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COPING DURING COVID: VETERANS' MENTAL HEALTH AND IMPLEMENTATION OF THE HANNON ACT

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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C O N T E N T S

WEDNESDAY, MARCH 24, 2021

SENATORS

WITNESSES

PANEL I

PANEL II

Page

APPENDIX

WITNESSES PREPARED STATEMENTS

STATEMENTS FOR THE RECORD

QUESTIONS FOR THE RECORD

RESOURCES ON MENTAL HEALTH AND HANNON

COPING DURING COVID: VETERANS' MENTAL HEALTH AND IMPLEMENTATION OF THE HANNON ACT

WEDNESDAY, MARCH 24, 2021

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3 p.m., via Webex and in room SD-G50, Dirksen Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding. Present: Senators Tester, Brown, Blumenthal, Hirono, Manchin, Hassan, Moran, Boozman, Sullivan, Cramer, and Tuberville.

OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. The hearing will come to order. I want to welcome everybody to the Senate Veterans' Affairs Committee hearing. Today we have got a great hearing scheduled, and I want to welcome everybody.

I have got good news today. The President signed our bipartisan Saves Lives Act into law. For those who do not know, this new law expands options where veterans and their families can receive the COVID–19 vaccine, ensuring that every veteran and their spouse and their caregiver will have access to protection they need from the VA, and it follows through on our shared goal of getting as many shots in the arms of veterans as possible.

I want to thank our great Ranking Member, Senator Moran, along with Senator Boozman and Senator Blumenthal and our House colleagues for helping all of us work together to push this bill through and get this pandemic behind us or take a step toward that and move our country forward.

As you might recall, it was just a month ago that we were sitting together in this room, at a VA vaccine hearing, and the idea of this bill came up, and I think it really speaks to the bipartisan nature of this Committee and how fast we can all work together to solve a problem when we recognize that there is a need out there.

I am looking forward to seeing what comes out of today's hearing, which is focused on veterans' mental health, a huge issue. Now I thank the veteran service organizations as well as the Department of Defense and Veterans Affairs officials that are with us here today.

Many of our men and women in uniform face isolation and mental health challenges when they return home from their service, and more than a year into his pandemic we now know that vet-

erans across the country experience mental health concerns at higher rates than ever, and that is why it is important that we gather today to talk about the challenges veterans have faced accessing mental health care during this pandemic, and to hear from both the VA and the DoD about what they are doing to address those concerns.

I want to commend the VA for its use of telehealth services and its quick shift to virtual operations for the Veterans Crisis Line when the virus took hold of the Nation.

As we know, the effects of this pandemic are far from over, and the number of veterans who die by suicide remains way too high, and that is why it is even more critical that the VA and the DoD takes swift action to implement the Commander John Scott Hannon Act, my bipartisan bill with the Ranking Member Moran, that was signed into law last fall. Named after a former Navy SEAL in Montana, Commander John Scott Hannon, this law honors his legacy and reaffirms our commitment to those who are selflessly served by taking aggressive action to approve mental health access in this country for our veterans.

The Hannon Act combines some of the best ideas from veterans, VSOs, VA, and mental health professionals to improve veterans' access to mental health care. It does so through strengthening telehealth and alternative therapies, better connections to care in the community, research through evidence-based treatments, and accountability for the VA's management of suicide prevention resources.

It also provides more local and complementary health care options, which brought Commander Hannon comfort back to Montana, by working in nature with other veterans. And it bolsters VA's mental health work force through a scholarship program to get more mental health professionals into our vet centers. There is no time to waste in implementing the important provisions of the Hannon Act, and I know Senator Moran and members of this Committee share that important goal.

Further, the transition from servicemember to veteran can also be very difficult for many. That is why I think it is essential that we have the DoD take part in these conversations as well. They have an important responsibility, shared with the VA, to implement the Hannon Act and improve the transition experience, make connections to mental health resources, and contribute to joint VA-DoD mental health programming. We need to continue to reduce the stigma of accessing mental health care, making sure our vets have every option available to them.

I would like to thank all that are here today for your commitment to bettering the health and well-being of our service men and women, veterans, and their families.

With that I will turn it over to you, Senator Moran.

OPENING STATEMENT OF SENATOR MORAN

Senator MORAN. Chairman Tester, thank you. Senator Tester and I serve on five of five committees together, and we share that joy or burden almost every day. Mr. Chairman, it has been a pleasure to work with you on a number of pieces of legislation, including the Save Act, and I thank President Biden for signing it into law

today. I cannot imagine there is another member of the United States Senate that I have teamed up with that has resulted in more legislation being passed and more legislation being signed into law. So thank you for your efforts to put up with me on five committees and to work together on legislation.

This issue, for me, arose when I was visiting the Topeka Colmery-O'Neil VA Medical Center and their vaccine site, now perhaps 3 weeks ago, and one of the items that was brought to me by the director, as well as by veterans, is a reluctance on the part of veterans to take the vaccine, to get the vaccine, in the absence of their spouse or caregiver being able to get it as well. And just common sense indicates that is a problem waiting for a solution, and I am pleased to see that that is taking place, and I thank the folks at Colmery-O'Neil for hosting me to see and talk to veterans about the vaccine, which led to my interest in this topic.

I am pleased also to be here this afternoon to discuss one of Senator Tester and I's top priorities, this Committee's top priority on veterans' mental health care as well as the comprehensive veteran suicide prevention legislation that we worked on last year, the Commander Hannon Act, which became law last year.

I want to thank all of our witnesses for being here today, and I extend a special welcome to Jim Lorraine for joining us. He is with the America's Warriors Partnership.

COVID–19 pandemic has exposed substantial gaps in America's mental health care system, both within the VA and throughout communities across the Nation. Many Americans have experienced devastation due to the loss of family members or friends, while others have experienced joblessness and financial uncertainty. While it is important we continue to prioritize vaccinations for all American adults as soon as possible, it is also critical that we do not forget about the mental health toll that this pandemic has taken on Americans, and especially on our veterans.

We know this pandemic has led to a rise in anxiety, depression, suicides, and overdose deaths. In fact, a study recently published by JAMA Psychiatry illustrated that emergency department visit rates for suicide attempts and overdoses were much higher from mid-March through October 2020, compared to the same period of time in 2019. For many veterans who already live with mental health conditions or an addiction, the added social isolation and the fear due to this pandemic has heightened these conditions.

A survey released last December by the Wounded Warrior Project found that 30 percent of the 30,000 veterans polled reported recent suicidal ideation, and roughly 60 percent reported symptoms of moderate to severe depression. This is another wake-up call for all of us.

Thankfully, Congress worked in a bipartisan manner last year to pass the Hannon Act. Now it is up to the VA, with alacrity, to implement this comprehensive suicide prevention law, consistent with congressional intent.

Getting results for veterans is what matters, and I am glad our oversight today is oriented toward that goal.

Taking into account the high rate of veteran suicide is now more important than ever for the VA to execute the lifesaving provisions contained in the John Scott Hannon Act. We know that connected-

ness to one another, to other veterans, to family, to community is an important protective factor for suicide.

We also know that two-thirds of veterans who die by suicide have no meaningful contact or interaction with the VA prior to their deaths. It is imperative that the VA move quickly to implement the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. This program will extend VA's reach to vulnerable veterans not under the Department's care and enable us to bolster organizations already serving veterans in communities across America.

Additionally, I was encouraged by the recent update my staff received on a provision in the Hannon Act regarding the VA's implementation of Safety Planning in the Emergency Department, SPED. SPED is an evidence-based intervention program that is shown to decrease suicide by 45 percent in the 6-month period following intervention. While SPED was originally rolled out in October 2018, only about 28 percent of VA facilities use this intervention. In January 2020, the VA had only marginally improved to 33 percent of facilities using this evidence-based intervention. Now, because of this Committee's oversight, the actions by the Department of Veterans Affairs, over 82 percent of all VA facilities have adopted it, and I applaud the Department for this dramatic improvement. I look forward to hearing from our witnesses today.

Before I close, though, I would indicate to any veteran that is in the crisis mode, anyone who is listening now that has an ideation about suicide or needs mental health counseling, please call 1–800–273–8255, and press 1. That is 1–800–273–TALK, and then press 1. And I yield back, Mr. Chairman.

Chairman TESTER. Thank you, Senator Moran. At today's hearing we are going to have a two-panel format. In the first panel we are going to hear from VA and veterans advocates about veterans' access to mental health care during the pandemic and beyond. Then, in the second panel, we are going to get to an update from the VA and DoD officials on the implementation of the Hannon Act.

I want to first introduce the panelists for our first panel. Some will be here virtually, others will be here in person. I first want to introduce Dr. David Carroll, head of the VA's Office of Mental Health and Suicide Prevention, to deliver the VA's opening Statement. Dr. Carroll is accompanied virtually by Dr. Lisa Kearney, Acting Director of the Veterans Crisis Line and Deputy Director for Suicide Prevention at the VA.

Then we are going to hear virtually from Ms. Tammy Barlet with the VFW, then in person from Mr. Tom Porter from IAVA, and Lt. Col. Jim Lorraine, who will be here in person, from the America's Warrior Partnership.

Dr. Carroll, we will start with your presentation. Go ahead.

PANEL I

STATEMENT OF DAVID CARROLL, ACCOMPANIED BY LISA K. KEARNEY

Mr. CARROLL. Good afternoon, Chairman Tester, Ranking Member Moran, and members of the Committee. Dr. Kearney and I are pleased to be here to discuss VA's delivery of mental health care and suicide prevention services during the COVID–19 pandemic.

Nothing is more important to VA than advancing the health and well-being of the Nation's veterans and their families, and suicide prevention is our No. 1 clinical priority. Our national vision for preventing veteran suicide is grounded in three tenets: suicide is preventable, it requires a public health approach, and everyone has a role to play in suicide prevention.

We know that pandemics, especially those involving quarantines, create psychological distress and negatively impacts society beyond the period of the pandemic itself. So guided by our public approach to suicide prevention and recent research, VA created a Mental Health COVID–19 Response Plan, organized around universal, selective, and indicated strategies. Our plan focuses on both the immediate and long-term impacts on mental health and suicide prevention, including support for the most vulnerable veterans, as well as for all 20 million veterans, as well as for all providers and leaders across VA.

The plan includes adaptations of our Suicide Prevention 2.0 initiative and our Suicide Prevention Now initiative, to include new COVID–19-related suicide prevention efforts.

VA has maintained continuity in mental health care and suicide prevention services during the pandemic, and we have conducted surveillance on the trends and facility-reported suicide-related behavior. Findings to date do not indicate there are pandemic-era increases in veteran suicides, non—fatal suicide attempts, or in the volume of emergency department visits related to suicide attempts, as reported by our facilities. However, the long-term impact in the rest of the data remain unknown.

We have worked to increase our communication and to bring veterans, providers, and leaders closer together across VA during the pandemic, and our work has been informed and influenced by the recent legislation, giving us opportunity to further expand our public health approach to suicide prevention and mental health. We appreciate the Committee's continued direction, support, and partnership in this shared mission.

Mr. Chairman, this concludes my Statement. My colleague and I are ready to answer any questions you and the members of the Committee may have. Thank you.

Chairman TESTER. Thank you, Dr. Carroll. And I assume that Dr. Kearney is there to support you?

Mr. CARROLL. Correct.

Chairman TESTER. Okay. So next we will hear from Ms.Tammy Barlet from the VFW.

STATEMENT OF TAMMY BARLET

Ms. BARLET. Chairman Tester, Ranking Member Moran, and members of the Senate Committee on Veterans' Affairs, on behalf of the men and women of the Veterans of Foreign Wars of the United States and its Auxiliary, thank you for the opportunity to provide our insight pertaining to veterans' mental health during the COVID–19 pandemic and the use of ATLAS pod sites. Linesville is a small, rural town in northwestern Pennsylvania, and is vulnerable to 81 inches of snow per year due to the Lake Erie snow effects. The nearest VA medical center is in Erie, which is over an hour's drive on days with normal weather conditions. This

past February in Linesville, a Vietnam Navy veteran left his home, drove to a VA video-connect VVC appointment and returned 35 minutes later, thanks in part to the ATLAS pod at the VFW Post 7842.

He admitted that he is not the most tech-savvy guy and expressed his gratitude for the short drive to the post and the onsite attendant to help guide him through the check-in process. He also mentioned that this relieved him of stress and hassles having to drive to Erie or try to connect to the video appointment on his own.

The VFW released a survey at the end of April 2020, through which VFW members provided a snapshot of their health care experiences 6 weeks into the COVID–19 national emergency.

My written testimony has a detailed breakdown of these statistics. The majority of the respondents stated they were in good health, with five or fewer days of poor physical health and poor mental health, which had little interference on their daily activities in the last 30 days. Although but a part of the remaining respondents expressed their experiences were either 6 to 10 days or 26 or more days out of the month. The VFW plans to conduct a following survey.

Telehealth plays a critical role in maintaining veterans' mental and physical well-being during the time of social distancing quarantine. The urgent transition from in-person appointments to telehealth left both patients and physicians relying on communication via telephone, which made up 81 percent of those encounters, according to a recently released Office of Inspector General VA report. But making eye contact and seeing facial body cues is essential to successful appointments, and the OAG sent a questionnaire regarding VVC barriers to the Veterans Health Administration primary care providers. The providers identified veterans' lack of internet connectivity and equipment, insufficient training and support for veterans, which included the test of it prior to the scheduled appointment and the problematic, two-system process for face-to-face care. The OIG recommended that VA assess VVC and take appropriate action to address the digital divide.

The VFW is proud to be part of this solution. Through the ATLAS pod sites the VFW worked with VA and Philips to leverage VA's anywhere-to-anywhere authority, to expand telehealth options for veterans who live in rural areas, or may have lack of access to internet, necessary equipment, and knowledge to facilitate VVC. In addition to secure and private VVC connectivity, the ATLAS locations contain a full suite of telehealth devices.

The first VFW post with the ATLAS site was in Eureka, Montana. Eureka is more than 60 miles from the nearest VA clinic, and more than 250 miles from the nearest VA hospital. The Eureka ATLAS site had many appointments before the temporary shutdown of the post due to the State's COVID–19 pandemic precautions, but since then the post as reopened, appointments continue, and several have been scheduled for the next 30 days.

The second VFW location is Linesville, Pennsylvania. The Post Commander, Norm Haas, is humbled to have this valuable resource for the veteran community. He would like to expand the hours of operation 15 hours a week to 40 hours a week. In the meantime, the Erie VA Medical Center has mailed out postcards

announcing the ATLAS pod availability and hours of operation to eligible veterans in the area.

Two additional VFW ATLAS locations are scheduled to open within the next month, VFW Post in Los Banos, California, and the other in Athens, Texas, and there is interest for 22 more locations. The VFW commends the Senate for passing the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, and the additional legislation to fund expansion of VA's telehealth services into law. The VA urges congressional oversight to ensure VA implements the legislation as written and intended, so VFW posts can continue to expand telehealth capabilities, which include mental health programs and suicide prevention to veterans in rural and highly rural areas.

Chairman Tester and Ranking Member Moran, this concludes my testimony. Thank you for the opportunity to present the VFW's input today, and I look forward to engaging in any further discussion you or any members of the Committee may have.

Chairman TESTER. Tammy, thank you for your testimony, and there will be some questions coming up. I have got a few myself for you, and I appreciate your testimony. Next we have Tom Porter, who is Executive Vice President of Government Affairs for Iraq and Afghanistan Veterans of America. Tom, the floor is yours.

STATEMENT OF THOMAS PORTER

Mr. PORTER. Thank you. Good afternoon, Chairman Tester, Ranking Member Moran, and good afternoon, Senator Tuberville. Thanks for having me here today. I appreciate the opportunity to testify.

Before I get started I would like to welcome our members who are virtually watching today. We normally have an in-person fly in for a week a few times a year but we cannot do that, so they are all watching from around the country, but meeting virtually with many of your offices. You can follow along this week with the hashtag allstaradvocacy on Twitter.

So as with everyone else, the last year has been challenging for IAVA. This time last year we had just wrapped up a very successful member fly in. Within a week of saying goodbye, we were in quarantine, and working remotely. Despite the challenges, IAVA was successful in adapting to continuing our advocacy.

We were able to help pass critical reforms, and we thank you for passing the Hannon Act, Deborah Sampson Act, and protections for student veterans as schools went online. Additionally, we helped to pass legislation to establish a three-digit national suicide hotline to improve access to suicide prevention resources. The pandemic has affected almost every facet of our lives. Our members report feeling more isolated than ever.

According to VA, almost a quarter of all veterans live in rural communities, areas that tend to have higher poverty rates and more elderly veterans. As VA focused more on telehealth at the start of the pandemic, rural veterans had particular challenges since a quarter of them do not have internet access at home. We are pleased that the Hannon Act expanded tele-mental health to increase accessibility.

According to recent VA data, veterans age 18 to 34 have the highest rate of suicide, and in our last survey, 65 percent of IAVA members reported service-connected PTSD, and over half reported anxiety or depression. COVID has exacerbated the issue, and data from last year's IAVA Quick Reaction Force demonstrates this. QRF is a safety net that provides free, comprehensive care and peer support for any veteran or member in need, regardless of service era or discharge status.

The needs of veterans remain high, particularly in light of the pandemic, and in 2020, QRF saw a 400 percent increase in clients served from 2019. QRF is built to address all aspects of a veteran's life and are in need of intervention and support, and we do this by providing holistic and comprehensive care. In 2020, more than 15 percent of all requests were mental health related. Additionally, IAVA continues a partnership with the Veterans Crisis Line and also has 24/7 in-house clinical support for those at suicide risk who reach out to us.

Outside of mental health needs, 56 percent of QRF requests were related to emergency financial assistance, the threat of homelessness, or both, which directly impacts one's well-being. Recent HUD data, released last week, shows that veteran homelessness increased before the pandemic hit. Between 2010 and 2019, homelessness decreased by over 50 percent. However, in January 2020, the number of homeless veterans had increased from the previous year.

This troubling data predates the pandemic. Data from HUD, coupled with IAVA's QRF data shows that veteran homelessness remains a problem.

Housing has been a concern while transitioning from service. In IAVA's last survey, 24 percent reported being homeless for over a year after leaving the military, and 81 percent reported couchsurfing temporarily. We must ensure that recently separated veterans are aware of benefits available to them during this difficult time.

Additionally, homeless veterans may have families to support, and women veterans are historically at higher risk for homelessness than civilian counterparts. Providing safe facilities for women that accept children is critical. Others are younger veterans who must need temporary support. The VA must continue partnerships to align services to adjust for these demographic shifts. Unemployment is also a concern. In February, the unemployment rate for all veterans was 5.5 percent below the 6.2 average nationally. However, the post-9/11 rate remains higher than their peers.

I want to thank Chairman Tester and Ranking Member Moran for passing the Veterans Economic Recovery Act, which will be very impactful in lowering unemployment. Strong oversight of this new law is necessary for it to be successful. Women veterans are more likely than males to face economic and personal challenges. They have higher unemployment, are more likely to be homeless, and be single parents. These issues have increased during the pandemic.

Women veterans are also at more than twice the risk of suicide than civilian peers, making it more imperative to address these issues. For these reasons, the Hannon Act must be quickly implemented. The community grant program is designed to identify the

14 veterans per day who die by suicide who are not participating in VA service, and connect them to lifesaving resources. The provision could not be more important now, when veterans are more disconnected than ever.

VA still faces a shortage of mental health professionals. Recent legislation targeted deficiencies in recruitment and retention by creating scholarship and student loan repayment programs by adding $65 million to VA's recruitment, relocation, and retention bonuses.

However, these scholarships are limited. VA needs to move psychologists under the hiring authority which provides more competitive salary than the Federal GS scale. The Hannon Act will have long-lasting effects, and veterans need those provisions today. So we ask for your oversight to ensure quick implementation.

Thank you again for the opportunity to testify for IAVA, and I look forward to any questions.

Chairman TESTER. Tom, thank you for your testimony. I appreciate it very much.

Next up we have Lt. Col. Jim Lorraine, United States Air Force, Retired, and he is the President and CEO of America's Warrior Partnership. Jim?

STATEMENT OF LT. COL. JIM LORRAINE

Colonel Lorraine. Thank you, sir. Chairman Tester, Ranking Member Moran, and members of the Committee, thank you for the invitation to testify today.

COVID–19 has devastated the United States over the last year. This devastation manifested itself in death, long-term illness, financial ruin, isolation, emotional strain, and loss of hope. Military-connected citizens were not immune to this devastation. However, in many cases veterans and their families led efforts to help fellow citizens and supported community-based programs to empower others to move forward, despite the adversity. At America's Warrior Partnership we recognize, through our studies, that local programs that had proactively developed relationships with their community veterans ahead of the crisis were much more prepared to serve during the pandemic than others.

In South Carolina, an affiliate community, Upstate Warrior Solution, used their close relationship with over 7,000 veterans living in the region to meet the majority of the needs. They connected by phone, text, email, and physically distanced check-ins. Programs like UpState Warrior Solution were able to mitigate many of the stressors facing veterans and their families. In the Arizona Navajo Nation, our veteran service program, the Dina Naazbaa' Partnership, reconnected with more than 300 veterans in the tribal areas, bringing them food, water, blankets, and firewood. However, the greatest gap for veterans during COVID is reduced access to health care. Syracuse University Institute for Veterans and Military Families identified medical care as the No. 1 resource need, followed by financial assistance and community support. Wounded Warrior Project surveyed more than 28,000 post-9/11 disabled veterans, finding that 59 percent reported that their physical health appointments and 38 percent that their mental health appointments had been postponed or canceled.

Additionally, Wounded Warrior Project found that lack of medical care compounded the negative response to COVID pandemic, and as the Ranking Member mentioned, 30 percent of the respondents expressed suicidal ideations. Similarly, Blue Star families found that access to medical care and overall mental health status of parents and children to be a leading concern. And still, a year later, we have heard from our communities and county partners that access to care is not improving.

On March 2020, Ranking Member Moran had concerns about the temporary pause in community care. And a year later, just this month, USA Today cited a congressional letter from the northeast detailing the cancellation of almost 20 million medical appointments to veterans during the pandemic. Last week, the Secretary of Veterans Affairs said that the VA is facing a significant backlog in health care.

Members of this Committee, we cannot wait for another crisis to occur. We believe COVID–19 pandemic impact will not be fully recognized for many years, and it is clear that access to care, by all means, is essential to stem the backlog. This cannot be done by consolidating care within the VA, but instead, maximizing the use of the MISSION Act, which you brought to us, and rapidly implementing the Hannon and COMPACT Act.

Yet, despite the polls and surveys, much of the impact of COVID–19 is difficult to fully identify without additional data. Through Operation Deep Dive, America's Warrior Partnership's nationwide veteran suicide study that seeks to identify data-driven, community-based suicide prevention measures, 15 percent of the States in the United States have provided death data covering the last 5 years. To date, the major takeaways indicate that States are undercounting former veteran suicide by approximately 20 to 25 percent. Overdose is the greatest contributor to non—natural causes of death, and dishonorable discharge status has little impact on the suicide rate of this population.

We are fortunate to share this data with the Department of Defense to validate which of the deceased had served in the armed forces. This partnership with the Department of Defense and a panelist in the next panel, Dr. Karin Orvis, has provided us with critical insight, not only into former servicemember suicides but natural and non-natural causes of death, such as cancers, overdose, strangulation, drowning, and firearms.

This relates to the impact of COVID, because Florida and Minnesota will be the first States to provide their 2020 death data this summer, which we will provide for greater insight into the impact of the pandemic, because we will be able to see the entire death rate for those two States. While we await the 2020 State data, we are missing VA data, which will allow us to connect the dots between State death details, DoD experience, and VA participation.

In summary, we have been changed by the pandemic. Secretary McDonough inherited a significant backlog that will require the VA to use all the tools at their disposal, especially the MISSION Act. The VA must rapidly implement the Hannon Act and COMPACT Act. And lastly, we hope that the VA will share critical data outside of the Department. Thank you for the opportunity to present to the Committee.

Chairman TESTER. Jim, thank you for your testimony, and I want to thank everybody who provided testimony this afternoon. I appreciate it.

We are going to start with questions. The first two questions I am going to ask are directed at you, Ms. Barlet, and I want to thank you for talking about telehealth. I think just about everybody did, that provided testimony.

And look, I think for the VA this can mean a video visit with a provider or sometimes just a phone call. The opening up of the ATLAS pod sites at the VFW posts can be another avenue for veterans to access mental health care from the VA, and I want to thank the VFW for opening their doors and providing this improved access to veterans in this country, especially in my home State of Montana and beyond.

I will tell you, Eureka, Montana is one of the most beautiful places in the world. It is not only rural, but it is frontier. So those pods are critically important if we are going to have veterans access health care.

But Ms. Barlet, the question is, what are the main barriers that veterans face in accessing care via telehealth? And can the ATLAS pod sites be something that we can implement all around this country? Will they be effective?

Ms. BARLET. Thank you, Senator Tester for that question. As far as the main barriers veterans face in access to telehealth, we are seeing the strongest one is broadband connectivity, followed by insufficient equipment and technology illiteracy. Like I mentioned earlier, with story from the gentleman at the VFW ATLAS pod, he was appreciative of that assistant who was there to connect him to the appointment and then troubleshoot, which they see at the ATLAS post. There is someone there to help troubleshoot in case they need it.

The ATLAS location pods itself, whether it is in the VFW or a Walmart, will have that technology to perform that VVC appointment, such as a suite of telehealth equipment.

Chairman TESTER. You know, it has been a few years ago now, I believe, they set up a pod here in the Russell Building, Philips did, and one of the things that really appealed to me is that you could go into these pods, and you might go in to have your blood pressure checked, or you might go in for a mental health issue you might be having, or you might be going in just because you have got a sore throat. How have you seen—and maybe you know maybe HIPAA will not allow you to know this—but how are veterans using those pods? Are they using it for more than just mental health, or is primarily just mental health care?

Ms. BARLET. Especially right now with the COVID pandemic we are seeing it used for both. As far as being specially equipped to have the sites for tele-mental health, you know, these pods on these sites are a secured, private space, where the veteran can talk to their provider, one-on-one. Like I mentioned earlier, the eye contact and body cues can definitely help the provider and the veteran in that appointment. There is also lighting color within these pods, that the veteran can adjust if they feel necessary. So the tele-mental health services can help provide group therapy sessions for con-

necting veterans who have similar experiences, in a safe, supported setting, regardless of where they live.

Chairman TESTER. That is great. So as the VA sets up grant programs for telehealth sites, what could organizations like the VFW use from the VA to make sure that these sites are successful in providing high quality telehealth care to veterans? That is for you, Ms. Barlet.

Ms. BARLET. Sure. Thank you, Senator Tester. To ensure that these sites are successful we need to ensure that the facility's infrastructure, electrical, and broadband connectivities are there and prepared to support the ATLAS location.

Chairman TESTER. That is good. Dr. Carroll, I would like you or Dr. Kearney to speak about any outreach the VA has done during this pandemic to COVID-positive veterans, to ensure that their mental health care needs are being met.

Mr. CARROLL. Yes, sir. Thank you for the question, and we appreciate the support of VFW in the ATLAS project. To your question about outreach, we have been able to identify veterans who test positive for COVID or are otherwise diagnosed with it, and then put into place a caring outreach program to them, particularly for anyone who we know may be already at high risk for suicide. We have set up programs to do very proactive outreach to those who have been diagnosed.

Chairman TESTER. How well has that been accepted by the veterans that have been diagnosed? Is it something that they have resisted or have they welcomed it?

Mr. CARROLL. To my knowledge, sir, it has been very well received, as well as by their family members.

Chairman TESTER. Okay. I will turn it over to you, Senator Moran.

Senator MORAN. Chairman, thank you. First of all, Ms. Barlet, thank you and the VFW for your support of the pod, and I appreciate particularly the selection of a location in Kansas, Emporia, and we look forward to coming online and being of value to veterans in that area.

Lt. Col. Lorraine, let me thank you for you highlighting Community Care. It is a significant component of how we can deliver care and should deliver care to veterans who are distanced or their specialty is something that is best suited in that community, in a community. And I have never understood the decision by the Department of Veterans Affairs to reduce Community Care during the pandemic, if it was available. It was the perfect place for care to be provided so that veterans were not traveling distances and congregating in a way that lent itself to the spread of the virus. We will continue to monitor that circumstance, and the Secretary and I have had this conversation, as well as the previous one.

Let me start with you, Mr. Lorraine. Your testimony talked a lot about data-sharing and exchanges with the Department of Defense. What caught my attention is you did not mention the Department of Veterans Affairs. And so do you not currently share data with the VA?

Colonel LORRAINE. We do not currently share data with the VA.

Senator MORAN. Is there an explanation for that?

Colonel LORRAINE. The HIPAA compliance and the PAI for the VA, in terms of releasing data. That is what the last word we heard back was.

Senator MORAN. Dr. Carroll, anything that you would tell me about the lack of sharing of data in this circumstance?

Mr. CARROLL. Sir, we are very eager to work with Mr. Lorraine and the America's Warrior Partnership on this. We do have an agreement to work with them in some other areas, and so we are working on what more we can do in terms of data-sharing, but very eager to do this.

Senator MORAN. Is the problem that Mr. Lorraine mentioned, are they insurmountable?

Mr. CARROLL. We are looking into that. I do not think there is an insurmountable problem here, sir. I think we have to make sure that we are able to protect, you know—we have information security requirements, HIPAA requirements. But those generally are manageable tasks, but we just have to work through them.

Senator MORAN. Thank you, Dr. Carroll. When the story becomes more clear would you please report to me or to the Committee staff and let us know what the status is? It seems odd to me that the Department of Veterans Affairs has not found the right security path to allow this, but the Department of Defense has, and it seems to me that this information-sharing is important.

Let me ask you, Dr. Carroll, about, again, the COVID–19 pandemic. We know that social isolation has an effect upon the topic of the day, mental health well-being as well as suicide and suicide prevention. Numerous conversations with the Department in the past have routinely informed me about the purchases of iPads. It was a very common response for meeting the needs of veterans with this virtual care.

I do know that many communities in Kansas and across the country still lack connectivity, and I am curious if there are other ways that you can share with me and with the Committee that there are proactive ways that the Department has worked to prevent suicide.

Mr. CARROLL. Yes. Thank you, sir, and I think Ms. Barlet teed up the issues very well before, in terms of thinking about bandwidth, equipment, and familiarity with using telehealth connections. And so VA has tried to address all of those over the last year. We have distributed over 109,000 iPads to veterans so they could connect into care. In the VA we have also provided hotspots where there would be an opportunity, but they do not have the bandwidth capability right now. We have also worked with veterans to engage them in the FCC's Lifeline program.

But we know that even under all of those circumstances, for some veterans there still may be a problem, which is why the ATLAS project is so incredibly important.

The other thing that we have done is for those who are not well familiar or comfortable we have put in place what we call a White Glove Program. So someone will reach out to that veteran and help them get connected, help them understand how the iPad works, and then they are ready for their appointment.

Senator MORAN. Dr. Carroll, thank you, and I know what challenging times this has been for individuals, including you, but your

team and workers, those who work at the Department of Veterans Affairs, and thank you for those efforts during difficult times and for your continued effort to reduce this challenge that we face of suicide and mental health issues. I will ask this just for the record, but I will say it verbally, and then my time is 10 seconds expired.

Mr. Lorraine, I understand the America's Warrior Partnership works with local veteran-serving organizations to build communities for veterans near their homes. We know that connectedness with your organization helps to build a protective factor against suicide for veterans. I would like to have you elaborate a bit more on how the VA could be more helpful in this partnership, in addition to quickly implementing the John Hannon Act, Section 201. I do not think I have time for your response, but if you would make sure that I learn what your suggestions are.

Colonel LORRAINE. Yes, sir.

Senator MORAN. Thank you.

Chairman TESTER. We appreciate that, Senator Moran, and that is a great question, so thank you. Next up we have Senator Maggie Hassan from New Hampshire.

SENATOR MARGARET WOOD HASSAN

Senator HASSAN. Thank you very much, Mr. Chair and Ranking Member Moran for holding this hearing, and to all of our witnesses for being here today but also for the work that you do. Dr. Carroll, I want to start with a question to you. I am concerned about veterans who are transitioning from military to civilian life, especially over the past year. Rates of death by suicide for veterans are historically twice as high during their first year after leaving the military. The VA's Solid Start program, through which the Department contacts new veterans three times in their first year of civilian life, is another important tool to help improve this transition. And I will be reintroducing the bipartisan, bicameral Solid Start Act in the coming weeks to amplify and expand this program. Dr. Carroll, can you talk to the value of efforts like Solid Start during the pandemic and what else the VA can do to help serve this population of new veterans who are transitioning to civilian life at this challenging time.

Mr. CARROLL. Thank you, Senator, for the question, and it is an issue of great concern to us as well, obviously, and the Solid Start program is a wonderful resource to help servicemembers make that transition. I think from listening to the stories of servicemembers, they have often underestimated the challenges of that transition, going through that switch from one way of life and one sense of purpose and belonging to another. Family members are concerned about that as well.

So our Solid Start program is important. The improvements that we have made with DoD in the Transition Assistance Program is important. We have some special resources, online resources for women veterans, focused on their special needs during that period of time. I think what we can do with our communities, throughout our Governor's Challenge program under our suicide prevention activities is incredibly important. So it is not just the VA that is reaching out but it is communities, and I think the more that we can do with our Federal partners, with this Committee, and other

Members of Congress to really make sure that our communities are there to recognize and welcome veterans back into their midst and help them make that transition successfully over time.

Senator HASSAN. Well, thank you for the answer, and I do think when I talk to people back in New Hampshire they are really eager to know who the veterans are in their midst, because they do want to be supporting veterans. They also want to be supporting active servicemembers' families, so something we all continue to work on.

I have another question, Dr. Carroll. From 2005 to 2018, veteran suicide rates increased by 25 percent among veterans with a recent VA health care use. But over the same period, the suicide rate increased by more than 57 percent among veterans who had not recently used VA health care. This data shows that we need to continue to improve VA care, but also shows how important it is that we engage with and support veterans who are not routinely coming to the VA for their care, to your point just now.

Dr. Carroll, can the VA support these veterans, and what tools or resources should Congress be exploring outside of the VA in order to reach these veterans? You talked a little bit about the community, but what else can we be doing?

Mr. CARROLL. Yes. Thank you, ma'am. I am going to ask Dr. Kearney to comment on this in just a moment. But I think I want to begin by saying our commitment, our desire is to help veterans connect to care wherever it makes sense for them. Certainly we welcome them into the VA. We know that our care is effective. But if, for some reason, they are not going to join us or cannot, we want to make sure that they get connected. But, Dr. Kearney, can you please elaborate?

Ms. KEARNEY. Absolutely, and thank you for the question. I think one of the important points for us to emphasize is VA knows we need a public health approach to address suicide prevention, and that is going to be community-based prevention plus clinically based intervention strategies.

So there are three particular prongs of what we call Suicide Prevention 2.0, where we are trying to reach out into the community. One is the Governor's Challenge, that Dr. Carroll just mentioned. One, that is a State level. There is interstate level, in which we are hiring CEPC, Community Education Partners, to work with communities to create suicide prevention coalitions and build on those already there, to strategize for suicide prevention.

And last, more rural-based, in which we are doing together with the veterans in helping to train veterans to outreach into their communities. So combined together, we are really focused on three priorities there. One is identifying who those servicemembers and veterans are and being able to screen for suicide, getting them into care, transitioning into care, and also helping with lethal means safety planning. So we absolutely agree with you that we need to do more, and we are doing that.

Senator HASSAN. Well, thank you very much. Thank you both, and I will followup with a question for the record, particularly about some of the rural issues we have. Thank you, Mr. Chair.

Chairman TESTER. Thank you, Senator Hassan. Are you ready, Senator Sullivan.

Senator SULLIVAN. No.

Chairman TESTER. Okay. Senator Cassidy from Louisiana.

Senator SULLIVAN. I will go next. Is that all right? I mean, after——

Chairman TESTER. Yep. No, you forfeit to the very end of the Committee meeting.

Senator SULLIVAN. No, no. We cannot do that.

Chairman TESTER. I am just kidding.

Senator SULLIVAN. Thank you, Mr. Chairman, for asking me, though. I obviously did not look ready.

Chairman TESTER. Senator Cassidy? Senator Cassidy?

[No response.]

Chairman TESTER. Okay, Senator Blumenthal from Connecticut.

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman. Ms. Barlet, as you know, 19 States have procedures in law for separating individuals who are in imminent risk of danger to themselves, or others, from their guns. The statistics, I think, show that two-thirds of all veteran suicides are done by firearm. Would you favor using those statutes, where someone is shown to a court, and a court issues an order to separate that person from his or her firearm, for some limited period of time when help could be provided?

Ms. BARLET. Thank you for that question, Senator Blumenthal. We do need to keep in mind of everyone's safety, including that veteran and their family. And I do know, in the House, Representative Underwood has a lethal means training legislation to be introduced as it was introduced in the past legislation. So we are looking to support that along the way and ensure VA employees throughout VA, just not VHA, have the knowledge and training to be able to have that type of conversation with their veterans.

Senator BLUMENTHAL. Would you be in favor of other States adopting those kinds of statutes?

Ms. BARLET. Senator Blumenthal, I would have to take that for the record and get back to you on that question.

> [Response to Senator Blumenthal's Question: We continue to gain an understanding of the statues in the 19 states, and are expanding our knowledge to states who currently do not have legislation on the books or in the process of creating legislation.]

Senator BLUMENTHAL. I would appreciate that. Mr. Porter, do you have a position on these kinds of extreme risk?

Mr. PORTER. Thank you, Senator. I would agree with my colleague at VFW on the lethal means training. We are very strongly supportive of expansion of that, so I would look more into it. At the States, I think it would depend a lot on where the States were on each of those issues, but I would want to look at it more closely.

Senator BLUMENTHAL. Do any of your members ever, peer-to-peer, take action to try to protect veterans from that kind of danger when they are in danger of taking their own lives?

Mr. PORTER. I would not want to speculate, Senator. I am sure they take lots of different actions. Our members, we hear often that they are very engaged in extending help in any way possible in any

of those situations, whether it is pushing them to the Veterans Crisis Line or local assistance. But a variety of different means.

Senator BLUMENTHAL. Mr. Carroll—I am sorry, Dr. Carroll—could you talk a little bit about how peer specialists are helpful, peer-to-peer? I was proud to sponsor the Peer Act, which was included in the 2018 MISSION Act, and required the VA to carry out a program to establish at least two peer specialists in patient-aligned care teams at VA medical centers. How has that program been working?

Mr. CARROLL. Thank you, Senator, and peer support has been one of the most transformative things that we have added to the VHA mental health and suicide prevention continuum. As you know, it has been in place for several years, and thank you for your support, the support of this Committee, and other Members of Congress in doing that.

We have over 1,100 peer support specialists working in mental health programs. Currently we have peer specialists working alongside our primary care integration providers, as well as many providers. We have both men and women peer support specialists. We are currently expanding peer support for women veterans by bringing the WoVeN program into VA. It is an incredibly important aspect. It is that veteran-to-veteran connection and that opportunity to talk with someone who has walked that same journey with you, and for the support and encouragement to continue and to do the things that are going to make a difference in your life.

Senator BLUMENTHAL. Thank you. Let me ask, finally,

Mr. Porter and Ms. Barlet and Mr. Lorraine. How can the VA further reduce the stigma, in so far as it continues to persist, of seeking mental health care, in addition to the peer specialists?

Mr. PORTER. I think I can answer that, sir. I think it takes a lot of communication, over-communicate, as we like to say. I think in the veteran and military community I think there is a lot of communication about suicide and mental health and needing to be able to go and seek help when you need it. But I also think in the broader community—not in the community, in the United States, Americans broadly, I do not think that that was far in the civilian world as we are in the military. So I think to be able to communicate about what all Americans can do to support veterans and avoiding suicide, and that is key, and also being able to communicate specifically to the veterans and military community about specific resources that are available. And I also want to point out that IAVA has a Quick Reaction Force at QuickReactionForce.org, and that we provide mental health resources to any veteran of all eras, for free, and their family members.

Senator BLUMENTHAL. Thank you. Ms. Barlet or Mr. Lorraine? Colonel Lorraine. Yes, Senator Blumenthal. You know, I think one of the things I would recognize is that suicide is more than just mental health. Mental health is a piece of it, but it is housing, employment, relationships, financial. It is a big-picture piece. To keep looking at suicide prevention as solely a mental health solution is somewhat alienating, but if you look at it holistically, that will reduce the stigma, and then it will bring people in enough to look and see, are there needs to be met.

So I think in order to do that it is to take suicide out of the mental health bucket and move it into the greater holistic bucket of how do we increase the hope of veterans overall. Thank you, sir.

Senator BLUMENTHAL. Thank you.

Ms. BARLET. And real quickly, Senator Blumenthal, the two gentlemen made some amazing points and very valid. But I also want to bring awareness of vet centers. These are out in the community, and not many veterans or family members realize that they do have access to these great, valuable centers.

Senator BLUMENTHAL. Thank you. Thank you, all. Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Blumenthal. Senator Sullivan from Alaska.

SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman, and thanks for convening this important hearing. I appreciate the witnesses being here. You know, like many of us who have served significant time in the military this issue confronts us all. It certainly confronted me in a personal, tragic way, in my Marine Corps career. And I am proud of the work that this Committee has undertaken. My first bill that I ever co-sponsored as a U.S. Senator was the Clay Hunt Suicide Prevention Act, which was signed into law by President Obama. But despite the passage of legislation, including the Hannon Act, we are seeing a rise in suicides. You know, Mr. Chairman, you and I worked hard on this issue of suicide prevention coordinators. They need to be fully resourced.

That is going to be an important issue. I had the opportunity to meet with a great group of veterans just this past weekend, on the Kenai Peninsula in Alaska, led by a strong veteran named Brandon Miller, who brought together a small group of vets to talk about these topics. And these veterans, my God, have seen a lot of combat but they have also seen a lot of suicide. And one of the issues they raised with me, it looks like the VA is starting to clear this procedure, which two of these veterans swore by as really saving their lives. It is this issue of stellate ganglion block treatment. I just got word, and we pressed this—I raised this with Secretary Wilkie a couple of years ago, that it is starting to be approved, starting to be approved in Alaska. Can you, gentlemen, comment on this quickly, just with regard to the importance of this issue and where the VA is on it?

Mr. CARROLL. Thank you, Senator. We are always looking for new, effective treatment for mental health conditions, and I would like to take this for the record so we get back to you with the most recent and current information.

Senator SULLIVAN. Good, Doctor. This is something that my veterans back home, again, just this past weekend, really think is important, and I have been raising this for a couple of years, from the evidence we have seen. It does not work for everybody, but it clearly is saving lives. So if you can get back to me and my constituents on that, that would be very helpful.

Dr. Carroll, let me ask, I want to followup here on this issue of some of the provisions in the Hannon Act. One of the things that I was part of the group of Senators that contributed to in that im-

portant act was this directed study with the VA to work with the National Academy of Sciences, focusing on the effects of opioids on all-cause mortality of veterans, specifically suicide. This goes into the whole issue of the overmedication of veterans, which has been a common problem at the VA. I think the VA is getting its arms around it, but there has been a lot of tragedy as it relates to this.

I know during the negotiation process of this legislation the VA opposed this provision, which essentially is an independent study, not a VA study. Now that the bill has been signed into law I am hearing that the VA is seeking the opposite of what was directed by Congress and is not going to implement or support an independent study by the National Academy of Sciences. Is this true? And if it is true, I find it completely unacceptable. Congress gave you a directive, you might not like it, but sometimes independent studies are what is needed. So can you give me a very up-front, no-wavering answer on what the heck is going on with this provision?

Mr. CARROLL. Yes. Thank you, Senator. I appreciate your question, and certainly VA's intention is to fully meet the intention of the direction given to us by our oversight body. As we said earlier, we are very grateful for the opportunity that this legislation provides us.

We want to make sure that we meet your intention, and I know that there are some studies currently underway, and I think that may be a point of a discussion that we would like to have at some point, I think, to talk through the details.

We would be very happy to sit down with you and other members of the Committee to talk through what may be some ways to address the full spirit and intention of the law and to see if that makes sense. Otherwise, we are fully prepared to move forward in whatever way the Committee feels is appropriate for us.

Senator SULLIVAN. Okay, Dr. Carroll, I appreciate that answer. I think, as I mentioned, we know that this was not a provision that was particularly liked by the VA. We still thought it was necessary. Mr. Chairman, I hope that, you know, in our oversight role we can work with the VA to institute the spirit, the intent, and the letter of the law, which I think is actually quite clear. But I appreciate you getting back to us in that spirit.

So let's make that happen, an independent study on an issue that we all care about here, overmedication of our vets, and the suicide issue. And we will work with you on that, but we want to make sure that what we directed the VA to do is what the VA does. So I look forward to working with you on that, Mr. Chairman and Dr. Carroll. Thank you.

Mr. CARROLL. Thank you, sir.

Chairman TESTER. Thank you, Senator Sullivan, and congressional intent is very important, so thank you.

Senator Brown?

SENATOR SHERROD BROWN

Senator BROWN. Thank you very much, Mr. Chairman and Ranking Member Moran. Thank you both for this really good hearing. I appreciated the comments of Senator Hassan, the questions and comments of Senator Hassan and also from Senator Blumenthal about suicide, and Senator Sullivan just now, particularly Senator

Blumenthal's discussion about the role of guns and suicide. There was a 2018 article, "Firearm Storage Practices Among American Vets" in the American Journal of Preventive Medicine, that said one in three veteran firearm owners store at least one firearm, loaded and unloaded.

If there is any good news in this it is that recently, for the first time after 20 years of Republicans cutting funding, and then banning funding to first CDC and then NIH to research this public health crisis of gun ownership and gun usage and situations like this, we are at least going to, for the first time, follow science when we gather this data—I can see Dr. Kearney nodding; thank you for that—and what that means. So I just associate myself with some of those other comments.

I have two questions, and both, I guess, of Mr. Porter. Yesterday I had a wonderful discussion with IAVA members in Ohio. Several were national, a couple were from Ohio. We are working on some Agent Orange sort of burn pit issues, at least Agent Orange, because we are working toward presumptive eligibility, I hope, Mr. Chairman, on burn pits. And I hope if we do it we can do it a lot faster than the Vietnam era continued denials of Agent Orange damage, and the same kind of burn pit issues.

But the handoff between DoD and VA is so important, so many issues including homelessness. Mr. Porter, we urge agencies to work together. It has been a long-time problem, as long as I have been in the Senate, way before that. What steps should we focus on now to make sure that that handoff does not end up resulting in homelessness, when people leave the service that they hand off as ready? Mr. Porter, if you would.

Mr. PORTER. Thank you, Senator. First I appreciate you meeting with our members. Again, before you arrived I pointed out that we are on the Hill virtually this week, from all around the country, and one of the top issues is toxic exposures. So we really strongly are communicating that we want a presumptive service connection for those exposed to burn pits and other toxic exposures.

But on the broader issue that you are talking about in terms of transitions, it is important for veterans to take advantage of their post-9/11 GI Bill, period. I think, as my friends at SVA like to talk about, they see the GI Bill as the gateway to the VA. So once you are using that GI Bill then you are going to find out about your access to the other VA benefits. So they need to find out what is out there for them and use that to be able to make a successful transition, professionally and educationally. Also they need to know about resources that they have available at the VA, at the local level, at the State level.

But then also IAVA has a pretty solid program called the Quick Reaction Force. You can call up QuickReactionForce.org, and we provide support to all veterans and families of all eras and discharge statuses. And that is from emergency housing assistance to navigation of Federal bureaucracies, and mental health and suicide prevention.

So all of the above, Senator, we would like to get people involved in more.

Senator BROWN. Expand on that, Mr. Porter. We know that thousands, probably way more, probably tens or hundreds of thousands

of servicemembers and veterans have fallen behind in their mortgage payments or their rentals, rental payments. We know it is affecting millions of people around the country. We put some money in the bipartisan bill at the end of the year, and then put a bigger chunk of money into the still bipartisan bill, bipartisan in terms of public support, that we passed earlier this month, to help with forbearance, that forbearance on servicemembers and veterans, forbearance on their mortgages, or helping with emergency rental assistance.

What do we need to do, Mr. Porter, or anybody else can weigh in here, but what do we need to do jointly, you and we, to make sure that our veterans and servicemembers can stay in their homes? These dollars are available, and we try to make sure that people who are months behind their rent or months behind their mortgages are not getting foreclosed on or made homeless through eviction or moving into their cousin's home or whatever. How can we work with IAVA and with the VA and other veteran groups or the VA to make sure that veterans are taken care of with this program, where there is money available if we reach them?

Mr. PORTER. Sure, Senator. Thanks for the question.

The recent COVID rescue plan, the American Rescue Plan, I know that it has got significant help for veterans, and especially for homelessness and home ownership. I know that there is, gosh, over $20 billion for emergency rental assistance, housing counseling for people in danger of homelessness, and then you have got a lot of money to help communities provide supportive services for veterans and their families in danger of becoming homeless.

So execute all of that, that you just passed, that is significant, but also I keep going back to our Quick Reaction Force, that provides significant benefits to veterans and their families that are in imminent need of funds if they are having trouble playing their rent or their mortgage.

Senator BROWN. Well, thank you, and if I could, Mr. Chairman, thank you for saying "execute that." I would also hand it to you, that the Chair and the Ranking Member of this Committee also serve with on the Housing, Banking, and Urban Affairs Committee, and both are very interested—and I can speak for them in this way for a moment—both very interested in what we do to make sure we do reach people.

You are right, there is $25 billion in this last plan, the American Rescue Act. We have got to make sure that veterans and other people who are on the verge of foreclosure or on the verge of eviction in their rental units are aware of this and the money gets out quickly, so they can stay in their place and landlords get paid and all that.

So my plea to you is just work with us to help make sure this happens.

Chairman TESTER. Thank you, Senator Brown. Senator Cramer of North Dakota.

SENATOR KEVIN CRAMER

Senator CRAMER. Thank you, Mr. Chairman, and thanks to all the witnesses for being here.

You know, one of my top priorities in the last Congress was the implementation of hyperbaric oxygen therapies for veterans. And I included language in the bill, the Hannon bill that we have been talking about, and will be talking about in the next group as well. And I am just going to give you a few of the highlights of the bill. It authorizes the Secretary of the VA to enter into public-private partnerships to research the effectiveness of hyperbaric oxygen therapy, it requires the VA to use an objective test to measure the effectiveness of HBOT, and it commissions a comprehensive review and study of HBOT, both within the VA and with outside organizations. And this study would be completed with a recommendation from the VA about the effectiveness of hyperbaric oxygen therapy.

And this is something I have talked to the Secretary about, both before his confirmation and after his confirmation and during the hearing, and it means a great deal to me.

Now through the law that I talked about we have provided VA these authorities related to HBOT, but it can only work, obviously, if the VA actually utilizes the authorities and cooperates in the research and the partnerships that have been authorized.

Now I have seen real benefits to this innovative therapy. I have met dozens of veterans that have used it, as well as athletes and others, and I just want to get an update, maybe from you, Dr. Carroll, what you know about the legislation and where the VA might be in that process. And probably even more importantly, frankly, get your views, just your experiences if you have observed any HBOT users, patients, and circumstances, and what you might know about it.

Mr. CARROLL. Thank you, Senator, and I appreciate the question, and as I said earlier, we are eager, as always, to expand the frontier of what we know and what we can bring to bear for the benefit of veterans in terms of their care and treatment and moving forward in their lives.

I know our teams that are working on the implementation of the Hannon Act are dug in on this and are moving forward.

We have some studies—well, we have some pilot programs, some clinical pilot programs underway that do include an evaluative component. I think this is one of those sections under the Hannon Act.

We are absolutely committed to meet the full intent of Congress in implementing this. There may be some opportunities to think about the format for this evaluation that has to be independent. I agree with you, it has to be a rigorous and fair evaluation. But we are also trying to reconcile that with the fact that we have many veterans already engaged in this, and how do we respect their information and also bring that forward into an evaluative process.

So this is one of those sections where we are totally on board with you and with the Committee in moving forward, but we would like to sit down with you and have the opportunity to talk about some ways that we think we can move this forward, perhaps very quickly, that we would like to discuss.

Senator CRAMER. Yes, no, you make a really important point, I think. There are a number of veterans that have utilized it. It has probably not been super coordinated.

There is no point in losing all of that good data and experience and it should become part of the discovery of the effects of this, while also working with other groups, communities, and treatment facilities.

So I am all about that. Any way we can get the most good information evaluated in an objective way and come up with an analysis that helps, I am all about that. I am grateful for that commitment and that restatement of commitment, and want to be as helpful as I can, from my end, as well. So thank you for that.

And with that, Mr. Chairman, I would yield the balance.

Chairman TESTER. Thank you, Senator Cramer. Senator Hirono from Hawaii.

SENATOR MAZIE HIRONO

Senator HIRONO. For Dr. Carroll, in the 2018 data analyzed in the 2020 National Veteran Suicide Prevention Annual Report, AAPI veterans had one of the highest suicide rates of any ethnic group among VHA users. Since these are veterans we know to be using VA health services, has VA done any outreach specific to this community, meaning the AAPI veteran community, especially with the uptick in hate speech and attacks on Asian Americans over the last year? What kind of outreach, if any, are you doing to this particular community?

Mr. CARROLL. Thank you, Senator. I am going to ask Dr. Kearney to comment on that.

Senator HIRONO. All right.

Ms. KEARNEY. Thank you, Dr. Carroll. Yes, I think one of the important things this particular year is the first year in our annual report where we have been able to begin to dissect some of our data by race and ethnicity, which is really critical for us to begin to identify how can we vary our community outreach with our Governor's Challenges for specific populations. What are the specific needs in each area?

So we are taking these data from our annual report and including it in our policy academies with the Governor's Challenges, and helping to inform localized strategies for outreach, and that is a critical piece in next steps. But we also need to continue more study and analysis across this population.

Senator HIRONO. So apparently this is the first time that you are basically doing disaggregated data collection, so you have not done or developed any kind of specific outreach program to the AAPI veteran community, I take it.

Ms. KEARNEY. Within suicide prevention we are working with coordinated communities locally to begin to initiate for every community what is needed in their particular area.

Senator HIRONO. Okay. So in other words you do not have any specific programs yet for this community or developing it. So I encourage that. Thank you.

For Mr. Lorraine, Col. Lorraine, I appreciate your willingness to continue to meet with this Committee to discuss veteran mental health. Since you testified on this subject in June 2019, has the VA improved its coordination with community partners when it comes to providing mental health support and services? This is for Mr. Lorraine.

Colonel Lorraine. Yes. Thank you, ma'am. You know, in my opening remarks and in my written testimony what I note is that the number of appointments that have been deferred or canceled during the pandemic is actually very high. I think the VA is starting to come back on board. I think, from what we hear from the communities is that they are working to get there. But what the communities are concerned about is the backlog that exists, and how do we get ahead of the backlog. How do we get ahead of the backlog so we can get back to normal operations? I think using the VFW's pods and others in these remote areas is fine, and telehealth, but telehealth still requires a capacity issue on the VA side, and if you want to increase the capacity what we are hoping is to use the community services that are already available.

Senator HIRONO. Did you say that you need to increase your telehealth capacity, because it is one of the ways that veterans who are in remote area can get access to services.

Colonel LORRAINE. Yes, ma'am. I said not only increase the telehealth capacity but then that calls into question, does the VA have the capacity to handle the backlog of more than 20 million appointments that were canceled or deferred. And so what I am saying is not only telehealth but to use all the tools that are available.

Senator HIRONO. I hope that you can provide this Committee with some approaches that we can take, funding or programmatic, to deal with the backlog and the other issues you just mentioned.

This is a question for Mr. Porter regarding veteran homelessness. You mentioned in your testimony housing insecurity directly impacts, of course, mental and physical well-being, and as you mentioned, for the first time in several years we saw veteran homelessness increase nationally, between 2019 and 2020. And while this data does not include the impact of the COVID–19 pandemic, we do know that housing insecurity among the general population has increased greatly over the last year.

So have the current programs, Mr. Porter, directed at alleviating and preventing veteran homelessness, are they sufficiently responding to any uptick in homelessness caused by the pandemic, among veterans?

Mr. PORTER. Thank you, Senator. I think what a lot of us point to are the HUD-VASH vouchers that have been available. I know the last year there was a number of them, quite a few of them that were left on the table. So we want to make sure that the VA is communicating to the veteran population about the availability of those vouchers, to be able to avoid a lot of the homelessness from veterans and their families. I hope that answers your question.

Senator HIRONO. Do you have a breakdown of how much of these vouchers were left on the table, by State?

Mr. PORTER. I do not. I am sorry, Senator.

Chairman TESTER. Thank you, Senator.

Senator HIRONO. Is this information unavailable?

Mr. PORTER. I would have to look at it, Senator, and get back to you, if I could.

Senator HIRONO. Okay. Please get back to me. Thank you, Mr. Chairman.

Chairman TESTER. Thank you, Senator Hirono. Coach Tuberville, you know, I know you have got connections with the Auburn Ti-

gers, but you have got to be saying "Roll Tide" right now. You are up.

SENATOR TOMMY TUBERVILLE

Senator TUBERVILLE. I cannot say it too loud, Mr. Chairman. Thank you very much. Thanks for being here today. Thank you for your work with our veterans.

I want to reiterate a little bit what Senator Cramer said. I have dealt with head injuries all my life in football. We had a lot of them. We have got a lot more of them. And we have had some success with hyperbaric chambers, but, you know, that is for further discussion.

I think we should do anything to help our veterans. I have got a lot of buddies that have gone and come back and cannot sleep at night, explosions in their head. When you cannot sleep you do crazy things, so we need to do as much as we possibly can.

But, you know, just talking about the Hannon Act, you know, it has been 158 days since we enacted this law, 18 suicides a day. That is 2,844 suicides since then, we have not really gotten going good in it yet. But we need to, and implementation needs to be a priority.

Jim, in your testimony you talked about a study your organization led in partnership with the University of Alabama—Roll Tide—that seeks to identify data-driven, community-based suicide prevention measures. Can you talk a bit more about the study and what data is being collected, and how the data is being used?

Colonel LORRAINE. Yes, sir. Thank you. War Eagles, right?

Senator TUBERVILLE. I love it.

Colonel LORRAINE. There you go. If you can say "Roll Tide" I can say "War Eagles."

Senator TUBERVILLE. That is right.

Colonel LORRAINE. Yes, sir. So Operation Deep Dive is a suicide study that we lead, America's Warrior Partnership, in partnership with the University of Alabama. It is funded by the Bristol Myers Squibb Foundation. It is a 4-year study. We are coming up on the end of it. But what we have right now is that we have ten States that either have given us data or are about to give us data. By the way, Alabama and Montana and Massachusetts came in yesterday, so we were able to take a look at that a little bit.

But what we have found is—Minnesota and Florida led the way, and they gave us not only all their data about the deaths, but the benefit is we have a relationship with the Department of Defense where we provide the names and Social Security numbers of those who died to DoD, and they come back and say this is who was in the military and served, and this is who were not.

What we are able to get with that, because when DoD sends us back their data, to Senator Hirono's question, we get the nationality, we get the name and age, we know the day that they came in the military, we know the reason why they left the military, we know the day they left the military, and we know the day they died. And so we can measure how long post-service, we can measure down to the county level what the impact has been on that community, with our goal of being able to hypothetically say, in Mobile, Alabama, the veteran who is most likely to take their life

has this characteristic, as compared to Tuscaloosa it might look different, in Huntsville it looks different, because we know the community factors play a lot into that.

So we are really happy to have our great partners at the University of Alabama. To the States that you asked, we have Florida, Minnesota, Alabama, Montana, and Massachusetts. On deck are New Hampshire, Maine, Oregon, and Michigan. And then once those come in we will be able to generate the same data. And we look forward to our great partners. We believe strongly, and our communities believe that we cannot do any work, communities cannot serve veterans without the VA. And so we look forward to partnering very closely with the VA to make sure that we can characterize the type of veteran who is most likely to take their life and get ahead of the curve and prevent it.

Senator TUBERVILLE. Thank you. For the 400,000 veterans that call Alabama home, I thank all of you for your hard work and efforts. Thank you very much.

Colonel LORRAINE. You bet. Thank you, sir.

Senator TUBERVILLE. Thank you, Mr. Chairman.

Chairman TESTER. Yes, thank you, Senator Tuberville. And I want to thank all the panelists for their input and expertise on this panel on it has affected the veterans' mental health during this pandemic. It is clear we have more work to do to ensure veterans can access mental health services.

Now I want to introduce the second panel, which will focus on implementation of the Hannon Act. I am pleased to have witnesses from both the VA and the DoD here to discuss their progress so far.

First we are going to hear from Dr. Clifford Smith, who is the Director of Field Support and Analytics for the VA's Office of Mental Health and Suicide Prevention. He is accompanied by Dr. Matthew Miller, Director of Suicide Prevention at the VA. Then we are going to hear from Dr. Karin Orvis, Director of Suicide Prevention Office, and Captain Chad Bradford, Director of Mental Health Policy and Oversight at the Department of Defense. Dr. Smith, you have the floor.

PANEL II

STATEMENT OF CLIFFORD A SMITH ACCOMPANIED BY MATTHEW A. MILLER

Mr. SMITH. Good afternoon, Chairman Tester, Ranking Member Moran, and the members of the Committee. I am pleased to be here today to discuss VA's implementation of the Commander John Scott Hannon Improvement Act of 2019. I am accompanied by Dr. Matthew Miller, National Director for Suicide Prevention. Nothing is more important to the VA than supporting the health and well-being of the Nation's veterans and families.

The Hannon Act supports the improvement of mental health care and suicide prevention services for veterans under three broad areas of focus. First, by improving access options to mental health and suicide prevention services via community-based prevention strategies, accomplished through a new grant-making authority.

Second, by improving rural veterans' access to care by expanding telehealth technology.

And third, by directing the VA to develop a strategic plan on how VA can provide health care to veterans during the first year following discharge or release from military service.

Further, the Hannon Act looks to expand the scope and breadth of services available to veterans by increasing research and investments in innovative and alternative treatment options. This expanded scope includes enhancing veterans' access to complementary and integrative health programs, such as animal therapy, agritherapy, and sports and recreation therapy. The final area highlighted seeks to improve equity for subpopulations of veterans, with the expansion of capabilities of the Women Veterans Call Center, to include text messaging and updating VA's websites to provide more information services available to women veterans.

Each of us has a role in suicide prevention and in the implementation of the VA National Strategy for Preventing Veteran Suicide. Community prevention efforts are as critical as VA intervention efforts. We are grateful for the Hannon Act to assist in further implementation of the public health approach to prevent veteran suicide and to improve veterans' mental health and well-being over the course of their lifetime. We appreciate the Committee's continued support and partnership in this shared mission.

Mr. Chairman, this concludes my statement. My colleague and I are ready to answer any questions you and the Committee may have.

Chairman TESTER. Thank you, Dr. Smith, for your testimony.

Next we have Dr. Karin Orvis, Director, Defense Suicide Prevention Office, Office of Force Resiliency, Office of the Under Secretary of Defense for Personnel and Readiness for the Department of Defense. Karin, the floor is yours.

STATEMENT OF KARIN A. ORVIS

Ms. ORVIS. Thank you. Chairman Tester, Ranking Member Moran, and distinguished members of the Committee, thank you for the opportunity to appear before you with our colleagues from the Department of Veterans Affairs. Both departments work together in strong partnership. Like you, we are steadfast in our commitment to the well-being of our servicemembers and veterans.

This is even more important now given the coronavirus pandemic. During this time, servicemembers and veterans may be feeling heightened stress, anxiety, and disconnectedness.

For some, such experiences can also be associated with an increased risk for suicide. My office, the Defense Suicide Prevention Office, works to enhance holistic, data-driven suicide prevention through nonclinical policy oversight and engagement.

With me today is my colleague, Captain Chad Bradford, the Director of Mental Health Policy and Oversight, who works on the clinical side. We recognize a fundamental truth: there is no one single solution to prevent suicide.

As such, we are committed to addressing suicide comprehensively, through a public health approach, which incorporates both community-based prevention efforts as well as clinical care to address suicide thoughts and behaviors.

We also leverage best practices from the scientific community, including the Centers for Disease Control and Prevention. DoD has many efforts underway, including cross—cutting research collaborations and several evidence—informed pilots related to help-seeking, problem-solving, and mean safety, which I am happy to discuss.

The Department is committed to successfully executing our responsibilities within the Hannon Act. As DoD Health Affairs has oversight of clinical and mental health policies and programs, Captain Chad Bradford can address any specific questions you may have on DoD's implementation of the Act.

I am grateful for the opportunity to appear before you today and to share more information about suicide prevention efforts. Thank you for your unwavering dedication and support of the men, women, and their families who greatly defend our Nation. I look forward to your questions.

Chairman TESTER. Thank you, Dr. Orvis. Next up we have Captain Chad Bradford, United States Navy, Director of Mental Policy and Oversight, Health Services Policy and Oversight, Office of the Assistant Secretary of Defense for Health Affairs, DoD. Captain, Bradford, you have the floor.

STATEMENT OF CHAD BRADFORD

Mr. BRADFORD. Thank you. Good afternoon, Chairman Tester, Ranking Member Moran, and members of the Committee.

[Pause.]

Mr. BRADFORD. Good afternoon.

Chairman TESTER. Good afternoon. Go ahead.

Captain Bradford. Chairman Tester, Ranking Member

Moran, and members of the Committee, thank you for the opportunity to testify before you today, along with our colleagues from the Department of Veterans Affairs. The Department of Defense is committed to providing the highest level of mental health care to servicemembers and veterans.

The Department is excited to share with you the important work we have undertaken in support of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, and to address the mental health needs of our servicemembers during the COVID–19 pandemic.

We would also like to inform you of our continuing efforts to combat the stigma associated with seeking mental health, and to help servicemembers address mental health needs during periods of transition.

Regarding the Mental Health Care Improvement Act that was signed last year, the Department has initiated collaborative work with the VA to ensure all elements of this important legislation are completed, and Congress has kept informed of our progress. Additional details of our work were included in our written Statement.

For many people, the mental health effects of COVID–19 are as important to address as the physical effects. The Military Health System has worked on two fronts to ensure that behavioral health needs are met during the COVID–19 pandemic. The first is delivery of quality behavioral health care to our enrolled population, whether that is through face-to-face encounters or through our sig-

nificantly expanded virtual behavioral health care offerings. And the second is preservation of the work force throughout our health system.

MHS has sustained its commitment to decreasing the stigma associated with mental health treatment throughout this pandemic. DoD policy and procedures are designed in a manner to remove the stigma associated with servicemembers seeking and receiving mental health services. The Real Warriors Campaign is DoD's award-winning, multimedia, public awareness campaign designed to combat the stigma associated with seeking care and encourage servicemembers to reach out for treatment. The Embedded Behavioral Health and integrated primary care behavioral health programs are also efforts to decrease stigma associated with mental health treatment by increasing immediate access and improving mental health literacy.

In order to help the transitioning servicemember's mental health needs, the DoD and VA work together to make the In Transition Program a vital resource. The In Transition Program is a free, confidential program that offers specialized coaching and assistance for all servicemembers and veterans, regardless of duration of service, time since discharge, or category of discharge.

We are grateful for the opportunity to speak with you today and discuss the Department's efforts in collaboration with the VA to support our servicemembers and veterans, including various resources, support care to addressing their mental health and well-being, among other needs.

Thank you for the opportunity to provide further detail on the DoD effort in support of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, and our other vital efforts to address the mental health needs of our servicemembers. We thank the members of this Committee for your commitment to the men and women of our armed forces and veterans, and the families and communities who support them. Thank you.

Chairman TESTER. Thank you, Captain Bradford, and I want to thank you all for testimony. Now for the questions, over to Senator Moran.

Senator MORAN. Chairman Tester, thank you for that consideration. Let me begin with Dr. Smith and Dr. Miller. My understanding is that the VA provided a briefing recently to my staff, on our staff, on the implementation of the John Hannon Act, and discussed a few items that the VA was pushing back deadlines or alternative approaches to accomplishing provisions included in the legislation.

And I just want to underscore for you that the provisions that are in the John Hannon Act were negotiated with the VA and with their agreement in the last Congress, both majority and minority, and we worked with the VA to get things that were contentious or difficult to be acceptable to both the Congress and the VA.

And I just hope that you would commit to continuing to work with us to ensure that the VA implements the John Q. Hannon Act, the provisions in it, in as timely as possible fashion, but also in fulfilling the agreements that were reached during the negotiations between this Committee and the VA.

Mr. SMITH. Senator, this is Dr. Smith. Absolutely, we are committed to meeting the spirit and the intent of the Hannon Act. There are, indeed, as we brought up at the briefing last week, several areas we would like additional discussion, just offhand, thinking one instance the date that the action was due has actually passed, due to the timing of when the bill was signed on October 17th.

So we would love, and it is our intention, to have honest conversations going forward about the actions that are required and our work in completing those actions.

Senator MORAN. Doctor, thank you for that. You are very good. You certainly brought up an example in which I do not know how to argue back that you should implement it in a date that has already passed.

Let me ask Dr. Miller, I mentioned in my opening Statement about SPED. At what point do you think the VA will be 100 percent implementation with this intervention at all medical centers?

Mr. MILLER. I am glad you asked that, sir. We are there. We are at 100 percent implementation with safety planning in the emergency department. It is a part of our Suicide Prevention Now plan, and incremental improvements within SPED implementation. We just received our February data for SPED performance across the Nation in all our facilities, and we noticed, and noted, as a matter of fact, today in a presentation to the Under Secretary's Health Operation Center team, notable improvements within SPED implementation, particularly engagement of the CSRE, when appropriate, in the emergency department and urgent care setting, as well as implementation of safety plans in the applicable situation, which, as you mentioned at the outset, saves lives, 45 percent out of the Brown study. So we are at 100 percent, sir.

Senator MORAN. Dr. Miller, I too am glad I asked the question and I appreciate very much the answer. When you say "VA facilities," what does that mean? If I am in Kansas that means the three medical centers, or something more than that?

Mr. MILLER. That means any medical center, any VA medical center that has an emergency department or has an urgent care center.

Senator MORAN. Okay. Thank you very much.

Dr. Orvis, can you provide the Committee with an update in regard to the progress that DoD and the VA have made on the alternative of analysis to establish a joint VA-DoD Intrepid Spirit Center?

Ms. ORVIS. Hi there. Actually, I would like to defer that question to Captain Chad Bradford, as that falls within Health Affairs at DoD.

Senator MORAN. Thank you. That is fine.

Captain BRADFORD. Yes. Thank you, Senator. So currently we have eight Intrepid Centers. The Intrepid Centers take care of our servicemembers who have been injured and diagnosed with PTSD and TBI. Comprehensive care is provided to them, including treatment for PTSD, neurologists, nutritionists, et cetera. Two more Intrepid Centers are in the works. We are currently in the process now of researching and determining whether or not additional centers are beneficial and cost-effective. Thank you.

Senator MORAN. And that research or that analysis is expected to be completed at some point in the near future, or do you have a timeframe?

Captain BRADFORD. I do not have a timeframe, but I could take that for the record and respond back to you.

Senator MORAN. Thank you very much for that. Mr. Chairman, thank you.

Chairman TESTER. Thank you, Senator Moran. This question is for Dr. Smith. Vet centers have been a huge success, and I will tell you they have been a great resource for mental health care for veteran servicemembers and their families.

Section 502 of the Hannon Act requires the VA to create a new scholarship program for students pursuing a degree in mental health discipline. These scholarships would then result in the student working full-time at a vet center for 6 years, and quite potentially would stay much longer after that.

Dr. Smith, my staff tells me that the first scholarship awards may not go out until 2023, almost 2 years after the required date and 3 years after the enactment of the Hannon Act. Could you tell me what the current status of the implementation for the vet center scholarship program, Section 502, and if, in fact, the awards are not going got go out until 2023, how can we expedite, or help the VA expedite that rollout?

Mr. SMITH. Thank you for the question, Senator. Yes, so immediately with the signing of the law there are four specialties noted—psychology, social work, marriage and family therapy, and counseling, or LMHPCs. The initial work was reviewing all of the qualification standards for each of those specialties, and they have been drafting the regulation language that will be needed to be implemented to issue those scholarships. That draft language of regulations is currently under review at this time. Once that is returned back to us it continues down the journey, through OGC comment, through the Office of Regulations comment, et cetera.

It is anticipated that outside of an interim final rule, the process that it would take for public comment, letting the professional bodies, the American Psychological Association, the National Association for Social Work, et cetera, time to respond to the regulation change or addition, all of that process to take place and completed, the Readjustment Counseling Service does anticipate the April 2023 timeline. That sets up the timing for when students are applying for scholarships versus 2022, which they do not feel can make it through the regulation process.

But we would be very happy to sit down with the Committee and work through that timeline with our professionals from RCS, who are very excited about this opportunity.

Chairman TESTER. We will take you up on that offer. And I would just say that you are right, as students tend to apply for scholarships more in the spring than they do in the fall. I have a notion this particular case these may be more nontraditional students, though, and so I would not write off the potential of getting this rule out earlier can help a lot of folks. But we will take you up on your offer.

This is for the VA and the DoD both. You both play essential roles in improving mental health for our servicemembers and vet-

erans. I have a new role as Chairman of the Defense Appropriations and I want to make sure that these departments are collaborating as much as possible, the VA and the DoD. I would say the last administration made a lot of promises that were not kept, about expanding VA mental health care to those transitioning out of the armed services.

And we know that the first year out is the most critical time for suicide prevention. Section 101 directs the VA and DoD to create a plan to extend a full year of VA health care to servicemembers transition to veteran status.

Dr. Smith, what progress has the VA made in implementing this provision, in coming up with a plan to offer VA health coverage to transitioning servicemembers?

Mr. SMITH. Thank you, Senator. Indeed, Section 101 calls for the VA to outline a plan. Currently, we have put in place a large workgroup that was empaneled and met for the first time in early January, consisting of broad SMEs from the VA and DoD, VBA. So it spans across multiple offices.

That workgroup has divided and built multiple sub-workgroups, looking at opportunities for enhancing information, looking at IT changes that will be needed, looking at eligibility criteria that may have to be updated through regulation. That group meets on a regular basis.

It is chaired by Dr. Matthews from our office in the VA and working closely with DoD partners alongside to fully implement the provision of health care in the first year of transition.

Chairman TESTER. Thank you. Dr. Bradford and Dr. Orvis, I would like you to respond to that question in writing.

With that I will go to Senator Boozman for questions. One more time for Senator Boozman. It looks like you are up, Coach, Coach Tuberville.

Senator TUBERVILLE. The early bird gets the worm, Mr. Chairman. Thank you very much.

Before I start I would just like to thank anybody who had a hand in the enactment of the Save Lives Act for our veterans and their spouses, for the vaccine, people in Alabama are very excited about that, so we appreciate President Biden signing that, I guess just very recently.

You know, the Hannon Act directed that within a year of enactment each VA medical center have at least once suicide prevention coordinator role, and that the VA conduct a study to determine how to align and reorganize the coordinators.

Dr. Smith, what do you envision the role of the suicide prevention coordinator to be right now, and what do you foresee changing under a potential realignment and reorganization of the coordinators?

Mr. SMITH. Thank you for the question, Senator. As part of our work with the Hannon Act we divided all of the sections up into a single point of contact. This section is actually with Dr. Miller as the point of contact and subject matter expert, so I will hand this off to him.

Mr. MILLER. Sure. Thanks, Dr. Smith. Thank you for the question, Senator. The suicide prevention coordinator is well defined and is elucidated within a suicide prevention coordinator guide that

we have recently published. In it, it outlines, I believe, in a very thorough way the expectations, the roles, the responsibilities, and applicable procedures and policy within the role.

Having one suicide prevention coordinator, and that one being defined as one FTE, across VA facilities is not a new standard, from our perspective. It is something that we measure and monitor on a monthly basis and work with facilities to correct. I am happy to report that as of today, exactly, literally today, all suicide prevention coordinator FTEs, in terms of one FTE per facility, have been satisfied, except for one that is OCONUS, and they are exploring possibilities for seeking an exemption, given the services that they offer and where they are located.

What we are finding with the staffing and documentation of the staffing, there is a particular portal where staffing numbers are entered in locally, and we have been able to work with facilities to discover errors in the documentation and reporting within this portal, and that has helped us to clarify present standings. So again, all positions, save one, and that one is exploring exemption opportunities.

With regard to the restructuring that you mentioned, that Section 506, thank you for bringing that up and raising it. We will be doing a feasibility and advisability analysis to thoroughly explore the advantages, the potential disadvantages of a shift in the organizational structure, which would have the suicide prevention coordinator instead of reporting locally, reporting nationally to the Suicide Prevention Office within Central Office.

The contract for that study has been awarded and we had our kickoff event earlier this week. We look forward to the results of that study and will receive an update regarding progress in approximately 2 months from now.

Senator TUBERVILLE. Thank you very much. Mr. Chairman, I yield the rest of my time to the West Virginia Mountaineer, Senator Manchin.

Chairman TESTER. You have got it. Senator Manchin, you are up.

SENATOR JOE MANCHIN

Senator MANCHIN. Hey, Coach, thank you. I appreciate that.

Senator TUBERVILLE. You are welcome.

Senator MANCHIN. Dr. Carroll, with our older veteran population increasingly becoming disconnected from the communities over the pandemic, especially in rural areas such as mine in West Virginia, they have lost the majority of their support networks. Just 2 months ago, we had a 70-year-old who committed suicide in the parking of the VA, which is unbelievable. So how are we tailoring outreach and care for older veterans?

Mr. MILLER. Senator——

Senator MANCHIN. Mr. Carroll?

Mr. CARROLL. Mr. Chairman, may I respond?

Senator MANCHIN. Yes, anybody. There we go. Jump right in there.

Mr. CARROLL. Thank you, sir, for the question, and Dr. Smith, Dr. Miller, since I was called upon I will kick it off, but you are welcome to join.

Thank you, sir. We are trying to tailor our outreach, our services in mental health and suicide prevention to all veterans, but to do it by groups, whether it is demographic groups, whether it is based upon age, whether it is based upon diagnosis or service status, whatever it is. Our outreach—and to the point of your question, I think that is probably the most critical piece—our outreach campaigns are tailored to different age groups, and we try and reach them through different means and resources. Our Make The Connection website has stories of veterans telling what they have done to move forward in their lives, based upon age and based upon period of service.

Senator MANCHIN. Let me throw this one at you then, because I know our time is going to be short. Let me throw this at you. Many people in rural areas, such as mine and the Chairman's here in Montana, do not have internet service. Telehealth has been a big thing. What do we do with those who do not have access or do not use the internet? How are you reaching out to them, making sure we are not missing somebody?

Mr. CARROLL. Through the communities is the shortest answer, sir. You know, we are working to expand the reach of telehealth through the broadband expansion, working with our VFW partners and other organizations who were with us in the first panel and otherwise. But I think trying to, through all of our suicide prevention activities, working with local communities, so promoting together with veteran programs in local communities so it becomes more of a veteran-to-veteran, community-based program, recognizing the unique circumstances and the unique——

Senator MANCHIN. I have another question for you then, OK? Speaking of the veterans being able to access the help they need, mental illness help and keeping them hopefully safe, we have a National Suicide Prevention Lifeline, the 800–273–8255. I do not know how many people can memorize that one. That is why we passed the three-digit dialing code for our hotline, which will not start until July 16, 2022.

So how are we getting this information out that they have help just a phone call away? How are we pursuing that, or how are we getting it out to the general public?

Mr. CARROLL. Dr. Miller is on the panel here, sir.

Senator MANCHIN. Whoever can answer that, we appreciate it. We will take anybody.

Mr. MILLER. Yes, sir. We have a paid media campaign active right now, targeting Veterans Crisis Line services and informing veterans as well as those who love and support veterans regarding VCL and how to get in touch with us, whether it be telephone, whether it be text, or whether it be chat.

The VCL paid media program is one of our most frequently utilized in terms of our statistics program——

Senator MANCHIN. Okay. I have got another question for you.

Mr. MILLER [continuing]. and engagement.

Senator MANCHIN. I have got another one for you. Thank you, Mr. Chairman. I appreciate it.

This one here has to do with the veterans in community, how they are overseeing non-VA care providers. This is about opiate.

Opiate has been rampant throughout my State, the opiate addiction, and it has really hit my veteran population extremely hard.

What we do not know, we cannot follow to find out when they come to the VA, where they have been before that and how we can follow. Are you all tied into the prescriptions from the drugs, all the drugs that have been prescribed throughout the State, in my West Virginia or any other State, so you do not overprescribe to a person who has already gotten their pills someplace else?

Mr. MILLER. Yes.

Senator MANCHIN. Anybody.

Mr. MILLER. Yes is the answer.

Mr. SMITH. Senator, Mr. Smith. The answer is yes.

Our prescribers, our primary care providers are able to check the State data bases for the prescribing of opiates.

Senator MANCHIN. Let me just say, though, I thank you all. I know it is a tough job. I mean, there are so many, but we have so much need out there, and these are the people that basically were willing to give their life for us, and that is why we feel so passionate.

I will say this too. The veterans are still the glue that holds this country together. They hold us together in Washington. They really do. They bring Democrats and Republicans together. And thank God for our veterans and our servicemembers that we have serving, because without them I do not know if we would be able to talk about much that we would agree on. But we do agree how special our veterans are, and that is why we just are so diligent and vigilant about the services that we are expected to give and that you all are doing. And we appreciate that, but we always need to do better. Thank you.

Chairman TESTER. Thank you, Senator Manchin. Senator Boozman, are you there?

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Yes, I am. I have finally figured the audio out and the video, and I know that you can relate to that. Dr. Miller, the John Scott Hannon Act was signed into law last October. Section 201 of the bill establishes a grant program that enables the VA to provide resources to community-based organizations to help reduce and prevent veteran suicide. The intent was to empower community organizations as quickly as possible to find veterans in the community and assure they had access to help.

Could you please give an update on what the VA has done since the bill was signed into law 6 months ago, what has happened up to today, and when can we expect the first grant to be awarded?

Mr. MILLER. Yes, sir. There are—and this gets to what Dr. Smith talked a little bit about with Senator Tester regarding the scholarships and grants. There are three phases within the process. The law is written very well in terms of outlining specific stipulations and procedures inherent within each of the three phases necessary to do this efficiently, right, and effectively. And I think we all can agree that those are top priorities, because we all agree that this has immense potential in terms of saving lives for veterans and working with the community.

Because of that, we understand the attention that is paid to, and we respect the attention that is paid to timelines and timing. Currently, we are in Phase 1 of the process. We are on the cusp of the step within the process that entails consulting the public. There is a requirement, as Step 1 in the process, of consulting the public, and that is what is called a Request for Information that is published to the Federal Register.

We are closely approximating that point, but we are also going to take an extra step during the consult the public aspect. We are going to add two town hall listening sessions to the process, which will require a second RFI, and going through the process for that.

Nonetheless, we believe that it is essential to maximize community input on the structure and the issuance of these grants. So over the next few months you will see us, and you will hear about us engaging these town hall sessions to hear from stakeholders and the public to help us shape this so that it can be done efficiently, right, and effectively.

Senator BOOZMAN. So when do you think the first grant will be awarded?

Mr. MILLER. There are, within each of the three phases—sir, I cannot give you a date. I do not want to dance around it, so I am going to respect your time and I am just going to tell you, honestly, I cannot give you a date.

Senator BOOZMAN. The VA has well-established grant programs like the Supportive Service for Veterans Families——

Mr. MILLER. Yes.

Senator BOOZMAN [continuing]. which helps prevent homelessness, and it has really been a great program. Some argue what makes the SSVF grant program so effective is its reflexive and adaptive nature to meet the ever-changing demands.

Mr. MILLER. Yes.

Senator BOOZMAN. The program is a flat organization with direct report from regional service directly to leadership. Can we expect that the grant program, as it is set up, to be organized and operated in a similar manner, building on that model, and what lessons were learned when standing up the SSVF program that are being applied to this program?

Mr. MILLER. Yes, sir. You can fully expect everything that you are asking for and outlining, and we fully agree with you regarding SSVF in terms of the efficiency, effectiveness, and rightness of the model that it presents.

They, and their leadership team, are on our steering committee for Section 201. They are serving in an advising and consulting capacity, helping us to understand steps along the way and helping us to navigate those steps, based upon lessons learned.

I will also note, sir, and I think you will appreciate this, that the Suicide Prevention Program has partnered with SSVF over the last year to support, as you mentioned, and I think so appropriately so, a flexible and adaptable implementation of SSVF. We are working together to fund particular at-risk populations and services going to them.

These are veterans at risk for suicide who have been homeless within the last 30 days and are living in a motel or a hotel.

So far, the collaboration that we have with SSVF on this has reached over 7,100 veterans. We are looking to double down on that effort this year as we are working through the implementation process of the Staff Sergeant Parker Gordon Fox Program.

Senator BOOZMAN. That is a great story. And do not misunderstand. What we want to do is help you cut through the bureaucracy. So I think I can speak for Senator Tester and Senator Moran, and then also my counterpart on the Appropriations, Chairman Heinrich. We really would like to be informed as to the progress. Can we get you to provide our staffs, within the next 2 weeks and then quarterly until the program is operational, exactly where we are at so that we can help you break down whatever barriers occur?

Mr. MILLER. We have a journey map graphic, sir, that outlines this process from start to finish. We would be more than happy to transparently sit down with you, your team, and interested stakeholders therein and walk through the journey map and answer questions that you may have.

Senator BOOZMAN. Good. Thank you so much. Thanks for all you do. Thank you, Mr. Chairman.

Chairman TESTER. Yes, thank you, Senator Boozman, and you can count, I think both Senator Moran and my staff is in on that briefing. It is a great question, Senator. Boozman.

I just want to thank our VSO representatives, VA officials, and DoD officials for being here today. The issue veteran suicide is of utmost importance to this Committee, and the Hannon Act sets a new landmark for veterans' mental health care. But it is up to us to make sure that it is implemented as intended, and with so many struggling due to this pandemic time is of the essence. So I want to thank everyone for participating today. We will keep the record open for a week. This hearing is adjourned.

[Whereupon, at 5:03 p.m., the Committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

WITNESSES PREPARED STATEMENTS

PREPARED STATEMENT OF DR. DAVID CARROLL
EXECUTIVE DIRECTOR
OFFICE OF MENTAL HEALTH AND SUICIDE PREVENTION (OMHSP) VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

Good afternoon Mr. Chairman, Ranking Member Moran and members of the Committee. I am pleased to be here today to discuss VA's delivery of Mental Health Care during the COVID-19 pandemic and the implementation of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act).* I am accompanied by Dr. Matthew Miller, Director of Suicide Prevention, Dr. Clifford Smith, Director of Field Support and Analytics, and Dr. Lisa Kearney, Deputy Director for Suicide Prevention and Acting Director for the Veterans Crisis Line.

Introduction

Nothing is more important to VA than supporting the health and well-being of our Nation's Veterans and their families. Suicide prevention is one of VA's top clinical priorities and this effort will take all of us to achieve. Building off the national strategy of the U.S. Surgeon General and National Action Alliance for Suicide Prevention, VA developed the *National Strategy for Preventing Veteran Suicide* (2018),[1] which laid the foundation of concepts core to VA's approach to suicide. This national vision for preventing Veteran suicide is grounded in three major tenets which we firmly believe: 1) Suicide is preventable, 2) Suicide requires a public health approach, combining community-based and clinical approaches, and 3) Everyone has a role to play in suicide prevention.

While the development of the National Strategy was groundbreaking in defining the vision of reaching and serving Veterans both within and outside VHA clinical care, VA moved to translate the vision of the 10-year National Strategy into operationalized plans of actions in: Suicide Prevention 2.0 (SP 2.0) combined with the Suicide Prevention Now initiative. SP 2.0 is a 6-year plan with national reach focused on the implementation of clinical and community-based prevention, intervention, and postvention services that reflect the National Strategy's four pillars. The SP 2.0 community-based domain focuses on enacting the National Strategy through the Veterans Integrated Service Network-Based Community Coalition and Collaboration Building, Veteran-to-Veteran coalition building through Together with Veterans (TWV) in rural communities, and state-based coalition and collaboration building in our joint

[1] Department of Veterans Affairs (2018). National Strategy for Preventing Veteran Suicide. Washington, DC. Available at https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-

Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.
efforts with the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Governor's Challenge, now in 27 states. The SP 2.0 clinical domain focuses on a practical strategy for implementing clinical practice guideline evidence-based treatments, such as Cognitive Behavioral Therapy for Suicide Prevention, through TeleMental Health services across all 140 VHA health care systems.

While VA works on the longer-term plan of SP 2.0 implementation in collaboration with community partners, 2020 also saw the launching of the SP Now initiative, a bundled set of interventions, across five key domains, in alignment with the vision of the National Strategy. The focus of SP Now includes goals that can be achieved within one year, including activities that will have a meaningful impact in preventing Veteran suicide, such as lethal means safety, enhancing suicide prevention in identified medical populations, paid media to reach Veterans inside and outside the VHA system, identification and outreach to Veterans who previously accessed VHA care, and enhancements of suicide prevention clinical efforts. The SP Now initiative was also adapted to include new COVID-19 related suicide prevention efforts when the pandemic began.

COVID-19 Impact and VA's Mental Health COVID-19 Response Plan

The Nation has now lost over 500,000 lives to COVID-19. We know that pandemics, especially those involving quarantines, create psychological distress and negatively impact societal infrastructure. Our public health approach to mental health and suicide prevention was critical to inform our mental health COVID-19 response plan, organized around universal, selective and indicated strategies. Based on historical evidence and the most recent research, OMHSP developed a Mental Health COVID Response focusing on both immediate and long-term impacts on suicide prevention and mental well-being, including supporting the most vulnerable Veterans, as well as providing outreach and resources to all 20 million Veterans and mental health leaders and providers across VHA. This has also included a targeted market segmentation approach related to our communications strategy, informed by data, to best reach a diverse population of Veterans and those who care about them. For example, VA is working with the George W. Bush Institute Veteran Wellness Alliance to better inform our suicide prevention outreach to segmented populations. Likewise, to ensure our communication strategies are grounded in research, VA developed an updated strategic communications plan in FY20 based on new data, innovative and creative communications approaches, emerging technologies, and proven public health best practices. This plan provides an overarching strategy that guides the development of all communications with a targeted market approach across four main communication initiatives: *Be There*, lethal means safety, Veterans Crisis Line, and Suicide Prevention Month.

Universal strategies to reach all Veterans include communication campaigns, which shifted a focus from driving awareness to engagement and activation. VA conducts a range of paid education and awareness campaigns focused on mental health literacy, crisis intervention, suicide prevention, reducing the stigma associated with mental health challenges, and encouraging help-seeking behavior among Veterans

and these efforts were further enhanced during COVID-19 with integrated and highly targeted paid media campaigns serving tailored messaging to specific populations. Our COVID-19 mental health and suicide prevention communication approach has included informative and targeted content across VA social media environments, such as Facebook, Instagram, and Twitter, advertising information on Be There, lethal means safety and Veterans Crisis Line information. ***Be There*** emphasizes that suicide is preventable and encourages Veterans and their loves ones to reach out to Veterans in crisis, focusing on a broader market to engage individuals to take action with those they care about proactively. Lethal Means Safety is focused on a selective population and aims to educate and encourage Veterans to safely store their guns and unused medication. Finally, our Veterans Crisis Line communications initiative focuses on those at highest risk, promoting the call, chat, and text resources available 24/7 to Veterans in crisis and their supporters. Wide-spread educational information has also been disseminated on newly developed websites, such as VA's MH Website for COVID-19[2] and the National Center for PTSD site on COVID-19[3]. VA's data-driven approach to our communications strategy guides our ongoing updates to our implementation, providing a consistent and sustained national presence of VA's suicide prevention and mental health resources among Veterans and their families and friends.

Selective Strategies, which target Veterans who may be at increased suicide risk or at increased risk of burden related to mental illness due to COVID-19 related stressors, physical distancing, changes in treatment resources, or loss of key supports, have been largely deployed. This has included launching the COVID Coach Mobile App, VA Medical Center outreach to identified Veterans with appointment cancellations to ensure engagement with mental health services, implementing a dashboard to identify Veterans who may be at increased risk due to COVID-19-related isolation and coordinating increased outreach, and shifting to telehealth modalities of care. VHA rapidly shifted to offer predominantly virtual mental health care. In February 2021, VHA provided over 1 million mental health telephone and televideo visits (77% of total VHA mental health visits). This includes over 630,000 telephone calls to over 383,000 Veterans. The February VA Video Connect (VVC) encounters represent an increase to over 452,000 visits, which is the highest monthly VVC volume to date. In February, over 109,000 VVC group visits were completed with over 30,000 Veterans, the highest VVC group utilization to date. VA has also continued to support the ongoing efforts of Solid Start, a program designed to conduct outbound calls to all Service members within 90 days of their expected date of separation from military service and at key intervals after separation (e.g., 90-, 180-, 365-days). From the onset of the program in 2019 until the end of January, over 152,000 individuals have been outreached with a successful outreach of 57.1%. Likewise, the program specifically prioritizes calls to Veterans who had a mental health appointment within their last year before separation and within this group the successful outreach is 72.4%.

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[2] https://www.mentalhealth.va.gov/coronavirus/index.asp
[3] https://www.ptsd.va.gov/covid/COVID_managing_stress.asp

Indicated Strategies, which target a smaller segment of Veterans at elevated risk of suicide or of escalation in mental illness associated with COVID-related stressors, have also been increased greatly. These include the expansion of the Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment (REACH VET) program, which uses predictive modeling to identify Veterans at risk for suicide and other adverse outcomes, and the Safety Planning in the Emergency Department (SPED initiative), with timely safety plan implementation improving by 20.65% from March to December 2020. The Veterans Crisis Line (VCL) has also implemented Caring Letters, an evidence-based intervention for suicide prevention found to reduce the rate of suicide death, attempts, and ideation. Since the launch of the VCL Caring Letters program in June 2020, 60,000 Veterans have been reached and are receiving 9 follow-up letters after their call to the VCL. VCL call volume has grown from FY19 to present, seeing an average annual rate of 13.2% with significant ongoing increases in call volume forecasted with the onset of 988. Signed into law in 2020, the National Suicide Hotline Designation Act authorized 988 as the new three-digit number for the National Suicide Prevention Lifeline. All telephone service providers in the U.S. must activate the number no later than July 2022; however, many providers will implement the service sooner. Once a Veteran's telephone service provider makes 988 available, Veterans will be able to dial 988 and press 1 to contact the Veterans Crisis Line.

While VA has implemented a comprehensive and proactive COVID-19 mental health response plan, we have also been conducting COVID-19 suicide prevention surveillance work since the onset of the pandemic. This includes evaluation of trends in VHA site-reported suicide-related behavior and information from VHA patient encounters, in the context of the COVID-19 pandemic. Findings to date do not indicate pandemic-related increases in site-reported Veteran suicides, nonfatal suicide attempts, on-campus attempts or deaths, or volume of emergency department visits related to suicide attempts. However, full assessment of the impact of COVID-19 on Veteran suicide requires death record searches for 2020, which will not be available until 2022. Our work continues and is also informed and influenced by recent legislation allowing us the opportunity to further expand our public health approach to mental health and suicide prevention.

Hannon Act

The Hannon Act was signed into law in October 2020 and builds upon VA's National Strategy for Preventing Veteran Suicide and public health approach model: blending community-based prevention and clinically-based intervention strategies. The Hannon Act supports the improvement of mental health care and suicide prevention services for Veterans three areas of focus. The first is improving access to mental health and suicide prevention services through grants that help improve rural Veterans' access to care through telehealth technology and through VA's development of a strategic plan for providing health care to Veterans during the first year following discharge or release from military service. The second is by expanding the scope and breadth of services available to Veterans through research and investment in innovative and alternative therapies. This expanded scope includes building on Veterans' access to complementary and integrative health programs through animal therapy, agritherapy,

sports and recreation therapy, and art therapy. In addition, the Hannon Act directs VA to explore posttraumatic growth programs through partnerships with non-Federal Government entities and to study the effectiveness of hyperbaric oxygen therapy for the treatment of traumatic brain injury and posttraumatic stress disorder among Veterans. The final focus is on improving equity for sub-populations of Veterans, with the expansion of capabilities of the Women Veterans Call Center to include text messaging and updating VA's websites to provide more information on services available to women Veterans.

A critical portion, Section 201 of the Hannon Act, is the grant-making authority for VA, which established the *Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program* (SSG Fox SPGP). This grant program enables VA to provide resources for community-based suicide prevention efforts to meet the needs of Veterans and their families through outreach, suicide prevention services, and connection to VA and community resources. VA currently has limited grant-making authorities. Three sections of the Act expand VA's portfolio by enabling VA to award grants and scholarships to support partnerships in the broader Veteran community as described below:

- **Section 201** establishes the SSG Fox SPGP, which will be modeled after VA's Supportive Services for Veteran Families (SSVF) grant program. Under SSVF, grants are awarded to community-based organizations to provide supportive services, including outreach, case management, and financial assistance to Veterans (who may not have had any contact with VA). SSG Fox SPGP is a $174 million, 3-year community-based grant program that will provide resources to community organizations serving certain Veterans and their families across the country. Organizations can apply for grants of up to $750,000 per fiscal year for up to 3 years.

- **Section 502** establishes a professional education scholarship program through the Readjustment Counseling Service for the professional education for mental health providers. Individuals eligible are pursuing a terminal degree in psychology, social work, marriage and family therapy, or mental health counseling. Recipients agree to six years of full-time employment at VA with priority selection given to Veterans and those who agree to work at strategically located Vet Centers following completion of their program of study, thereby improving community outreach and suicide prevention efforts.

- **Section 701** enables VA to award grants to entities for the expansion of telehealth technology for secure and private telehealth services. VA is currently spearheading several initiatives with private partners, including Philips, Veterans of Foreign Wars and The American Legion, to provide convenient locations with the broadband and telehealth technology necessary to expand telehealth services and reach Veterans in underserved communities.

Conclusion

Each of us has a role in suicide prevention and in the implementation of VA's National Strategy. Community prevention efforts are as critical as our clinical intervention efforts. We are grateful to Congress for the Hannon Act to assist in further

implementation of the public health approach to prevent Veteran suicide and to improve Veterans mental health and well-being over the course of their lifetime. We appreciate the Committee's continued support and partnership in this shared mission.

PREPARED STATEMENT OF

TAMMY BARLET, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

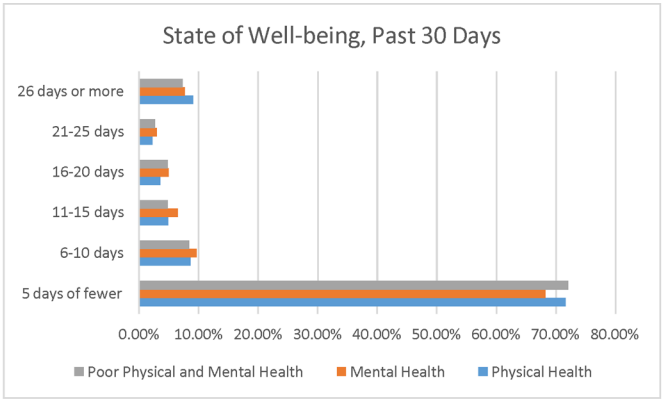
"Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act"

WASHINGTON, D.C. March 24, 2021

Chairman Tester, Ranking Member Moran, and members of the Senate Committee on Veterans' Affairs, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our insight pertaining to veterans' mental health during the COVID-19 pandemic and the use of ATLAS pod sites.

In the past year, we have lived in a world of isolation and social distancing to stay safe from contracting the COVID-19 virus. Many veterans experienced an increase in stress, fear, anxiety, and depression triggered by loneliness. Coping and self-care strategies were adjusted to daily living within our four walls, visiting friends and family through screens, attending school from our kitchen tables, working from home in a quiet space, and receiving health care through telephone or video appointments.

The VFW released a survey at the end of April 2020 through which VFW members provided a snapshot of their health care experiences six weeks into the COVID-19 national emergency. When asked about their general health, 39% of respondents stated they were in good health, 33% were very good, 17% were fair, 8% were excellent, and 3% were poor. In an assessment of physical health during the past 30 days, 72% of participants responded they had five days or fewer of poor physical health, 9% had 26 days or more, and 8% had six to ten days. Regarding mental health days deemed not good, 62% of participants stated they had five days or fewer, 10% had six to ten days, and 8% had 26 days or more. Poor physical and mental health can keep individuals from performing daily activities, including self-care, work, or recreation. Seventy-two percent of the participants responded they had five days or less of poor physical and mental health interference, 8% had six to ten days, 7% had 26 days or more. This survey was a baseline for the VFW membership to self-evaluate their physical and mental health. The VFW plans to conduct a follow-up survey in one year.



Telehealth plays a critical role in maintaining veterans' mental and physical well-being during a time of social distancing and quarantine. During the pandemic, the need for telehealth expanded, and the Department of Veterans Affairs (VA) was ready. The majority 47% of veterans who responded to the VFW's COVID-19 survey stated their routine care appointments were converted to telehealth. Telehealth appointments allowed veterans access to their care in the safety and comfort of their own homes. Retaining telehealth as a tool decreases the barriers of transportation, inconvenience, the economic impact of taking time off from work, child care, and exposure to sexual harassment or assault. Although, new issues arose like limited access to high-speed internet, technology illiteracy, and lack of access to smartphones, tablets, or computers.

Even with the success of the technology, a digital divide is created. In a recently released Office of Inspector General (OIG) VA report, face-to-face primary care encounters decreased while telephone and VA Video Connect (VVC) appointments increased from February to June 2020. The urgent transition from in-person appointments to telehealth left both patients and physicians relying on communication via telephone, which made up 81% of those encounters. But making eye contact and seeing facial and body cues is essential to successful appointments. The OIG sent a questionnaire regarding VVC barriers to the Veterans Health Administration (VHA) primary care providers. The providers identified veterans' lack of internet connectivity and equipment, insufficient training and support for veterans, inclusion of test visits prior to scheduled appointments, and the problematic two-system scheduling process for face-to-face care. The OIG report recommended that VA assess VVC and take appropriate action to address the digital divide.

The VFW is proud to be part of the solution. Through Accessing Telehealth through Local Area Stations (ATLAS) pod sites, the VFW has worked with VA and Philips to leverage VA's anywhere-to-anywhere authority to expand telehealth options for veterans who live in rural areas, or who may lack access to the internet, necessary equipment, and knowledge to facilitate VVC video calls. In addition to secure and private VVC connectivity, the ATLAS locations contain a full suite of telehealth devices, such as blood pressure cuffs, scales, oximeters, thermometers, and glucose monitors.

The first VFW post with an ATLAS site was VFW Post 6786 in Eureka, Montana. Eureka is more than 60 miles from the nearest VA clinic and more than 250 miles from the nearest VA hospital. The travel time is often considerably increased by winter weather conditions. Like many VFW posts throughout the nation, the state's COVID-19 pandemic precautions rendered the posts temporarily closed, including the ATLAS sites. Thus far, the Eureka ATLAS site has had 19 appointments, with two additional appointments scheduled within the next 30 days.

In February 2021, VFW Post 7842 in Linesville, Pennsylvania, became the second VFW ALTAS location, allowing veterans and their families to virtually connect to care with the Erie VA Medical Center (VAMC). Travel time from the post to the Erie VAMC can take over an hour on a mild weather day, but Linesville is vulnerable to 81 inches of snow per year due to Lake Erie snow effect. A Vietnam Navy veteran was the first to use the ATLAS pod at the post for a VVC appointment with his provider at the Erie VAMC. He expressed his gratitude for the on-site attendant who guided him through the check-in process. VFW Post 7842 Commander Norm Haas is humbled to have this valuable resource for the veterans' community. He would like to expand the hours of operation from three days a week/five and half hours a day to five days a week/eight hours a day. The commander mentioned the only current deficiencies of the ATLAS site are the waiting room furniture and an automated external defibrillator that was promised in the letter of agreement with VA and Philips. Recently, Erie VAMC mailed postcards announcing the ALTAS pod availability and hours of operation to eligible veterans in the area.

Two additional VFW ATLAS locations are scheduled to open within the next month—VFW Post 2487 in Los Banos, California, and VFW Post 7103 in Athens, Texas. Additionally, there is an interest in 22 more locations. The implementation of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* will provide the grant funding opportunity to allow these VFW posts to expand telehealth capabilities for mental health programs and suicide prevention to veterans in rural and highly rural areas.

The COVID-19 pandemic brought awareness to the need for telehealth, but it also illuminated barriers to digital care. Certain specialties like mental health services have greatly benefited from telehealth. However, others like orthopedics may require in-person appointments for patient assessment. The *MISSION ACT of 2018* expanded telehealth services beyond state lines to ensure veterans can receive the continuum of care even if their health care providers or the veterans move to other locations. Telehealth services can also benefit veterans via group therapy sessions by connecting veterans with similar experiences in safe and supportive settings regardless of where they live.

The VFW commends the Senate for passing the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*, and the additional legislation to fund expansion of VA's telehealth services into law. The VFW urges congressional oversight to ensure VA implements the legislation as written and intended.

Chairman Tester, Ranking Member Moran, this concludes my testimony. Thank you for the opportunity to present the VFW's input today. I look forward to engaging in further discussion with you or any members of the committee on these issues.

Prepared Statement of Tom Porter
Executive Vice President, Government Relations
of
Iraq and Afghanistan Veterans of America
before a hearing of the
Senate Veterans Affairs Committee

Chairman Tester, Ranking Member Moran and members of the Committee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members, I would like to thank you for the opportunity to testify here today.

As with everyone else, the last year has been extremely challenging for IAVA. This time last year we had just wrapped up a hugely successful member fly-in event involving our veterans from across the country. Although the centerpiece of it is advocacy, it also serves as our primary member training and professional development exercise.

Within a week of saying goodbye to our members, we were all in quarantine and have been working remotely ever since across multiple states. Despite the unprecedented challenges, IAVA was successful in adapting to the circumstances and responded the best we could to continue our advocacy and veteran assistance efforts.

We were able to pass critical reforms that will positively affect many veterans for years to come, including in areas of mental health care, women veterans, and veterans education. We had urged you all to pass the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* and the *Deborah Sampson Act*, and I thank you for getting both of those bills signed into law. We also worked to help pass timely protections for military-connected students that were facing an incredible amount of uncertainty as their schools went fully remote. Additionally, we helped to pass legislation last year to establish a national suicide prevention hotline, 9-8-8, to ensure that all Americans, including veterans, have easier access in times of crisis to lifesaving mental health and suicide prevention resources.

We are greatly appreciative that Congress acted quickly in a bipartisan manner at the outset of the pandemic to ensure student veterans would not see a reduction in their Post-9/11 GI Bill housing allowance after their schools took their classes online. The prospect of seeing a significant reduction in that allowance was certain to have caused extreme stress for many of those families impacted.

Accurate and speedy information in a crisis is critical. At the outset of the pandemic many veterans found the information about the scope of the problem and plans to conquer it lacking out of the Administration. We are very appreciative of the efforts by SVAC and the House committee to improve the information flow to our community.

The pandemic has affected almost every facet of our lives, and veterans have been no exception. IAVA members report feeling more isolated than ever before, with entire communities shutting down. We are hopeful that the worst is behind us, but we must be aware that the effects of this pandemic are going to be long reaching. According to VA, almost a quarter of all veterans live in rural communities, which have only amplified these issues. Even before the pandemic rural communities tend to have had higher poverty rates and more elderly residents. However, rural veterans are more likely to be enrolled in VA care compared to their urban counterparts, but there are still enormous challenges in care. As VA moved to a telehealth model at the start of the pandemic to protect vulnerable veterans, rural veterans had particular challenges, namely that over a quarter of all rural veterans do not have access to the internet at home. We are pleased that the *Commander Hannon Act* expanded tele-mental health care, and emphasize that these issues must be addressed in order to sustain this model and ensure that it is accessible to the most vulnerable populations.

According to the most recent VA data, the youngest cohort of veterans, post-9/11 veterans aged 18 to 34, have the highest rate of suicide. And while not always an indicator of suicide, mental health injuries continue to disproportionately impact the post-9/11 generation. In our latest member survey, a stunning 65% of IAVA members reported service-connected PTSD and over half reported anxiety (58%) or depression (56%). We know that the ongoing pandemic has only exacerbated the issue, and the data from the last year of IAVA's Quick Reaction Force (QRF) demonstrate as much.

QRF is a safety net for veterans and families that provides comprehensive care management, resource connections and 24/7 peer-to-peer support for any veteran or family member in need. QRF's services are free and confidential and are available to any veteran or family member, regardless of service era, discharge status or location, making the barrier of entry very low. The needs of veterans remain high, particularly in light of the COVID-19 pandemic and in 2020, QRF saw a 400% increase in clients served from 2019. QRF is built to address all aspects of a veteran's life that are in need of intervention and support and we do this by providing holistic and comprehensive care for all of our clients. In 2020 more than 15% of all client requests were directly related to mental health needs. Additionally, IAVA continues to have a Memorandum of Understanding (MOU) with the Veterans Crisis Line (VCL) and also has 24/7 in-house clinical support for clients that reach out to the program and are at risk for suicide. The new 9-8-8 national hotline, when fully implemented, will make access in a crisis even more easier.

Outside of direct mental health needs, an additional 56% of QRF client requests were related to emergency financial assistance, the threat of homelessness, or both, which directly impacts an individual's overall well-being and stability. Recent data from the Department of Housing and Urban Development (HUD) released last week that veteran homlessness increased *before* the pandemic hit America. Between 2010 to 2019 veteran homelessness decreased by over 50%, however in January 2020 the number of homeless veterans had increased from the previous year. This data predates the pandemic and is extremely troubling. The data from HUD, coupled with IAVA's QRF data shows that veteran homelessness is a problem that we must redouble our efforts to address.

Housing has been a particular area of concern while transitioning out of the service. In IAVA's latest survey, 24% reported going without a home for over a year after they transitioned out of the military, and 81% reported couchsurfing temporarily. We must remain vigilant to ensure that recently separated veterans are aware of the programs and benefits available to them during this incredibly difficult time. Additionally, homeless veterans today may have families to support or are women veterans. Women veterans historically are at higher risk for homelessness than their civilian counterparts. Providing safe facilities for women that will address their specific needs is critical. Ensuring these facilities also accept children is vital. Others are younger veterans who may just need temporary support. The VA must continue partnerships to align effective, dynamic services to these demographic shifts.

Another issue that can affect recently separated veterans is timely access to VBA claim decisions. Prior to the pandemic VA took great strides in reducing the backlog and ensuring that veterans were getting timely decisions. However, as a result of the pandemic the backlog is once again on the rise. There are currently over 450,000 claims still working through the system, with over 200,000 of those pending for 125 days or more. While many of these are due to the cancelation of in person exams, they must be high priority for VA. Additionally, veterans often face significant financial and emotional stress while waiting for the benefits and care that they have earned. We must ensure that these men and women who feel unsafe completing their in-person exams are given proper extensions until it is safe to do so.

When a service member transitions out of the military, one of the largest and most significant barriers to veteran employment is not only pairing military skills to relevant civilian careers but also reside in the realm of licensure and formal accreditation. Almost 70% of IAVA members did not have a job secured when they left the military. Veteran unemployment is another area of concern during the pandemic. As of February, the veteran unemployment rate across all eras of veterans is at 5.5%, slightly below the national average of 6.2%. However, the post-9/11 veteran unemployment rate remains higher than their peers. Veteran unemployment, especially for

younger veterans, has been hit particularly hard by the pandemic, and it will require unique solutions to solve this ongoing problem. I want to thank Chairman Tester, Ranking Member Moran and this Committee for your important bipartisan work in passage of the *Veterans Economic Recovery Act*, which will be an incredibly impactful tool to lower the veteran unemployment rate. While this program may not be directly related to mental health, it can reduce additional stress from the loss of a job due to the pandemic by providing a generous housing allowance and training in new in-demand skills. Strong oversight will be necessary to keep this new benefit on track for success.

Women veterans are more likely than their male peers to face economic and personal challenges. They have higher rates of unemployment, are more likely to be homeless, and to be single parents. These issues have only increased since the start of the COVID-19 pandemic. We must ensure that pandemic relief is focused and able to address the unique challenges of women veterans. We must focus our resources on policies that are inclusive of women and all minority populations. Women veterans are also more than twice as likely to die by suicide than their civilian peers, making it all the more imperative that these socio-economic issues that could increase their risk factors be addressed.

It is for these reasons that the *Hannon Act* must be successfully, and timely, implemented. This legislation will result in critical reforms in how America combats the suicide crisis. A key provision includes the creation of a community grant program to help identify isolated veterans and provide mental health services, modeled after the extremely successful Supportive Services for Veteran Families (SSVF) program. These targeted programs are designed to identify the 14 veterans per day who die by suicide not currently participating in VA services and connect them to lifesaving resources. This provision could not be more important in a time when veterans are feeling more disconnected than ever before.

VA still faces a shortage of mental health care professionals, specifically in rural areas. Recent legislation targeted deficiencies in recruitment and retention by creating separate scholarship and student loan repayment programs and by adding $65 million to VA's recruitment, relocation, and retention bonuses budget. However, these scholarships are extremely limited in number and capacity. IAVA recommends that VA take additional measures in order to address the shortage of qualified medical professionals within VHA. Moving psychologists under the Hiring Authority, Title 38, which would provide a more competitive salary rather than the federal GS pay scale is one viable option. Private sector psychologists earn a considerably higher salary than their VA colleagues. Furthermore, psychologists and some pharmacists are the only doctorate-level medical professionals at VA who are not included in Title 38.

The *Hannon Act* was a groundbreaking piece of legislation that will have long lasting effects on veterans mental health care for years to come. However, due to the unprecedented nature of the ongoing pandemic, it is clear that veterans need these provisions as soon as possible. IAVA is deeply appreciative of this Committee's work to not only pass the *Hannon Act,* but ensure that it will be implemented properly and quickly.

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

Prepared statement of
Lt Col James Lorraine, USAF (retired)
President & CEO
America's Warrior Partnership
Augusta, GA

Before the
U.S. Senate Committee on Veterans Affairs

Testimony on "Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act."

Chairman Tester, Ranking Member Moran, and Members of the Committee. Thank you for the invitation to testify today.

It is an honor to present testimony to the Committee regarding the impact of Novel Coronavirus disease 2019, or COVID-19, on our nation's veterans and their families. While the past year has been one of tribulations throughout the nation, the leadership of these Committees in the House and Senate have been a welcome beacon of promise to our nation's veteran's community. The hard work and countless hours spent passing significant legislative accomplishments and reforms into law over the past 14 months is nothing short of remarkable – especially considering how the pandemic has made communication and coordination much more difficult than ever.

In short – thank you to all the Committee Members and staff for your diligent work.

COVID-19 devastated the United States and the world over the last year. This devastation manifested itself in deaths, long-term illness, financial ruin, isolation, emotional strain, and loss of hope. Military connected veterans, service members, and their families were not immune to this devastation. However, in many cases, these individuals led efforts to help their fellow citizens or were supported by community-based programs that empowered them to move forward despite the adversity they were facing.

I served many years under United States Special Operations Command. Within the Special Operations Forces, or SOF, five truths that were established early at its formation guide the development of special operations.

- The first SOF truth is "Humans are more important than hardware."

- The second SOF truth is "Quality is better than quantity."
- The third SOF truth is "SOF can't be mass produced."
- The fourth SOF truth is "Competent Special Operations Forces cannot be created after emergencies occur."
- And the fifth SOF truth is "Most special operations require non-SOF support."

Each of these truths applies to the service of veterans.

- The pandemic has demonstrated that we can't solely rely on technology to serve our veterans and their families;
- Second, a small county based veteran service program that has a relationship with their veterans is better than 100 websites;
- Third it takes time to train and educate these communities to best serve their veterans;
- Fourth, we can't wait for a crisis to occur, or current crisis to finish, before we act;
- And finally, no one organization, even the VA, can serve veterans and their families alone.

Through our expertise in collaborating with community leaders, we see where humans are more important than hardware. In northern South Carolina, Upstate Warrior Solution (UWS), a community group affiliated with America's Warrior Partnership capitalized on the proactive relationship they had previously established with over 7,000 veterans which included 80% of post 9/11 veterans living in their region to connect by phone, text, email, or physically distanced check-ins. Like other community programs with previous relationships in their community veterans, UWS was able to mitigate many of the stressors facing veterans and their families. Mission Roll Call, a program that unifies the message of veterans through story telling started a "Be A Leader" initiative where prominent veterans encouraged Mission Roll Call's million plus followers to lead as they did in the military, take care of your follow citizen, and follow prevention measures. In the Navajo Nation, our veteran service program, the Dine' Naazbaa' Partnership (DNP) re-connected with more than 300 veterans living over a large area to bring them food, water, blankets, and firewood to cook or heat their homes.

In these examples, the impact was immediate, personal, and significant. County Veteran Service Officers across the nation moved to remote work locations but continued to work aggressively to care for and advocate for their community veterans. At America's Warrior Partnership we recognized that local programs that had proactively developed relationships with their community veterans were much more prepared to serve during the pandemic than those communities who struggled with lack of personal contact to help during the pandemic.

In short, COVID-19 has undeniably impacted our veterans, but veterans who were in a community that used a proactive, integrated response to assist with issues had much more positive results.

Many national organizations polled, surveyed, and studied veterans, their families, and their communities during the pandemic. It's not surprising that the findings of these assessments aligned regardless of whether a veteran, their family, or the community was being assessed. In May 2020, America's Warrior Partnership surveyed 69 community-based service providers across the country and learned that communities were seeking greater access to food and household supplies, short-term financial assistance, employment assistance, housing, and access to medical care. Ninety three percent of communities felt that they could address veteran's needs locally. America's Warrior Partnership recommended continuing to safely outreach to veterans and community programs and to be creative on how to address community level issues. During the same period, Syracuse University's Institute for Veterans and Military Families (IVMF) conducted polls that found 93% of veterans feared for the impact on US Economy and 72% feared for lack of community resources. IVMF's April 2020 snapshot poll recommended that communities immediately "Seek ways to promote continuity of operations and sustainability of critical community-based providers that serve veterans and military families." and in the longer-term "Double-down on resources and interventions that address known family and individual stressors, enable access to care and services, and reduce the risk for adverse outcomes (e.g., unemployment, housing/financial insecurity, suicidal ideation)."

IVMF's follow-up snap-shot poll from May 2020 identified medical care as veterans' #1 resource need, followed by financial assistance, community support, legal services, and career support. Wounded Warrior Project's December 2020 survey of 28,282 post-9/11 veterans, which was administered during the same period of IVMF's snap-shot poll stated "Over half of warriors (59%) reported that their physical health appointments had been postponed or canceled, and 38% reported their mental health appointments had been postponed or canceled. Lack of care, combined with long-standing mental health conditions and the stressors of the pandemic environment, led us to explore the additional burden WWP warriors face."

Wounded Warrior Project found that the complexity of their alumni and the lack of medical care compounded the negative response to the COVID pandemic which could be seen through a 30% response on suicidal ideations. Similarly, Blue Star Families found veterans families found access to medical care and the overall mental health status of parents and children to be a leading concern. Additionally, County Veteran Service offices noted not only reduced access to medical care, but for low

income or rural veterans, the lack of transportation and difficulty navigating the VA's online scheduling and reimbursement system was a barrier due to lack of access to needed technology.

As demonstrated from studies and experience, healthcare access for veterans was and continues to be a serious issue for veterans. Wounded Warrior Project's studies show the lack of access to health care was detrimental to the veterans they serve. In March 2020, the New York Times quoted the Ranking Member Jerry Moran "I have serious concerns with the V.A. putting a temporary pause on community care. When the V.A. cannot provide care to veterans, the V.A. is required under the Mission Act to send them to the community."

However – we have heard from our communities and county partners that access to care is not improving.

On March 5, 2021, USA Today wrote citing a letter to the VA from Congressional members "The COVID-19 pandemic has led to the cancellation, delay or rescheduling of almost 20 million medical appointments for veterans. Part of that is a result of many Veterans Affairs medical facilities being fully or partially shut down because of the pandemic. But that's only half the story. For those who can't get care at a VA facility, community care under the VA MISSION Act should be an alternative. It isn't working out that way."

And on March 18, 2021, the Secretary of Veterans Affairs said on a MSNBC that the VA is facing a significant backlog that will be addressed with the support of the American Rescue Plan funding. Yet this doesn't even match with the VA's own "Vantage Point Blog," who wrote in the opening line of a March 15, 2021 post that "No matter how you measure it, the VA has dramatically improved access to health care for veterans."

Members of the Committee - we can't wait for another crisis to occur. It is imperative that we act now.

America's Warrior Partnership, along with many members of the VSO community, supported the nomination of Secretary McDonough to lead the VA. And his testimony before this Committee reflected a welcome attitude and promise of increasing access to care and closely following the law and intent of Congress.

The VA must use all the tools available to them to maximize access to healthcare, and not use this pandemic as an opportunity to consolidate care inside the VA at the cost of veteran's access. We

believe the COVID-19 pandemic has had a significant negative impact on the health of our veterans and their families that likely will not be fully recognized for many years, but it is clear that access to care by all means is essential to stem the tide of absent care. This includes maximizing the use of The Mission Act and rapidly implementing the Hannon Act as well as the COMPACT Act so that healthcare, community services, and programs such as Post Traumatic Growth can be made available to veterans and their families who went without during this last year. We hope Secretary McDonough will continue to follow through on his testimony and fix these issues.

America's Warrior Partnership stands ready to assist the Department of Veterans Affairs and this committee in the service to our veterans and their families across the nation. Yet much of the impact from COVID-19 is tough to fully identify without further information and data. More data is needed. But even in areas where data exists, it is tough to fully access and qualify the data the VA already has.

In partnership the University of Alabama and funded by the Bristol Myers Squibb Foundation, America's Warrior Partnership has led a nationwide former service member suicide study that seeks to identify data driven, community-based suicide prevention measures. To date 15% of states have shared the last five years of death data, which we share with the Department of Defense to validate which decedents had served in the armed forces and share their service experience. This partnership with the Department of Defense and Dr. Karin Orvis has provided us critical insight into not only former service member suicides, but non-natural causes of death such as overdose, strangulation, drowning, and firearms.

One of the first major takeaways we have been able to identify that states are under-counting former service member suicide by approximately 20-25%. How this relates to the impact on COVID is that both Florida and Minnesota will provide their 2020 death records to our study this summer and with this data we can gain greater insight into the pandemic period causes of death and relationship to those who did not serve in the military.

The worst part, is that all these findings are likely amplified during times of crisis. While we await the 2020 state data covering the pandemic period we also await data from the VA which will allow Operation Deep Dive to connect the dots between state death data, Department of Defense service history, and the former service members Department of Veterans Affairs experience. Without all the puzzle pieces we are assuming the severity the pandemic has had on our veterans. We look forward to working with the Committee and the government to truly understand the impact this pandemic has had on our nation.

In summary, the time to act is now! The COVID-19 pandemic has undoubtedly impacted the lives of veterans and their families. Secretary McDonough has inherited a significant backlog which will require the VA use all the tools at its disposal to increase access and continuity of medical and behavioral care, especially maximizing the use of the Mission Act. The VA must rapidly seek the means to actively partner with community partners, especially in rural communities throughout the nation. The VA should not look at every solution to a problem as a VA program. And lastly, we hope the VA will increase their willingness to share critical data outside the Department.

I am hopeful. Hopeful for our military, hopeful for our veterans, and hopeful for our success in ending veteran suicide. Thank you for the opportunity to present to the committee.

PREPARED STATEMENT

OF

KARIN A. ORVIS, PH.D.

DIRECTOR

DEFENSE SUICIDE PREVENTION OFFICE

and

CHAD BRADFORD, CAPT, MC, USN

DIRECTOR, MENTAL HEALTH POLICY & OVERSIGHT

HEALTH AFFAIRS

REGARDING

COMMANDER JOHN SCOTT HANNON VETERANS MENTAL HEALTH CARE IMPROVEMENT ACT OF 2019 (PUBLIC LAW NO: 116-171)

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

March 24, 2021

Chairman Tester, Ranking Member Moran, and members of the Committee, thank you for the opportunity to testify before you today, along with our colleagues from the Department of Veterans Affairs (VA).

The Department of Defense (DoD) is committed to providing the highest level of mental health care to Service members and Veterans. Toward this effort, DoD supports the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019. Like you, we are steadfast in our commitment to ensuring that those who serve our Nation receive timely and quality health care, including care to addressing their mental health needs, and access to suicide prevention resources. Certainly this is of even greater importance now given the coronavirus pandemic. During this time, Service members and Veterans may be experiencing heightened feelings of stress, anxiety, uncertainty, and disconnectedness. For some, such experiences can be associated with an increased risk for suicide. Like our colleagues from the VA, we are closely monitoring the potential impacts on the well-being of our Service members and families, and have been taking proactive measures since the start of the pandemic to support our military community. We look forward to discussing the Department's collaboration with the VA to implement provisions of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 to ensure transitioning Service members and Veterans have seamless access to mental health care and suicide prevention resources.

Today, the Department will provide an update to the Committee on six sections of this Act. The first, Section 101, directs the creation of a strategic plan on expansion of health care coverage for veterans transitioning from service in the Armed Forces. The second Section 102, calls for a review of records of former members of the Armed Forces who die by suicide within one year of separation from the Armed Forces. The third, Section 405, pertains to the joint

mental health programs by the VA and DoD. The fourth, Section 302, directs the establishment of a clinical provider treatment toolkit and accompanying training materials for comorbidities by the VA, in consultation with DoD. The fifth, Section 303, calls for an update of clinical practice guidelines for assessment and management of patients at risk for suicide. The sixth, Section 304, requires the establishment of clinical practice guidelines for the treatment of serious mental illness by VA, in consultation with DoD and the Secretary of Health and Human Services.

The Department regularly and closely collaborates with the VA on matters related to Service members' and veterans' mental health. In January 2021, the Department joined with the VA in a newly formed, inter-agency Integrated Project Team (IPT) to support VA's response to Section 101. The Section 101 IPT is established to determine metrics for success, project increased demand of care against current availability and what level of expansion is required for successful delivery, perform enrollment analysis, provide input on communication to Veterans and reduce barriers to seeking mental health services, and identify points of integration throughout the Veterans Health Administration, Veterans Benefits Administration, and DoD that will inform the overall strategic plan. The outcome of this work will be reviewed by senior leaders in both Departments and delivered within the legislatively directed timeline.

Section 102 states that DoD and VA shall jointly review the records of each former member of the Armed Forces who died by suicide within one year following the discharge or release of the former member from active military, naval, or air service during the five-year period preceding the date of the enactment of this Act. The DoD and VA respective collaboration offices – the DoD/VA Collaboration Office within DoD and VA's Interagency Collaboration Office – are currently making progress to develop the inter-agency working group structures to fulfill this requirement. The Department is committed to executing this important

effort in partnership with VA and is currently working to ensure the appropriate infrastructure and other resources are in place for success.

The Department joined with the VA to form an inter-agency work group in response to Section 405 of the Act, which (a) established a new annual report on all VA and DoD mental health programs, including transition and secondary programs that support mental health, such as employment, housing assistance, and financial literacy programs; (b) asked to identify any areas for potential joint programming to improve mental health care at VA and DoD, and (c) directed evaluation of efforts to create a joint Intrepid Spirit Center at a location that is geographically distinct from already existing and planned Spirit Centers, may be located in a rural or highly rural area, is on an installation of DoD or property of a VA Medical Center, and potentially involves private or philanthropic entities in carrying out the activities of the center.

The work group completed planning sessions to discuss the requests and identify the specific information required to address each request. We solicited and received feedback from key stakeholders and subject matter experts and are currently formulating a response. We remain on schedule to meet the established timeline for completion.

Sections 302, 303, and 304 call for VA and DoD collaboration in the establishment of a clinical provider treatment toolkit and accompanying training materials for comorbidities, on an update to the VA/DoD CPG for Assessment and Management of Patients at Risk for Suicide that: 1) considers gender-specific factors; and 2) includes guidance with respect to the efficacy of certain alternative therapies, such as meditation and animal therapy, and 3) to publish a CPG on serious mental illness. VA and DoD are developing the comorbidities toolkit and most effective catalog of training opportunities. The VA/DoD CPG on Suicide Risk was most recently updated in 2019 with accompanying provider and patient toolkits. Gender considerations were included

and will continue to receive attention in future updates. DoD will continue to collaborate with our colleagues at VA to develop two CPGs on serious mental illness: an update to an archived CPG on bipolar disorder, and a new CPG on schizophrenia and schizoaffective disorder.

We are grateful for the opportunity to speak with you today and discuss the Department's efforts, in collaboration with VA, to support our Service members and Veterans, including various resources, support, and care to addressing their mental health and well-being, among other needs. We are also happy to discuss other mental health and clinical and non-clinical suicide prevention efforts underway, including new promising practices we are piloting based on research advances from the civilian sector. Supporting our military and Veteran communities, particularly during these unprecedented times, is paramount. We acknowledge we have more work to do, and more progress to make. We take this charge very seriously. Our efforts will continue to address the many aspects of life that impact mental health and suicide, and we are committed to addressing these challenges comprehensively.

Thank you for the opportunity to provide further detail on DoD efforts in support of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019. We also thank the members of this Committee for your commitment to the men and women of our Armed Forces, our Veterans, and the families and communities who support them.

STATEMENTS FOR THE RECORD

PARALYZED VETERANS OF AMERICA

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

"COPING DURING COVID: VETERANS' MENTAL HEALTH AND IMPLEMENTATION OF THE HANNON ACT"

MARCH 24, 2021

Chairman Tester, Ranking Member Moran, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to provide our views on the impact of the pandemic on mental health and considerations as the Department of Veterans Affairs (VA) begins implementation of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act (P.L. 116-171). No group of veterans understand the full scope of benefits and care provided by VA better than our members—veterans who have incurred a spinal cord injury or disorder (SCI/D).

The many and varied provisions of the Hannon Act have the potential to dramatically improve the delivery of mental health care for the millions of veterans using the Veterans Health Administration for their care. This law will ensure service members have more support as they transition from the military, empower communities to support suicide preventions efforts, require reporting to ensure efforts to improve programming and policy changes are effective, and help us discover what more can be done. It also strengthens oversight of VA as the Department works to stem the tide of veteran suicide and bolsters VA's workforce to help ensure appropriate staffing to meet the need.

It is early in the implementation of Act and many of the reporting requirements are coming close to their enactment dates and required deadlines. We look forward to reading the reports. If they were conducted as designed, there were intentional efforts to recruit a diverse group of participants, including individuals with SCI/D. Also, it is important the data is presented in a way that allows us to better understand how the various intersections of demographics impact mental health care.

According to the Centers for Disease Control, "Fear or concern about the impact of COVID-19 on physical health and daily life may contribute to the onset of or worsen existing mental health problems."[1] Substance use or misuse problems may occur or worsen as a result from the stress of social isolation and other COVID-19 restrictions.[2]

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[1] Centers for Disease Control and Prevention. (2020, December). Support for veterans. Retrieved March 22, 2021, from https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/stress-coping/veterans.html

[2] Michigan Medicine Department of Psychiatry. (2020, April 22). Addiction, substance use and recovery during the COVID-19 Pandemic: Psychiatry: Michigan Medicine. Retrieved March 22, 2021, from https://medicine.umich.edu/dept/psychiatry/michigan-psychiatry-resources-covid-19/specific-mental-health-conditions/addiction-substance-use-recovery-during-covid-19-pandemic

We do not know yet the impact of COVID-19 on the mental health of this population. Because of the risk of adverse outcomes from the virus, many veterans have remained isolated in their home, only leaving when medically necessary. Some describe this as feeling trapped or prisoners in their own home. We know participation in group sports and involvement in the workplace can help the resilience and improve the emotional well-being of this population and with many activities cancelled, and jobs lost, their isolation and loneliness have increased. We also observe the return-to-work rate is much slower among individuals with disabilities. Also impacted are those who relied on public transportation whose availability was reduced or eliminated altogether because of the pandemic.

As we look at the implementation of the Hannon Act, when conversations about minority populations occur, one group often overlooked is those living with disabilities. And yet, they are a protected class just as are race, color, religion, national origin, sex, and familial status. But we know disability is only one dynamic of an individual's self and recognize there can be multiple intersections impacting a person's ability to obtain and receive health care.

The Staff Sergeant Parker Gordon Suicide Prevention Grant Program, included in P.L. 116-171, authorizes VA to award grants to eligible entities for the provision of suicide prevention services. It is essential that veterans with catastrophic disabilities also have access to suicide prevention services. As VA develops policies for the award of such grants, it is imperative they ensure that grantees demonstrate how they will make their programming accessible to individuals with disabilities. Not requiring accessibility creates an inequality of service provision that would leave many VA is charged with caring for, who may need this care, left behind.

While the Hannon Act has many provisions that will impact the overall mental health of veterans, the lack of focus on veterans with catastrophic disabilities means there is more work to do. Among individuals with SCI, mental health conditions and substance use disorders (SUDs) tend to be under recognized and undertreated, even in light of the fact that individuals with SCI usually have regular and frequent contact with health care professionals. Since mental health disorders are often not recognized they are often not fully addressed. Under-recognition may occur because SCI is a catastrophic injury that blurs the lines between normal emotional responses and mental health disorders. This could be because other, more obvious physical health impairments caused by SCI dominate conversations with providers. Many physical symptoms of mental health illnesses, for example shortness of breath, sweating, increased blood pressure, and rapid heart rate are common issues among individuals with SCI/D and those with anxiety; so, a positive screen does not always mean a diagnosis. Undertreatment may stem not only from poor recognition, but also failure to use rehabilitation as a window of opportunity to intervene in mental health and SUD conditions. Comorbid mental illnesses and SUDs adversely influence SCI-related symptoms such as pain, as well as functioning, level of independence, community participation, quality of life, and mortality. Then there are the traditional barriers all veterans face regarding the stigma that surrounds mental health disorders.

Another barrier is that fact that many of the screening tools for mental health illnesses as well as psychopharmacology are not calibrated for individuals with SCI/D. An SCI often involves exposure to a life-threatening traumatic event. Anxiety and posttraumatic stress disorder (PTSD) are at least twice as prevalent than among those without SCI/D, and depression and substance use is also significantly more prevalent.[3] These figures are similar among veterans with SCI/D, and in some cases, worse. We know from research that depression and pain are positively associated in the SCI population and that the relationship may be bidirectional.[4] Post-injury stressors such as care transitions or marital stress, as well as financial, housing, and social insecurity, can also increase the risk of an adjustment disorder.[5] The efforts to research the mental health needs of veterans with SCI/D must continue.

As VA works to implement the measures in Title III of the Hannon Act, it is our recommendation they incorporate clinical guidelines recently published by PVA in collaboration with the Consortium for Spinal Cord Medicine for clinicians to follow when treating veterans with SCI/D. This information includes recommendations on when and how often to screen individuals with SCI/D for anxiety, PTSD, depression, SUDs, and suicide. Since recent VA data shows that the first three, and twelve-month points are the highest risk periods for suicide among veterans with SCI/D, existing and future guidelines should incorporate information from the PVA clinical recommendations. Specifically, more screening around the onset of injury and faster connection to services and organizations that serve this population to improve veterans' quality of life and connection to their community.

Individuals with SCI/D are three to five times more likely to die by suicide.[6] And according to recent information from VA, among veterans with SCI/D the suicide rate is 68.1/100,000 versus the veteran population without SCI/D which is around 27.5/100,000.[7] We need to be aware that due to the higher staffing needs and care concerns for SCI/D veterans with bowel and bladder care or ventilators, there are few places within VA or the community that can handle the mental health inpatient care needs of these veterans.

Disturbingly, veterans with an SCI/D and living with SUD are often left to detox at home or in a hospital versus a traditional SUD type program. SUDs are prevalent and associated with poor outcomes in individuals with SCI/D, with 14 percent of individuals with SCI/D reporting significant alcohol-related problems and 19.3 percent reporting

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[3] Williams R, Murray A. Prevalence of depression after spinal cord injury: A meta-analysis. Arch Phys Med Rehabil. Jan 2015;96(1):133-140.

[4] Paralyzed Veterans of America. (2021). Management of mental health disorders, substance use disorders, and suicide in adults with spinal cord injury. The Journal of Spinal Cord Medicine, 44(1), 102-162. doi:10.1080/10790268.2021.1863738

[5] Ibid; 16

[6] Ibid; ii

[7] Rep. No. Department of Veterans Affairs-2020 National Veteran Suicide Prevention Annual Report at 1-49 (2020).

heavy drinking.[8] We must look for ways to better integrate their care, especially those on ventilators or with bowel and bladder care in inpatient treatment settings.

We also recommend that screening include preinjury history of mental health and substance use problems because individuals with SCI have high rates of preinjury mental health disorders and SUDs, and a history of these disorders is predictive of post-SCI mental health. Researchers found that the odds of having a psychological disorder after SCI were 24 times greater if the individual had been treated for a psychological disorder before the SCI.[9]

Research

Section 302 of the Hannon Act calls for VA and the Department of Defense to establish a clinical provider treatment toolkit and accompanying training materials for comorbidities. As this is created, we hope that it will include research regarding medication assisted treatment (MAT), and that these toolkits include information on the unique concerns of MAT among veterans with SCI/D. The need for more and better research on the mental health needs and psychopharmacology among veterans with SCI/D remains high. There is no literature available on the efficacy of using MAT for SUDs in individuals with SCI/D. Therefore, VA uses evidence-based practices based on other populations, which might increase the risk for autonomic dysreflexia to occur. More research is needed to know how MAT interplays with the system of someone with an SCI/D to ensure they can safely withdraw from illicit substances and alcohol. We need comparative effectiveness studies that help health care providers and patients choose the best treatment for each individual.

Research will also be needed to understand the impact of the pandemic on these veterans' mental health. PVA is using online programming to engage our members during the pandemic to help reduce isolation and loneliness but we are hearing comments from some members that it is not quite as enjoyable as being in person. For this reason, we also feel research is needed on the effectiveness of alternative mental health treatment delivery models such as telephone, videoconference, web-based, and app-based interventions to ensure that veterans needs are being fully met. We have heard from some of our members that either they or their provider have lost clinical time due to not knowing how to work the technology or poor broadband access.

In general, additional research is needed as VA cares for veterans living with SCI/D. Based on PVA's clinical practical guidelines, new studies are needed on:

- Ways to improve the transition from inpatient to outpatient settings and how transition strategies can prevent and mitigate mental health problems.

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[8] Bombardier, C. H., Azuero, C. B., Fann, J. R., Kautz, D. D., Richards, D. S., & Sabharwal, S. (In Publication). Management of Mental Health Disorders, Substance Use Disorders, and Suicide in Adults with Spinal Cord Injury. Washington, DC: Paralyzed Veterans of America.

[9] Ibid; 12

- Use of peer-led interventions for mental health disorders, SUDs, and suicide risk.
- Combined treatments and alternative treatments, such as transcranial magnetic stimulation and ketamine for treatment-resistant depression.
- Diagnostic validity testing for substance use screening measures in individuals with SCI/D; studies on the acceptability, feasibility, efficacy, and effectiveness of integrated SUD treatment during inpatient or outpatient rehabilitation for individuals with SCI/D; efficacy of psychosocial treatments and MATs alone and in combination for SUD in individuals with SCI/D; and the effect of mental health and SUD treatment on the overall cost and effectiveness of SCI rehabilitation.
- Examining the psychological effects and suicide risk associated with SCI-related pain as well as effects of nonopioid and nonpharmacological pain interventions on opioid use, opioid addiction, and other mental health outcomes.
- Evidence-based pharmacotherapy and psychotherapy for anxiety spectrum disorder and PTSD in individuals with SCI/D.
- Measures to mitigate suicide risk following SCI/D, including the role and effectiveness of efforts to augment protective factors.

PVA would once again like to thank the Committee for the opportunity to submit our views on the impact of the pandemic on mental health and considerations as VA begins implementation of P.L. 116-171. We look forward to working with you as you provide oversight of this monumental piece of legislation.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2020

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $253,337.

Fiscal Year 2019

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $193,247.

Fiscal Year 2018

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events — Grant to support rehabilitation sports activities — $181,000.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

National Service & Legislative Headquarters
807 Maine Avenue SW
Washington, DC 20024-2410
Phone: 202-554-3501
Fax: 202-554-3581

STATEMENT FOR THE RECORD
JOY J. ILEM
NATIONAL LEGISLATIVE DIRECTOR
DISABLED AMERICAN VETERANS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
MARCH 24, 2021

Chairman Tester, Ranking Member Moran, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to submit testimony on our views about the impact of the COVID-19 pandemic on veterans' mental health and access to Department of Veterans Affairs (VA) mental health services during the public health crisis. As a veterans service organization comprised exclusively of wartime service-disabled veterans—reliable access to VA's specialized mental health programs is critical for many of our more than one million members.

In the Veterans Health Administration, as with other health care systems around the globe, COVID-19 and the onset of the pandemic substantially changed the way health care was delivered, emphasized existing gaps and weaknesses in health systems and altered existing policy and planning for the future. The pandemic has also had an impact on the mental health of all Americans, including our nation's veterans, their family members and VA staff. Struggles with isolation, uncertainty, death of family members and friends have taken an emotional toll—especially on veterans who were already facing mental health challenges such as post-traumatic stress disorder (PTSD), depression, substance use disorders and anxiety due to their military service.

As COVID-19 vaccines become more widely available throughout our nation and life begins to hopefully return to a "new normal," it is appropriate for VA, Congress and veteran stakeholders to evaluate not only lessons learned over the past year and to plan for the future, but to look at issues that existed before the pandemic as well as those that have arisen or become exacerbated since the public health emergency began.

Prior to March 2019, VA was focused on improving access to VA mental health services and lowering the rates of suicide among veterans. Despite VA's efforts and targeted initiatives to eliminate the tragedy of veterans' suicide—suicide rates for veterans and service members remained plateaued at higher rates than their non-veteran peers. VA established a number of public awareness campaigns that aimed to teach community and family members how to recognize important symptoms and behaviors and engage with veterans and others who were struggling, in crisis or at risk

for suicide. The VA's Office of Mental Health and Suicide Prevention identified that both male and female veterans were more likely to use firearms in self-directed violence when compared to their non-veteran peers, and informed providers and family members about the importance of talking to veterans who are in crisis about lethal means safe storage practices for medications and firearms. VA ramped up evidence-based programs such as its SPED (Suicide Prevention for Emergency Departments) program, a safety planning intervention with follow-up contact for suicidal patients and its REACH-VET initiative, which analyzes existing data to identify veterans who are at an elevated risk for suicide and allows VA to provide them with preemptive care and support services. VA also focused on improving its clinical practice guidelines, crisis hotline, access to Vet Centers, peer support networks and peer support specialists to respond to veterans in crisis in accessible, more culturally appropriate ways.

DAV believes these initiatives and collective efforts have been important in addressing emergent needs in the veteran population and, had VA not had them in place, VA would likely be seeing significant increases in rates of suicide rather than holding the line. While initial data on veterans' suicide since the pandemic began suggests that this existing trend is continuing, it is too early to tell how rates of suicide among veterans will be affected.

Prior to the start of the pandemic and public health emergency, VA was also focused on timely access for veterans seeking VA mental health care services and implementation of the Veterans Community Care Program. Social distancing requirements to reduce spread of the virus required VA to quickly shift to telehealth for routine medical care and conduct outreach to veteran patients using VA mental health services, to ensure their care would not be interrupted. VA posted information online informing enrolled veterans that mental health services were available and urging them to reach out for help if it was needed.

Standing up COVID-related safety measures at VA health care facilities was a priority and some treatment and outreach efforts were stalled or replaced with alternative options such as tele-mental health. Telehealth appointments and tele-mental health, in the form of telephone or video connect meetings, increased dramatically and provided veterans' continued access to routine primary care and mental health services. Many veterans embraced—or at least accepted—Telehealth, but for those with broadband access issues or veterans who are not used to working with technology, it likely added some stress to attaining necessary treatment. VA expressed concern that many patients fearful of becoming ill due to the virus, especially those requiring ongoing care for chronic conditions, may have delayed care by choosing to wait until the COVID pandemic is quelled to receive face-to-face support. This will likely result in a significant demand for care as the population has access to COVID vaccines and feels more comfortable seeking in-person care. Likewise, some VA research is already recognizing suppressed demand for mental health care.[1]

[1] Mitchell L, Fuehrlein B. Patient Volume and Dispositions in a VA Psychiatric Emergency Room During COVID-19. Community Ment Health J. 2021 Jan 30:1–3. doi: 10.1007/s10597-021-00778-w. Epub ahead of print. PMID: 33515359; PMCID: PMC7846908.

While many VA medical centers are reporting waiting times that meet VA standards of less than 30 days (as of Feb. 17, average waits for mental health for new patients are 10.3 days and 3.3 days for established patients),[2] some VA clinics already report they are not accepting new patients. While VA's Office of Inspector General reported significant vacancies for psychologists since 2015,[3] its most recent report did not list psychologists as a critical occupational shortage, yet psychiatry was cited most frequently among VA medical centers as their most severe occupational shortage (60% of all facilities). While DAV is supportive of the new authority allowing VA to care for recently discharged service members[4] and provide emergency mental health to veterans with "bad paper" discharges, this expansion for eligibility will potentially add more veterans to the already overburdened queues.

In the months ahead, we will likely have to ask even more of VA leadership and clinical staff in managing the anticipated fallout and pent-up demand for care that may come from these difficult times. We are hopeful that Congress will continue its oversight and generous support for VA and provide the additional staff and resources that the Department will likely require to meet demand.

VA's employees, in addition to all of our frontline health care workers, deserve our support and gratitude as the pandemic continues. We have asked so much of them. VA providers and support staff have struggled to cope with managing the crisis and the tremendous burden of severe disease and loss of life—with VA treating 239,770 cumulative cases of COVID-19 among veterans and employees and seeing more than 11,000 deaths as of March 23.[5] Health care staff have experienced continued threats to their own personal health and safety, and that of their families and loved ones. VA employees have also experienced a number of stressors, including: shortages in critical medical supplies and equipment and personal protective equipment necessary to protect themselves; lack of effective life-saving treatments in the early months of the pandemic; being the primary support for critically ill veteran patients who could not have loved ones by their side as they were dying, as well as the unimaginable loss of veteran patients in their care.

DAV reached out to VA mental health providers to find out about their experiences and how they continued to provide needed mental health care and support to veterans. One clinician noted that he and his staff remained onsite at their hospital during the pandemic to assist veterans undergoing difficult or frightening procedures and to ensure hospitalized veterans who were isolated and fearful had iPads allowing them to have contact with their loved ones. Some providers took the place of loved ones at the bedside, remaining with veterans who would have otherwise died alone. One provider noted that he is just now beginning to see new patient referrals of veterans, many of whom are seeking mental health support for the first time, for issues like depression and anxiety that developed during the public health crisis. We are eternally

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[2] https://www.accesstocare.va.gov/Healthcare/Overall
[3] https://www.va.gov/oig/pubs/VAOIG-20-01249-259.pdf
[4] Service members recently discharged from military service are now eligible for VA care one-year post discharge under Executive Order 13822 (83 Fed.Reg. 1513).
[5] https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary accessed 3/24/21.

indebted and want to thank the frontline workers—our nurses, doctors and mental health professionals and support staff who have remained on the job from the beginning of the pandemic and continue to do this difficult and soul-wrenching work as the health crisis continues.

Some of the early research findings looking at the impact of the pandemic on the mental health of Americans suggest increased reporting of symptoms of depression when compared to 2019 and increasing substance use to cope with stress or emotions related to COVID-19.[6] There were also reports of difficulty sleeping, eating, and increased alcohol consumption due to worry and stress over the coronavirus. As the pandemic wears on, ongoing and necessary public health measures will likely continue to impact many people experiencing situations linked to poor mental health outcomes, such as isolation and job loss.[7]

Given these findings and reports from health professionals, we expect that the pandemic and its social and economic fallout will likely exact a heavy toll on our veterans and their families. Like others around the globe, veterans have experienced personal loss, social upheaval, compromised health, loss of jobs or productive work engagement and social isolation. These circumstances may create or exacerbate mental health conditions including depression, anxiety and substance-use disorders. Loss of gainful employment may increase homelessness, poverty and family dissolution—all of which increase veterans' risk of suicide.

VA has already begun to study those who may be most affected by the pandemic. One study investigated the effect of the pandemic on veterans with mental health conditions prior to the pandemic and assessed them for suicidal ideation. Veterans found to have suicidal ideation (19.2% of the studied population) were more likely to have lower incomes, to have been infected with COVID-19, to be financially and socially affected by the virus and to be older than veterans without suicidal ideation. Conversely, veterans without suicidal ideation tended to be higher income and have a purpose in life.[8] VA must continue this research and heighten its efforts to screen and engage veterans in treatment for conditions that may have arisen or become exacerbated as a result of the pandemic—even if veterans were previously stable.

VA researchers are also looking at the differences in how the pandemic has affected minority veteran populations. Relatively early in the pandemic, VA found that Black and Hispanic veterans were experiencing significantly higher (two times) the rates

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[6] Mark É. Czeisler1,2; Rashon I. Lane, MA3; Emiko Petrosky, MD3; Joshua F. Wiley, PhD1; Aleta Christensen, MPH3; Rashid Njai, PhD3; Matthew D. Weaver, PhD1,4,5; Rebecca Robbins, PhD4,5; Elise R. Facer-Childs, PhD1; Laura K. Barger, PhD4,5; Charles A. Czeisler, MD, PhD1,4,5; Mark E. Howard, MBBS, PhD1,2,6; Shantha M.W. Rajaratnam, PhD. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States. June 24–30, 2020. CDC. 2020 June.

[7] Nirmita Panchal , Rabah Kamal , Cynthia Cox Follow @cynthiaccox on Twitter , and Rachel Garfield Follow @RachelLGarfield on Twitter KFF Issue Brief: The Implications of COVID-19 for Mental Health and Substance Use
Published: Feb 10, 2021.

[8] https://www.sciencedirect.com/science/article/pii/S0022395621001655

of COVID-19 infection as their white peers.[9] Research now indicates that their rates of hospitalization and adverse outcomes also appear to differ.[10] Because of these disparities, VA will need to carefully monitor and assess the mental health needs of veterans who have been substantially impacted by the pandemic due to loss of employment and/or their home, chronic illness resulting from COVID-19 (long-haulers) and loss of family members or friends.

DAV is concerned that an expected surge in demand may compel VA to look to referring veteran patients to providers in the community who do not have the same knowledge about common mental health conditions among veterans, their particular risks for suicide or the experience in delivering evidence-based treatments used by VA's mental health providers. We are hopeful that to the extent VA must use community providers to ensure VA meets demand for care in a timely manner, VA and Congress will consider requiring access and quality standards for community partners that better inform VA referrals and scheduling of community care appointments. In addition, we want to ensure VA maintains its role as the primary health care coordinator for veterans during community care episodes.

In addition to addressing the issues many veterans will likely face in a post-COVID environment, Congress took important steps in the 116th Congress to address existing gaps in VA's suicide prevention and mental health programs—particularly for veterans who do not use VA. DAV supported Public Law 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act), and is pleased that the Committee is focused on implementation of the many important provisions in this law.

We appreciate that the Hannon Act aims to create new community-based outlets for mental health and other supportive services aimed at preventing suicide, particularly among veterans who have not sought VA care, and we look forward to research and analysis about the effectiveness of the grants providing this mix of services. DAV suggests these efforts include a targeted awareness campaign about VA mental health services for this veteran population as, according to VA's own survey, veterans cite lack of awareness about VA, its services and their eligibility as primary reasons for not using VA health care.[11] We also support the requirement for VA to develop a plan to appropriately staff its mental health programs. It is critical for VA to develop a concrete plan for meeting ongoing staffing shortages in its mental health programs with goals and timelines for meeting them. Congress must also commit to funding this plan.

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[9] Rentsch, C. T., Kidwai-Khan, F., Tate, J. P., Park, L. S., King, J. T., Jr, Skanderson, M., Hauser, R. G., Schultze, A., Jarvis, C. I., Holodniy, M., Re, V. L., 3rd, Akgün, K. M., Crothers, K., Taddei, T. H., Freiberg, M. S., & Justice, A. C. (2020). Covid-19 by Race and Ethnicity: A National Cohort Study of 6 Million United States Veterans. *medRxiv : the preprint server for health sciences*, 2020.05.12.20099135. https://doi.org/10.1101/2020.05.12.20099135

[10] Cardemil CV, Dahl R, Prill MM, Cates J, Brown S, Perea A, Marconi V, Bell L, Rodriguez-Barradas MC, Rivera-Dominguez G, Beenhouwer D, Poteshkina A, Holodniy M, Lucero-Obusan C, Balachandran N, Hall AJ, Kim L, Langley G. COVID-19-Related Hospitalization Rates and Severe Outcomes Among Veterans From 5 Veterans Affairs Medical Centers: Hospital-Based Surveillance Study. JMIR Public Health Surveill. 2021 Jan 22;7(1):e24502. doi: 10.2196/24502. PMID: 33338028; PMCID: PMC7836907.

[11] National Survey of Veterans 2010. https://www.va.gov/vetdata/docs/SurveysAndStudies/NVSSurveyFinalWeightedReport.pdf

There are a number of provisions included in Public Law 116-171 that will help VA develop new treatment options and overall, improve mental health services for the veterans under its care. We appreciate this Committee's commitment to ensuring expeditious implementation of these important and potentially life-saving programs and services.

Mr. Chairman, thank you for inviting DAV to provide testimony for this important hearing.

AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

Statement of:

Katherine B. McGuire
Chief Advocacy Officer
American Psychological Association
American Psychological Association Services Inc.

Submitted to the:
United States Senate Committee on Veterans' Affairs

March 24, 2021

"Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act"

Chairman Tester, Ranking Member Moran, and members of the Committee, the American Psychological Association (APA) would like to thank you for the opportunity to provide information about Veterans' mental health during COVID as well as the implementation of P.L. 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act.

APA is the largest scientific and professional organization representing psychology in the United States, numbering more than 122,000 researchers, educators, clinicians, consultants, and students. For decades, psychologists have played vital roles within the Department of Veterans Affairs (VA), as providers of clinical services to Veterans; as educators and trainers, ensuring the next generation of mental health providers are able to care for Veterans in a culturally competent way; and as scientific researchers investigating mental health issues that frequently affect Veterans, such as Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). Today, VA employs more than 6,000 psychologists who, along with psychologists in the community and academia, continue to bring unique and critical expertise that is essential to meeting the mental health needs of Veterans.

APA would like to provide the following recommendations to the committee:

1. Congress and VA must work together to ensure that VA offers **culturally competent mental health care** to Veterans across the VA system.
2. VA must ensure **availability and physical accessibility to the full continuum of care** for Veterans, from at-home telehealth to in-person outpatient care to inpatient and residential care.
3. VA must continue to focus on **Veteran reemployment initiatives** through Veteran Readiness and Employment and collaborate with other departments and agencies, such as DOL VETS, as a way to improve mental health and wellbeing.
4. Congress must fully fund, and VA must fully implement provisions from P.L. 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act that **increase VA mental health staffing**.

The COVID-19 pandemic has unquestionably had negative mental health implications across the country and around the world. APA recently released findings from our *Stress in America*™: *One Year*

Later, A New Wave of Pandemic Health Concerns survey[i] indicating that 25% of essential workers have been diagnosed with a mental health disorder since the beginning of the pandemic and 47% of Americans delayed or cancelled health care services over the past year. These findings are not Veteran-specific, but they do represent a trend that VA and lawmakers should be paying close attention to. The increased diagnoses of mental health conditions and delaying of needed treatment indicates an increased demand for care. In order to address this demand, VA must invest in expanding the psychology and mental health workforce in order to provide timely, culturally competent services for all Veterans. And this cultural competency is not only military cultural competency, it is also racial, ethnic, and linguistic cultural competency as well.

VA researchers have found that Black and Hispanic Veterans are significantly more likely to test positive for COVID-19 compared to White Veterans,[ii] and the *Stress in America*™ study showed that Black adults are most likely to report feeling concerned about returning to in-person interaction and living life like they did before the pandemic compared to other racial/ethnic groups. The confluence of increased COVID-19 rates and the racial justice uprisings in the wake of the murder of George Floyd and the recent murder of several Asian American women in Georgia, make it clear that Black, Indigenous, and people of color are experiencing extreme stress during this time. This extends to Veterans as well – the Veteran community has more Black, Indigenous and people of color compared to the general population.[iii] Several VA facilities across the country offer culturally specific care, such as the sweat lodge at Ft. Harrison, Montana. Initiatives like these need to be expanded in order to **ensure that Veterans from all cultural backgrounds have access to the types of mental health services that they want to receive and are culturally relevant.**

Because of its robust telehealth offerings, VA was able to pivot quickly to virtual care at the beginning of the pandemic. While many Veterans had to delay care, the vast majority had their appointments rescheduled in a reasonable time frame.[iv] VA's long commitment to providing care to the Veteran regardless where the Veteran is located paid dividends these past 12 months. Even with that adjustment, there is likely to be a large backlog of Veterans seeking care, especially inpatient or residential care. Many studies have shown the equivalence of telepsychology and in-person services,[v] yet some services must be provided in person, such as inpatient and residential substance use disorder care. Especially as more Americans have turned to alcohol and other substances to cope with the pandemic,[vi] it is critical that VA is prepared to care for Veterans on an inpatient and residential basis as quickly as possible. Pre-pandemic, this care already had months-long waiting lists in some locations. In order to ensure that Veterans are able to fully recover from pandemic stress and setbacks, **the entire continuum of care must be made available in a timely manner, from at-home telehealth services, to in-person, inpatient, and residential care. Care must be taken to ensure any in-person services are physically accessible for Veterans with disabilities.**

The pandemic has also significantly increased unemployment for all Americans, including Veterans. According the U.S. Bureau of Labor Statistics, the unemployment rate for Veterans was 6.5% at the end of 2020; the unemployment rate for post-9/11 Veterans was 7.3%.[vii] These figures are up from a low of 3.1% pre-pandemic. Studies since the 1980s have found an association between unemployment and poor mental health.[viii,ix] The recent unemployment figures indicate an increased need for mental health care, potentially for Veterans who have never sought this type of care before. **VA must continue to focus on Veteran reemployment initiatives through Veteran Readiness and Employment and other**

services, including collaboration with other agencies and departments, such as DOL VETS, as a way to improve mental health and wellbeing.

All of this data points to an increased demand for mental health care. Fortunately, many provisions have been signed into law as part of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act that may help alleviate some of these burdens if implemented in a timely and effective manner.

First, VA must fully invest in implementing Sec. 502, which would provide scholarships to students pursuing degrees in mental health professions if they agree to work at Vet Centers for a certain period of time upon graduating. Since 2015, psychologists have ranked in the top 5 clinical shortage occupations in the Veterans Health Administration (VHA), and it is estimated that VHA must hire an additional 650 psychologists per year in order to maintain the growth in the workforce seen over the past few years.[x] By fully funding and implementing this section, VA will not only strengthen its own workforce, but also strengthen the mental health workforce of the nation as a whole as we grapple with provider shortages nationally.

Second, VA must ensure that all organizations receiving funding from grants administered in Sec. 201 are competent in military culture and other cultural competencies, as well as adequately trained in suicide prevention, including firearm suicide prevention. With the pre-pandemic rate of suicide amongst Veterans rising for the last several years and the pandemic magnifying the needs and vulnerabilities across the country, it is crucial that any entity receiving VA funds to serve Veterans have the training they need to save lives. VA's Suicide Risk Management Consultation Program is a great first step that should be heavily advertised and promoted to community grant recipients in addition to formal training that should be required of these entities.[xi]

Third, Sec. 701 must be implemented faithfully to ensure that access to VA telehealth services is expanded to areas that lack adequate broadband. Throughout this pandemic we have seen the importance of access to reliable broadband. Even before the pandemic, lack of high-speed internet was a huge concern for Veterans living in rural areas and lower income Veterans. Now more than ever, VA must ensure that Veterans have access to a reliable internet connection, whether that is in their home or at a local Veteran Service Organization post.

Finally, the bill includes several sections aimed at addressing the staffing shortages of VA mental health professionals. Staffing shortages of mental health professionals continue to be a problem across the VA system, and VA must continue to focus on recruiting and retaining these professionals. In addition to the staffing provisions included in the bill, moving psychologists to full Title 38 hiring authority would go a long way to retaining mid-career psychologists.

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act touches on areas that VHA has been in the process of implementing for several years as part of the National Strategy for Suicide Prevention. Both the bill and National Strategy highlight the importance of collaboration, innovation, and grounding suicide prevention strategies in evidence and research. Psychologists have long played a vital role in ensuring VHA advances in mental health priorities for Servicemembers, Veterans and their Families are based in evidence and research.

This year marks the 75th anniversary of APA's Division 18, Psychologists in Public Service, VA Section and VHA's first psychology training programs in 1946. Since then, psychologists have played a fundamental role in providing the full spectrum of mental health services to Veterans. On this anniversary, our nation is experiencing the devastating impacts of the COVID-19 pandemic. With more than 30 million Americans infected and more than 540,000 deaths, the short- and long-term impact on the nation's mental health remains unmeasurable. The pandemic has had a disproportionate impact on people of color, and the poorest and most vulnerable communities, including our Veterans. APA and Psychologists in Public Service will continue to play key roles in promoting public safety, providing support to essential workers and frontline health care professionals, and mitigating the psychological impact of the pandemic.

If you have any questions, please reach out to Sophie Friedl (sfriedl@apa.org), Director of Congressional and Federal Affairs, Military and Veterans Health Policy.

Katherine B. McGuire
Chief Advocacy Officer

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Comment Prepared by: The Institute for Veterans and Military Families (IVMF)

Submitted to: United States Senate Veterans' Affairs Committee

Regarding: Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act

March 24, 2021

The Institute for Veterans and Military Families would like to thank the Committee for passing the Hannon Act last year and applaud the Committee members for your continued focus on the next and crucial step: implementation. We appreciate the opportunity to provide our thoughts and reflections for your consideration.

IVMF's contribution to veteran suicide prevention stems from our experience with our AmericaServes initiative, a care coordination network of over 1,000 providers across 18 communities and 11 states, serving over 40,000 clients since its launch in 2015. Data and feedback from communities demonstrate that helping veterans navigate social services is integral to comprehensive suicide prevention, which requires more than acute mental health interventions. Evidence continues to indicate that veteran mental wellness is impacted by diagnosable mental health challenges such as post-traumatic stress, as well as other economic and social stressors that present during the military-to-civilian transition. These stressors include a range of challenges such as unemployment, financial uncertainty, housing instability, and food security to list a few.

Addressing Precursors to Suicidality

Research shows that each additional social or economic stressor such as those listed above is correlated with a 64 percent increase in suicidal ideation. In other words, a veteran dealing with simultaneous stressors such as housing instability, unemployment or other challenges experience a heightened likelihood of suicidal ideation. AmericaServes and other care coordination initiatives address this problem by ***integrating the health and social care available to veterans***, including clinical care at VA hospitals and social care in communities provided by nonprofit organizations.

During the COVID-19 crisis, supporting veteran mental health has become an even bigger challenge. Factors such as social isolation and difficulties accessing healthcare were in the forefront. At the same time, unemployment skyrocketed and food insecurity increased. A national moratorium on evictions has often been the only thing standing between many veteran families and homelessness.

To understand the needs of veterans and their families during crisis, the IVMF launched a polling effort last April in partnership with Military Times. We found that many of the top needs for veterans and their families in the early months of the pandemic were social and economic needs. Some challenges were cited more frequently than a need immediate mental healthcare (32%). Fifty-nine percent of respondents cited needing community support, 41% needed financial assistance, and 30% needed food assistance. Data from our AmericaServes program confirm this trend. During April and May this year, food assistance was the most requested service nationally. In nearly six years of supporting coordinated care networks around the country, food assistance has never cracked the top three requested services overall.

Accessing social services for many different needs at once is challenging under normal circumstances and were exacerbated during the pandemic. The severity of need increased, and the types of needs increased for veterans and their families across the board. These moments of crisis highlight the increasing importance of coordinated social services.

Before the COVID-19 outbreak, about 45% of AmericaServes clients requested multiple services at once, and 76% of those (or 34% overall) requested services across multiple service categories. With the pandemic's onset, the number of AmericaServes clients experiencing simultaneous needs **increased**. Fifty-one percent (51%) of clients requested multiple services and 77% of those, 40% overall, requested services across multiple service categories. This change tells us veterans and their families are experiencing more needs across more categories, with each additional stressor risking a measurable impact on their mental health.

Figure 1. COVID-19 Related Client and Service Requests in AmericaServes Networks (Feb 2020-Feb 2021)

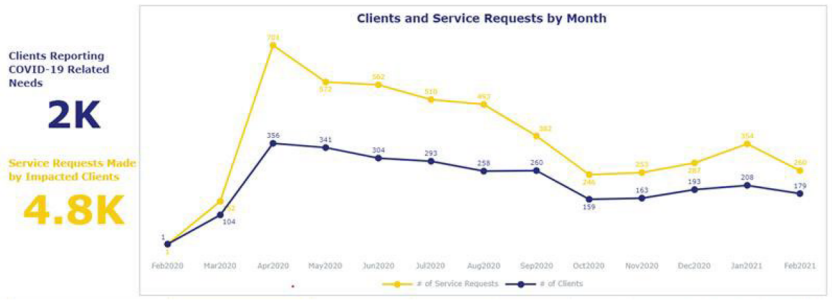
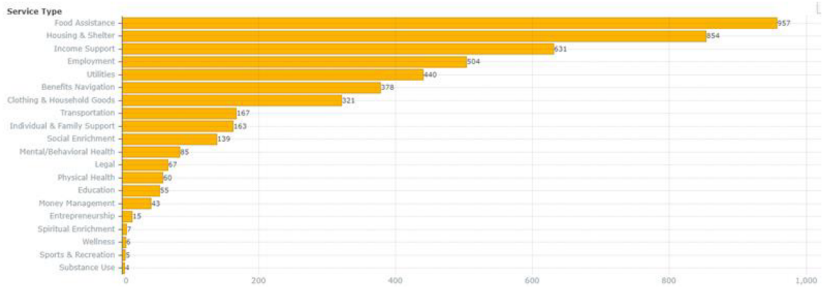


Figure 2. AmericaServes Total Service Requests by Type and Volume (Feb 2020 - Feb 2021)



Our AmericaServes network in Pittsburgh directly witnessed how these trends impacted veterans and military families throughout the pandemic. And, by monitoring our data and partnering with community organizations on the ground, the care coordination team addressed emergent community needs quickly and effectively. For example, the PAServes network saw an unprecedented increase in food assistance requests. The team responded to these data by finding new resources and community programs and tailoring their outreach approach to

specifically resolve the food insecurity need. Research is increasingly showing that food insecurity, specifically, is a stressor linked to suicidal ideation. To put it plainly, **this work is suicide prevention work.**

Key Insights for Hannon Act Implementation

The Hannon Act's Grant Section 201 has the potential to significantly improve our nation's efforts to prevent veteran suicide through initiatives like the AmericaServes network and others coordinating care across both health and social services. Yes, grant dollars will support community-based mental health organizations who are providing critically needed mental health services. Yet, in our view, the innovation of the bill lies in the language that gives preference to grantees that "demonstrated the ability to provide or coordinate suicide prevention services."

The best implementation strategy of the Hannon Act would be one that leverages the power of communities to **coordinate** the provision of suicide prevention services, to include direct mental health services **and** services addressing the social determinants of health. Grant dollars would be most effective going to organizations with a diverse, robust network of community partnerships already in place. These types of grantees will be able to connect veterans with both mental health services and social services that will address needs impacting their mental health, and track and monitor case outcomes through a closed-loop referral process. Effective suicide prevention work includes services treating the stressors and precursors to suicidality—not solely mental health services.

By prioritizing a *network* approach to preventing veteran suicide, grantees may be able to connect veterans with needed services outside of the veteran service organization sector. Veterans are served by a wide variety of organizations, some of which do not serve veterans exclusively. If used effectively, these grant dollars could break down silos that have traditionally separated veteran and non-veteran social sector organizations. Ideally grantees would be dynamic, well-connected community organizations positioned to coordinate services between clinical, non-clinical, veteran-specific, and non-veteran-specific programs and partners. As our research and community data show, COVID-19 increased the variation and severity of needs experienced by the veteran population. No one organization has what it takes to address these needs at once. The combination of the veteran suicide crisis and the pandemic necessitates coordinated community effort.

This approach would be unlike anything the VA has undertaken before. Ending veteran suicide is a mission that requires nothing less of us and it is a mission we can no longer fail to address.

Background on AmericaServes

AmericaServes was created in response to a persistence of concurrent, unmet social needs within the veteran community, despite an overwhelming array of available services. AmericaServes established the nation's first coordinated system of public, private, and nonprofit organizations working to serve veterans, transitioning service members, and their families. AmericaServes builds and supports regional networks of community-based human and social services organizations to improve veterans' access to and navigation of available resources with the help of a care coordination team housed at a local, trusted organization. The care coordination center employs a small core staff that cultivates strong connections with participating organizations and provides individualized care coordination for clients when appropriate, following clients until they no longer need or desire assistance. No matter how clients enter the network - whether self-directed via phone or web form, or by referral from a participating organization - demographic information, service requests, and outcomes are managed in a shared referral management technology platform to ensure accountability and transparency throughout the care process.

STATEMENT FOR THE RECORD

MILITARY OFFICERS ASSOCIATION OF AMERICA

COPING DURING COVID: VETERANS' MENTAL HEALTH AND IMPLEMENTATION OF THE HANNON ACT

1st SESSION of the 117th CONGRESS

Before the

SENATE COMMITTEE ON VETERANS' AFFAIRS

March 24, 2021

CHAIRMAN TESTER, RANKING MEMBER MORAN, and Members of the Senate Committee on Veterans' Affairs, the Military Officers Association of America (MOAA) is pleased to submit this statement for the record offering our views on veterans' access to mental health care during the pandemic and the implementation of Public Law 116-171, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (the Hannon Act). MOAA does not receive any grants or contracts from the federal government.

EXECUTIVE SUMMARY

MOAA is grateful for the bipartisan, bicameral support in the 116th Congress to enact critical legislation to address mental health needs and suicides within the uniformed service and veteran communities. Thanks to the Senate and House committees' leadership and member commitment, some significant and transformative legislation became law last year. One such measure is the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019. It is one of the most comprehensive and innovative pieces of legislation undertaken by Congress aimed at improving mental health care delivered in the VA health care system. Generally, it will:

- provide care for transitioning servicemembers,
- provide suicide prevention resources,
- launch programs and studies on mental health,
- increase oversight of mental health care and suicide prevention efforts, and
- enhance medical workforce and telehealth services.

MOAA is particularly pleased to see the incorporation of a variety of ideas and contributions from multiple stakeholders – including veterans' organizations like ours, mental health awareness groups, and other advocacy organizations – to produce this landmark bill. Passage and implementation of the monumental legislation could not come at a more critical time, as COVID-19 and the economic fallout of the pandemic continues to create havoc and tremendous pressures on Americans, including servicemembers and veterans, their families, caregivers, and surviving family members.

Like many federal agencies, the Department of Veterans Affairs (VA) has been challenged by the pandemic. It has been forced to respond to a national health crisis and other natural disasters simultaneously. While the pressures are extensive in battling the pandemic, failure to ensure full implementation of the Hannon Act, or the inability of the VA to fully embrace lessons learned from this crisis, could have lasting and irreversible consequences on veterans' mental health and well-being for decades to come.

MOAA recommends Congress and the VA provide the necessary oversight and ongoing transparency in implementing the Hannon Act. Further, MOAA urges the VA to fully capture lessons learned and implement best practices from the pandemic related to mental health care and suicide prevention to assure these lessons are institutionalized and not forgotten.

VETERANS ACCESS TO MENTAL HEALTH CARE DURING THE COVID-19 PANDEMIC

VA'S RESPONSE

VA's response efforts during the pandemic have been impressive. Unlike any health system in America, the Veterans Health Administration (VHA) has demonstrated great agility, innovation, and perseverance in executing its primary mission of delivering health care to veterans and in carrying out VA's Fourth Mission — to provide an aggressive public health response to protect and care for veterans, their families, health care providers, and staff in the face of the emerging health risk brought about by the coronavirus.

The VHA has worked tirelessly to expand medical and mental health care services in recent years, and even more so since the pandemic, by increasing staffing and capacity for delivering services through its direct care system and community care networks. And, thanks to additional funding and authorities by Congress, the VA was able to:

- Employ rapid hiring practices to bring on more staff.
- Expand telehealth and tele-mental health services, along with other technological advances.
- Streamline access to emergency and urgent care services.
- Address medical supply chain management issues.
- Pause collection of medical and other veteran debt.
- Roll out a highly efficient process for administering the COVID-19 vaccine.

The VHA certainly has learned a great deal during the pandemic, both through its own actions and from its federal, state, and local partners. It is now time for the VA to take what has worked well, identify gaps, and look for applications it can apply in future crises and when normal operations resume.

CHALLENGES

While VA's progress in improving health care services is promising, many of the challenges facing veterans prior to the crisis have been exacerbated by the pandemic. Big gaps still exist in how the VA communicates with and responds to the needs of veterans, their family members, and caregivers. Difficulties in navigating and accessing the health care system and community care services create confusion and frustration. And, more importantly, how the department delivers the kind of wraparound services and continuity of care needed for veterans suffering from mental health issues or exposed to traumatic injuries remains problematic.

EXAMPLES:

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MOAA Member and 35-year-old Woman Veteran: *"I keep reaching out to VA by phone and MyHealtheVet for wellness and mental health appointments. VA did respond with one wellness appointment through a community provider but after that, radio silence for a mental health appointment and the follow-on health care appointments I need. I'm so tired of always having to contact and follow-up with VA and COVID just makes it harder to get a response from VA. I don't think VA even cares."*

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63-year-old Male Veteran: *"When I went to the VA hospital emergency room in January because of a fall VA told me it had no room because of COVID and sent me to a civilian hospital where I was released a few days later. There was no follow-up from VA or checking to see if I was okay though I am a high-risk patient with multiple chronic conditions including PTSD. I did, however, receive a bill for the civilian ambulance and emergency room visit services. The bill just made me more depressed and anxious since the COVID-lockdown began. My health further deteriorated to the point of being in and out of the VA hospital and acute care facility for almost three months because VA didn't do the necessary follow-up I needed after the initial civilian emergency room visit this year."*

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Because of the pandemic, the ongoing gaps in VHA health care delivery, and the growing problem of suicide in our nation and within the uniformed service and veteran populations, there must be a greater sense of urgency directed at these problem areas. While the Hannon Act and other recently enacted legislation aim to address these urgent issues, MOAA believes the time is now and the need is far too great not to remain laser focused on:

- Increasing inpatient and long-term residential care services.
- Improving scheduling and reducing wait time for behavioral and health care appointments.
- Training VHA staff, veterans, and family members on the use of technology for delivering telehealth services.
- Recognizing the limited pipeline for recruiting mental health providers from the civilian sector and the need for the VHA to determine a path forward for addressing what is expected to be a significantly higher level of demand for mental health and medical care post-pandemic.
- Exercising full scope of authorities for practicing VHA providers, expanding training, and the use of staff to the greatest extent possible to maximize existing capabilities.
- Conducting lethal means employee training and counseling for veterans accessing all VA and contractor services.
- Increasing VA's efforts in implementing its mental health and suicide prevention strategies, combining evidenced-based clinical interventions and proactive community-

based prevention strategies, understanding health care disparities and risk factors within population segments, and collecting real-time data through research and surveillance to more effectively and rapidly deploy solutions to improve health outcomes.

- Expanding cultural competency and sensitivity training for VA and Department of Defense (DoD) direct care system and community care providers to better understand the diversity and the experiences of those who serve in uniform, and to ensure more inclusive care and positive health outcomes.
- Bolstering employment and retraining programs and addressing homelessness and food insecurity issues among veterans and their families.

Finally, veterans' families, especially children, have not been immune to the impact of the pandemic. MOAA joined forces with 43 other military and veterans service organizations and stakeholders to help one small but deserving cohort during these difficult times. The goal: to secure health care for children whose veteran parents are disabled or who have died from a service-connected disability.

The pandemic is hitting children and young adults across our country especially hard. Many young adults are graduating from high school and planning to attend college only to find they must put their education goals on hold because of health and economic uncertainties. Others are seeking employment in a challenging job market or have experienced unexpected job loss. As this national crisis continues, millions more will lose life-saving coverage for medical or COVID-related health conditions, including the children of veterans no longer eligible for coverage under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Employer-sponsored health care plans have been required to cover adult beneficiaries' children up to age 26 with no separate premium since 2010, when the Patient Protection and Affordable Care Act (ACA) became law. A year later, Congress established the TRICARE Young Adult Program to provide health care coverage for adult children of currently serving and retired servicemembers for a monthly premium that covers all program costs.

Unfortunately, adult children of veterans were not offered a similar option through CHAMPVA, as intended by the ACA. Instead, these young adults remain stuck with outdated CHAMPVA regulations, which provide health care coverage up to the age of 18 (or age 23 for beneficiaries enrolled as full-time students). Coverage ends for these young adults once they marry or are no longer enrolled as a full-time student.

Our organizations recently sent a letter in support of the CHAMPVA Children's Protection Act – legislation introduced by Sen. Sherrod Brown (D-Ohio) and Rep. Julia Brownley (D-Calif.). MOAA urges Congress to put veteran parents' minds at ease by enacting this essential legislation this year.

MOAA's Mental Health and Suicide Prevention Priorities for the 117th Congress:

- ***Addressing the above-mentioned gaps in VHA medical and mental health care through ongoing congressional and VA oversight.***
- ***Sustaining governmental and non-governmental funding for preventative programs and services, including research to identify underlying causes and significant risk and protective factors for each of these populations.***
- ***Ensuring VA and DoD transparency and data sharing surrounding their annual suicide reports and program collaboration efforts.***
- ***Accelerating effective prevention, treatment, and training programs to address military sexual trauma (MST) experienced by women and men during and after service, and seeking joint congressional oversight hearings to improve VA and DoD policies and procedures to care for and compensate veterans suffering from MST.***
- ***Supporting expansion of evidence-based and complementary integrative medical treatment approaches to improve delivery of care and veteran's health outcomes.***
- ***Investing in resources and programs to aggressively promote prevention before crisis, incorporating self-help tools and services for empowering, educating, and engaging veterans in managing their individual health care.***
- ***Closing the age parity gap and providing CHAMPVA-eligible young adult children lifesaving health and mental care coverage needed during these unprecedented times to eliminate this unacceptable inequity.***

HANNON ACT VIEWS AND PRIORITIES

Like Congress, MOAA is closely monitoring VA's implementation of the provisions in the Hannon Act this year.

MOAA was an early supporter of the Hannon Act.

In testimony at the Senate and House Veterans' Affairs Committee Hearing on March 12, 2019, MOAA stated*: "There is no doubt VA has made great strides in expanding its health care services to help veterans with mental health conditions. However, these efforts are not enough to address the growing demand for mental health services and the frightening statistics related to veteran suicides. This legislation is exactly what is needed to close existing gaps so VA can deliver the kind of wraparound services and continuity of care so desperately needed by veterans suffering from mental health or traumatic conditions."*

Clearly the need and demand for the services and care outlined in the legislation are critical and timely. MOAA is particularly focused on VA's implementation of the following provisions in the Hannon Act:

- Establishment of VA and DoD clinical practice guidelines for treatment of serious mental health illness.
- Precision medicine initiative to identify and validate brain and mental health biomarkers.

- Oversight of joint VA and DoD mental health programs, including improving collaboration between DoD and the VA on mental health research, transition assistance programs, and clinical and nonclinical mental health initiatives.
- Improvements to strengthen and incentivize the VHA mental health workforce.
- Expansion of health care services and access to information for women veterans.
- Expansion of physical access points for veterans seeking to use VA telehealth and virtual care offerings.
- To furnish, reimburse, or pay for emergent suicide care, including transportation costs, at a VA or non-VA facility for certain veterans who are in an acute suicidal crisis.
- Extend VA's reach into the community, expand its programming through nonprofits, and improve interventions to protect against veteran suicide.
- Establishment of a program for the education and training of caregivers and family members of veterans with mental health disorders.
- Study and investment in innovative and alternative treatment options like yoga; meditation; and recreational, animal, and agricultural-related therapies.

CONCLUSION

The pandemic makes it even more challenging for veterans to engage effectively with the VHA, with appointment cancellations and long wait times for appointments or in-person assistance putting their health and welfare in jeopardy. Veterans and caregivers often give up trying to get care, feeling as though their VA has given up on them.

We cannot let veterans, their families, caregivers, and survivors give up on the VA. MOAA is optimistic 2021 will provide a unique opportunity to effectively implement the Hannon Act and to partner and strengthen collective stakeholder relationships as we work together to improve the health and well-being of those who serve their nation.

The Association looks forward to working with Congress and the VA to provide the necessary oversight and to advance additional measures to enhance VA suicide prevention and mental health programs and services.

NATIONAL ASSOCIATION OF

COUNTY VETERANS SERVICE OFFICERS

Senate Committee on Veterans' Affairs

Oversight Hearing: Coping during COVID: Veterans' Mental Health and

Implementation of the Hannon Act

March 24, 2021

Chairman Tester, Ranking Member Moran, and Members of the Senate Committee on Veterans' Affairs, on behalf of the National Association of County Veterans Service Officers (NACVSO) and our 1,766 members consisting of local governmental and tribal employees across the nation, thank you for the opportunity to provide a statement regarding Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act.

NACVSO's members are situated in County, Tribal and Municipal offices around the Country. During the COVID pandemic, local governmental staff have been on the frontlines of assisting constituents of all backgrounds to attain initial and continued access to State and Federal services. This is especially true when it come veterans seeking initial enrollment and continuity of care for mental health services from the Veterans Health Administration (VHA). Our members' offices have largely remained open throughout the pandemic and available for in-person appointments with veterans, and as a result have become crucial access points for veterans in need of mental health services.

NACVSO members appreciate VHA's efforts to overcome the increased challenges veterans face accessing mental health services during the COVID-19 pandemic. Those efforts include increasing VHA's telehealth capabilities to offer more services in a virtual setting. Many of our members have reported that at this point in the pandemic, veterans have an easier time accessing mental health services via telehealth than they did before

the pandemic or at its start. NACVSO members have also reported a noticeable increase in VHA primary care clinic/provider willingness to make community care referrals so veterans can access in-person mental health services from private providers within the community.

The added strain of the pandemic has also exposed shortcomings in VHA's current system and has provided a reminder of challenges that existed prior to COVID-19. The challenges associated with means tests and tiered VHA eligibility have been exacerbated during COVID-19 - not only in determining a veteran's ability to access a COVID-19 vaccine through VHA, but also in determining a veteran's ability to access the full spectrum of mental health services. NACVSO applauds the passing of the Save Lives Act that circumvents the means test to grant veterans access to a VHA provided COVID vaccine, but without addressing the barriers to care posed by the means test, many veterans will not be able to obtain the mental health services they need more desperately than ever today in the face of the pandemic.

The enrollment process has a systematic problem when an honorably discharged veteran is first questioned if they have a service-connected disability, or if they would like to file a disability claim, or asked how much money they and their spouse make before being told if they can access care. VA does provide for emergency mental health services to triage a veteran who is in a mental health crisis regardless of enrollment status, but many times veterans attempt to enroll in VHA before their mental health gets to crisis levels.

NACVSO believes that VHA should place more emphasis on ensuring all veterans have access to the full spectrum of mental health services, including primary care, before they are in crisis. Sadly, we continue to get reports from our members that veterans who have wished to enroll in VHA during the pandemic and use mental health services but do not meet any of the VHA enrollment priority groups are denied access to this preventative care.

Chairman Tester, Ranking Member Moran, and Members of the Senate Committee on Veterans' Affairs—on behalf of NACVSO and its members we appreciate the important work you are doing to support those who have served this great nation. NACVSO maintains that there is no system better situated to provide veterans with the full spectrum of mental health care services than VHA. We believe that it is foolish under normal circumstances, let alone during a pandemic, to prevent a large portion of the veteran population from having access to these lifesaving services. Hopefully the testimonies and findings of this hearing will identify solutions that address this vital need. NACVSO and its members stand ready to work with this Committee and VA to improve access for any veteran in need.

Respectfully,

Herman K. Breuer
Combat Wounded Veteran
NACVSO President

Michael L. McLaughlin
NACVSO Legislative Chair

QUESTIONS FOR THE RECORD

Department of Veterans Affairs (VA) Answers to Questions for the Record of a Hearing Titled "Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act"

Committee on Veterans' Affairs United States Senate

Questions for the Record from Ranking Member Jerry Moran

Question 1. **In regard to Sec. 103 of P.L. 116-171, please provide an update on the Department's report on REACH-VET. Can the Committee expect the report by the April 15, 2021 deadline?**

VA Response. Yes. The CMR Reach Vet was sent to Congress on April 8, 2021.

Question 2. **In regard to Sec. 203 of P.L. 116-171, can the Department provide an update on the progress of implementation, specifically beginning the agritherapy pilot program?**

VA Response. VA is currently planning implementation of a 3-year pilot program to provide Veterans with access to Complementary and Integrative Health Programs (e.g., Equine therapy, other animal therapy, Agri-therapy, Recreation Therapy, Art Therapy and Sports) in compliance with Section 203 of the Hannon Act. Many, if not most, VA facilities currently offer many of these services (e.g., recreation therapy, animal therapy and equine therapy) as part of their delivery of care and services not only to Veterans with mental health-related disorders, but also to all enrolled Veterans who receive health care services (e.g., general rehabilitation, whole health, Community Living Center residents, etc.). Providing these services has been interrupted due to the COVID-19 pandemic and are slowly resuming as VA medical centers return to normal operations. Presently, 10 VA facilities, including 3 rural locations, have been identified as potential pilot sites, and coordination is underway with those sites to implement Section 203. VA proposes commencing the pilot program at sites by the end of FY 2021.

The Military Construction, Veterans Affairs, And Related Agencies Appropriation Bill, 2018 Senate Report 115-130, directed the Veterans Health Administration (VHA) to create "a pilot program to train veterans in agricultural vocations while also tending to behavioral and mental health needs with behavioral healthcare services and treatments."

In response, VHA created the 10-pilot site VA Farming and Recovery Mental Health Services (VA FARMS) Program. The VHA Office of Rural Health (ORH) developed the program on Agri-therapy at 10 VA facilities between 2018 to 2020 in collaboration with

the Offices of Care Management and Social Work, Mental Health and Suicide Prevention, Nutrition and Food Service, and Community Engagement. This program continues at eight sites through FY 2022, with expansion anticipated in 2023. Veteran participants stated the program met their goals and expectations and helped them with socialization and life skills; relaxation and anxiety reduction; agriculture knowledge and vocational skills for employment or vocation; and referrals for additional VA and community programs and opportunities. The VA FARMS programs enrolled 490 Veterans and reached 3,600 additional Veterans through demonstrations, informational presentations and town-hall discussions. In addition, VA FARMS reached over 3,300 community members and 2,400 VA employees through outreach events and partnerships.

Question 3: **In regard to sec. 204 of P.L. 116-171, the Committee has been made aware that the National Academies of Sciences (NAS) has reached out to the Department on multiple occasions since the Hannon Act was signed into law to begin work on this provision. The Committee was disappointed to hear that the VA has not yet responded to NAS. Can the Department provide the Committee with a timeline for implementation of this provision? Further, does the Department plan on straying from explicit Congressional intent on this provision?**

VA Response. VA is committed to meeting the legislative intent of Section 204 to examine the effects of opioid and benzodiazepine prescribing on Veteran mortality. In March 2020, we briefed SVAC staff to discuss our initial assessment of the protocol developed by National Academies of Sciences, Engineering and Medicine (NASEM) and alternatives that will meet the intent in a more timely and efficient manner. We conveyed that the VA population does not have enough patients who are on opioids and benzodiazepines to conduct the protocol designed by NASEM. However, we do support supplementing an ongoing national study that includes all such patients. We apologize for the delays in communicating with NASEM, which were the result of our efforts to reach resolution on these issues. VHA spoke directly with NASEM on April 12, 2021 regarding Section 204.

VA researchers have been working to conduct analyses consistent with the aims of the original NASEM protocol and will have results to report in late May. VA will work with NASEM to provide independent review of the methods and results of this work as soon as we can get a contract in place and an expert panel convened. We discussed this approach with NASEM staff on April 12, 2021, and they were fully supportive of this approach, noting that they are not equipped to carry out research on VA data and would have to contract out through university partners. They also agree with VA that the greatest value to Veterans would be to focus on more recent prescribing practices (2017 and onward) that reflect numerous policy changes made in VA to see how they can be further improved. A focus on earlier periods, which predate what we have learned about safe opioid prescribing in the past decade, would be less likely to lead to actionable results. We believe this strategy is the best and most timely way of achieving the goals of section 204, which we strongly support.

Question 4. **In regard to sec. 305 of P.L. 116-171, does the Office of Research & Development have all of the IT resources and equipment necessary in order to properly carry out the directed brain and mental health biomarker research, in the timelines directed in the legislation?**

VA Response. Fifty thousand Veterans will be enrolled in the new precision mental health initiative called MVP-MIND (Million Veteran Program- Measures Investigating Neuropsychiatric Disorders) from across the VA health care system. However, structural and functional images obtained during standard diagnostic workup at the VA medical centers are stored locally and are not part of MVP-MIND. To move images to a central database for research purposes, ORD will need IT resources to establish a central database and obtain regulatory, privacy and security approvals. As an alternative and with the resources currently available, ORD plans to obtain reports of structural and functional magnetic resonance imaging (MRI) tests from the Electronic Health Record (EHR), when available, and for Veterans enrolled in MVP-MIND plans to curate, de-identify and make the data available for research. This plan will allow ORD to meet the intent of this section. Data access to researchers will be made available through the VA Data Commons hosted by the University of Chicago, which should be sufficient.

Question 5. **In regard to sec. 405 of P.L. 116-171, can the VA and the Department of Defense provide a detailed response to the projected timeline of completion for the AoA directed in (b) of the section?**

VA Response. VA and the Department of Defense (DoD) began a coordinated effort to respond to P.L. 116-171 § 405(b) in December 2020. From January 2021 to March 2021, VA and DoD subject matter experts collaborated to collect and analyze data, and to draft the Congressional report. A final report was entered into DoD/VA coordination in and is expected to be signed by the VA Secretary by the end of June.

Question 6. **In regard to sec. 507 of P.L. 116-171, the Committee was glad to receive updates on the Departments progress in implementing the Safety Planning in the Emergency Departments (SPED) Intervention in 100% of VA Medical Center Emergency Departments and Urgent Care facilities. As a follow-up, can the Department provide more detail regarding the type of FTE at each ED and Urgent Care facility that is completing the safety plans? Additionally, can the Department provide more detail regarding the type of FTE making the follow-up calls to check-in on the veteran patient after the encounter and initial safety plan was made?**

VA Response. The VA Suicide Prevention Safety Plan and Suicide Behavior and Overdose Templates Staff Specific Guidance permits the following staff members to complete safety Plans: Medical Doctor/Doctor of Osteopathic Medicine; Doctor of Philosophy/Doctor of Psychology; Clinical Pharmacy Specialist; Licensed Clinical Social Worker/Licensed Master of Social Work/Licensed Independent Social Worker; Licensed Marriage and Family Therapist; Licensed Professional Mental Health Counselor; Addiction Therapist; Registered Nurse; Advanced Practice Registered Nurse: Nurse

Practitioner/Clinical Nurse Specialist; Physician's Assistant; and Rehabilitation Counselor. A trainee in any of these categories also may complete safety plans with an appropriate co-signer.

Facilities employ a team-based approach and determine an appropriate staff who partners with the emergency department/urgent care center staff to ensure structured follow-up efforts are in place until the patient has engaged in outpatient mental health care. Staff must be able to engage the patient in suicide risk assessment; review and update of the safety plan; review of upcoming appointments; and identification and problem-solving around any barriers to care.

Question 7. **In regard to sec. 701 of P.L. 116-171, and the directed expansion of telehealth services. Can VA provide an update on the overall implementation of this provision? Specifically, can the Department provide a detailed timeline of the award of grants for new or expanded telehealth agreements?**

VA Response. VA is working to establish a grant program through Section 701 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171), which would offer non-VA entities the opportunity to apply for funding to stand up and sustain an Accessing Telehealth through Local Area Stations (ATLAS) site. VA is drafting regulations and anticipates that the regulations will be published as final in approximately 24 months. VA must complete the Federal rulemaking (regulation) process prior to the implementation of this program as mandated by law. Given the complex nature of rulemaking, a more specific timeframe for final publication is not available at this time. VA is working to maximize efficiencies within each step of the process to reduce the total timeframe. It is anticipated also that the first award for an ATLAS grant will be 30 days after the regulations are published as final.

Question 8. **In regard to sec. 704 of P.L. 116-171, can the Department provide detailed examples and further information on why VA believes implementation of this section is difficult? Does the Department need further direction or authority from Congress to successfully implement this provision?**

VA Response. VA appreciates the opportunity to seek direction from Congress on sec. 704 of P.L. 116-171 to ensure that VA complies with Congress' intent on Section 704(c):

> (c) REPORT.— (1) IN GENERAL.—Not later than 90 days after the completion of the policy revisions under subsection (a), and annually thereafter, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on all approvals of institutional review boards used by the Department, including central institutional review boards and commercial institutional review boards. (2) ELEMENTS. —The report required by paragraph (1) shall include, at a minimum, the following: (A) The name of each clinical trial with respect to which the use of an institutional review board

has been approved. (B) The institutional review board or institutional review boards used in the approval process for each clinical trial. (C) The amount of time between submission and approval.

Section 704, *Use by Department of Veterans Affairs of Commercial Institutional Review Boards in Sponsored Research Trials,* specifically references the use of commercial institutional review boards (IRBs) in sponsored research trials. However, section 704(c)(1) states that VA must report "on all approvals of institutional review boards used by the Department, including central institutional review boards and commercial institutional review boards." The language is unclear as to whether VA is to report on all IRBs, including but not limited to central institutional review boards and commercial institutional review boards, or whether VA is to report only on central institutional review boards and commercial institutional review boards. As written, the language appears to require VA to report all IRB approvals of any VA approved clinical trial, regardless of whether it is (a) sponsored or unfunded, and (b) whether it is approved by commercial, VA, or university affiliates' IRB.

VA requests the following three revisions to Section 704 to ensure VA successfully implements this provision:

Revision 1. VA requests it be required to report only on funded clinical trials.

VA approves hundreds of student research studies each year because of the academic affiliations between VA facilities and their affiliated universities. Many of these student research studies meet the definition of a clinical trial under the Federal regulations for the protection of human subjects, codified by the Department as 38 CFR Part 16, but do not meet the definition of a clinical investigation under the U.S. Food and Drug Administration (FDA) regulations. Requiring reporting of these unfunded clinical trials or clinical investigations to Congress yearly does not appear to be information that is the intent of the Act.

Revision 2. VA requests that the scope of clinical trials to be reported annually be limited to FDA-regulated clinical investigations trials.

The FDA's definition of a clinical investigation differs from the Federal policy regarding human subjects' protections codified by VA under 38 CFR Part 16. Federal policy under 38 C.F.R. § 16.102(b) states:

> (b) Clinical trial means a research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of the interventions on biomedical or behavioral health-related outcomes.

Questions for the Record from Senator Blumenthal

Question 1. **Dr. Clifford Smith, Dr. Matthew Miller: Recent VA reports revealed suicide rates were some of the highest amongst Native American and youngerveterans. In your view, what factors have contributed to higher rates of suicidefor these populations respectively?**

VA Response. Many factors may affect suicide rates among American Indian/AlaskaNative and younger Veterans. Suicide has no single causal explanation or pathway (Turecki & Brent, 2016), but rather reflects a complex interactions of factors at the international (global pandemic), national (income inequality), community (health care access), relational (social support), and individual debt levels (2020 National VeteranSuicide Prevention Annual Report).

Suicide rates vary by race and ethnicity in the U.S. general population as well as the Veteran population. For both males and females in the U.S. general population, age-adjusted suicide rates were highest among American Indian and Alaska Native populations in 2014 (Curtin & Hedegaard, 2019). Racial and ethnic groups differ in theirexperiences of discrimination and historical trauma, as well as in their access to culturally appropriate mental health treatment, which may be related to increased suicide risk (Joe, Silvia, & Romer, 2008; 2020 National Veteran Suicide Prevention Annual Report).

Risk factors among American Indian and Alaska Native Veterans include substance use, psychological disorders, perceived burdensomeness, community stigma, historical trauma and cultural identification (reviewed in O'Keefe & Reger, 2017). There are also important cultural strengths and protective factors in American Indian and Alaska Nativecommunities, including cultural traditions, community self-determination and tribal sovereignty (reviewed in O'Keefe & Reger, 2017).

It is important to note that there are fewer Veterans in the younger age groups, so smallfluctuations in the number of suicides can result in larger changes in the suicide rate.
Younger Veterans may have more recently separated from service. The first year following military separation is a time of adjustments and psychosocial stressors (e.g., financial strains, changes in health care access; Castro & Kintzle, 2014; Pease, Billera, Gerard, 2016; Ravindran et al., 2020), as well as elevated suicide risk (Ravindran et al.,2020).

Question 2. **What type of suicide prevention media outreach is VA engaging in toreach these respective populations?**

VA Response. VA's Office of Mental Health and Suicide Prevention (OMHSP) leveragespaid media to target Veterans, including younger Veterans and American Indian Veterans, and their families based on first-and third-party data related to demographics such as age Veteran status, interests and previously viewed social and

website content.

The OMHSP campaign reaches Veterans at every stage of their mental health journey,including audiences that are considered being at high-risk for suicide including:

- Transitioning and recently transitioned Veterans
- Veterans age 55 and older
- Women Veterans

Using a data-driven approach and a wide variety of advertising platforms and targeting tactics allow the team to reach our audiences where they are online and in-person. Theselection of platforms used by the campaign also serves to hyper-target specific audiences (e.g., Veterans age 18-34 who are likely to use Twitter and women Veteranswho are likely to use Facebook).

While the campaign does not target high-risk Veterans specifically, advertising assets are tailored with photography and messaging aligned those audiences. The team usesthe following targeting tactics across all platforms:

- Interest in relevant military branches
- Affiliation with VA
- Affiliation with Veterans Service Organizations (VSOs)
- Past interactions with content (segmented by topic)
- Interest in general Veteran-related topics
- Interest in gun ownership and medication storage
- Demographics, including Veteran status, Veteran households and Veteransupporters
- Previous visits to pages approved by VA for remarketing
- Lookalike to anyone who has viewed one of the campaign ads or videos
- Lookalike to anyone who has visited VeteranCrisisline.net andMentalhealth.va.gov

Targets are based on the FY 2021 contract budget, select advertising platforms and recent campaign performance. Goals, metrics and targets are consistently analyzed andevaluated to ensure campaign effectiveness while considering and adjusting for factors that could influence goals and affect performance.

Question 3. **Dr. Matthew Miller: In working with your Department of Defensepartners, what key strategic decisions have been made on better systems**

upstream to proactively engage transitioning servicemembers by enrolling theminto VA services before underlying mental health problems worsen?

VA Response. In accordance with Executive Order 13822, *Supporting our Veterans*

During Their Transition from Uniformed Service to Civilian Life, the Suicide Prevention Joint Action Plan Implementation Team (SP-JAPIT) was established to provide a formalized structure to facilitate cooperation and collaboration between the Departmentof Veterans Affairs (VA), the Department of Defense (DoD) and the Department of Homeland Security (DHS) to reduce the number of Veteran and Service member suicides. This team facilitates and track outcomes for the three main SP-JAPIT initiatives that were developed to achieve an integrated approach to improve mental health care for all transitioning Service members (TSMs) and Veterans.

The SP-JAPIT is co-chaired by the Director of VA Suicide Prevention, Director of the Defense Suicide Prevention Office and the DHS Deputy Director of Workforce Health and Safety. The collaboration between the Departments directly impacts suicide prevention efforts aimed at TSMs, including members of the Reserve and National Guard, the United States Coast Guard and Veterans. The Joint Action Plan consists of16 initiatives organized under three overarching goals:

> **Goal 1.** Ensure all transitioning Service members are aware of and haveaccess to mental health resources.
>
> **Goal 2.** Ensure the needs of at-risk Veterans are identified andaddressed.
>
> **Goal 3.** Improve mental health and suicide prevention services forindividuals that have been identified in need of care.

At the close of FY 2020, 15 of these initiatives were complete and the Joint Executive Committee leadership is tracking metrics to measure impact. Below are the major activities and milestones that are direct results of the collaboration between the three Departments in this effort.

Transition Assistance Program (TAP) Modification

TAP is required of all Service members prior to separating from the military. TAP wasmodified to allow TSMs the opportunity to register online for VA health care and to ensure new Veterans are aware of mental health resources available during the first-year post-separation and beyond. TAP provides information, tools and training to ensure Service members and their spouses are prepared for the next step in their civilian life.

VA Solid Start (VASS)

VASS conducted outbound calls to all Service members at key intervals after separation(90-180-365-days). Specially trained VA representatives used active scripting to provideinformation on access to peer support, availability of mental health

care, eligibility for health care and other VA benefits; a list of available local and national resources; and a name and a point of contact for any immediate needs. In addition to calls, Veterans receive information on benefits and eligibility in written format to include email or regularmail. From December 2019 through December 31, 2020, VA contacted 82,072 TSMs and Veterans, which represents an overall contact success rate of 57.5% and a 73.6% successful contact rate for Priority Veterans. For this effort, "Priority Veterans" refers to Veterans who had a mental health care appointment during their last year of active duty.

Peer Support

Peer Support implemented support outreach to TSMs during the first-year post-separation from the military and a warm hand-off for TSMs in need of or requesting additional psychosocial support to follow-on peer support services. The outreach effort has resulted in contact with 100% of TSMs who opted-in with valid emails. The goal of the warm hand-off effort is follow-on peer engagement, within 180 days post-transition, for 90% of TSMs who received a warm hand-off to peer support services. As of January2021, 100% of TSMs who received a warm hand-off to peer support services were connected to peer support. This percentage does not include TSMs who received referrals to other psychosocial support services, such as non-medical counseling, prior to the warm hand-off process. Continuous communication and collaboration between Department partners to ensure TSMs are aware of taking advantage of Military OneSource services is ongoing.

Support for Underserved Populations

VA's Readjustment Counseling Service (RCS), in collaboration with DoD's Psychological Health Center of Excellence (PHCOE), developed and implemented a referral process that guides Vet Center counselors through a referral matrix that includes access to DoD consultation. The collaboration ensured that each Vet Center
(300) and district leaders were briefed on the referral process. In FY 2020, RCS experienced a 10% increase in the number of Service members seen for military sexualtrauma (MST) and a 28% increase in MST services provided to Service members compared to FY 2019.

Question 4. **Dr. Clifford Smith, Dr. Matthew Miller: In your view, how is VA servingveterans with other-than-honorable discharges who are seeking mental health services at VA?**

VA Response. VA has traditionally served a small number of enrollment-eligible Veterans or service-connected Service members with an administrative Other Than Honorable (OTH) discharge. In March 2017, Secretary Shulkin announced his intent to expand VA mental health coverage to Service members with OTH administrative discharges. At that time, VA initiated work with key internal and external stakeholders,

including members of Congress, VSOs and community partners on the issue. On July 5,2017, all VHA medical centers began offering emergency stabilization care for former Service members who present at the facility with an emergent mental health need.
Under this initiative, former Service members with an OTH administrative discharge may receive care for their mental health emergency for an initial period of up to 90 days,which can include inpatient, residential or outpatient care. At that time, a series of training calls and informational flyers were distributed to facility staff and VSOs.

Passed in 2018, P.L. 115-141, Section 258 modified 38 U.S.C. § 1720I, which requiredVA to notify all currently known former Service members with OTH discharges that theymay be eligible for a mental health benefit from VA. The law specifically allows VA to provide ongoing mental health care to individuals who are former members of the Armed Forces, including the Reserves; have been discharged under a condition that is not honorable, but also not dishonorable or by court martial; and have served in the Armed Forces for more than 100 cumulative days and been deployed in combat operations or while serving have experienced MST.

In January 2019, VA mailed 477,404 letters to OTH former Service members' last known addresses. VA continues to conduct focused outreach to OTH Servicemembers.For example, VA's Office of Public and Intergovernmental Affairs (OPIA) assisted the OMHSP and Veterans Benefits Administration (VBA) with internal and external digital media engagement to augment the January notification by mail to the OTH former Service member cohort. OPIA published a blog (https://www.blogs.va.gov/VAntage/60349/other-than-honorable-discharge/) to amplify the information regarding the Honor Our Commitment Act. OPIA digital media further amplified this message on VA's social media platforms, to include VA's Facebook page(1.19M followers) and Twitter feed (624K followers). VHA (104K followers) also tweetedthe information, and both VBA (115K followers) and the VA Center on Homelessness shared the Tweet. In addition, OPIA distributed the message as part of the "This Week"newsletter to 1.1 million subscribers. VA continues to collaborate with VSOs to ensure this information is provided to support VSO and key stakeholder groups that may have contact with OTH separated Service members.

In December 2019, VA launched the Solid Start call center which proactively contacts all newly separated Service members at least three times during their first year of transition from the military. These outreach calls include those Service members with anOTH administrative discharge. To date, out of 3,943 eligible OTH Service members, 1,803 (45.7%) have been contacted through the Solid Start outreach calls.

In FY 2020, there were a total of 5,416 Service members with an OTH discharge seenin VHA. Of these, 3,246 were seen for mental health care compared to 2,651 OTH
Veterans seen in FY 2019. Mental health care provided spanned the entire

continuumof services from outpatient treatment, to residential care, to acute inpatient psychiatriccare. Notably, prior to the COVID-19 pandemic, VHA on average received approximately 100 requests each week for a character of discharge review for health care consideration. Since the pandemic onset, this weekly average has dropped to approximately 66.

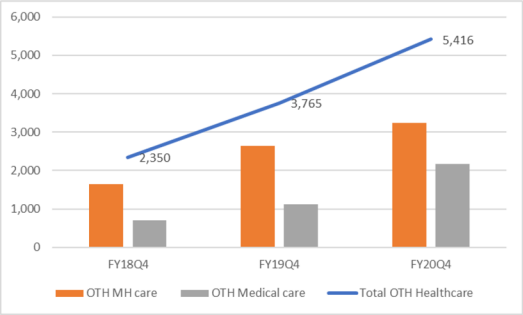

Figure 1. Health care services to OTH population.

As noted, for those who have reached out to engage VHA for care under 38 U.S.C. § 1720I, we are providing mental health services across the continuum of care, including outpatient care, residential treatment and acute psychiatric stabilization. However, thereremain opportunities for ongoing engagement of Service members with an OTH discharge. First, we need to continue to address cultural patterns. Service members with an OTH discharge historically have been shunned from VA engagement.
Bitterness, rejection and anger were experienced and it is not surprising that only a small number of the estimated 500,000 Service members with an OTH discharge have sought VA engagement. The recently developed Solid Start Program and the commitment to reach out and call all Veterans and Service members is a significant start in changing the culture. Further, ongoing communications (blogs, VA messaging, military messaging) will be critical in continuing to address the historical culture OTH Veterans. Second, ongoing VHA staff education is critical. Learned behavioral patterns are difficult to change and updating policy is not sufficient. Continuous training and localoversight are critical.

Question 5. **Dr. Clifford Smith, Dr. Matthew Miller: In the implementation of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act,how can the VA ensure that veterans with other-than-honorable discharges are not unlawfully turned away?**

VA Response. Ongoing, anecdotal reports of Service members with an OTH dischargewho are eligible for care through updated policy and legal statute yet are turned away from care are deeply troubling. There are no provisions within the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of*

2019 specially addressing access to care for those with OTH discharge. P.L. 116-171, section 104 is the only section that specifically applies to Service members with OTH discharge as it amends 38 U.S.C. § 1720I(f); however, it only amends the annual reporting requirements of that section. Several sections pertaining to access opportunities in general apply to Veterans as well as Service members with OTH discharge. For example, enrolled Veterans as well as Service members with an OTH discharge receiving mental health care will be eligible to participate in P.L. 116-171, the complementary and integrative health (CIH) pilot programs at the respective VA medicalcenters. Similarly, ongoing expansion of mental health care to rural Veterans and Service members with OTH discharges through enhanced telehealth availability (P.L.116-171, section 701) will provide ongoing opportunities for engagement.

Questions for the Record from Senator Kyrsten Sinema

Question 1. **The VA Office of the Inspector General released a report on March 23rd regarding a 2019 death by suicide of a veteran who had been seeking mental health care as a patient of the Phoenix VA. In that report, the Inspector General outlined some extremely concerning gaps in care for this veteran and made seven recommendations to the Phoenix VA based on their findings. My office has spoken with the Phoenix VA leadership about steps they have and continue to take to address these recommendations. How is VA Central Office supporting the Phoenix VA as they work to review and implement the recommendations in the report?**

VA Response. The Suicide Prevention Program (SPP) was not involved with the development of plans for follow-up by the Phoenix VA Director. However, SPP has reached out to the VISN 18 Chief Mental Health Officer, Phoenix VA Leadership and the Suicide Prevention Coordinator to offer consultation and assistance. Included in this outreach was connection with both SPP subject matter experts and the Mental Health Quality Improvement and Implementation Consultant Team from the Office of Mental Health and Suicide Prevention (OMHSP).

Several of the policies that were relevant in the referenced case also are supported through ongoing technical assistance. For example, support for understanding the frequency and nature of suicide risk assessment is provided to all VA health care systems through monthly open technical assistance calls and a SharePoint/frequently asked questions (FAQ) documents.

The Access Office will support Phoenix VA medical center by ensuring that Phoenix is following procedures as outlined in VHA Directive 1230, *Outpatient Scheduling Processes and Procedures* (Jan 7, 2021), and by working with their local trainer to ensure up-to-date education on scheduling processes. Both the directive and training include guidance for contacting Veterans after missed appointments.

Question 2. **What action is VA Central Office taking to assess how widespread the gaps in care and administrative procedure outlined in the report are across the VA Health Care system and what steps are you taking to address them system-wide?**

VA Response. The SPP assesses relevant performance through a series of metrics that track processes such as suicide risk screening and care management for patients with a high risk for suicide record flag. SPP also has developed an overview of lessons learned from this report to share with Suicide Prevention Coordinators on our regular technical assistance calls to encourage local review of compliance with national policies addressed in the report. Currently, SPP also is designing a pilot site visit process that will allow more in-depth reviews of suicide prevention programming locally, which are not able to be monitored through our data system metrics.

SPP offers ongoing system-wide technical assistance through the following:

- Technical assistance (TA) calls including weekly VA Risk ID and SPED Technical Assistance Call and monthly National Suicide Prevention Coordinator Office Hours Call. When performance is consistently below target in select measures, individual VISN level TA calls are provided using implementation science principles
- Patient level dashboards to monitor processes such as suicide risk screening and assessment (RISK ID), management of Veterans with a high-risk-for-suicide patient record flag and Veterans receiving safety planning in the emergency department. Dashboards feature resources including user guides and frequently asked questions (FAQs)
- Suicide Risk Identification and Management SharePoint that includes multiple resources
- Talent Management System (TMS) trainings
- Suicide Prevention Program Guide

The Access Office currently provides national guidance on scheduling and contact attempts for Veteran appointments for compliance with VHA Directive 1230, through the scheduler training community and other Access Office-led community-of-practice calls.

Question 3. **Isolation and challenges accessing support can contribute to suicidal ideations. This pandemic has affected every aspect of our lives—including financial stability, employment, housing and relationships. How has this pandemic highlighted ways that VA can better coordinate across the Administrations to ensure VHA, VBA and NCA are using an enterprise-wide approach to identify and support Veterans in the VA system who need help?**

VA Response. The pandemic has highlighted the following ways that VA can better coordinate across the Administrations to ensure VBA, VHA and National Cemetery Administration (NCA) are using an enterprise-wide approach to identify and support Veterans in the VA system who need help and those efforts are identified below:

(1) Prior to COVID-19, VA had limited virtual engagements with our internal and external partners. We have since learned that there are various ways to successfully collaborate via virtual platforms such as Teams, Adobe Connect, etc. VA continues virtual VBA, VHA and NCA Integrated Project Teams as these efforts encourage information sharing and resource identification. Moreover, it facilitates timely connection of transitioning Service members (TSMs) and Veterans to VA benefits and resources. We continue to encourage the practice of electronic submission of benefits applications and supporting documentation if TSMs and Veterans can do so. This practice will help expedite connection to benefits and services.

(2) Veteran Readiness and Employment (VR&E) has established a new partnership between VR&E's electronic Virtual Assistant (e-VA) and the Veteran Crisis Line (VCL). This collaborative partnership creates an indispensable link between the care received during crisis and the follow-up care necessary to maintain improved mental health and

employment outcomes for our service-connected Veterans over time. New functionality within the e-VA platform allows for the scanning of electronic Veteran communication for keywords and phrases containing harmful or self-destructive language. Once this language is identified, a referral is sent to VCL with pertinent Veteran information to initiate follow up contact. Electronic email or text message communication also is sent to the Veteran with information on how to contact VCL for additional assistance if needed. This collaborative approach will ensure Veterans, who may not have previously had additional VHA support, are receiving adequate mental health follow up care.

(3) In response to increased risk of mental health challenges as a result of the global pandemic, VA implemented a Mental Health COVID-19 response plan focused on immediate and long-term impact on suicide prevention and mental well-being. This included supporting the most vulnerable Veterans and providing outreach and resources to all 20 million Veterans, mental health leaders and providers across VA. VA's COVID response plan uses a public health model (universal, selective and indicated) to support Veterans, staff and caregivers.

(4) While VA has implemented the Mental Health COVID-19 response plan, VA also continues to work with VBA and DoD to ensure active duty Service members learn about VA resources during their service, particularly during TAP. The instructor-led module in TAP walks Service members through the actual registration for VA health care and includes modules on health care and mental health care information. At the beginning of transition, Service members who are engaged in or identified as needing mental health care prior to transition are referred to the in Transition program that will assist in ensuring continuity in care. In addition, the VA Solid Start prioritizes calls to eligible Veterans who had a mental health appointment within their last year of active-duty service and meet other criteria. Representatives are trained to connect Veterans in crisis to the Veterans Crisis Line through a warm transfer, remaining on the line until the Veteran is connected.

(5) VBA has recently hired a National Program Director for Suicide Prevention to organize VBA suicide prevention efforts and support VBA and VA enterprise-wide suicide prevention efforts and initiatives. The VBA National Program Director will serve as the focal point for VBA suicide prevention strategies, activities, and research.

(6) Despite COVID-19, VA continues to assist Veterans with obtaining, retaining and adapting homes. For loan servicing, program operations have included the development of policies to assist Veteran borrowers who have been financially impacted by the national pandemic. From a VA Home Loan perspective, collaboration activities include:

- VA Loan Technicians conduct soft transfers to the VCL for further assistance when a Veteran borrower identifies he or she is experiencing mental distress because of financial challenges.

- VA sends a letter that provides contact information for the VCL and other crisis-related resources for Veteran borrowers who are experiencing distress and would like to contact VHA for assistance.

- VA Loan Guaranty Servicing staff also participate in Suicide Prevention workgroups with VBA and VHA to identify coordination and best practices for suicide prevention efforts.

(7) The Office of Financial Management (OFM), Benefits Delivery Protection & Remediation (BDP&R) staff is working actively with Homes For Our Troops (HFOT), which is a non-profit Veteran-centric organization that prides itself on building and donating specially adapted custom homes nationwide for severely injured post-9/11 Veterans, thus enabling them to rebuild their lives (see Rebuilding Injured Veterans Lives | Homes For Our Troops (hfotusa.org).

(8) During this COVID-19 pandemic, the BDP&R staff continues to protect Veterans and VBA benefits programs by identifying and remediating current cases of fraud, preventing future fraud cases and eliminating waste and abuse to ensure the integrity of the agency. The BDP&R staff reached out to the HFOT Director for Construction Operations to discuss findings of criminal exploitation of information found on their website for almost 400 Veterans. BDP&R staff discussed the findings noting a statistically significant number of Veterans for whom HFOT provided housing were being defrauded by criminals exploiting the HFOT website to gain information on Veterans with high rates of VA Compensation and Special Monthly Compensation benefits. To stop fraudulent activity, the BDP&R staff hosted a meeting with HFOT leadership to collaborate and ensure our Nation's Heroes are protected against fraud.

(9) Education Service collaborated with other VBA business lines and VHA to provide information to GI Bill students regarding resources and tools available to them to mitigate the economic and mental health impacts from COVID-19. Materials produced and widely shared with GI Bill students featured information from VHA on its COVID Coach wellness mobile application and available health care benefits.

Question 3a. **What changes has the VA made and what role has VA's Office of Mental Health and Suicide Prevention played to ensure that staff across the VA enterprise are appropriately trained and protocols are in place to offer a safety net to veterans well before they might consider suicide?**

VA Response. VA has taken numerous steps to ensure staff across the enterprise are ready and able to assist Veterans' needs at any point. VA released the updated *VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide* (CPG) in summer 2019. The updated guidance included new recommendations for the identification of suicide risk, evaluation of risk level and management of patients at risk for suicide and has shaped much of our current efforts.

In April 2020, the required suicide prevention course for VHA clinical health care providers was updated and replaced with *Skills Training for Evaluation and Management of Suicide* (TMS 39351) or *STEMS*. The course, overall, is aimed at building several skills related to suicide assessment, risk identification, intervention and follow up, and takes an interactive approach through simulated discussions with Veterans. With the goal of expanding a previously released VHA memo, VA released an agency-wide mandatory suicide prevention training memo on October 15, 2020, which requires all VA employees, regardless of office or the clinical/non-clinical status, to take a corresponding suicide prevention training within their first 90 days of hire and a refresher course annually. Clinical health care providers across VA are mandated to take STEMS and non-clinical staff are required to take VA S.A.V.E (Signs, Ask, Validate, Encourage/Expedite).

In addition, the SPP has created a facilitator's guide for those who want to present VA S.A.V.E. in a confident and competent way to their office or community. This guide has been disseminated to partner offices such as Caregiver Support and our National Homeless Program, as well as to community stakeholders to allow for the best quality use of the VA S.A.V.E. training.

On November 2, 2020, as part of the 2020 SPP NOW plan, VA TMS course VA34560, *Lethal Means Safety Education and Counseling for Providers*, was updated and required as a onetime mandatory requirement for all clinical health care providers within VHA, which had to be completed within 90 days. During the course, participants will learn about the purpose of Lethal Means Safety Counseling, including how to work with Veterans and their friends and family to facilitate lethal means safety during high-risk periods. The training emphasizes Veteran autonomy and teaches clinicians to work collaboratively with Veterans towards solutions that align with each Veteran's values and preferences.

Question 3b. **How will these lessons-learned inform future operations across the VA-enterprise?**

VA Response. SPP conducted a presentation of recent Office of the Inspector General (OIG) reports in Dayton and Phoenix during April's national Suicide Prevention Coordinator Office Hours Call and presented lessons learned and education related to reminders for implementation of national policy on proper risk assessment, flagging, Mental Health follow up and staffing recommendations.

To identify and support Veteran employees and external Veteran customers who need help, NCA, in consultation with VHA, implemented several initiatives, to include:

- Inclusion of information in our COVID guide on Coping Resources with information on how to access the Employee Assistance program; on access to virtual, on demand, self-help resources to support the mind, body and soul; and on resources for managing workplace fatigue. This effort is more focused on NCA's work force which is about 75% Veterans.

- NCA intranet, internet and mobile sites were modified to ensure that the telephone number for the Veterans Crisis Line was prominently displayed.
- Posters advertising prevention and the Veterans Crisis Line phone number were shipped to each facility and office.
- NCA participated on VA's PREVENTS effort, which is the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide. The goal of PREVENTS is to prevent suicide among not only Veterans but also all Americans.

Question 4. **Dr. Kearney, my casework team uses the Veterans Crisis Line as the first line of defense whenever a veteran or servicemember in mental distress or suicidal ideations calls our office. Your team quickly triages the situation with my team to ensure that the veteran receives the proper resources and care they need. We appreciate the support of the crisis line staff and suicide prevention coordinators on these calls.**

During the pandemic, your staff has had to transition working from home. The crisis line staff have extremely difficult and emotionally demanding jobs. How are you ensuring that even as your staff work remotely, they have the support that they need to self-care and protect against burn out and the emotional demands of their jobs?

VA Response. VCL is grateful for the opportunity to collaborate with the committee and members of Congress to support Veterans and Service members in crisis. We greatly appreciate the support all your team members provide to Veterans and Service members facing challenges.

We greatly appreciate the Committee's concern and care for our VCL team members who are implementing this important Mission each day. The VCL team is facing challenges as we work to prepare for increasing call volume with the implementation of the Suicide Prevention 988 expansion initiative. The Quadruple Aim guides us in implementation of the 988 expansion, as we work to ensure not only access to the highest quality services, but also attend to cost and efficiency, Veteran/Service member satisfaction and employee experience. We must ensure full attention to staff experience when attending to the needs of each Veteran and Service member who calls, texts or chats with the Veterans Crisis Line/Military Crisis Line (VCL/MCL). We know at least two factors significantly impact staff experience: (1) reaching and maintaining staffing levels sufficient to address growing demand with allowances built-in for the pursuit of wellness, professional development, supervision, and peer interaction and (2) maintaining a structured wellness program that actively promotes and reinforces resiliency across the work force.

Regarding staffing levels, the VCL seeks to maintain staffing levels that reliably create an hourly cadre wherein staff are not asked to satisfy unreasonable or unsustainable levels of direct care. VCL leadership carefully monitors forecasting data as well as proximal and remote historical data to create staff work schedules that minimize asking

staff to push beyond targeted productivity/occupancy ceilings. Minute by minute each day, operations are monitored by a VCL Air Traffic Controller, who can immediately observe, document, adjust and report demand and capacity dynamics and needs.

Regarding wellness promotion, VCL has developed an Employee Wellness Program based in the Substance Abuse Mental Health Services Administration's (SAMHSA) *8 Dimensions of Wellness* to support the readiness and resiliency of VCL staff. Additionally, Employee Assistance Program services are available 24/7 with up to 8 sessions to provide counseling and unlimited group grief counseling, which is marketed to the team regularly. During FY 2021, we are deploying *WorkLife4You,* which will provide the opportunity for additional resources of support to our employees. Wellness coaches are available on each shift to provide staff support and the opportunity to check-in, two wellness activities per shift, and ongoing opportunities to engage in the Wellness instant messaging system when not on a call.

Peer Groups are also available and serve as another opportunity for support. Weekly Wellness Wire newsletters were implemented during the COVID-19 pandemic to provide all staff with a quick snapshot of tips, activities and articles to help with social connectedness and suggestions for self-care and wellness. Bi-weekly Team Talks also were implemented during the COVID-19 pandemic to provide an opportunity for staff to hear and see members of leadership in a video teleconference meeting, allowing them time to ask questions and share ideas and concerns. VCL has scheduled regular employee webinars (three per month) which include many topics related to employee wellness.

Question 5. **Dr. Kearney, what challenges has the Crisis Line faced during this pandemic and how have you overcome those challenges? What lessons have you learned in the process that you expect will carry over to improve operations and staff support as we transition back from a fully remote working environment?**

VA Response. VCL serves a very high-risk population with a 22 times higher risk for suicide than the overall Veteran rate within the first month of a VCL call and 8 times higher risk for suicide than the overall Veteran rate across 12 months following a VCL call (Hanneman et al., 2020). The ongoing implementation of the VCL Mission has been critical during the COVID-19 pandemic as we work to support Veterans and Service members alike during a time of heightened strain. While we have worked to care for Veterans and Service members during this challenging time, we have also worked to support and care for our VCL team.

In February 2020, VCL began implementation of processes for ensuring the well-being of staff and uninterrupted service for Veterans in crisis considering the COVID-19 pandemic. By April 24, 2020, 100% of ready and willing VCL employees were working from home. Since that time, VCL has tracked and reviewed data across the Quadruple Aim considering quality care outcomes; Veteran and Employee Experience; and cost, efficiency and access. VCL has seen a significant increase in call volume since the beginning of the COVID-19 pandemic. Yet we have found working in a telework status

to be very effective for VCL's Mission as we have maintained our performance metrics while also being able to support our team members. The move to telework also assisted VCL with hiring as more qualified individuals applied with the benefit of telework status. The largest lesson learned is that a call center can operate in a telework status successfully. The Office of Inspector General (OIG) also reviewed VCL's COVID-19 response during this time and found no recommendations for improvement (OIG, 2020). Due to the benefits identified and with support from leadership, VCL is implementing a significant expansion of remote work on a permanent basis while we continue to engage in our ongoing preparations for 988 implementation.

Question 6. **Dr. Kearney, what are you considering as you think about how and when to bring your (VCL) staff back into the call center safely and responsibly?**

VA Response. As part of our preparations for the expansion of VCL in response to the 988 expansion, VCL reviewed options for staff expansion to support increased call volume projections. Based on the successful telework deployment as outlined above and to meet the need to hire many qualified responders, VCL will be implementing ongoing virtual operations. Quality care outcomes; Veteran and Employee Experience; and cost, efficiency and access will continue to be monitored closely to ensure ongoing operations meet and exceed call center quality standards.

Questions for the Record from Senator Maggie Hassan

Question 1. **The most recent VA data on veteran suicide shows that in 2018 there were higher rates of suicide for those in rural areas than in more urban environments. COVID-19 has only intensified feelings of disconnectedness and isolation among all veterans, and that impact has been felt most by rural veterans, including those in New Hampshire's North Country.**

Last year, I asked the Secretary of VA for information on the services available to veterans in rural areas, and the VA's outreach to those veterans. I was pleased to learn about the VA's work to increase telehealth capabilities and ensure that veterans' needs were being met by assisting veterans with a variety of issues, like access to adequate technology and broadband internet access.

Please provide an update on how many rural veterans VA estimates still don't have access to telehealth capabilities and what steps are being done to ensure that all veterans have access to care.

VA Response. Based on December 2019 estimates from the VHA Office of Rural Health, Geospatial Outcomes Division (GSOD), approximately 416,000 or 14% of VA - enrolled Veterans residing in rural, highly rural and insular island areas lack access to telehealth capabilities because broadband connectivity is unavailable. Additionally, Veterans enrolled in rural, highly rural and insular island areas sometimes lack access to telehealth because they don't have the personal technology to access telehealth care from home. VA has taken the following actions to improve overall access to telehealth services for these Veterans:

- VA advanced partnerships with major wireless carriers (T-Mobile, SafeLink by Tracfone, Verizon and AT&T) who support Veterans, their caregivers and families by allowing them to use VA's telehealth application, VA Video Connect, without incurring data fees (zero rating) on their networks.
- In 2020, 53,489 internet connected tablets were distributed to Veterans so they could connect to their VA services through telehealth. This number represents a 303% increase in tablets distributed to Veterans through this initiative when compared to totals at the conclusion of FY 2019. As of January 2021, VA has purchased 116,557 tablets with internet service as part of this program and presently there are approximately 93,609 tablets in the hands of Veterans.
- To assist Veterans who don't have the internet or technology needed to access telehealth services from home, VA launched the digital divide consult. Two primary options currently exist to assist Veterans through the digital divide consult. One option is the Connected Device program. Through this program, VA will loan Veterans a tablet or phone that includes internet connectivity. The other option is the FCC Lifeline program. The Lifeline program provides internet and technology subsidies to qualified participants so they can obtain or maintain their own device. As part of the VA digital divide process, VA social workers help Veterans determine their Lifeline eligibility and support them in the application

process. VA wants every Veteran to have convenient access to their health care services and sees the Digital Divide Consult as one way to help achieve this goal.

- As of February 2021, VA has purchased 28,864 Android phones with pre-paid internet service data plans to distribute to Homeless Program Veterans using CARES Act funds. This effort helps ensure Homeless Program Veterans can communicate with VA and receive telehealth services during the COVID-19 pandemic, including through telehealth.

The ATLAS (Accessing Telehealth through Local Area Stations) Program has extended the reach of VA clinicians, especially in rural communities. Through this program, VA works with private partners, including Philips, Walmart and Veteran Service Organizations to provide private telehealth-equipped appointment space close to the Veteran's home. Equipped with the appropriate broadband and technology, these stations allow Veterans to access their VA care via telehealth without having to travel far and or have broadband at home. The ATLAS Program hopes to further address the digital divide, while also cutting down on Veteran travel times and ultimately making VA care easier to access. VA has 11 ATLAS locations nationally open and available for scheduling. By the end of 2021, we anticipate a total of 15 ATLAS sites will offer clinical services by telehealth from VA providers.

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Senator Blackburn

Questions for the Record
Senate Veterans' Affairs Committee
Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act

Question for Thomas Porter, Iraq and Afghanistan Veterans of America

In January, President Trump signed legislation into law that included the Deborah Sampson Act,which I cosponsored. This legislation will eliminate barriers to care and services that many women veterans face and would help ensure the VA addresses the needs of women veterans whoare more likely to face homelessness, unemployment, and go without needed health care.

Question 1. **Mr. Porter, how do you see the Commander John Scott Hannon Veterans Mental Health Care Improvement Act being used to identify women veterans who are at risk for suicide and in need of mental health services when these veterans are less likely toseek care than their male peers?**

IAVA Response. The Hannon Act includes a host of provisions to improve access across the board for veterans, but perhaps most significantly, Section 201 of the Hannon Act establishes anew grant program that requires the VA to support community organizations which are alreadyserving veterans, including women veterans. This collaboration should result in earlier identification at risk of suicide and the increased ability to get those veterans the mental health services they need. Also, those organizations would then refer the veteran back to the VA for additional care if it is clinically appropriate.

IAVA encourages the Committee to exercise oversight to ensure the new grant programsufficiently serves women and minority populations.

Also, the Hannon Act includes two provisions previously included in the Deborah Sampson Actto benefit women veterans: One to require the VA to expand the capabilities of the Women Veterans Call Center by including a text messaging capability; another to require the VA to publish a website providing information for women veterans about the
benefits and services available to them.

Senator Blackburn
Questions for the Record
Senate Veterans' Affairs Committee
Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act
March 24, 2021

Questions for Tammy Barlet, VFW

I appreciate the VFW's efforts to close the digital divide in our rural areas using the Accessing Telehealth through Local Stations (ATLAS) pod sites. In your testimony, you said implementation of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act will provide the grant funding opportunity to allow VFW posts to expand telehealth capabilities for mental health programs and suicide prevention to veterans in rural and highly rural areas.

Question 1. **Do you envision using the ATLAS pods to expand access to mental health services? If so, how do you envision that working? If not, do you have other programs in the works to expand access to mental health services by telehealth?**

RESPONSE: By bringing broadband, technology, on-site tech support, secured, and calming atmosphere (option to change the color of the lighting with the site) to a location that can reach rural veterans, the ALTAS Pods will help eliminate the barriers veterans currently face when gaining access to mental health services.

Question 2. **You mentioned you would like to expand the hours that ATLAS pods are available. What are the barriers to making that happen?**

RESPONSE: The VFW post commander mentioned the post and the on-site attendants can accommodate the expanded hours. By elimination, that leave VA to allow for appointments made during the current hours.

Senator Blackburn
Questions for the Record
Senate Veterans' Affairs Committee
Coping during COVID: Veterans' Mental Health and Implementation of the Hannon Act
March 24, 2021

Question for Captain Chad Bradford, USN and Karen A. Orvis, PhD

Captain Bradford and Dr. Orvis, in your testimony you said DOD was closely monitoring the potential impacts on the well-being of our service members and families, and have been taking proactive measures since the start of the pandemic to support our military community.

Question 1. ***Please describe these proactive measures.***

{Response not received in time for printing}

RESOURCES ON MENTAL HEALTH AND HANNON

Commander John Scott Hannon Veterans Mental Health Care Improvement Act Section-by-Section

Title I – Improvement of Transition of Individuals to Service from Department of Veterans Affairs

Sec. 101. Strategic plan on expansion of health care coverage for veterans transitioning from service in the Armed Forces.

Would direct VA, in consultation with DOD, to develop a strategic plan to extend VA health care eligibility to transitioning veterans for a full year after their separation or discharge from the Armed Forces.

This plan would include:

- A description of how the goals would be achieved.
- Anticipated additional resources needed and their cost.
- Analysis of anticipated health care needs, including mental health care, separated by geographic area.
- Any legislative or administrative action required to carry out the plan.

Based on Executive Order 13822, Joint Action Plan, Goal 3.1.

Sec. 102. Review of Records of Former Members of the Armed Forces Who Die by Suicide Within One Year of Separation From the Armed Forces

Section 102 would direct a joint VA/DOD five-year retrospective study of the records of each service member who died by suicide in the one year following their separation from DOD.

The elements of this study would include:

- Whether the veteran was flagged as high risk for suicide while in DOD.
- The presence of evidence-based and empirically-supported contextual and individual risk factors (such as exposure to violence, exposure to suicide, housing instability, financial instability, vocational problems, legal problems, relational problems, and limited access to health care).
- Services the member was receiving from VA, DOD, or other entity.
- Demographic factors such as age, location of residence one month prior to death, branch of service in the Armed Forces, marital status, reason for separating, and rank in the Armed Forces before separating.

S. 3195, Promoting Coordination for Veteran Suicide Prevention Act of 2020. Cassidy/Tester bill

Sec. 103. Report on REACH VET Program of Department of Veterans Affairs

Section 103 would direct VA to assess the impact of the REACH VET program on suicide rates among veterans, REACH VET limitations, a description of how REACH VET inputs were chosen, and an assessment of the feasibility of incorporating VBA data into the REACH VET model.

Sec. 104. Report on Care for Former Members of the Armed forces with other than honorable discharge

Section 104 would add the following to VA's annual report on furnishing care provided under section 1720I(f) of Title 38:

- A concrete date when the report is due
- The demographics of veterans using care under this section
- The types of mental health conditions that these veterans are presenting with
- The era and branch of service
- The average number of visits completed per veteran

Title II – Suicide Prevention

Sec. 201. Financial Assistance to Certain Entities to Provide or Coordinate the Provision of Suicide Prevention Services for Eligible Individuals and Their Families.

Section 201 would provide grants to eligible community organizations to provide or coordinate suicide prevention services to veterans and their families. This section would also allow veterans to get an initial mental health assessment at VA and then have VA furnish ongoing mental health care, regardless if they are eligible for VHA care, if such care is necessary.

Sec. 202. Analysis on Feasibility and Advisability of the Department of Veterans Affairs Providing Certain Complementary and Integrative Health Services

Section 202 would require VA to conduct a feasibility and advisability analysis on providing certain CIH treatments, including yoga, meditation, acupuncture, and chiropractic care, at all VA medical facilities, either in person or through telehealth. The analysis must include an assessment of the final report of the COVER Commission.

VA would be required to submit a report to the Senate and House Committees on Veterans' Affairs on the outcome of the analysis and any recommendations for furnishing these CIH therapies at VA facilities.

Sec. 203. Pilot Program to Provide Veterans Access to Complementary and Integrative Health Services through Animal Therapy, Agritherapy, and Sports and Recreation Therapy

Section 203 would require VA to conduct a pilot program no less than 180 days following the final report of the COVER Commission to provide certain CIH treatments and programs at no fewer than 5 VA facilities, three of which must be in rural or highly rural areas.

Agritherapy based on MilCon/VA FY19 Senate Appropriations Report, pg. 61

Sec. 204. Department of Veterans Affairs Study of All-cause Mortality of Veterans, including, by Suicide and Review of Staffing Levels of Mental Health Professionals.

Section 204 would require VA to enter into an agreement with the National Academies of Sciences under which the Secretary must collaborate with the National Academies on a revised study design to evaluate the effects of opioids and benzodiazepine on all-cause mortality of veterans, including suicide, regardless of whether information relating to such deaths has been reported by the Centers for Disease Control and Prevention.

VA must provide a briefing on the initial results to Congress within 24 months of entering into this agreement.

This section would also require VA to enter into an agreement with the Comptroller General of the United States to conduct a review of the staffing levels for mental health professionals including:

- A description of staffing levels of mental health professionals and other staffing related requirements
- Impediments to educating, training and hiring mental health counselors and marriage and family therapists.
- A description of plans to increase representation of counselors and therapists in the behavioral health workforce including:
    - Qualification criteria and a comparison of the criteria to other behavioral health professions in the Department
    - Assessment of participation in the mental health professionals trainee program and impediments to the program
- How VA and OPM are working together to develop an occupational series for marriage and family therapists and mental health counselors

S. 2991, Veteran Overmedication and Suicide Prevention Act (Sullivan/Baldwin)

Sec. 205. Comptroller General Report on Management by Department of Veterans Affairs of Veterans at High Risk for Suicide.

Section 205 would require a GAO report on how VA handles patients at high risk for suicide, including:

- How VA identifies these high risk patients, including an analysis of the effectiveness and accuracy of the REACH-VET program;
- How VA intervenes once a patient is identified as high risk;
- How high risk patients are monitored and followed-up with over the long-term; and

- Staffing levels of Suicide Prevention Coordinators, including distribution and shortages.
- Resources and programming available to veterans' friends and family in order to assist in a veterans' recovery

Title III – Programs and Studies on Mental Health

Sec. 301. Study on Connection Between Living at High Altitude and Suicide Risk Factors Among Veterans

Section 301 would direct VA to carry out a study of living at high altitude as a risk factor for developing suicidal ideation or dying by suicide among veterans.

If VA determines that living at high altitude is a risk factor for developing suicidal ideation or dying by suicide, another study would be carried out to determine why living at high altitude is a risk factor and how to combat this risk factor.

Based on several studies that outline the potential link between living at high altitude and suicide. However, these studies were conducted in such a way to calculate population risk and not individual risk, so this study would focus on gauging individual risk.

Sec. 302. Establishment by Department of Veterans and Department of Defense of a Clinical Provider Treatment Toolkit and Accompanying Training Materials for Comorbidities

Section 302 would direct VA to work with DOD to create a clinical provider treatment toolkit and relevant training materials for the evidence-based management of comorbid mental health conditions, comorbid mental health and substance use disorders, and a comorbid mental health condition and chronic pain.

Based on IB Veterans Agenda for the 116th Congress Mental Health Services Recommendations.

Sec. 303. Update of Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide

Section 303 would direct VA to work with DOD to update the Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide in the next publication of the Guidelines by taking into account specific risk factors and specific treatment efficacy of pharmacotherapy and psychotherapy.

This section would also update the Guidelines to include guidance on the efficacy of complementary and integrative therapies, including yoga, meditation, equine therapy, other animal therapy, training and caring for service dogs, agritherapy, outdoor sports therapy, yoga therapy, and any other alternative treatment that the Work Group considers appropriate.

Based on DAV's 2019 and 2018 Women Veterans Priorities.

Sec. 304. Establishment by Department of Veterans Affairs and Department of Defense of Clinical Practice Guidelines for the Treatment of Serious Mental Illness

Section 304 would direct VA to work with DOD and HHS to create within two years Clinical Practice Guidelines for the treatment of serious mental illness, including schizophrenia; schizoaffective disorder; persistent mood disorder, including bipolar I and II; and any other disorder significantly impacting major life activities.

This section would include a requirement that in two years VA, DOD, and HHS review the Clinical Practice Guidelines for the Management of Major Depressive Disorders to determine if an update is necessary.

This section would direct the Guidelines to include guidance on evidence-based therapies and pharmacological therapy or therapies for the management of these conditions. The Work Group would be established in accordance with other work groups that create VA/DOD Clinical Practice Guidelines.

Sec. 305. Precision Medicine Initiative of the Department of Veterans Affairs to Identify and Validate Brain and Mental Health Biomarkers

Section 305 would direct VA to develop and establish a Precision Medicine for Veterans Initiative in order to identify and validate brain and mental health biomarkers, with a particular focus on PTSD, TBI, anxiety, bipolar disorder, and depression.

Based on IB Veterans Agenda for the 116th Congress Mental Health Services Recommendations.

Sec. 306. Statistical Analysis and Data Evaluation by Department of Veterans Affairs

Section 306 would allow the Secretary to contract with academic institutions or qualified entities to carry out statistical analyses and data evaluation as required.

Title IV – Oversight of Mental Health Care and Related Services

Sec. 401. Study on Effectiveness of Suicide Prevention and Mental Health Outreach Programs of the Department of Veterans Affairs

Section 401 would require VA contract to carry out a focus study on the effectiveness of VA's suicide prevention and mental health media outreach materials. VA would be required to convene focus groups to evaluate the effectiveness of media outreach materials and campaigns. Focus group participants would represent veterans with diverse backgrounds and locations to ensure that current and future outreach efforts effectively target different groups of veterans. VA would then produce a report based on the findings from the focus groups.

This section also would require that all future contracts that VA enters into for suicide prevention and mental health outreach must include a clause that would require contractors to perform focus group

studies that measure the effectiveness of any future suicide prevention and mental health outreach. It also would require future contractors to subcontract only with those contractors who have a history of creating media campaigns that successfully reach 18-34 year olds.

Sec. 402. Oversight of Mental Health and Suicide Prevention Media Outreach Conducted by Department of Veterans Affairs

Section 402 would codify GAO's recommendations that they made in their December report that highlighted VA's failure to spend their mental health and suicide prevention outreach budget (VA HEALTH CARE: Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation).

This section would require VA to establish goals for suicide prevention and mental health media outreach, metrics to measure those goals, and targets for those metrics, based on Recommendation 2 in the GAO Report. This section also lays out specific metrics that the Department should be using, based on media type, if they are not already.

Based on GAO Report recommendations.

Sec. 403. Comptroller General Management Review of Mental Health and Suicide Prevention Services of Department of Veterans Affairs

Section 403 would require a GAO review of the management and organizational structure of the Office of Mental Health and Suicide Prevention, including:

- Infrastructure;
- Governance structure;
- Policies and procedures, including how those policies and procedures are implemented;
- Staffing levels, including the types of positions and the location of those staffing deficiencies;
- The Nurse Advice Line pilot program;
- Rural recruitment initiatives for mental health professionals of the Department;
- Strategic planning; and
- Communication, both at central office and between central office and the field, and between central office and community providers.

Sec. 404. Comptroller General Report on Efforts of Department of Veterans Affairs to Integrate Mental Health Care into Primary Care Clinics

Section 404 would require a GAO report on the effectiveness of VA's efforts to integrate mental health care into a primary care setting, along with any improvement to veteran care and recommendations for areas where VA could better integrate mental health care into primary care clinics.

This section also includes a follow-up GAO study of VA's efforts to integrate community-based mental health care into VHA care, including the effectiveness of that integration and recommendations on how the integration can be improved.

Sec. 405 Joint Mental Health Programs by Department of Veterans Affairs and Department of Defense

Section 405 would require VA and DOD to report on mental health programs in each of their departments, including transition assistance, clinical mental health initiatives, mental health research initiatives, and secondary programs that improve mental health, including employment, housing assistance, and financial literacy programs.

This section also would require a report on any joint programs, as well as any areas for potential joint programming to improve mental health care at VA and DOD.

This section also would require that VA and DOD evaluate current ongoing efforts to create a joint Intrepid Spirit Center at a location that is geographically distinct from already existing and planned Spirit Centers, may be a rural or highly rural area, is on an installation of DOD or property of a VAMC, and potentially involves private or philanthropic entities in carrying out the activities of the center.

Based on MilCon/VA FY19 Senate Appropriations Report, pg. 38.

Title V –Medical Workforce

Sec. 501. Staffing Improvement Plan for Mental Health Providers of the Department of Veterans Affairs

Section 501 would require VA, in consultation with the Inspector General's Office, to create a staffing improvement plan for the hiring of mental health providers, including the number of positions and where those positions are located, that need to be filled in order to meet demand, and what regional-specific steps are being taken to address the shortages.

This section would also mandate VA work with OPM to create an occupational series for licensed professional mental health counselors and marriage and family therapists.

Based on MilCon/VA FY19 Senate Appropriations Report, pg. 59 (OPM requirement)

Based on VA OIG Staffing Shortage List. Psychologists have been on OIG's Staffing Shortage List since the first iteration in Jan. 2015. Psychiatrists were ranked as the top clinical occupation with staffing shortages in the FY18 report.

Sec. 502. Establishment of Department of Veterans Affairs Readjustment Counseling Service Scholarship Program

Section 502 would direct VA to establish a scholarship program for students pursuing a degree in psychology, social work, marriage and family therapy, or mental health counseling at an accredited educational institution. Those students would enter into an agreement to work full-time at a Vet Center for six-year period following completion of their program of study.

Sec. 503. Comptroller General Report on Readjustment Counseling Service of Department of Veterans Affairs

Section 503 would require a GAO report assessing the Readjustment Counseling Service, specifically:

- Adequacy of treatment offered at Vet Centers, and recommendations on how services could be expanded;
- Efficacy of outreach efforts, and recommendations on how efforts could be improved;
- Any barriers to care at Vet Centers, and recommendations for overcoming barriers;
- Efficacy and frequency of tele-mental health use at Vet Centers, and recommendations on how the use of telehealth can be improved; and
- Feasibility and advisability of expanding RCS eligibility, including what criteria could be expanded, and an assessment of potential costs, both human capital and infrastructure, if eligibility is expanded.
- Utilization of Vet Centers by never formally federally activated Guards or Reservists
- An assessment of the efficacy of group therapy and training of providers on administering group therapy
- An assessment of the use of Vet Centers by Native Americans and recommendations on how to better reach them.

Sec. 504. Expansion of Reporting Requirements on Readjustment Counseling Service of the Department of Veterans Affairs

Section 504 would add reporting requirements to RCS' current annual report:

- Assessment of resources required to meet any unmet needs
- Every two years, RCS would include a prediction of trends in demand of care, any long-term investments, maintenance of infrastructure

Sec. 505. Briefing on Allowance of Alternative Work Schedules for Employees of Veterans Health Administration

Section 505 would direct VA to conduct a survey on the feasibility and advisability of offering alternative work schedules for employees of the Veterans Health Administration.

- Includes a survey of enrolled veterans' opinions towards appointments offered in off hours.
- Includes a survey of employees' opinions toward working alternative work schedules.

Would require a briefing from VA on the results of the survey within 270 days.

Based on Veterans Rural Health Advisory Committee 2018 Recommendations to create alternative work schedules.

Sec. 506. Suicide Prevention Coordinators

Section 506 would direct VA to staff every VAMC with at least one suicide prevention coordinator (SPC).

This section would also direct VA to conduct a feasibility and advisability study of creating a suicide prevention coordinator program office and a realignment of SPCs under the Office of Mental Health and Suicide Prevention.

Sec. 507. Report on Efforts by Department of Veterans Affairs to Implement Safety Planning in Emergency Departments

Section 507 includes findings of Congress that there needs to be a more effective approach to reducing veteran suicide, the Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAVE VET) is a promising new practice to reduce suicide following an emergency room visit.

This section also would require a report to Congress about the implementation of a discharge plan for veterans who present with suicidal ideation at a VA emergency room, known as the SPED program (Safety Planning in Emergency Departments program). The training of clinicians in administering SPED and criteria for measuring quality of SPED as well as other discharge safety planning protocols.

A review of the quality of safety plans being issued to veterans would be required, as well as the number of veterans who are involved in the SPED program, a description of how primary coordinators are deployed and their description of duties, training and location. An assessment of the feasibility and advisability of expanding the number of SPED primary coordinators, providing SPED through telehealth and any recommendations for how to improve the program would also be required.

Title VI – Improvement of Care and Services for Women Veterans

Sec. 601. Expansion of Capabilities of Women Veterans Call Center to Include Text Messaging

Section 601 would require VA to expand the Women Veterans Call Center to include text messaging.

Sec. 602. Requirement for Department of Veterans Affairs Internet Website to Provide Information on Services Available to Women Veterans

Section 602 would require VA to assess information already available online for women veterans and update that information to make it more centralized and accessible to women veterans in a new website. This website must also provide the name and contact information for the women's health coordinator and other relevant VA staff for each geographic region.

Title VII – Other Matters

Sec. 701. Expanded Telehealth from Department of Veterans Affairs

Section 701 would provide funding to expand existing or create new partnerships that increase the number of locations that VA telehealth care is available at a non-VA facility.

Funds could be used to improve existing infrastructure to better provide telehealth to veterans, including new hardware or software, improved internet access, improved security protocols, or minor construction projects to increase privacy and a more therapeutic environment. Funds cannot be used for major construction projects or the purchase of new property.

Based on VFW 2019 Priority Goals to expand telehealth services.

Sec. 702. Partnerships with Non-Federal Government Entities to Provide Hyperbaric Oxygen Therapy to Veterans and Studies on the use of Such Therapy for Treatment of Post-Traumatic Stress Disorder and Traumatic Brain Injury

Section 702 would allow VA, in consultation with the VA's Center for Compassionate Innovation, to enter into partnerships with entities to provide hyperbaric oxygen treatment (HBOT) to veterans in order to research HBOT's effectiveness. No federal funding could be used to carry out these partnerships.

Sec. 703. Prescription of Technical Qualifications for Licensed Hearing Aid Specialists and Requirement for Appointment of Such Specialists

Section 703 would require VA to create technical qualifications for licensed hearing aid specialists employed by the Department. The qualifications would be based on standards required by a majority of states and any other competencies needed per laws administered by the Secretary.

This section also would require that VA staff each VAMC with at least one licensed hearing aid specialist no later than the end of FY22. The Secretary would be required to submit an annual report beginning at the end of FY22 on VA's progress towards hiring hearing aid specialists and audiologists and any obstacles or obstacles towards hiring these employees. The report must include an assessment on patients' access to hearing health care services.

Sec. 704 Use by Department of Veterans Affairs of Commercial Institutional Review Boards in Sponsored Research Trials

Section 704 would change the Department's directive to allow VA sponsored clinical research trials to use accredited commercial institutional review boards (IRBs) to review their research proposals. Commercial IRBs are used by most non-university related clinical trials, and the goal of this section is to speed up the process for approving research while maintaining human subject protections.

This section also would require a report on the use of commercial IRBs.

Suggestion from Coalition to Heal Invisible Wounds, a group seeking to improve research into PTSD and TBI treatments for veterans.

Sec. 705. Creation of Office of Research Reviews within the Office of Information and Technology of the Department of Veterans Affairs

Section 705 would also direct the Secretary to create an Office of Research Reviews within the Office of Information and Technology that would (1) perform centralized security reviews for approved non-VA sponsored research with a focus on multi-site clinical trials and (2) maintain a list of secure commercially available software for use in VA sponsored clinical trials.

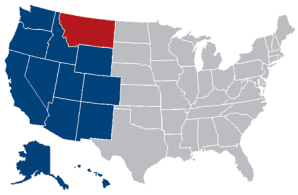
This section also would require a report on the functioning of the new Office of Research Reviews.

Suggestion from Coalition to Heal Invisible Wounds, a group of non-profit organizations and private companies seeking to improve research into PTSD and TBI treatments for veterans.

Sec. 704 and 705 are from S. 3224, VA Research Approval Efficiency Act of 2020 (Cassidy/Tester Bill)

MONTANA

Veteran Suicide Data Sheet, 2018



The U.S. Department of Veterans Affairs (VA) is leading efforts to understand suicide risk factors, develop evidence-based prevention programs, and prevent Veteran suicide through a public health approach. As part of its work, VA analyzes data at the national and state levels to guide the design and execution of the most effective strategies to prevent Veteran suicide.

The 2018 state data sheets present the latest findings from VA's ongoing analysis of suicide rates and include the most up-to-date state-level suicide information for the United States.[a] This data sheet includes information about Montana Veteran suicides by age, sex, and suicide method and compares this with regional and national data.

Western Region

- Alaska
- Arizona
- California
- Colorado
- Hawaii
- Idaho
- Montana
- Nevada
- New Mexico
- Oregon
- Utah
- Washington
- Wyoming

After accounting for age differences,[b] the Veteran suicide rate in Montana:

- **Was significantly higher** than the national Veteran suicide rate
- **Was significantly higher** than the national general population suicide rate

Montana Veteran Suicide Deaths, 2018

Sex	Veteran Suicides
Total	56
Male	50–60
Female	<10

To protect confidentiality, suicide death counts are presented in ranges when the number of deaths in any one category was lower than 10.

Montana, Western Region, and National Veteran Suicide Deaths by Age Group, 2018[c]

Age Group	Montana Veteran Suicides	Western Region Veteran Suicides	National Veteran Suicides	Montana Veteran Suicide Rate	Western Region Veteran Suicide Rate	National Veteran Suicide Rate
Total	56	1,627	6,435	60.9	36.0	32.0
18–34	10	218	874	111.1*	47.2	45.9
35–54	13	409	1,730	56.5*	35.8	33.4
55–74	22	658	2,587	55.0	34.9	30.4
75+	11	338	1,237	55.0*	32.9	27.4

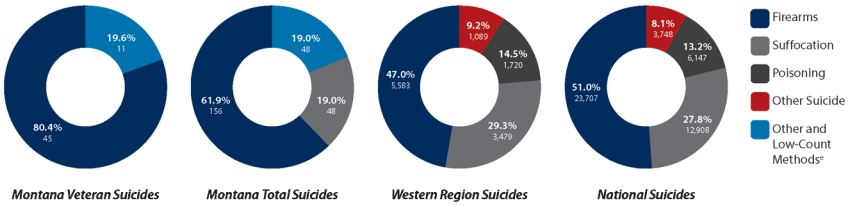
Montana Veteran and Total Montana, Western Region, and National Suicide Deaths by Age Group, 2018[c]

Age Group	Montana Veteran Suicides	Montana Total Suicides	Western Region Total Suicides	National Total Suicides	Montana Veteran Suicide Rate	Montana Suicide Rate	Western Region Suicide Rate	National Suicide Rate
Total	56	252	11,871	46,510	60.9	30.4	19.8	18.4
18–34	10	78	3,408	13,002	111.1*	34.2	18.3	17.3
35–54	13	85	3,963	15,866	56.5*	34.2	19.9	19.1
55–74	22	70	3,394	13,514	55.0	25.7	20.6	18.6
75+	11	19	1,106	4,128	55.0*	24.0*	23.0	18.9

* Rates calculated from suicide counts lower than 20 are considered unreliable.

VA | U.S. Department of Veterans Affairs

Montana Veteran and Total Montana, Western Region, and National Suicide Deaths by Method,[d] 2018



These 2018 state data sheets are based on a collaborative effort among the U.S. Department of Veterans Affairs (VA), the U.S. Department of Defense (DoD), and the National Center for Health Statistics (NCHS). The statistics presented are derived from multiple data sources, including the VA Office of Enterprise Integration, the VA Serious Mental Illness Treatment Resource and Evaluation Center, VA Post-Deployment Health Services, the VA Center of Excellence for Suicide Prevention, and the DoD Defense Suicide Prevention Office.

These sheets include information on the Veteran population and general U.S. population age 18 and older, with deaths reported in the contiguous United States, Alaska, and Hawaii. The total state, regional, and national counts and rates presented include both Veterans and non-Veterans.

Suicide deaths are identified based on the underlying cause of death indicated on the state death certificate. For Veteran decedents, this information comes from the NCHS National Death Index (NDI) and was obtained from the joint VA/DoD Mortality Data Repository (MDR). Suicide death counts for the general U.S. population were obtained from Centers for Disease Control and Prevention (CDC) WONDER (Wide-ranging ONline Data for Epidemiologic Research).[i] Underlying cause of death is defined as (a) the disease or injury that initiated the train of events leading directly to death, or (b) the circumstances of the accident or violence that produced the fatal injury.[g] The ICD-10 (International Classification of Diseases, 10th revision) codes used to define suicide deaths are X60–X84, U03, and Y87.0.

Suicide rates presented are unadjusted rates per 100,000, calculated as the number of suicide deaths in 2018 divided by the estimated population and multiplied by 100,000. Significance statements are based on the ratio of direct age-adjusted rates, using the 2000 standard U.S. population.[h] The Veteran Population Projection Model 2018 (VetPop2018) was used in calculating rates to estimate the Veteran population for each state and age group.[i] The U.S. Census Bureau American Community Survey (ACS) one-year estimates were used to estimate the general U.S. population.[j]

Veteran age-specific counts may not sum to the total counts because there are a small number of deaths for which age information is unavailable. These deaths are included in overall counts and rates but are not distributed among age groups; therefore, they are not included in age-specific counts, age-specific rates, or age-adjusted rates. Rates are marked with an asterisk (*) when the rate is calculated from fewer than 20 deaths. Rates based on small numbers of deaths are considered statistically unreliable because a small change in the number of deaths might result in a large change in the rate. Because suicide rates based on fewer than 20 suicide deaths are considered statistically unreliable, any comparisons between age-adjusted rates and underlying age-specific rates based on fewer than 20 suicide deaths should be interpreted with caution.

To protect privacy and to prevent revealing information that may identify specific decedents, counts and rates are suppressed when based on 0 to 9 individuals. For suicide deaths by method, in cases where the number of deaths in any one of the categories was lower than 10, the categories with the smallest counts were combined until the minimum count of 10 was reached, to maintain confidentiality.

[a] The 2018 state data sheets contain suicide information for all 50 states and the District of Columbia.
[b] Suicide rates presented in the tables are unadjusted for age. Age-adjusting suicide rates ensures that the differences in rates are not due to differences in the age distributions of the populations being compared. In some cases, the results of comparisons of age-adjusted rates differ from those of unadjusted rates. Comparison of rates is based on the ratio of age-adjusted rates; significance is determined based on a p-value <0.05.
[c] Rates presented are unadjusted rates per 100,000. To protect privacy, and prevent revealing information that may identify specific individuals, counts and rates are suppressed when based on 0 to 9 people. Rates calculated with a numerator of less than 20 are considered statistically unreliable, as indicated by an asterisk (*).
[d] Methods are based on ICD-10 codes X72 to X74 for firearms, X60 to X69 for poisoning (including intentional overdose), and X70 for suffocation (including strangulation). "Other Suicide" includes all other intentional self-harm, including cutting/piercing, drowning, falling, fire/flame, other land transport, being struck by/against, and other specified or unspecified injury.
[e] "Other Suicide" refers to all methods of suicide death apart from firearms, suffocation, and poisoning. "Low-Count Methods" refers to methods used in fewer than 10 deaths in a given state or territory. In states or territories with fewer than 10 firearm deaths, suffocation deaths, or poisoning deaths, those data are represented in the "Other and Low-Count Methods" category to protect the privacy of individual suicide decedents.
[f] National, regional, and state general population suicide counts are obtained from the CDC WONDER online database. For more information on CDC WONDER, please refer to http://wonder.cdc.gov/ucd-icd10.html.
[g] World Health Organization, Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, based on the recommendations of the Ninth Revision Conference, 1975; Geneva, 1977.
[h] Klein, RJ, and Schoenborn, CA. Age adjustment using the 2000 projected U.S. population. Healthy People Statistical Notes, No. 20. Hyattsville, Maryland: National Center for Health Statistics. January 2001.
[i] Veteran Population Model 2018 (VetPop2018), Predictive Analytics and Actuary, Office of Enterprise Integration, Department of Veterans Affairs.
[j] U.S. general population estimates used for rate calculations are obtained from the U.S. Census Bureau, 2018 American Community Survey one-year estimates.

VETERANS HEALTH ADMINISTRATION

The Veterans Health Administration's Rapid Conversion to Virtual Mental Health Care During the COVID-19 Pandemic

Dr. Kendra Weaver
Office of Mental Health & Suicide Prevention (OMHSP) *in partnership with Office of Connected Care (OCC)*
March 2021 presentation

Agenda

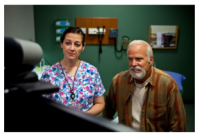
- Describe VHA's rapid conversion to virtual care during the COVID-19 response

  - VHA's history and promotion of telemental health (TMH) pre-COVID
  - TMH's impact on VHA's mental health services for Veterans during COVID-19
  - Lessons learned
  - Moving forward

VA Telemental Health (TMH) Services

The use of information and telecommunication technologies to deliver mental health services when the provider and the Veteran are separated by geographical distance.

- Delivered by VA mental health professionals
- To address most mental health issues
- By providing consultation and treatment:
  - Assessment & consultation
  - Medication management
  - Individual, group, and family/couples therapies
- At multiple sites of care—VA medical centers, Community Based Outpatient Clinics, Veterans' homes and other preferred locations



Abbreviations

- ATLAS: Accessing Telehealth Through Local Area Stations
- CVT: Clinical Video Telehealth
- FY: Fiscal Year
- NTMHC: National Telemental Health Center
- OIT: Office of Information & Technology
- TMH: Telemental Health
- VA: Department of Veterans Affairs
- VHA: Veterans Health Administration
- VISN: Veterans Integrated Service Network
- VSO: Veterans Service Organization
- VVC: VA Video Connect (VA's video platform; shorthand for TMH-to-home)

VA's History and Promotion of Telemental Health: How it Prepared Us for COVID-19 Response

VHA's History and Promotion of Telemental Health: Last 20 Years

Timeline of Major Milestones

2002: VA National TMH

2010: NTMHC

2013: TMH to Home

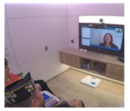
2016: TMH Hubs

2016: Tablet Initiative

2017: VVC platform

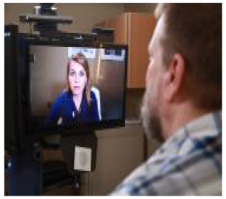
2018: MISSION Act

2019: ATLAS



VA TMH Services Prior to COVID

Clinical Video Telehealth



Clinic Based

Into the Home and non-VA sites

VISN Clinical Resource Hubs

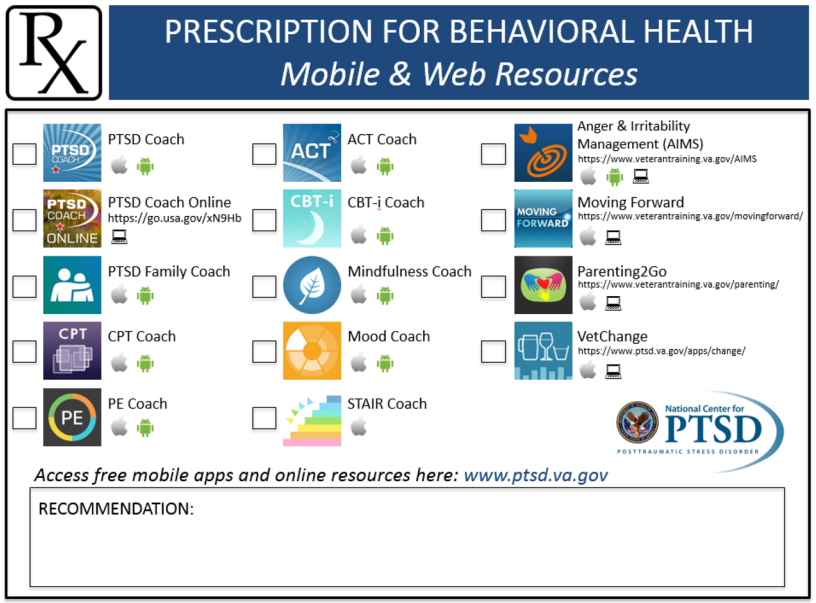
National Expert Consultation

Free, Publicly Available Mobile Apps & Web Resources

https://www.mobile.va.gov/appstore/mental-health

www.VeteranTraining.va.gov

https://www.ptsd.va.gov/apvid/mobile/index.asp

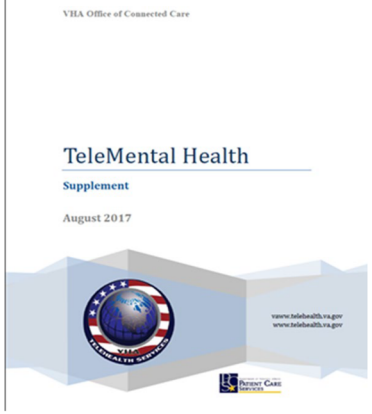


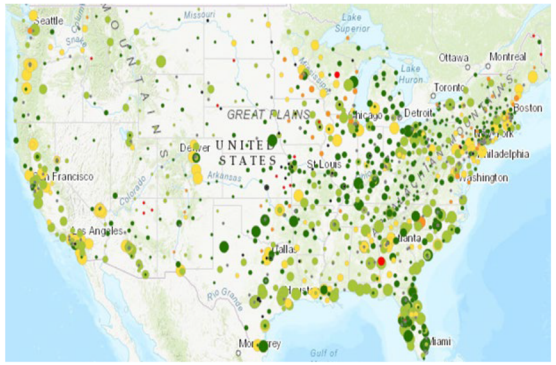
VHA's History and Promotion of Telemental Health

Foundations

Organizational Infrastructure

- VA Providers/Staff
- Veterans
- VA National Guidance
- Legislation
- OIT Infrastructure/Bandwidth





TMH Evidence Base

*Rigorous research consistently supports that mental health services, including psychotherapy and psychiatry, delivered over clinic-based and home-based Clinical Video Telehealth (CVT) modalities are as clinically effective as traditional in-person care for treating a range of mental health conditions in **Veterans** and civilians.*

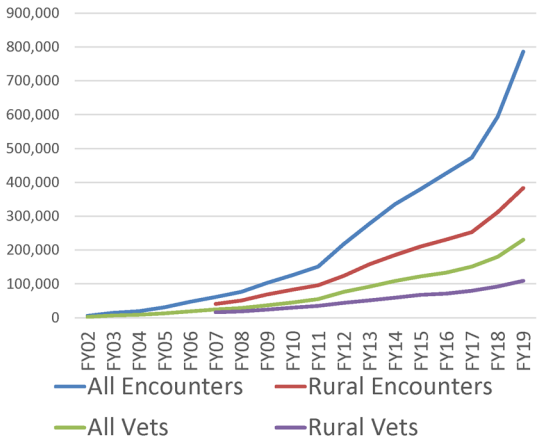
- As **clinically effective** compared to in-person care in multiple *RCTs and non-inferiority trials
- Demonstrated patient and provider **satisfaction**
- Similar **therapeutic alliance** for CVT and in-person MH care, according to patients and providers
- Comparable **retention** between CVT and in-person modalities for delivering MH services

Preliminary research suggests telephone therapy may be an option to provide some MH care effectively.

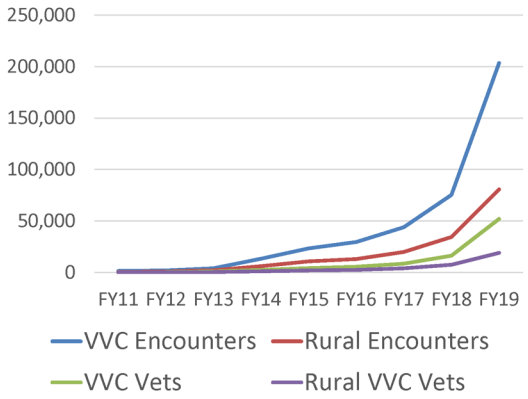
*RCTs=randomized controlled trials

Telemental Health (TMH) Growth Before COVID-19

In FY2019, VA provided TMH services to >230,000 Veterans during >786,000 visits (33% increase in visits over FY2018).



Of Veterans receiving TMH care, >52,000 Veterans (37% rural) received over 203,500 total TMH sessions *directly into their homes or other place of choice.* 26% of all TMH visits were into the home, a 169% increase over FY2018.

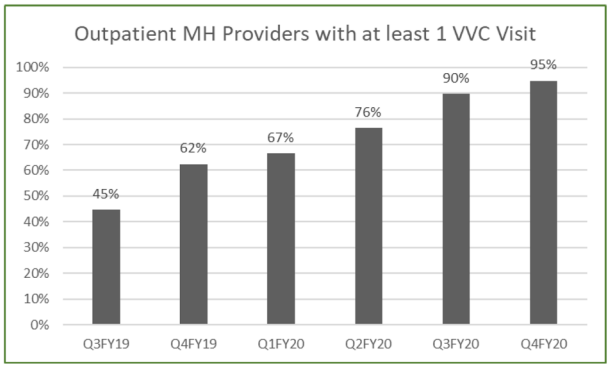


VHA's History and Promotion of Telemental Health

Vision and Performance Goals

- **Vision:** Leverage telehealth to enhance accessibility, capacity, quality and experience of VA health care for Veterans, their families, and their caregivers anywhere in the country
- **Goal:** By FY20 end, **100%** MH clinicians will be VVC-**capable; 60%** will complete a VVC visit.

END OF FY18	MID FY19	END OF FY19	END OF FY20
20%	45%	75%	100%

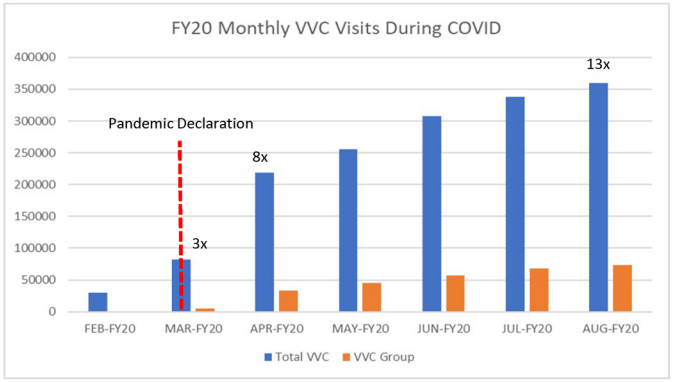


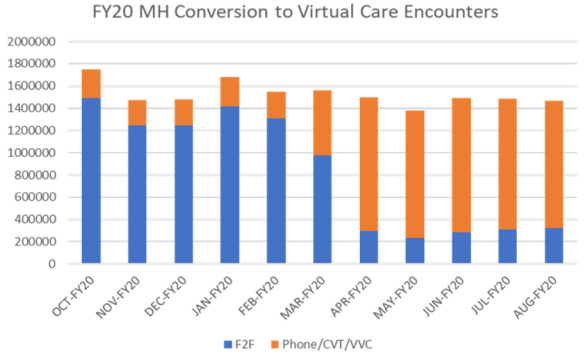
VA's Rapid Conversion to Virtual Mental Health Care

Rapid Acceleration of TMH During COVID-19 Response

Rise of MH VVC (Video to Home) and Virtual Visits

- Within a week, MH VVC visits doubled compared to pre-COVID levels--with continued, steady growth. Telephone care and VVC were critical early on to sustain workload.





Rapid Acceleration of TMH During COVID-19 Response

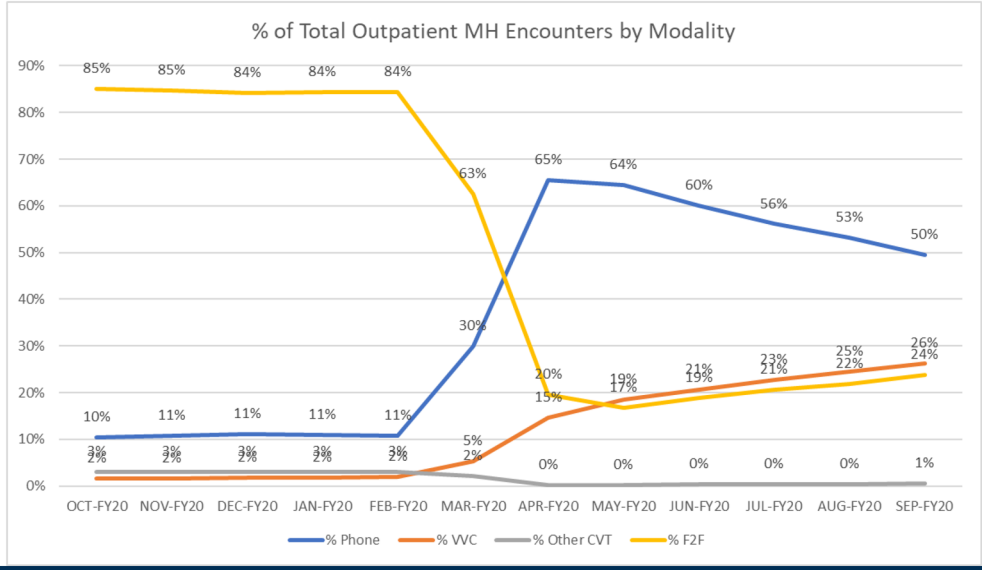
Conversion of In-Person to Virtual Care

Care Modality Dashboard

April 2020:

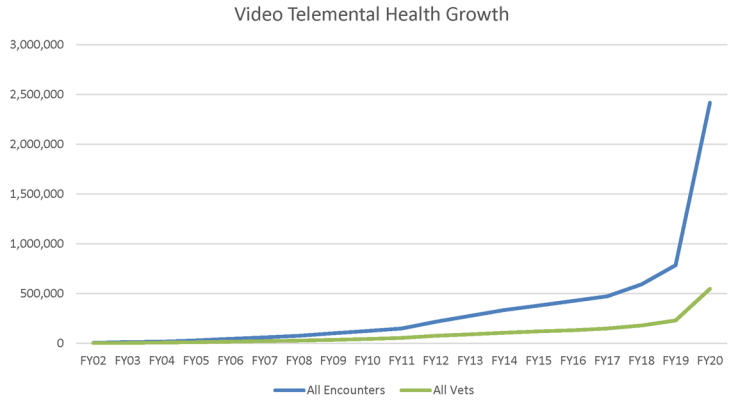
1.5M MH visits (80% virtual)

- >979,000 calls (6-fold increase over pre-COVID levels)
- >222,500 televideo
  - 218,500 VVC (8-fold increase)
  - >4100 other CVT
- >294,000 in-person



In Perspective: Telemental Health Growth Over the Years

Telemental Health Visits FY02–20



In FY2020, VA provided telemental health services to nearly 550,000 Veterans during > 2.4M visits (1.6M more visits than FY19—a 207% increase); > 444K of these Veterans received nearly 2.1M TMH video visits directly into their home or location of choice (a 932% increase in visits over FY19).

COVID-19 Response Plan to Ensure Continuity

Principle-based Leadership

- **Safety** was first priority.
- Key ingredient was FLEXIBILITY.
  - Where staff worked
  - How staff worked
  - What staff did
- VA leveraged its existing infrastructure and planning to quickly transition.
- The Veteran was always at the heart of the mission.

Foundations Supporting VA's Response

VA Providers/Staff

- Promoted telehealth-telework capability, safety, and continuity of care
- Leveraged existing groups, early adopters, champions, training, and wellness
  - https://www.mentalhealth.va.gov/coronavirus/index.asp

Veterans

- Outreached to Veterans, VSOs, and public (webinars, blogs, social media, etc.)
  - https://www.va.gov/coronavirus-veteran-frequently-asked-questions/
  - https://www.ptsd.va.gov/covid/COVID_managing_stress.asp

VA National Guidance and Tools

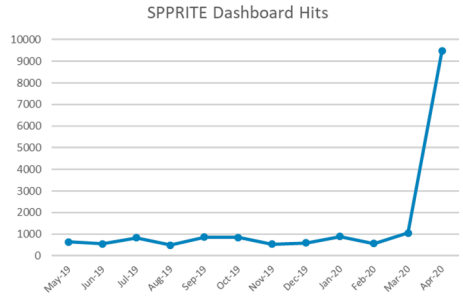
- Created new resources & expanded existing ones to promote safe, effective care

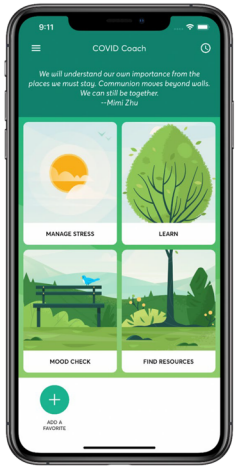
National External Regulations (flexibilities)

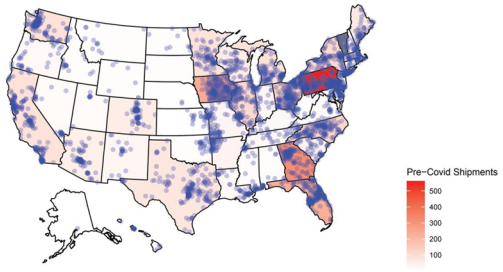
Technology Infrastructure (bandwidth, capacity)

Examples of Resource Enhancements

Suicide Prevention Dashboard, COVID Coach App, and Tablet Initiative







Patterns of tablet shipments early in the pandemic, superimposed on pre-COVID tablet shipment patterns

https://mobile.va.gov/app/covid-coach

TMH's Impact on Mental Health Services for Veterans

TMH Services: Summary of Positive Impact

Access

- Facilitated sustained access (~80% of MH visits are virtual care)
- VVC visits increased >14-fold (FY20 October to September: <2% vs. 26% of MH care)
- VVC increased across the population

Quality

- Used throughout MH Continuum of Care & maintained quality

Provider Capability

- By end of FY20, >12,000 (95%) of all outpatient MH providers had completed at least 1 VVC visit

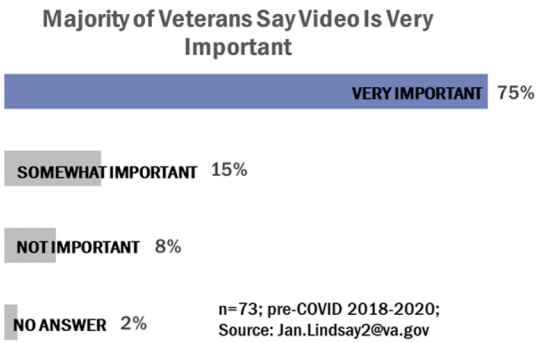
Veteran Capability

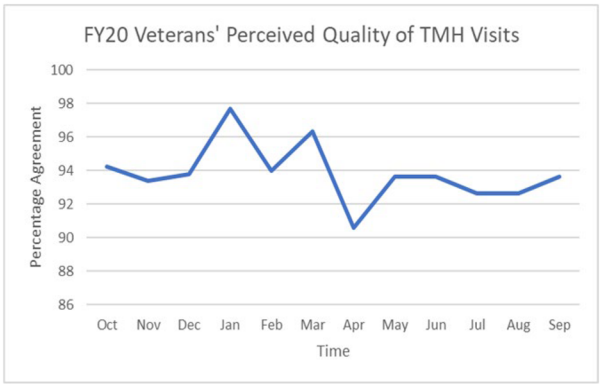
- Cumulatively in FY20, >550,000 Veterans received 2.4M TMH visits
- Satisfaction is generally high

Impact of TMH Services For Veterans: Veteran Voice

Veterans prefer and appreciate video visits.

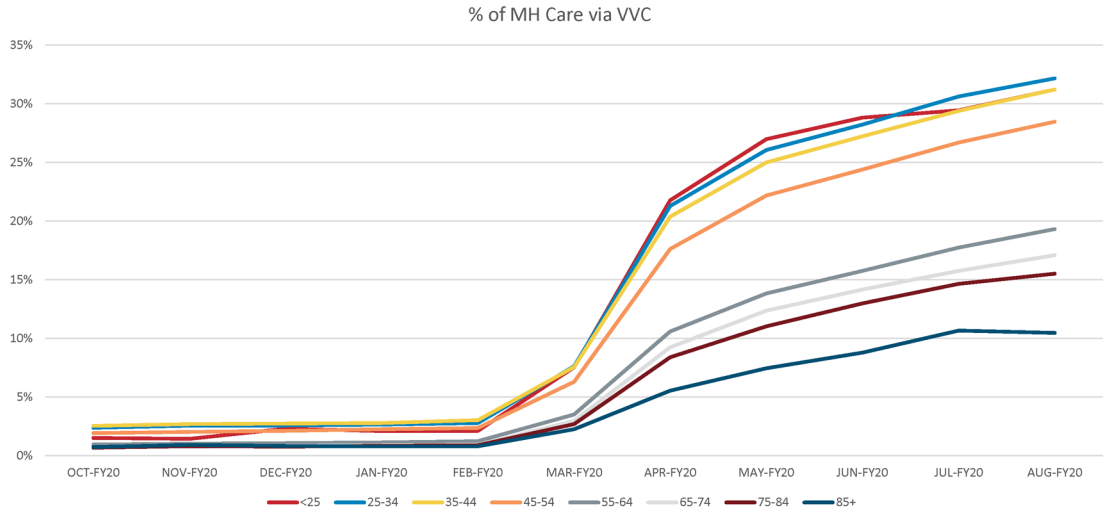
- "With Telemental Health, I'm able to receive the help I need in a comfortable setting, without the stress of traffic and hospital waiting rooms. My doctor brings me back into focus and helps me deal with a very dark time."
- "[VVC] gives me a sense of security feeling like I'm being COVID-compliant. It cannot be underestimated how much that is saving lives and reducing spread."





Impact of TMH Services For Veterans: MH VVC Visits by Age

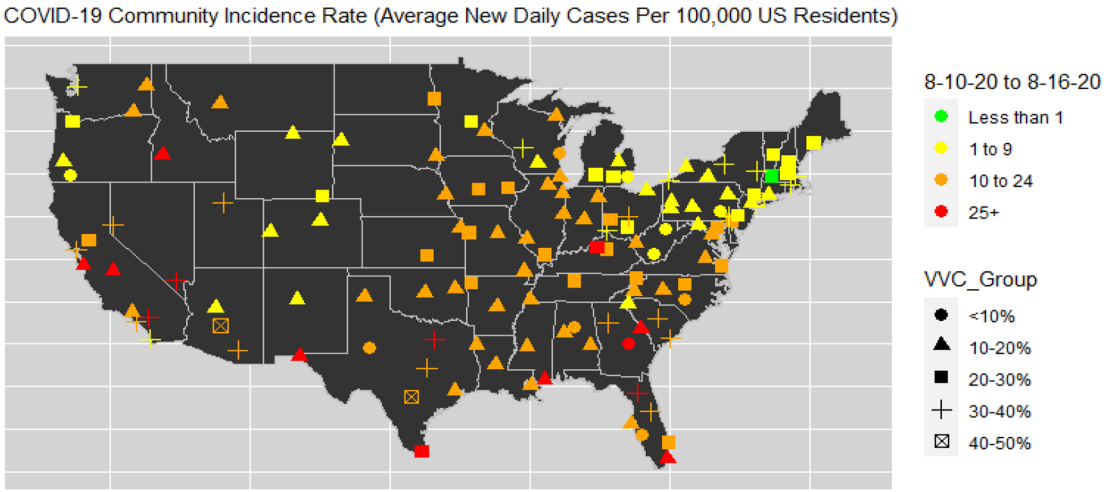
Veterans in younger age groups use VVC at higher rates than Veterans 55+.



Age	AUG-FY20
<25	31%
25-34	32%
35-44	31%
45-54	28%
55-64	19%
65-74	17%
75-84	16%
85+	10%

Impact of TMH Services For Veterans: Tools

August 2020 COVID-19 Incidence & VVC Utilization



Lessons Learned & Moving Forward

Lessons Learned

Foundations are critical: IT infrastructure, technology, legal authority, policy, & staff

- Bi-directional communication, flexibility and creativity are necessary in a crisis.
- People who use telemental health generally like it.
- The COVID-19 response increased support for TMH as a safe and effective care modality.
- It is important to address the digital divide and gaps in tech-readiness.
- Investing in telemental health care is the right direction.

Moving Forward

Top Goals for TMH Sustainment

- *2021: Ensure all outpatient MH providers are VVC-capable and confident*
- *2021: Ensure all schedulers supporting MH clinics are capable of scheduling VVC appointments*
- *2021: Increase TMH integration into the routine clinical practice of all outpatient MH staff*
- Increase Veterans' telehealth capability
- Continue strategic planning, research, evaluation, and quality improvement
- Identify and address healthcare disparities
- Expand Clinical Resource Hub specialty MH coverage
- Support long-term updates to legislation/regulations

Takeaways

VHA built on its strong TMH foundation to rapidly accelerate virtual care during the COVID-19 response.

- TMH promoted enhanced access, quality, and positive patient experiences.
- Future focus on sustainment and the telehealth experience are critical.

Commander John Scott Hannon Veterans Mental Health Care Improvement Act (P.L. 116-171) Implementation Kick-Off and Special Provision

March 19, 2021

Choose VA

VA | U.S. Department of Veterans Affairs

Commander John Scott Hannon Veterans Mental Health Care Improvement Act (P.L. 116-171) Briefing

Agenda
Hannon Act Implementation Kick-off
Overview and Key Elements
Grants and Scholarship Programs
Section Spotlights
Status On VA Actions
Next Steps and Discussion
Hannon Act Special Provision Briefing
Timeline Issues
Alternative Approach Proposals

Hannon Act Briefing: Subject Matter Experts

Program Office	Subject Matter Expert
Mental Health and Suicide Prevention	David Carroll, Executive Director, Office of Mental Health and Suicide Prevention (OMHSP) Matt Miller, National Director, Suicide Prevention, OMHSP Clifford Smith, Director, Field Support and Analytics, OMHSP Lisa Kearney, Deputy Director, Suicide Prevention, OMHSP Lisa Brenner, Director, VA Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC) John McCarthy, Director, Data and Surveillance, Suicide Prevention, OMHSP
Community Engagement	Tracy Weistreich, Nurse Executive, National Center for Compassionate Care Innovation, Office of Community Engagement (OCE) Christine Eickhoff, Health System Specialist, National Center for Compassionate Care Innovation, OCE
Human Capital Management	Jeffrey Kleiner, Human Resources Consultant, Human Resources Center of Expertise, Workforce Management and Consulting Office
Readjustment Counseling	Al Ozanian, Deputy Chief Officer, Readjustment Counseling Service (RCS) Charles Flora, Social Science Program Specialist, RCS
Rehabilitation and Prosthetics Service	David Otto, National Program Director, Recreation Therapy Service, Rehabilitation & Prosthetic Services
Research and Development	David Atkins, Director, Health Services Research & Development (HSR&D), Office of Research and Development (ORD) Karen Jeans, Director of Regulatory Affairs, ORD Robert O'Brien, Scientific Program Manager, Mental and Behavioral Health and Traumatic Brain Injury Research, HSR&D, ORD Naomi Tomoyasu, Deputy Director, HSR&D, ORD

Hannon Act Implementation Kick-off Briefing

Hannon Act Background

Commander John Scott Hannon

Following a decorated 23-year career with the Navy SEALs, Commander John Scott Hannon retired to his family home in Helena, Montana, where he received VA treatment for Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), depression, and bipolar disorder. Commander Hannon found solace and recovery in many local organizations that allowed him to give back to his fellow Veterans and his community, including the National Alliance for Mental Illness (NAMI), animal rescue and rehabilitation, working with at-risk youth, and helping Veterans access the outdoors. Commander Hannon died by suicide on February 25, 2018, at the age of 46.

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) was signed into law on October 17, 2020. The law enhances VA programs for mental health care, suicide prevention, care for women Veterans and telehealth care for Veterans and transitioning service members.

Hannon Act Overview

- The Hannon Act will build upon VA's National Strategy for Preventing Veteran Suicide and public health approach model, blending community-based prevention and clinically-based intervention strategies.
- The Hannon Act will advance efforts by VA, other Federal partners, and local communities in preventing suicide and promoting mental health and well-being among Veterans.
- The Hannon Act builds upon VA's public health approach in further implementing both community and clinical strategies inside and outside the VHA system. A critical portion of this is the expansion of community-based efforts through grant making in Section 201.

Overview of the 7 Titles of the Hannon Act

Title VII - Other Matters
(Sections 701-705)
- Expanded VA telehealth
- Partnerships with non-Federal Government entities to provide hyperbaric oxygen therapy to Veterans and studies on the use of such therapy
- Technical qualifications for licensed hearing aid specialists and requirement for specialist appointment
- Use Commercial Institutional Review Boards in Sponsored Research Trials
- Creation of Office of Research Reviews within VA OI&T

Title VI - Improvement of Care and Services for Women Veterans
(Sections 601-602)
- Expansion of capabilities of Women Veterans Call Center to include text messaging
- Requirement for VA website to provide information on services available to women Veterans

Title V - Improvement of Mental Health Medical Workforce
(Sections 501-507)
- Staffing improvement plan for VA mental health providers
- Establishment of VA Readjustment Counseling Service Scholarship Program
- Comptroller General report on VA Readjustment Counseling Service
- Expansion of reporting requirements on VA Readjustment Counseling Service
- Briefing on alternative work schedules for VHA employees
- Staffing VHA suicide prevention coordinators
- Report on VA efforts to implement safety planning in emergency departments

Title I - Improvement to Transition of Individuals to Services from Department of Veterans Affairs
(Sections 101-104)
- Strategic plan on expansion of health care coverage for Veterans transitioning from service in the Armed Forces
- Review records of former members of the Armed Forces who die by suicide within one year of separation from the Armed Forces
- Report on VA REACH VET program
- Report on care for former members of the Armed Forces with other than honorable discharge

Title IV - Oversight of Mental Health Care and Related Services
(Sections 401-405)
- Study on effectiveness of VA suicide prevention and mental health outreach programs
- Oversight of mental health and suicide prevention media outreach conducted by VA
- Comptroller General management review of mental health and suicide prevention services of VA
- Comptroller General report on efforts of VA to integrate mental health care into primary care clinics
- Report on joint mental health programs by VA and DoD

Title II - Suicide Prevention
(Sections 201-205)
- Financial assistance to certain entities to provide or coordinate the provision of suicide prevention services for eligible individuals and their families
- Analysis on feasibility and advisability of VA providing certain complementary and integrative health services
- Pilot program to provide Veterans access to complementary and integrative health programs
- VA study of all-cause mortality of Veterans, including by suicide, and review of staffing levels of mental health professionals
- Report on VA's management of Veterans at high risk for suicide

Title III - Programs, Studies, and Guidelines on Mental Health
(Sections 301-306)
- Study on connection between living at high altitude and suicide risk factors among Veterans
- Establishment by VA and DoD of a clinical provider treatment toolkit and accompanying training materials for comorbidities
- Update of clinical practice guidelines for assessment and management of patients at risk for suicide
- Establishment by VA and DoD of clinical practice guidelines for the treatment of serious mental illness
- Precision medicine initiative of VA to identify and validate brain and mental health biomarkers
- Statistical analyses and data evaluation by Department of Veterans Affairs

Key Elements of Hannon Act

Improve access options to mental health and suicide prevention services

- Expanding community-based prevention strategies.
- Improving rural Veterans' access to care.
- Developing a strategic plan on how VA can provide health care to Veterans during the one-year period following discharge from military service.

Support the expanded scope and breadth services available to Veterans

- Expanding Veterans' access to alternative therapies to include programs such as animal therapy, agritherapy, sports and recreation therapy, art therapy, and posttraumatic growth programs and partnerships with non-Federal Government entities.

Improve equity for sub-populations of Veterans

- Expansion of capabilities of the Women Veterans Call Center to include text messaging.
- Enhancing current suicide prevention efforts by establishing a grant program and enabling VA to award grants to entities for the expansion of telehealth technology for secure and private telehealth services.

Spotlight: Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program

A $173.9 million, three-year community-based grant program that will provide resources to community organizations serving certain Veterans at risk of suicide and their family across the country.

Hannon Act Grant and Scholarship Initiatives

The Hannon Act enables VA to award grants and scholarships that will improve mental health and suicide prevention services and Veteran care through multiple touchpoints, to meet the needs of Veterans and their families.

- **Community Based Intervention:** *Section 201,Staff Sergeant Parker Gordon Fox Suicide Grant Program*, a $174 million, three-year community-based grant program that enables VA to provide resources to community organizations serving Veterans.
- **Framework for Education and Prevention:** *Section 502, Readjustment Counseling Service Scholarship Program*, provides scholarships for students pursuing a degree in psychology, social work, marriage and family therapy, or mental health counseling.
- **Improved Access in Underserved Communities**: *Section 701, Expanded telehealth from Department of Veterans Affairs*, enables VA to award grants to entities for the expansion of telehealth technology for secure and private telehealth services.

Hannon Act Section Spotlight

Hannon Act Section Spotlight

Section 201: Staff Sergeant Parker Gordon Fox Suicide Grant Program: Financial assistance to provide the provision of suicide prevention services for eligible individuals and their families.

- The Hannon Act enables the VA to provide additional resources toward community-based suicide prevention efforts to meet the needs of Veterans and their families through statutory authority to establish a suicide prevention grant program entitled the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP).

- VA is developing regulations to implement this authority in coordination with VHA's Office of Mental Health and Suicide Prevention (OMHSP), President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) and other VA legal and regulatory offices.

- VA is making efforts to expedite publication of regulation, allowing implementation of this vital program and grant funding to community agencies combating Veteran suicide.

Section 203: Pilot Program to Provide Veterans Access to Complementary and Integrative Health Programs

- Requires VA to conduct a three-year pilot program to provide animal therapy, agritherapy, sports and recreation therapy, art therapy, and posttraumatic growth programs to eligible veterans for the treatment of post-traumatic stress disorder, depression, anxiety, or other conditions.
  - The pilot provides therapies through VA programs or using non-Department entities.
  - Facilities included in the pilot shall be in geographically diverse areas and include not fewer than three facilities that serve veterans in rural or highly rural areas.

- Many VA medical centers provide the various therapies and interventions cited in this requirement.
  - 10 VAMCs have been identified as potential Pilot sites.
  - Pilot will commence as VAMCs providing these therapies and interventions resume normal operations (begin October 1, 2021).

Section 305: Precision Medicine Initiative of the Department of Veterans Affairs to Identify and Validate Brain and Mental Health Biomarkers

- VA will launch a Mental Health Precision Medicine Initiative in close coordination with the Million Veteran Program (MVP), called MVP-MIND (Measures Investigating Neuropsychological Disorders). MVP was launched in 2011 and has enrolled over 830,000 Veterans to date.
  - MVP-MIND will establish a cohort of 50,000 Veterans with severe mental illness and substance use disorders.
  - Participants will include Veterans with depression, anxiety, PTSD, schizophrenia, bipolar disorder, and substance use disorders (TBI has been added).
  - Blood specimens will be collected and analyzed for genetic and other biomarkers.
  - Deidentified data sets will be provisioned to researchers in the VA Data Commons.

Section 506: Suicide Prevention Coordinator Feasibility Study

- The Hannon Act requires VA to ensure that each VA Medical Center has at least one suicide prevention coordinator (SPC). The law also requires VA to conduct a study to determine the feasibility and advisability of the realignment and reorganization of suicide prevention coordinators within the VA Office of Mental Health and Suicide Prevention and the creation of a suicide prevention coordinator program office.

- The first requirement to have Suicide Prevention Coordinators (SPCs) at every VA Medical Center was already completed, as VA already required every VA Medical Center to have at least one SPC.

- VA is conducting the study to provide an assessment of the feasibility and advisability of creating a new part of the suicide prevention program in the Office of Mental Health and Suicide Prevention to oversee and monitor suicide prevention coordinators and suicide prevention case managers across all health care systems.

Hannon Act Section Spotlight

Section 702: Partnerships with Non-federal Government Entities to Provide Hyperbaric Oxygen Therapy (HBOT) to Veterans and Studies on the Use of Such Therapy for Treatment of Post-traumatic Stress Disorder and Traumatic Brain Injury.

- The Hannon Act states that VA, may enter into partnerships with non-Federal Government entities to provide HBOT to Veterans to research effectiveness of such therapy.
- This section also requires that VA commence the conduct of a follow-up study on all individuals receiving HBOT through the current pilot program of the Department for the provision of HBOT to veterans to determine the efficacy and effectiveness of HBOT for the treatment of post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI).
- VA is working to develop an alternative approach proposal to comply with statute requirements and yield outcomes that determine whether HBOT should be made available to all Veterans with PTSD and TBI.

Hannon Act Completed Sections

Section 104: Report on Care for Former Members of the Armed Forces with Other Than Honorable Discharge

Notice of Completion

Section Summary

This section requires VA to provide an annual report on the mental and behavioral health care services, with respect to the year preceding the report, the number of eligible individuals who were furnished mental and behavioral health care services, disaggregated by the number of men who received such services; the number of women who received such services; and the number of individuals who requested an initial mental health assessment.

Work Completed/Current Status

- On February 3, 2021, VA submitted to Congress the annual report on Care for Former Members of the Armed Forces with Other Than Honorable Discharge with the additions of branch of service, service area, and location of service included in the report.
- VA committed $2.8M to establish a contract for design and implementation of critical improvements in the EHR to include information on the provision of care for OTH Service members.

Section 306: Statistical Analyses and Data Evaluation by Department of Veterans Affairs

Notice of Completion

Section Summary

This section allows VA to enter into a contract or other agreement with academic institutions or other qualified entities, as determined by the Secretary, to carry out statistical analyses and data evaluation as required of the Secretary by law.

Work Completed/Current Status

- Section 306 does not require any specific action on the part of VA.
- VA appreciates Congress providing this option and will utilize it as needed.

Section 601: Expansion of Capabilities of Women Veterans Call Center to include Text Messaging

Notice of Completion

Section Summary

This section requires that the Secretary of Veterans Affairs expand the capabilities of the Women Veterans Call Center (WVCC) of the Department of Veterans Affairs to include a text messaging capability.

Work Completed/Current Status

- On April 13, 2019, VA expanded WVCC offerings to include real-time text messaging services that enable women Veterans to text and anonymously chat with a WVCC representative.
- WVCC connects women Veterans with trained staff who can answer questions about benefits, eligibility, and services.

Ongoing Congressional Briefings

- VA will continue to provide updates as determined by the interest of the Committees.

- Ongoing briefings will be conducted in coordination with VHA program office-specific briefings.

Hannon Act Special Provision Briefing

Bottom Line Up Front

- **Background:** Signed into law on October 17, 2020, P.L. 116-171 Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) will provide critical mental health care resources to Veteran populations throughout the Department of Veterans Affairs (VA).
- **Purpose of Briefing:** To brief Congress on only the most challenging Hannon Act provisions to implement; a Hannon Act Implementation Kick-Off briefing on progress on the entire Hannon Act will be provided separately.

Hannon Act Highlights

- The Hannon Act will enhance existing VA mental health services and build upon national suicide prevention strategies.
- The Hannon Act aligns with VA's top clinical priority in suicide prevention.
- The Act's focus on evaluation of mental health and suicide prevention resources and treatment protocols will advance VA efforts in promoting mental health and well-being for Veterans.
- VA is well situated to implement the Hannon Act and has assigned each section of the law to VHA workstream leads to oversee fulfillment of requirements.

Sections of Hannon Act with Special Challenges

- The sections below have special challenges in implementation and are described in more detail in the following slides:

Category	Sections
Timeline Issue (3)	203 - Pilot Program to Provide Veterans Access to Complementary and Integrative Health Programs through Animal Therapy, Agritherapy, Sports and Recreation Therapy, Art Therapy, and Posttraumatic Growth Programs
	502 - Establishment of VA Readjustment Counseling Service Scholarship Program
	703 - Prescription of Technical Qualifications for Licensed Hearing Aid Specialists and Requirement for Appointment of Such Specialists
Alternative Approach Proposals (5)	204 – VA Study of All-Cause Mortality of Veterans, Including by Suicide, and Review of Staffing Levels of Mental Health Professionals
	301 - Study on Connection between Living at High Altitude and Suicide Risk Factors among Veterans
	505 - Briefing on Alternative Work Schedules for Employees of VHA
	702 - Partnerships with Non-Federal Government Entities to Provide Hyperbaric Oxygen Therapy to Veterans and Studies on the use of Such Therapy for Treatment of Post-Traumatic Stress Disorder and Traumatic Brain Injury
	704 - Use by VA of Commercial Institutional Review Boards in Sponsored Research Trials

Section 203: Pilot Program to Provide Veterans Access to Complementary and Integrative Health Programs through Animal Therapy, Agritherapy, Sports and Recreation Therapy, Art Therapy, and Posttraumatic Growth Programs

Timeline Issue

Bottom Line Up Front

Summary of Section 203

- This section requires VA to conduct a three-year pilot program to provide complementary and integrative health programs described in this legislation. This pilot is to commence not later than 180 days after the Creating Options for Veterans' Expedited Recovery (COVER) Commission submits its final report.

VA's Recommendation

- VA advises the committee on the difficulty in meeting the date in section 203(a) for commencing the pilot program. VA recommends a new date of December 31, 2021.

Situation and Constraints

- Commencement of a pilot program was required by July 24, 2020 (NLT 180 days from submission of the COVER Commission final report).
- Commencement of a pilot program has been impacted by the COVID-19 pandemic and the ability of VAMCs to provide access to programs described in this legislation.

Analysis (Why Change is Needed)

- The COVER Commission final report was submitted in January 2020, therefore the parameter to commence the conduct of a pilot program no later than 180 days after submission of the final report preceded the date of enactment of P.L. 116-171.
- Modifications in treatment practices due to COVID is impeding the ability of VA facilities to offer the in-person services necessary for the pilot.

Section 502: Establishment of Department of Veterans Affairs Readjustment Counseling Service Scholarship Program

Timeline Issue and Suggestion for Modification

Bottom Line Up Front

Summary of Section 502

- This section requires VA is to carry out Readjustment Counseling Service (RCS) Scholarship Program under the Educational Assistance Program. The legislation requires awarding of scholarships within one year of enactment (October 17, 2021).
- This section also requires that VA amend report submitted for 38 USC 1706 section 6632 to include scholarship data.

VA's Recommendation

- Request 1: Given regulatory development and mandatory review needs for the scholarship program, the Committee may want to consider a change to the statutory deadline. VA recommends an award date of April 30, 2023 for the RCS scholarships.
- Request 2: VA recommends a technical correction to include outcome reporting of the scholarship program into the existing RCS annual report required by title 38 USC 7309.

Situation and Constraints

- Implementation of this new scholarship program requires regulation development, to include drafting, concurrence, OMB review and public comment. Coordination of the process is required across VA and non-VA entities.
- The report identified for incorporating RCS scholarship data was terminated in 2000.

Analysis (Why Change is Needed)

- Given the mandatory review steps and public comment periods that are part of the regulatory process, rulemaking will not be completed in time to begin the award of scholarships by the required date of October 17, 2021.
- VA will not be able to provide scholarship outcome data because the report referenced no longer exists.

Section 703: Prescription of Technical Qualifications for Licensed Hearing Aid Specialists and Requirement for Appointment of Such Specialists

Timeline Issue

Bottom Line Up Front

Summary of Section 703

- This section requires VA to prescribe technical qualifications for the Department's licensed hearing aid specialists no later than 180 days after enactment (April 15, 2021).

VA's Recommendation

- VA advises the committee on the difficulty in meeting the date in the statute to prescribe technical qualifications for VA licensed hearing aid specialists. VA recommends adjusting the date to December 31, 2021. VA is still analyzing other requirements in section 703 that may merit discussion at a later time.

Situation and Constraints

- There is a lack of consistent educational requirements and standardized clinical training. Additional time is needed to establish technical qualifications for the Department's licensed hearing aid specialists.

Analysis (Why Change is Needed)

- The process for establishing qualification requirements ordinarily requires one year at a minimum for professions with national standardized requirements for education, training and certification. It is unlikely VA will be able to prescribe the technical qualifications by April 15, 2021.

Section 204: Department of Veterans Affairs Study of All-cause Mortality Of Veterans, including by Suicide, and Review of Staffing Levels of Mental Health Professionals

Alternative Approach Proposal

Bottom Line Up Front

Summary of Section 204

- This section requires VA seek to enter into an agreement with the National Academies of Sciences, Engineering, and Medicine (NASEM) to study effects of opioids and benzodiazepine on all-cause mortality of Veterans, including suicide, regardless of whether information has been reported by Centers for Disease Control and Prevention.

VA's Recommendation

- VA recommends using its own ongoing research and research capacity to address the study requirements of this section.

Situation and Constraints

- VA determined that the previously contracted NASEM study protocol was not feasible to be implemented. Subsequently, VA funded a supplement to an ongoing study of all-cause mortality among opioid and benzodiazepine recipients, which meets the intent of this section.

Analysis (Why Change is Needed)

- The VA has conducted research to understand the high-risk prescribing practices of our past, and our current studies focus on finding solutions that will help Veterans now and in the future. Starting a new study would be duplicative of existing VA studies.

Section 301: Study on Connection between Living at High Altitude and Suicide Risk Factors among Veterans

Alternative Approach Proposal

Bottom Line Up Front

Summary of Section 301

- This section requires VA to conduct a study on the connection between living at high altitude and the risk of developing depression or dying by suicide among Veterans no later than 180 days after the date of enactment (April 15, 2021).

VA's Recommendation

- VA recommends leveraging existing literature and Veteran data sources to verify the association between high altitude and suicidality and depression, while meeting the requirement for not just providing results at a geographic level.

Situation and Constraints

- There are several existing studies from VA, Department of Energy, other Federal agencies and academia that will allow for this assessment.
- The initiation of a new study specifically examining the relationship between high altitude and suicidality and depression at the individual level will be time intensive and costly.

Analysis (Why Change is Needed)

- VA has identified strategies and approaches to understand the association between high altitude, suicidality, and depression at the individual level without the initiation of a new study.

Section 505: Briefing on Alternative Work Schedules for Employees of Veterans Health Administration

Alternative Approach Proposal

Bottom Line Up Front

Summary of Section 505

- This section states that VA must conduct a survey of the attitudes of eligible Veterans toward VA offering appointments outside the usual operating hours of VA facilities. It also states VA is to study feasibility and advisability of offering appointments outside usual operating hours.

VA's Recommendation

- VA recommends using existing and ongoing survey data to complete this requirement.

Situation and Constraints

- VHA's Outpatient Clinic Management Directive mandates extended hours appointment access for Veterans across the enterprise.
- VA already surveys Veterans as mandated by §505(a)(1) on an ongoing basis, collecting data from more than 150,000 eligible Veterans per month (or over 1.8 million eligible Veterans per year).

Analysis (Why Change is Needed)

- Section 505(a)(1) mandate to conduct a survey of eligible Veterans not later than 180 days of the statute's enactment (April 15, 2021) is a duplication of effort.
- Substantial data regarding Veterans' attitudes toward after-hours appointments, both traditional and telehealth-based, already exists within current Veteran survey mechanisms.

Section 702: Partnerships with Non-federal Government Entities to Provide Hyperbaric Oxygen Therapy to Veterans and Studies on the Use of Such Therapy for Treatment of Post-traumatic Stress Disorder and Traumatic Brain Injury

Alternative Approach Proposal

Bottom Line Up Front

Summary of Section 702

- This section requires that VA commence the conduct of a of a follow-up study on all individuals receiving hyperbaric oxygen therapy through the current pilot program of the Department for the provision of hyperbaric oxygen therapy to veterans to determine the efficacy and effectiveness of hyperbaric oxygen therapy for the treatment of post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) (§702d).

VA's Recommendation

- VA recommends deleting or modifying the language in section 702 subsection (d) due to significant design and ethical concerns. We believe fulfillment of other parts of the bill will yield useful information.

Situation and Constraints

- Since 2017, the Center for Compassionate Innovation (CCI) has supported a clinical (non-research) program evaluation on the feasibility of referring Veterans diagnosed with PTSD (with or without a history of mild TBI) for Hyperbaric Oxygen Treatment (HBOT) treatment provided by Department of Defense facilities or clinics in the community outside of the VHA system.

Analysis (Why Change is Needed)

- The follow-up research study described in §702(d) would build upon the HBOT for PTSD clinical program evaluation. Commencing research activities with Veterans who have signed up for the HBOT for PTSD clinical program evaluation, which is not a research study, would have an unethical impact on both Veterans and VA staff involved.

Section 704: Use by Department of Veterans Affairs of Commercial Institutional Review Boards in Sponsored Research Trials

Alternative Approach Proposal with Suggestion for Modification

Bottom Line Up Front

Summary of Section 704

- This section requires VA to amend VHA Directive 1200.05 titled "Requirements for the Protection of Human Subjects in Research" and allow VA sponsored clinical research trials to use accredited commercial IRBs to review VA research proposal protocols.

VA's Recommendation

- VA requests clarification of this section and recommends either deleting the word "accredited" or substituting the word "designated" for accredited in Section 704(a).
- Confirmation by Congress that VA's process for identifying commercial IRBs is consistent with Congress' intent.
- The scope of required reporting should be specific to FDA regulated clinical trials approved by commercial IRBs and federal agency IRBs

Situation and Constraints

- §704(a) requires VA to create policy permitting use of accredited commercial IRBs. Utilization of accredited commercial IRBs is not a VA standard.
- §704 (b)(1) requires VA to identify accredited commercial IRBs. It is unclear if VA is required to identify all commercial IRBs in the US that could potentially be utilized by VA.
- §704(c)(1) requires VA to produce reports on all approvals of IRBs used by VA. VA does not have a centralized method to collect all IRB approvals.

Analysis (Why Change is Needed)

- If modifications and clarifications are not obtained, VA cannot comply with Section 704 as currently written without additional policy revisions and creation of processes that would create undue burden upon the Agency.