels, if you will, and they will go out to rural areas. We are trying to target when and where to place them.

And we have a movement underway that allows for that to happen. So that is the third. And then the fourth is we are using partners. And so while we may not be able to outreach and get after this issue with every single person ourselves, we are trying to have our partners help serve as force multipliers and help us with this

outreach as well. So when there are local entities and community-based folks, that—people that live in rural America know well and trust well, and they are equipped with the signs and symptoms of risk, and they can carry VA's message and help us in a coordinated fashion. I think that adds to it.

But it is a difficult phenomenon that we have to continue to work on in rural America.

Mr. BRINDISI. Okay. Well, I am always willing to work with you guys on that, representing a very large rural district. And we know that access to health care is very hard to come by, especially for our veterans in those communities. So any initiatives that you would like to partner on, I am always willing to work on that.

Just one last question. I know in your testimony, it says that the VA's mental health hiring initiative is active and is addressing current hiring plans. What is the timeline? And I know that also it said that the suicide prevention coordinator program guidebook and suicide prevention program directive are currently in development; what is the timeline on those initiatives?

Ms. FRANKLIN. Yes. For the mental health hiring initiative, we had a goal of June 2019 to hire over 1,000 mental health providers and we have exceeded that goal. I believe it is at 1,065. We still—we do still have some shortcomings in the area of suicide prevention—coordinators, I am sorry.

Mr. BRINDISI. Yeah.

Ms. FRANKLIN. We did an analysis of that job bucket and we determined that we needed an additional 386, of which we have hired a good number and we have 244 remaining of that analysis in order to get even with that—with the Board with that community. So June '19 to answer your specific question on the date.

I do not have the timeline for the directive and the suicide prevention guidebook, which will really be the force function for working with the suicide prevention coordinators on how to do their day to day jobs, an increased layer of accountability, if you will, from the VACO office and the local SPC. But I committed to one of the Congresswomen earlier this morning that I would bring those dates. And as soon as I get back to the office, I will pull it. I just hesitate to give one that might be off.

Mr. BRINDISI. Absolutely. If you could share that with us down the road—

Ms. FRANKLIN. Will do.

Mr. BRINDISI [continued]. —we would certainly appreciate that.

Ms. FRANKLIN. Yes.

Mr. BRINDISI. I yield back my time.

Ms. BROWNLEY. Thank you very much. And I think that ends our hearing, but before closing, I wanted to make a couple of points and really just two. And one is around the topic of suicide prevention and we have several bills here today that address suicide prevention and I just encourage the VA, the VSOs, the author of the bills to try to work together to make these bills work because I think their intention, and I think most everybody agrees that their intention is good and making sure that we can succeed in that.

And I think, obviously, with suicide prevention, we still have a lot more to do. And last night's hearing was good. This one has been good. And I am sure we will have more hearings on it.

And the second piece is around the cannabis piece too, and trying to make that work. And I will say I have heard from my constituents and my veterans as well this issue of fear of testing positively and being worried that their benefits will be taken away from them. And I remember a couple of years ago, we had a family come in to testify whose son had committed suicide. And he committed suicide and he left a suicide note. And he basically said he was trapped in his body, that he had been so medicated and trapped in his body that just life wasn't worth living anymore.

And so I do think this cannabis issue and proceeding with it, and this relationship to suicide prevention, there is a nexus here, and I think we just have to really be committed to the cannabis issue and to the suicide issue, but where this nexus is. And so those are the two points and my two take-aways from the Committee. And again, I just wanted to reiterate this Committee hearing. The Members and witnesses went over a little bit in their time, which I allowed. I want to keep the conversation as free flowing as I possibly can.

Other hearings, I might have to call it, this one, we seemed to have the time to be able to do it. So I think it was a good hearing and again I thank the witnesses for being here. And Mr. Barr, if you have any closing comments, the time is yours.

Mr. BARR. Just again, thank you to our witnesses. Thank you for your service for addressing these very important issues. We have got to get this veteran suicide issued under control. Twenty a day is unconscionable, it is intolerable, and I appreciate everyone here, both on this side of the desk and also at the table for working with us to tackle this very important problem. And Madam Chairwoman, thank you for your commitment to that issue as well. I yield back.

Ms. BROWNLEY. Thank you, Mr. Barr. And with that, all Members will have 5 legislative days to revise and extend their remarks and include extraneous materials. And without objection, this Subcommittee stands adjourned. Thank you.

[Whereupon, at 11:49 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Congressman J. Luis Correa (CA–46)

Chairwoman Brownley and Ranking Member Dunn, thank you for the invitation to appear before you today. I appreciate the opportunity to testify about my bipartisan legislation, H.R. 712, the "VA Medicinal Cannabis Research Act."

As you know, veterans experience physical and psychological injuries at higher rates than their civilian counterparts as a result of their military service to our country. Unfortunately, the current clinical treatment of prescription opioids to address post-traumatic stress disorder (PTSD) and chronic pain have at times been ineffective or at worst had dangerous results such as addiction or death. In response to the opioids crisis, Congress, the VA, and veterans service organizations nationwide correctly focused their attention on reducing opioids addiction and overdoses. As twenty veterans tragically die from suicide each day, we, as policymakers, should consider alternatives to the treatment of PTSD and chronic pain.

One alternative treatment that has been discussed by veterans that I have met in my congressional district and cited by nationwide surveys commissioned by the American Legion and Iraq and Afghanistan Veterans of America (I–A-V–A) is the therapeutic benefits of medical cannabis to manage chronic pain and other health ailments. According to the Legion, 92 percent of veteran households surveyed supported medical cannabis research while an estimated twenty-two percent of veterans reported the use of medical cannabis to treat a mental or physical condition. Similarly, the I–A-V–A survey demonstrated that over 80 percent of their membership supported the legalization of medical cannabis.

Therefore, with my colleague and friend Congressman Clay Higgins, I introduced the bipartisan VA Medicinal Cannabis Research Act to promote understanding of the safety and effectiveness of medical cannabis use by veterans diagnosed with post-traumatic stress disorder (PTSD) and chronic pain. This bill requires VA to conduct a double-blind clinical trial on the impact of different forms and delivery methods of cannabis on specific health conditions of eligible veterans with PTSD and chronic pain.

With twenty-two percent of veterans currently using cannabis for medicinal purposes, it is important that doctors be able to fully advise veterans on the potential impacts and benefits of medical cannabis use on post-traumatic stress disorder (PTSD) and chronic pain. Research into medical cannabis is necessary and supported by the veteran community.

I want to thank Disabled American Veterans, Veterans of Foreign Wars, Iraq and Afghanistan Veterans of America, and the many other veterans and medical groups for their support of the bill.

Thank you again for inviting me to testify about H.R. 712, the VA Medicinal Cannabis Research Act. This legislation is a pragmatic and sensible approach for research on medical cannabis that will hopefully result in safe, alternative treatments for our veterans and reduce the number of veterans suicides.

We owe this to our veterans who were willing to make the ultimate sacrifice for our Nation's freedom. I look forward to working with you all to move this bill forward and am happy to answer any questions you may have.

Prepared Statement of Conor Lamb Vice Chair, HVAC

Whole Veteran Testimony:

Madam Chairwoman, I know you and everyone in this room shares my deep concern regarding the high rate of veteran suicide across the country.

It is essential that we make all necessary tools available to veterans as they face their individual mental health challenges.

Instead of concentrating on an isolated condition, Whole Health programs and treatments focus on the whole veteran.

Physical, emotional, and mental health are all interconnected, and the VA has the important responsibility of supporting veterans in achieving their highest overall well-being.

VA's Whole Health Program is integral to VA's suicide prevention efforts, yet these services are not available at every facility leaving many veterans wanting.

The Whole Veteran Act requires the VA to provide Congress with information regarding the accessibility and availability of components of Whole Health programs.

By identifying the current gaps in availability, the VA can take the adequate steps to improve the mental health and well-being of all our veterans no matter where they live.

Thank you and I yield back.

Prepared Statement of Dr. Keita Franklin

Good morning, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services. With me today are Dr. Tracy Gaudet, Director, Office of Patient Centered Care, Veterans Health Administration, and Dr. Larry Mole, Chief Consultant, Population Health, Veterans Health Administration.

We are providing views on H.R. 100, H.R. 712, H.R. 1647, H.R. 2191, and four draft bills relating to Suicide Prevention and Mental Health Memoranda between VA and non-VA entities, VA Suicide Prevention Coordinators, Congressional notifications of Veteran suicides and attempts, and a report on VA's Whole Health Transformation.

H.R. 100 - Veteran Overmedication and Suicide Prevention Act of 2019

H.R. 100 would direct VA to seek to enter into an agreement with the National Academies of Sciences, Engineering, and Medicine (NASEM) to conduct an independent review of the deaths by suicide of certain covered Veterans during the previous 5 years, regardless of whether such deaths have been reported by the Centers for Disease Control and Prevention (CDC).

The review would include the following:

- a description of and the total number of Veterans who died by suicide, violent death, and accidental death;
- a comprehensive list of prescribed medications and legal and illegal substances as annotated on toxicology reports of these Veterans;
- a summary of medical diagnoses by agency physicians or through programs of the agency that led to the prescribing of medications in the comprehensive list in cases of posttraumatic stress disorder (PTSD), traumatic brain injury, military sexual trauma, and other anxiety and depressive disorders;
- the number of instances in which one of these Veterans was concurrently on multiple medications to treat these disorders;
- the number of these Veterans who were not taking any medication prescribed by VA or through a VA program;
- the percentage of these Veterans who received a non-medication first-line treatment compared to the percentage who received medication only;
- the number of instances in which a non-medication first-line treatment was attempted and determined ineffective, which then led to prescribing a medication;
- a description and example of how VA determines and updates the clinical guidelines governing medication prescribing;
- an analysis of VA's use of pain scores during clinical encounters and an evaluation of the relationship between the use of such measurements and the number of Veterans on multiple medications;
- a description of VA efforts to maintain mental health professional staffing levels;
- the percentage of Veterans with combat experience or trauma related to combat;
- identification of VA medical facilities with markedly high prescription rates and suicide rates;
- an analysis of collaboration by VA programs with state Medicaid agencies and the Centers for Medicare and Medicaid Services;
- an analysis of the collaboration between VA medical centers (VAMC) with medical examiners' offices or local jurisdictions to determine Veteran mortality and cause of death;

- an identification and determination of a best practice model to collect and share death certificate data;
- a description of how data relating to death certificates of Veterans is collected, determined, and reported by VA;
- an assessment of any apparent patterns; and
- recommendations for further action to improve the safety and well-being of Veterans.

Not later than 180 days after entering into the agreement, NASEM will complete its review and provide a report to the Secretary containing the results of the review. Not later than 30 days after completion of NASEM's review, the Secretary will submit to the Committees on Veterans' Affairs of the House of Representatives and Senate a report on the results of the review, which will also be publicly available.

VA does not support this proposed legislation. This bill would be redundant because of the current work occurring with NASEM. The Joint Explanatory Statement for the Consolidated Appropriations Act of 2018 stated that VA's appropriations included $500,000 for NASEM to assess the potential overmedication of Veterans during Fiscal Years (FY) 2010 to 2017 that led to suicides, deaths, mental disorders, and combat-related traumas. This protocol can be easily augmented to examine additional psychotropic medications as needed before the study is funded for implementation without additional legislation. In addition, hiring and workforce management for mental health professionals is currently ongoing and being tracked and is easily reportable without legislative action.

Section 2(a)(1) would require that NASEM use data that would likely provide misleading results. VA becomes aware of most suicide deaths through data obtained from the National Death Index established by CDC's National Center for Health Statistics. However, these data are available only after a delay, so the most recent information on individuals dying from suicide would not be available within the bill's required timeframe. CDC data provides the most comprehensive source for determining Veterans' causes of death; utilizing other sources would result in incomplete identification of covered Veterans who died from suicide. Therefore, requesting a review of deaths by suicide regardless of whether these deaths have been reported to CDC, as required by section 2(a)(1), could lead to inaccurate or misleading data results.

Much of the data required to be collected under section 2(a)(2) would be difficult to obtain and accurately interpret. Physicians are not the only providers who prescribe medications, toxicology reports may not always be done following death by suicide, and obtaining complete and accurate information about what is (or is not) taken by the patient outside VA would be challenging.

Section 2(a)(3) discusses the compilation of data, and to the extent that any of these data could be re-identified to a specific Veteran, then an analysis of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Act and any other applicable laws or regulations meant to protect personal health information would be required.

Finally, the deadline for completion and review of the report in section 2(a)(4) is unrealistic. It does not seem possible to provide the sheer volume of data the bill demands and have NASEM analyze it within 180 days, particularly given that probably hundreds of different offices at the local and state levels would have to be contacted to provide certain information. Requiring VA's response within 30 days of NASEM's findings could also limit our ability to thoughtfully and carefully review the evidence they present, which could limit the utility of this information.

H.R. 712 - VA Medical Cannabis Research Act 2019

H.R. 712 would require VA conduct a clinical trial of a size and scope to include multiple strains of cannabis and multiple routes of administration and to collect, analyze, and report data on covered Veterans with multiple medical diagnoses and a multitude of clinical outcome measures.

VA has a rich history of scientifically driven contributions that have advanced health care through planning and implementing high quality clinical trials so that we can all better understand the results and potential for changing clinical practice when trials are complete. VA's Office of Research and Development has a program in place to fund clinical trials that are submitted to our expert peer review system for evaluation of scientific merit based upon the rationale, design, and feasibility of a proposal. Such trials could include the topic of medical uses of cannabis for conditions that impact Veterans. Clinical trial applications must detail the underlying rationale for the use of an experimental intervention such as cannabis for use in humans.

The proposed legislation with the mandated requirements is not consistent with the practice of scientific design for randomized clinical trials nor is it possible to conduct a single trial to obtain the information desired. The specification in the legislation of the multiple requirements such as type and content, administration route, diagnostic specifications representing potential inclusion and exclusion criteria, and outcome measures are not consistent with the current state of scientific evidence, which suggests that smaller, early phase controlled clinical trials with a focused set of specific aims are warranted to determine initial proof of concept for medical marijuana for a specific condition. Any trial with human subjects must include evaluation of risks and benefits/safety and include the smallest number of participants needed to avoid putting subjects at risk unnecessarily. In any study, the size of the experimental population is determined statistically so that the power or ability to detect group differences (between control and experimental groups) is based on known effects that can be shown using a specific outcome measure. For a cannabis trial, some of these effects are not known, thus a circumscribed approach to determine dose, administration modality, and best outcome measure(s) must still be studied or shown in a proof of concept approach to ensure the research would have the ability to detect the impact of the intervention in a controlled way. Typically, smaller early phase trial designs, instead of the extremely large study suggested in legislation, would be used to advance our knowledge of benefits and risks regarding cannabis before moving to the type of more expansive approach described in this proposed legislation, which is more akin to a program of research than a single clinical trial. The requirements to simultaneously address different modes of administration, different compositions, and different medical diagnoses without consideration of underlying rationale and mechanisms would not be a good use of taxpayer money, and in fact would not engender a favorable scientific peer review evaluation or regulatory approval. A plan forward to determine the legislative mandate should start with a scientific query or review of what is known for diagnostic categories of interest and what is logically called for in exploring next level clinical investigation.

VA is actively encouraging a logical pathway to contribute to the overall understanding of the possible contribution of cannabis and derivative compounds and products to Veterans' health care. VA is reviewing the current clinical evidence regarding use of marijuana for medical purposes, and has concluded more research is needed, especially related to clinical trials. VA is currently supporting a clinical trial of cannabidiol for PTSD based upon a strong design and rationalized mechanism in a trial that will assess risks and benefits. VA has also encouraged other research on possible medical uses for marijuana and compounds or products derived from it. For all these reasons, VA is not supportive of this proposed legislation.

H.R. 1647 - Veteran Equal Access Act

This bill would require VA to authorize its physicians and other health care providers to provide recommendations and opinions to Veterans who are residents of states with state-approved marijuana programs regarding participation in such programs and to complete forms reflecting such recommendations and opinions.

The Veterans Health Administration's (VHA) policy prohibiting VA providers from recommending or making referrals to or completing paperwork for Veteran participation in state marijuana programs is based on guidance provided to VA by the United States Drug Enforcement Administration (DEA), the agency with authority to interpret the Controlled Substances Act (CSA).

Under CSA, marijuana is a schedule I controlled substance with a high potential for abuse and has no currently accepted medical use in treatment in the United States. DEA has advised VA there is no provision of CSA that would exempt from criminal sanctions a VA physician who acts with intent to provide a patient with the means to obtain marijuana, including by filling out forms for state marijuana programs. VA defers to the Department of Justice (DOJ) to determine the legal effect of the phrase "notwithstanding any other provision of law" on the enforcement of CSA against VA providers who might assist Veterans in participating in state-approved marijuana programs.

VA encourages its providers to discuss marijuana use with Veterans who are participating in state-approved marijuana programs, but we do not support VA providers prescribing marijuana to Veterans and so do not support this bill. The clinical benefit of most products derived from the marijuana plant is still not proven scientifically, and VA must provide consistent, safe, science-based care for all Veterans. Further, the marijuana industry is largely unregulated, and products are often not accurately labeled, so providers cannot ascertain the strength and levels of active ingredients in the product being used by a particular patient, complicating medication management and treatment.

H.R. 2191 - Veterans Cannabis Use for Safe Healing Act (Veterans CUSH Act)

Section 2(a) of H.R. 2191 would prohibit VA from denying a Veteran a benefit under the laws administered by the Secretary because of their participation in a state-approved marijuana program. Section 2(b) would require the Secretary to ensure that VA providers discuss marijuana use with patients, adjust treatment plans accordingly, and record information about marijuana use in the patient's medical records. In addition, section 2(c) of the bill would authorize VA providers to furnish recommendations and opinions to Veterans who reside in states with state-approved marijuana programs regarding participation in such programs.

VA does not support this bill. Sections 2(a) and 2(b) are unnecessary. VHA policy, VHA Directive 1315, Access to VHA Clinical Programs for Veterans Participating in State-Approved Marijuana Programs, is very clear that Veterans may not be denied VHA services solely because they are participating in state-approved marijuana programs. Veterans may continue to receive VHA benefits, and providers should discuss with patients how their use of state-approved medical marijuana to treat medical or psychiatric symptoms or conditions may affect other clinical decisions (e.g., discuss how marijuana use may impact other aspects of the overall care of the Veteran such as treatment for pain management, PTSD, or substance use disorder, or how it may interact with other medications the Veteran is taking). VA treatment plans may be modified based on marijuana use on a case-by-case basis and in partnership with the Veteran.

The content of Section 2(c) is the same as one of the requirements of H.R. 1647, discussed above. As noted in the previous discussion of that bill, VHA's policy prohibiting VA providers from recommending or making referrals to (or completing paperwork for) Veteran participation in state marijuana programs is based on guidance provided to VA by DEA, the agency charged with interpreting the CSA. Also, as noted, DEA has advised VA that the CSA contains no provision that would exempt a VA physician, who acts with intent to provide a patient with the means to obtain marijuana, including by filling out state marijuana program forms, from criminal sanctions, and VA would defer to DOJ on the enforcement of CSA against VA providers.

If the intent of the bill is simply to authorize VA providers to discuss marijuana use with their patients, such clinical discussions are already allowed under VHA policy, as discussed above.

Draft "GAO MOU and MOA" Bill

This bill would direct the Comptroller General of the United States to conduct an assessment of the effectiveness of all memoranda of understanding and memoranda of agreement entered into by the Under Secretary of Health and non-VA entities relating to (1) suicide prevention activities and outreach and (2) the provision and coordination of mental health services in the last 5 years.

VA defers to the Comptroller General for views on this bill, as the bill relates to action to be taken by the Government Accountability Office and has no direct cost implications for VA. Although VA defers to the Comptroller General on this bill, we note our belief that the Congress already has the authority to request this information without legislation.

Draft GAO Suicide Prevention Bill

This proposed legislation would direct the Comptroller General of the United States to conduct an assessment of the responsibilities, workload, and vacancy rates of VA suicide prevention coordinators.

VA defers to the Comptroller General for views on this bill, as the bill relates to action to be taken by the Government Accountability Office and has no direct cost implications for VA. In any case, a new Suicide Prevention Coordinator (SPC) program guidebook and Suicide Prevention Program directive are currently in development, which will include guidance on responsibilities, workload, training, and staffing levels for SPCs. VA's Mental Health Hiring Initiative is active and addresses current hiring plans for, as well as retention of, SPCs.

Draft Suicide Notification Bill

This bill would require VA to submit notification of a Veteran suicide death or suicide attempt that occurs in, or on the grounds of, a VA facility to the Committees on Veterans' Affairs of the House of Representatives and Senate and members of Congress representing the district of the facility, within 7 days of the event. Information is to be provided by VA within 60 days regarding the Veteran's VA enrollment status; military service period; marital, employment, and housing status; and

confirmation that immediate family members have been provided notice of any VA support or assistance for which the family may be eligible.

VA could support this legislation provided certain clarifying technical changes are made and provided that the Congress provides the necessary resources. We would be pleased to work with the Subcommittee on such changes. Also, it should be noted that section 2(B)(i) of the bill, which calls for providing the enrollment status of the Veteran for health care, might not satisfy the intent of this legislation's reporting requirement, since certain categories of Veterans and certain treatment authorities do not require Veterans to be enrolled.

We estimate that enactment of this bill would result in costs of $507,000 for FY 2020, $2.739 million over the 5-year period from FY 2020 through FY 2024, and $6.054 million over the 10-year period from FY 2020 through FY 2029.

Draft "VA - Whole Health" Bill

This draft bill would require VA to submit to Congress within 180 days after the date of enactment a report on the implementation of VA's memorandum, dated February 1, 2019, on the subject of Advancing Whole Health Transformation Across VHA (hereafter referred to as the "Memorandum"). Specifically, the report would need to include an analysis of the accessibility and availability of each of the following 12 services with respect to the implementation of the Memorandum: (1) massage therapy; (2) chiropractic services; (3) whole health clinician services; (4) whole health coaching; (5) acupuncture; (6) healing touch; (7) whole health group services; (8) guided imagery; (9) meditation; (10) clinical hypnosis; (11) yoga; and (12) tai chi or qi gong. The report must also include the same analysis for any other service the Secretary determines appropriate.

The Whole Health System includes three components: 1) Empower: The Pathway - in partnership with peers, empowers Veterans to explore mission, aspiration, and purpose and begin personal health planning. 2) Equip: Well-being Programs equip Veterans with self-care tools, skill-building, and support. Services may include proactive Complementary and Integrative Health (CIH) approaches such as yoga, tai chi, or mindfulness. 3) Treat: Whole Health Clinical Care - in VA, the community, or both, clinicians are trained in Whole Health and incorporate CIH approaches based on the Veteran's personalized health plan. VA staff have been working with Veterans around the country to bring elements of this Whole Health approach to life. In conjunction with VA's implementation of section 933 of Public Law (P.L.) 114–198, the Comprehensive Addiction and Recovery Act of 2016, VA began implementation of the full Whole Health System at 18 flagship facilities in the beginning of FY 2018. This constituted the first wave of facilities to be included in the national deployment of VA's Whole Health System.

Flagship facility implementation of the Whole Health System is proceeding over a 3-year period (FY 2018 - FY 2020) and is supported by a well-proven collaborative model which drives large scale organizational change. In addition to the implementation guide, flagship facilities are receiving education and training, resources and tools, and on-site support. These sites also have designated funding for the start-up costs needed. In addition, Veteran outcomes, Veteran satisfaction, cost, and utilization rates are being tracked as well as the impact, to the extent determinable, of the Whole Health approach on opioid safety, suicide prevention, and impact on the VHA workforce.

More specifically, the Memorandum announces the launch of Whole Health Learning Collaborative 2: Driving Cultural Transformation and requests that each Veterans Integrated Service Network identify 2 sites to participate, for a total of 36 sites across VA (separate from the 18 flagship facilities mentioned previously). This collaborative initiative will help further Whole Health delivery and innovation. The collaborative kick-off is scheduled for June 2019 with selection of sites currently underway. These 36 sites will then be supported through the subsequent 18 months as part of this Learning Collaborative process. At this time, specific start-up funding for the 36 sites has not been identified.

It is unclear if the drafters intended to limit the mandated analysis and report requirement to the 36 sites participating in the Learning Collaborative (under the Memorandum.) In other words, the draft bill's incorporation of the Memorandum by specific reference could, in operation, limit us to the 36 sites participating in the Learning Collaborative initiative. Congress may wish to consider extending the draft bill's reporting requirement to the 170 VAMCs and myriad outpatient sites operated by the Department.

VA supports this draft bill, and we would look forward to working with you. The reporting required by this bill can be produced by current VA staff and would require no additional resources to complete.

Madam Chair, I conclude my remarks with the following highlights of VA's suicide prevention efforts. VA is moving from a purely hospital-based suicide prevention model to a public health model. We continue to care for those in crises, with VA suicide prevention coordinators managing care for almost 11,000 Veterans who are clinically at high-risk for suicide. VA's Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment (REACH–VET) program uses predictive analytics to identify Veterans with high statistical risk for suicide. Annually, 30,000 Veterans receive care review and outreach to ensure they are well engaged in care and their needs are being met.

Under VA's new universal screening for suicidal intent, more than 2,057,000 Veterans have received a standardized risk screen since October 1, 2018; more than 62,000 of these Veterans have received more complex screening based on a positive initial screen; and more than 8,000 have received a full clinical assessment after screening positive.

At the same time, we are implementing the National Strategy for Veteran Suicide Prevention and are aggressively pursuing partnerships necessary to help us reach all Veterans. Just as suicide is a complex issue with no single cause, no single organization can end Veteran suicide alone. Every person, system, and organization must work together to save lives. We have, for example, in partnership with Johnson & Johnson, released a Public Service Announcement (PSA), "No Veteran Left Behind," featuring Tom Hanks via social media and a communications plan led by Johnson & Johnson. VA continues to use the #BeThere Campaign to raise awareness about mental health and suicide prevention and educate Veterans, their families, and communities about the suicide prevention resources available to them. The National Action Alliance helped spread the #BeThere campaign to hundreds of partners using #BeThere and the Veterans Crisis Line information during 2018 Suicide Prevention Month activities.

We created more than 30 new cross-sector partnerships to involve peers, family members, and communities in preventing Veteran suicide. We also deliver monthly partnership updates to include content about the S.A.V.E. online suicide prevention training video to 60 informal and formal partners, providing communications materials (blog posts, social media, and emails) for use. The acronym S.A.V.E. summarizes the steps needed to take an active and valuable role in suicide prevention (Signs of suicidal thinking, Ask questions, Validate the person's experience, and Encourage treatment and expedite getting help).

As you may know, this month we started working with you and other Members of Congress to spread awareness about the important topic of Veteran suicide through a PSA drive on Capitol Hill. VA's suicide prevention experts developed two suggested PSA scripts that Members can customize for their specific locations and audiences. The scripts are designed to use safe messaging best practices, provide hope, encourage help-seeking, and direct viewers to available mental health and suicide prevention resources. Thank you to those of you who have already developed your PSAs. If you have not yet developed yours, you can schedule time to record your PSA at either the House or Senate Recording Studio. Please let us know if VA can provide you with any further assistance, and we look forward to our continued collaborations.

Conclusion

This concludes my statement. I would be happy to answer any questions you or other Members of the Committee may have.

Prepared Statement of Joy J. Ilem

Chairwoman Brownley and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Subcommittee on Health. As you know, DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration by the Subcommittee.

H.R. 100, the Veterans Overmedication and Suicide Prevention Act of 2019

This bill would require VA to enter into a contract with the National Academies of Sciences, Engineering and Medicine to retrospectively study suicides of any veteran using Department of Veterans Affairs (VA) facilities for health care treatment

for any of the past five years ending with the date of enactment. It would require the age, gender, race, and ethnicity among studied veterans and include deaths considered violent or accidental among veterans' suicides. In particular, the study would evaluate prescription and other drug utilization, including VA's prescribing of medications with black box warning labels, use of multiple prescription drugs and the number of instances when first line treatment therapies without use of prescription medications were used with particular regard for veterans with diagnosed conditions of posttraumatic stress, traumatic brain injury (TBI), military sexual trauma (MST), anxiety and depression. The study would also consider staffing levels, VA's use and barriers to use of marital and family counselors, and a compilation of pain management protocols being used while prescribing medications for other high risk diagnoses.

It appears the study called for by this legislation is intended to identify problematic prescribing patterns for mental health care conditions in the VA that may be attributable to suicides among veterans. While there have been cases of documented over prescribed or inappropriate prescription drug therapy, we believe the information called for by this legislation could paint a distorted or inaccurate picture of mental health practices within VA. Additionally, we believe most of the data and analysis called for in this measure can be obtained through VA.

It is difficult to determine whether the drugs prescribed by VA for a particular patient were appropriate unless each individual case is studied. In calling for the number of instances in which a non-medication frontline intervention was attempted and determined to be "ineffective" for the veteran, the bill also seems to mistakenly assume that VA's clinical practice guidelines do not include use of prescription drugs. In fact, VA's training for and use of evidence-based or "front line" practices for conditions such as post-traumatic stress disorder (PTSD), MST, depression and anxiety include clinical practice guidelines for prescribing medications when clinically indicated, and prescription drugs are often given concurrently with other types of treatment.

VA's use of evidence-based practices also far exceeds the use of such practices in the private sector. In one RAND study, investigators determined that only about 2 percent of private sector providers in New York were adequately prepared to meet veterans' needs by making use of evidence-based clinical practice guidelines, appropriately screening for and managing conditions common to veterans such as TBI, PTSD and MST, or asking about military status and being culturally competent in delivering care. [1]

VA's patients are often clinically complex and have a variety of mental and physical disorders that frequently require comprehensive care and supportive social services. Veterans who are suicidal often have a multitude of issues with which they are struggling such as homelessness, poverty, unemployment, mental and physical disabilities, war-related readjustment issues, substance use and family dissolution. Without fully understanding the unique complications within this population, this study may unfairly suggest VA prescribing practices are excessive and somehow different than those of other health care providers. In our opinion without any basis of comparison, this study would not serve to enlighten clinical practice.

DAV certainly agrees that research is essential to determine dangerous or ineffective clinical practices, but does not believe that this study, as proposed, will be able to provide clear evidence of use of such practices in VA. Because of its utilization of a centralized electronic health record with a pharmaceutical component, VA is able to collect and analyze data about polypharmacy issues and regularly does so to ensure that it continues to improve patient safety, quality of care and clinical outcomes.

DAV agrees it is important for VA to look at case studies of veterans prescribed medications with black box warnings to determine if prescribing was properly indicated and use appropriately monitored for certain patients if it is not doing so already. We also agree with sections in the bill calling for identifying the adequacy of mental health staffing levels, including VA's use of marriage and family counselors. In accordance with DAV Resolution No. 293, we support enhancing resources to ensure that VA mental health providers are able to provide timely comprehensive mental health services to veterans who need such care. We also believe more research is necessary to determine the root causes of higher suicide rates among veterans in addition to identifying the most effective monitoring systems and therapies for reducing rates of suicide and suicidal ideation for all veterans and certain sub-

[1] Tanielian, Terri, Carrie M. Farmer, Rachel M. Burns, Erin L. Duffy, and Claude Messan Setodji, Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans. Santa Monica, CA: RAND Corporation, 2018. https://www.rand.org/pubs/research—reports/RR2298.html. Also available in print form.

populations, such as women veterans. While we support certain sections in H.R. 100, we urge the subcommittee to work with VA subject matter experts to revise provisions within this bill to advance improved clinical practice.

H.R. 712, the VA Medicinal Cannabis Research Act of 2019

DAV supports and urges swift passage of H.R. 712, the VA Medicinal Cannabis Research Act of 2019. This is a bipartisan bill that would direct the VA to perform clinical research to determine whether cannabis is able to reduce symptoms associated with chronic pain such as inflammation, sleep disorders, spasticity, and agitation and effects on the use or dosage of opioids, benzodiazepines or alcohol for veterans with PTSD. DAV Resolution No. 023, adopted by our members during our 2018 National Convention, calls for comprehensive and scientifically rigorous research by the VA into the therapeutic benefits and risks of cannabis and cannabis-derived products as a possible treatment for service-connected disabled veterans.

At this time, there are few definitive answers about risks and benefits associated with the use of cannabis on various medical conditions and illnesses. Research is necessary to help clinicians better understand the safety and efficacy of cannabis use for specific conditions that co-occur with other common conditions found in the veteran population such as chronic pain and post-traumatic stress.

H.R. 1647, the Veterans Equal Access Act

H.R. 2191, the "Veterans Cannabis Use for Safe Healing Act" or the "Veterans CUSH Act"

The December 8, 2017 Veterans Health Administration (VHA) Directive 1315 sets out the Department's policy on access to VHA clinical programs for veterans participating in a State-approved marijuana program. VA's policy encourages VHA clinicians to discuss and provide information to veterans about cannabis as part of comprehensive care planning, and adjust individual treatment plans as necessary. VA's policy also ensures veterans that participation in state marijuana programs will not affect their eligibility for VA care and services.

However, while several states have approved the use of marijuana for medical and/or recreational use, Federal law classifies marijuana as a Schedule I Controlled Substance, which makes it illegal to be prescribed, or for a prescription to be filled by the Federal government. VA's policy is that VA employed providers may not recommend or assist veterans to obtain cannabis unless otherwise approved by the Food and Drug Administration for medical use, such as the one cannabis-derived seizure medication Epidiolex, and three cannabis-related drug products; Marinol, Cesamet and Syndros.

H.R. 1647, the Veterans Equal Access Act and H.R. 2191, the Veterans CUSH Act, are aimed at clarifying VA's policy, which currently treats recommending marijuana as equivalent to prescribing marijuana. This measure would allow VA clinicians to provide recommendations and opinions, and to complete forms reflecting such recommendations and opinions, to veterans regarding participation in state marijuana programs. The CUSH Act adds that VA may not deny a veteran any VA benefit due to the veteran participating in a State-approved marijuana program and must discuss cannabis use with the veteran related to his or her treatment plan.

DAV does not have a resolution specific to the issues addressed in these bills and therefore, takes no position on H.R. 1647 or H.R. 2191.

Draft bill, to direct the Comptroller General of the United States to conduct an assessment of the responsibilities, workload, and vacancy rates of Department of Veterans Affairs suicide prevention coordinators

This bill would require the Government Accountability Office (GAO) to study the role of Suicide Prevention Coordinators within VA. The study would be required to determine the adequacy and appropriateness of training for these coordinators, if their caseloads are appropriate and how much these factors vary across the system. It would also determine who has responsibility for oversight of Suicide Prevention Coordinators.

VHA Handbook 1160.01 states that its purpose is to standardize the practice of mental health within VHA. It assigns ultimate authority for ensuring program coherence and integrity to the Mental Health Executive Council, which oversees facility wide practices in suicide prevention, but since these councils are made up of professionals representative of mental health practitioners, DAV believes lines of authority with regard to Suicide Prevention Coordinators may be unclear. The Handbook also defines the responsibilities of Suicide Prevention Coordinators, making

them full-time positions and requiring that they have additional support from medical centers to perform their duties if necessary. These individuals are to report monthly to mental health leadership and the National Suicide Prevention Coordinator on veterans who attempt or complete suicide, but there are otherwise no requirements for oversight defined.

Because of these ambiguities and the importance of the Suicide Prevention Coordinator's responsibilities, we agree this study could yield important information and thus support this draft bill.

Draft bill, to direct the Secretary of Veterans Affairs to submit to Congress a report on the Department of Veterans Affairs advancing of whole health transformation

This draft legislation would require the VA to report on access and availability on each of several complementary and integrative medicine practices, including: massage; chiropractic services; acupuncture; meditation; yoga, Tai Chi or Oi sang; and Whole Health group services.

We are pleased to support this draft measure focused on advancing VA's Whole Health transformation in accordance with DAV Resolution 277, which supports the provision of comprehensive VA health care services to enrolled veterans, and specifically calls upon Congress to provide funding to guarantee access to a full continuum of care, from preventive through hospice services, including alternative and complementary care such as yoga, massage, acupuncture, chiropractic and other nontraditional therapies.

DAV is aware that some VA facilities have set limits upon provision of these practices-for example, a veteran may not be able to get both yoga and acupuncture. Facilities may also limit the number of visits or treatments allowed or have long wait times for massage and other popular services. These limitations are likely the result of policy that encourages use of, but does not specifically require, these services. The report this draft bill calls for would help to determine the extent to which these services are available to veterans that need them in accordance with VHA Directive 1137. To provide a more complete picture, DAV suggests that the study also include integrative services VA provides through its Veterans Community Care Program (VCCP) Network.

Draft bill, to direct the Comptroller General of the United States to conduct an assessment of all memoranda of understanding and memoranda of agreement between Under Secretary of Health and non-Department of Veterans Affairs entities relating to suicide prevention and mental health services

This draft bill would require GAO to report on the effectiveness of VA memoranda of agreement and memoranda of understanding with non-VA providers to carry out suicide prevention activities and mental health case management services, including regional variations, and care for certain populations such as women, minorities, older, and younger veterans. It requires GAO to look at staffing, licensure and accreditation and other relevant program features to determine if these entities are adequately addressing roles as identified in MOUs and MOAs.

DAV has been disappointed in the lack of focus on required quality standards proposed for non-VA providers who will participate in the MISSION Act community care program. Ensuring veterans, who are referred by VA to the community or select private sector care, have access to quality care is essential to good health outcomes. Notable research institutions, such as RAND have questioned private providers' understanding of the complexity of treating veteran patients and conditions specially related to military service. In accordance with DAV Resolution No. 293, which calls on VA to collect data to ensure the quality and integrity of mental health services for veterans we support this draft bill which would provide an additional layer of oversight as VA moves toward more access to care in the community and expand its role in suicide prevention to all at-risk veterans using a public health model.

Draft bill, to direct the Secretary of Veterans Affairs to provide to Congress notice of any suicide or attempted suicide of a veteran in a Department of Veterans Affairs facility

This draft measure would require VA to notify the Congressional Committees on Veterans' Affairs in the case of suicide or attempted suicide of any veteran that occurs in or on the grounds of a VA facility. The bill further requires information

about the veteran including military service, age, marital, housing and employment status, and the date of VA's last documented contact with the veteran.

While DAV has no specific resolution concerning this issue we understand the Committees' desire for VA to communicate any suicides or attempted suicides that occur on VA grounds to Congress, thus we have no objection to favorable consideration of this bill.

Chairwoman Brownley, this concludes my testimony. DAV would be pleased to respond to any questions from you or Subcommittee members concerning our views on the bills under consideration today.

Prepared Statement of Carlos Fuentes

Chairwoman Brownley, Ranking Member Dunn, and members of the subcommittee, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on legislation pending before this subcommittee.

H.R. 712, the VA Medicinal Cannabis Research Act of 2019

This legislation would require the Department of Veterans Affairs (VA) to conduct a double blind scientific study on the efficacy of medical cannabis. The VFW is proud to support this important bill and thanks this subcommittee for its consideration.

VA is making concerted efforts to ensure it appropriately uses pharmaceutical treatments when providing mental health care. Under the Opioid Safety Initiative, VA has reduced the number of patients to whom it prescribes opioids by more than 22 percent. Prescribed use of opioids for chronic pain management has unfortunately led to addiction to these drugs for many veterans, as well as for many other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of post-traumatic stress disorder, chronic pain, and substance use disorder (SUD) because medical trials have found them to be effective. To reduce the use of high-dose opioids, VA must expand research on the efficacy of non-traditional medical therapies, such as medical cannabis and other holistic approaches.

Medical cannabis is currently legal in 33 states and the District of Columbia. This means veterans are able to legally obtain cannabis for medical purposes in more than half the country. For veterans who use medical cannabis and are also VA patients, they are doing this without the medical understanding or proper guidance from their coordinators of care at VA. Many states have conducted research for mental health, chronic pain, and oncology at the state level. States that have legalized medical cannabis have also seen a 15–35 percent decrease in opioid overdose and abuse. A comprehensive study by the National Academy of Sciences and the National Academic Press also concluded that cannabinoids are effective for treating chronic pain, chemotherapy-induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia—all of which are prevalent in the veteran population. While VA has testified that it has the authority to study Schedule 1 drugs, it has failed to do so and veterans are tired of waiting for VA.

VFW–Student Veterans of America Fellow Christopher Lamy, an Army veteran and Louisiana State University law school student, focused his semester-long research project and advocacy effort on this important bill. Chris' research discovered that veterans experience chronic pain at 40 percent higher rates than non-veterans and if not properly treated, such chronic pain often leads to depression, anxiety, and decreased quality of life. Chris also found that states with medical cannabis programs have, on average, a 25 percent lower rate of death from opioid overdose than non-medical cannabis states.

Veterans Health Administration (VHA) Directive 1315, Access to VHA Clinical Programs for Veterans Participating in State-Approved Marijuana Programs, provides protections for veterans who use medical cannabis. However, Chris found that veterans who discuss their use of medical cannabis with their doctors are ostracized and have their medications changed or discontinued. The fear of reprisal for medical cannabis prevents veterans from disclosing information to their VA health care providers, which can lead to problems caused by drug interactions. This legislation would prohibit VA from making eligibility determinations for benefits based on participation in the study. To ensure veterans who participate in the study do not have their VA health care impacted, the VFW recommends this subcommittee amend the bill to prohibit VA from denying or altering treatment to veterans who participate in the study. Doing so would provide veterans peace of mind.

H.R. 1647, the Veterans Equal Access Act

This legislation would authorize VA health care providers to provide recommendations for participation in state-approved medical marijuana programs. The VFW agrees with the intent of this legislation, but cannot offer its support at this time.

The VFW agrees that veterans who rely on the VA health care system must have access to medical cannabis, if such therapies are proven to assist in treating certain health conditions. Without such evidence, VA would not have the authority to prescribe or provide medical cannabis to veterans. The VFW believes it is unacceptable for VA providers to recommend a treatment that they are unable to provide veterans and force patients to pay for the full cost of such care. If VA recommends a treatment plan, it must be able to provide required therapies or prescriptions. That is why the VFW supports H.R. 712, which would enable veterans to participate in medical cannabis research without having to bear the full cost of treatment.

H.R. 2191, the Veterans Cannabis Use for Safe Healing Act

This legislation would require VA providers to discuss and record veterans' use of medical cannabis and participation in state-approved marijuana programs. It would also authorize VA health care providers to recommend participation in such programs and prohibit VA from denying veterans access to benefits solely based on their use of marijuana.

The VFW strongly supports provisions to protect veterans from having their earned benefits eroded or denied simply based on their participation in a state-approved marijuana program. Veterans who participate in such programs must not fear that VA will take away benefits they have earned and deserve. The VFW also believes it is important for VA to properly track veterans who use medical cannabis. However, the VFW is concerned VA may not implement the requirement to record medical cannabis use as intended.

VHA Directive 1315, Access to VHA Clinical Programs for Veterans Participating in State-Approved Marijuana Programs, instructs VA health care professionals to record marijuana use "into the 'non-VA/herbal/Over the Counter (OTC) medication section' of the Veteran's electronic medical record." Yet, the VFW continues to hear from veterans who have been recorded as having a SUD for testing positive for marijuana or because their VA health care provider did not follow the guidance included in the directive. Veterans who report participation in state-approved marijuana programs must not be recorded as having a SUD. To ensure the recording requirement is implemented properly, the VFW recommends this subcommittee require VA to create diagnostic codes for medical cannabis use or prohibit VA from recording such use as SUD.

This legislation would also authorize VA health care providers to recommend participation in state-approved marijuana programs. As discussed above, the VFW cannot support such authority if VA is unable to provide a recommended course of treatment.

H.R. 100, the Veteran Overmedication and Suicide Prevention Act of 2019

This legislation would commission research and require that VA report data on veteran suicides. The VFW supports this legislation and has a recommendation to improve it.

In partnership with the Department of Defense, the Centers for Disease Control and Prevention, and other Federal agencies, VA has compiled the most comprehensive data and analysis of veteran suicides that has ever existed. The most recent analysis of veteran suicide data from 2016 found suicide has remained fairly consistent within the veteran community in recent years. An average of 20 veterans and service members die by suicide every day. While this number must be reduced to zero, it is worth noting that the number of veterans who die by suicide has remained consistent in recent years, while non-veteran suicides have continued to increase.

However, VA's National Suicide Data Report is delayed by two years and misses certain elements which this legislation would include, such as the impact of staffing levels on suicide prevention efforts. The VFW has long argued that VA's lack of staffing models and inability to properly staff its health care facilities impact its ability to provide timely and high-quality health care to veterans who face mental health crises.

The report commissioned by this legislation would be conducted by a third party, which would also ensure VA bias is eliminated. While the majority of veterans who die by suicide every day are not active users of the VA health care system, VA must do everything possible to save the lives of those who rely on VA. An external anal-

ysis of VA practices and procedures would ensure VA is doing what it necessary to save the lives of the six VA health care users who die by suicide every day.

To better assist all veterans, the VFW urges this subcommittee to require the study to include research and data collection on the 14 veterans and service members who die by suicide every day without receiving VA health care. This legislation would limit the study to veterans who have used VA health care within the past five years. Doing so would exclude about two-thirds of veterans who die by suicide each day without any contact with VA. The VFW urges this subcommittee to amend this legislation to include and analyze the demographics, illnesses, socioeconomic status, and military discharges of such population. There are questions that need to be answered in order to properly address this epidemic: did those 14 use private sector care? Were they eligible to use VA? Were they among the many who were discharged without due process for untreated or undiagnosed mental health disorders? Were they discharged for unjust and undiagnosed personality disorders due to transgenderism or during the era of "Don't Ask, Don't Tell?" Have they used other VA benefits such as the GI Bill?

H.R. 2333, the Support for Suicide Prevention Coordinators Act

The VFW supports this legislation, which would commission an assessment of VA suicide prevention coordinators.

Suicide prevention coordinators are instrumental in the efforts to reduce suicides among veterans. These caring and hardworking individuals are at the front line of suicide prevention efforts at VA medical facilities, including case management of veterans who are at high risk of suicide. The legislation would rightfully evaluate if VA is properly supporting those who support veterans in their time of greatest need.

Draft Legislation to Submit to Congress a Report on VA Advancing of Whole Health Transformation

The VFW supports this legislation, which would require VA to report on its implementation of complementary and integrative therapies throughout the VA health care system.

Countless veterans have experienced first hand the dangerous side effects of pharmacotherapy. Many of these medications, if incorrectly prescribed, have been proven to render veterans incapable of interacting with their loved ones and even contemplate suicide. VA must ensure it affords veterans the opportunity to access effective treatments that minimize adverse outcomes.

Thanks to the VFW-supported Jason Simcakoski Memorial and Promise Act, medications are being more closely monitored. Through VA's Opioid Safety Initiative, opioids are being prescribed on a less frequent basis for mental health conditions and are better monitored for negative consequences such as addiction. However, many veterans report being abruptly taken off opioids they have relied on for years to cope with their pain management, without receiving a proper treatment plan to transition them to alternative therapies. Doing so leads veterans to seek alternatives outside of VA or to self-medicate.

With the growing body of research on the efficacy of complementary and integrative therapies, such as meditation, acupuncture, and massage to treat mental health conditions and manage pain, the VFW believes more work must be done to ensure veterans are afforded the opportunity to receive these safe and effective alternatives to pharmacotherapy. This legislation would provide oversight of VA's efforts to taper veterans off high-dose opioid and switch to effective alternatives.

Madam Chairwoman, this concludes my testimony. I am prepared to take any questions you or the subcommittee members may have.

Prepared Statement of Stephanie Mullen

Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the subcommittee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members worldwide, I would like to thank you for the opportunity to testify here today on the pending legislation before the subcommittee.

As the Research Director for IAVA, I get to take the collective experiences and views of IAVA members to support our policy and programmatic work - giving numbers to the narratives of IAVA members everyday. I am truly honored to serve those who have served this great nation and feel a special privilege in working with the post-9/11 generation, many of whom are my teachers, leaders, and friends, on the issues that impact them most. I am the product of a military family; the daughter

of a retired U.S. Air Force Lieutenant Colonel who spent twenty years of her life fighting on the front lines - from Kuwait in the First Gulf War to being one of the few women in leadership roles during the 1970s, 80s, and 90s. And yet, my mom still gets asked where her husband is when she walked into VA facility and constantly deals with many of the wounds of war we see similarly in the post-9/11 generation like chronic pain and arthritis. So many of the issues IAVA tirelessly advocates for directly impacts the people I love most, and it drives my work to ensure that veterans of all generations are receiving the best care and treatment possible across all areas of society.

Support for Veteran Medicinal Cannabis Use is an incredibly important part of our work; it is why it's one of our Bix Six Priorities for 2019, which includes, in addition to Support for Veteran Cannabis Use, the Campaign to Combat Suicide, Defense of Education Benefits, Support and Recognition of Women Veterans, Government Reform for Veterans, Support for Injuries from Burn Pits and Toxic Exposures.

For years, IAVA members have been supportive of medical cannabis. In IAVA's latest Member Survey, 83% of IAVA members agree that cannabis should be legal for medical purposes. And a resounding 90% believe cannabis should be researched for medicinal uses. IAVA members are already there in terms of cannabis research, and it's time for the Department of Veterans Affairs (VA) to catch up.

IAVA is proud to support the VA Medicinal Cannabis Research Act (H.R. 712) which will advance research and understanding around the safety and effectiveness of cannabis to treat the signature injuries of war. At this time, we have limited evidence on cannabis' effectiveness to treat the injuries that impact huge swaths of the post-9/11 generation.

Without research done by VA surrounding cannabis, veterans will not have conclusive answers to how cannabis can aide their health needs. This is unacceptable. VA houses some of the most innovative and best-in-class research this country has to offer. It should not be shutting its doors on a potentially effective treatment option because of politics and stigma. This nation's veterans deserve better.

In IAVA's most recent Member Survey, a staggering 72% of veteran and military members reported suffering from chronic pain. Sixty-six percent report joint injuries, and over 50% report either PTSD, anxiety, or depression. Cannabis may be an effective treatment option for all of these service-connected injuries; but we must invest in the research to ensure it is. The VA Medicinal Cannabis Research Act will build on this evidence and provide further data to explore the effectiveness of cannabis as a treatment option.

However, research takes time - years in fact. And there are veterans suffering with the signature injuries of war now. Thirty-three states and the District of Columbia have already legalized medical cannabis. Unfortunately, VA's lackadaisical approach to cannabis forces many veterans to circumvent VA to access cannabis. In just the last month, over 100 IAVA members have shared their stories of their cannabis use, with dozens sharing how VA retaliated against or mishandled them and dozens more sharing that they flat out refuse to tell VA about their use. Left unchecked, this practice is harmful and dangerous.

VA's policies inhibit realistic discussion and open conversations around cannabis. While current VA policy allows for clinicians to talk to their veteran patients about cannabis, VA clinicians are unable to recommend cannabis to their patients, are unable to fill out state cannabis medical forms, and are unable to recommend the best programs and options for their patients.

It is unrealistic to think these limitations do not have negative impacts. Ensuring clinicians have a full view of what their patients are taking and experiencing is paramount to ensuring the veteran is getting the best treatment and care possible. But, if veterans are unable to have this open discussion or feel unwelcome to do so, it can lead to potentially devastating consequences. The access is there, and if veterans are unable to go through VA to get medical cannabis, they'll go around it. But they shouldn't have to; VA care is an earned benefit for our nation's veterans, they shouldn't feel that they have to hide and circumvent VA to access a standard of care their civilian counterparts access easily.

We know this is already occurring from IAVA members nationwide. Twenty percent of IAVA members report using cannabis for medicinal use and of those, only 31% have talked to their doctor about their cannabis use and 24% either do not feel comfortable or feel slightly comfortable talking about their cannabis use with their doctors. For the vast majority of those that use cannabis, they are not talking to their doctors about their cannabis use.

For just one of these stories, we have to look no further than our IAVA Member Leaders. After serving for four and half years in the Army, one IAVA Member Leader was medically retired with service-connected migraines, traumatic brain injury

and post-traumatic stress disorder. He was later diagnosed with an autoimmune disorder, fibromyalgia, that his doctors believe is related to burn pits and toxic exposures. He has spent years in and out of doctors' offices for treatment of the signature injuries of the post-9/11 conflicts, leading to a moment of crisis and a suicide attempt just a few years ago.

Since then, he has found a way forward and found relief through cannabidiol (CBD) and medical cannabis. However, because CBD and medical cannabis are not a treatment option through VA, he had to find alternative pathways to relief. He was forced to go outside of VA for health care and pay out of pocket for treatments that have actually helped him move forward in his life. He does not share this information with VA for fear of retribution.

We must ensure that VA clinicians can have open and honest discussions with their patients, allowing VA clinicians to recommend cannabis to their patients when appropriate, and ensure VA clinicians can submit forms for state medical cannabis programs for their veteran patients.

For these reasons, IAVA is proud to support the Veterans Equal Access Act (H.R. 1647) that will allow VA clinicians to provide recommendations and fill out forms for state cannabis programs. IAVA is also proud to support the Veterans Cannabis Use for Safe Healing Act (H.R. 2191), which will codify current VA policy around medical cannabis and ensure no veteran is punished for speaking to their clinician about their cannabis use.

Additionally, IAVA is pleased to support DRAFT VA - Whole Health bill which will examine VA's Whole Health initiative including the complementary and alternative therapies provided within the program like yoga, meditation, and chiropractic care. IAVA believes that whole health is essential to the overall health and care of veterans. In practice, 63% of IAVA members use complementary and alternative therapies to treat a service-connected injury, most often using meditation, chiropractic care, and yoga as therapies. While research is still developing around many of these alternative treatments, they have proven effective for IAVA members in treating the signature injuries of war and we are encouraged to see interest in assessing the efficacy of this program at VA.

Though cannabis reform is an important pillar in our advocacy efforts, the top priority for IAVA and among our membership is suicide prevention among troops and veterans. In 2016, the latest data available, an average of 20 servicemembers and veterans die by suicide each day accounting for over 7,000 deaths each year. Each one of these deaths impacts an entire community: a family, friends, a military unit, and the lives of each and every person that veteran or servicemember touched. We often say one death by suicide is too many, and it is so true, because every life has value and every death has impact far beyond just one moment of crisis. IAVA members know this well; 65% of our members know a post-9/11 veteran who has died by suicide, a rise of 19% since 2014. And when IAVA planted 5,520 flags on the National Mall on October 3rd, 2018 to represent the 20 veteran and military souls lost to suicide that year to date, many silently wept remembering either those who were lost, or their own personal struggles.

When it comes to accurately understanding and addressing veteran suicide, we must know the scope of the problem. While VA does release veteran suicide data, it is often years behind and only as good as the data provided by the Centers for Disease Control and the National Death Index.

IAVA is pleased to see Congress address this issue through the Veteran Overmedication and Suicide Prevention Act (H.R. 100), which will commission a study through the National Academies of Sciences to analyze violent and accidental veteran deaths. It has been a long standing concern of IAVA that there are veteran deaths by suicide lost in these other categories and we are not accurately counting all deaths by suicide, potentially missing the scope of the problem. That means we are also not targeting solutions accurately.

IAVA also thanks this Subcommittee for highlighting this public health crisis by considering additional draft legislation. In 2015, IAVA and our veteran service organization partners worked hand in hand with Congress to pass the Clay Hunt Suicide Prevention for American Veterans (SAV) Act. This landmark legislation focused on mental health care and suicide prevention at VA. Progress has been made, in particular, under Section 6 of the law in which partnerships with nonprofit organizations specializing in mental health care were expanded. But the Clay Hunt SAV Act is still lacking overall in timely implementation of the loan repayment provision for psychiatrists and the final report on the Clay Hunt peer support pilot programs showed a systemic need for dedicated funding and increased staffing to ensure the program is successful.

We are pleased to support draft legislation GAO MOU and MOA bill, which will review and assess these and other partnerships between VA and nonprofit organiza-

tions supporting VA's suicide prevention work. Similarly, we are pleased to support Draft GAO Suicide Prevention bill which will analyze the workload and reporting structure of VA's Suicide Prevention Coordinators, those that serve at the front line of this public health crisis. Increasing our understanding of veteran suicide, the risk factors and protective factors, and the effectiveness of suicide prevention programs at VA are all essential to tackling this issue.

While we recognize and appreciate the intent behind DRAFT Suicide Notification bill regarding veteran suicides on VA property, IAVA is concerned that this legislation will not address the underlying issues regarding these tragic events and violates the veterans' privacy and personal information without the approval of the veterans' next of kin. When a veteran dies by suicide on VA property, it indicates that the foundation of trust between the public and VA has been catastrophically undercut; VA is supposed to be where veterans go to get healthy and seek treatment. When this moment of crisis happens on VA facility grounds, it is truly heartbreaking and feels preventable. However, it is important that we recognize that every death by suicide is different, there are different risk factors, triggers, and moments of crisis in each case and a death by suicide on VA property is just as tragic and just as great a loss as a death by suicide in a veterans' own home, car or workplace. Regardless, these tragic events should be a call to action; to ensure that all VA policies and procedures surrounding VA emergency mental health care, facility security, and personnel training are up to date, acceptable, and being implemented correctly. A failure in the system should and must be addressed. IAVA recommends that the proposed legislation focus on these procedures and policies at VA facilities that may be able to intervene in a moment of crisis rather than the individual factors surrounding the tragic event itself.

Members of the Subcommittee, thank you again for the opportunity to share IAVA's views on these issues today. I look forward to answering any questions you may have and working with the subcommittee in the future.

Materials Submitted For The Record (Upon Request)

Draft Bill, Suicide Notification

Draft Bill, Suicide Prevention

Draft Bill, VA Whole Health

Draft Bill, Hon. Steube

H.R. 100

H.R. 712

H.R. 1647

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