MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2018

THURSDAY, APRIL 27, 2017

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:33 a.m. in room SD–124, Dirksen Senate Office Building, Hon. Jerry Moran (chairman) presiding.

Present: Senators Moran, Murkowski, Hoeven, Collins, Boozman, Capito, Rubio, Schatz, Tester, Murray, Udall, Baldwin and Murphy.

VETERANS HEALTH ADMINISTRATION

STATEMENT OF DR. CAROLYN M. CLANCY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE

ACCOMPANIED BY:

DR. HAROLD S. KUDLER, M.D., CHIEF CONSULTANT FOR MENTAL HEALTH SERVICES

STEPHANIE A. DAVIS, PH.D., SUICIDE PREVENTION COORDINATOR AND STAFF PSYCHOLOGIST, VA EASTERN KANSAS HEALTH CARE SYSTEM

OPENING STATEMENT OF SENATOR JERRY MORAN

Senator MORAN. Good morning, everyone. Welcome to my colleagues. And I think there will be more coming. As usual, we have more than one hearing occurring at the same time. And we're delighted to have our panelists join us. And we look forward to your testimony and our opportunity to ask you questions.

This is our second subcommittee hearing in 2017. We were most recently at the Arlington National Cemetery, in which we looked at issues related to that aspect of this subcommittee's jurisdiction. But we take our responsibility very seriously when it comes to appropriations in involving the VA. And unfortunately we have a very serious and challenging difficult topic of conversation today. And I do think it's appropriate that this subcommittee's first hearing here in this building dealing with the Department of Veterans Affairs is related to something that has to be a priority for each and every one of us. The latest data suggests that 20 veterans a day take their own lives, and there is no one who would disagree that that number should be zero.

We have a large panel, but each of the folks who are going to testify today and who we will have a conversation with have a lot of expertise in how to deal with veterans in crisis.

Today, we'll discuss the impact of the Department's efforts to combat veteran suicide as well as how community-based organizations and cutting edge research are leading and supporting initiatives to eliminate that suicide.

I do want to note that while headlines have often brought attention to the deficiencies of the VA's management of certain programs, the news does not tell the stories of the lives saved. And this hearing is also about bringing awareness not only to the issues that still need work, but also to share the successes that are occurring every day by mental health professionals across the VA who are saving lives of veterans. Thank you for your commitment to those of you who work at the Department of Veterans Affairs to see that we have even greater success.

The subcommittee has responded with increased funding for veteran suicide prevention programs, the Veteran Crisis Line, and mental health care. There have been increases in funding each year, yet since 2001, the rate of veterans using VA health care who were diagnosed with a mental health or substance abuse disorder rose substantially from 27 percent to more than 40 percent, and we've seen veteran suicides, the rate, remain pretty constant.

I want to hear today from the Department on the plan to address that disconnect. If it's not an increase in funding, then what is required? I do not see a connection between increased funding and better outcomes. And I hope the community witnesses will speak to that disconnect, provide their perspective on resources, and share where they see the greatest need or opportunity for better investment to prevent suicide among our veterans.

What should we be doing differently? What are we not doing that should be done? Where appropriate, are there complementary and alternative treatments that should be embraced? How are job training and education incorporated in the treatment plan for veterans? What about family support: marriage and family counseling, caregiver support, providing mechanisms for connecting families caring for veterans in need?

We know especially in rural parts of our country, access to mental health care can be extraordinarily difficult. We need to make certain that no veteran feels abandoned by the country they served when they make the brave decision to seek mental health care services. I hope to hear today that the Department has a plan for increasing access to this crucial type of care in places that need it the most.

Congress needs to know better how to support the Department. The Department needs to seek community partners and embrace the helpful findings of outside experts, and veteran-supporting groups need to be vocal about the needs of those in crisis and their families. I hope this hearing helps bring us together to end veteran suicide.

I would like to introduce the panel.

Dr. Carolyn Clancy, M.D., is the Deputy Under Secretary for Health for Organizational Excellence at the Veterans Health Ad-

ministration. She is accompanied by Dr. Harold Kudler, M.D., Chief Consultant for Mental Health Services.

Dr. Stephanie Davis is a Suicide Prevention Coordinator and Staff Psychologist from the VA Eastern Kansas Health Care System.

Ms. Melissa Jarboe is the Chief Executive Officer and Founder of the Military Veteran Project located in Topeka, Kansas, but with a worldwide presence. Melissa is a Gold Star Wife who has dedicated her life to support veterans and soldiers, a promise that she made to her late husband, Staff Sergeant Jamie Jarboe.

The Honorable Michael Missal is the Inspector General at the Department of Veterans Affairs. And we welcome you and your debut appearance to this subcommittee, one that I expect will be repeated more than once.

And Dr. Rajeev Ramchand is the Senior Behavioral Scientist at RAND Corporation who is an expert on the prevalence, prevention, and treatment of mental health in service members.

Thank you very much, Doctor, for joining us.

[The statement follows:]

PREPARED STATEMENT OF SENATOR JERRY MORAN

Welcome to our second subcommittee hearing of 2017. The Subcommittee will come to order. Good morning. Thank you all for being here today to consider the important and tragic topic of veteran suicide. The latest data available suggests 20 veterans a day take their own life, and we all agree that even one is too many.

Today we have a large panel—but each member brings valuable expertise on how to help veterans in crisis. Today we will discuss the impact of the Department's efforts to combat veteran suicide as well as how community-based organizations and cutting-edge research are leading and supporting initiatives to eliminate veteran suicide. I do want to note that while headlines have brought attention to deficiencies in the VA's management of certain programs, the news does not tell the stories of lives that are saved. This hearing is about bringing awareness not only to the issues that may need work, but also to share the success that is occurring every day by mental health professionals across the VA who are saving the lives of veterans.

This subcommittee has responded with increases in funding for veteran suicide prevention programs, the Veterans Crisis Line, and mental healthcare. There have been increases in funding each year. Yet, since 2001, the rate of veterans using VA healthcare who were diagnosed with a mental health or substance abuse disorder rose "substantially" from 27 percent to more than 40 percent; and we have seen veteran suicide rates remain steady. I want to hear today from the Department on the plan to address this disconnect—if not an increase in funding then what? I do not see a connection between increased funding and better outcomes. I hope our community witnesses will speak to that disconnect, provide their perspective on resources, and share where they see the greatest need or opportunity for better investments to prevent suicide among our veterans.

What should we be doing differently; what are we not doing that should be done? Where appropriate, are there complementary and alternative treatments that should be embraced? How are job training and education incorporated into a treatment plan for veterans? What about family support—marriage and family counseling, caregiver support, providing mechanisms for connecting families caring for veterans in need?

We know, especially in our rural areas, access to mental healthcare can be extraordinarily difficult. We need to make certain no veteran feels abandoned by the country they served when they make the brave decision to seek mental healthcare services. I hope to hear today that the Department has a plan for increasing access to this crucial type of care in the places that need it the most.

Congress needs to know better how to support the Department, the Department needs to seek community partners and embrace the helpful findings of outside experts, and veteran-supporting groups need to be vocal about the needs of in-crisis veterans and their families. I hope this hearing helps bring us together to end veteran suicide.

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The Honorable Michael Missal is the Inspector General at the Department of Veterans Affairs; and,

Mr. Rajeev Ramchand is a Senior Behavioral Scientist at the RAND Corporation who is an expert on the prevalence, prevention, and treatment of mental health in service members.

Senator MORAN. We welcome all of you.

I now recognize my colleague, the Senator from Hawaii, Dr. Schatz. Dr. Schatz—Senator Schatz.

OPENING STATEMENT OF SENATOR BRIAN SCHATZ

Senator SCHATZ. That's my father. Thank you, Mr. Chairman, for holding this hearing to shine a light on a life-or-death matter for many Americans, veterans who are struggling with painful and sometimes overwhelming mental health problems related to the unique challenges of military service, particularly during wartime.

I want to welcome our witnesses, and I look forward to your testimony.

Mr. Chairman, I commend you for assembling an impressive lineup of witnesses, and I'm glad to see you've reached out to witnesses from your home state of Kansas who are on the front lines in dealing with veteran suicide prevention at the local level and can give us their unique perspective.

I have a longer statement, which I will insert into the record, but I am particularly interested in what we're doing about stigma. I'm particularly interested in the transition from being an active service member to veteran status. I think that there is still work to do in articulating the transition, talking to individual veterans, both in the active duty and guard context, it's not at all clear that we're doing everything that we can to open that aperture for people in that moment to avail themselves of mental health services.

And I'll just note that it was around 2005, I was the executive director of a nonprofit that provided mental health services, and my head psychologist came to testify before the Veterans Committee, Chairman Daniel Akaka, and we talked a lot about what peers could do for peers in that context. So I'm particularly interested in whether there is any innovative thinking around peer counseling and peer support to make sure that people understand that they are entitled to and should seek mental health assistance before things accelerate and get worse.

So with that, Mr. Chairman, I look forward to the testimony.

[The statement follows:]

PREPARED STATEMENT OF SENATOR BRIAN SCHATZ

Thank you, Mr. Chairman. I appreciate your holding this hearing to shine a light on an issue that is truly a life-or-death matter to thousands of America's veterans who are struggling with painful, and sometimes overwhelming, mental health problems related to the unique challenges of military service, particularly during wartime.

I would like to welcome our witnesses today, and I look forward to their testimony. Mr. Chairman, I commend you for assembling an impressive lineup of witnesses, and I am glad to see that you have reached out to witnesses from your home State of Kansas, who are on the front lines in dealing with veteran suicide prevention at the local level and can give us their unique perspective.

Make no mistake about it, veteran suicide prevention is an all-hands-on-deck imperative. According to the VA approximately 20 veterans commit suicide every day. Tragically, of those 20 veterans, only six are getting care in the VA healthcare system. In other words, more than two-thirds of veterans who commit suicide on a given day have either never tried, or tried and failed, to receive help from the VA.

This, I believe, is the crux of the problem. Veterans not only face unique risks of developing mental health issues, but they also face unique barriers to accessing treatment within the VA.

Perceived stigma associated with seeking mental health treatment is particularly acute among veterans transitioning from a military culture that emphasizes individual toughness and aggressiveness. As a result, veterans are more likely to be deterred by pride, shame or embarrassment from seeking help.

Simple logistical problems ranging from long travel distances to a shortage of clinicians in some areas, particularly rural and remote areas, can make it challenging to access treatment. Lack of understanding or awareness of mental health problems and VA treatment options are additional barriers. Unfortunately, studies have shown that as a result of these barriers, many veterans turn instead to self-medication with drugs or alcohol, exacerbating their mental health problems and heightening their risk for suicide.

This calculus must change. I was heartened to see that Secretary Shulkin has said that veteran suicide prevention is his number one clinical priority. This is a laudable goal, but we now need to see the details. I hope that his plan starts with a veteran-centered approach to provide outreach at every possible opportunity, starting at the point of transition from the military and extending to routine VA healthcare visits, aggressive awareness campaigns, street-level contact with homeless veterans—whatever it takes to reach veterans before they reach a point of crisis. Identifying and reaching out to at-risk veterans to alleviate any barriers to access to care must be the first line of defense against veteran suicide.

Mr. Chairman, I again thank you for holding this important hearing, and I look forward to hearing from our witnesses.

Senator MORAN. Thank you. Dr. Schatz would be proud of Senator Schatz.

We now turn our attention to Dr. Clancy for her 5-minute opening statement.

Doctor, thank you.

SUMMARY STATEMENT OF DR. CAROLYN M. CLANCY

Dr. CLANCY. Good morning, Chairman Moran, Ranking Member Schatz, and distinguished members of the subcommittee. Thank you for the opportunity to discuss the important topic of suicide prevention among our nation's veterans. I am joined today by Dr. Harold Kudler, Chief Consultant for Mental Health Services for VHA, and Dr. Stephanie Davis, Suicide Prevention Coordinator for the VA Eastern Kansas Health Care System.

Our conversation and focus today happens at a time when suicide rates are up for all Americans, particularly in rural areas. This affects veterans more acutely, as shown by the recent research finding that 20 veterans die by suicide each day.

We are committed to ensuring the safety of our veterans especially when they're in crisis. Losing one veteran to suicide shatters their family, their loved ones, and caregivers. Veterans who are at risk or reach out for help must receive assistance when and where they need it in terms they value.

Our commitment is to prevent suicide among the veterans we serve directly and to reach all veterans through partnership and

collaboration. To that end, I serve as co-chair of the National Action Alliance for Suicide Prevention, a public-private partnership with organizations across the Nation.

Suicide prevention begins with tracking and managing suicide's possible precursors, whether that's mental health conditions, chronic pain, economic problems, or family issues. We can help veterans navigate these, but only when we reach them. The fact that 14 of the 20 veterans who die by suicide on average each day do not currently receive care within VA indicates that we at VA need to do more to engage them or connect them with partners who can assist. For those veterans who are receiving VA care, we have developed the largest integrated suicide prevention program in the country.

Senator, when you spoke about the lives saved that sometimes don't warrant press coverage, that's Dr. Davis's job, and she has many fine, fine colleagues across the country. Screening and assessment processes have been distributed throughout our system to assist in identifying those at risk. Patients who have been identified as high risk receive enhanced care, including follow-ups of missed appointments, safety planning, weekly follow-up visits, and care plans that directly address their suicidality.

Reporting and tracking systems have been established in order to learn more about veterans who may be at risk, to prioritize our areas for intervention. We also have two centers devoted to research, education, and clinical practice in suicide prevention. The centers focus on developing and testing clinical and public health intervention strategies as well as identifying clinical conditions and neurobiological factors that lead to increased risk of suicide, the implementation of interventions aimed at decreasing negative outcomes, and training future leaders in the area of VA suicide prevention.

At VA, we believe that suicide prevention is everyone's business. To eliminate veteran suicides, all providers must be engaged. VA's basic strategy for suicide prevention requires ready access to high-quality mental health services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high-risk patients.

To address all possible approaches to reduce veteran suicide, we've initiated a program called REACH VET (VET Initiative Helps Saves Veterans Lives), which proactively identifies veterans at the highest predicted risk of suicide. Using a new statistical model derived from health records data, veterans receive enhanced outreach and services to potentially prevent further distress or crises. We also provide crisis assistance through the Veterans Crisis Line, and in the past 6 months, we have nearly doubled the capacity to ensure appropriate access to veterans.

Since January of this year, we at VA have answered over 99 percent of calls received on a daily basis by the two VA call centers, thereby expediting access to services and assistance.

We need to find a way to provide care and assistance to all veterans, not just those receiving care within VA. Therefore, VA intends to expand access to emergent mental health care for former service members with other-than-honorable, or OTH, administrative discharges. This initiative specifically focuses on expanding ac-

cess to assist former service members with OTH discharge who are in mental health distress and may be at risk for suicide or other adverse behaviors. It's estimated there are just over 500,000 former service members in this group. These service members may come to VA seeking mental health care in emergency circumstances, and a VA provider will evaluate and treat the patient for their mental health condition for a period of up to 90 days.

Mr. Chairman, all of us at VA are devastated by the crisis of suicide among our veterans. Our work to effectively treat veterans who desire or need mental health care continues to be our top clinical priority. We emphasize that we remain committed to preventing veteran suicide, and we are aware that prevention requires our system-wide support and intervention in addressing those precursors or risk factors for suicide. We appreciate your support and look forward to responding to any questions you have.

[The statement follows:]

PREPARED STATEMENT OF DR. CAROLYN CLANCY

Good morning Chairman Moran, Ranking Member Schatz, and distinguished members of the Subcommittee. Thank you for the opportunity to discuss the important topic of suicide prevention among our Nation's Veterans. I am joined today by Dr. Harold Kudler, Chief Consultant for Mental Health Services for the Veterans Health Administration (VHA) and Dr. Stephanie Davis, Suicide Prevention Coordinator for the VA Eastern Kansas Health Care System.

Recent research suggests that 20 Veterans die by suicide each day, putting Veterans at even greater risk than the general public. VA is committed to ensuring the safety of our Veterans, especially when they are in crisis. Losing one Veteran to suicide shatters their family, loved ones and caregivers. Veterans who are at risk or reach out for help must receive assistance when and where they need it in terms that they value. Our commitment is to do everything possible to prevent suicide among the Veterans we serve and to reach all Veterans through partnerships and collaboration.

SUICIDE PREVENTION OVERVIEW

VA has developed the largest integrated suicide prevention program in the country. We have over 1,100 dedicated and passionate employees, including Suicide Prevention Coordinators, Mental Health providers, Veterans Crisis Line staff, epidemiologists, and researchers, who spend each and every day solely working on suicide prevention efforts and care for our Veterans. Screening and assessment processes have been set up throughout the system to assist in the identification of patients at risk for suicide. VA also developed a chart "flagging" system to ensure continuity of care and provide awareness among providers. Patients who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, weekly follow-up visits, and care plans that directly address their suicidality.

Reporting and tracking systems have been established in order to learn more about Veterans who may be at risk and help determine areas for intervention. We also have two centers devoted to research, education, and clinical practice in the area of suicide prevention. VA's Veterans Integrated Service Network (VISN) 2 Center of Excellence in Canandaigua, New York, develops and tests clinical and public health intervention strategies for suicide prevention. VA's VISN 19 Mental Illness Research Education and Clinical Center (MIRECC) in Denver, Colorado, focuses on: (1) clinical conditions and neurobiological underpinnings that can lead to increased suicide risk; (2) the implementation of interventions aimed at decreasing negative outcomes; and (3) training future leaders in the area of VA suicide prevention.

CURRENT INITIATIVES

Every Veteran suicide is a tragic outcome and regardless of the numbers or rates, one Veteran suicide is too many. We continue to spread the word throughout VA that "Suicide Prevention is Everyone's Business." The ultimate goal is to proactively eliminate suicide among Veterans via: strategic community partnerships, identification of risk, training, treatment engagement, effective treatment, lethal means edu-

cation, research, and data science. Although we understand why some Veterans may be at increased risk, we continue to investigate and take proactive steps. The ultimate goal is eliminating suicide among Veterans. VA's basic strategy for suicide prevention requires ready access to high quality mental health services supplemented by programs designed to help individuals and families engage in care, and to address suicide prevention in high-risk patients.

REACH VET

Suicide prevention is VA's highest clinical priority. As part of VA's commitment to put resources, services, and all technology available to reduce Veteran suicide, Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET) was initiated. This new program was launched by VA in November 2016 and was fully implemented in February 2017. REACH VET uses a new predictive model in order to analyze existing data from Veterans' health records to identify those who are at a statistically-elevated risk for suicide, hospitalization, illnesses, and other adverse outcomes. Not all Veterans who are identified have experienced suicidal ideation or behavior. However, REACH VET allows VA to provide support and pre-emptive enhanced care in order to lessen the likelihood that challenges Veterans face will become a crisis.

The VA REACH VET team and Army Study to Assess Risk and Reslience in Servicemembers (Army STARRS) teams have worked closely together, as both groups have developed predictive analytics capabilities. Because modeling risk is highly dependent on the available data, the approaches of both groups differ.

DoD and VA have integrated a public health approach to suicide prevention, intervention, and postvention using a range of medical and non-medical resources through:

—Data and Surveillance
—Messaging and Outreach
—Evidence-based Practices
—Workforce Development
—Federal and Non-government Organization Engagements

Once a Veteran is identified, his or her mental health or primary care provider will review their treatment plan and current condition(s) to determine if any enhanced care options are indicated. The provider will then reach out to Veterans to check on their well-being and inform them that they have been identified as a patient who may benefit from enhanced care. This allows the Veteran to participate in a collaborative discussion about their healthcare, including specific clinical interventions to help reduce suicidal risk.

Veterans Crisis Line

Since 2007, VCL has answered over 2.8 million calls and dispatched emergency services to callers in crisis over 75,000 times. The VCL implemented a series of initiatives to provide the best customer service for every caller, making notable advances to improve access and the quality of crisis care available to our Veterans, such as:

—Launching "Veterans Chat" in 2009, an online, one-to-one chat service for Veterans who prefer reaching out for assistance using the Internet. Since its inception, we have answered more than 336,000 requests for chat.
—Expanding modalities to our Veteran population by adding text services in November 2011, resulting in nearly 69,000 requests for text services.
—Opening a second VCL site in Atlanta in October 2016, with over 200 crisis responders and support staff.
—Implementing a comprehensive workforce management system and optimizing staffing patterns to provide callers with immediate service and achieve zero percent routine rollover to contracted back-up centers.

VCL is the strongest it has ever been since its inception in 2007. VCL staff has forwarded over 463,000 referrals to local Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with their local VA providers. Initially housed in 2007 at the Canandaigua VA Medical Center in New York, it began with 14 responders and 2 healthcare technicians answering four phone lines. In the past 6 months, VCL has nearly doubled the capacity to ensure appropriate access to Veterans. Today, the facilities in Canandaigua and Atlanta employ more than 500 professionals, and VA is hiring more to handle the growing volume of calls. Atlanta offers 200 call responders and 25 social service assistants and support staff, while Canandaigua houses 310 and 43, respectively. Despite all this, there still is more that we can do.

Prior to opening the Atlanta VCL call center in October 2016, VCL saw in excess of 3,000 calls per week roll over to back-up call centers. From January 8–14, 2017, we rolled over only 58 phone calls. Since then, we continue to keep rollover calls well below 1 percent. This means that on average, we answer over 99 percent of calls received on a daily basis by the Canandaigua and Atlanta call centers.

The No Veterans Crisis Line Call Should Go Unanswered Act (Public Law 114–247) directed VA to develop a quality assurance document to use in carrying out VCL. It also required VA to develop a plan to ensure that each telephone call, text message, and other communication to VCL, including at a backup call center, is answered in a timely manner by a trained crisis hotline responder. This is consistent with the guidance established by the American Association of Suicidology. In addition to adhering to the requirements of the law, VCL has enhanced the workforce with qualified responders to eliminate routine rollover of calls to the contracted backup center. We also implemented a quality management system, to monitor the effectiveness of the services provided by VCL. This also will enable us to identify opportunities for continued improvement. As required by law, VA will submit a report containing this document and the required plan to the House and Senate Veterans' Affairs Committees by May 27, 2017.

Other Than Honorable Discharges

We know that 14 of the 20 Veterans who commit suicide on average each day do not receive care within VA. We need to find a way to provide care or assistance to all of these individuals. Therefore, VA intends to expand access to emergent mental healthcare for former Servicemembers with other than honorable (OTH) administrative discharges. This initiative specifically focuses on expanding access to assist former Servicemembers with OTH administrative discharges who are in mental health distress and may be at risk for suicide or other adverse behaviors. It is estimated that there are a little more than 500,000 former Servicemembers with OTH administrative discharges. As part of the initiative, former Servicemembers with OTH administrative discharges who present to VA seeking mental healthcare in emergency circumstances for a condition the former Servicemember asserts is related to military service would be eligible for evaluation and treatment for their mental health condition.

VA has authority to furnish care for service-connected conditions for former Servicemembers with OTH administrative discharges if those individuals are not legally barred from benefits. Such individuals may access the system for emergency mental health services by calling the Veteran Crisis Line, or visiting a VA Emergency Room, Outpatient Clinic, or Vet Center. Services may include: assessment, medication management/pharmacotherapy, lab work, case management, psycho-education, and psychotherapy. We may also provide services via telehealth.

EXPANDING MENTAL HEALTH SERVICES

While focusing on suicide prevention, we know that preventing suicide for the population we serve does not begin with an intervention as someone is about to take an action that could end his or her life. Just as we work to prevent fatal heart attacks, we must similarly focus on prevention, which includes addressing many factors that contribute to someone feeling suicidal. We are aware that access to mental healthcare is one significant part of preventing suicide. VA is determined to address systemic problems with access to care in general and to mental healthcare in particular. VA has recommitted to a culture that puts the Veteran first. To serve the growing number of Veterans seeking mental healthcare, VA has deployed significant resources and increased staff in mental health services. Between 2005 and 2016, the number of Veterans who received mental healthcare from VA grew by more than 80 percent. This rate of increase is more than three times that seen in the overall number of VA users. This reflects VA's concerted efforts to engage Veterans who are new to our system and stimulate better access to mental health services for Veterans within our system. In addition, this reflects VA's efforts to eliminate barriers to receiving mental healthcare, including reducing the stigma associated with receiving mental healthcare.

Making it easier for Veterans to receive care from mental health providers also has allowed more Veterans to receive care. VA is leveraging telemental healthcare by establishing four regional telemental health hubs across the VA healthcare system. VA telemental health innovations provided more than 427,000 encounters to over 133,500 Veterans in 2016. Telemental health reaches Veterans where and when they are best served. VA is a leader across the United States and internationally in these efforts. VA's MaketheConnection.net, Suicide Prevention campaigns, and the Posttraumatic Stress Disorder (PTSD) mobile app (which has been downloaded over 280,000 times) contribute to increasing mental health access and

utilization. VA has also created a suite of award-winning tools that can be utilized as self-help resources or as an adjunct to active mental health services.

Additionally, in 2007, VA began national implementation of integrated mental health services in primary care clinics. Primary Care-Mental Health Integration (PC-MHI) services include co-located collaborative functions and evidence-based care management, as well as a telephone-based modality of care. By co-locating mental health providers within primary care clinics, VA is able to introduce Veterans on the same day to their primary care team and a mental health provider in the clinic, thereby reducing wait times and no show rates for mental health services. Additionally, integration of mental health providers within primary care has been shown to improve the identification of mental health disorders and increase the rates of treatment. Several studies of the program have also shown that treatment within PC-MHI increases the likelihood of attending future mental health appointments and engaging in specialty mental health treatment. Finally, the integration of primary care and mental health has shown consistent improvement of quality of care and outcomes, including patient satisfaction. The PC-MHI program continues to expand, and through January 2017, VA has provided over 6.8 million PC-MHI clinic encounters, serving over 1.5 million individuals since October 1, 2007.

HIRING PRACTICES

At VA, we have the opportunity, and the responsibility, to anticipate the needs of returning Veterans. As they reintegrate into their communities, we must ensure that all Veterans have access to quality mental healthcare. To serve the growing number of Veterans seeking mental healthcare, VA has deployed significant resources and increases in staff toward mental health services. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from over 900,000 in fiscal year 2006 to more than 1.65 million in fiscal year 2016.

We anticipate that VA's requirements for providing mental healthcare will continue to grow for a decade or more after current operational missions have come to an end. VA has taken aggressive action to recruit, hire, and retain mental health professionals in order to improve Veterans' access to mental healthcare. As part of our ongoing comprehensive review of mental health operations, VA has considered a number of factors to determine additional staffing levels distributed across the system, including the following: Veteran population in the service area; the mental health needs of Veterans in that population; and the range and complexity of mental health services provided in the service area.

Since there are no industry standards defining accurate mental health staffing ratios, VA is setting the standard, as we have for other dimensions of mental healthcare. VHA has developed a prototype staffing model for general mental health and is expanding the model to include specialty mental health. VHA will build upon the successes of the primary care staffing model and apply these principles to mental health practices. VHA has developed and implemented an aggressive recruitment and marketing effort to fill specialty mental healthcare occupations. Key initiatives include targeted advertising and outreach, aggressive recruitment of qualified trainees/residents to leverage against mission critical mental health vacancies, and providing consultative services to VISN and VA stakeholders.

VA is committed to working with public and private partners across the country to support full hiring to ensure that no matter where a Veteran lives, he or she can access quality, timely mental healthcare. For example, multiple professional organizations, including the American Psychiatric Association and American Psychological Association, have offered support in getting announcements to their members about fulfilling career opportunities with VA.

CONCLUSION

Mr. Chairman, all of us at VA are saddened by the crisis of suicide among Veterans. We remain focused on providing the highest quality care our Veterans have earned and deserve and which our Nation trusts us to provide. Our work to effectively treat Veterans who desire or need mental healthcare continues to be a top priority. We emphasize that we remain committed to preventing Veteran suicide, aware that prevention requires our system-wide support and intervention in preventing precursors of suicide. We appreciate the support of Congress and look forward to responding to any questions you may have.

Senator MORAN. Doctor, thank you.

Dr. Davis, I understand that you don't have an opening statement, but we would be delighted to hear anything you would like to say, even if it's very brief.

Dr. DAVIS. I don't have an opening statement prepared. I'm just grateful for being here, and thank you. This is an honor, and I just feel humbled. And I'm happy to answer any questions that you all have.

Senator MORAN. We're honored to have you with us, and we look forward to having a dialogue.

I now would recognize Melissa Jarboe. Welcome.

STATEMENT OF MELISSA D. JARBOE, CHIEF EXECUTIVE DIRECTOR, MILITARY VETERAN PROJECT

Ms. JARBOE. Thank you, Chairman Moran, Ranking Member Senator Schatz, and other members, for the opportunity to appear before the committee today to discuss veteran suicide.

Six years ago, my husband, Staff Sergeant Jamie Jarboe, was shot by a sniper while on patrol in Afghanistan. The sniper's bullet instantly paralyzed my husband from the chest down. We spent 11 months inside seven different hospitals stateside in an effort to heal him physically, however, it was during this fight of survival that we noticed a change in my husband mentally.

With the assistance of doctors from across the Nation willing to educate me and take a moment to talk to a military spouse, I was able to assist Jamie's care plan and make recommendations of how to help my husband. We began tapering down his medications. Valium, Oxy, Percocet, and Klonopin were just a few of the nearly 50 doses of medication my husband was administered daily. That is when I came across a man by the name of Dr. Daniel Amen, a man who has researched the brain using SPECT imaging. SPECT imaging is a single-photo emission computed tomography imaging to focus on the physiology of the brain. We're looking at the underlining function instead of the anatomy, which is what our MRI and CT does.

Through Dr. Amen and Dr. Van Kamp and their training, I learned that post-traumatic stress is indicated by an increased relative blood flow in the upper extremity of the brain. I further learned that ongoing usage of sensory deprivation as an alternative to narcotic medication has been proven in some places successful.

We introduced sensory deprivation to my husband in October of 2011. Sensory deprivation works on resetting the brain by allowing it to shut down in a soundproof barrier.

Now, while post-traumatic stress should not be confused with traumatic brain injury, it is indicated that post-traumatic stress has a decreased relative blood flow in the lower extremity of the brain. When combined with post-traumatic stress or if you have a veteran being treated for post-traumatic stress or post-traumatic stress disorder, and has TBI, the situations can be devastating effects to the brain if not properly diagnosed.

We continued our efforts to taper down my husband's narcotics, and under the direct care of his primary doctors and pain management team, we introduced hypobaric chamber for his traumatic brain injury. The chamber helped heal him. Jamie sustained a traumatic brain injury when he was shot due to lack of oxygen.

By January of 2012, Jamie was able to carry on somewhat of a normal schedule, with our ending goal to be home in Kansas to live out the American dream. On March 10, 2012, that dream was shat-

tered when we were told that Jamie was not able to come home and that he was rendered terminal. My husband's tracheal and esophageal area detached from his upper extremity. The doctors told us it would only be a matter of time before my husband suffocated to death.

We used the remaining moments of his life to help me plan the rest of my life. Jamie requested I carry on three dying wishes. The second wish that my husband made is the reason why I am addressing you today. In my husband's dying moments, he asked me to care for his fellow service members. To carry on this wish, I created the Military Veteran Project, a worldwide nonprofit now with the mission of military suicide prevention through research and alternative treatments.

In the last 5 years, I have met with veterans in crisis contemplating suicide, widows, family members, and organizations helping assist. The bottom line is our men and women are returning home from war to fight a new battle on American soil. And each day, the casualties are increasing. It is estimated that anywhere from 14 to 22 veterans and active duty service members are taking their own lives. That would mean since September 11, 2001, we have lost, using 14 veterans a day, 76,930 veterans on American soil.

Why has the number of suicides increased over the last few years? Well, the requirements to join the military were lowered to combat the attrition, and as a result, the increased number of service members with preexisting conditions were now deemed fit and suitable for service. For example, Robert Schultz, who suffered a prior mental diagnosis and psychological symptoms was now passed and allowed to join the United States military after 9/11 to rev up for the numbers.

The need for the Department of Defense to bolster those numbers 16 years ago has put a tremendous strain on our Veterans Administration. By allowing these men and women who may be in physically or mentally fragile states to continue to serve, we have compromised not only the national security and the mission they have on foreign soil, but our families they come home to.

We know without a question that our men and women who are in combat environment are exposed to traumatic events, and in direct impact of shock, trauma, and sleep deprivation during the average combat tour. The following recommendations would help start and assist with veteran suicide prevention.

First in all, I do believe that our service members leaving the armed forces must be required and mandatory to register with our VA before they're relieved of duty.

Secondly, we need to give our combat veterans veteran preference at our local Veterans Administrations to seek the care they so definitely need.

Third is to open and create possibilities of community partnerships with organizations to assist with the credibility of our local Veterans Administrations to bridge the gap between the veterans that are not registering and the veterans that have, and allow the nonprofits like ours, as Military Veteran Project, and others to help fill the attrition the VA is missing with veterans not registering.

In closing, I ask you to join in my mission to fulfill my husband's dying wish to care for his fellow service members because it's not something I can do alone.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF MELISSA JARBOE

Thank you Chairman and Ranking Member(s) for the opportunity to appear before this committee to discuss the topic of Veteran Suicide.

Six years ago, on April 10, 2011, as I was driving to work, I received a phone call informing me that my husband, Staff Sergeant Jamie Jarboe, was shot by a sniper while on patrol in the Zhari District of Afghanistan. The sniper's bullet entered the left side of my husband's neck, and exited through the lower part of his right shoulder blade instantly paralyzing him from the chest down. Forty-eight hours later, I was standing at his bedside at Walter Reed Hospital. Jamie was able to open his eyes just long enough for me to tell him, "I love you. Continue to fight because your family needs you". My husband did just that. Over an 11-month period, Jamie endured over 100 surgical procedures in an effort to heal him physically; however, it was during this fight for survival that I noticed dramatic changes in my husband mentally. The hospital staff would come in, administer medications, day after day, hour after hour. At one point, he was on 59 different doses of medication in a single day. There would be entire days when Jamie would not even be able to open his eyes, and when I asked why my husband was so over-medicated, lethargic, the hospital staff would respond "How would you like us to care for your husband?" That is when I began to do my own research on symptoms, medications, and brain patterns. With the assistance of doctors from the Mayo Clinic, John Hopkins and Kennedy Krieger, I was able to educate myself, and those around me, on how to adequately care for Jamie. We began by tapering down his medications, starting with Elixir, Valium, Roxycotin, Oxycontin, Percocet, and Klonopin, just to name a few. We then introduced sensory deprivation treatments. This treatment is where one basically works on resetting the brain by allowing it to shut down in a soundproof barrier for 60 to 90 minutes at a time. The characteristics of post-traumatic stress my husband displayed was manifested each morning at 7:34 a.m., when he would gear up, put on his helmet, his vest, pick up his machine gun and then mime as if he was marching, ending when his head would suddenly jolt back violently. It took me weeks to figure out that my husband was reliving the fateful day when he was shot, over, and over, and over, in his mind. I was determined to find a way to help Jamie mentally, while Walter Reed continued to help him physically. That is when I came across a man by the name of Dr. Daniel Amen, who has researched the brain using SPECT imaging. From Dr. Amen, I learned that post-traumatic stress is indicated by an increased relative blood flow of the upper extremity of the brain. I further learned that ongoing usage of sensory deprivation as an alternative to narcotic medication has been proven successful. Dr. Amen also explained that a traumatic brain injury is indicated by the decreased relative blood flow in the lower extremity of the brain, and when combined with PTS, can have devastating affects on the brain, if not treated in a timely manner. We continued our efforts to taper down Jamie's narcotic dosages under the direct care of his primary doctors and pain management team, and introduced hyperbaric chamber treatments to Jamie's regimen. This assisted with the cerebral hypoxia his brain had sustained due to a lack of oxygen at the time of his injury. By January of 2012, Jamie was able to carry on a somewhat normal daily schedule: where he woke up at 7:30am, did daily activities for agility, and was able to finally sleep at night due to the fatiguing of his body both physically & mentally. Each day for the 11 months Jamie was in the hospital, we both did everything we could to get back home to our children and family waiting for us in Kansas. All we wanted to do was live our own American dream, have a home with a white picket fence, raise our children, and love one another forever. On March 10, 2012 that dream was shattered when we were told that Jamie would not be coming home. Jamie's tracheal and esophageal area detached and it was only a matter of time before my husband would suffocate. I remember looking at my husband, in complete shock,after we got the news. With his crooked smile, he looked back at me and said, "It figures that would happen. Honey, I want to get a pen and paper, so we can use the remaining moments of my life to help you plan the rest of yours." That day, my husband asked three wishes of me. One, never to re-enter the corporate world. Two, to care for his fellow service members, and three to never become bitter or tainted by this tragedy, so that I might find love again. The second wish of my husband, Staff Sergeant Jamie Jarboe, is why I address you today. To

help me carry out Jamie's second wish, I created the Military Veteran Project, a 501c3 military non-profit, with a mission of military suicide prevention through research and alternative treatments.

In the last 5 years, I have personally met with veterans in crisis, veterans contemplating suicide, widows and family members who have lost their veteran loved one to suicide, and organizations assisting those affected by these all too frequent tragedies. The bottom line is our men and women are returning home from war to fight a new battle on their home soil, and each day the casualties are increasing. It is estimated that anywhere from 14 to 22 veterans and active duty service members take their own lives every day. That would mean since September 11, 2001, using the conservative estimate of 14 veteran suicides a day, we have lost 76,930 heroes. So where does that leave us? Well, a few statistical questions remain unanswered. It is unclear the number of veterans that were combat-experienced versus non-combat, and the number of veterans that were enrolled in the Veterans Administration or not enrolled in the V.A. What is clear is that we have an information gap between the Department of Defense and the V.A. Currently, the computer systems, or databases, between these two government agencies are not compatible. The V.A. is currently relying only on documents veterans hand carry in, to render benefits and/or determine care. If these documents do not reflect a pattern of medical issues, services will not be provided. The disconnect is further evidenced by the discrepancy in Department of Defense discharges and registrations with the V.A. If the DoD releases 1,000 service members this year for retirement or service contract completion, only 37 percent will register with the Veterans Administration within the allotted time frame.

The VA is further hampered by changes to recruitment quotas initiated after September 11th. Post 9/11, there was a steady increase in enlistment quotas recruiters were required to fill in order to prepare for the war on terrorism. The requirements to join the military were lowered to combat the attrition, and as a result, an increased number of service members withpre-existing conditions were deemed "fit for service,whereas before they would have been classified "not fit for duty." For example John Doe, who suffered prior mental diagnosis, or psychological symptoms, was passed and allowed to join the Armed Services after 9/11, while prior John Doe would have been dismissed. The need for the Department of Defense to bolster numbers 16 years ago has put a tremendous strain on our Veterans' Administration today. By allowing these men and women, who may be in physically and/or mentally fragile states, to serve, we have caused them further harm.

There is also the very real fact that non-combat veterans make up a large percentage of those being served by our V.A. This can directly impact the wait times and availability of services for combat veterans who may be suffering.

In reviewing the numerous cases we have received at the Military Veteran Project, and in consultation with medical and research teams across the nation, we find that the best approach to assisting with veteran suicide prevention is starting where the problem first manifests, in the brain. We know, without question, that our men and women, who are placed in the combat environment, are exposed to a myriad of traumatic events. Add in the direct impact of shock, trauma, sleep deprivation, and malnourishment during the average combat tour, and the resulting damage to the brain is nearly inevitable. If we can properly diagnose our veterans using brain scans or SPECT imaging to identify the harmful effects of combat service, and track them through the entirety of their military career, then we could apply the information gained to adequately diagnose and treat our heroes throughout and immediately following their service.

The suffering of the men and women sent to protect us can no longer be considered status quo. We must take responsibility for providing the care that is necessary to protect them. To achieve this, we need to allocate a budget that allows the VA to properly diagnose our veterans. We need to adequately fund alternative treatment programs, which will empower our veterans to better understand their diagnosis, and result in more effective care plans for them. Have no delusions, this is only the first step in our mission to vanquish veteran suicide, and this is a battle our veterans should not have to fight alone. As a country, we can choose to stand up and unite as one and help our VA system succeed in the treatment of our veterans. We can show every veteran we have their six. The bottom line is this, if we continue to fight against our Veterans Administration we, as a country, will abandon our veterans, and each of us will be responsible for not helping to save a life.

In closing, I ask you to remember the men and women of our military, not only while they hold a rifle and travel to distant lands to fight, but to remember them when they come home. I ask that you honor them by not merely thanking them for their service, but by taking care of them in their time of need, by fighting for them

as they have for us. I ask that you fulfill my husband's dying wish, "take care of my fellow soldiers."

Thank you for the invitation to join you this evening and for your leadership on this critical matter. I'm confident in our ability to unite for this bipartisan issue, together we can prevent military suicide. Thank you.

Senator MORAN. Melissa, thank you for being here and thank you for your testimony. And we honor you and your husband's service to our nation.

Michael Missal.

STATEMENT OF THE HONORABLE MICHAEL L. MISSAL, INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. MISSAL. Thank you, Chairman Moran, Ranking Member Schatz, and members of the subcommittee. I appreciate the opportunity to discuss the Office of Inspector General's recent work on the operations of the Veterans Crisis Line.

The tragedy of veteran suicide is one of VA's most critical issues. The rate of suicide among veterans is significantly higher than the rate of suicide among U.S. civilian adults. VA's most recent estimate calculates that 20 veterans commit suicide a day. Of those veterans, approximately 14 have not been seen by VA. The VCL (Veterans Crisis Line) is essential to reduce veteran suicide for those who call in crisis.

In our February 2016 VCL report, we identified several problems with the VCL, including crisis calls going to voicemail, a lack of a published VHA directive to guide organizational structure, quality assurance gaps, and contract problems. Our February 2016 report resulted in seven recommendations, and VHA concurred with the findings and recommendations. VHA provided an action plan and timeframe to implement those recommendations by September 30, 2016.

In June 2016, we received an allegation related to the experience of a veteran with the VCL and its backup call centers. As a result of the complaint and in light of the open recommendations from our February 2016 report, we expanded our scope to conduct an in-depth inspection of the VCL. We also received in August 2016 a request from the Office of Special Counsel to investigate allegations regarding training and oversight deficiencies with social service assistance who assist call responders.

Our March 2017 VCL report made the following findings.

We substantiated that VCL staff did not respond adequately to a veteran's urgent needs during multiple calls to the VCL and its backup call centers. We also identified deficiencies in the internal review of the matter by the VCL staff. In the interest of privacy, information specific to this veteran is not included in our report. However, relevant information has been provided in detail to VHA.

With respect to the governance structure, operations, and quality assurance functions, we identified a number of deficiencies. Among other findings, we reported that there was a lack of effective utilization of clinical decision-makers at the highest level of VCL governance, a lack of permanent leadership during much of the last few years, a failure to collect the appropriate clinical data necessary to assess performance, deficient oversight of the backup centers, lack of background and training in quality management prin-

ciples, and the limited experience of supervisors in the new Atlanta call center.

With respect to the allegations referred by the Office of Special Counsel, we found that the VCL lacked a process for monitoring the quality of performance by social service assistance and deficiencies in SSA training.

Our 23 recommendations from our 2016 and 2017 VCL reports fall into the categories of governance, operations, and quality assurance. Governance recommendations include the establishment of a VCL directive that guides structure, roles, and responsibilities, appropriate collaboration between clinical and administrative leadership, and lines of authority that delineate that clinical policy decisions be made by clinical leadership.

Operations recommendations include information technology infrastructure improvements, a better tracking of updated policies and procedures and related staff training, and that contractors be held to the same standards as the VCL.

Quality assurance recommendations include QA leadership be fully trained in QA principles, negative clinical outcomes evaluated in order to improve, quality data be used to enhance performance, call recordings be used for quality assurance, and that the performance for the Canandaigua and Atlanta call centers be analyzed separately.

We recognize the difficulties and great challenges in operating a crisis hotline. Our 2016 and 2017 reports identified various challenges facing the VCL in their mission to provide suicide prevention and crisis intervention services to veterans, service members, and the family members. Until VHA implements fully all of the recommendations from our two reports, they will continue to have challenges meeting VCL's critical important mission.

Mr. Chairman, this concludes my statement. I'll be happy to answer any questions that you or other members of the subcommittee may have.

[The statement follows:]

PREPARED STATEMENT OF HON. MICHAEL J. MISSAL

Mr. Chairman, Ranking Member Schatz, and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent work on the operations of the Department of Veterans Affairs' (VA) Veterans Crisis Line (VCL). My statement will discuss two OIG reports, one from March 2017, Healthcare Inspection—Evaluation of the Veterans Health Administration Veterans Crisis Line, and one from February 2016, Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York.

BACKGROUND

The tragedy of veteran suicide is one of the Veterans Health Administration's (VHA) most significant issues. The rate of suicide among veterans is significantly higher than the rate of suicide among U.S. civilian adults. VA's most recent estimate calculates that 20 veterans commit suicide a day. Of those veterans, approximately 14 have not been seen in VHA.

In 2007, VHA established a telephone suicide crisis hotline located at the Canandaigua, New York, VA campus. Initially called the National Veterans Suicide Prevention Hotline, its name changed to the VCL in 2011.[1] VHA established the VCL through an agreement with the U.S. Department of Health and Human Serv-

[1] Veterans Crisis Line 1–800–273–8255 Press 1, https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx. Accessed December 4, 2016.

ices' Substance Abuse and Mental Health Services Administration (SAMHSA). This agreement provided for VHA's use of the already existing National Suicide Prevention Line (NSPL) toll-free number for crisis calls.[2] The VCL was managed by the VHA Office of Mental Health Operations at the time of the February 2016 OIG report. Subsequently the VCL was realigned under VHA Member Services (Member Services), an organization within the Chief Business Office that runs customer call centers for VHA.[3]

The VCL is part of an overall strategy to reach out to veterans in a time of crisis with the goal of reduction of veteran suicide.[4] The VCL's primary mission is "to provide 24/7, world class, suicide prevention and crisis intervention services to veterans, service members, and their family members."[5] Since its launch in 2007, VCL staff have answered nearly 2.8 million calls and initiated the dispatch of emergency services to callers in crisis over 74,000 times.[6] Currently, the VCL responds to over 500,000 calls per year, along with thousands of electronic chats and text messages. The VCL initiates rescue processes for callers judged at immediate risk of self-harm. The number of calls to the VCL has increased markedly since the VCL's first full year of operation in 2007, with a corresponding increase in VCL annual funding. The total number of calls answered by the VCL and backup centers was 9,379 in 2007 and grew to 510,173 in fiscal year 2016. In fiscal year 2010, the VCL was funded at $9.4 million, increasing to $31.1 million in fiscal year 2016.

A component of the VCL's long-term continuing operations plan was to expand beyond the Canandaigua Call Center to a second site, to ensure geographic redundancy and meet increasing VCL demands. The VCL and VHA Member Services leadership determined that the Canandaigua Call Center location did not have the necessary space or applicant pool to allow for the needed future growth. An expansion site was chosen in Atlanta, Georgia, because Member Services had a pre-existing call center infrastructure at its Atlanta-based Health Eligibility Center (HEC).[7] Planning began in July 2016 with a phased rollout of responding to calls starting in October 2016 and continuing over the next 2 months.

In our February 2016 VCL report, we identified several problems including crisis calls going to voicemail, a lack of a published VHA directive to guide organizational structure, quality assurance gaps, and contract problems. The February 2016 report resulted in seven recommendations and VHA concurred with the findings and recommendations. VHA provided an action plan and timeframe to implement those recommendations by September 30, 2016.

INSPECTION OF VETERANS HEALTH ADMINISTRATION VETERANS CRISIS LINE

In June 2016, we received an allegation related to the experience of a veteran with the VCL and its backup call centers. As a result of the complaint, and in light of the open recommendations from the OIG's February 2016 report, we expanded our scope to conduct an in-depth inspection of the VCL. During our inspection, in August of 2016, we received a request from the Office of Special Counsel (OSC) to investigate allegations regarding training and oversight deficiencies with staff that assist call responders (Social Service Assistants/SSAs). This inspection, in addition to our previous inspection, found organizational deficiencies and foundational problems in the VCL. We also identified key changes needed by VA in order to achieve VA goals of service for veterans in crisis.

Our inspection included the following objectives:

—To respond to a complaint alleging that the VCL did not respond adequately to a veteran's urgent needs.
—To perform a detailed review of the VCL's governance structure, operations, and quality assurance functions in order to assess whether the VCL was effectively serving the needs of veterans.

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[2] The toll-free number is (800) 273–8255.
[3] VHA Member Services Member Services is an operation and support office within the Chief Business Office and has two main "front-end" elements of interaction with VA's healthcare enrollee population, providing oversight, review, and direct service in the following areas: Eligibility and Enrollment Determination and Contact Management.
[4] https://www.va.gov/opa/publications/factsheets/Suicide__Prevention__FactSheet__New__VA__Stats__070616–1400.pdf.
[5] VCL Mission Statement.
[6] https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx. Accessed on March 27, 2017.
[7] The HEC provides information and customer service on key veteran issues such as benefits, eligibility, billing, and pharmacy. https://www.va.gov/CBO/memberservices.asp. Accessed December 1, 2016.

—To evaluate whether VHA completed planned actions in response to OIG recommendations for the VCL, published on February 11, 2016, in our report titled Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York.
—To address complaints received from the OSC alleging inadequate training of VCL SSAs resulting in deficiencies in coordinating immediate emergency rescue services needed to prevent harm.

VETERAN'S URGENT NEEDS

Regarding the first objective, we substantiated that VCL staff did not respond adequately to a veteran's urgent needs during multiple calls to the VCL and its backup call centers. We also identified deficiencies in the internal review of the matter by the VCL staff. In the interest of privacy, information specific to this veteran is not included in the report. However, relevant information has been provided in detail to VHA.

GOVERNANCE, OPERATIONS, QUALITY ASSURANCE FUNCTIONS

Governance is defined as the establishment of policies, and the continuous monitoring of their proper implementation, by members of the governing body of an organization.[8] During the time of our review,[9] the leadership, governance, and committee structure was in an immature state of development. Examples include a governance structure without clear policies and unclear mandates to review clinical performance measures and make improvements. These structural problems led to operational and quality assurance gaps.

In our February 2016 report, we cited the absence of a VCL directive as a contributor to some of the quality assurance gaps identified in the review. VHA concurred with this recommendation and provided an initial target date for completion of June 1, 2016. As of the publication of our March 2017 report, this action was not complete. We found continuing deficiencies in governance and oversight of VCL operations.

During the August 2016 site visit to Canandaigua, the VCL's acting director told us that the VCL was using the Baldridge[10] framework for governance. For the VCL, the central leadership group in this model would be the Executive Leadership Council (ELC).[11] The ELC integrates the business and clinical aspects of operating the VCL. We requested all ELC draft policies to ensure that the ELC had a process for achieving its intended goals. We were informed that no current policies related to the ELC existed and that creation of such policies was in progress. The VCL and the services it provides have grown considerably since 2007, but VCL leadership did not develop a plan until 2016 that defined the strategic approach for the VCL to provide consistent, timely, and high quality suicide prevention services. For its Baldridge framework goals, VCL leadership was unable to provide policies, dashboards, or quality monitors for this governance initiative.

Shortly after the publication of the 2016 OIG report, the VCL was realigned under VHA Member Services, although VA leadership stated that the VCL would remain closely tethered to VHA's clinical operations. VHA's Office of Suicide Prevention[12] leads suicide prevention efforts for VHA and coordinates and disseminates evidence-based findings related to suicide prevention. However, we found a disconnect between the VHA Office of Suicide Prevention and Member Services in communicating about suicide prevention and the VCL. While the expectation was that Member Services and subject matter experts on suicide prevention would work closely together, we found substantial disagreement about key decisions and oversight between the two groups.

The lack of effective utilization of clinical decision makers at the highest level of VCL governance resulted in the failure to include fully clinical perspectives impact-

[8] Business Dictionary's definition of governance.
[9] Our review period was from June through December 2016.
[10] The Malcolm Baldrige National Quality Award is the highest level of national recognition for performance excellence that a U.S. organization can receive. The award focuses on performance in five key areas: product and process outcomes, customer outcomes, workforce outcomes, leadership and governance outcomes, financial and market outcomes. https://www.nist.gov/baldrige/baldrige-award. Accessed December 23, 2016.
[11] ELC membership includes VCL Director, Chairperson, VCL Deputy Director, Business Operations Lead, Veteran Experience Lead, Employee Experience Lead, Partnerships Lead, Clinical Quality Lead, AFGE Leadership Member, Union Leadership Member, Clinical Psychologist, and CAC.
[12] The Office of Suicide Prevention leads suicide prevention efforts for VHA and coordinates and disseminates evidence-based findings related to suicide prevention.

ing the operations of the VCL. Administrative staff made decisions that had clinical implications. Examples include disagreements about the scope of services associated with core versus non-core calls[13] and the selection of training staff who did not have clinical backgrounds. Clinical leaders stated concerns about staff morale, decisions impacting VCL capacity of responders to assist callers in crisis promptly, and effective training of new responders.

Another example of deficient governance was a lack of permanent VCL leadership. During most of 2015, the VCL was without a permanent director. At the end of 2015, a permanent director was chosen. However, the new permanent director resigned his position in June 2016. As of December 2016, the VCL continued to operate without a permanent director.

OPERATIONS

The VCL was undergoing changes throughout our review. For example, there were three versions of the VCL organizational chart between June 2016 and September 2016. The evolving VCL staffing model was based on a service level of zero percent rollover, answering all calls within 5 seconds, and forecasting call volume based on historical interval data.

Calls to VCL and Contracted Backup Centers

To reach the VCL (Canandaigua or Atlanta) through its toll-free number, a caller is instructed to press 1 (for veterans) on the telephone keypad. If the caller does not press 1, the caller is routed to a National Suicide Prevention Line center. The caller still speaks with a responder. However, this route will take the caller to a non-VCL and non-VA contracted backup call center. If the caller presses 1, as instructed for veterans, and the call cannot be answered within 30 seconds by the VCL, it rolls over to a VA contracted backup center.

During our review, VHA leadership was in the process of implementing an automatic transfer function, which directly connected veterans who call their local VA Medical Centers to the VCL by pressing 7 during the initial automated phone greeting. Member Services leadership determined that the implementation of various communication enhancements that increased VCL access, including Press 7, voice recognition technology, vets.gov, and MyVA311,[14] created increased demand for services.

When a call is answered by VCL staff, a trained crisis responder answers the call, and after engaging with the caller and building rapport, the responder asks about suicidal ideation.[15] Depending upon the caller's answer, the responder may conduct a more detailed assessment of lethality, which addresses a range of both suicide risk factors as well as protective factors. Callers may choose to remain anonymous and the responder may only be able to identify the caller by phone number.

We identified a deficiency in the VCL's processes for managing incoming telephone calls. Callers may decide to remain anonymous, but in every case responders document the incoming telephone number. However, responders must manually enter the number into the electronic documentation system, increasing the risk of human error. While reviewing responders' call documentation, we found that the documentation was often lacking in sufficient detail to facilitate retrospective assessment of the interaction between the caller and responder.

VCL call complaint data included callers' complaints about being on hold. We found that some contracted backup call centers used a queuing (waiting) process that callers may perceive as being on hold. During the queue time, or wait time, the caller waits for a responder to answer. The caller's only option is to abandon the call (hang up) and call back, or continue to wait for a responder to pick up. The backup centers had processes to record wait times and abandonment rates. We found that VCL leadership had not established expectations or targets for queued call times, or thresholds for taking action on queue times, resulting in a systems deficiency for addressing these types of complaints. At the time of our review, there were four contracted backup centers. Two of the backup centers queued calls and two did not queue calls.

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[13] Core calls are calls defined as calls resulting in referral to the Suicide Prevention Coordinator and/or calls requiring the application of crisis management skills (example: a suicidal caller). Non-core calls are defined as those that do not require specific crisis intervention skills (example: a caller inquiring about benefits).

[14] VA is introducing 1–844–MyVA311 (1–844–698–2311) as a go-to source for veterans and their families who do not know what number to call.

[15] Suicidal ideation is thinking about, considering, or planning suicide. Centers for Disease Control and Prevention, http://www.cdc.gov/violenceprevention/suicide/definitions.html. Accessed December 2, 2016.

VHA contracted with an external vendor[16] to manage backup center performance and report back to the VCL, with administrative and clinical oversight of the contract terms by VCL managers. We found that the VHA contracting staff and Member Services and VCL leaders responsible for verifying and enforcing terms of the contract did not provide the necessary oversight and did not validate that the contracted vendor provided the required services before authorizing payment.

Atlanta Call Center

On July 21, 2016, planning for the new Atlanta-based call center started. By November 21, 2016, Member Services anticipated that staffing at the Atlanta Call Center would be sufficient to allow for zero rollover calls to backup call centers.[17] Member Services leaders planned to have the Atlanta facility fully staffed and telephonically operational by December 31, 2016. Text and chat services would begin in June 2017.[18]

Member Services leaders made the decision to roll out the Atlanta Call Center without first establishing on-site leadership, a critical piece to ensuring proficient execution of call center function. The September 2016 VCL organizational chart called for Atlanta to have its own Deputy Director and Director for Team Operations. However as of September 20, 2016, even though the leadership positions had not even been advertised much less filled, the Atlanta office held its inaugural responder training class with plans to begin operations on October 10, 2016. As of November 8, 2016, this iteration of the organizational chart had been rescinded. VCL leadership structure reverted to that outlined in the July 2016 organizational chart, which does not include either a Deputy Director, a Director of Team Operations for Atlanta, or other leadership positions specific to the Atlanta Call Center.

Bringing the Atlanta Call Center online in a three-month period entailed the rapid hiring and training of new staff. The training content is the same for responders at both the Atlanta and Canandaigua sites, but with notable differences in trainer-to-learner ratios. For instance, in order to accommodate the sizable number of trainees, class sizes were larger at the Atlanta Call Center, ranging from 44 to 62 trainees, versus 20 trainees per class at the Canandaigua Call Center. Once the responders completed classroom training and passed a proficiency test, they were assigned to work with a preceptor for one to three weeks. The preceptor-to-responder ratio at the Canandaigua Call Center is 1:1. The original plan for the Atlanta Call Center called for a 1:2 or 1:3 preceptor to responder ratio. However, due to limited preceptor availability and large class sizes, the ratios were as high as 1:16.

The supervisors hired to work at the Atlanta Call Center did not have the same skill set as those at the Canandaigua Call Center. Canandaigua Call Center supervisors first served in a responder role, while most Atlanta Call Center supervisors had not. Because of this, we were told that Atlanta Call Center supervisors would be required to complete responder training prior to supervisor training. One VCL supervisor told us that inexperience might detrimentally affect practice at the Atlanta Call Center because new responders, particularly linked with new supervisors, may be too quick to call rescues whereas more experienced responders may be able to de-escalate the situation. Despite the experiential and training differences between sites and the potential for variances in practice, with the exception of silent monitoring, we found no documentation of plans to compare metrics between sites, including rescue rates.

The rapid establishment of the Atlanta Call Center required that a substantial number of staff from the Canandaigua Call Center be detailed to the Atlanta Call Center to train staff as well as assist with workload. The diversion of Canandaigua Call Center staff to Atlanta in order to achieve VCL programmatic milestones also contributed to a delay in the development and implementation of policies, programs, and procedures for the VCL. Examples of delays cited by staff include the deferral of annual lethality assessment training for responders, the delayed rollout of chat and text monitoring at the Canandaigua Call Center, and delayed implementation and utilization of wellness programs.

Prior to the end of our review in December 2016, the VCL implemented audio call recording capability for incoming and outgoing calls for quality assurance purposes, but had yet to provide procedures, protocols, or policies that provided guidance for listening to or using recorded call information. VCL Quality Management (QM) program leaders could enhance performance improvement evaluations by using call recording to monitor the quality of interactions between responders and callers and

[16] Link2Health Solutions, Inc.

[17] Backup centers will be used on a contingent basis.

[18] Responders are required to have 6 months of VCL telephone experience, prior to engaging in training for text and chat services.

by collecting and analyzing performance data from the new Atlanta Call Center separately from the Canandaigua Call Center. The new call center in Atlanta could have QM concerns that are no different from its Canandaigua partner, but the ability to recognize site-specific issues, especially in a new program, is facilitated by separating quality data elements by site.

QUALITY ASSURANCE

Systematic collection of relevant and actionable data for analysis is crucial when making decisions that will prevent problems. To be effective, VCL's QM data collection and analysis should be accurate and inform VHA and VCL leadership and staff whether their actions effectively serve veterans and others who use VCL services. In our February 2016 report, we recommended that VHA establish a formal quality assurance process and develop a VHA directive or VHA handbook for the VCL. We reviewed the VCL QM program structure and processes, the VCL QM program manual, and the draft VCL directive and identified systems deficiencies in QM program processes. We further found that neither the VCL QM program manual nor the draft VCL directive provided a framework for a QM program structure.

Quality Management Leadership

VHA does have a directive that outlines leadership responsibilities for program integration and communication, and the designation of individuals with appropriate background and skills to provide leadership to promote quality and safety of care.[19] In order to implement the foundational principles of QM, leaders within a program must be able to promote, provide, and recognize QM practices that will lead to better outcomes. After reviewing the number and types of QM roles in the VCL, as well as QM staff experience and background, we determined that the challenges likely stemmed from the QM staff's lack of training in QM principles. Member Services leadership tasked QM staff with multiple responsibilities and competing priorities that included VCL QM program and policy development, data collection and analysis, data presentation for evaluation and action planning, and identification of outcomes measures. However, the QM staff had not been provided with training in the skills needed to provide leadership to promote quality and safety of care, leading to deficiencies in the QM program.

Quality Management Data Analysis

We found that while VCL staff collect data on clinical quality performance measures, the QM program lacked defined processes for analyzing and presenting data and for developing a committee structure for reporting the analysis, making recommendations and following up.

Quality Management Committees and Planning

VHA requires a standing committee to review data, information and risk intelligence, and to ensure that key quality, safety and value functions are discussed and integrated on a regular basis. This committee should be comprised of a multidisciplinary group, should meet quarterly, and should be chaired by the Director. We did not identify a VCL standing committee that met the intent of VHA requirements outlined in Directive 1026.

Policies, Procedures, and Handbooks

VHA Directive 6330 (1), Controlled National Policy/Directive Management System, established policy and responsibilities for managing, distributing, and communicating VHA directives. VCL policies have been created in response to external reviews and internal processes but a controlling directive has not yet been published. A draft directive was in development, dated April 4, 2016; however, it lacked defined roles and responsibilities for VCL leaders, such as the VCL Director. We found that VCL policies, procedures, or handbooks were not readily accessible for staff reference.

VCL leaders developed a QM Program Manual which was updated in July 2016 (no initial publication date was available). The program manual did not outline a framework for the QM program that is consistent with relevant existing VHA directives providing guidance for QM programs.

Outcome Measures for Quality Improvement

We found that while the VCL measured internal performance of its staff (silent monitors, End of Call Satisfaction question, and complaints), its QM data analysis

[19] VHA Directive 1028, VHA Enterprise for Framework for Quality, Safety, and Value, August 2, 2013.

did not include measures of clinical outcomes for callers. During interviews, we inquired about outcome measures to evaluate the success of a veteran's transition from the VCL to other dispositions. We identified deficiencies in the VCL QM program including data analysis and presentation of clinical quality performance measures, lack of development of a directive consistent with established VHA guidance, lack of a reporting structure for regular review of performance measures, and frequent changes in the organizational structure of the QM program. We found that deficiencies in the QM program were related to VHA leadership failing to provide a developmental plan, appointing staff into positions without formal QM training, and assigning staff multiple competing priorities.[20]

Measurement of Program Success with Adverse Outcomes Reviews

We found that the VCL had no process in place for routinely obtaining or reviewing data on serious adverse outcomes, such as attempted or completed suicides by veterans who made contact with the VCL prior to the event. We learned that adverse outcomes were not aggregated for review by VCL leadership in order to measure performance improvement for achieving more successful outcomes. The Acting Director and Acting Quality Assurance Clinical Officer confirmed that debriefings or other reviews were not conducted after known suicide attempts or completions. By not reviewing serious adverse outcomes, VCL QM managers missed opportunities for quality improvement.

We reported systems deficiencies in the VCL Quality Management program in our 2016 and 2017 reports. VHA provides a framework for QM program structure and leadership to ensure delivery of safe and effective care; however, we found multiple program deficiencies remained during our second review.

INADEQUATE TRAINING ALLEGATIONS RECEIVED FROM OSC

We found that VCL managers developed a process for monitoring the quality of crisis intervention services provided by responders; however, VCL lacked a process for monitoring the quality of performance by SSAs. We identified deficiencies in SSA training and substantiated complaints referred to us by the OSC in regard to SSA training and performance. Specifically, we substantiated that SSAs were allowed to coordinate emergency rescue responses independently after the end of a 2-week training period, without supervision and regardless of performance or final evaluation; that in mid-2016, a newly trained SSA contacted a caller in crisis by telephone to solicit the veteran's location, although we found that no harm resulted from the interaction; and we substantiated a lack of documentation by an SSA when closing out a veteran's case in mid-2016. We could not substantiate an allegation that documentation by an SSA resulted in conflicting information about a veteran being contacted within 24 hours. The complainant (who remained anonymous) was not interviewed by us, and we did not have identifiers for the veteran caller.

REPORT RECOMMENDATIONS

The OIG recommendations from 2016 and 2017 fall into the categories of governance/leadership, operations, and quality assurance. It is noteworthy that many of these recommendations cut across all three categories.

—*Governance*.—Governance recommendations include the establishment of a VCL directive that guides structure, roles, and responsibilities. Additional recommendations include that the governance structure ensures cooperation between clinical and administrative leadership. We also recommended that lines of authority delineate that clinical leadership make clinical policy decisions.

—*Operations*.—Operations recommendations include that SSAs are certified by supervisors before engaging in independent assistance with rescues. Other recommendations involve information technology infrastructure including an automated process for transcription of telephone numbers, and audio call recording with related policies and procedures. We recommended improved control of policy and document management so that updated policies and procedures and related staff training can be tracked. We issued recommendations related to backup center and contractor performance, including an enforceable quality assurance surveillance plan for contracted backup centers, and establishing targets for rollovers and call queuing. We recommended that contractors are held to the same standards as the VCL, and contract performance is monitored to assure that the terms of the contract are met. We also recommended that contractor performance is verified prior to payment.

[20] VHA Directive 1026, VHA Enterprise for Framework for Quality, Safety, and Value, August 2, 2013.

—*Quality Assurance*.—Quality assurance recommendations include establishing a formal quality assurance process that incorporates policies and procedures consistent with the VHA framework. Other recommendations include QA leadership being fully trained in QA principles, evaluating negative clinical outcomes in order to improve, and ensuring that VCL silent monitoring frequency meets established VCL standards. We also recommended that VCL develop structured oversight processes for tracking and trending of clinical quality performance measures. We recommended that quality data be used to enhance performance, that call recording be used for quality assurance, and that Canandaigua and Atlanta are analyzed separately with performance measures. We recommended consistent quality assurance and monitoring policies are established for responder staff and SSAs.

A complete listing of the individual recommendations from both reports is attached in Appendix A and Appendix B.

CONCLUSION

Our 2016 and 2017 VCL inspections identified various challenges facing the VCL in their mission to provide "suicide prevention and crisis intervention services to veterans, service members, and their family members." We found numerous deficiencies and made seven recommendations in the 2016 inspection and sixteen additional recommendations in the 2017 inspection. Until VHA implements fully these recommendations, they will continue to have challenges meeting the VCL's critically important mission.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Subcommittee may have.

APPENDIX A

RECOMMENDATIONS FROM HEALTHCARE INSPECTION—VETERANS CRISIS LINE CALLER RESPONSE AND QUALITY ASSURANCE CONCERNS CANANDAIGUA, NEW YORK (FEBRUARY 11, 2016)

Recommendation 1. We recommended that the OMHO (now VHA Member Services)[21] Executive Director ensure that issues regarding response hold times when callers are routed to backup crisis centers are addressed and that data is collected, analyzed, tracked, and trended on an ongoing basis to identify system issues.

Recommendation 2. We recommended that the Member Services Executive Director ensure that orientation and ongoing training for all VCL staff is completed and documented.

Recommendation 3. We recommended that the Member Services Executive Director ensure that silent monitoring frequency meets the VCL and American Association of Suicidology requirements and that compliance is monitored.

Recommendation 4. We recommended that the Member Services Executive Director establish a formal quality assurance process, as required by VHA, to identify system issues by collecting, analyzing, tracking, and trending data from the VCL routing system and backup centers, and that subsequent actions are implemented and tracked to resolution.

Recommendation 5. We recommended that the Member Services Executive Director consider the development of a VHA directive or handbook for the VCL.

Recommendation 6. We recommended that the Member Services Executive Director ensure that contractual arrangements concerning the VCL include specific language regarding training compliance, supervision, comprehensiveness of information provided in contact and disposition emails, and quality assurance tasks.

Recommendation 7. We recommended that the Member Services Executive Director consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.[22]

[21] The VCL was realigned under VHA Member Services in the spring of 2016. At the time the February 2016 OIG report regarding the VCL was published, the Office of Mental Health Operations was responsible for the VCL.

[22] VCL staff consider rescues, welfare checks, and dispatch of emergency services to be equivalent terms.

APPENDIX B

RECOMMENDATIONS FROM HEALTHCARE INSPECTION—EVALUATION OF THE VETERANS HEALTH ADMINISTRATION VETERANS CRISIS LINE (MARCH 20, 2017)

Recommendation 1. We recommended that the Under Secretary for Health implement an automated transcription function for callers' phone numbers in the Veterans Crisis Line call documentation recording system.

Recommendation 2. We recommended that the Under Secretary for Health ensure that Veterans Crisis Line policies and procedures, staff education, Information Technology support, and monitoring are in place for audio call recording.

Recommendation 3. We recommended that the Under Secretary for Health implement a Veterans Crisis Line governance structure that ensures cooperation and collaboration between VHA Member Services and the Office of Suicide Prevention.

Recommendation 4. We recommended that the Under Secretary for Health develop clear guidelines that delineate clinical and administrative decisionmaking, assuring that clinical staff make decisions directly affecting clinical care of veterans in accordance with sound clinical practice.

Recommendation 5. We recommended that the Under Secretary for Health ensure processes are in place for routine reviewing of backup call center data, establish wait- time targets for call queuing and rollover, and ensure plans are in place for corrective action when wait-time targets are exceeded.

Recommendation 6. We recommended that the Under Secretary for Health ensure processes are in place to require contracted backup centers to have the same standards as the Veterans Crisis Line related to call queuing and wait-time targets.

Recommendation 7. We recommended that the Under Secretary for Health ensure that VHA Member Services leadership, Veterans Crisis Line leadership, VHA Contracting Officers, and Contracting Officer Representatives implement the quality control plan and conduct ongoing oversight to ensure contractor accountability in accordance with their roles as specified in the contract with backup call centers.

Recommendation 8. We recommended that the Under Secretary for Health ensure that training is provided to Veterans Crisis Line quality management staff in the skills needed to provide leadership to promote quality and safety of care.

Recommendation 9. We recommended that the Under Secretary for Health ensure the development of structured oversight processes for tracking, trending, and reporting of clinical quality performance measures.

Appendix B

Recommendation 10. We recommended that the Under Secretary for Health ensure processes for Veterans Crisis Line quality management staff to collect and review adverse outcomes so that established cohorts of severe adverse outcomes are analyzed.

Recommendation 11. We recommended that the Under Secretary for Health direct the Veterans Health Administration Assistant Deputy Under Secretary for Health for Quality, Safety, and Value to review existing Veterans Crisis Line policies and determine whether the policies incorporate the appropriate Veterans Health Administration policies for veteran safety and risk management, and if not, establish appropriate action plans.

Recommendation 12. We recommended that the Under Secretary for Health ensure that Veterans Crisis Line quality management staff incorporate call audio recording into quality management data analysis.

Recommendation 13. We recommended that the Under Secretary for Health ensure that processes are in place to analyze performance and quality data from the Atlanta Call Center separately from the Canandaigua Call Center data.

Recommendation 14. We recommended that the Under Secretary for Health ensure that quality assurance monitoring policies and procedures are in place and consistent for both Social Service Assistants and responders.

Recommendation 15. We recommended that the Under Secretary for Health ensure that supervisors certify Social Service Assistant training prior to engaging in independent assistance with rescues.

Recommendation 16. We recommended that the Under Secretary for Health ensure a process is in place to establish, maintain, distribute, and educate staff on all Veterans Crisis Line policies and directives that includes verifying the use of current versions when policies and directives are modified.

Senator MORAN. Thank you so very much.

Dr. Ramchand.

STATEMENT OF RAJEEV RAMCHAND, PH.D., SENIOR BEHAVIORAL SCIENTIST, RAND CORPORATION

Dr. RAMCHAND. Thank you, Chairman Moran, Ranking Member Schatz, and members of the subcommittee, for inviting me to testify today. My name is Rajeev Ramchand, and I'm a senior behavioral scientist at RAND. For nearly 10 years, I've been studying suicide and the best ways to prevent people from taking their own lives. I've interviewed hundreds of people preventing suicide at crisis lines and suicide prevention programs. I've also spoken with the spouses, parents, siblings, children, and battle buddies affected by the death of a loved one. Today, I will summarize where our research shows efforts to prevent veteran suicide are working and where more effort is needed.

The VA is the largest integrated health care system in the United States, and it provides the care, offers the programs, and conducts the research that make it a national leader in suicide prevention. The VA sees over 6 million patients each year, most of whom are middle-aged white men. This is the group at highest risk of suicide nationally.

Many VA patients have also been exposed to atrocities in war zones from Vietnam to Afghanistan. As a result, a sizeable number have both visible and invisible wounds. RAND research shows that the VA is serving these veterans with the high-quality care that they deserve. Our analyses reveal that the mental health care delivered at the VA generally exceeds the care offered in other health systems and that the services provided by the Veterans Crisis Line surpasses most crisis lines operating in the USA today.

As a member of a panel that reviews and scores VA research proposals, I can attest firsthand to the high-quality research proposed and funded by the VA that will continue to promote it as a national leader in suicide prevention. This is why the biggest challenge the VA currently faces is preventing suicide among those not enrolled in VA care.

In 2015, we learned that veterans with other-than-honorable discharges had double the risk of suicide relative to those who separated honorably. Last month, Secretary Shulkin announced plans to extend services to these veterans who are traditionally ineligible for VA care.

We also need to focus on women veterans. The rate of suicide among the youngest cohort of women veterans was 35 per 100,000, a rate seven times that of their civilian counterparts. In collaboration with the VA, RAND interviewed responders working at the Veterans Crisis Line to investigate why women callers may be unreceptive to VA care. The women these responders talked to on the phones referred to a "male-oriented" culture at the VA that begins as early as check-in when receptionists presume a woman is supporting her husband and is not a veteran herself.

Women most satisfied with the care they tend to receive have received services specifically for women veterans or who have developed strong therapeutic relationships with their health care providers. Women and those with other-than-honorable discharges are only two groups at risk.

We must continue to figure out what other groups of veterans are at high risk of suicide, understand why they are not accessing

care, and address those barriers as well. But not all veterans will ultimately access VA care, which is why community-based suicide prevention is a necessary part of preventing suicide. This requires support and leadership outside of the VA.

Gun sellers, shooting ranges, and advocacy groups are playing a role with new campaigns that raise awareness and promote safe firearm storage. Veterans involved with the justice system likely represent another group at high risk. They can be enrolled in veterans' treatment, drug, and mental health courts, in which the goal is to rehabilitate and not punish. But only some veterans can access these services. These programs need to be evaluated so that we can determine whether there is a social business case to justify their continued expansion.

Suicide is not just a veterans' issue. It is a national public health threat. Suicide is increasing nationwide, for young and old, men and women, white, black, and Hispanic. Strengthening community-based programs would not only help prevent veteran suicide, but could also help turn back the rising tide of suicides nationally.

The VA could play a role in stemming this tide as well. Evidence-based suicide prevention strategies within the VA should be promoted and adopted by communities, many of which are facing acute suicide threats and are in dire need of support. It's only when we come together in a spirit of support and collaboration that we will begin to make a real dent in the public health threat that suicide poses to America today.

Thank you again for inviting me to testify. I'll be happy to answer your questions.

[The statement follows:]

PREPARED STATEMENT OF RAJEEV RAMCHAND[1]

THE RAND CORPORATION[2]

Thank you, Chairman Moran, Ranking Member Schatz, and members of the subcommittee, for inviting me to testify today. My name is Rajeev Ramchand, and I am a senior behavioral scientist at RAND. For nearly 10 years, I have studied suicide and thebest ways to prevent people from taking their own lives. I have interviewed hundreds of people preventing suicide at crisis lines and prevention programs. I also have spoken with the spouses, parents, siblings, children, and battle buddies affected by the death of a loved one. Today, I will summarize areas where our research shows efforts to prevent veteran suicide are working, as well as areas where more effort is needed.

The Department of Veterans Affairs (VA) is the largest integrated healthcare system in the United States, and it provides the care, offers the programs, and conducts the research that make it a national leader in suicide prevention. The VA sees over six million patients each year, most of whom are middle-aged white men.[3] This is the group at highest risk of suicide nationally.Many VA patients have also been exposed to atrocities in war zones from Vietnam to Afghanistan. As a result, a sizeable number have both visible and invisible wounds.[4] RAND research shows that

[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

[2] The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

[3] RAND Health, Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs, Santa Monica, Calif.: RAND Corporation, RR–1165/1–VA, 2015.

[4] Rajeev Ramchand, Terry L. Schell, Benjamin R. Karney, Karen Chan Osilla, Rachel M. Burns, and Leah Barnes Calderone, "Disparate Prevalence Estimates of PTSD Among Service Members Who Served in Iraq and Afghanistan: Possible Explanations," Journal of Traumatic Stress, Vol. 23, No. 1, 2010, pp. 59–68.

the VA is serving these veterans with the high-quality care that they deserve. Our analyses reveal that the mental healthcare delivered at the VA generally exceeds the care offered in other health systems,[5] and that the services provided by the Veterans Crisis Line surpass most crisis lines operating in the United States today.[6] As a member of a panel that reviews and scores VA research proposals, I can attest firsthand to the high-quality research proposed and funded by the VA that will continue to promote it as a national leader in suicide prevention.

This is why the biggest challenge the VA currently faces is preventing suicide among those not enrolled in VA care. In 2015, we learned that veterans with other-than-honorable discharges had double the risk of suicide relative to those who separated honorably. Last month, Secretary Shulkin announced plans to extend services to these veterans who were traditionally ineligible for VA care.[7] We also need to focus on women veterans: The rate of suicide among the youngest cohort of women veterans was 35 per 100,000, a rate seven times that of their civilian counterparts.[8] In collaboration with the VA, RAND interviewed responders working at the Veterans Crisis Line to investigate why women callers might be unreceptive to VA care. The women these responders talk to on the phones refer to a "male-oriented" culture at the VA that begins as early as check in, when receptionists presume a woman is supporting her husband and is not a veteran herself. Women most satisfied with their care tend to have received services specifically for female veterans or have developed strong therapeutic relationships with their healthcare providers.[9] Women and those with other-than-honorable discharges are only two groups at risk: We must continue to figure out what other groups of veterans are at high risk of suicide, understand why they are not accessing care, and address those barriers as well.

But not all veterans will ultimately access VA care, which is why community-based suicide prevention is a necessary part of preventing veteran suicide. This requires support and leadership outside the VA. Gun sellers, shooting ranges, and advocacy groups are playing a role, with new campaigns that raise awareness and promote safe firearm storage.[10] Veterans involved with the justice system likely represent another group at high risk. They can be enrolled in veterans' treatment, mental health, or drug courts, in which the goal is to rehabilitate, not to punish. But only some veterans can access these programs, and such programs need to be evaluated so that we can determine whether there is a social business case to justify their continued expansion.

Suicide is not just a veterans' issue. It is a national public health threat. Suicide is increasing nationwide, among young and old, men and women, white, black, and Hispanic.[11] Strengthening community-based programs would not only help prevent veteran suicide, but could help turn back the rising tide of suicides nationally. The VA could play a role in stemming this tide as well: Evidence-based suicide preven-

[5] Rajeev Ramchan, Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans, Santa Monica, Calif: RAND Corporation, RR–1165/2–VA, 2015; Katherine E. Watkins, Harold Alan Pincus, Brad Smith, Susan M. Paddock, Thomas E. Mannie, Jr., Abigail Woodroffe, Jake Solomon, Melony E. Sorbero, Carrie M. Farmer, Kimberly A. Hepner, David M. Adamson, Lanna Forrest, and Catherine Call, Veterans Health Administration Mental Health Program Evaluation: Capstone Report, Santa Monica, Calif.: RAND Corporation, TR–956–VA, 2011.

[6] Rajeev Ramchand, "Is America's Crisis 'System' in Crisis?" US News and World Report, July 17, 2016.

[7] Mark A. Reger, Derek J. Smolenski, and Nancy A. Skopp, "Risk of Suicide Among US Military Service Members Following Operation Enduring Freedom or Operation Iraqi Freedom Deployment and Separation From the US Military," JAMA Psychiatry, Vol. 72, No. 6, pp. 561–569, 2015; Office of Public and Intergovernmental Affairs, Department of Veterans Affairs, "VA Secretary Announces Intention to Expand Mental Health Care to Former Service Members with Other-Than-Honorable Discharges and in Crisis," press release, March 8, 2017.

[8] Office of Suicide Prevention, Department of Veterans Affairs, Suicide Among Veterans and Other Americans: 2002–2014, Washington, D.C., 2016.

[9] R. Ramchand, L. Ayer, V. Kotzias, C. Engel, Z. Predmore, P. Ebner, J. E. Kemp, E. Karnas, and G. Haas, "Suicide Risk Among Female Veterans in Distress: Perspectives of Responders on the Veterans Crisis Line," Women's Health Issues, Vol. 26, No. 6, 2016, pp. 667–673; Charles Engel, Virginia Kotzias, Rajeev Ramchand, Lynsay Ayer, Zachary Predmore, Patricia Ebner, Elizabeth Karras, Janet E. Kemp, and Gretchen Haas, "Mental Health Service Preferences and Utilization Among Women Veterans in Crisis: Perspectives of Veterans Crisis Line Responders," presented at the American Association of Suicidology 50th Annual Conference, April 27, 2016.

[10] M. Vriniotis, C. Barber, E. Frank, R. Demicco, and the New Hampshire Firearm Safety Coalition, "A Suicide Prevention Campaign for Firearm Dealers in New Hampshire," Suicide and Life Threatening Behavior, Vol. 45, No. 2, 2015, pp. 157–163.

[11] Sally C. Curtin, Margaret Warner, and Holly Hedegaard, Increase in Suicide in the United States, 1999–2014, data brief No. 241, Hyattsville, Md.: National Center for Health Statistics, 2016.

tion strategies within the VA should be promoted and adopted by communities, many of which are facing acute suicide threats and are in dire need of support. It's only when we come together in a spirit of support and collaboration that we will begin to make a real dent in the public health threat that suicide poses to America today.

Thank you again for inviting me to testify. I will be happy to answer your questions.

Senator MORAN. Thank you for accepting our invitation.

Let me begin with Dr. Clancy.

You indicated in your opening remarks that suicide rates are increasing, especially in rural areas. What do you attribute that to? Is there a relationship between the inability to access care because of the rural geography, the demographics and programs that are available? Or do you have a basis for which that conclusion was reached? Is that just a fact or do you have an explanation?

Dr. CLANCY. That is a fact, and we are still working on an explanation. So it could be isolation that may be more common in rural areas. At the same time, that's often accompanied by a certain resilience and self-sufficiency. It could be that people with mental health conditions that may predispose them to being more vulnerable to the risk of suicide, for example, post-traumatic stress disorder, and so forth, may actually be more likely to move to rural areas, but we need to learn more about that. But that doesn't mean that we can't reach out now and work as hard as we can with partners in rural areas. And we have one very important asset, as I think you know, Senator, which is the capacity to reach these veterans virtually by telehealth and other capabilities.

Senator MORAN. Let me ask Dr. Ramchand, do you have research or know of research that addresses the causal relationship between rural veterans and increasing rates of suicide?

Dr. RAMCHAND. Not among veterans. This is a national trend that we see higher rates of suicide in rural communities. And as Dr. Clancy pointed out and as you suggest in your question, access to mental health care is certainly one of the explanations that has been hypothesized. They've ranged. Some people have looked at altitude. A lot of people have thought about the high prevalence of firearms in households within rural communities relative to urban areas as well as potential causal factors as to why there might be this disparity in rural versus urban access to care.

Senator MORAN. Is my statement that access to care, mental health services, suicide prevention efforts, is it a true statement that it is less available in rural America?

Dr. RAMCHAND. Absolutely.

Senator MORAN. That's a given.

Dr. RAMCHAND. Yes.

Senator MORAN. Okay. And then, Dr. Clancy, how has the Choice Act given you additional tools or other VA community care programs? How have you integrated into mental health services to suicide prevention the opportunities that Congress gave the VA to allow private care to be provided?

Dr. CLANCY. So we have utilized the resources that you gave us to hire more mental health professionals as well as the strong encouragement from the Clay Hunt Act. I believe over the past several years—in any given year, we have roughly an 8 percent turnover among all health professionals, but on top of that turnover, we

have hired a net of just over 400 new mental health professionals, psychiatrists specifically, and more in other disciplines, so that is good news. So that's within our own system.

Where we can and where there are resources available in rural communities, then we can actually purchase that through Choice for veterans who can't actually get into our facilities. And not specific to Choice, we have greatly expanded our capacity in telemental health, which, by the way, there's an awful lot of health care you can do by telehealth, but the strongest evidence base actually is for mental health.

Senator MORAN. That's a good point that I would be happy to make. The Choice Act, when I was asking the question, I was thinking of community providers. There was also $5 billion made available for the VA to hire additional professionals.

Dr. CLANCY. Yes.

Senator MORAN. And can you tell us how that—what the consequences of that $5 billion has been in hiring mental health professionals?

Dr. CLANCY. Well, that's why I noted that we have a net increase of just over 400 psychiatrists over the time since the law was passed. So even with turnover that we expect at all times, we have seen a net increase. Do we need to hire more? Yes. And ultimately this is an area where we're in competition with community providers, particularly in some areas that aren't necessarily instantaneously attractive to people as a place to live.

Senator MORAN. That's well spoken. You mentioned psychiatrists. I'll come later in questions about other professionals within the mental health arena and how the VA is or isn't utilizing those services.

Is there anything that you could describe to me that's different today in almost May of 2017 than in December of 2016 with a new Secretary? Has anything changed in regard to your efforts in the last 5 months?

Dr. CLANCY. So the two big changes is, one, the plan to expand emergency availability for service members with other-than-honorable discharges for all the reasons that my colleague from RAND just described and why it's important.

The second is this deployment of the statistical model, which we call REACH VET, which actually says to veterans, "We have reason to believe that you may be at increased risk of suicide and we'd like to stay in touch with you more often because we care." I understand that most of the time that conversation goes reasonably well, but it is a brand-new feature of health care in general—Right? To say, "Gosh, no, I don't have a blood test, Senator Moran, but based on some numbers crunching, I'm worried about you." I mean, that's essentially what the conversation is.

So those are the two biggest areas. I will tell you, there are two other features going on recently. One is that our experts here in D.C., working with colleagues across the country, including suicide prevention coordinators, community groups, VSOs, and so forth, were literally locked in a room all last week really focusing very hard on, "What more, what more, what more can we be doing?" And they came up with a lot of good ideas, so we'll be sharing a lot of that with you as we put this all together, very strong focus

on tighter integration with the Department of Defense, which is good news. And I think those are the biggest differences. And Dr. Shulkin has made it very, very clear this is his top clinical priority period.

Senator MORAN. Dr. Clancy, I'll be back to you about the disconnect between increasing resources and not necessarily increasing outcomes in a follow-up opportunity, but let me now turn to Senator Schatz.

Senator SCHATZ. Thank you, Mr. Chairman. Following up on the conversation about the transition from DOD to VA, in my conversations with veterans in the state of Hawaii, they sort of describe a scenario—and I don't know that it's precisely true, but certainly the sense of it is that the last question asked before you get to see your girlfriend, your spouse, your mother, your children, is, "Are you experiencing any mental health difficulties?" And unless you are incapable of getting through the rest of the day without getting some clinical assistance, your answer is very likely to be, "No, I'm fine," so you can see your loved one.

And I guess the first question is, Is that still true? And in a lot of ways, I think you would agree that even if it's not exactly true, if that's the experience that a veteran has, a service member has, in transitioning out, then we have a challenge there. And I would like you to speak to that if you could.

Dr. CLANCY. I certainly have heard that same experience described just the way that you did. Without actually directly observing or in some ways doing it systematically, I can't say with any precision how often it happens.

I would say, to make a broad statement, that in our country, we have often discounted signs of distress, of feeling hopeless as something one needs to just get over and pull up your socks and feel better about it. If you take people who have been trained for combat and have developed very sophisticated skills, and then say, "Oh, by the way, is your mind playing tricks on you?" you know, there are a lot of signals to say, "No, I'm great." In fact, we have developed a public service announcement to just that effect. Where people keep saying, "I'm good," "I'm good," "I'm good." Well, not really.

Senator SCHATZ. What worries me the most, though, is that I think you've all got the right clinical and human perspective here, but to the extent that some of this happens on the DOD side of the fence, I'm wondering where the integration comes and how much you can reach over to when they are active service members because that transition is sort of your golden moment to convey that it is not just okay, it is expected, it is part of your obligation, to make sure that you're okay as you transition back to civilian life, if that's what you're doing.

And I'm not persuaded that—I think you say all the right things, and I think when we hear from the service branches, they say all the right things, and yet in that moment, I'm not at all persuaded that much has changed, because you have the stigma, you have the sort of warrior ethic where, "I'm fine, I can handle this."

I understand all that, but I think we really need to work harder on systems, processes, slowing that piece down, and making sure there is DOD and VA integration in that moment because it seems

to me that that's your sort of—to borrow a clinical term, that's your assessment and intake even though it's really not that because they haven't volunteered that they need assistance, that's the moment. And if they go back home, it may be 18 months, and they may be in bad shape by the time they come back to you.

Dr. CLANCY. Yes. So if I were to just say it back to you—and tell me if I got this right—a warm handoff at the time of transition really can't overcome many, many messages about stigma and so forth. So I would say that our integrating more tightly and effectively with Department of Defense probably has to move upstream of that point because I think of the transition program as almost being the mirror image of sort of new employee orientation. I mean, you want to be done and get out of here, right? A lot of people come home, and their family members will say, "So where are your insurance papers?" "Oh, I don't know. I just wanted out." So mental health issues are not the only thing getting overlooked at that moment.

We have made some efforts with the Department of Defense. We clearly need to do a lot more. The really good news is our two suicide prevention programs work very effectively now. And Secretary Shulkin and Secretary Mattis have already met on this and agree that it is a priority.

Senator SCHATZ. I also want to follow up—and, Ms. Jarboe, first of all, thank you for everything you've done, thank you for your service to this country, for your husband's service to the country—this idea that sort of upstream chronologically that you have this moment as they're discharged to put them in front of someone who can be helpful to them over time. But I think you're really right, that whatever we do systems-wise, process-wise, there are going to be people who still just get right out the door and then have to come back 3, 4, 5 months later. But I think it's peers. I think it's community groups. I think it's not-for-profit organizations that have community credibility that are going to be able to reconnect these service members to VA in a way that doesn't feel daunting, that doesn't feel institutional, doesn't feel like you're showing any weakness. And, Ms. Jarboe, I'm over time, but if you wouldn't mind commenting on that.

Ms. JARBOE. I would agree with you, Senator Schatz. I think community partnerships, we—that's one of our organic reaches for the Military Veteran Project. We've partnered with all of our fellow organizations, we partner with Department of Defense, we've partnered with everybody we could for a united effort to help with military suicide prevention. We use the Elizabeth Dole Foundation to help our caregivers and give our families the support they need. And then if we do have a widow or a family that has sustained loss, we utilize Tragic Assistant Program for Survivors, and we also use the American Widow Project. So I think there's a lot of community partnerships we can do for an overall success of this measure.

Senator SCHATZ. Thank you.

Senator MORAN. Senator, thank you.

The Senator from West Virginia.

Senator CAPITO. Thank you. Thank you, Mr. Chairman, and thank all of you for being here today.

Dr. Clancy, thank you for coming to West Virginia and to talk with our VAs there.

I would just like to start by saying that we have a researcher at WVU, Dr. Robert Bossarte, who does a lot of suicide research and has shared with me some trends and figures nationally, and I just want to recognize him for his—and I see some shaking heads on the panel, so thank you for that.

Ms. Jarboe, thank you for coming. And your dedication to a cause greater than all of us is really impressive, and we thank you for that. But something that you said in your opening statement really hit me when you were talking about your husband, and you were talking about the combination of drugs that he was on and how you had begun to try to wean him off of that. And I think some of the statistics that come out show that in the VA's Suicide Data Report that rates of suicide are higher among those with opioid drug disorder than even depression. Now, we know we have blanketing across, particularly rural areas again here, this whole opioid and heroin abuse issue, and I'm certain that with our veterans, it's hitting them especially hard, too.

So I guess my question would be, and I don't know who can answer this, in the research and in the follow-up through the VA, as you're tracking what kind of medications people are on, if they're on some opioids that could maybe lead to some addictive issues, are you tracking that, and are you seeing any nexus of that and the rate of suicide with our veterans? Does anybody have an answer to that?

Yes, Doctor.

Dr. KUDLER. Yes. You know, we've been tracking opiates for some years now, actually long before a lot of people became aware of the issue. And there definitely is an association between suicide and opiate use and between all kinds of reasons for death and opioid use. These are very dangerous drugs. And we also have, through an academic detailing initiative and a general safety initiative and an education and training program, been working to reduce, and successfully, the number of veterans receiving opiates and the amount of opiates they receive, and certain combinations with opiates, as Ms. Jarboe was speaking about, that are particularly dangerous.

Senator CAPITO. Well, we have had situations of veterans, a father who lost his son, and fully convinced—and I believe it to be true—that the combination of medications that he was on through the VA caused him to not wake up one morning, and I think this has happened. And I think the VA has addressed, begun addressing, this issue, not just today, but many, many years ago.

But it does, I think, provide—when we're talking about veterans that are not accessing services, if you can track some medications, and you're trying to figure out how to get people more into the system to follow up with them after they've been released, particularly in rural areas, is that an avenue to maybe broaden the scope? I mean, Dr. Clancy, is that something you all have looked at?

Dr. CLANCY. We haven't looked at it specifically, but I think it's a terrific idea, particularly now that all of our facilities are reporting to the state prescription drug monitoring programs and so forth. The only thing I would add to what Dr. Kudler and you were

just discussing is a lot of this comes down to effective pain management.

About one in three Americans has chronic pain issues. It's a little over half of veterans. So on the one hand, you want to manage pain effectively and safely. On the other hand, some people actually are prompted to end their lives if we are too strongly encouraging that they stop, and so forth.

Senator CAPITO. Right.

Dr. CLANCY. I think, importantly, we have seen dramatically big reductions in the proportion of veterans who are on an opioid and another drug usually in the antianxiety agent class that particularly puts them at high risk for this. But we have a lot more to do. And I think one of the most promising avenues for pain management is going to be the use of alternative and complementary interventions.

Senator CAPITO. And that mirrors what we're seeing in the rest of the population certainly through some of the initiatives that have been going on and I think are going to be strengthened through the Care Act bill and the 21st Century Cures bill that we passed.

Dr. CLANCY. Yes. Yes.

Senator CAPITO. And we had an incident over in our VA in Martinsburg in our psych unit that they had originally been serving folks in Virginia, Maryland, and West Virginia. They were going to close because they were losing their professionals. The folks are having to serve long hours and just burned out. "Burned out" would be I guess the term. They reversed their decision to close the unit thankfully. But is this something that you said you've hired 400 more psychiatrists and others? Is this something that's happening across the country where you've just got such tremendous burnout because of the lack of professionals, but also the burgeoning need for help?

Dr. CLANCY. We are seeing more of it. To some extent, we're seeing more of it. At the time, the Inspector General was giving us some very good feedback, even if tough to hear, about the Crisis Line, was also the time when we made it much easier to call the Crisis Line. It used to be if you called one of our facilities, they would tell you the number. So presumably, if you were in crisis at that moment, you would be writing down 1–800 and so forth, and then you'd hang up and call back. And we changed that, so that from any of our facilities now, you hit 7 and you're directly connected. Needless to say, that increased the volume, so we had to increase the capacity, and at times we were way behind.

There is no question that we have a shortage of mental health professionals across all disciplines in this country, and that's going to hit some areas harder than others. And, frankly, the heroic work that our suicide prevention coordinators, mental health nurses, and other professionals do does put them at some risk for burnout. It's an issue we're paying a lot of attention to, but it's something that we need to monitor closely.

Senator CAPITO. Thank you very much.

Senator MORAN. Thank you, Senator.

The Senator from Montana.

Senator TESTER. Thank you, Mr. Chairman.

Dr. Clancy, did you just say that over half the veterans within the VA are dealing with pain in some manner or another?

Dr. CLANCY. Yes, they have pain, often from service-connected injuries.

Senator TESTER. Boy, you've got a tough job. And I'll tell you, recently I had a—well, it's been a little bit ago, I had a town meeting, and I had three or four veterans stand up and say, "The VA will not give me the pain killers I need to deal with my back problems." The very next person got up and said, "The VA overprescribed me, and my son committed suicide."

Dr. CLANCY. Yeah.

Senator TESTER. I think we really need to focus on trying to figure out if we can get a non-opioid pain killer out there to help fix this problem, or it's never going to—so you're caught between a rock and a hard place.

Dr. CLANCY. Exactly.

Senator TESTER. That's not what I intended to talk about. But it's my understanding the OMB lifted the hiring freeze. That may not actually be the case, and waivers are still required in some non-exempt positions. In the context of this hearing, I know that mental health providers have been largely exempted, but there are a lot of other folks critical to the provision of mental health care that have not, whether it's administrative support staff or even HR folks needed to hire and process the hiring of more mental health professionals. So the question is, has the hiring freeze been lifted for the VA or not?

Dr. CLANCY. I think, as you know, Senator, we had about 45,000 vacancies, and initially Dr. Shulkin got exemptions for about 38,000, which was mostly focused on those providing direct front-line care. HR and other administrative professionals for the most part were not part of that exemption. We are now working very hard on figuring out which others we will be getting exemptions for.

Senator TESTER. So the prioritization has been for front-line folks?

Dr. CLANCY. Yes.

Senator TESTER. Are waivers still needed?

Dr. CLANCY. Not for front-line folks, no.

Senator TESTER. Okay. So for 38,000 of 45,000 folks, there are no waivers that are needed, is that correct?

Dr. CLANCY. Correct.

Senator TESTER. Okay. So I've got a 100 percent service-connected vet who was offered and accepted a job at the VA. He sold his house. The hiring freeze was implemented. Now he's jobless, he doesn't have a house, and he's in limbo, and he can't get a waiver. What's happening?

I mean, look, we hear stories all the time. You guys deal with a lot of people, and you can't be 100 percent successful all the time, but if I was this guy, I'd be ready to bounce somebody off the wall.

Dr. CLANCY. I would agree with that. We would be happy to follow up with him specifically and also to take for the record a very clear accounting of which other additional positions have been exempted.

Senator TESTER. But you're here to tell me of the 45,000 people you need as front-line health care staff, you can hire 38,000.

Dr. CLANCY. Yes.

Senator TESTER. You can hire all of them that are front line.

Dr. CLANCY. No. 45,000 is the total number of vacancies roughly in VHA, and of that, we estimated that about 38,000 were front-line.

Senator TESTER. How about VBA?

Dr. CLANCY. That I would have to take for the record. I just——

Senator TESTER. Is the hiring freeze still on for VBA?

Dr. CLANCY. Technically, it's been lifted, but we are supposed to submit formal plans I believe to—the hiring freeze is lifted in the context of our developing formal plans for streamlining and so forth.

Senator TESTER. Well, I'm going to see President Trump this afternoon at the VA, and I'm going to take this issue up with him because I think that hopefully he will understand how critically important it is. You cannot do your job if you do not have the manpower.

Dr. CLANCY. Yes.

Senator TESTER. And so we need to make sure that you have that manpower.

So the OIG listed three reports on staffing shortages—this is for you, Dr. Clancy—as required by the 2014 Choice law, and we know that mental health is central to that discussion. According to the VA this month, there are at least 17 mental health care vacancies within Montana VA alone. And if anything, I think we may be heading the wrong direction. We're losing ground. We've tried to provide resources, as the Chairman pointed out, and hiring assistance over the past few years, loan repayment programs. Can you tell me how VHA is maximizing the tools that we've given you?

Dr. CLANCY. I believe that we have for the first time over the past couple of years actually spent every nickel of the Loan Reduction Program and very, very pleased to have that. It's an important tool for people facing huge debt when they finish school and training. So that has been one tool.

There are areas where it is still very difficult to recruit health professionals. And I would say for mental health professionals and primary care, those are going to be our toughest competition points with the private sector.

Senator TESTER. And so are there any other tools that you need other than the loan repayment? Is there anything else out there that you can think of that can get particularly mental health care folks into the VA? I would say rural areas, but the truth is you need them in urban areas, too.

Dr. CLANCY. Oh, absolutely.

Senator TESTER. Are there any other tools that we need to give you to be able to attract more people to help our veterans?

Dr. KUDLER. Well, as Dr. Clancy mentioned, we have spent every nickel in our education debt reduction program, including the monies for the Clay Hunt——

Senator TESTER. I got that. Is there anything else we can do?

Dr. KUDLER. Yes. More support for graduate medical education. The help we got through VACA to get more residency slots has

been helpful, but there is still a big need in psychiatry, but in all fields. Psychology is actually our number one critical shortage area.

Senator TESTER. I thank you very much. If there's a second round, I may try to get back.

Thank you, Mr. Chairman.

Senator MORAN. I would anticipate we have a second round.

The Senator from North Dakota.

Senator HOEVEN. Thank you, Mr. Chairman.

Thank you for being here today and addressing this very, very important issue.

My first question is for Inspector General Missal. As noted in your testimony, the Office of Inspector General released a report that found unacceptable results related to the Veterans Crisis Line. Your office found that calls to the VCL went unanswered or were directed to a voicemail system. And obviously this is a very important tool to help save a veteran's life, particularly in rural areas, where mental health care access is not always immediately available.

So my understanding is that the Office of the Inspector General made seven different recommendations regarding the Veterans Crisis Line.

Since the report was released, which recommendations have been implemented, and are there any of the recommendations that have not been implemented? And if so, why?

Mr. MISSAL. Senator, the report you're referring to was issued in February of 2016. We subsequently issued another one in March of 2017. At the time of our release of the March 2017 report, all seven recommendations from the February 2016 report were still open. Just this week, we've met again with representatives of the VCL and VHA. We're hoping to close a few of the open seven recommendations, and so we're in the process of doing that now. But there still are going to be open recommendations from February 2016, including all 16 from the March 2017 report. Those remain open as well.

Senator HOEVEN. Why the time to get them addressed? Why is it taking as long getting them addressed?

Mr. MISSAL. I don't have a great explanation. We are always open to discussing with VHA what we're expecting to close the recommendations. The way the process works, we put out a recommendation, they have concurred with it. They give us an action plan with a date in which they believe they can close it. We then test it when they provide us information, documents, or anything else, to determine whether we have sufficient information and that we're comfortable that they've closed the recommendation. We're always willing to discuss with them.

One of the issues we found is it seemed like we were talking across each other. We would explain what we need. Let me give you an example. In the 2016 report, we said the VCL needs a VCL handbook because there have been a lot of governance changes, a lot of personnel changes. It's got to be clear who's doing what, who's responsible for what thing, how it's supposed to work. And what we got several times was an employee handbook talking about how the employees should operate. And we've explained to them that's not what we want; we want a VCL handbook.

So just this week we're working through them, hoping to close that one. But that's an example of where they just don't seem to understand exactly how to best close these recommendations.

Senator HOEVEN. Dr. Clancy, do you want to respond to that one as well?

Dr. CLANCY. As Mr. Missal described, we have made some progress with the recommendations. I think that our biggest challenge—and you can correct me if you disagree—is actually making sure that the administrative portions of the Veterans Crisis Line, attending to the call centers and so forth, and making sure that the lines are answered, and, frankly, if there's an issue like the power source goes down or some problem with the power grid, that that is immediately picked up by the other center. That was the reason to open a second one. That's sort of the admin support, but that there is a very clear, easy, and effective handoff to the suicide prevention coordinators across our system and so forth.

I do want to make one correction just so that all of you are aware. When calls roll over, they go to another crisis line that has been certified by SAMHSA (Substance Abuse and Mental Health Services Administration), which is part of HHS, with trained crisis counselors. They are not going to limbo or a voicemail. And that's actually very, very important to us. We think we can more rapidly expedite the transition to care and assistance if we can answer the majority, if not all, of the calls. And we're at about 99 percent since early January, so that's a good thing. But that was our top priority. At least one of the open recommendations requires a contract, which does not happen too, too swiftly.

The issue about directives I think is very real in both the administrative and clinical area, and it is a high priority for us at the moment.

Senator HOEVEN. How about for other means, like text, email, those kind of things? Are you covering that as well?

Dr. CLANCY. Yes. You can text the Crisis Line, you can get into an online chat. We think it's very, very important to have 24/7 coverage. And I myself have witnessed many, many instances of effective text exchanges and complete with follow-through to what happened next. If you are a clinician and refer someone to the Crisis Line, you get a very clear report-out, and it's kind of amazing to read about the heroic next steps.

Senator HOEVEN. Well, and clearly that's very important and going to continue to be more important just because of the way people communicate.

Dr. CLANCY. Yes. Yes, exactly.

Senator HOEVEN. Thank you.

Senator MORAN. Senator, thank you.

The Senator from Washington.

Senator MURRAY. Thank you very much, Mr. Chairman. And before I start, I do want to take a moment and just recognize and thank the Crisis Line staff. They have an incredibly difficult, stressful job, and lives are on the line every minute of the day, and their dedication and compassion is truly heroic, and I think we should recognize that. There is no more important role for VA than to be there when a veteran is in crisis, to take their own life, and when they have the courage to reach out, ask for help, the VA has

to be there every single time, and that is true at the VA hospitals and the clinics, at the Crisis Line or anywhere else, so I just want to make that clear.

I want to follow up on what Senator Hoeven was just asking about because it is deeply troubling to me that the VA has not implemented the IG recommendations or the GAO recommendations. There is still no governance structure or quality measures for the Crisis Line? That just doesn't feel to me like any sense of urgency whatsoever. And I expect the VA to deal with this problem.

So, Dr. Clancy, let me just ask you directly, why has the VA failed for nearly a decade now to fix these issues? And who is being held accountable?

Dr. CLANCY. Mr. Missal just referred to sort of talking past some of our colleagues. In terms of the quality of care provided, I think in some instances we were using several different languages in terms of, what is the right kind of thing to do? We are now doing a lot more silent monitoring for the quality of that interaction and also the quality of the follow-through. We do have a quality assurance process in place. I believe that's with the Inspector General now for adjudication.

I think our first focus was on capacity. We knew that it was urgently important to make it as easy as possible to reach the crisis line, but that that required capacity. We expected an increase in demand. I think it's fair to say that what we got was a bigger demand surge than that.

Senator MURRAY. Well, Mr. Missal, thank you for being here. Thank you for what you're focused on here. I just am really disturbed by your finding in your testimony that disagreements, lack of collaboration, impacted important operations at the Crisis Line. You mentioned a number of problems. You just talked about the VCL handbook. Do you feel there's a sense of urgency from the VA to deal with this?

Mr. MISSAL. Certainly in talking to a number of people, there is an urgency, but then we have the opposite effect, that these recommendations are not getting closed out as quickly as certainly we would like it so that veterans can be served even better. So that's why we're always available to talk with VHA to make sure they really understand what we're going to need to explain it. And again I just go back to they gave us the plan of what they thought they needed to do. We accepted the plan. So it's just implementing that plan so that we can close out these recommendations.

Senator MURRAY. Yeah, it just feels to me like it's kind of bureaucratic infighting occurring at the VA and people not talking to each other. We've got people on the verge of suicide and crisis.

Mr. MISSAL. Yes.

Senator MURRAY. There has to be a sense of urgency. I just have to tell you as someone who has been involved in veterans' issues and been on top of this for a long time, these are issues that have to be resolved immediately.

And I believe, Mr. Chairman, that this subcommittee should be updated monthly until they are met. And I hope that we can request, and I would like to ask that we request, that the VA update this committee on a monthly basis, and, Mr. Missal, your team

validate that so that we know that these issues are being addressed.

Dr. CLANCY. And, Senator, if I might, we have made some internal changes to reinforce the issues and the effectiveness of bringing the administrative and the clinical pieces and the governance together. We will be bringing that to you I would guess within the next few weeks. We're realigning our internal focus on policy with those who focus on operations with the intent of getting to exactly the issues you're addressing.

Senator MURRAY. I appreciate that. I just want to see it, and I hope that this committee would, too.

Dr. CLANCY. Yes.

[The information follows:]

VHA Directive 1503 Operations of Veterans Crisis Line Center is in the concurrence phase which is expected to be completed in the near term. Following organizational concurrence, the Directive will be presented to Labor Management Relations for review of any requirements to bargain by our union partners.

The directive interfaces the Member Services business and administrative operations with the Office of Mental Health Operations and the Office of Suicide Prevention clinical operations by outlining roles and responsibilities.

Senator MORAN. Senator Murray, thank you very much for the intensity with which you raise this issue. And I share your concerns. The point being that the VA and the Inspector General has reached a conclusion as to what needs to be done. The issue is it's not being done——

Senator MURRAY. Correct, and so that's why I would like to have a report——

Senator MORAN [continuing]. And let's have a report in a matter of weeks from the——

Senator MURRAY [continuing]. By both.

Senator MORAN. A month from now we ought not be having this same conversation.

Dr. CLANCY. I especially agree, 10 years from now, yes.

Senator MURRAY. Okay. Thank you very much, Mr. Chairman.

Dr. Ramchand, thank you very much. You mentioned the high rate of suicide for women veterans, including a rate among the youngest cohort of women that is seven times the comparable civilian rate. That is deeply disturbing. And you found, and I've seen the same thing, that women veterans are often put off by a male-oriented culture at the VA that assumes that women are not veterans when they call, or either the woman assumes it or the person answering the call or talking to them.

Dr. RAMCHAND. Not necessarily at the Crisis Line. So we interviewed responders at the Crisis Line to ask them what women said were barriers when they were answering calls and they were trying to recommend that women go to the VA. What were the barriers that the women who they spoke to raised? And this was one barrier that did get mentioned by the responders when they were talking to us.

Senator MURRAY. Are there cultural shortcomings at the VA that would help explain the high rate of suicide among women veterans? Or are there other factors, other policies, that you think might impact this?

Dr. RAMCHAND. In terms of policies, I think what we know from RAND's assessment through VA Choice is that there is variability

in kind of women's services that are offered in the VA centers. So I think that variability, in some places, it's very well resourced and there is comprehensive women's care, and in others, there's not as strong of a focus on women veterans services.

Senator MURRAY. So across the VA, we don't have a directive that is followed that says women veterans have to be responded to as a woman veteran?

Dr. RAMCHAND. There are services, there are requirements for women, but there's variability in whether——

Senator MURRAY. Implementation.

Dr. RAMCHAND. Yes.

Senator MURRAY. All part of this. Okay. I am way over my time, Mr. Chairman, but thank you very much.

Senator MORAN. Thank you, Senator Murray.

The Senator from New Hampshire.

Senator COLLINS. No.

Senator MORAN. Maine.

Senator COLLINS. The great State of Maine.

Senator MORAN. I've never been to Maine.

Senator COLLINS. How could you confuse the two?

Senator MORAN. That's why I forgot about it. I've never been invited to Maine.

Senator COLLINS. Oh, you're now invited. You can do a field hearing of this subcommittee in Maine. We would welcome that. Mr. Chairman, thank you very much for holding this really important hearing. This has been one of those mornings where I was chairing a hearing myself in the Aging Committee, and I also had the HELP Committee markup, and so I apologize for my late arrival. It does not in any way reflect lack of appreciation for your holding this very important hearing.

I was going to ask the very question that Senator Murray just asked. I'm very concerned that we're not seeing the kind of progress among suicides for women veterans compared to the adult civilian population. And I know we've made some progress, but clearly there are either cultural or other obstacles. And in Maine, at our VA hospital at Togus, we have a wonderful new women's center, and I think it's made a real difference in encouraging women to come to the VA for care. It is so different from the way it was 10 years ago when I would visit the hospital.

So, Dr. Kudler, I would be interested in knowing whether you're replicating those kinds of women's centers in your CBOCs and in your—it's hard to run a community-based clinic, I realize, but in your veterans hospitals.

Dr. KUDLER. Yes, we are. In fact, we started doing this. I know—I worked the Durham VA for about 30 years, and about 15 years ago we opened what was the seventh comprehensive women's health program in the country, and it was combined primary care and mental health, and we've learned an awful lot of lessons.

This is a cultural growth factor for VA, and I think it really is true. Front-line staff, people who park your cars, doctors, how to set up the rooms, how to have a waiting room. Should there be a window to the outside if you're on the first floor if you're the women's clinic? Women, it turned out, really felt observed in a fish bowl. We had to fix all sorts of things. But we're learning how to

do this, and we're making cultural inroads into the community of women veterans.

Another aspect is—I just want to mention in this context—the relation of women veterans using firearms to end their lives, which is something you don't see in the civilian section, and which 9 out of 10 times that will be lethal as opposed to other means used by civilian women is a major factor. But we have to figure out the messaging to work with women veterans about firearms safety and means restriction.

Senator COLLINS. Thank you.

Dr. Clancy, according to the VA's 2016 Suicide Data Report, rates of suicide have decreased among VHA patients diagnosed with a mental health or substance use disorder with one exception, and that is the rate of suicide has increased for patients diagnosed with an opioid use disorder.

In 2014, I worked to ensure that our service members and veterans could participate in safe prescription drug disposal programs that would be located at VA clinics and hospitals, and that effort provides veterans with a reliable, safe, accessible, and accountable method to dispose of unneeded medications, and that obviously reduces the risk of diversion and theft as well as overdose or misuse. And, indeed, drug take-back programs are occurring across the country this weekend.

Additionally, in the Comprehensive Addiction and Recovery Act, which became law last year, there are numerous provisions to combat opioid abuse, such as mandating VA's participation in state prescription drug monitoring programs. There was a front page article in a Maine paper yesterday saying that there have been real problems getting the VA to comply with the new state law in Maine.

Could you give us an update on the VA's opioid safety initiative and participation in those state prescription drug monitoring programs?

Dr. CLANCY. Thank you for that question, Senator. We are participating with all 49 States that have a prescription drug monitoring program. I believe it's the State of Missouri that does not yet have one. And, in fact, we can track it.

[The information follows:]

A recent local newspaper article detailed the fact that the VA is not bound by a new state of Maine law limiting opiate prescribing (since the VA is a Federal facility). However, as noted in the article, the VA's internal Opiate Safety Initiative mirrors many of the requirements in the law, and VA Maine continues to seek an aggressive program to reduce opiate prescribing. The attached fact sheet below details a summary of these activities at VA Maine.

OVERVIEW

The VA Maine Opioid Safety Initiative (OSI) is a highly coordinated, system-wide program designed to improve opioid safety for Veterans, opioid safety education for all clinical staff members, improve access to and utilization of alternative pain treatments and support services, improve utilization of opioid safety universal precautions including naloxone, and prepare VA Maine for Maine PL Chapter 488.

Components of the initiative include: Strategic Planning Pain Team led by Chief of Staff, clinical staff education, Academic Detailing Program, Naloxone Education and Distribution, quality improvement project (PDMP utilization), opioid tapering to meet objectives of Maine PL Chapter 488, community outreach to veterans and healthcare professionals

OUTCOMES

Universal Precautions Chronic Opioid Cohort* as of April 2017
- —95 percent have informed consent (1111/1164)
- —90 percent have a urine drug screen in the past year (1045/1164)
- —95 percent have a PDMP review in the past year (1109/1164)
- —At least 95 percent Maine PDMP enrollment among opioid prescribers
- —157 naloxone kits dispensed to chronic opioid users at high risk of overdose as of April 2017 (defined as patients with MED>100 or co-prescribed a benzodiazepine)
- —306 naloxone kits dispensed to any patient at risk of overdose as of 5/1/17

Chronic Opioid Cohort* population changes as of April 2017
- —Total number of chronic opioid patients decreased 19 percent from 1449 to 1179 since March 2016
- —Sum of MED in chronic opioid patients decreased 32 percent from 76,110 to 51,775 since March 2016
- —55 percent decrease in # patients with > 100 MED from 186 to 84 since March 2016
- —82 percent decrease in # patients with > 300 MED from 22 to 4 since March 2016
- —30 percent decrease in # patients co-prescribed a benzodiazepine from 338 to 242 since March 2016

Pharmacy Data (all patients, all opioids)
- —17 percent decrease in number of opioid tablets dispensed from VA Maine pharmacy in March 2017 compared to March 2016 (from 233,598 to 194,471)
- —10 percent decrease in number of opioid prescriptions dispensed from VA Maine pharmacy in March 2017 (2401) compared to March 2016 (2642)

Educational Outreach
- —Greater than 95 percent of opioid prescribers have received an academic detailing visit
- —100 percent of high priority opioid prescribers in primary care have received an academic detailing visit

*Per VISN 1 metrics (excludes, palliative care, suboxone, and tramadol)

Dr. CLANCY. We developed and deployed and broadly disseminated a tool really focused on primary care clinicians so that they can see in one panel in a very easy way all of their patients who are on opioids, whether they are complying with recommended clinical practice guidelines, what the dose has been over time, what are their pain scores doing? what other medications are they on? and so forth. That same tool is a platform for us to track, how often have the state PDMPs been queried?

I had not heard any particular problems with Maine, but I would be happy to check into it and follow up with you.

Senator COLLINS. Thank you. I would very much appreciate that. Thank you, Mr. Chairman.

Senator MORAN. Thank you, Senator from Maine.

The Senator from New Mexico.

Senator UDALL. Thank you, Mr. Chairman, and thank you to the panel. This has been excellent testimony here today. This is obviously a very difficult problem, and it's difficult for many to talk about and let alone solve, and bringing the veteran suicide rate to zero is obviously a daunting task, and I commend each of you for your work in that area.

I wanted to focus on the issue of doctors and the DOD that want to get into the VA. But first a little bit about New Mexico and what's happening there. The increasing rate of suicide is a national crisis that strikes communities throughout my home state of New Mexico. In 2014, New Mexico was among five states with the highest suicide rate. And as you know, this rate is even higher among

veterans, and I think that case is true also in New Mexico. The problem is made worse by a severe shortage of mental health practitioners, especially at the VA. Just this last week, Secretary Shulkin informed me that out of 80 beds in the mental health ward in Albuquerque, 20 are out of commission due to staffing problems, and even more beds are empty because an air conditioner is broken.

And I've worked in this committee to improve the VA's ability to incentivize doctors, nurses, and PAs to work at the VA. And I know there are also doctors who are seeking to transition out of the DOD into the VA, but face a month-long application process.

Is there a system in place that allows fully licensed and certified practitioners within the DOD to quickly and easily transition to providing mental health care at the VA?

Dr. CLANCY. We do have an overarching memorandum of understanding with the Department of Defense. To be completely candid, I'm not actually sure that at every single corner of our system everyone is aware of it, not for lack of effort, but we can actually quickly bring in—and you don't have to go through the credentialing process, and so forth if you've already been credentialed and privileged by the Department of Defense. I'll be happy to follow up and to make sure that the Albuquerque facility is plainly aware of that, but we'll double-check on that. It may or may not address the nurse staffing issue.

[The information follows:]

In 2011, VA and the Department of Defense (DoD) entered into a Memorandum of Understanding (MOU) for the sharing of practitioner credentials to facilitate assisting one another expeditiously. This MOU is intended to facilitate the credentialing of healthcare providers between VA and DoD and establish guidelines for sharing the credentialing data collected and verified by one Department with the other, expediting the appointment process of those providers who are shared across Departments. VA and DoD similarly credential many healthcare professions in accordance with the Joint Commission (JC) standards. The process involves the sharing of the credentialing information and primary source verifications from the provider's credentialing records as outlined in the MOU. VA is able to share this information electronically by giving the appropriate DoD official access to the respective file in VetPro. DoD is unable to share the file electronically at this time so the sharing of information with VA is in paper form (i.e., their Interfacility Credentials Transfer Brief (ICTB) with supporting documentation).

This credentialing information is used to support the facility specific privileges that must be requested by the provider to reflect services that he/she is being asked to perform in their assignment. The privileges must still be reviewed by the receiving facility's Executive Committee of the Medical Staff (ECMS) and approved by the Director in accordance with Joint Commission standards. Facilities may call an ad hoc/emergent meeting of their ECMS for expeditious processing. The receiving facility is responsible for monitoring the provider's clinical performance through the Focused Professional Practice Evaluation/Ongoing Professional Practice Evaluation (FPPE/OPPE). In those rare instances where concerns related to substandard care, professional misconduct, professional competence, or professional conduct are identified, the VA Chief of Staff must contact the Chief of Staff at the DoD facility with documentation of concern. As the privileging authority, the VA Chief of Staff must ensure the investigation of all clinical care concerns and any necessary privileging actions in conjunction with VA care are addressed in accordance with VHA Handbook 1100.19, "Credentialing and Privileging" and reported to the National Practitioner Data Bank and State Licensing Boards accordingly. If the provider's services will be a long term need, exceeding more than 180 calendar days, the provider will be fully credentialed during that time.

In Summer 2018, DoD and VA will share a credentialing software platform and a common database of all providers credentialed in both agencies. At that time, the credentialing files will be easily shared electronically between agencies eliminating the need for two separate credentialing files or transfer of paper records.

Regarding the Albuquerque VAMC, the VAMC's credentialing staff has been made aware of the VA/DoD MOU for the sharing of practitioner credentials to facilitate assisting one another expeditiously.

Department of Veterans Affairs

Memorandum

Date: FEB 28 2011

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Sharing Credentials with the Department of Defense

To: VA Medical Center Directors
VISN Directors (10N1 - 10N23)

1. The Department of Veterans Affairs (VA) and the Department of Defense (DoD) have entered into an Memorandum of Understanding (MOU) for the sharing of practitioner credentials. This MOU is intended to facilitate the credentialing of health care providers between VA and DoD establishing the guidelines for sharing the credentialing data collected and verified by one Department with the other which will expedite the appointment process of those providers who are shared across Departments. VA and DoD similarly credential many health care professions in accordance with the Joint Commission (TJC) standards. When these professionals are shared across Departments, this activity becomes duplicative not only in information, but also in costs. The implementation of this guidance will reduce not only the duplicity, but also the time to complete the credentialing process in preparation for appointment.

2. Attachment 1 is a table that identifies the compliance with TJC data sharing principles of each Department, individually as well as jointly in some instances, for the completeness, accuracy, and timeliness of information provided in their performance of credentials verification. The principles listed in the table are the basis for this guidance.

3. Attachment 2 explains the format and necessary information for the exchange of verified credentials information. It is expected that providers will still apply for the appropriate privileges at the DoD facility, completing any necessary paperwork and providing any additional information. Attachment 3 is a sample letter that you may use for consideration when submitting a credentials package to a DoD facility.

4. In order to respond to questions about this process, it is critical to collect information concerning the number of practitioners and practitioner demographics. Therefore, each time a credentials verification package is shared with a DoD facility, the following information should be submitted to Kathryn Enchelmayer, Director, Credentialing and Privileging. This information should be submitted in an e-mail message:

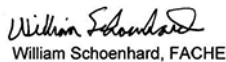
VA FORM MAR 1989 2105

Page 2

Subj: Sharing Credentials with the Department of Defense

a. Practitioner name
b. Occupational category/provider type (i.e. physician, dentist, psychologist, etc.)
c. Board/specialty certification(s)
d. Area of Practice
e. Name of facility, City, and State of permanent VA appointment
f. Name of facility, City, State of DoD assignment facility
g. Initial date of DoD assignment
h. Assignment expectation (full time, part-time, as needed)
i. Expected length of DoD assignment
j. End date of DoD assignment

5. Questions concerning this process should be directed to Kathryn Enchelmayer, Director, Credentialing and Privileging at (919) 474-3905, or via outlook at Kathryn.enchelmayer@va.gov.



William Schoenhard, FACHE

Attachments

Senator UDALL. You bet. Thank you, Dr. Clancy.

Dr. Clancy and Mr. Missal, it's troubling that so many veterans slip through the cracks. In your testimony, you described that over two-thirds of those veterans who take their life have never received care from the VA, and nearly 9 out of 10 have never received mental health care. For years, this committee has examined and funded systems to make it easier for those who do seek treatment at the VA to bring their health records with them. And I recognize that no one can force a veteran to seek treatment.

Currently, does the VA, in cooperation with the military branches, ensure that service members who have demonstrated need for mental health care when they are discharged, and they don't seek treatment at the VA, are they followed up on? So that's identified and then the discharge. And whether this is in the area of traumatic brain injury, PTSD, or suicidal ideation.

Dr. CLANCY. We make that warm welcome very, very apparent as, you are correct, we can't force anyone to come to VA, and some will get jobs and other insurance-related through employment or whatnot, and hopefully get care elsewhere. Very high on our urgency list, though, is tightening that link with integrating with the Department of Defense both at the time of transition, which is critical, but also upstream from that transition, particularly where it comes to minimizing stigma.

Mr. MISSAL. I don't have anything more to add. Obviously that's an issue that we are well aware of, and it may be appropriate for a future project for us.

Senator UDALL. Great. Great. Thank you.

And then just a quick question on telehealth. Dr. Clancy, I share your optimism for telehealth and the possibility of increased access to VA mental health care in rural areas. What is the VA doing to ensure that these areas are not left behind because of the latest developments in telehealth? You know, there are a lot of these areas that don't have broadband, and so you can't utilize telehealth. What are you all doing on that front?

Dr. CLANCY. So for our system, many times people are getting telehealth at a small outlying clinic, so it is not purely reliant on broadband availability in the area, which helps a lot. In other words, we're doing it through a hardline connection.

Ultimately, with greater availability of broadband, it would be much, much nicer I think for many veterans to be able to not have to come to one of our facilities, particularly depending on where they live. Some get it at home. I have spoken with a number of veterans at home, not about their clinical issues, but, you know, because they happen to be at the end of a session that they had with one of our professionals.

Senator UDALL. Thank you very much.

Thank you.

Senator MORAN. The Senator from Florida, Senator Rubio.

Senator RUBIO. Thank you very much. Thank you all for being here.

I want to begin with you, Mr. Missal. First of all, I want to preface everything I say by saying I think the enormous vast majority of the people at the Veterans Administration do extraordinary work. These are incredible people who work hard, and many of them are veterans themselves.

I think it's always important to say and to thank them for what they do, but we all understand that there are shortcomings in the system. And I know that you recently conducted an evaluation of the quality of care provided at the Orlando VA, obviously in Florida, and you reviewed several aspects of key clinical and administrative processes that affect patient care outcomes, including policies and procedures that address safe medication management and contraband detection.

And potentially what I'm about to ask is outside the scope because I think you focused on anticoagulation medications specifically, but I want to ask your judgment on opioid medication because it's been reported that VA employees illegally diverted or stole controlled substances, including opioids. This, of course, is unacceptable. And the fact that a nurse was allowed to resign and another employee was merely suspended for 2 weeks I believe is outrageous and intolerable.

And I lay that as a predicate for the follow-up question I have, but what can we first do? What recommendations do you have, whether it's opiates or anticoagulation, that we could impose to better mitigate the protocol and the abuse of these medications?

I know we're focused on suicide prevention, but we've seen the link between substance abuse and suicide in veterans. And so it would be tragic if the source of whether it's an opiate addiction or the like is the VA system.

So what can we do? What can be done to better mitigate the protocol, or change the protocol, and the abuse of medications?

Mr. MISSAL. Well, we're looking at this from a number of different perspectives. In the past, as part of our inspection program, we inspect the medical facilities at least every 3 years or so. In the past, we've had a protocol to look at it and to make any recommendations where their procedures may not have been as effective as they could be or that they weren't implementing those procedures.

We also have a very aggressive criminal investigation into a number of drug diversions of controlled substances, another one. Unfortunately, we have a number of open investigations now.

In the past, we've worked with the Department of Justice to prosecute a number of people, whether they were VA employees or those who had access to controlled substances within VA medical centers. And one of our goals is to try to act as a deterrent there to make sure that it's clear that if VA staff or others divert, steal, controlled substances, that we're going to be very aggressive in terms of the prosecution.

Senator RUBIO. Is there any indication that the diversion problem at the VA is substantially broader than what you may find at any other facility?

Mr. MISSAL. I've seen some studies on that, and it's a problem across a number of facilities. I don't think it's substantially greater at VA than some of the others, but I'm not sure if all the studies are that broad.

Senator RUBIO. And so my follow-up question is for you, Dr. Clancy, and again I want to reiterate, as I said, the incredible work that the people who work under you are doing at the Administration. But I remain concerned, and that's why I've sponsored legislation to address it, that under existing civil service laws and rules, we're either unwilling or unable to sometimes hold the remaining few who are doing a poor job, whether it's a bad job or even worse in some instances, some of the things you've just outlined here today, that under the existing civil service laws, we are either unable or unwilling to hold accountable people for their actions.

And so is it your view generally that the Department currently has the authority it needs to manage the workforce and its employees accordingly, and, in particular, hold people accountable?

Dr. CLANCY. We do have authority. I think where we have fallen down in the past is that it can be a lengthy process. And I will say in the area of opioid narcotic diversion, Secretary Shulkin has made it very clear our tolerance level is zero and that we will react promptly when employees divert that medication. We believe that it is, if anything, less than the private sector, but it's not easy to find consistently good data in the private sector.

Secretary Shulkin has made accountability one of his top priorities. So I think that you're going to see that it's a new day at VA, and I will leave it at that. But we would be happy to follow up with specific questions for the record.

Senator RUBIO. Absolutely. And my closing, just to say that we have worked and continue to work on accountability legislation that the Secretary supports to give them the authority to remove people.

Dr. CLANCY. Absolutely.

Senator RUBIO. Not in an unfair way, we're not interested in witch hunts, we're not interested—we need good people. I don't think there is any interest in removing good people.

Dr. CLANCY. No.

Senator RUBIO. For political purposes or otherwise, but we remain concerned, and I think the Secretary shares this view in his public statements, that the VA at this time does not have the authority it needs to remove people in an expeditious manner if they choose or find the need to do so. And so I look forward to hopefully working with you and others to get that done.

Mr. Chairman, thank you.

Dr. CLANCY. Well, if I might just note, Senator, just that this week we've had senior leaders across our system all together out at a meeting. And so the Secretary was very, very, very clear about this, and actually was doing problem-solving with individuals to say, "How can we help you?" Because oftentimes our leaders want to act more expeditiously, and it's tricky. And he walked us through what the legislation is and that he welcomes it.

Senator MORAN. The Senator from Wisconsin, Senator Baldwin.

Senator BALDWIN. Thank you.

For Mr. Missal and Dr. Clancy, I would like to ask both of you about the VA's domiciliary program. I continue to have serious concerns about the safety of residents in those facilities and whether those facilities are appropriate for veterans who are at risk of suicide or overdose.

Mr. Missal, as you know, I've been in communication with the Inspector General's Office since February of 2015 about multiple events that have happened in Milwaukee's domiciliary that have illustrated failures in security protocol and operations including a tragic drug overdose of veteran Cole Schuler. For well over a year, your office has been conducting an investigation into Mr. Schuler's death, and into overall operations at the domiciliary.

So I want to ask you a couple of questions. First of all, when will your office complete and publicly release this investigation? And then I guess I have to emphasize the urgency of a timely review. We want to see a review and your recommendations and think they are urgently needed. Earlier this month, a syringe of heroin was found in a resident's possession at the domiciliary after he got it past security.

And I'm going to start with you, and then I have additional questions of Dr. Clancy relating to the domiciliary program.

Mr. MISSAL. I don't have a specific date. I know it's a priority for our office. I have been focused on this. I think there are issues across the country with the doms. They do provide an important service. I've personally been in some of them, and what I found is inconsistency in the approaches there. But we will get you that report as soon as possible, and then if you would like, we would personally brief you and your staff about it.

Senator BALDWIN. I very much would like to have that happen.

And to you, Dr. Clancy, I would like to ask about the status of the Department's assessment that was required by last year's committee report of these security concerns that I'm discussing and whether the current domiciliary program can meet the needs of veterans who are at heightened risk for overdose or suicide. Our

committee also directed the VA to include alternatives to the domiciliary program if it finds that the current program cannot meet the needs of these at-risk veterans.

So what is the current protocol for monitoring residents, and, if necessary, intervening to move someone from the residential rehabilitation setting to an acute inpatient setting or another more supervised setting when warranted?

Dr. CLANCY. I'm going to ask my colleague, Dr. Kudler, to address this. He's closer to the details.

Senator BALDWIN. Very good.

Dr. Kudler.

Dr. KUDLER. Yes. This year we've actually launched, in part because of the concerns raised, and we also have been observing these events, a national what we're calling a safety surge in domiciliaries. We have almost 8,000 domiciliary beds. They perform a unique function. There really aren't many places in America where a person can now go and get residential care, especially people who have been homeless and have sort of lost the ability to pull themselves out of that cycle. VA provides a way, a path, especially if you have a severe mental health problem and you're homeless and maybe drug addicted. These programs are really invaluable to veterans, and I think it's one reason why our program is a fully integrated mental health program. No others exist like this.

Having said that, our homeless programs need additional training, additional staffing. Some of the facilities are older, have lots of blind spots, and long hallways, and we need new and better ways for surveillance. And certainly anytime a clinician in a residential rehab program sees that there is an acute problem, that patient can and should be and can be sent up to a higher level of care. It's certainly our intention to treat people in the least restrictive environment but at the highest level of care that's appropriate to them.

[The information follows:]

Domiciliary Program—The Committee notes recent reports of safety gaps in the VA domiciliary program. Therefore, the Committee directs the Department to address security concerns and assess whether the current program can meet the needs of veterans who are at heightened risk for overdose or suicide. The Department's assessment should include alternatives to the domiciliary program if it finds the current program cannot meet the needs of these veterans.

Addressing Safety Concerns in MH RRTP Programs:

In response to increasing adverse event trends in the Mental Health Residential Rehabilitation Treatment Programs (MH RRTP), otherwise known as Domiciliary Care programs, that included an increase in reported opioid overdoses and suicide attempts, all facilities with an MH RRTP were directed to conduct a Culture of Safety Stand Down of residential operations on November 16, 2016. The Stand Down required all MH RRTPs to suspend clinical operations for one day to complete a series of safety improvement activities that incorporated:

—Facility and Mental Health leadership involvement
—Completion of a unit Health and Safety Inspection including contraband search
—Completion of a 52-item Annual Safety and Security Assessment by a team of program staff, Veterans and facility safety experts
—Completion of mock safety drills on each shift
—Schedule of events that include both Veteran and Staff activities with required areas of focus on safety
—Engagement of staff that work during non-administrative hours
—Mitigation of any safety gaps identified during the stand down

As follow-up to these safety improvement efforts the medical centers were required to conduct a Surge on Safety starting March 16, 2017. The MH RRTP Surge

on Safety was a comprehensive effort that leveraged support from across all levels of VHA to ensure safe, high quality care in the MH RRTPs. Review of information from program managers and Veterans served as well as data from recent adverse events and available root cause analysis (RCA) reports had identified potential factors that may be impacting safety. These lessons learned provide the foundation for the ten steps for improving safety in MH RRTP which medical centers were required to review and implement as part of the Surge on Safety. The ten steps included:

—Develop a medical center MH RRTP Safety Committee which includes the facility Safety Officer, Patient Safety Manager, VA Police Chief, Suicide Prevention Coordinator (SPC), MH RRTP Manager or Dom Chief, Resident Veteran and other stakeholders as needed. The committee should meet at least monthly to identify and address safety, security and supervision issues. The MH RRTP Safety Committee should provide medical center leadership with on-going reports on needed actions and as appropriate mitigation strategies to address gaps related to safety.

—Review the medical center's fiscal year 2017 MH RRTP Annual Safety and Security Assessment (ASSA) and ensure any items assessed as "partially met" or "not met" are prioritized for appropriate action to address identified deficiencies.

—Review the results of the "Culture of Safety Stand-Down" which each medical center completed in November 2016. Ensure issues identified during the Stand Down were addressed and that processes are implemented to ensure an ongoing focus on safety throughout the year.

—Review current MH RRTP staff vacancies to assess impact on safety, security, and 24/7 supervision. Specific attention should be focused on 24/7 and nursing staff, psychiatrists, psychologists, social workers, and medical staff. Ensure mitigation strategies are developed and implemented to address safety gaps related to staff gaps until vacancies can be filled. In reviewing 24/7 and nursing requirements, consideration of the physical layout of the residential facility and the recently released MH RRTP Nurse Staffing Methodology should be taken into account.

—Develop a written discharge checklist that ensures:

—all treatment team members participate in a decision to discharge a Veteran;

—verification of appropriate housing and transportation;

—a follow-up appointment within seven days of discharge has been scheduled and a warm hand-off to an outpatient provider has occurred;

—alerting the Mental Health Treatment Coordinator (MHTC) and, as appropriate, the Suicide Prevention Coordinator (SPC) prior to a Veteran's discharge; and

—VA Police are alerted when an irregular discharge has occurred.

—Review screening criteria to ensure Veterans are not denied MH RRTP services based solely on a history of suicidality, opioid use disorder, recent overdose or suicide attempt, current length of abstinence or housing status.

—Review medical center availability for access to Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD) as recommended by the VA-Department of Defense (DoD) Clinical Practice Guideline for the Management of Substance Use Disorders. For OUD this would include buprenorphine, methadone and extended release injectable naltrexone and, for AUD, acamprosate, disulfiram, naltrexone, topiramate, and gabapentin. Further ensure naloxone is made available to Veterans in the MHRRTP during their residential admission via prescription and made available for staff use when responding to emergent situations involving potential opioid overdoses.

—Review local MH RRTP program policy and procedures to ensure an integrated, individualized, Veteran-centered, recovery oriented service delivery model that reduces the utilization of rules-based approaches to milieu management. These procedures should include peer support approaches including assigning each Veteran a "Recovery Buddy" and use of a Veteran run Repair Council. The medical center's Local Recovery Coordinator should collaborate in the review, policy development and staff education

—Ensure the Suicide Prevention Coordinator and MHRRTP treatment team reviews the safety needs and, as appropriate, makes necessary adjustments to the treatment or safety plan for Veteran's identified in the REACH–VET data base that are referred for residential treatment, currently pending residential admission, or already admitted. As appropriate, consideration should be given to expediting admission for those Veterans identified through REACH–VET who have been referred for residential treatment.

—In collaboration with other programs and services at the facility, review, identify, and remove any access barriers to facility mental health or medical services not available directly within the MH RRTP that are necessary to meet the

needs of Veterans such as, but not limited to, provision of pain management, primary care, and specialty mental health or medical care.

Meeting the needs of Veterans who are at heightened risk for overdose or suicide in MH RRTPs:

National trends in opioid overdoses and suicide rates are highly visible in MHRRTPs. These programs are open residential units where all admissions are voluntary. Veterans admitted are, by the nature of their medical, mental health and substance use disorders, at risk for negative outcomes. Lessons learned indicate a variety of factors impact safety in MHRRTP settings. As programs experience multiple risk factors, the probability of adverse events occurring increases when:

—there are resource gaps, critical staffing gaps, staff turnover and burnout;
—conformance to safety, security and supervision policy is not maintained;
—program service delivery is rules-based rather the Veteran Centered and Recovery Oriented;
—there is an over-reliance on group and self-help services and lack of individualized services and integrated care;
—there are deficits in care coordination with other medical center services;
—there are deficits in transition planning and coordination; and
—the complexity and acuity of Veterans served is increasing.

VHAs policies and procedures are designed to mitigate these safety risks. However, no institutional setting (public or private) can completely eliminate the risk for a negative outcome. In fiscal year 2016, VHA provided over 2.1 million bed days of care to over 33,000 unique Veteran in MH RRTPs. During this same period there were five Veteran suicides and six Veteran overdose deaths just prior to admission, during the program or just after discharge from an MH RRTP. VHA believes that even one Veteran death is too many and continually strives to improve safety. These efforts include comprehensive external reviews through dual accreditation by both the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF). MH RRTPs meet or exceed the Residential Treatment Standards and Health and Safety Standards of both accrediting organizations. VHA also adheres to both the American Society for Addiction Medicine (ASAM) and the VA/DoD Guidelines for the Treatment of Substance Use Disorders which both supports residential treatment.

When operated in conformance with national and local policy and resourced appropriately, MH RRTPs are safe and are an essential component of the broader mental health continuum of care. When a Veteran is assessed at heightened risk for self-harm, the Veteran is transferred to a VHA inpatient unit.

Senator BALDWIN. Mr. Chairman, I have an additional question. Are you planning on a second round of—okay, I will hold on.

Senator MORAN. Thank you very much.

I recognize the Senator from Alaska.

Senator MURKOWSKI. Thank you, Mr. Chairman. And thanks to each of you for your testimony and all that you do for our veterans.

I appreciated the question that Senator Udall was asking when I came in about the access to care that's provided to our veterans in rural parts of the country. And, of course, in Alaska, we're beyond rural.

And it is a reality that more often than not, the services that may be provided when it comes to that level of support, maybe the Crisis Line on the phone or what we are doing through video conferencing technologies and effectively utilizing these technologies that allow us to connect a little bit better, it's not the preferred alternative, but it does give us some opportunities. And I had worked with this subcommittee a few years back to put some language in pushing VA to do more with allowing readily available video conferencing technology, so it's good to hear that we're making some progress there.

I'm reading the comments from you, Dr. Ramchand, about the role of community-based prevention. And, again, in so many parts of Alaska, our veterans are out in a small rural village. There are

no services. We may not have ability to hook into any technology that might be available for others. And so it is the community that more often than not that provides that support, and unfortunately our suicide statistics in the broader community are far and above other states in terms of our numbers. So we have a suicide issue amongst all of our population, and then our veteran population just adds to the real consequences and the severity of the problem.

So to your comments, Dr. Ramchand, and the role that the community plays, I've had an opportunity just this past week to be down on the Kenai Peninsula, where I went to a facility where they are utilizing dogs to partner with our veterans who are suffering from PTSD and associated issues, to just allow an outlet, a focus, on something, a calming sense. I have personally seen, coming to my office here in Washington, D.C., several Alaskan vets who have their animals with them, and they tell me that in terms of ways that they are able to address PTSD without the benefit, if you will, of drugs, these dogs are providing a great deal. Veterans' therapeutic courts is something that is also being considered. So there are these alternatives that are out there that I think the community can be very helpful.

Can you speak to what we're seeing in terms of some of the innovation? It's one thing to talk about video technology, but the other areas that we can be more proactive from a community-based perspective in providing the assistance for these veterans particularly in our rural areas.

Dr. RAMCHAND. Sure. From a research perspective, I think about this kind of a triad of innovation, quality, and effectiveness really. And unfortunately with suicide prevention, we don't have many studies that have been proven effective. But people are consistently thinking about new innovative ways to identify populations and to get programs that appear to work and that look valid, at least on the face. I know there's a lot of effort right now with respect to social media and ways that we can use social media to intervene, and I think that has a lot of potential, especially with younger veterans, high school students, who may be experiencing suicidal thoughts, but I think we need to test those interventions, and especially people in rural areas who are connected and who are on social media platforms, but we have to test how those things work.

Senator MURKOWSKI. Well, let me ask then, if any of these more experimental or perhaps less traditional—let's say that—are being considered beyond just the telehealth.

Dr. CLANCY. Absolutely. We know that we can learn a lot from social media. It probably is not for all age ranges of veterans, but particularly for younger veterans, this is actually a way of life, this is not out there, this is real life, right? And, frankly, we would leave no stone unturned.

And, you know, as a senior official at the Department, I've often gotten emails from veterans saying, "I don't know this person, but I saw it on my Facebook," or, "I saw it somewhere else. Can you reach out and help?" And I would say more than 90 percent of the time somebody can locate that person. It's a different world, but it can be very, very effective, particularly for veterans who often use this as a lifeline to maintain connections with the community of people with whom they served.

Senator MURKOWSKI. Thank you.

My time has expired, Mr. Chairman.

Senator MORAN. Thank you very much, Senator.

The Senator from Connecticut, Senator Murphy.

Senator MURPHY. Thank you, Mr. Chairman.

Thank all of you for your testimony and the VA and all of the staff you represent. We have a lot of veterans in Connecticut who are very pleased with their care, very proud of the association, so thank you.

Dr. Clancy, I wanted to drill down a little bit more into this issue of care provided to veterans with bad paper discharges, those who have less-than-honorable discharges. You know, the numbers are pretty startling. If you have an other-than-honorable discharge, you are twice as likely to commit suicide, and if you're outside of the VA system, you're somewhere around 30 percent more likely to commit suicide, and I think the VA has recognized that.

I had a back-and-forth about a year ago with Dr. Shulkin about the statutory authorization that I believe clearly allows the VA to provide care to those that have bad paper discharges. Again, these are individuals who have not been given a dishonorable discharge, but because of some conduct that they engaged in that was likely connected to their injury that was caused through their service, they have been given a less-than-honorable discharge. You've made a decision now, and you noted this in your testimony, to provide a small amount of care, 90 days of care, to individuals who are in emergency circumstances.

So let me first just get the predicate question out of the way. There was for a while an uncertainty about whether VA had the statutory authorization to provide this care to individuals who have bad paper discharges. With your decision to provide care in this limited manner, are we now clear that the VA has the statutory authorization to provide care for this population?

Dr. CLANCY. Yes. And I think the sense of urgency that came out at the summit that Dr. Shulkin had just over a year ago, Dr. Ramchand was quite insistent that if we were serious, we needed to focus on veterans with bad paper because of the increased risk. And as you point out, some subset of that group, which we believe to be just over 500,000 altogether, may actually be able to confirm a service connection for that diagnosis. That will take time to evaluate, but in the meantime, they will have at least that initial 90-day period.

For those for whom we can't document that connection and therefore get them a path to enrolling in VA care permanently, then we will have time to actually enroll them and get them connected with other sources of mental health care.

Senator MURPHY. As you know, a very well-publicized recent report identified within the Army as that subset being 24,000 veterans who had a less-than-honorable discharge who had a service-connected disability but were denied services in some way, shape, or form because of that less-than-honorable discharge.

So then if it is clear that you have the statutory authorization, why limit care to 90 days? That's not a number that's based in medicine. Many of these veterans have no other outlet for care be-

sides the VA. Why the 90-day limitation if there's not a dispute any longer over the statutory authorization?

Dr. CLANCY. So we can provide care on a humanitarian basis to anyone who shows up at one of our facilities on an emergency basis, that is a given, veteran or otherwise. Ninety days was what we thought was a reasonable timeframe to establish whether they could be permanently enrolled in VHA, and our lawyers agreed with that call after doing a lot of deep analysis of existing statutes.

Senator MURPHY. So there is an opportunity then at the end of that 90-day period to stay in VA care.

Dr. CLANCY. Yes. Yes. If we can establish service connection or other eligibility, yes.

Senator MURPHY. And then this term "emergent mental illness" or someone who's in an emergency status, that again is a—what's the guidance given to people who are doing intake as to what qualifies as being in emergency status?

Dr. CLANCY. So in general, it is more or less a prudent layperson. If the veteran thinks it is urgent, it is urgent, period. I mean, I'm referring to prudent layperson as a broader definition for use of any emergency room in America by any person, right? If you call it an emergency, if you, the patient, think—consider it an emergency, it is, period.

And as you know, we have made access to care same day available for all the people enrolled in our system at our major medical centers as of the end of '16 everywhere, same day, for primary care and mental health. And in addition to that, we've reached a lot of the outpatient clinics already, and over the next couple of months, we're going to close that gap, so that actually you can go anywhere, and we will be following that very rigorously.

Senator MURPHY. I think this is really important progress that you've made here. I would argue that there's no reason to limit the care to those who are in emergency situations, nor to limit it to 90 days. And you were talking about the most vulnerable population. You're often talking about young men who just went AWOL for a short period of time because of a very serious service-connected disability, because of a TBI or PTSD, and because of that, they got a bad paper discharge, and then that disqualifies them for services. And, again, you're talking about a number that we know is in the tens of thousands at the very least.

So I would hope that you continue your progress in opening up the pathway and not having these what I would argue are arbitrary limitations, and I don't think you need a statutory authorization, but to the extent you do, I don't see any reason why we wouldn't try to work together to give it to you.

Dr. CLANCY. We will be back. I promise you that. And I think part of working with the Department of Defense in a tighter link in integration isn't just the transition, that's important, but it's also upstream in terms of the kind of evaluation that you just referenced with respect to the Army.

Senator MORAN. Senator Murphy, thank you very much.

We're going to have a second round, and try to make it— at least I'll try to make mine quick, and I'll have an opportunity at the end if I have more. But to get to Senator Baldwin in particular.

Let me, though, ask Dr. Davis, I described when I introduced you what your job title was. What does that mean? What do you do on a daily basis? And then I'll follow up from there.

Dr. DAVIS. Thank you, Senator. You know, I think probably the only typical thing about my job is that there is no typical day. So it's sort of difficult to describe what I do on a daily basis because I could have all the best-laid plans, and then a crisis occurs. And so I'm going to drop everything that I had planned in order to help that veteran in acute need.

But in general, my job description, what I do is—one of my primary jobs is to administratively flag the charts of veterans who are considered to be at acute risk for suicide. Oftentimes, I will——

Senator MORAN. These are veterans that are otherwise in the—that are in the VA hospital in Topeka for other reasons.

Dr. DAVIS [continuing]. Absolutely. So they're probably being treated in our mental health clinic, or they may come in through other avenues. Oftentimes they're identified when they've come in through our acute psych unit after significant suicidal ideation or even an attempt. And so I will go up on the unit and meet with them and assess them and just make sure that they know who I am and so that they have a friendly face that they can call if they need anything at all.

So we will flag those charts as being at acute risk for suicide, and typically those flags stay on for 90 days. And then if they're doing okay at the end of that, then we'll go ahead and remove that flag because it's designed to be—it's designed to genuinely tell providers, "Listen, this is somebody that you need to pay attention to, you need to ask those follow-up questions of." If I don't see them in person for assessment, then we will take provider recommendations of somebody that needs to be flagged as high risk for suicide.

Another primary part of my job is to respond to people who have called the Veterans Crisis Line. And so every morning when I come in, that's one of the first things that I do, is I pull up the list of people that called the Crisis Line the night before, and I start calling them back.

Senator MORAN. What's happened between the time that call was made by a veteran and your arrival in the morning in which you then call that caller back? What's transpired during the night?

Dr. DAVIS. So when a veteran calls the Crisis Line, there are trained responders 24/7 that will answer the phone. And I have had responders that have stayed on the line for over an hour with a veteran just because they needed to talk. If it's an emergency situation, if that veteran is at imminent risk for self-harm or for any reason, sometimes they've had medical emergencies that responders have responded to, they'll send out emergency vehicles to bring the veteran into the hospital so that they can be treated immediately. If it's not an emergency situation, then they'll ask at the end of that call, "Do you want a referral to your suicide prevention coordinator?" And so they are aware that it will be a 24-hour business day return call. And so that's when I will—I will start calling them back in the morning. Most—oh, go ahead.

Senator MORAN. And the veteran apparently has the option of saying, "No, I don't want to be referred"?

Dr. DAVIS. They do. And sometimes that does happen. And so I'm not aware of the veterans in our area who have called the Crisis Line if they say, "No, I don't want a referral." So that doesn't show up in my database, and I don't follow up with that.

So then once—as I'm tracking them down, more often than not, I'm able to reach them, and those needs vary from maybe somebody who's never been enrolled in the VA system and they want to get enrolled for care. It might be somebody who has an established mental health team, and they've kind of fallen away from them, they've missed several appointments, they've stopped taking medications, and their symptoms are starting to increase. And so they just need to be reconnected with their mental health team.

Senator MORAN. Doctor, is it your experience in the follow-up that the individuals who indicated they wanted to have a conversation with you, have they been cared for appropriately in the intervening time in which they made the call and the time that you make the call to connect with them? In other words, are the right decisions being made by the individual on the phone during the night?

Dr. DAVIS. You mean the actual—the veteran who's calling or——

Senator MORAN. Is the veteran receiving—is it your experience that when you talk to those individuals, that they have received the appropriate care they need during the timeframe from which they made the call on the hotline to the time that you actually talked to them? The right decision is being made about that veteran at the appropriate time.

Dr. DAVIS. Yes. For the most part, actually what I've even heard from veterans is they got kind of ticked that the responder called emergency services because they were like, "I was just talking," or, "I was just expanding on something." But——

Senator MORAN. Suggesting—I wouldn't suggest we would ever overreact because who knows what the circumstance is —

Dr. DAVIS. Right, you never want to.

Senator MORAN [continuing]. But we're not underreacting is my question.

Dr. DAVIS. That's been my experience. And, in fact, we actually had a situation where the Crisis Line responders, we had a really unfortunate situation where over a period of about 3 days, myself, other mental health providers, were in contact with a veteran who was considering ending his life, and ultimately did, but he had also been in touch with the Veterans Crisis Line. And what we ended up finding out was that those Crisis Line responders were really emotionally involved in the situation as well, and they were reaching back out. They were initiating contact with this veteran desperately trying to get him help.

And so at the end of that experience, it was emotionally difficult. And I actually ended up connecting with the Crisis Line responder that spent the most amount of time on the phone with him just because the two of us sort of needed to debrief.

Senator MORAN. Providing counseling to the counselors. Yeah. I interrupted your story about what you do on a day-to-day basis. Is there more to be said?

Dr. DAVIS. There's lots more to be said.

Senator MORAN. Yeah.

Dr. DAVIS. So those are the Veterans Crisis Line responses. I also provide consultation to people throughout the hospital. That might be—so an example of consultation that happened recently was a primary care psychologist who they were—you know, we were talking about the opioid issue, but I think one of the pieces that we don't see as much is when we do reduce opioid pain medication, then people's pain is there, and they may be at an increased risk for attempted suicide.

And so I was consulting with the primary care psychologist in terms of kind of how to preplan for this because a veteran who they were going to discontinue their opioids with had previously stated that she would become suicidal if in fact that happened. So we were kind of creating a contingency plan there. Fortunately, it worked out well.

Other consultations may be I might get an instant message on my computer that a staff member is on the phone with somebody and he has a gun to his head, and he's ready to end his life. I also provide training throughout the hospital in terms of best practices to happen when somebody enters the hospital with suicidal ideation.

I'm also doing outreach into the community because, as we know, 14 of those 20 veterans who die each day by suicide aren't connected with the VA hospital. And so we recognize that we cannot do this alone. It's important for us to partner with our community resources as well.

So I do a lot of outreach in the community. We've got Fort Leavenworth in our catchment area, and so one of the partners that I have spoken with frequently, as I provide annual trainings, some of the annual trainings, on suicide prevention for active duty and retired military there, and at the Command and General Staff College as well.

I work very closely with our law enforcement agencies. So I am involved in crisis intervention training, so helping first responders understand what to do in a mental health crisis so that they are responding appropriately, and they can bring that veteran in for care rather than turning that into a legal situation if it doesn't need to be.

We also—we partner with other of our traditional and non-traditional veteran service organizations. We recently had a—there was the Combat Veterans Motorcycle Association recently lost one of their own to suicide. And so they wanted to hold a memorial and a rally, and so we partnered with them. And we had over 100 motorcycles that came into the VA. They were escorted by the police. And there were two widows of veteran suicide who spoke elegantly and poignantly at that event. And it was an emotional event.

And so as I'm talking to people in the community, I'm always saying to them, "Awareness is one thing, but this is a call to action." And I say to them what I suppose I will say to all of you in this room, is each one of you here has somebody who you are worried about in your life, somebody who maybe has drifted away or maybe even somebody that you see on a regular basis and you don't even know their name, but you know they're hurting. And so my challenge always, as I outreach to the community is, "Do some-

thing about that. Don't let this opportunity pass by. Reach out and be willing to ask that big question, 'Are you thinking about suicide?' And if they are, call the National Suicide Prevention Hotline or the Veterans Crisis Line.

Senator MORAN. Doctor, I'll be able to follow up with you momentarily. Let me turn to Senator Schatz. I would say now that I've asked you what you do every day, I would say thank you for doing what you do every day.

Senator SCHATZ. Thank you, Mr. Chairman. I want to follow up on two issues. You know, a number of us on this panel are proponents of telehealth, and we've been very impressed with both what VA and DOD are doing, and we have legislation in this space. And what Senator Udall spoke about in terms of broadband availability, I know impacts the ability for VA to provide telehealth.

But I would like to ask Dr. Clancy a question specifically about telehealth, but also if you could broaden it to tech generally. I'm a little concerned that if we allow the rate-limiting factor in terms of the uptake for telehealth to be broadband availability, there are going to be communities that are still unable to access care. Obviously, that observational aspect of psychiatry and psychology and clinical work cannot ever be replaced. But as you've talked about, tech can work but requires a broadband connection.

And so I'm interested in maybe you don't call it officially telehealth, but how are we using tech to give better care? I'm thinking of when I ran a not-for-profit that provided clinical services for adults with severe and persistent mental illness, half the time, literally half the time, that our social workers were spending was finding the client. And I'm really interested in the extent to which either through GPS, as long as it's permission-based, that some of these problems can be eliminated or mitigated. I'm thinking about that.

I'm thinking about the rep payee programs, which it seems to me might be able to be automated. Even 10 years ago when I was an executive director, we were starting to do direct deposit, auto bill pay.

But I'm just very interested in how we can utilize modern technology to service veterans and their mental health care needs better.

So, Dr. Clancy.

Dr. CLANCY. So there are a number of examples I could give, and I would also ask Dr. Kudler to chime in, in a moment.

Senator SCHATZ. Sure.

Dr. CLANCY. One is the growing popularity of apps. So there are a lot of apps that we make available and point out to people that for folks who live by their and die by their smartphones, that this is a lifeline of sorts, whether that's the Virtual Hope Box or some other source of information about coping strategies if things are getting tough. That's one kind of thing. Video conferencing is another type of approach.

Reaching Out is kind of interesting because of privacy concerns and so forth, but certainly reaching out to established groups via Facebook and so forth.

I also neglected to mention—this is not so much technology, but it would be a message that we would be delivering through various

platforms—the importance of our vet centers. We have about 800 points of contact, and many of them have partnerships. I mean, it's astonishing really with like local libraries and other kinds of facilities, again, expanding our reach in a different way.

The one thing I would want to just say before turning to Dr. Kudler, I don't actually see this for mental health as a kind of cheap and almost as good alternative. In many ways, it's actually better because some people feel a little bit less intimidated if they are speaking virtually. And there are studies that show that people are more likely to share if they aren't in a face-to-face literal situation where they may feel a bit intimidated by their provider.

Senator SCHATZ. Every parent knows that.

Dr. CLANCY. Yes, exactly.

Senator SCHATZ. Dr. Kudler.

Dr. KUDLER. I'll add, you know, our 80 mobile vet centers actually have satellite links, they don't need broadband, and we can see patients through that. PTSD Coach, which VA developed with DOD, has not only been downloaded hundreds of thousands of times, but it's been translated into like 20 or 30 other languages. It's used all over the world as a kind of self-help tool that also leads you into care. If in fact you do a self-assessment and you need help, it then connects you with that help, through your smartphone that you're carrying.

I want to point out that in addition to more broadband and more high-tech equipment, if there were a legal solution to the problem of being able to project telehealth across state lines, that is probably the single biggest limitation to successful implementation of telehealth. So I can hire somebody in Chicago who can do treatment in Hawaii. They would have to be an insomniac, but they could do it. And I think those are things that would help.

And we're also experimenting with apps. We're working through our innovation centers looking at, for instance, if your app in the morning tells you, "You know, you didn't sleep last night," "You know, you haven't been out of your house in the last 48 hours," and can trigger you to other behaviors and connect you to care where people can help you, these are other kind of tech things we can do short of the broadband and traditional solutions.

Senator SCHATZ. Thank you, Dr. Kudler. Just a point of clarification. The inability to provide telehealth services across state lines, is that a matter of state licensure? Is that what the statutory limitation is?

Dr. KUDLER. I'm not a lawyer, but my understanding is that there has been a great deal of resistance against the idea of allowing doctors, even in VA, even with the idea of Federal supremacy, to say we're one system. I have one license in North Carolina, and I can practice through VA in any state I work in VA, but I can't do telehealth across state lines within my license. I would be vulnerable to being censored by the state in which I was offering the care, "You don't have a license in my state," and that needs to be clarified.

Senator SCHATZ. We'll follow up in writing. This seems like a problem that is very significant, but also solvable, but in the interest of time, I'll defer to my——

Dr. CLANCY. Can I just add one very quick?

Senator SCHATZ. Sure.

Dr. CLANCY. That's particularly problematic for veterans who may want to get their treatment at home, across state lines. Dr. Kudler can provide care by telehealth within our system from D.C., North Carolina, wherever, and many of our mental health professionals do that, but if the veteran is at home and it crosses a state line, that has been a challenge.

Senator SCHATZ. Thank you.

Senator MORAN. Senator Baldwin.

Senator BALDWIN. Thank you. The question I was posing right before time ran out, Dr. Clancy, was about the status of the Department's assessment required in last year's committee report of the security concerns relating to the domiciliary program. And I wanted to just revisit, is it complete yet? And will the subcommittee receive a report communicating the results of your assessment that we can then use and study?

Dr. CLANCY. I would have to check on current status, and we'll follow up with you promptly about that.

Senator BALDWIN. Thank you.

Dr. CLANCY. I do want to recognize that the Inspector General's terrific report in July of 2015 was a huge help for us. This was a comprehensive review of all of our domiciliary facilities, which really prompted and motivated the safety surge and stronger focus on security in particular.

Senator BALDWIN. Okay. So if you will get back to me on that. And I certainly would want to have the full subcommittee to be able to receive a report.

The next question, Dr. Clancy, in 2015, I worked to ensure that the annual independent evaluation of VA mental health care and suicide prevention programs, as required by the Clay Hunt Act, includes a review of opioid prescribing practices. Veterans experiencing chronic pain, many of whom are prescribed opioids to manage it, also experience higher rates of mental health comorbidities like PTSD and depression. The Jason Simcakoski Memorial Opioid Safety Act, which was enacted into law as part of the Comprehensive Addiction and Recovery Act, requires enhanced guidelines in the newly updated clinical practice guideline for opioid therapy for chronic pain with respect to the treatment of patients who are at risk of suicide.

So I was pleased to see that the updated guidelines includes a recommendation to assess suicide risk when considering initiating or continuing long-term opioid therapy and intervening when necessary. And I just would like to hear from you about the VA's efforts to assess, mitigate, reduce the risk factor of suicidality in the context of opioid therapy.

Dr. CLANCY. So, as you know, the clinical practice guideline was recently released and is in the kind of early dissemination phases, so we have not built a tracking system for that, although many of the features of what you're talking about we can actually build into that audit tool, which is also a kind of central focus of the Jason Simcakoski Act. Importantly, I think you know this, but the Simcakoski parents and family gave us valuable input on that guideline as well.

Senator BALDWIN. Absolutely.

Dr. CLANCY. So very, very appreciative of that input.

And we recognize that the two issues are very much interdependent. That is not to say that everyone at risk of suicide has an opioid problem or vice versa, but as part of lethal means reduction, for example, that's why we leaned forward very early to make naloxone distribution a very big priority, because, in essence, the medications that some people get are a lethal means if stored up and so forth. I'm not sure I'm answering your question, though.

Senator BALDWIN. It sounds, though, as though, if you haven't fully implemented it, you can't answer the question.

Dr. CLANCY. Yes.

Senator BALDWIN. So I guess I will ask it again when you return. But I wanted to hear about the VA's efforts to mitigate the risk factor of suicidality in the context of initiating or continuing long-term opioid therapy.

Dr. CLANCY. Yes. Well, I can tell you it is on our list of near-term priorities for what we're doing to, frankly, address the question, what else and what more we can do to address suicide. And we would be happy to follow up with your staff or you.

[The information follows:]

VA has developed a factsheet with respect to Chronic Pain and the risk of suicidality, which is included with this response below.

VA deployed two state-of-the art tools to help providers manage risk for Veterans receiving opioids. These tools are available now to all staff in VA facilities.

—The Stratification Tool for Opioid Risk Mitigation (STORM) was designed to identify higher risk patients receiving opioid prescriptions for proactive care management and review. The STORM tool may be used to assess risk in patients on opioid medication and also in patients not on opioid medication that may be considered for opioid therapy. STORM incorporates predictive models to estimate the risk that a patient will experience a suicide-related event or overdose, respiratory depression event, or an accident or fall. STORM generates a nightly-updated report, including: current risk estimates, a list of clinical and prescription risk factors, a tailored checklist of recommended risk mitigation strategies, and information for care coordination. STORM can also provide risk estimates for any VHA patient considering opioid therapy, estimating their risk of adverse events if they were to initiate a low, medium or high dose trial of opioid medication. These estimates can help guide risk-benefit discussions and shared decisionmaking regarding pain management plans.

—The Opioid Therapy Risk Report (OTRR) is a national dashboard that was developed to help primary care teams manage Veteran patients on long term opioid therapy. It includes information about the dosages of opioids and other sedative medications, significant medical and psychiatric co-morbidities that could potentially increase the likelihood of an adverse reaction, implementation of opioid risk mitigation strategies, and care coordination parameters. Thus, the tool aides in the review and management of complex patients. Primary care providers can get an overview of all patients in their panel and then review individual patients in detail. The tool is also available now to providers outside of primary care to review their patients on opioid medication.

VA has deployed Veteran focused education and outreach. These programs include:

—The Opioid Overdose Education and Naloxone Program (OEND) which aims to reduce harm and risk of life-threatening opioid-related overdose and deaths among Veterans. Key components of the OEND program include education and training regarding opioid overdose prevention, recognition of opioid overdose, opioid overdose rescue response, and issuing naloxone products. As of March, 2017, VA had dispensed over 70,000 naloxone kits to Veterans.

—Patient Education campaigns including waiting room posters, pamphlets, and letters educating Veterans on the risks of taking too many medications, new treatments for pain and PTSD, and the VA Opioid Safety Initiative related to tapering of opioids.

VA | U.S. Department of Veterans Affairs

Suicide and Patients with Chronic Pain

Why Should We Be Concerned?

Pain conditions independently increase risk for suicidal ideation (SI) and suicide attempts[1–5] and chronic pain is estimated to double the risk of death by suicide.[6]

- Individuals with chronic pain have a high prevalence of co-morbid psychiatric disorders, including depression, which are strongly associated with suicidal behaviors[3,7]
- Longer duration of opioid utilization has been associated with increased risk of developing depression[1]
- The presence of pain may impair the detection and treatment of depression and other psychiatric disorders[6–8]
- Depression in those with and without chronic pain is associated with SI, suicide attempts and death[6–8]

It is estimated that twenty-two Veterans die by suicide every day[9]

It is estimated that 45% of people who ultimately die from suicide were seen by their primary care provider within one month of their suicide.[9] Patients with chronic pain who are using prescribed opioids have ready access to lethal medication. Opioid prescriptions are the most common medications present in drug overdose deaths.[10] Therefore, weighing the risks and benefits of opioid use for all Veterans is essential.

It is very important to identify suicidal thoughts and take necessary action to reduce suicide attempts.

What Should I Look For (Risk Factors, Warning Signs and Protective Factors)?
Risk Factors and Warning Signs[11]
• **Suicidal ideation and intent**: wish to die • **Previous suicide attempt(s)** or family history of • **Current/past psychiatric diagnosis:** e.g., mood or anxiety disorder, substance use disorder/ withdrawal or family history of depression • **Precipitants/Stressors/Interpersonal:** triggering event leading to humiliation, shame or despair (e.g. breakups, financial or legal problems, grief, suicide of relative), history of assault (physical, emotional, sexual), terminal disease, limited social support

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What Should I Look For (Risk Factors, Warning Signs and Protective Factors)?
Pain-Specific Risk Factors and Warning Signs[3,6,8–18]
• **Pain:** severe pain intensity, chronicity (>3 months), and pain location with > risk (headache, abdominal, low back, generalized); pain-related helplessness and/or losses (e.g. job, relationship, hobbies) • **Precipitants/Stressors/Interpersonal:** insomnia/poor sleep quality, catastrophizing behavior, social withdrawal, perceived burdensomeness, impulsivity, medication misuse, physical and/or mental impairments affecting normal activities
Protective Factors*
• Resilience, religious beliefs, higher frustration tolerance, responsibility to family or pets, positive therapeutic relationships (e.g. longitudinal and positive relationship with health care providers), social supports, employment *Protective factors, even if present, may not counteract significant acute risk

Strategies for Working with Patients to Reduce Suicide

Always ask specific questions about suicidal thoughts, plans, behavior and intent

- ✓ **Screen** patients with chronic pain, mental health and substance use disorders by asking about SI and behaviors
- ✓ **Assess** suicide risk factors, warning signs and protective factors in patients with chronic pain; repeat assessments with appropriate frequency when increased risk is detected
- ✓ **Refer** as needed for mental health treatment and behavioral management of chronic pain (e.g., Cognitive Behavioral Therapy) and refer for emergency psychiatric evaluation if evidence of SI, intent, and/or behavior is present
- ✓ **Consider** high acute risk for suicide attempt and acute psychiatric instability (e.g. severe depression) to be a contraindication to opioid therapy unless Veteran is closely monitored; discontinue opioids as appropriate*, offer patients safer drug and nondrug pain treatments and provide frequent follow up **(*discontinuing without proper safeguards can increase suicide risk)**
- ✓ **Arrange** for risk stratified frequent follow-up and offer a naloxone kit as part of opioid overdose education
- ✓ **Provide** Veterans Crisis Line information: 1-800-273-8255, press 1 or **Veterans Crisis Line Website**

What Additional Steps Can I Employ to Reduce Suicide Risk in Patients Taking Opioids?[15,18]
✓ Perform consistent and frequent urine drug screens ∘ Opioid risk classification*: moderate (at least 2/year); high (at least 3–4/year) ∘ Follow-up on inconsistent results and order confirmatory testing when appropriate ✓ Follow-up within 4 weeks after initiation of opioids especially with long acting opioids ✓ Avoid sedative co-prescriptions with opioids ✓ Ensure that patients with diagnosed substance use disorders (SUD) are actively receiving SUD specialty treatment and/or SUD specific pharmacotherapies while on opioid therapy
*Please see page 8 of the Opioid Safety-Educational Guide for additional information on risk classification (**VA Pain Management Opioid Safety Initiative Toolkit Website**)

What Should I Do If I Suspect My Patient Is Suicidal?

Suicide Risk and Suggested Actions[11]		
ACUTE Risk for Suicide Attempt	**Indicators for Suicide Risk**	**Initial Action Based on Level of Risk**
High	• Persistent SI or thoughts • Strong intention to act or has a plan • Not able to control impulses or recent suicide attempt	• Maintain direct observational control of patient • Limit access to lethal means (e.g. drugs, weapons, other avenues for self-harm) • Immediate transfer with escort to urgent/emergency care setting for hospitalization
Intermediate	• Current SI or thoughts • No plan or intention to act • Able to control the impulse • No recent attempt, preparatory behavior or rehearsal of act	• Contact behavioral health provider to determine acuity of referral • Refer to behavioral health provider for complete evaluation and intervention • Limit access to lethal means of self-harm
Low	• Recent SI or thoughts • No plan or intention to act • Able to control the impulse • No planning or rehearsing a suicide act • No previous attempt	• Consider consultation with behavioral health to determine the need for referral/treatment • Treat presenting problems • Address safety issues
Undetermined	• Difficulty determining risk • Provider concern despite denial of ideation or intent	• Refer to behavioral health provider to determine acuity of referral and/or for complete evaluation and intervention • Limit access to lethal means of self-harm
Always Document: risk level and rationale; treatment plan to address/reduce current risk. Make close follow-up appointment(s) to re-evaluate stability and provide contact information to patient.		
Modifiers that increase risk: acute state of psychiatric symptoms or disorder, substance abuse or precipitating event(s); access to means (firearms, medications, toxins); multiple risk factors or warning signs; lack of protective factors		
For complete information on assessment and management of patients at risk for suicide: **VA/DoD Clinical Practice Guidelines Web page**		

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These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient's clinical condition.

This reference guide was created to be used as a tool for VA providers and is available to use from the VA PBM Academic Detailing Service SharePoint Site: https://vaww.portal2.va.gov/sites/ad

Senator BALDWIN. Thank you.

Senator MORAN. Thank you, Senator Baldwin.

Senator Schatz tells me he has no more questions.

I have a few more.

And, Tammy, anything?

[No audible response.]

Okay. We are about to conclude our hearing, and thank you all for your continued attention and patience.

Dr. Ramchand, you indicated about care tailored for women. And one of the things that caught my attention is in the programs that the VA now is implementing with VA Choice and other community programs, does that increase the chance that—increase or de-

crease—is there a consequence to women veterans in the nature, the kind of care, the attitude, with which they are approached? Are there more community options for better care for women or more tailored care for women outside the VA than within?

Dr. RAMCHAND. I can't answer the question of whether there are more options available through VA Choice. What I can say is that women responders, when we asked responders at the Veterans Crisis Line, were women accessing community-based care, and why were they choosing community-based care? Sometimes it had to do with services specifically for women, other times it had to do with logistics issues, that the center offered child care or that a center had scheduling availability during outside of work hours. So they were responsive to kind of competing demands placed upon women, especially work and family-related concerns.

So women who are accessing this care preferred community-based care sometimes because of those reasons.

Senator MORAN. Thank you for that answer.

Ms. Jarboe, I think you have so much that you could tell us about alternative care. Most of our questions this morning have been directed as to what the VA is doing. What's the increasing role or what's the opportunity you see for the kinds of services that you and other not-for-profits, volunteers, provide veterans? And what's the increasing chances that those opportunities create greater success in ending suicide?

Ms. JARBOE. Well, that's a big question. I would say from the Military Veteran Project's standpoint, we are looking towards alternative treatments in the sense of sensory deprivation, hypobaric chamber, to kind of help our men and women sleep.

If someone says, "I have been diagnosed with PTS, here are my medications I'm on," we ask them about their sleep patterns. Our doctors, our medical team, go through and walk them through their diets, their exercise, everything, to see who this person is. But when we also take time, we look at the wife, and we talk to the children. And then we introduce a battle buddy program from an alternative—an alternate organization to help that wife or help that spouse and the children to kind of cope and deal with what's going on from an educational point. So to answer that, it's just like a—it's a big broad spectrum of everything we do here. So I would say that——

Senator MORAN. I could ask the question this way——

Ms. JARBOE. Yeah, thank you.

Senator MORAN. What has been the VA's response? What's your relationship with the VA and their interest in the things that you find in your work?

Ms. JARBOE. I would say we are on—we both have the same goal in mind, and that's preventing veteran suicide. But I also think that we're both doing two different things. I think we've been able to organically growth through social media and Facebook the Military Veteran Project and other military organizations with the credibility that the younger generation sees in us and the trust that they'll come forward with us. We're trying to siphon that into the Veterans Administration to help our Veterans Administration grow nationally as well to fill the void of some of the men and women who have not applied. We do not currently have a strong

partnership with the Veterans Administration. We are there if they need us. We are not asked to attend any of their boards. We are not a part of their direct community approach or outreaches. But we will still eagerly assist the Veterans Administration when they're in crisis or in need because that's what we're supposed to do as Americans.

Senator MORAN. So any of the veterans who use the call center would not end up receiving any attention by you. If they're talking to the VA, they don't ultimately end up in a program that you're involved in.

Ms. JARBOE. No. No, sir, they don't, but 10 times to 1, we may have our Battle In Distress coordinators actually on the phone making that veteran call the veteran crisis service to fill in to make sure that they're going somewhere good.

Senator MORAN. So one of your recommendations from your volunteers would be call the crisis center.

Ms. JARBOE. Yes. We do. We're trying to promote the Veterans Administration. We're trying to shine a light on the progressive growth and the positivity the Veterans Administration has done in the past year or two, and trying to siphon our veterans into the system. So we may have programs that are a benefit. We also know that the big VA has a greater program and a greater goal and mission that we all need to unite for.

Senator MORAN. I hadn't thought of this until it came up in this hearing about vet centers. And they don't seemingly—and maybe this is me and not thinking about it— but they don't receive the attention now. In large part, my understanding is they came into existence following the Vietnam War, and many of those veterans were not interested in going to a big brick-and-mortar VA facility, and vet centers became kind of the storefront opportunity in a more subtle and less challenging environment interface with the VA. Do you have experience with vet centers as well?

Ms. JARBOE. I have visited some of the vet centers just to get an idea what our veterans are seeing when they attend. Sometimes I'll attend with a veteran. But I don't have an overall view of all of the vet centers in the Nation.

Senator MORAN. And this may be a question for the VA, or you, or maybe Ms. Davis, Dr. Davis, what happens at a vet center different than what if you present yourself at the Topeka—at the Colmery-O'Neil VA Hospital, what's different than when you present yourself in Manhattan, Kansas, at the vet center? What takes place differently?

Ms. JARBOE. I would defer to Ms. Davis.

Senator MORAN. Ms. Davis defers to Ms. Clancy.

Dr. CLANCY. Or Dr. Kudler.

[Laughter.]

Dr. CLANCY. I mean, I have visited the one in my neighborhood, and my impression is that there is a lot of counseling, and right there, and I mean like literally 3 feet away, there are also people helping you with employment opportunities and things like that. And it's, frankly, also a place for veterans to be together.

Senator MORAN. Socialize.

Dr. CLANCY. Yeah. And for some veterans who actually don't have that many places to go, this is pretty vital. And you're com-

pletely right, Senator, these were established at a time when people wanted—veterans wanted nothing to do with government or official.

So there's a lot of informal communication between the vet centers and our VA facilities. In fact, when I visited mine, the one in my neighborhood, not too long ago, they were interested in using our telehealth capabilities for continuing education with local colleagues.

Senator MORAN. I would also highlight, this may be nationwide, but in Kansas, we have mobile vet centers who travel the state in a large truck van and——

Dr. CLANCY. Yes. Oh, they're great. There are about 80 of them, and as Dr. Kudler just pointed out, they also have the satellite technology, so you don't need broadband.

Senator MORAN. Dr. Kudler, does something different happen if you show up at the vet center than if you show up at the Colmery-O'Neil Hospital?

Dr. KUDLER. Yeah. The fact is that the vet centers, as you say, were created for people who didn't really want to medicalize their issues and maybe were a little afraid about talking mental health, and yet the vet centers are staffed primarily by combat veterans, the majority of people who staff the vet centers are veterans, and usually combat veterans. They're there for readjustment counseling, that's the official name, "readjustment counseling service," so you don't have that stigma. "I'm not going for mental health, I'm just going for readjustment counseling," whatever that may be.

They can actually read VA medical records. If you're seeing a social worker or a psychologist at the vet center, they can read our record. We cannot read their record, and that's because veterans don't want it to go in that direction. But the idea is our teams can work together to coordinate care. For 10 years, I did telehealth every month into one vet center, and I would drive out to another vet center and work with their staff and with patients. It is an outstanding complement to the range of what we do, and it greatly extends it. And we have yet to recognize the full potential of the vet center program.

Senator MORAN. Dr. Davis, let me follow up on your job description: people like you. I can better understand Kansas than I can all 50 states. So we have all of Kansas in the same region, and the eastern Kansas, you talked about Leavenworth and Topeka, and then we have the Dole VA Hospital headquartered in Wichita. So who in that, in our expanse of our state, does what you do? How many more of you are there?

Dr. DAVIS. Jason Deselms is in Wichita.

Senator MORAN. So there are two of you.

Dr. DAVIS. Mm-hmm.

Senator MORAN. One at the Dole VA Hospital and one at the Colmery-O'Neil.

Dr. DAVIS. We now have two suicide prevention case managers at our VA, and they have one suicide prevention case manager at the Dole VA.

Senator MORAN. And what does your staff consist of you and those two case managers?

Dr. DAVIS. That's us.

Senator MORAN. That's it.
Dr. DAVIS. Yes.
Senator MORAN. And I don't know that you'd know this, but the amount of geography that you cover or the number of veterans, it's a significant expanse for three people.
Dr. DAVIS. It is.
Senator MORAN. Three. And a significant demand sufficient that we have two VA hospitals in that region with three people doing what you do.
Dr. DAVIS. And those are roughly 65 miles apart. And I work for both campuses, so I'm traveling back and forth between the two as well. But I think that the suicide prevention team is there in that moment of acute crisis, and then it's necessary for us to hand off care then of the veteran to the mental health teams. And so that partnership is essential between us and the mental health providers.
Senator MORAN. Okay. And is your staffing sufficient to meet the goals that you've established for Colmery-O'Neil in eastern Kansas?
Dr. DAVIS. You know, it is—what we do is an overwhelming task. And I've talked about before that when I go meet with our mental health teams, unfortunately oftentimes when I'm talking about additional duties that we might need for enhanced care strategies for somebody who might be at acute risk or with the new REACH VET program, when I go meet with those treatment teams, I have more than once been met with tears of just anguish and frustration, because I think we've worked really hard to increase access to care at our VA, and with that, and with the increased influx through the Veterans Crisis Line, these providers have ever-expanding panels of pretty high-acuity mental health needs. And more than one provider has said to me that they feel sort of this ethical dilemma between trying to provide access to care and also providing the standard of care that they feel acceptable not only for our high-risk veterans, but also just for the general veteran.
Senator MORAN. You have a Ph.D. after your title, you have a title with a Ph.D. Tell me what your background is.
Dr. DAVIS. Sure. I received my undergraduate in psychology from the University of Iowa, and I have a Ph.D. in counseling psychology from the University of Kansas.
Senator MORAN. And the two case workers, they have mental health professional credentials?
Dr. DAVIS. So one is a mental health nurse. He recently transitioned over from our mental health clinic. And the other is a social worker.
Senator MORAN. Okay. A part of the theme of my conversation with you all today has been the Choice Act. It's been a constant conversation of mine with the VA over a long period of time. Dr. Davis, do you have the ability to refer those people that you talk to the next morning to providers in the community? And do you do that?
Dr. DAVIS. So if we know that they won't be able to be seen in the mental health clinic within a reasonable time, they can be placed on the Choice list.
Senator MORAN. Let me ask this question, can they be placed on the Choice list simply if they want to be placed on the Choice list

and don't want to come to the hospital, to the mental health center?

Dr. DAVIS. Not necessarily. There have been some extenuating circumstances where a veteran, for very valid reasons, it's not appropriate for that person to be seen at the VA, maybe because of experiences that they've had. And so in those situations, what I've found is that our local leadership is responsive and veteran-centric, and they will absolutely allow that person to be placed on the Choice list, even if they don't meet the criteria for the number of days out for that appointment or I think it's 40 miles to the nearest community-based outpatient clinic or hospital. So they will make those exceptions.

But what I've found in my own personal experience is that we're talking about the needs of a lot of these rural health veterans, when we try to refer out to the community, the VA really does a nice job of providing treatment especially for PTSD and combat-related PTSD, and there just may not be those providers out in the community that are able to do that.

Senator MORAN. I think that's a good point. There are certain things that the VA has through history and volume, experience, and the collection of professionals that don't exist in many other places.

Let me ask then that question, the question related to that, you talked about the mental health center, we would send them to the mental health center within the VA is what you're telling me. What are the professionals there at your two hospitals? What's that mental health center? What do those professionals consist of?

Dr. DAVIS. Sure. So we call them BHIP teams, Behavioral Health something. I'm not sure exactly what that stands for, but the mental health teams consist of typically a prescribing provider, so that's either a psychiatrist or a nurse practitioner, maybe a physician assistant, with a mental health nurse and a social worker and a psychologist. And so there are kind of varying iterations of that makeup. And so those teams exist, and they have veteran panels that consistently return to that team to be seen.

Senator MORAN. Okay. And, Ms. Jarboe, my assumption is that the people that Dr. Davis is describing in the mental health center at the Colmery-O'Neil VA Hospital don't have—I should ask the question more neutrally—do they have any experiences with the kinds of therapies and programs that your not-for-profit promotes and utilizes?

Ms. JARBOE. I don't know exactly who is being seen there for sure, but I know that we've gone out to the Veterans Administration, and some people that have gone through an alternative program through MVP, we have been the ones who placed them in the VA care for additional support, whether it be for drug or alcohol treatment or other things. So we could kind of swipe back and forth, but I don't have an actual factual number.

We don't bring people outside the PTSD ward from the VA and say, "The Military Veteran Project has the cure-all, we're going to fix you today," but we're going to say, "Look, we can assist you, but we want to start with the research, too, because we also want to see what the pattern is, what the diagnosis is."

Dr. CLANCY. And, Senator, if I might just add briefly, the really good news in this space is notwithstanding a shortage of health professionals in mental health, we have a growing array of options. The real opportunity is going to be trying to figure out how to precisely match the options in our toolbox to the specific needs of the veterans. So to some extent, there is still a bit of shopping around on the part of individuals and a little bit of guesswork on the part of professionals. So we're getting smarter about that. It's a focus of our research and so forth, but there is no precise profile that says this veteran should fit in over here.

Senator MORAN. Dr. Clancy, tell me if my concern, the nature of these questions is, do we have a separate path that the Department of Veterans Affairs believes this is the care and treatment that should be provided, and these not-for-profit community organizations have a different set of techniques and care, and the two shall never meet? And I assume that you're going to tell me that that's not the case, we're trying to find the best care and treatment for each and every veteran based upon their circumstance.

Dr. CLANCY. That is absolutely true, Senator. And, frankly, it's a big guiding principle in terms of our thinking about, what does Choice 2.0 or the future of that program look like? To simply pay for what we're providing already, I mean, to use it as surge capacity is helpful, but Dr. Shulkin's aspirations are much higher in terms of creating a high-performing network. And we recognize that partnerships with organizations like the one that Melissa has started, which, I mean, just sounds phenomenal to me, enough to make me go to Kansas very soon.

Senator MORAN. We would welcome.

Dr. CLANCY. But, you know, we need to learn from each other frankly.

Senator MORAN. Ms. Jarboe, do you get compensated for any of the treatment that you provide, the counseling? Does somebody pay you?

Ms. JARBOE. No, sir.

Senator MORAN. All right.

Ms. JARBOE. I am 100 percent volunteer. Our 1,100 volunteers, everybody is not paid.

Senator MORAN. And under Choice or other community programs, does the VA have the ability to—you talked about a partnership, but you could not reimburse an organization, a not-for-profit volunteer organization, for services provided?

Dr. CLANCY. I'm going to use Dr. Kudler's line and just mention that I'm not a lawyer. I believe the original language of VACAA actually framed this in terms of services that Medicare pays for.

Senator MORAN. So you would have to have a Medicare provider number in order to——

Dr. CLANCY. And that kind of thing, yes. How to make that more flexible in the spirit of moving beyond the 40-mile, 30-day——

Senator MORAN. [continuing] go with what you were just describing as your goal, there may be providers that are different than what we're using today.

Dr. CLANCY. Yes. Correct.

Senator MORAN. Okay. This I think is my final question. And it's to highlight once again, Dr. Kudler and I had a dialogue back in

a hearing in the Senate Veterans Committee in 2014, and I raised the topic—and I'm going to ask this of Dr. Clancy—I've been working to get other professionals included within the VA system.

I know from my experience in Kansas, as a rural state, it's hard to attract and retain professionals that we need anyplace within the mental health provider system. And one of the arenas that we've thought and the VA has admitted has a role to play is marriage and family therapists and licensed professional mental health counselors.

And the conversation that Dr. Kudler and I had now 2½ years ago indicated that those professions were being integrated into the VA across the country. I can't find any evidence that that's the case. And so while that direction has been given, the numbers—maybe again we can follow up and tell me how many people are now working who have that licensure within the VA system. But it's one more set of professionals that could help fill the gap in the VA. And it seems to me that there is a reluctance.

In fact, the hiring of those individuals now go through the—what's the word? Someone help me. Outside. USAJOBS, which apparently adds a whole new set of criteria and is very discouraging to anybody who is looking to find a job in any kind of timeframe. And if you're trying to recruit people, sending somebody—you don't do this with all professionals at the VA, but these two categories have to go through that program, a different organization, to recruit, and it's diminishing the capabilities of you hiring folks that I think you want to be hiring. And I don't understand why it's more difficult for those individuals to find a job within the VA than other mental health professionals.

Dr. CLANCY. So we have always had some—one sticking point historically had been the accreditation of the training programs that some of these people pursued for their terminal degrees. It is my understanding that we have expanded our thinking, I think might be a better way to say it. And even before we did that, throughout our system there were some of these people hired anyway.

I would like, with your permission, to take this for the record so that we could give you a very clear lay-down of the precise numbers that we have right now.

[The information follows:]

The addition of LPMHCs and MFTs to the VA mental health workforce has expanded VA facilities' staffing options and enabled VA to better meet the needs of a Veteran population increasingly in need of mental healthcare services.

On September 28, 2010, VA facilities were authorized to hire Licensed Professional Mental Health Counselors (LPMHCs) and Marriage and Family Therapists (MFTs) as specialty mental health providers. This was after Congress recognized LPMHCs and MFTs as a specific occupational category of mental health specialists in the "Veterans Benefits, Health Care, and Information Technology Act of 2006" (Public Law 109–461). It is important to note the qualification standards for each core mental health profession require that an individual in that discipline graduate from a program that is accredited by an approved accrediting body that credits training programs in that discipline. This rule applies to all VA core mental health disciplines (Psychology, Psychiatry, Social Work, Nursing, Licensed Professional Mental Health Counseling, and Marriage and Family Therapy). Thus, the current standards for MFT and LPMHC graduate program accreditation are similar to and no higher than the standards for graduate program accreditation for other mental health professions in VA.

As of March 1, 2017, there are now 263 LPMHCs and 123 MFTs onboard in the VA. As VA's demand for mental health professionals grows, we expect that VA will continue to successfully recruit LPMHCs and MFTs into its mental health workforce. LPMHCs and MFTs are still a relatively new profession within VA and decisions to hire into these occupations are made at a local level, thus the pace of hiring may vary from site to site. To ensure mental health leaders in the VA are familiar with the LPMHC and MFT professions and are aware of the many roles that these disciplines can serve, Veterans Health Administration (VHA) Mental Health Services (MHS) has presented information on the benefits of hiring LPMHCs and MFTs to VISN and facility level mental health leadership and local human resources staff. In addition, VHA MH also provided a detailed written presentation about the LPMHC and MFT professions for facilities to use in locally marketing these professions and promoting them as one of the "core mental health professions" within VA.

With regards to "liberalizing the hiring authorities", the hiring authorities are the same for these professions as for all other Title 38 hybrid professions. Of note, the qualification standards for the Licensed Professional Mental Health Counselors and Marriage and Family Therapists are in the process of being updated.

Senator MORAN. Okay. Let me conclude this part of my conversation by saying it appears to me that there are significant impediments and not much results in the hiring of these professionals. And if there is a justification for that, I would like to know it. If it's something just bureaucratic or cultural, let's see if we can get it resolved and solved for the benefit of our veterans.

Dr. CLANCY. Got it.

Senator MORAN. Okay.

Dr. CLANCY. Thank you.

Senator MORAN. The other one I would raise, in that same hearing, I raised the topic of the VA using community mental health centers. In Kansas, we have 105 counties, all of them are covered by a community mental health center. They are a gatekeeper. They are the community professionals that provide community counseling. And if they need hospitalization, we have two state hospitals in which they could be referred through that gatekeeper within the community.

The goal of mine for a long time, long even before Choice was in place, was to get the VA to contract with those community mental health centers so there would be a point of contact.

Now, Dr. Davis indicated that there are not enough professionals out there, but when it comes to counseling, and certainly the people who are professional trained and in our state are the ones who are by law to make a decision about what needs to happen next to someone with mental health issues, we still don't have that relationship going between the Department of Veterans Affairs and those community mental health centers. And I don't know what the impediment was, but if you would put that on your—as number two on that list of follow-through with me, that would be appreciated.

Dr. CLANCY. Absolutely.

Senator MORAN. Thank you. My final and usual question in a hearing like this is, is there anybody on the panel who feels like they have not had the opportunity to say what they want to say? And you have to say it in less time than I do. Anything? Does someone feel like they need to make the record more clear or a point that they failed to be able to make because of the nature of our questions?

Dr. CLANCY. I would like to thank you and your colleagues, Senator. I told one of your staff coming in here that the only thing that

would have had me worried about this hearing was if you didn't care or weren't interested, and that is clearly not the case.

[The information follows:]

In follow up of Senator Moran's request during Dr. Kudler's testimony to the Senate Committee of Veterans Affairs on October 28, 2015, Dr. Kudler requested that Dr. Rajeev Trehan, Mental Health Lead for VISN 15, open a discussion with the Community Mental Health Centers (CMHCs) of Kansas about how VA could partner with them to best meet the needs of Veterans. This led to a series of telephone and email discussions culminating in a meeting with the leaders of the Association of Leaders of CMHCs of Kansas held on February 19, 2016. Among those in attendance were representatives of 26 Kansas CMHCs, Dr. Trehan, the VISN 15 Business Manager, Chief Nurse and Rural Health Lead, and TriWest Healthcare Alliance leaders for Kansas. VA, Kansas CMHCs and TriWest leads shared information and considered options and opportunities. A key finding was that many Kansas CMHCs already had good relations with VA, but not all were aware of the possibility of becoming a Choice provider.

Dr. Trehan remains in touch with Mr. Kyle Kessler who leads the Association of CMHCs of Kansas. They have discussed new options under what is being referred to as "Choice 2.0" (currently under development). Dr. Trehan is requesting that Mr. Kessler conduct an inventory of how many Kansas CMHCs are now Choice providers. Based on those findings, Dr. Trehan will work with the Association to explore current and newly evolving opportunities for Kansas CMHCs to become Choice providers. This would simplify issues of VA reimbursement to Kansas CMHCs and also open up new possibilities for exchange of medical records, secure communications and other synergies in the shared provision of Mental Health services to Kansas Veterans. VA, CMHCs, and the Choice network are working to ensure Veterans have ease of access to a full continuum of mental healthcare to meet their needs.

Senator MORAN. Thank you very much. And in that regard, I would compliment you. We've had a case in Kansas in which a physician assistant has been now charged of committing sexual acts against veterans within one of our hospitals, and you, Dr. Clancy, have been the one who seems most interested in providing accountability and answers to other veterans in that circumstance. Thank you.

This gives me the opportunity to bring this hearing to a conclusion. Before I do that, I have four outside witness testimonies that I would like to have entered into the record: one is from Cerner, one is from TriWest, one is from Health Net and one is from the veterans of Foreign Wars (VFW). They are talking about their research in regard to detecting, determining, potential individuals who might be prone to suicide and other issues related to this topic today. And without objection, I would—I think I'm going to carry the day——

[Laughter.]

Senator MORAN [continuing]. Without objection those reports will be made part of our record.

And then, again, thank you all very much for being with us today. In my view, this has been useful. You saw I think almost every subcommittee member here for a significant part of this hearing, and we take this seriously.

For veterans who may be watching or listening to the hearing, we want you to know that we care. People at this table care about you. And by "table," I meant the one in front of me, but it's also true of the ones to my left and to my right. There is that 800 number, 1–800–273–8255, or text 838255, and it may be somebody who knows somebody who needs our attention. And one of the things that we've discovered in our efforts over a long period of time is there are many veterans and many veteran family members and

friends who don't know what services are available. And so we send you to the call line.

I would also say, with Ms. Jarboe in the room, there are people and volunteer organizations and not-for-profits who are interesting and willing in helping you with any challenges that you face. And so we encourage you to see folks at your community mental health center or VA vet centers, VA medical centers, our clinics, crisis centers, as well as suicide prevention coordinator at our hospitals.

For members of the subcommittee, if you have any questions that you would like to place in the record to be answered by our panelists, please do so, and we would ask that you do that no later than May the 4th.

CONCLUSION OF HEARINGS

And with that our hearing is concluded.

[Whereupon, at 1:02 p.m., Thursday, April 27, the hearing was adjourned and the subcommitee was recessed, to reconvene subject to the call of the Chair.]

MATERIAL SUBMITTED SUBSEQUENT TO THE HEARING

[CLERK'S NOTE.—The following testimony was received subsequent to the hearing for inclusion in the record.]

PREPARED STATEMENT OF DOUGLAS S. MCNAIR, ENGINEERING FELLOW AND PRESIDENT CERNER MATH INC.

CERNER

At Cerner, our mission is to contribute to the systemic improvement of healthcare delivery. We develop our solutions with the patient in mind, assisting providers with making care decisions that create a future where the healthcare system works to improve the long-term well-being of individuals and communities. Cerner's health information technologies connect people, information and systems at more than 25,000 provider facilities. Cerner Millennium is the largest globally-deployed electronic health record (EHR), and we support clients in more than 35 countries, including national health programs in the U.K., Australia, the Middle East, South America and Europe. Cerner's clinical solutions integrate behavioral health, lab and pathology, imaging, oncology, rehab and pharmacy needs to streamline information access and operations, but also to provide insight into diagnosis and care planning and make the patient's overall care experience a positive one.

CERNER: A PARTNER WHO UNDERSTANDS THE UNIQUE GOVERNMENT ENVIRONMENT

Cerner supports several Federal agencies including the U.S. Departments of Defense, Veterans Affairs, and Centers for Disease Control, with their respective missions and healthcare programs to better manage processes, as well as clinical data, from beginning to end—across all departments, disciplines and care settings—to help improve operational efficiencies, cost savings, and the business of healthcare. We work closely with our partner clients to get a deep understanding of their needs and challenges, then engage and empower stakeholders to be champions of change within their own agency. We also provide a network of adoption resources, and help to tangibly demonstrate value for agency clients by providing the data needed to make objective, informed decisions. We also support over 150 state, local, tribal and territorial public health agencies, and their health centers, safety net clinics, federally qualified health centers, community mental health centers, tribal health and drug treatment facilities.

Cerner, as part of the Leidos Partnership for Defense Health, is delivering a modern and integrated health IT solution for the U.S. Department of Defense (DoD) and the Defense Health Agency (DHA), supporting their healthcare mission to provide safe and quality care for our nation's 9.6 million active-duty service members, military retirees, and family members. This integrated medical and dental health record, called MHS GENESIS, is built using one code set that is commercially available, off-the-shelf, with relatively little customization; that will ultimately inform the clinical decisions of the more than 150,000 healthcare professionals in the military health system. Access to medical records from the clinic to the battlefield will now be seamless, resulting in less errors and delays, improving safety and the quality of care for our men and women in uniform. MHS GENESIS replaces three existing EHRs to create a single patient record and is interoperable with 24 existing military tools and systems, including the DoD–VA Joint Legacy Viewer, which allows data sharing between the two agencies. The system also is engineered to enable interoperability between the private care system and public sectors allowing for easy access to a service member's comprehensive medical and health history, and the potential for service members to maintain their longitudinal healthcare history as they transition from active duty to civilian life.

PREPARED STATEMENT OF DAVID J. MCINTYRE, JR., PRESIDENT AND CEO OF TRIWEST HEALTHCARE ALLIANCE

INTRODUCTION

Chairman Moran, Ranking Member Schatz and Members of the Committee, I deeply respect you for holding this hearing on the critically important issue of preventing Veterans' suicides. As long as there is even one Veteran suicide in any community anywhere in our country, we should not rest. We should treat the loss of

even one Veteran to suicide as a national tragedy and the loss of 20 Veterans a day as a national crisis.

Veteran suicide is a heart-breaking issue, a complex issue that defies simple solutions. If the solutions were simple, Congress and VA would already have implemented those solutions. DoD and VA deserve credit for having invested untold efforts and resources into solving the suicide crisis, but the crisis continues because each case can be different from every other.

While we might not ever be able to prevent every suicide, it should nevertheless be our goal. Striving for it should be our mission, together.

I wish I could offer you today a guaranteed solution to this crisis, but no one can do that. What I am grateful and humbled to have the privilege to do is to share with you some of the lessons learned by TriWest as we have worked in partnership with DoD and VA for 21 years to reduce suicides by those who wear or have worn our nation's uniform. If sharing our experiences with you can help save the life of even one Veteran, I will forever be grateful to you for holding this important hearing.

Mr. Chairman, I will share with you some background on TriWest Healthcare Alliance for one and only one purpose today: to help you understand the nature of our work and the lessons learned regarding suicide prevention.

If I could summarize the most important lessons learned from TriWest's 21 years of working in support of DoD's and VA's suicide prevention efforts, it would be these:

1. First, when a service member or Veteran is at the cliff's edge, it is critical that there is a clear, simple and quick way for them to reach out for help.
2. Second, it is crucial that a Veteran on the verge of committing suicide can talk to someone who can relate to their service and situation. The insight of an Army General might explain this when he once said, "Before the soldiers care about what I say to them, they have to know I care about them." In short, the Veteran needs empathy from a fellow comrade, not sympathy from a well-intentioned civilian.
3. Third, the most effective way to prevent Veteran suicide is to intervene with accessible, timely and quality mental healthcare services long before the Veteran is seriously considering suicide. No healthcare system in our Nation is better equipped to provide that expert care than our VA healthcare system. Its expertise in dealing with PTSD, TBI, military sexual trauma and war-related combat wounds is second to none. However, until the day when VA has enough mental healthcare providers within its system to handle all mental healthcare patients' needs on a timely basis, VA community care must be used, expanded and improved to prevent the tragedy of Veteran suicide.

Ensuring our nation's Veterans have access to the full range of timely, high-quality mental health services they have earned and deserve must be our collective mission. Meeting our Veterans' ever-growing demand for mental health services is an urgent, life-saving priority. We owe it to those who have sacrificed so much for us to provide them with the best care humanly possible. We should strive to not only prevent tragedy from striking, but also afford our Veterans an opportunity to live a healthy, full life.

HISTORY

Twenty-one years ago, TriWest Healthcare Alliance was formed by a group of non-profit health plans and university hospital systems. For the leadership team of TriWest and our more than 3,000 employees, most of whom are Veterans or family members of Veterans, what we do is more than a job; it is an honor to which we are steadfastly and passionately committed. Our first 18 years were spent helping DoD stand-up and operate the TRICARE program in a 21-state area.

Today, TriWest serves as a partner to VA, administering the Patient-Centered Community Care (PC3) Program and Veterans Choice Program in our geographic area of responsibility, which includes 28 states and three U.S. territories. Through this program, TriWest serves as a relief valve to VA when it is unable to provide the needed care to Veterans in house. TriWest now has over 185,000 community healthcare providers in our network, and we have helped over 860,000 Veterans receive more than 4.5 million total medical appointments since the start of the programs we administer on behalf of VA. This includes over 25,000 behavioral health providers helping Veterans receive over 56,000 behavioral healthcare appointments in their community when they cannot be seen by VA.

Of particular focus to TriWest over the past 21 years has been serving the mental health needs of our nation's Veterans, active duty service members and their families. During our 18-year engagement with TRICARE, we learned a great deal and built an extensive mental health network around military bases in the 21 states we

served. We continue to leverage much of that network today in support of the Veterans Choice Program and every VA Medical Center in our region.

KEY MENTAL HEALTH INITIATIVES

Through our 21 years of operation, we have developed substantial experience in providing quality, accessible mental healthcare services and administering suicide prevention programs. We offer the following initiatives for your consideration as VA and Congress continue their work together to improve mental healthcare services and to prevent suicides for at risk service members and Veterans.

1. Expand peer-to-peer support programs. In 2010, the U.S. Marine Corps asked TriWest for help in designing a pilot to increase access to mental health support for Marine Corps personnel returning from deployment(s). We were privileged to help create the "DSTRESS Line" pilot providing 24/7/365, Marine-to-Marine Peer-to-Peer Call Center access to stress/suicide prevention support, staffed by Veteran Marines, Fleet Marine Force Navy Corpsmen who were previously attached to the Marine Corps, Marine spouses and family members, and licensed behavioral health counselors trained in Marine Corps culture. Under the program, we provided phone, chat and videoconference capability for non-medical, short-term, solution-focused counseling and briefings for circumstances amenable to brief intervention, including but not limited to stress and anger management, grief and loss, the deployment cycle, parent-child relationships, couples' communication, marital issues, relationships, and relocations based on the needs of the community being served. The Marine Corps leadership believes the program has been hugely successful as an efficient, effective and innovative peer support program for Marines to access mental health support by talking with a fellow Marine they can trust. TriWest provides the staffing resources for these critical programs aimed at serving the U.S. Marine Corps. On average, there are over 6,000 total program interactions each year through calls, chats, and Skype. We believe there are some valuable best practices learned in this program that could serve VA well as it continues to expand and enhance behavioral health services for Veterans.

Another related program was launched by TriWest in 2016 with the Defense Suicide Prevention Office (DSPO). This program, the BeThere Peer Support Call and Outreach Center, provides peer-to-peer support as part of the DoD's efforts to combat suicide. TriWest provides a 24/7, global peer-to-peer suicide prevention program to serve all military service members, Guardsmen and Reservists, and their families. This program, staffed by Veterans of all the Service branches, builds on the successful DSTRESS program that TriWest has been running for the U.S. Marine Corps for nearly 7 years. The DSPO contract provides all Service personnel and their families with 24/7 comprehensive service member peer-to-peer support services through telephone, chat, text and email. Calls to the peer assistance line have increased steadily since the program launched in October, with an average of 60 interactions per week.

2. Expand mental health training for community providers serving Veterans. With a desire to enhance access to needed behavioral health services to give VA the enhanced access to these critical services it needs, TriWest is moving beyond simply appointing to our substantial mental health network of more than 25,000 providers. We have invested in and are training our community mental health providers in evidenced-based therapies that are known to be maximally effective in meeting the needs of Veterans. Known as Operation Treat a Veteran, this collaboration between TriWest, the Department of Veterans Affairs, the Center for Deployment Psychology, and PsychArmor Institute offers evidence-based training to all community-based network providers in the 28-state TriWest Healthcare Alliance regions of care. Training covers two broad topics: Military Lifestyle and Culture; and Evidence-based Psychotherapy. The three learning paths have four levels of training. Each level of completion corresponds to a level of patient acuity. With the completion of each level, TriWest will refer Veterans who require primary or specialty care, or the treatment of PTSD with either Cognitive Processing or Prolonged Exposure Therapy.

3. Expand community-based tele-mental healthcare services serving Veterans. TriWest has designed and deployed a tele-behavioral health platform to connect community behavioral health providers with Veterans in need of counseling, who desire the use of this tested modality of care delivery. The initial rollout of this initiative was in Phoenix, San Diego and Texas, with geographic expansion to come soon as this begins to take hold. Under this prototype, we now have served almost 230 Veterans. As long as there is a shortage of mental healthcare providers in many parts of our country, tele-mental health can truly be a life saver for Veterans who would otherwise not receive timely mental healthcare services.

4. Expand community mental health options for urgent care. To ensure that those who are presenting themselves in VA Medical Center Emergency Rooms, where there is a lack of inpatient mental health beds to meet the needs of Veterans, VA and TriWest just designed and deployed a pilot program in Wichita, Kansas, that would enable us to place the Veteran in an inpatient bed with one of our nearby behavioral health network providers rather than letting him or her wander out the front door without receiving potentially live saving services. This pilot builds on a successful, similar one we conducted in Phoenix. While we have developed the prototype and have it ready to deploy, VA has not yet used this valuable tool in Kansas.

5. Make it easier for Veterans to schedule an appointment. We are working with community providers to make scheduling easier for Veterans, including the launch of a self-appointing pilot in Tennessee. Under this pilot, Veterans can schedule their own community care appointments using TriWest's innovative self-scheduling solution, whereby Veterans are able to schedule and confirm appointments, and perform other functions such as receive appointment reminders, rate providers, or use chat to reach TriWest's customer service personnel. Simplifying a Veteran's access to timely care could mean the difference between life and death when it comes to providing urgently needed mental healthcare services. While the pilot currently is narrowly focused to fully evaluate the concept, mental health services are included in the pilot. In fact, the first successfully completed self appointment was for mental healthcare.

CONCLUSION

Mr. Chairman, I salute you and this committee for placing a high priority on the issue of preventing Veterans' suicide. Our Veterans risk their lives to protect American values and society, so when their lives are at risk here at home, it is our moral obligation to protect them. They have had our back, so now we should have theirs. Collectively, we must seize the opportunity to enhance access and make the healthcare delivery model more efficient and effective. I believe doing so will necessitate leveraging the best of both the public and private sectors. No private healthcare system in the country has more expertise than VA in addressing the mental healthcare issues that put Veterans' lives at risk. The work ahead should not be to replace the VA system, but to learn from it and to supplement that VA care in the community, when necessary. We look forward to doing our part to support VA Secretary Dr. David Shulkin and his team in many areas going forward, including in the critical space of supporting VA in delivering on the mental healthcare need.

As TriWest has done for 21 years, we stand ready today to do whatever it takes to work with Congress and VA to help protect the lives of our nation's heroes. Together, we can succeed and we must succeed in this mission, because our Veterans and their families deserve no less.

PREPARED STATEMENT OF BILLY MAYNARD, PRESIDENT AND CEO OF HEALTH NET FEDERAL SERVICES, LLC

Chairman Moran and Ranking Member Schatz, thank you for this opportunity to discuss how our experience at Health Net Federal Services (HNFS) can assist the Department of Veterans Affairs with effort to reduce the incidents of veteran suicides in the United States. Building upon almost 30 years of experience serving active duty military service members, their families, and Veterans, Health Net has developed a full continuum of programs to meet the behavioral health needs of this population. Throughout the design and implementation of these various programs, Health Net has collaborated with VA and DoD in delivering high quality, accessible programs which augment existing capacity and capability, both within VA and DoD.

Specifically, I would like to focus on our experience with the Military Family Life Program (MFLC). The Department of Defense has engaged private sector firms like HNFS as partners in addressing the needs of service members and their families up to the point of discharge from the service through the (MFLC) Program. The MFLC Program provides short-term, problem- solving situational counseling; program includes a network of more than 5,000 credentialed, trained, and experienced counselors supporting 118 military installations in 23 states and territories, and 14 countries. In our work on the MFLC Program HNFS provides approximately 35,000 total support contacts each week and averages over 1000 Briefings, Presentations and Trainings each week to the military and their families. Military Family Life Counselors provide brief, problem-oriented non-clinical counseling services. They are required to assess risk in the context of non-medical interactions and to make referral into clinical behavioral health services when indicated. They have particular ex-

pertise in engaging service members and their families in ways that minimize or mitigate stigma. Military Family Life Counselors are deployed on an as needed basis. When they are not deployed in support of the MFLC program, many of these masters-level behavioral health providers maintain clinical behavioral health practices in their home communities. As part of our program, MFLC counselors receive extensive readiness training and orientation to include military cultural sensitivity training. Many of the services developed for service members and their families as a result of this partnership are innovative, proven effective, and now considered "best practices" throughout the military. Among the "best practices" developed through this partnership are the following:

—The development and deployment of a standby capacity that is delivered when and where it is needed on a temporary basis. This "surge" capability can provide brief, non-medical, problem-oriented counseling to address issues that arise in connection with service related issues such as deployment-demobilization-redeployment cycles of the troops and their families. For service members and their families, this means that issues that might have otherwise turned into tragedies were instead recognized proactively, addressed and referred to the appropriate resources for resolution.

—The engagement of civilian and community-based networks of trained, credentialed, mental health professionals to reach the service members and their families who are not in the vicinity of a Military Treatment Facility. This is often the case for the National Guard and Reserve components. The networks also meet the clinical behavioral health needs of military beneficiaries assigned to a Military Treatment Facility when the demand for behavioral health services exceed the capacity or the scope of care which can be provided within the military facility.

In May 2016, HNFS was tasked to begin supporting the United States Air Force surge effort to support the service goal to reduce Air Force suicides by 50 percent in CY 2016. In support of this mission, HNFS quickly deployed Military Family Life Counselors to 30 Air Force locations throughout the world providing support from 90 to 180 days. The MFLC programs' non-medical counseling structure allows for proactive support to be deployed to high risk areas.

These are proven approaches to quickly and effectively address Veterans' need for mental health services, thus reducing the backlog and allowing VHA to provide timely appointments for new and established patients. To support VA in providing patients with timely access, organizations with a large network of mental health professionals with specialized training in military healthcare are able to immediately implement a "surge" model that offers rapid deployment of professional clinicians to alleviate short-term demand requirements at a VA Medical Center (VAMC) or a Community Based Outpatient Clinic (CBOC).

These rapid-response providers could work alongside VA providers to enable the early identification of Veterans who might be at risk for suicide or have other serious mental health issues. Such Veterans could then be triaged to high priority access to VA providers and facilities as soon as possible.

The surge model could be designed to meet the immediate care needs of Veterans, as specially trained clinicians are able to rapidly deploy in the communities where Veterans reside. The model works in partnership with VA and leverages VA clinical guidelines to deliver the high quality care for which VA is recognized. The surge model is cost-effective; it maximizes the resources of VA by serving as a short term solution to fill in staffing gaps while VA determines long term capacity requirements and recruits staff to meet veterans' needs. The ability to provide specialized mental health clinicians with immediate flexibility to deploy to a VAMC or CBOC would offer powerful support to VA in addressing capacity issues and reducing the backlog. It would be a significant means to address the urgent mental health needs of today's Veterans and help mitigate and prevent larger mental healthcare crises, including suicide.

We appreciate and commend the Subcommittee's attention to this important issue and recommend that Congress direct the Department of Veterans Affairs to implement a surge program similar to DoD's MFLC Program to address the immediate shortfall in mental healthcare providers across the Veterans Health Administration.

PREPARED STATEMENT OF CARLOS FUENTES, DIRECTOR NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Chairman Moran, Ranking Member Schatz and members of the Subcommittee, 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 share our views on how to prevent veteran suicides.

DESTIGMATIZING

The VFW has worked tirelessly alongside Congress and the Department of Veterans Affairs (VA) to address suicide prevention. This topic, a long-standing priority for the VFW, has been in dire need of addressing from many angles. First, the VFW values the importance of getting the conversation started about mental health in daily life in efforts to destigmatize mental illness. As the stigma decreases, our nation's veterans will have the opportunity to become better educated about mental well-being and how to address suicide prevention.

This is why the VFW launched our Mental Wellness Campaign in fall 2016. We partnered with organizations such as The Elizabeth Dole Foundation, Give an Hour, PatientsLikeMe, Walgreens and VA to make certain the veterans community engages in conversations about mental health. This allows veterans to feel empowered about not only their own mental health status, but to also feel empowered to care for their fellow brothers and sisters who may be struggling as well. In October 2016, the VFW launched a worldwide campaign to change direction and the narrative on how veterans and the general public discuss mental wellness. Throughout the world, over 200 VFW posts partook in various events based around education and discussion, with 17,000 service members, veterans, their families and communities joined together to discuss resources available to veterans and family members suffering from mental health conditions. This campaign is continuous, as we partner with Student Veterans of America to continue outreach and host more events to change direction. Now, the 17,000 who have already partaken know to look for the five signs of mental distress: personality change, agitation, withdrawn behavior, poor self-care and feelings of hopelessness.

Thanks to new research conducted by VA and other government agencies, we now have a more accurate average of 20 veterans who die by suicide every day. Yet, only six out of these 20 use VA healthcare.

This is why the VFW urges Congress and VA to expand mental health outreach efforts. VA must strive to remove the stigmas associated with mental health conditions. VA must also do more outreach to ensure veterans know of the mental health treatments and resources available to them not just in VA, but in local communities as well. If we fail to improve and expand outreach efforts, the unacceptable number of veterans who die by suicide may not decrease.

ACCESS

In order to eliminate veteran suicides, VA must also increase access to competent mental healthcare that is individualized to the patient. While VA data shows their mental healthcare is making a positive impact on those who use it, there is still room for improvement. More studies must be conducted to find more innovative, empirically proven ways to treat mental health conditions. VA has conducted research pertaining to areas such as service animals and emerging technologies, but other therapeutic alternatives need to be studied.

When veterans do turn to VA in moments of mental health crisis, VA must be able to address these veterans' specific needs. Unfortunately, we have all heard stories of veterans who turned to VA in times of crisis and were denied the inpatient mental healthcare they urgently needed. Congress must fully fund VA inpatient mental health clinics so lack of beds is never a reason a veteran takes his or her life. Additionally, Congress and VA must expand peer-to-peer support programs, which have been successful in helping veterans cope with mental health conditions by partnering them with fellow veterans who have overcome similar challenges and received specialized training to help others do the same. In instances where VA is not able to provide immediate assistance, or a veteran requesting assistance does not meet the criteria for receiving inpatient care, VA must ensure veterans in need are given the opportunity to talk to and receive assistance from a peer support specialist. It is common practice in the private sector for hospitals and medical facilities to have professionals on call to assist patients who check into the emergency room, such as in cases of sexual trauma. If VA trains more peer-to-peer support specialists, VA medical centers would be able to have scheduled, on-call veterans to assist others in mental health crises.

In the past 3 years, the VFW has conducted more than six surveys and compiled five reports on the VA healthcare system, which can be found at www.vfw.org/vawatch. A consistent concern we have heard from veterans is that VA needs to hire more mental healthcare providers. This shortage of providers has been continually highlighted by GAO and VAOIG reports in past years. Specifically, the VAOIG's

yearly determination of occupational staffing shortages across the VA healthcare system has placed psychologists among the top five VA healthcare professions' staffing shortages. While this shortage of psychologists is not a problem specific to VA, but rather to the nation, Congress needs to ensure VA has the appropriations and authorization to properly hire and retain staffing necessities for providers.

VETERAN CRISIS LINE

For veterans who are not physically at a VA facility, but struggle with a mental health crisis, the Veteran Crisis Line (VCL) is of dire importance. The VCL was established to provide 24/7 suicide prevention and crisis intervention to veterans, service members, and their families. This was necessary as a means of constant availability to individuals in need of crisis intervention. The VCL provides crisis intervention services to veterans in urgent need, and helps them begin their path toward improving their mental wellness. Each individual employee at the VCL is answering an average of nine calls per day, and those calls are being answered quicker than 911 and the National Emergency Number Association standards. This means that every VCL employee is assisting an average of nine veterans in need of immediate assistance on a daily basis. When necessary, employees at VCL also dispatch emergency assistance for callers in immediate risk of harming themselves or others.

The VCL plays a vital role in VA's initiative of suicide prevention, and ongoing efforts to decrease veteran suicide. Yet adjustments are necessary for VCL to meet its full potential. The VFW believes expanding VA's Office of Patient Advocacy would greatly benefit the VCL. By improving and expanding the patient advocacy offices throughout VA, employees of these offices would have better visibility and means to assist non-crisis patients. If veterans become more aware of the patient advocate mission and capabilities, non-crisis callers to the VCL would decrease. The VFW has been working to expand and improve patient advocacy within VA and we will continue to monitor progress. The VFW urges this subcommittee to conduct extensive oversight of the VA Patient Advocate Program to ensure veterans are able to have their non-emergent concerns addressed without having to call the VCL.

Employees at VCL undergo extensive training before being allowed to answer calls, and it takes at least 6 months before they may begin training to also answer chat and text conversations with veterans in crisis. Yet, it was not until late December 2016 that the VCL had the capability to record and monitor their calls. Without this crucial technological capability, there was no way for calls to be truly monitored for quality control. Now that this capability is available, the technology must be properly utilized. Staff at the Veterans Health Administration (VHA) and the VCL monitor some ongoing calls for quality assurance, but a better, constant process must be implemented to ensure these recordings are being used to improve the training and capabilities of VCL responders. This would not only improve crisis intervention, but would assist with ending allegations of responders not understanding or following protocol, instructions, and resources.

There is no doubt that clinical oversight at the VCL is a necessity. Clinical decisionmaking must be made by clinicians and not by operations and administrative staff. Leadership running the VCL must also have clinical background. This would ensure veterans in crisis who call the VCL receive the best clinical judgement and assistance possible. Clear guidelines must be established for the VCL so non-clinicians are not forcing a clinically based crisis line to operate as a business. This has a clear link to quality control as well. The VFW believes that while the number of calls going to backup centers decreasing at such a rapid rate is a positive, it is not a sign of the quality of work being provided. Veterans, service members and their families deserve the best clinical care available, and VA is known for outperforming the private sector in many areas of healthcare. In fact, of the estimated 20 veterans who commit suicide every day, only six of them are enrolled in VHA. This shows that clinicians within VA know what they are doing, and they do it well.

The VFW believes VHA must establish both clinical and operational policies specific to the VCL. This would allow for easier protocol standards to be understood and met on a regular basis, while establishing guidance and regulations to continue being followed by employees without clinicians stepping on the toes of operations, or operations stepping on the toes of clinicians.

In March 2016, the VCL established a Clinical Advisory Board at the request of VHA Member Services. This board was intended to assist and work with VHA Member Services, to assure no clinical necessities were being dismissed after VCL operations were moved to the non-clinical office within VHA. This group was intended to assist VHA Member Services in collective expertise of clinicians to improve the veteran experience, efficiencies of employees and increased access to the VCL. The charter for the advisory board was later changed by different leadership within VHA

Member Services. The board now has one meeting per month where they call in for one hour. Call data is presented to the board members, but a monthly hour-long meeting does not provide them with the means to effectively obtain clinical input for policy decisions to improve the VCL.

The VFW firmly believes the VCL has improved and will continue to improve. Though that improvement will continue to be slow, frustrating and life-endangering if the VCL does not begin collaborating with others. Aside from working with patient advocacy offices to cut down on non-crisis calls and VHA Member Services to readjust the advisory board and increase clinicians, the VCL must also work more closely with the Office of Suicide Prevention (OSP). Member Services has undoubtedly assisted the VCL in quantity control, but OSP can also assist the VCL in quality control. If the goal of the VCL is to intervene for veterans in need of immediate assistance while they are in the middle of a mental health crisis, the VCL should be working with the subject matter experts and leaders in suicide prevention and outreach for VA. If all three offices could collaborate together, with better guidelines, Member Services must be able to continue improving the VCL call center expertise and business, while OSP can make sure the VCL is up-to-date with the most current clinical expertise on suicide prevention and outreach.