

**STATEMENT OF  
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DEPARTMENT OF VETERANS AFFAIRS (VA)  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH  
U.S. HOUSE OF REPRESENTATIVES**

**OCTOBER 13, 2021**

Chairwoman Brownley, Ranking Member Bergman and other Members of the Subcommittee: thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Dr. Robert Sherrier, Executive Director of VHA's National Teleradiology Program, Karen Ott, Director for Policy, Legislation, and Professional Standards for VHA's Office of Nursing Services, and Michael Fisher, Chief Readjustment Counseling Officer.

**H.R. 2819    Solid Start Act of 2021**

This bill would codify VA's Solid Start (VASS) Program and would implement improved and expanded program initiatives. VA supports H.R. 2819 in part but has some concerns regarding some of the requirements to implement certain program initiatives.

VA and the Departments of Defense (DoD) and Homeland Security (DHS) issued a joint action plan to provide seamless access to mental health care and suicide prevention resources in response to Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*. On December 2, 2019, VA, in coordination with DoD and DHS, launched VASS to implement Task 1.1 of that joint action plan to make early and consistent caring contact with recently separated Service members three times during their first year after separation (at 90, 180, and 365 days following separation). The purpose of these calls is to help each Veteran establish a relationship with VA, increase their awareness of available VA benefits and services, lower barriers to obtain VA mental health care services and support successful transition to civilian life.

Since launching the VASS Program on December 2, 2019, VA successfully connected with over 148,000 VASS eligible individuals as of August 31, 2021, achieving a 58.4% successful contact rate. During this same period, VASS successfully connected with over 24,000 Priority Veterans, achieving a 74.7% successful contact rate. For VASS, a Priority Veteran is defined as an individual who had a mental health care appointment during the last year of active duty. A successful contact is defined as speaking with the Veteran and completing at least one VASS conversation during the period of eligibility.

Assuming appropriations are provided for this purpose, VA supports the program initiatives set forth in the proposed new section 6320(b)(1) in section 4(a) of the bill. Subsections (b)(1)(A)-(E) of section 6320 would require VA, in coordination with DoD, to: collect up-to-date contact information of transitioning Service members; call each recently separated Veteran, regardless of separation type or characterization of service, three times within the first year after separation; provide information about the VASS Program on VA's website, in transition booklets and other resources; ensure calls are tailored to the Veteran's needs; and prioritize outreach to Veterans who accessed mental health resources prior to separation from service. The remaining requirements for the proposed initiatives align with current VASS Program practices. Subsection (b)(1)(F) would require that women Veterans are provided with information tailored to their specific health care and benefits. Subsection (b)(1)(G) would require that VA, where feasible, provide information on access to state and local Veteran resources, to include Vet Centers and Veterans Service Organizations (VSO). Subsection (b)(1)(H) would require collecting and analyzing data to evaluate the effectiveness of the program. VA is also currently developing new VASS Program performance measures, which will include a means of assessing long-term outcomes to confirm that the VASS Program is providing concrete improvement throughout a Veteran's post-separation life journey.

VA notes some concerns with the provisions of proposed new section 6320(b)(2) in section 4 of the bill, recognizing that these provisions are permissive and not mandatory. Subsection (b)(2)(A) would authorize VA, in coordination with DoD, to encourage transitioning Service members to authorize alternate points of contact whom VA may contact if the Veteran is unavailable at the time of VA contact attempts during the first year after their separation from service. VA believes this provision may be duplicative of current efforts under P. L. 116-214 § 101 of the Veterans Comprehensive Prevention, Access to Care and Treatment (COMPACT) Act of 2020, which requires VA to develop a pilot program that allows transitioning Service members to designate up to 10 individuals VA may send information to regarding VA assistance and benefits for Veterans.

Subsection (b)(2)(B) would authorize VA to send tailored mailings to Veterans whom VASS is unable to contact by phone. VA is concerned that tailored mailings may be less effective than emails to recently separated Veterans and may be duplicative of emails.

VA opposes subsection (b)(2)(C), which would authorize VA, where feasible, to contact Veterans who separated from service prior to VASS' initiation to provide these individuals with similar services. Although VA appreciates the bill's apparent attempt to ensure that VA is conducting effective outreach to all Veterans, VA is concerned that this provision may not align with VASS' specific mission to provide tailored support to Veterans during the critical first year after their separation from service as these individuals transition from military to civilian life. Moreover, VA currently has comprehensive outreach programs and strategies in place to reach Veterans who are beyond the first year of their transition period from military to civilian life.

While this bill would require appropriations to fund VASS, VA cannot provide cost estimates at this time.

### **H.R. 2916 VA Medicinal Cannabis Research Act**

H.R. 2916 would require VA to conduct a series of clinical trials of at least seven strains of cannabis, with varying ratios of tetrahydrocannabinol (THC) to cannabidiol (CBD) and to collect, analyze and report on the effect of these strains on multiple symptoms of chronic pain and post-traumatic stress disorder (PTSD).

VA has a history of scientifically driven research and high-quality clinical trials that have advanced Veterans' and the Nation's health care. VA's Office of Research and Development regularly funds clinical trials approved through its expert peer review system, which evaluates studies for scientific merit based upon the rationale, design and feasibility of the study proposal. Such trials already include medical uses of cannabis for conditions that impact Veterans.

The proposed legislation is not consistent with VA's practice of ensuring scientific merit as the basis for a randomized clinical trial. The requirement in the legislation to study at least seven types of cannabis and their effects on PTSD symptoms and chronic pain is 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 optimal to determine proof of concept for using cannabis to treat specific conditions.

Human subjects research must include an evaluation of risks and benefits and should include the smallest number of participants needed to avoid unnecessarily putting subjects at risk. In any study, the size of the experimental population is determined statistically so that the power to detect differences between the control group and the experimental group is based on known effects, using a specific outcome measure. With cannabis, some of these effects are not known, thus a circumscribed approach to determine dose, administration modality and best outcome measure must be shown in a proof-of-concept approach to ensure the validity of the research.

Further, the scientific peer review system would not favor simultaneously studying seven variants of cannabis and their effects on varying diagnoses without first demonstrating a specific rationale for each of the queries. Progress in cannabis research must start with a scientific query of what is already known for specific diagnostic categories of interest, then moving to next level clinical investigation.

To that end, VA has and continues to examine the current clinical evidence regarding marijuana use for medical purposes and agrees that more research is needed. VA has utilized the scientific peer review system and is currently supporting a clinical trial of CBD to treat PTSD where CBD is used as an add-on treatment to standard of care psychotherapy. The results from this study should be available next year.

Additionally, VA recently convened a team of experts who worked together to design another interventional cannabis study, focused on chronic, diabetic neuropathic pain. The resulting study is a double-blind, randomized, placebo-controlled study with randomization to one of four treatment arms: placebo, THC, CBD or a combination of THC and CBD. The first subjects are scheduled to enroll in January 2022.

VA is already dedicating resources and research expertise to study the effects of cannabis on conditions affecting Veterans. VA's approved interventional studies were subject to peer review and have been approved as scientifically valid and posing the least possible risk to Veteran subjects. Furthermore, the proposed legislation is redundant to the extent that VA is already examining risks and benefits of cannabis in treating PTSD and chronic pain. For these reasons, VA does not support this proposed legislation.

#### **H.R. 4575 Veterans Peer Specialist Act**

H.R. 4575 would amend section 506 of the *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018* (P. L. 115-182, 38 U.S.C. § 1701 note) to insert a new subsection (d) to make permanent and expand the peer specialist program required by section 506. VA would be required to add two peer specialists at an additional 25 VA medical centers (VAMC) each year for the 5-year period following the date of the enactment of this Act until the program is carried out at each VAMC. In selecting additional VAMCs, VA would be required to prioritize medical centers in rural and underserved areas, areas that are not near an active-duty military installation and areas representing different geographic locations, such as census tracts established by the Census Bureau.

We support the goals of this proposed legislation, but we do not believe it is necessary because VA already has the authority to appoint peer specialists at VA medical centers. In implementing section 506 of the VA MISSION Act of 2018 (P.L. 115-182), VA found that expanding peer specialist services in patient-aligned care teams benefited Veterans and was associated with increased participation and engagement in care. VA also found that Veterans valued these services. As stated in VA's final report

to Congress on its implementation of section 506 of the VA MISSION Act of 2018, peer specialists were highly beneficial to Veterans. They delivered services through individual and group-based interactions that were in-person, over the phone, or by other telehealth technology. Early interactions with Veterans yielded lasting, positive relationships between Veterans and peer specialists with many benefits. Anecdotally, VA heard from family members who expressed their gratitude for the peer services that were provided. Peer specialists provided emotional, tangible, and personalized services. Veterans shared that peer specialists enhance engagement in mental health and other types of care. Peer specialists can bridge gaps between clinical care and behavioral health support outside the clinic as well, while helping Veterans engage with community resources such as food pantries, interfaith and community centers, community colleges, and clothing, housing, and transportation services. VA's Office of Mental Health and Suicide Prevention (OMHSP) and the Center for Integrated Healthcare (CIH) are prepared to share the lessons learned through implementation of section 506 with VA facilities who elect to adapt existing peer support programs or expand such programs through hiring additional peer specialists specifically for work in patient-aligned care teams (PACT). As of the end of August 2021, VA has more than 1,200 peer specialists working in mental health programs across the Nation.

VA's final report to Congress on this authority in November 2020 found that dedicated and sustained funding was essential to ensuring implementation of these specialists at VA facilities. We believe that funding each position for a period of three years is necessary to cover costs and ensure positions are fully functioning prior to the costs for these employees being assumed by the facility or Veterans Integrated Service Networks (VISN). As such, this would require extending the bill's proposed timeline from five years to seven years (to allow a full three years of support for the final phase of peer specialists added in year five). Without additional appropriated funds to support these efforts, we believe VA's current authority, which allows facilities to opt to provide peer specialists, is a better approach. Peer specialists require initial and ongoing training, as well as supervisory support. A program of the scale in the bill would require implementation support and evaluation, which would increase the associated budgetary needs. We do not believe the \$5 million authorized for each fiscal year (FY) between FY 2022 and FY 2027 would be sufficient to implement the bill's requirements.

#### **H.R. 4794 MAMMO for Veterans Act**

H.R. 4794 seeks to improve VA's mammography services. We share the Committee's goal of ensuring all Veterans have access to high-quality breast imaging services. We are currently finalizing a strategic plan that will address many of the provisions in this bill, and we believe this plan, which we expect to be finalized by the end of second quarter calendar year 2022, will further VA's goal to provide excellent access and quality in mammography for Veterans across the Nation. On this basis, VA does not support this bill as written. When the strategic plan is finalized, VA can discuss it with Congress to better inform future legislative provisions, if needed.

Section 101 of H.R. 4794 would require VA, within one year of enacting this Act, to submit to the House and Senate Committees on Veterans' Affairs, a strategic plan for improving breast imaging services for Veterans. The plan would have to cover the evolving needs of women Veterans; address geographic disparities of breast imaging furnished at VA facilities and the use of breast imaging through non-VA providers; address the use of digital breast tomosynthesis (DBT-3D breast imaging); address the needs of male Veterans who require breast cancer screening services; and provide recommendations on potentially expanding breast imaging services furnished at VA facilities (including infrastructure and staffing needs), the use of DBT-3D breast imaging, the use of mobile mammography and other access and equity improvements for breast imaging.

We support the goals of this section, but we do not believe it is necessary because VA is already finalizing a strategic plan for the provision of breast imaging services for Veterans. We are already in the process of finalizing a breast imaging strategic plan that addresses the critical elements of this section. We would be happy to brief the Committee when the strategic plan is complete.

Section 102 of the bill would require VA, within one year of the date of enacting this Act, to carry out a three-year pilot program to provide telemammography services for Veterans who live in states where VA does not offer breast imaging services at a VA facility or locations where access to breast imaging services at a VA facility is difficult or not feasible. The pilot program could use community-based outpatient clinics (CBOC), mobile mammography, federally qualified health centers, rural health clinics, critical access hospitals, clinics of the Indian Health service and other sites as VA determines feasible to provide mammograms. Under the pilot program, mammography images generated would be sent to VA's centralized telemammography center for interpretation by expert radiologists and results would be shared with the Veteran and their primary care provider. Within one year of the conclusion of the pilot program, VA would be required to submit to the House and Senate Committees on Veterans' Affairs a report which evaluates the pilot program, including a quality assessment of the mammography provided, feedback from Veterans and providers participating in the pilot program and a recommendation on either continuing or discontinuing the pilot program.

While VA supports the goals of this section, we do not support this section as written. VA shares the Committee's goal of ensuring all Veterans have access to high-quality breast imaging services. To this end, VA has established a robust network of community mammography centers to augment services provided by our in-house mammography programs. Independent third-party metrics confirm that women Veterans are more likely to receive timely breast cancer screening than women covered by a commercial health management organization or a preferred provider organization, or by Medicare or Medicaid benefits. We would be happy to brief the Committee or share this research at your request.

Tele-screening mammography (that is, remote electronic interpretation of a screening mammogram by a specially trained physician breast radiologist) may be useful in certain circumstances, but this would be only one component of a comprehensive breast imaging service. For many women, a screening mammogram may be sufficient to exclude breast cancer. However, when an area of concern is identified on a screening exam, additional diagnostic workup (e.g., additional mammogram views, ultrasound, MRI, etc.) is clinically indicated. For optimal patient care, a diagnostic exam (as opposed to a screening exam) requires the physical presence of a breast radiologist to personally direct the workup, perform a physical examination if needed, correlate findings and to counsel the patient. Tele-screening mammography is only useful in areas where referral sites are readily available to provide appropriate follow-up diagnostic imaging care, which may limit the use of the proposed pilot in rural or underserved areas, as these referral sites may not be accessible. Even in areas where diagnostic services are accessible in the community, coordination with a full-service breast imaging center presents challenges to ensuring continuity of care.

Fundamentally, the proposed scope of this section is too broad for a pilot program for logistical reasons. Sustaining high-quality breast imaging services requires enough women Veterans to maintain technical proficiency. Many of the sites VA would be able to select under this section would not meet these minimum requirements. Identifying specific locations where VA in-house mammography programs have limited breast radiologist support could be a useful starting point, and in this regard, a pilot program may identify additional use cases. Mobile screening mammography with remote interpretation may be a consideration in selected areas, specifically where supporting diagnostic and interventional services are available, although mobile screening's utility as a comprehensive service in remote areas is limited. Another barrier for tele-screening mammography would be the difficulty in obtaining prior mammography examinations for comparison from other imaging centers. Comparison images are helpful to limit patient recalls for follow-up imaging of otherwise indeterminate findings. The section also proposes screening mammography performed by community imaging centers with centralized interpretation by VA providers. While this may prove a viable long-term solution, we are concerned that the technical and cybersecurity requirements may not be feasible within the time constraints of a pilot study. Additionally, we are concerned the proposed one-year timeframe may prove insufficient to implement a pilot. If this section were to become law, we would need to balance the requirements of accreditation, certification and professional competence with the section's requirements to offer these services at additional locations. This could limit the number of sites where the pilot could be implemented.

We would like to discuss our current efforts with the Committee before further actions is taken on this section at this time, and we look forward to working with you to provide the highest quality care for our Veterans.

Section 103 of the bill would require VA, within two years of the date of enacting this Act, to upgrade all mammography services at VA facilities that provide such services to use DBT-3D and to submit a report to the House and Senate Committees on Veterans' Affairs indicating that the upgrade has been completed and listing the facilities or other VA locations at which DBT-3D is used.

We support the goals of this section, which is consistent with VA's current plans, but we do not believe this section is necessary because we already have sufficient authority in this area. Currently, 62 of the 68 VA mammography programs offer DBT-3D. The six sites that do not offer this technology are in the process of conducting market research or are reviewing construction options to upgrade to the latest technology. We are concerned that the proposed timeline may not be realistic, or could result in additional expenses to VA, as procurement and construction could take longer than this time period. Two years may be inadequate to upgrade all mammography sites without DBT-3D.

Section 104 of the bill would require VA to conduct a study on the availability of access to testing for the breast cancer gene for Veterans diagnosed with breast cancer, as recommended by the guidelines set forth by the National Comprehensive Cancer Network. In conducting the study, VA would have to examine (1) the feasibility of expanding VA's Joint (sic) Medicine Service to provide genetic testing and counseling for Veterans with breast cancer and (2) access to such testing and counseling for Veterans living in rural or highly rural areas. Section 104 would also require VA to update guidelines or institute new guidelines to increase the use of testing for the breast cancer gene and genetic counseling for Veterans diagnosed with breast cancer; VA could develop clinical decision support tools to facilitate delivery of breast cancer care that is in line with national cancer guidelines. Not later than two years after the enactment date of this Act, VA would be required to submit a report to the House and Senate Committees on Veterans' Affairs on the results of the study, any updates to guidelines or new guidelines instituted and any progress by VA in improving access to and usage of testing for the breast cancer gene among Veterans diagnosed with breast cancer, including Veterans in rural or highly rural areas.

We agree with the goal of this section, but we believe our current efforts are already increasing the availability of access to genetic testing. If VA were required to conduct a study as well, VA would require additional resources (funding for both VA health care and information technology requirements, as well as personnel) beyond those VA has already planned to use to implement improved testing and care. In terms of developing guidelines to increase the use of testing and clinical decision support tools, we anticipate these could be completed with some additional financial support. We note as a technical matter that the bill refers to VA's Joint Medicine Service, but we believe this should instead be to VA's Genomic Medicine Service.

Section 105 would require VA to conduct a study on the accessibility of breast imaging services at VA facilities for Veterans with paralysis, spinal cord injury or disorder (SCI/D) or another disability. The study would have to assess the accessibility

of the physical infrastructure at VA breast cancer imaging facilities, including the imaging equipment, transfer assistance and the room in which services will be provided, as well as the adherence to best practices for screening and treating Veterans with SCI/D. The study would have to include a measurement of breast cancer screening rates for Veterans with SCI/D during the two-year period before the commencement of the study, including a breakout of the screening rates for such Veterans living in rural or highly rural areas. Not later than two years after the enactment date of this Act, VA would be required to submit a report to the House and Senate Committees on Veterans' Affairs on the findings of the study, including the rates of screening among Veterans with SCI/D, including Veterans living in rural or highly rural areas. VA would further be required to update VA policies and directives to ensure that, in referring a Veteran with SCI/D for care from a non-VA provider, the Secretary confirms with the provider the accessibility of the breast imaging site, including the imaging equipment, transfer assistance and the room in which the services will be provided; and provide additional information to the provider on best practices for screening and treating Veterans with SCI/D.

We support the goal of this section, but we do not support it as written. VA can assess the physical infrastructure for providing in-house mammography services to paralyzed Veterans or those with SCI/D and other disabilities. We would like to discuss our current efforts and plans with the Committee to determine where we can work together in this regard.

Section 106 would require VA's Office of Inspector General (OIG) to submit a report to the House and Senate Committees on Veterans' Affairs on VA's mammography services. The report would be required to include an assessment of the access of Veterans to mammography screenings, including any VA staffing concerns in providing screenings, the quality of screenings and reading of the images, the communication of the results of the screening, the performance of VA's Women's Breast Oncology System of Excellence and the access of Veterans diagnosed with breast cancer to a VA comprehensive breast cancer care team. Within 180 days of submitting this report, the Secretary would be required to submit a plan to the House and Senate Committees on Veterans' Affairs to address the deficiencies identified in the report.

While VA defers to OIG on this provision, we note that VA's Women's Breast Oncology System of Excellence is focused on care delivery and not mammography screening; additionally, the Center will be implemented in FY 2022 and FY 2023. Consequently, we believe asking the OIG to assess the performance of this Center at this time would be premature.

Section 201 would require VA to enter into partnerships with one or more cancer centers of the National Cancer Institute (NCI) Centers in each VISN to expand access to high quality cancer care for women Veterans. In carrying out these partnerships, VA would have to ensure that Veterans with breast cancer who reside in rural areas or states without a cancer center that has entered into such a partnership with VA can

receive care through such a partnership via telehealth. Not later than 180 days after the enactment date of this Act, VA would be required to submit a report to the House and Senate Committees on Veterans' Affairs on how VA will ensure that the advancements to provide Veterans with access to clinical cancer research trials made through the existing partnership between VA and NCI are permanently implemented and VA's determination whether expanding such partnership to more than the original 12 VA facilities that were selected is feasible. Not later than three years after the date of enacting this Act, and every three years thereafter, VA would be required to submit a report to the House and Senate Committees on Veterans' Affairs assessing how the partnerships have impacted Veterans' access to NCI-Designated Cancer Centers, including an assessment of the telehealth options made available and used pursuant to such partnerships; the report would also need to describe the advancements made with respect to access by Veterans to clinical cancer research trials through these partnerships, including how many of those Veterans were women Veterans, minority Veterans and rural Veterans, and identifying opportunities for further innovation.

VA supports the general goal of this section, but we do not believe it is necessary because we already have sufficient authority in this area, and we have some concerns with it as written. There are nearly 50 NCI-Designated Cancer Centers that have academic affiliations already with a VA facility or are near one, and many of these already support breast cancer care at the affiliated VAMC. VA's Breast Cancer System of Excellence plans to use telehealth to expand access to expert breast cancer care using staff from NCI-Designated Cancer Centers to provide care to Veterans in every VISN, but these experts will not necessarily be located in each VISN. By using tele-oncology, VA can ensure coverage for patients no matter where they live while also ensuring access to experts that may not be available in specific communities. Cancer treatment is highly specialized, so having a center or an agreement is no guarantee that the center has the expertise to address a particular patient's clinical needs. The System of Excellence being developed by VA will bring this expertise to every community.

Additionally, we have some concerns with the technical language of this section. For example, we note that this section would direct VA to enter into partnerships with cancer centers, but these centers are private entities, and VA cannot compel them to enter into a partnership or agreement. We would be pleased to work with the Committee to address these concerns.

Section 202 would require VA, not later than 180 days after the date of enacting this Act, in collaboration with DoD, to submit to Congress a report on all current research and health care collaborations between VA and DoD on treating Veterans and members of the Armed Forces with breast cancer. The report would have to include a description of potential opportunities for further interagency collaboration between VA and DoD with respect to treating and researching breast cancer and may include a focus on (1) transitions to VA of women members of the Armed Forces who are undergoing screening for breast cancer, (2) collaborative breast cancer research opportunities between VA and DoD, (3) access to clinical trials and (4) such other matters as VA and DoD consider appropriate.

VA is pleased to share information regarding its work and collaborations with DoD, but we do not believe this section is necessary because we already have sufficient authority in this area. VA currently reports regularly on various collaborations, including the Applied Proteogenomics Organizational Learning and Outcomes Network. These collaborations have been useful, and VA and DoD are working closely on several efforts. We would be pleased to brief the Committee on this work in general or any specific projects upon your request.

### **H.R. 5029    Expanding the Families of Veterans Access to Mental Health Services Act**

H.R. 5029 would amend 38 U.S.C. § 1712A to make available through VA's Readjustment Counseling Service counseling to family members of a Veteran or member of the Armed Forces who died by suicide to the degree that counseling is found to aid in coping with the effects of such suicide. This counseling could include a comprehensive individual assessment of the individual's psychological, social and other characteristics to ascertain whether the family member has difficulties associated with coping with the effects of a suicide by a Veteran or a member of the Armed Forces.

VA supports H.R. 5029, which would allow Vet Centers to provide bereavement counseling to family members of Veterans and Service members who die by suicide. This is consistent with the mission of VA's Vet Centers, which already provide bereavement counseling to families of active-duty Service members who pass regardless of the cause of death provided the death was determined to be in the line of service.

We estimate this bill would cost \$4.21 million in FY 2022, \$18.97 million over 5 years and \$33.55 million over 10 years.

### **H.R. 5073    REACH for Veterans Act**

Section 101 of H.R. 5073 would require VA to enter into an agreement with an organization outside VA, such as the American Association of Suicidology (AAS), to review the training for call responders for the Veterans Crisis Line (VCL) on assisting callers in crisis. This review would have to be completed not later than one year after the enactment date of this Act. This review would have to consist of a review of the training provided by VA on subjects including risk assessment, lethal means assessment, substance use and overdose risk assessment, safety planning, referrals to care, supervisory consultation and emergency dispatch. If any deficiencies in the training for VCL call responders are found, VA would have to update such training and associated standards of practice to correct those deficiencies not later than one year after the completion of the review.

VA agrees with the goals of this section but does not believe it is necessary because we already have sufficient authority in this area and our current efforts exceed the requirements of the legislation. Rather than reviewing VCL training standards

according to baseline accreditation requirements, VA recommends incorporating a consultative review by the Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC) for Suicide Prevention to provide recommendations for ongoing training enhancements from the latest research evidence base while we await the next revision of the [VA/DOD Clinical Practice Guideline for The Assessment and Management of Patients at Risk for Suicide \(2019\)](#). Currently, VCL maintains accreditation with AAS, the Commission on Accreditation of Rehabilitation Facilities and the International Customer Management Institute. VA currently exceeds the requirements this bill would impose; for example, AAS expectations are for a minimum of 6 days in precepting, but on average, VCL responders complete over 85 days of training and precepting before being released for independent work. VA's training for VCL responders include subjects such as military culture, PTSD and moral injury, military sexual trauma, suicide risk assessment, violence risk assessment, lethal means safety, substance use and overdose risk, crisis intervention, police perspective and more.

Section 102 of the bill would require VA, not later than one year after the enactment date of this Act, to develop guidelines on retraining and quality management for when a VCL call responder has an adverse event or when a quality review check by a supervisor of such a call responder denotes that the call responder needs improvement. These guidelines would have to specify the subjects and quantity of retraining recommended and how supervisors should implement increased use of silent monitoring or other performance review mechanisms.

VA does not support this section because its requirements would be redundant to current policy. VA already requires supervisor to conduct investigation and oversight after critical incidents or any scenario in which responders need quality review. VA uses data to inform training initiatives through a continuous quality improvement cycle that includes data collection, analysis, feedback and training.

Section 111 of the bill would direct VA to require that no fewer than two calls per month for each VCL call responder be subject to supervisory silent monitoring. VA would have to establish benchmarks for requirements and performance of VCL call responders on supervisory silent monitored calls. Not less frequently than quarterly, VA would have to submit to the Office of Mental Health and Suicide Prevention (OMHSP) a report on occurrence and outcomes of supervisory silent monitoring of VCL calls.

VA does not support this section because it is unnecessary; we already have sufficient authority in this area, and we do not believe it is prudent to legislate specific methods for quality measurement, as this could limit VA's ability to adopt innovative approaches in the future. VA already has in place three monitors (one performance and two quality assurance) per responder per month, so adding a second supervisory performance monitor is unnecessary. VCL quality assurance monitoring, which includes coaching sessions, is done by quality assurance staff and examines overall VCL quality. VCL performance monitoring is performed by supervisors and can result directly in performance or conduct actions. This section would also direct that quarterly monitoring reports be prepared, but VCL currently generates monthly reports on quality monitoring targets and supervisory monitoring data.

Section 112 of the bill would require, not later than one year after the date of enacting this Act, VCL leadership to establish quality management processes and expectations for VCL staff, including with respect to reporting of adverse events and close calls.

VA does not support this section because it is unnecessary. In August 2021, VA issued a new policy and standard operating procedures (SOP) that establish the overall policy of reporting adverse events and close calls, as well as expectations for responders, supervisors, quality management staff and others. VCL is monitoring training of all staff in this new SOP with 97.2% of staff completing the training to date. This new SOP has also been incorporated into our new employee orientation. VCL quality assurance is monitoring daily reporting with monthly reviews by VCL leadership to ensure ongoing implementation and adherence.

Section 113 of the bill would require VA, not less than annually, to perform a common cause analysis for all identified VCL callers that died by suicide during the one-year period preceding the conduct of the analysis before the caller received contact with emergency services and in which VCL was the last point of contact. VA would submit the results of each analysis to OMHSP. VA would be required to apply any themes or lessons learned under an analysis to update training and standards of practice for VCL staff.

VA does not support this section because it is unnecessary; we already have sufficient authority in this area, and we do not believe it is prudent to legislate specific methods of analysis, as this could limit VA's ability to adopt innovative approaches in the future. The policy VA issued in August 2021 defines the aggregate analysis process that VCL will conduct to identify themes and determine any necessary actions to address quality, continuous improvement or technological solutions.

Section 121 of the bill would require VA, not later than one year after the enactment date of this Act, in consultation with VA national experts on substance use disorder (SUD) and overdose, to (1) develop enhanced guidance and procedures to respond to VCL calls related to SUD and overdose risk, (2) update training materials for VCL staff in response to such enhanced guidance and procedures and (3) update criteria for monitoring compliance with such enhanced guidance and procedures.

VA does not support this section because it is unnecessary given VA's actions to implement OIG's recommendations. OIG recommended that VA update SUD and overdose risk policies and staff-wide training; lethal means assessment training and job aides; and communication between staff regarding emergency dispatch and disconnected callers. VA has taken actions in each of these areas. VA's enhanced guidance and training was informed based on consultation with mental health and SUD experts, and consultations occur with Poison Control Centers of America to provide real-time management of potential overdose cases. VA has also developed enhanced criteria for monitoring staff in this area, with coaching completed by silent monitoring staff; VA will be tracking these criteria and will be reporting monitoring data as it becomes available.

Section 122 of the bill would require VA, not later than one year after the date of enacting this Act, to review the current emergency dispatch SOPs of VCL to identify any additions to such procedure to strengthen communication regarding emergency dispatch for disconnected callers and the role of social service assistants in requesting emergency dispatch and recording such dispatches. VA would also have to update such procedure to include the additions identified above. VA would be required to ensure that all VCL staff are trained on all updates to VCL's emergency dispatch SOP.

VA does not support this section because it is unnecessary as we already have sufficient authority in this area. VA updated its SOPs for emergency dispatch in June 2021 to include additional steps for responders to take when conducting emergency dispatch requests with VCL customers. Responders are required to communicate status updates with Social Service Assistant (SSA) staff when a call disconnects. The new process also provides guidance to responders to ascertain customer status through VCL resources, such as reviewing incoming calls through caller ID. VA is further evaluating outcomes of VCL emergency dispatches and facility transport plans, and these findings may inform additional process improvements.

Section 131 of the bill would require VA, not later than one year after the enactment date of this Act, to establish oversight mechanisms to ensure that SSAs and supervisory SSAs working with VCL are trained appropriately and implementing VA guidance regarding VCL. VA would also be required to refine SOPs to delineate rules and responsibilities for all levels of supervisory SSAs working with VCL.

VA does not support this section because it is unnecessary, as VA has already delivered enhanced training on SSA roles and responsibilities to all SSAs, supervisors and support staff. New SOPs will be released soon for SSA responsibilities regarding facility transportation plans, consult check-ins and carryovers.

Section 201 of the bill would require VA, not later than 180 days after the date of enacting this Act, to carry out a pilot program to determine whether a lengthier, templated safety plan used in clinical settings could be applied in VCL call centers. Not later than two years after the date of enactment of this Act, VA would be required to brief Congress on its findings, including such recommendations as VA may have for either continuing or discontinuing the pilot program.

VA does not support this section because it is unnecessary as VA has sufficient authority in this area and is already nearing completion of a pilot program where a select group of responders have been trained in implementing VA's standardized six-part safety plans. VCL responders are attempting to complete these plans with any Veteran caller when they identify a need for risk mitigation. VA will review the results of this pilot program to determine next steps for any broader implementation. We would be happy to share the results with the Committee when they are available.

Section 202 of the bill would require VA, not later than one year after the date of enactment of this Act, to carry out a pilot program on using crisis line facilitations to increase VCL use among high-risk Veterans. Not later than two years after the date of enacting this Act, VA would be required to brief Congress on its findings, including such recommendations as VA may have for either continuing or discontinuing the pilot program.

VA does not support this section because it is unnecessary, as VA completed a pilot study on crisis line facilitation in 2019 and is already considering the possibility of a broader pilot or staged implementation. We would be happy to report to the Committee on this pilot upon request.

Section 211 of the bill would authorize \$5 million to be appropriated for VA's MIRECC to conduct research on VCL's effectiveness and areas for improvement.

VA does not support this section because it is not needed at this time. Instead, we recommend that Congress could consider appropriating funds to VA to implement recommendations, including ongoing program evaluation projects with the Rocky Mountain MIRECC, and implementing a five-year program evaluation plan with the VA Partnered Evidence-Based Policy Resource Center.

Section 301 of the bill would require VA to solicit feedback from VSOs on how to conduct outreach to members of the Armed Forces, Veterans, their family members and other members of the military and Veterans community on the move to 988 as the new, national three-digit suicide and mental health crisis hotline to minimize confusion and ensure Veterans are aware of their options for reaching the VCL. The Federal Advisory Committee Act (5 U.S.C. App.) would not apply to any feedback solicited under this section.

VA supports the goal of this section, but it is unnecessary because VA's current efforts already meet the requirements of the bill. VA is briefing and soliciting feedback on VA's 988 Communication Plan with federally chartered VSOs during monthly meetings.

For the above reasons, VA does not support this bill as most of the goals of this legislation are already being met. VA would be happy to provide briefings and other details on existing quality assurance measures to the Committee as needed.

### **H.R. XXXX Expanding Eligibility for Health Care for Veterans of World War II**

The draft bill would amend 38 U.S.C. § 1710(a)(2)(E) to expand hospital care, medical services and nursing home care to Veterans of World War II (WWII). Currently, this provision provides VA hospital care, medical services and nursing home care to Veterans of the Mexican border period and World War I.

VA supports this bill, assuming appropriations are provided for this purpose. The proposed legislation could potentially provide health care services to a Veteran population who may not otherwise be eligible for VA health care. While VA expects that the majority of the WWII Veteran population is already eligible for Medicare and will rely on Medicare coverage for a significant portion of their health care needs, VA would welcome providing care for these Veterans. Notably, VA provides prescription drugs at copayment levels that tend to be significantly below the cost sharing requirements of Medicare beneficiaries.

If enacted, this legislation would grant Priority Group 6 eligibility to all WWII Veterans. Veterans that are currently enrolled in VA health care under Priority Groups 7 and 8 would be reclassified under Priority Group 6. Copayments for Veterans in Priority Group 6 are less than copayments for Priority Groups 7 and 8. The lower copayments could also induce higher reliance for those already enrolled and encourage new enrollment by currently eligible WWII Veterans that are not enrolled.

WWII Veterans with service-connected conditions and those meeting income eligibility thresholds are currently eligible to enroll in VA health care. VA estimates that 14,000 currently ineligible WWII Veterans would be eligible to enroll in FY 2022, and 5,000 would be eligible to enroll in FY 2025. If the bill were enacted, however, only a portion of WWII Veterans that become newly eligible are likely to enroll in VA health care. The projected average annual expenditure per enrollee for FY 2022 would be

\$2,800, and \$3,300 for FY 2025, based on age-adjusted enrollee benchmarks. Thus, the maximum estimated costs are approximately \$39.2 million in FY 2022 and \$16.5 million in FY 2025, though actual costs would likely be lower. We can discuss these estimates with the Committee, if needed.

## **H.R. XXXX Vet CENTERS for Mental Health Act**

Section 2(a) of the draft bill would require the Secretary to determine if a state meets each requirement described in subsection (c), (d) or (e); if the Secretary determines that such requirements are met, the Secretary would be required to ensure that the number of covered Vet Centers located in the state is increased from the number of covered Vet Centers that were located in the state on December 31, 2020. Section 2(b) of the draft bill would authorize VA, in establishing an additional covered Vet Center, to establish such Vet Center at a facility made available by the head of a state, local government or federally recognized Indian tribe, regardless of whether such facility is made available at a cost to VA. Section 2(c) of the draft bill would set forth four requirements concerning the states in which VA would be required to increase the number of covered Vet Centers. These conditions would be, with respect to the 2020 calendar year (CY), that: (1) the total population of the state exceeded 6 million, as determined by the U.S. Census Bureau; (2) the average population density of the state exceeded 200 individuals per square mile, as determined by the U.S. Census Bureau; (3) the total Veteran population in the state was greater than 250,000 Veterans, as estimated by VA; and (4) the ratio of Veteran population in the state to covered Vet Centers located in the state exceeded 50,000 Veterans per one covered Vet Center, as determined by VA. Section 2(d) of the draft bill would provide three alternative requirements: (1) the state does not share a land border with another state; (2) the state is located at least 2,000 miles from the continuous United States; and (3) there is no covered Vet Center in the state. Section 2(e) of the draft bill would provide four additional alternative requirements: (1) there are fewer than five covered Vet Centers located in the state; (2) the land area of the state exceeds 75,000 square miles; (3) the total population of the state during CY 2020 exceeded 5 million individuals, as determined by the U.S. Census Bureau; and (4) during CY 2020, the ratio of Veteran population in the state to covered Vet Centers located in the state exceeded 75,000 Veterans per one covered Vet Center, as determined by VA. Section 2(g) of the draft bill would require VA to establish such additional covered Vet Centers or covered CBOCs as may be required by not later than two years after the date of the enactment of this Act. Section 2(h) of the draft bill would define the term covered CBOC to mean a VA CBOC that is scheduled to be open for providing community-based outpatient services for a minimum of eight hours per day during five days of the week, except that the Vet Center [sic] may be open for less than such minimum on a temporary basis as a result of a Federal holiday, weather concern, safety concern, pandemic or for other reasons as may be determined appropriate by VA. The term covered Vet Center would be defined to mean a Vet Center that is scheduled to be open for providing community-based outpatient services for a minimum of eight hours per day during five days of the week, except that the Vet Center may be open for less than such minimum on a temporary basis as a result of a Federal holiday, weather concern, safety concern,

pandemic or for other reasons as may be determined appropriate by VA; Vet Center outstations would not be considered a covered Vet Center. The term State would have the meaning given that term in 38 U.S.C. § 101.

VA strongly supports the concept of expanding health care access through CBOCs and Vet Center services. We also fully embrace the need to increase access to services, reduce barriers to readjustment counseling and health care and meet the needs of those eligible for Vet Center services. However, we do not support the draft bill. The methodology for expanding Vet Centers and CBOCs set forth in this bill would eliminate VA's ability to shift resources to meet growing demand in locations with high growth potential, would not be an efficient use of resources and would have a negative impact on VA's ability to meet the readjustment counseling needs of all eligible Veterans, active-duty Service members, Reserve Component Service members, Coast Guard members and family members across all states and Territories.

As noted above, the draft bill would fundamentally change VA's demand-based model for determining resource allocation of readjustment counseling services. Further, the statutory definition of Vet Center in 38 U.S.C. § 1712A defines the term "Vet Center" and includes Vet Center Community Access Points and Vet Center Outstations, while the draft bill would exclude these latter two service locations from the definition of covered Vet Centers, which would be incongruent with current law and practice. VA uses Community Access Points and Outstations to allow for progressive growth to a full-service Vet Center as local demand for services increase.

Section 2(a) states that if VA determines that a state meets the requirements in any of subsections (c)-(e), VA would have to establish at least one additional covered Vet Center within the state. The draft bill's requirements in subsections (c), (d) and (e) would identify 11 States that would qualify for an additional covered Vet Center (9 pursuant to subsection (c), and 1 pursuant to subsections (d) and (e) each). While the draft bill only appears to require a one-time determination, if VA were required to make additional determinations under section 2(a), we believe the requirement in section 2(c)(4), that the ratio of Veteran population in the state to covered Vet Centers located in the state exceeded 50,000 Veteran per one covered Vet Center, would force VA to establish an additional 45 Vet Centers (beyond the first 11 Vet Centers identified before for a total of 56 Vet Centers) across these states. Absent significant additional resources, we believe this would result in a significant shift of Vet Center resources in ways inconsistent with VA's historical approach to allocating such resources.

Ultimately, we are unsure of the empirical basis or justification for the criteria in these subsections; it appears these criteria would be inequitable when applied universally, resulting in disparities in potential Vet Center resource allocations. The requirement to establish a full Vet Center would result in placing Vet Center facilities and associated staffing that could over-resource some states while under-resourcing others. For example, under these requirements, New York and Massachusetts would be over-resourced and would require fewer Vet Centers. These criteria would reduce the efficiency of Vet Center staff, who would be allocated to low-demand areas solely based

on population or land area; this would impose additional costs and burdens on VA and would be a poor use of taxpayer dollars. Further, by focusing specifically on state borders, the bill does not account for the fact that multiple Vet Centers serve Veterans from more than one state. By not recognizing the workload of these Vet Centers, the bill would likely result in redundant facilities and services.

Similarly, the bill's focus on Veteran populations does not account for the populations of active-duty Service members, Reserve Component members, Coast Guard members and family members that are eligible for Vet Center services. These individuals make up a significant portion of the population eligible for Vet Center services, and recent changes to Vet Center eligibility have increased eligibility among these populations even further. Without consideration for these populations, we believe the bill would have adverse effects on VA's ability to locate Vet Centers near large military bases or in states with a large Reserve Component demand. This would shift VA's resources toward areas of lower demand but higher Veteran populations without accounting for specific consideration of whether the Veteran population in the state is eligible for Vet Center services. A state with a population of 250,000 Veterans, only 50,000 of whom are eligible for Vet Center services, would potentially require 4 additional Vet Centers even though 80% of the Veterans in that state would be ineligible for services from these Vet Centers. Another state with only 240,000 Veterans, but with an equal number of eligible persons who were not Veterans, would receive no additional Vet Centers. This would not result in optimal service to those whom Vet Centers were designed to assist.

VA notes other concerns with the bill as well. The language in section 2(b) appears intended to support VA's efforts to establish Vet Centers at facilities made available to VA by state, local government or federally recognized Indian tribes, but VA already has broad authority to enter into agreements with such entities, and others, so this language would actually constrain VA's options by limiting from whom VA could lease space. Finally, we do not believe the two-year timeframe for implementation in section 2(g) would be realistic; the typical lead time for planning and subsequent contracting for new CBOCs and Vet Centers is three years.

If VA were required to establish 56 additional Vet Centers, we estimate the bill would cost approximately \$73.9 million compared with the estimated cost of establishing only 11 additional Vet Centers at a cost of \$14.5 million. Actual costs could be much higher depending on the specific staffing and facility requirements at each location. VA would be unable to support the costs associated with requiring an additional 56 Vet Centers without additional budgetary resources.

Section 2(f) of the draft bill would require VA to establish a covered CBOC in each state that the Secretary determines meet the following three requirements: (1) the state does not share a land border with another state; (2) the state is located at least 2,000 miles from the continuous United States; and (3) there is no covered CBOC in the state. These criteria would only apply to U.S. territories in the Pacific. VA does not support this provision, as establishing CBOCs in every territory is neither clinically nor operationally feasible.

## **H.R. XXXX VA Governor's Challenge Expansion Act of 2021**

The draft bill would require VA to carry out a grant program to be known as the Governors Challenge Program under which VA would provide technical assistance to states and American Indian and Alaska Native tribes for developing suicide prevention activities. The Governors Challenge Implementation Grant Program would be for the purpose of developing and implementing plans developed by eligible entities to prevent Veteran suicide. Eligible entities would include a state or an American Indian or Alaska Native tribe that develops a Veteran suicide prevention plan and that submits to VA a proposal for implementing such plan that contains such information and assurances as VA may require. VA would be required to award grants to 20 eligible entities for FY 2022, and to 24 eligible entities for each of FY 2023 and 2024. Grants could not exceed \$500,000 for any fiscal year for a maximum of three years, and grantees could not use more than 10% of the grant for administrative costs. The bill would authorize \$10 million to be appropriated for FY 2022, \$12 million for FY 2023 and \$14 million for FY 2024. These amounts would be in addition to any other amounts otherwise available for the Governors Challenge Program.

VA supports the goal of this legislation, but we would appreciate the opportunity to discuss this idea in greater detail to consider potential alternatives and address technical issues with this legislation. VA would need to engage in rulemaking to establish a new grant program like this, which could delay delivery of services and support for these efforts. We believe discussion with the Committee and other Federal agencies, such as the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration or the Centers for Disease Control and Prevention, might identify either alternatives that could be pursued within existing authority or similar but distinct approaches to legislation. We also note that VA is currently taking steps to implement the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program required by section 201 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* (P.L. 116-171), and this program may overlap with the program in the draft bill.

VA estimates its administrative costs for this grant program would be approximately \$3.4 million per year.

## **H.R. XXXX Furnishing Seasonal Influenza Vaccines to Certain Individuals**

The draft bill would amend the Strengthening and Amplifying Vaccination Efforts to Locally Immunize All Veterans and Every Spouse Act (P.L. 117-4; 38 U.S.C. § 1701 note) to authorize VA to provide seasonal influenza vaccines, in addition to or independent of, vaccines for COVID-19 for covered individuals.

VA supports this draft bill. Furnishing a seasonal influenza vaccine, a COVID-19 vaccine or both to covered individuals will provide protection against these infections. Given the surge of COVID-19 infections from the Delta variant and the subsequent hospitalizations and deaths from COVID-19, providing protection against COVID-19 and influenza will benefit individuals, communities and public health generally. We recommend if Congress plans to enact this bill, it do so quickly enough to address the peak of the upcoming flu season (between December and February).

We estimate this bill would cost \$1.17 million in FY 2022.

## **H.R. XXXX Improving the Veterans Justice Outreach Program**

The draft bill would require VA to conduct outreach regarding the Veterans Justice Outreach (VJO) Program to justice-involved Veterans, military and VSOs and relevant stakeholders in the criminal justice community. The outreach would have to be designed to spread awareness and understanding of the VJO program, to spread awareness and understanding of Veteran eligibility for the program and to improve the identifying justice-involved Veterans. VA would also be required to increase the number of VJO specialists responsible for supporting justice-involved Veterans, including Veterans in rural, remote or underserved areas. VA would have to establish performance goals, measures and implementation timelines for the VJO program and for VJO outreach specialists and to support research regarding justice-involved Veterans. Not later than one year after the date of the enactment of this Act, VA would have to submit to Congress a report on the program's performance goals, measures and implementation timelines. VA would also have to ensure that VJO specialists receive training not less frequently than annually on best practices for identifying and conducting outreach to justice-involved Veterans and relevant stakeholders in the criminal justice community and Veteran eligibility for the VJO program. Not later than one year after the enactment date of this Act, VA would have to submit a report to Congress on the availability and efficacy of Veterans Treatment Courts (VTC), best practices for VTCs in meeting the needs of both justice-involved Veterans and local criminal justice systems and the ability of justice-involved Veterans to access VTCs, including any barriers that exist to increasing access to VTCs for justice-involved Veterans.

VA strongly supports efforts to support justice-involved Veterans and has been working to assist such Veterans for several years. VA supports the goal of this draft bill, but we do not support it as written and we do not believe it is necessary. VA is either currently meeting, or will soon be meeting, most of the bill's requirements as it

implements the VJO Program's Strategic Plan and continues to respond to the recommendations from the Government Accountability Office's (GAO) recent report titled, "Veterans Justice Outreach Program: Further Actions to Identify and Address Barriers to Participation Would Promote Access to Services." GAO Report 21-564 (September 14, 2021).

Outreach to justice-involved Veterans and community or criminal justice stakeholders is the central function of the VJO Program. In FY 2022, VA will enhance provision of this outreach by delivering more in-depth training for VJO Specialists on VA health care eligibility, with a specific focus on Veterans with other-than-honorable (OTH) discharges. This training will include communication strategies to address possible misunderstandings Veterans or criminal justice stakeholders may have regarding eligibility and is intended to encourage Veterans with OTH discharges to engage with VJOs and other VA staff. VA will also continue training field staff on best practices for identifying and outreach. VA will also be increasing the number of VJO specialists in FY 2022 and will encourage and prioritize requests from VAMCs serving justice-involved Veterans in rural and underserved areas. Further, VA will establish performance goals, measures and implementation timelines while also supporting research regarding justice-involved Veterans.

VA would be unable to report on VTCs because VA's role in these courts is limited to the linkage to and provision of VA health care to Veteran participants. VA does not establish, fund, operate or determine eligibility criteria for these courts or conduct evaluations of their operations. We would be happy to work with the Committee to provide technical assistance regarding the availability of and potential sources for the information requested by this reporting requirement.

#### **H.R. XXXX    Requiring a Report on the Veterans Integration to Academic Leadership Program**

The draft bill would require VA, not later than one year after the date of the enactment of this Act, to submit to the House and Senate Committees on Veterans' Affairs a report on the Veterans Integration to Academic Leadership (VITAL) program. The report would have to include the number of VAMCs, institutions of higher learning, non-college degree programs and student Veterans supported by the program, and relevant trends since the program began; the staff and resources allocated to the program and relevant trends since the program began; and an assessment of the outcomes and effectiveness of the programs in various areas. VA would also be required to establish best practices, goals and measures for the VITAL program that are uniform among VAMCs. VA would be required to conduct outreach among the Armed Forces, VSOs, institutions of higher learning and non-college degree programs with respect to the VITAL program. VA would be required to assess the feasibility and advisability of including the suicide rate for student Veterans in the National Veteran Suicide Prevention Annual Report from VA's OMHSP.

While VA fully supports assisting student Veteran's health care and academic success, we do not support this bill as written. Specifically, VA would have difficulty evaluating outcomes and effectiveness of the program because this program has been supported through guidance on best practices rather than formal policy; because VA did not adopt formal policy, it has not established specific performance measures applicable to all locations. Among the 34 programs currently operated as part of the VITAL program, there is significant variability, which makes comparison and analysis of outcomes difficult, if not impossible. Some of the current programs only provide outreach, while others also provide clinical services and case management. Staffing levels also vary among these programs, which can similarly influence outcomes and results. These differences in approach have been an asset, as it has allowed different facilities to offer the services they can, while also providing an opportunity to explore different approaches to furnishing care and support. VA will continue to support local facilities in determining how best to engage the local Veteran community. It is important to note that many VA facilities already provide outreach to student Veterans separate from the VITAL program. The Veterans Benefits Administration's Regional Offices also conduct outreach. Additionally, we do not believe we would be able to identify suicide rates for student Veterans specifically, as the data we receive on suicides does not flag whether or not the person is a student.

#### **H.R. XXXX VA Nurse and Physician Assistant RAISE Act**

The draft bill would amend 38 U.S.C. § 7451 to increase the maximum rate of basic pay for different positions. Specifically, the maximum rate of basic pay for Advanced Practice Nurses and Physician Assistants would be the rate established for positions in Level I of the Executive Schedule (5 U.S.C. § 5312), which applies to Cabinet-level officials; the maximum rate of basic pay for registered nurses (RN) would be the rate established for positions in Level II of the Executive Schedule (5 U.S.C. § 5313), which applies generally to executives at the Deputy Secretary level; and the maximum rate of basic pay for any other covered position would be the rate established for positions in Level IV of the Executive Schedule (5 U.S.C. § 5315), which applies generally to executives at the Assistant Secretary level.

We appreciate the Committee's interest in providing VA additional flexibility to compensate nurses and other health care professionals. There are several elements of the draft bill that we do support. We support changes the draft bill would make to set the rate of pay for Advanced Practice Nurses and Physician Assistants to level I of the Executive Schedule, and the rate of pay for all other RNs at level II of the Executive Schedule, which is consistent with one of VA's legislative proposals from the Department's FY 2022 budget request. We would appreciate the opportunity to work with the Committee to develop and propose a few modifications to revise the draft bill. Specifically, 38 U.S.C. § 7451(c)(2) currently contains language allowing certified Registered Nurse Anesthetists (CRNA) to exceed the provided pay cap, based on adjustments under 38 U.S.C. § 7451(d). This flexibility is critical for VA's recruitment and retention of CRNAs, especially in high-cost labor markets, so VA recommends this sentence remain in the statute. Additionally, VA seeks a corresponding amendment to

38 U.S.C. §§ 7404(a) and 7404(e) to allow nurses and physician assistants appointed under 38 U.S.C. §§ 7401(4) and 7306 to receive pay under subchapter IV, Chapter 74 of title 38. These changes would support VA's goals of hiring and retaining the best talent in competitive labor markets.

We estimate the bill, if amended as VA recommends, would cost \$2.41 million in FY 2022, \$44.25 million over 5 years and \$161.43 million over 10 years.

## **Conclusion**

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