MULTIORGANIZATIONAL STATEMENT FOR THE RECORD

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

With respect to

Pending Legislation

September 11, 2024

by the

American Psychological Association
Association of VA Psychologist Leaders
Association of VA Social Workers
National Association of Veterans Affairs Physicians and Dentists
Nurses Organization of Veterans Affairs
Veterans Healthcare Policy Institute

(All are independent organizations, not representing the Department of Veterans Affairs)

Chairman Bost, Ranking Member Takano, and Distinguished Members of the Committee:

On behalf of our organizations, we thank you for inviting us to submit a statement for the record for today's hearing on multiple veteran-related bills. Many members of our organizations have published papers on these topics in peer-reviewed journals. Many of us have also had long careers serving veterans and have previously presented testimony to your committee. In today's statement, we want to convey our appreciation for your leadership and continuing commitment to ensuring that veterans receive the highest level of healthcare and services from the Department of Veterans Affairs (VA) and supplementary care in the private sector when it's necessitated.

While there are 16 bills being considered today, we comment below on the four most closely aligned with our expertise. Those are: Grants to Medical Facilities for the Provision of Culturally Competent, Evidence-based Mental Health Care for Veterans Act, No Wrong Door for Veterans Act, Ensuring Continuity in Veterans Health Act and the Veterans Sentinel Act.

<u>Grants to Medical Facilities for the Provision of Culturally Competent, Evidence-based Mental Health Care for Veterans Act</u> (Draft)

This bill allocates $60 million in grants over three years to eligible mental health care facilities for the provision of culturally competent, evidence-based mental health care for veterans. This proposed legislation presents multiple significant challenges and would severely weaken the VA's integrated healthcare system, as identified below:

Undermines the Veterans Community Care Program (VCCP) created by the MISSION Act

For the last five years, veterans in need of mental health care are eligible for care via the Veterans Community Care Program (VCCP) if the VA cannot provide it within 20 days or 30 minutes of drive time. This bill creates a system parallel to the existing VCCP. This new structure:

(a) Introduces competing eligibility rules. For veterans receiving community care through the VCCP, VA serves as the authorizer of care when a veteran is eligible. For veterans receiving care through the grant, VA's role in authorizing community care would be bypassed.
(b) Ends the principle that VA is the default provider of care when available in a timely and convenient manner. Under this bill, even when VA services are nearby and quickly available, a veteran would be entitled to obtain non-VA care.
(c) Demonstrates a lack of faith in the MISSION Act's framework for utilizing community resources.
(d) Duplicates VA- and VCCP-provided services, unlike the Fox Grant program which purchases services not offered by VA.

The bill's approach sets a precedent that could extend beyond mental health care, potentially leading to a system that is the exact opposite of what the MISSION Act intended, which was to rely on community resources to supplement and not supplant VA care.

Reduces, not enhances, the provision of culturally competent, evidence-based care

The bill mandates that each grant-receiving facility must have at least one clinician trained in culturally competent veterans mental health care. It does not require any providers to be trained in evidence-based care. The requirement of one culturally competent clinician would impact approximately 30 veterans per week at each location. Consequently, most services provided under a $1.5 million grant—or potentially multiple grants of this size—may be delivered by clinicians lacking both cultural competence and evidence-based training. It's important to note that the MISSION Act tasked the VA to establish evidence-based mental healthcare standards for community providers, but no required standards were ever put into place.

Further, there is no requirement for veteran-specific suicide prevention training despite prioritizing areas with large numbers of veterans at high risk of suicide.

Offers no assured improvement in access
While the bill is intended to reduce wait times for initiating mental health care, it fails to establish any concrete standards for timeliness of service. As a result, grantees could potentially have even longer wait times than those currently experienced with VA and VCCP services, undermining the bill's stated objective.

Legitimizes and incentivizes double dipping
The bill allows for "double dipping" by enabling existing VCCP facilities to receive additional funding without increasing services.

Reduces oversight and accountability
The bill lacks crucial quality standards and facility accreditation requirements. It notably omits mandates for accreditation by organizations like the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. It also fails to require a semi-annual peer review quality assurance system. These standards are integral to VA-delivered mental health care, highlighting a significant disparity in quality assurance between VA and grant-funded facilities.

Furthermore, unlike the VCCP, there's no requirement for grantees to share health records with the VA. Consequently, VA providers won't have access to veterans' records from grant-funded facilities, making care coordination nearly impossible.

Contradicts Expert Findings
The recent Red Team Report strongly recommended expanding VA-delivered care to prevent the VA system's collapse. However, this bill moves in the opposite direction, potentially exacerbating the very issues the report sought to address.

Furthermore, the bill lacks provisions regarding the salary pay structure and other reimbursements at non-VCCP grant facilities. If grant facilities use higher pay scales, there will be pressure for the VCCP to match them. This would lead to an escalation in veteran healthcare costs, which are already under strain.

Recommendation
This bill is unsupportable.

If the goal is to reduce wait times for mental health care initiation in VA and VCCP settings, the most effective solution would be to invest in the training and recruitment of an increased number of VA mental health clinicians rather than create a parallel system with little oversight and lower standards of care. Medical facilities that are not currently participating in the VCCP who wish to furnish mental healthcare to veterans should be actively encouraged to join the VCCP.

<u>No Wrong Door for Veterans Act</u> (Draft)

The No Wrong Door for Veterans Act proposes to renew and modify the 2020 Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. This pilot initiative allocated $174 million over three years to a diverse array of private and government entities, including veterans' associations, social service agencies, and tribal nations. These organizations partnered with the VA to combat veteran suicide at the local level.

Under the Fox Grant Program, 80 grantees receive up to $750,000 annually. Their primary role is to identify and engage veterans exhibiting one or more of 14 defined suicide risk factors. Once identified, these at-risk veterans and their families are provided with targeted services aimed at suicide prevention.

Two sections of the No Wrong Door for Veterans Act are concerning and in need of amendment:

Greatly undermines the existing access standard for VA mental health care
The bill's Sec. 2(e) states "Emergent Suicide Care: If the Secretary does not provide services under paragraph (1) to an eligible individual during the 72-hour period following a referral under subsection (m), such eligible individual shall be treated as eligible for emergent suicide care under section 1720J of title 38, United States Code.''

By way of reference, the alluded Hannon Act Sec. 201 subsection (m) stipulates: "REFERRAL FOR CARE.—(1) MENTAL HEALTH ASSESSMENT.—If an eligible entity in receipt of a grant under this section determines that an eligible individual is at-risk of suicide **or other mental or behavioral health condition** pursuant to a baseline mental health screening conducted under subsection (q)(11)(A)(ii) with respect to the individual, the entity shall refer the eligible individual to the Department for additional care under subsection (n) or any other provision of law." (2) EMERGENCY TREATMENT. —If an eligible entity in receipt of a grant under this section determines that an eligible individual furnished clinical services for emergency treatment under subsection (q)(11)(A)(iv) **requires ongoing services,** the entity shall refer the eligible individual to the Department for additional care under subsection (n)." (**bold** emphasis added).

The June 2024 Fox Grant Interim Report indicated there were thousands of "non-emergency mental health referrals" to the VA in the first year of the program.

Under the COMPACT Act, intervention for high suicide risk is already required to be immediate. The No Wrong Door bill introduces a stringent 72-hour deadline for the VA to provide services following a veteran's referral for follow-up care related to a non-suicidal mental or behavioral health condition. If the VA fails to meet this timeline, the veteran automatically becomes eligible for non-VA care (including outside of the Veterans Community Care Program). This provision dramatically reduces the wait time access standard for VA mental health care for Fox Grantee veterans from the current 20-day standard to three days. Such an aggressive timeframe poses significant challenges for the VA, potentially making consistent compliance impossible. Once Fox Grant-referred veterans seeking VA mental health care are afforded a three-day access standard, non-Fox referrals will likely soon follow. This No Wrong Door provision would

have far-reaching adverse consequences for the VA healthcare system and the veterans it serves. Congress must invest in building the behavioral health workforce to ensure veterans get the care they need.

Weakens the use of measures to evaluate a grantee's effectiveness
The No Wrong Door Act Sec. 2 (h) REQUIRED USE OF CERTAIN SCREENING PROTOCOL stipulates that ''In the case of a grantee awarded a grant under this section on or after the date of the enactment of the No Wrong Door for Veterans Act, such screening shall be the Columbia Protocol (also known as the Columbia-Suicide Severity Rating Scale (C-SSRS))''. This stipulation would likely reduce or eradicate the use of data to measure individual grantee's program effectiveness.

The original Fox Grant law made an important, long-overdue change in procuring community services to supplement VA efforts. Congressman Jack Bergman, the bill's co-author, emphasized: "This bill would develop measurement tools to track the effectiveness of these community-level programs in order to address the suicide crisis and its impact on Veterans." It authorized the VA to establish and apply a comprehensive baseline mental health screening that would be used for outcome metrics. The VA indicated: "Having this screening occur at the beginning and again prior to services ending is important in evaluating the effectiveness of the services provided."

Five well-validated measures were identified for grantees to administer at the beginning and end of participants' involvement. One, the Patient Health Questionnaire-9, explicitly assesses recent suicidal ideation. The others examine mood symptoms, self-efficacy, mental well-being, socioeconomic status, and social support. These additional measures are crucial, given that the programs are not clinical and are expected to impact suicidality downstream. A program's progress and yearly funding renewal are supposed to be based on demonstrated improvement in these instrument scores.

The Columbia Suicide Severity Rating Scale is initially administered to identify high-risk participants requiring immediate intervention. It is not part of the pre- and post-program evaluations.

While the No Wrong Door Act mandates the continued use of the Columbia Suicide Severity Rating Scale, it notably omits any mention of other screening measures used as outcome metrics. This omission of pre- and post-assessment tools from the bill's language potentially compromises the ability to effectively evaluate Fox Grant recipients' impact on psychosocial risk factors. Without these crucial evaluation metrics, it is challenging to accurately assess any program's success in addressing the complex issues surrounding veteran suicide prevention.

Last year, two Senate Veterans Affairs' Committee members introduced the Not Just a Number Act to expand the VA's annual veteran suicide prevention report. Committee Chairman John Tester (D-Mont), one of the bill's co-authors, avowed that, "when it comes to preventing veteran suicide, we've got to be looking at all the data we have on hand to see what's working and what's not." The other author, Senator John Boozman

(R-Ark.), argued, “by coordinating with successful veteran-serving organizations, (the Act) continues our commitment to modernize how we reach and serve veterans who struggle to get the mental health care and support they need. This legislation will help us make better data-driven policy decisions.” Senators Tester and Boozman were exactly right that obtaining, utilizing and publicizing of data are pivotal in policy decisions affecting veterans’ suicides.

The Interim Report on the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program covering the first year of operation revealed **extremely significant gaps in outcome measurement**. Of the 80 grant program recipients, 55 failed to report any post-service outcome measurements for participants. The remaining 25 grantees had a total of 196 participants (an average of approximately 8 participants per program) who completed services and underwent some degree of pre/post measurement. Twenty-seven percent of eligible participants did not complete even one instrument upon entering their program. Thus, **as of today, grantee effectiveness has been impossible to ascertain—either at the disaggregated grantee level or the entire Fox Grant program**.

Recommendation
The No Wrong Door for Veterans Act weakens the Fox grant program by omitting overt language about outcome measures for mandated screenings. To address this shortcoming, the Act must add stipulations that **explicitly reinforce the requirement for Fox Grant recipients to conduct pre- and post-intervention assessments** across relevant metrics. This approach would ensure robust data collection, enabling a clear understanding of how veterans' scores on the five key measures improve after participating in each grantee's services. The resulting data would equip grant administrators with information needed for informed resource allocation, ultimately contributing to the ongoing efforts to reduce the rate of veteran suicides.

Leveraging non-clinical community organizations is undeniably a crucial component of an effective upstream public health approach to suicide prevention. However, until there is concrete proof of the Fox Grant program's efficacy, and until the mandated MITRE Corporation three-year evaluation is completed, renewal should proceed on a year-to-year basis and avoid inserting the new stipulations identified above.

Ensuring Continuity in Veterans Health Act (Draft)

The Ensuring Continuity in Veterans Health Act aims to amend the MISSION Act's Veterans Community Care Program decision-making process. It would require considering "continuity of care" when determining a patient's best medical interest. However, incorporating the terminology into VCCP referral decisions **could have significant deleterious consequences.**

This bill appears to be a direct response to the March 2024 Red Team Executive Report, titled "The Urgent Need to Address VHA Community Care Spending and Access Strategies," compiled by six impartial experts in healthcare systems and quality. A key recommendation from this report was for the VA to transfer its veterans to VA inpatient units (and subsequent follow-up care) when available, after receiving emergency care in the community.

This Red Team recommendation addresses a critical issue: emergency services constitute the largest category of out-of-network healthcare for veterans, accounting for about 30% of community care spending. Of this, 84% is for inpatient care in community hospitals following ED transfers. The standard practice should involve transferring veterans to local VA hospitals, when beds are available, and the veteran is medically stable for transport. Follow-up care should also be provided by the VA when meeting access standards.

The Red Team Report highlighted that these cost savings would significantly contribute to the long-term viability of the VA healthcare system, which they deemed to be facing "an existential crisis." It noted that the rapidly increasing costs of community care are inadvertently reducing high-quality care choices for millions of veterans who prefer using the VA direct care system for all or part of their medical needs.

The report revealed that community care referrals have been increasing by 15-20% annually in recent years. In FY 2022, over 40% of enrolled veterans received care through the VCCP. The program's cost surged from $14.8 billion in FY2018 to $28.5 billion in FY2023, with projections indicating continued rapid growth unless Congress and VA leaders act swiftly to contain community care referrals and enhance the accessibility of VA's direct care system.

If "continuity of care" becomes the sanctioned justification for admitting post-ED visit veterans into the VCCP, VA's ability to achieve the financial stability necessary for its long-term survival could be hampered.

It's about more than just finances; the quality of healthcare is paramount Just last week, VA hospitals significantly outperformed non-VA facilities in two major independent, nationwide star-rating reviews for patient satisfaction and care quality.

<u>Veterans Sentinel Act</u> (H.R. 6330)

The Veterans Sentinel Act proposes a pilot program for the VA to collect and analyze data on veteran suicides and attempted suicides occurring on VA property. This initiative aims to improve the VA's information gathering process and innovate suicide prevention strategies.

We fully endorse the bill's intentions. Thorough tracking of veteran suicides and attempts, particularly those on VA medical facility grounds, is crucial. Quality improvement indeed begins with comprehensive data.

However, while well-intentioned, the bill omits an indispensable component. More than 40% of enrolled veterans are provided care through the VCCP, and veterans exclusively using VCCP have higher suicide rates than those solely using VA facilities. Yet, the bill doesn't address collecting data on suicides and attempts at VCCP facilities.

An effective Veterans Sentinel Act should address suicides and suicide attempts that occur at VA as well as VCCP facilities. The study should also evaluate the thoroughness of VA and VCCP investigations into suicide deaths and mental health-related sentinel events. This should include the completion of

- Behavioral Health Autopsy Program (BHAP) and Family Interview Contact (FIT-C) forms within 30 days of notification of a veteran's death by suicide,
- mental health-related sentinel events being entered into the Joint Patient Safety Reporting (JPSR) system within 24 hours of event awareness, and investigated and closed within 14 days of the date of entry,
- Root Cause Analyses (RCAs) within 45 days of identified highest-risk patient safety events.

These are the VA's established quality and patient safety standards.

To successfully address veteran suicide, an amendment is necessary. There needs to be a balanced approach that examines the issue across all veteran care settings, not just VA facilities to provide a more complete picture of veteran suicide risks and prevention opportunities.

We thank you for the opportunity to provide our perspectives on the bills. We look forward to working with the Committee to ensure that challenges facing VA are met with parity among all providers so that veterans can continue to receive timely, high quality compassionate care now and into the future.

Respectfully,

American Psychological Association csmith@apa.org
Association of VA Psychologist Leaders president1@avapl.org
Association of VA Social Workers president@vasocialworkers.org
National Association of Veterans Affairs Physicians and Dentists president@navapd.org
Nurses Organization of Veterans Affairs tmorris@vanurse.org
Veterans Healthcare Policy Institute russelllemle@comcast.net