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**STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 10, 2020**

Chairman Takano and Members of the Committee:

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

H.R. 6092, Veteran's Prostate Cancer Treatment and Research Act

Prostate cancer is the number one type of cancer diagnosed in the Veterans Health Administration, with more than 489,000 veterans undergoing treatment. We know that exposure to toxic substances, such as Agent Orange and certain chemicals commonly used in firefighting, motor vehicle and aircraft maintenance, can greatly enhance the risk and severity of the disease and, as with any form of cancer, early detection and treatment are key.

H.R. 6092 calls for the VA to establish a critical pathway to manage all stages of the disease, from early detection and treatment to end-of-life care in collaboration with the National Institutes for Health, the National Cancer Institute and other relevant institutions. The bill also seeks to further prostate cancer research through the VA's Office of Research and Development, and to establish a real-time registry to track patient progress and broaden access to cutting-edge resources and clinical trials. Additionally, the bill calls for a recommended screening protocol for those with evidence-based risk factors.

DAV Resolution No.133 supports new and ongoing VA medical research programs to study and address the injuries and illnesses linked to military service. Given service members increased risk for exposure to toxic substances during military services and the significant prevalence of prostate cancer among veterans, we believe further research on risk factors and screening practices for this disease are warranted. As such, DAV is pleased to support H.R. 6092.

H.R. 7504, VA Clinical TEAM Culture Act of 2020

H.R. 7504 would require mental health providers participating in VA's Community Care Network program to meet the same clinical standards and requirements as those applicable to VA mental health providers. It further requires that community care providers engage in training on military culture and a number of other courses including, screening and management of suicidal ideation, military sexual trauma, post-traumatic stress disorder and traumatic brain injury. Together these conditions affect a broad cross-section of the veterans' population.

DAV has had longstanding concerns about the inability to gauge the quality and accessibility of services provided by non-VA providers for specialized mental health care—particularly for treatment of conditions unique to military service such post-traumatic stress disorder related to combat and military sexual trauma. A 2018 study published by the RAND Corporation found that many non-VA providers in New York state expressed reservations about their lack of preparedness for treating conditions related to veterans' military service.¹

We strongly believe that veterans deserve the same standard of care when seeking care through VA's Community Care Network. DAV is pleased to support H.R. 7504, in accordance with DAV Resolution No. 378, which notes that care provided to veterans in the community when VA care is inaccessible should be delivered through responsive integrated networks that deliver culturally competent, high quality evidence-based care.

H.R. 7541, VA Zero Suicide Demonstration Project Act

H.R. 7541 would require VA to establish a demonstration project—the Zero Suicide Initiative—to assess the use of a behavioral mental health care model based on the Henry Ford Zero Suicide program. The legislation would require the development of an educational curriculum and training institute to study the best practices for suicide care and prevention including screening practices, lethal means counseling, comprehensive assessment and individual risk management. It would then require extensive training of staff team leaders and selection of five sites at which the program would operate. VA would be required to assess the program on a number of measures in comparison with non-demonstration sites within the Department.

The model has a goal of eliminating suicide through changing and improving systems of care with proponents of the prevention model reporting dramatic (75%) and sustained reductions in suicide among their patient population.² A key focus in the model includes viewing errors or near misses as system failures to learn from and

¹ Tanielian, Terri, Carrie M. Farmer, Rachel M. Burns, Erin Lindsey Duffy, and Claude Messan Setodji, Are Private Health Care Providers Ready to Treat Veterans? Evidence from New York State. Santa Monica, CA: RAND Corporation, 2018. https://www.rand.org/pubs/research_briefs/RB10006.html.

²Coffey, C.E., VISION ZERO: A Model for Eliminating Suicide and Transforming Health Care, Statement before the House Committee on Veterans' Affairs, January 29 2020.

developing a health care culture that seeks "... recovery, restoration, and improvement, not blame, punishment, or retribution."³

While the Henry Ford Behavioral Health concept of zero suicides and care pathways to lower suicide risk for patients is laudable, it appears that VA already incorporates many of the aspects of the Zero suicide model in its care plans for veterans at risk for suicide. VA has a comprehensive, integrated mental health program including clinical practice guidelines jointly developed with the Department of Defense for suicide prevention as well as conditions related to suicidal behavior including management of depression, post-traumatic stress disorder, substance use disorders and traumatic brain injury. These clinical practice guidelines take into account the full spectrum of services (and wrap-around services) available to veterans and service members in the systems that serve them in addition to educational resources on specific issues associated with military service that may impact mental health and behavior.

Despite the VA's comprehensive mental health care model and focus on suicide prevention, this pilot offers an opportunity for VA to focus on addressing systemic gaps in care for veteran patients who are at risk for suicide and to compare differences between the models, best practices and related health outcomes. For these reasons, DAV is pleased to support H.R. 7541, in accordance with DAV Resolution No. 370.

H.R. 7747, VA Solid Start Reporting Act

This bill would require the VA to submit an annual report to Congress on its Solid Start program. This program requires VA representatives to make calls to newly separated service members over the first year post-transition period that would help them navigate the process for accessing their VA benefits or any other resources they may need for a successful transition from military service. During these calls VA representatives check on the veteran's overall transition experience, answers questions and directs veterans to needed resources, supportive services and programs. H.R. 7747 also requires VA to submit a report that includes demographic information on veterans contacted to confirm what referrals were made and what services were actually rendered as a result of the Solid Start program's outreach efforts.

DAV supports H.R. 7747 and the efforts of Congress to monitor, review, and report on VA's efforts to ensure that all transitioning service members have the tools they need to establish healthy and productive lives post-service in accordance with DAV Resolution No. 100.

H.R. 7879, VA Telehealth Expansion Act

This bill would require the VA to award grants to entities for the expansion of telehealth capabilities and provision of telehealth services to veterans through the VA

³Coffey, C.E., VISION ZERO: A Model for Eliminating Suicide and Transforming Health Care, Statement before the House Committee on Veterans' Affairs, January 29 2020.

and the Veterans Community Care Program (VCCP). VA would be required to give preference to entities that represent veterans in rural or highly rural areas or entities that operate in a medically underserved community. Grants would be limited to no more than \$75,000 annually and funds would be authorized for purchasing or upgrading hardware or software, security applications, training employees and making modifications to existing infrastructure for privacy and to meet ADA standards. The bill would also authorize VA to enter into an agreement with an entity to establish a telehealth access point for veterans without applying for a grant.

Finally, the VA must assess and report on the barriers veterans face in accessing telehealth services and a plan on how to address identified or potential barriers. From the onset of the COVID-19 pandemic, VA significantly increased use of telehealth services to ensure enrolled veterans had access to necessary health care services. This bill would help facilitate new options and telehealth access points for veterans in medically underserved and highly rural communities.

We are pleased to support H.R. 7879 in accordance with DAV Resolution No. 368, which calls for VA to expand availability of health care services to meet the diverse needs of future veterans including veterans who reside in rural or remote regions.

H.R. 7888, REACH VET Reporting Act

This bill pertains to VA's REACH VET program (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment) a suicide prevention tool that uses predictive modeling and medical record data to identify veterans at highest risk for suicide. The goal of this program is to deploy preventative outreach measures to assess a veteran's well-being and treatment plan to determine if additional care is needed before a crisis point.

H.R. 7888 would require the VA to submit a report to Congress on the REACH VET program and include the following information:

- an assessment of the REACH VET program on suicide rates among veterans;
- evidence based and explanatory information related to what conditions are and are not part of the model;
- cap on the number of veterans who may be flagged as high risk for suicide; and
- feasibility of incorporating certain VBA economic data into the program (including financial data and employment status).

A report on this novel suicide prevention tool could yield critical evidence that may lead to potential improvements in the predictive model and reduce suicide in the veteran population. For these reasons, DAV supports H.R. 7888—the REACH VET Reporting Act in accordance with DAV Resolution No. 370, which supports legislation to improve and enhance VA's mental health programs and suicide prevention efforts.

Discussion Draft, ANS for Veterans' ACCESS Act

This draft bill would require the VA Secretary to furnish or pay for emergent suicide care to certain veterans (veterans enrolled in VA health care and individuals who served in the Armed Forces, including reserve components, for more than 90 cumulative days) at a VA medical care facility or non-VA community medical facility. Such care, including transportation, would be considered emergency treatment and provided, at no charge, to an eligible individual who is in acute suicidal crisis. The VA may collect payment from an eligible individual's health plan if such care is covered. Emergency treatment includes inpatient or crisis residential care not to exceed 30 days and outpatient care not to exceed 90 days if inpatient services are unavailable. If the veteran remains in an acute suicidal crisis, the Secretary may extend the treatment period if appropriate.

During the emergency treatment period, VA is required to make appropriate referrals to the VA Suicide Prevention Coordinator, the VA's Office of Community Care and determine the individual's eligibility for other VA programs and benefits. The bill also requires VA to submit an annual report to the House and Senate Veterans' Affairs Committees on the number of eligible veterans who were provided emergent suicide care and the total cost for such care. Finally, the bill would require VA to improve and expand where and how information about VA mental health services is made available to transitioning service members and veterans.

VA notes that suicide prevention for veterans is the top clinical priority for the Department but acknowledges the challenge of reducing suicide in the veteran population and particularly meeting the mental health needs of veterans that do not seek VA care. While DAV does not have a resolution supporting VA payment for health care for non-enrolled veterans in non-VA medical facilities—we support the intent of the bill given the higher rates of suicide in the veteran population and the need to find new ways to reduce suicide among our nation's veterans.

We do have concerns about the potential complexity of the administrative process for this benefit, particularly reimbursement to non-VA medical facilities for emergency services rendered to non-enrolled veterans. We recognize the intent of the legislation is to ensure that any veteran in crisis who needs emergency care will not be charged for such services. We don't anticipate problems in the case of non-enrolled veterans seeking care at a VA facility or with an established VA Community Care Network provider. However, we continue to hear complaints from enrolled, service-disabled veterans eligible for emergency care at a community medical facility (at VA expense) being billed and held liable for payment of such services when reimbursement by VA is delayed. If this bill is approved, it is important the Committee work with VA to resolve existing and potential billing issues related to its emergency care benefit.

**Discussion Draft, COMPACT Act of 2020 (Veterans Comprehensive Prevention,
Access to Care, and Treatment Act of 2020)**

**TITLE I—IMPROVEMENT OF TRANSITION OF INDIVIDUALS TO
SERVICES FROM DEPARTMENT OF VETERANS AFFAIRS**

Sec. 101. Expansion of health care coverage for veterans. This section codifies the one-year post discharge eligibility now implemented through Executive Order 13822 signed by the President on January 9, 2018. DAV has no resolution on expanding eligibility to this group, but understands that the measure may allow for screening, early identification and treatment of service-connected conditions, including treatment for suicidal behavior. We urge Congress to ensure that the initiative receives adequate resources to ensure access is not adversely impacted for veterans with service-connected conditions.

Sec. 102. Review of records of former members of the Armed Forces who die within one year of separation from the Armed Forces. DAV understands the importance of carrying out research on suicide to ensure that VA and DoD are able to identify and target interventions for subpopulations of service members and veterans who are at the highest risk. We support this section under DAV Resolution No. 370.

Sec. 103. Report on care for former members of the Armed Forces with other than honorable discharge—In accordance with DAV Resolution No. 057, DAV supports a more liberal review of other than honorable discharges of veterans who may have service-related conditions or exposures that went undiagnosed, such as post traumatic stress disorder, traumatic brain injury, or military sexual trauma that led to certain behavior and resulted in the military characterizing their discharge as less than honorable. DAV is in favor of a report that could lead to better understanding of the medical and mental health care needs of this population and how VA assisted them in meeting such needs.

Sec. 104. Physical examination and mental health assessment required during the 90-day period before separation from the Armed Forces.

It appears the intent of this section is to serve the purpose of early identification of transitioning service members who may require assistance from VA for a health or mental health issue. While we support appropriate referrals for VA care, treatment and other services they may need—we do have concerns about potential unintended consequences of this section. There are a number of reasons a service member may not reveal symptoms, (such as anxiety, depression or nightmares) they are experiencing related to a mental health issue during the transition mental health assessment. The service member may believe that revealing such information could reflect poorly on their military record, affect their discharge status, delay their discharge from military service or be detrimental to securing certain types of employment following military service, specifically a position that requires a secret clearance. A potential consequence

of not revealing existing symptoms or a possible mental health condition could result in the denial of a future VA claim for benefits—particularly if the mental health examiner conducting the assessment specifically notes the service member denies any mental health symptoms/issues. For these reasons we ask the Committee to work with veterans service organizations on a possible amendment to this section to ensure transitioning service members would not be negatively impacted.

Sec. 105. Medical examinations for certain veterans. This section requires VA to contact veterans who are enrolled in VA’s patient enrollment system for health care services, but who have not received services within the past two years, to receive a comprehensive physical and mental health exam, as well as audiological and eye exams (if not received in past year). DAV believes this provision serves the needs of veterans who rely on VA for health care, including those with service-connected conditions and, thus, supports this section under DAV Resolution No. 378, which calls upon VA to deliver a full continuum of high quality comprehensive health care services to veterans.

Sec. 106. Pilot program on information sharing between VA and designated relatives and friends of veterans regarding the assistance, health care and other benefits available to the veteran. DAV understands the importance of social connectedness in ensuring the health and wellness of veterans and reducing their risk of self-harm. DAV has no objection to favorable consideration of this section, but suggests some “tiering” of the information needs of identified friends and family members. Too much information for individuals who are not residing with the veteran, in one’s immediate family or in a caregiving role may be overwhelming if some friends are just looking for a brief synopsis of how to help a friend who may be struggling.

Sec. 107. National survey of veterans. It is in the best interest of veterans to have a database to look at use of services and benefits by relevant subpopulations to ensure equity. DAV has no resolution relevant to this section, but has called for this type of data in policy documents and recognizes it is beneficial to helping meet the needs of veterans, thus has no objection to favorable consideration.

TITLE II—SUICIDE PREVENTION

Sec. 201. Department of Veterans Affairs training and counseling in suicide prevention and lethal means safety. Requires the Secretary to develop training for all primary care providers in VA and in Veterans Community Care Program (VCCP) on suicide prevention, risk assessment, safety and lethal means counseling. This provision would require primary care providers to assess each veteran using VA or VCCP for suicidal risk and access to lethal means with a focus on safety and goal of identifying a support system for the veteran during a crisis period. DAV supports this section under DAV Resolution No. 370.

Sec. 202. This section requires the VA Secretary to provide financial assistance through the award of grants each fiscal year (authorized over three fiscal years) to provide and coordinate the provision of suicide prevention services to eligible individuals and their family to reduce the risk of suicide. Specifically, it requires:

- Coordination with the PREVENTS Task Force (President’s Roadmap to Empower Veterans and End the National Tragedy of Suicide) to the extent practicable.
- Maximum amount to be awarded under the grant can be no greater than \$750,000 per grantee per fiscal year;
- Secretary may prioritize the award of grants in—(i) rural communities; (ii) Tribal lands; (iii) territories of the United States; (iv) medically underserved areas; (v) areas with a high number or percentage of minority veterans or women veterans; and (vi) areas with a high number or percentage of calls to the Veterans Crisis Line.
- Secretary shall ensure that, to the extent practicable, financial assistance is distributed— (i) to states and territories with high rates or a high burden of veteran suicide; (ii) to eligible entities that can assist eligible individuals at risk of suicide who are not currently receiving health care furnished by the VA.
- The Secretary shall give preference in the provision of financial assistance under this section to eligible entities that have demonstrated the ability to provide or coordinate multiple suicide prevention services using a collective impact model.

Mr. Chairman, although we do not have a resolution specific to this issue, we recognize the challenges that exist in assisting veterans who are in crisis but not enrolled for VA care and thus support this provision as a means of serving veterans not using VA services who are at risk of suicide.

Sec. 203. Interagency Task Force on Outdoor Recreation for Veterans. This section would create an inter-agency task force co-chaired by the Secretary of VA and the Secretary of the Interior. The task force would be responsible for identifying barriers to efficiently using public lands for integrative health treatment options for veterans under the care of the VA. Additionally, the task force would be required to provide Congress with recommendations on removing identified barriers.

DAV Resolution No. 186 cites the therapeutic values of programs like the Winter Sports Clinic, wilderness retreats and other complementary integrative health programs involving outdoor activities, thus DAV supports this provision.

Sec. 204. Department of Veterans Affairs independent reviews of certain deaths of veterans by suicide and staffing levels of mental health professionals.

This section requires the VA Secretary to contract with the National Academy of Sciences, Engineering and Medicine for a five-year retrospective study on suicides and

accidental deaths of veterans. The study would evaluate the use of prescribed medications with “black box” warnings and any adverse health outcomes for veterans. In addition, this section calls for a study of VA’s use and barrier to use of mental health counselors, family and marriage counselors (please see our position statement on H.R. 8145, the VA Counseling Act for this provision.

It appears that the purpose of this legislation is to identify VA’s clinical prescribing patterns for “black-box” medications at the expense of treatments that do not involve use of controlled substances. If the intent of this legislation is as DAV has expressed, we believe there are more constructive methods for assuring more widespread use of complementary integrative health treatments that do not involve use of prescription drugs. Identifying best practices that do not rely upon the use of pharmaceutical drugs, incorporating them into existing clinical practice guidelines and ensuring adequate training and dissemination to staff, could be more effective in our opinion, than a five-year retrospective study into suicides, accidents and violent deaths that may, or may not, be related to the use of medication with black box warnings.

Given VA’s intense use of data and research to determine appropriate evidence-based treatment protocols and best practices for preventing suicide, it would be appropriate to inquire if there has already been a medication review as outlined in this section. DAV would support more scientifically based inquiries into the correlations between suicidal behavior and use of black-box drugs, but would ask Congress to consider a study with more rigor that would lead to actual correlations.

Sec. 205. Comptroller General report on management by Department of Veterans Affairs of veterans at high risk for suicide. This section would require GAO to study VA’s REACH-VET program as well as its follow up with veterans identified as high-risk through this process. It would further require a review of staffing of suicide prevention counselors, and resources available for family and friends involved in caregiving for veterans at high risk for suicide. DAV addresses these issues in more detail in position statements on H.R. 7888 and Discussion draft, Access to Suicide Prevention Coordinators Act, but has no objection to the Comptroller General assessing these VA programs.

Sec. 206. Authority for Secretary of Veterans Affairs to award contracts and grants to states to promote health and wellness, prevent suicide, and improve outreach to veterans.

This section would provide contracts and grants to states to carry out programs that promote health and wellness, strengthen the coordination, implementation, and evaluation of comprehensive veteran suicide prevention programs, offer a high probability of improving outreach and assistance to veterans and the spouses, children, and parents of veterans to ensure that such individuals are fully informed about, and assisted in applying for, any veterans and veterans-related benefits and programs (including state veterans programs) for which they may be eligible.

A grant may be used to provide education and training, including on-the-job training, for state, county, local, and tribal government employees who provide (or when trained will provide) veterans outreach services in order for those employees to obtain and maintain VA accreditation.

DAV supports this section, as it will enhance VA's top clinical priority, suicide prevention and is in alignment with DAV Resolution No. 370. By providing grants, training, and programs for county veterans officers and tribal leaders, this provision is in alignment with one of DAV's core principles outlined in DAV Resolution No. 001—enhanced outreach to ensure that disabled veterans receive all of the benefits they have earned through their service and sacrifice.

TITLE III—PROGRAMS, STUDIES, AND GUIDELINES ON MENTAL HEALTH

Sec. 301. Establishment (by Department of Veterans Affairs and Department of Defense) of a clinical provider treatment toolkit and accompanying training materials for evidence-based management of co-occurring mental health disorders and substance-use disorders, and trauma-related mental health conditions and chronic pain. DAV strongly supports the development and periodic review and updating of its evidence-based practices for treating veterans with complex, co-occurring mental health conditions. We support this provision under DAV Resolution No. 370.

Sec. 302. Update of clinical practice guidelines for assessment and management of patients at risk for suicide. Requires VA and DOD to update clinical practice guideline on suicide prevention including plans for dissemination and training. It would also require VA to specifically address gender-specific and sexual orientation-specific risk factors for suicide and suicidal ideation; gender-specific and sexual orientation-specific treatment efficacy for depression and suicide prevention; gender-specific and sexual orientation-specific pharmacotherapy efficacy; and gender-specific and sexual orientation-specific psychotherapy efficacy in addition to guidance from the COVER Commission. DAV supports this section under DAV Resolution No. 370.

TITLE IV—OVERSIGHT OF MENTAL HEALTH CARE AND RELATED SERVICES

Sec. 401. Study to inform suicide prevention and mental health outreach programs of Department of Veterans Affairs. This section would require VA to contract with a non-federal entity to assess the effectiveness of VA's mental health and suicide prevention outreach materials and campaigns for veterans in certain subgroups through use of focus groups and a survey.

Understanding why veterans use or do not use VA services and programs is important to understanding veterans' use of programs and services that can prevent suicide. We are also cognizant that messaging and awareness is an important part of an effective public health strategy. We hope that this study will also look at ways veterans learn about VA services and reasons they may

decide to use them, seek care elsewhere or go without services. We would like future efforts to also look at effectiveness of messaging to veterans' families, health and mental care providers and agencies outside of the VA. DAV supports the proposal outlined in this section.

Sec. 402. Oversight of mental health and suicide prevention media outreach conducted by Department of Veterans Affairs. This section would require VA to create measurable metrics and objectives for assessing its mental health and suicide prevention media campaigns to track progress and effectiveness of such initiatives. VA would be required to include metrics for certain media groups in consultation with various stakeholders including veterans' groups. It would also require VA to report on the expenses of the Office of Mental Health and Suicide Prevention. DAV supports this provision.

Sec. 403. Comptroller General management review of mental health and suicide prevention services of Department of Veterans Affairs. This section requires GAO to assess VA's mental health and suicide prevention services and report on the management and organizational structure (including roles and responsibilities for each position), operational policies and processes, and practices and initiatives of the Office of Mental Health and Suicide Prevention. The discussion draft also requires an assessment of VA's implementation, thus far, of its strategic plan for suicide prevention for 2018-2028, as well as an assessment of staffing levels. DAV supports this provision.

Sec. 404. Comptroller General report on efforts of Department of Veterans Affairs to integrate mental health care into primary care clinics.

This section would require GAO report on the effectiveness of VA's initiative to integrate behavioral health into primary health care settings. When VA began to embed mental health professionals into primary care, it was touted by many as a vanguard measure that would result in overcoming barriers veterans face in seeking mental health care including stigma, while making such services more convenient and accessible. Primary care providers now routinely screen veterans for common conditions such as depression; sexual trauma, PTSD, and substance use disorders and make referrals, when appropriate, to a mental health professional the same day. A mental health provider will then assess the urgency of the veteran's need and make appropriate follow up care arrangements.

We commended VA for establishing an integrated primary care mental health services model as an essential part of addressing the veteran's whole health. A comprehensive assessment of this initiative will help to determine the overall effectiveness of this model, care coordination and health outcomes and provide an opportunity for recommendations to improve the care model. The bill also requires GAO to assess how care integration and coordination is provided

between community mental health providers and VA as well as any disparities. DAV supports this provision as a means of improving this bold initiative.

Sec. 405. Joint mental health programs by Department of Veterans Affairs and Department of Defense. Sec. 405 would direct VA and the military to report on joint efforts including its Centers of Excellence in TBI and PTSD and its Transition Assistance programs. It also requires the Agencies to report on the programs it operates separately to include identification of mental health programs for which the agencies might work more efficiently together and any recommendations for new joint programs. It then asks VA to work with DoD on an agreement with private partners to establish a “Joint VA/DoD National Intrepid Center of Excellence Intrepid Spirit Center” for the joint treatment of veterans, active duty service members and members of the reserve components who require treatment for PTSD or other mental health conditions and reside in rural or highly rural areas. Mr. Chairman, DAV has no objection to VA entering into such an agreement to improve access to specialized mental health care for rural veterans.

TITLE V—WORKFORCE IMPROVEMENT

Sec. 501. Establishment of Department of Veterans Affairs Readjustment Counseling Service Scholarship Program. VA’s Vet Center program is an essential part of VA’s services for treating post-deployment mental health issues. DAV is pleased to support this initiative to attract and retain high quality mental health professionals in Vet Centers.

Sec. 502. Comptroller General report on Readjustment Counseling Service of Department of Veterans Affairs. DAV has a special relationship with the Vet Center program having established the prototype for these centers in the wake of the Vietnam War. We understand that these programs are an important lifeline for veterans that need help with transitioning from military service to civilian life and dealing with post deployment mental health readjustment challenges. GAO would be required to conduct a comprehensive assessment of the Vet Center program to determine overall effectiveness of the program, outreach efforts, access, staffing, and advise on the feasibility of expanding eligibility. DAV supports this provision as a means of enhancing VA mental health services in accordance with DAV Resolution Nos. 370 and 083.

Sec. 503. Expansion of reporting requirements on Readjustment Counseling Service of Department of Veterans Affairs. In accordance with DAV Resolution No. 083, we support additional reporting requirements that assist Congress in appropriate funding of this program based on demand for services and relevant oversight activities.

Sec. 504. Treatment of psychologists.

Section 504 would re-categorize psychologists now under Hybrid title 5/title 38 authority to full title 38 authority. DAV has no specific resolution on this issue but wants to be sure that recruitment and retention of psychologists—an occupation that VA's Office of Inspector General has identified as having a large staff shortfall for the past several years—would not be negatively impacted by this proposed change. DAV asks the Committee to consider removing this provision and working with organizations representing these employees to garner more information about the impact of this change on leave policies, pay practices, collective bargaining rights, retirement and other rights and benefits valued by current employees and job candidates.

Sec. 505. Pilot program on prescription of medication by psychologists of Department of Veterans Affairs. This provision would require VA to conduct a survey of all licensed psychologists to determine how many hold a master's degree in clinical psychopharmacology. The provision would also establish a two-year pilot program under which covered psychologists would be permitted to prescribe medication regardless of where they are licensed or certified to practice if they meet certain test-score requirements.

DAV has no resolution on this issue and offers no formal position. We do however, note that ensuring veterans' safety is our primary concern in all health care related matters and suggest such decisions about prescribing are left up to VHA leadership based on research and standard and acceptable practices within any clinical field. Veterans should always be provided treatment and medications from health care providers who are medically trained to understand the biochemical complexities of prescribing to patients who may be especially vulnerable due to complex medical and mental health histories, comorbidities and polypharmacy issues.

TITLE VI—IMPROVEMENT OF CARE AND SERVICES FOR WOMEN VETERANS

DAV has expressed strong support for enhancing women veterans' benefits and services in our 2014 report, *Women Veterans: The Long Journey Home* and 2018 report, *Women Veterans: The Journey Ahead*. Combined, these reports made dozens of recommendations for improving the policy, programming, resources, training, coordination, and oversight of federal programs serving women veterans. We also invite you to review our statements for each of the Women's Task Force roundtable discussions and hearings convened during the 116th Congress. We have advocated for the Senate to take up the House-passed version of the Deborah Sampson Act (H.R. 3224) and pass it swiftly to ensure women veterans have equal access to high quality comprehensive health care services and VA's specialized programs.

DAV has testified previously in support of many of the provisions under this section, which were also included in the Deborah Sampson Act passed by the House in November 2019, including Sec. 601, 602, 605, 607, and 608. We

also strongly support sections 603, 604, 606, 610 and 611. DAV has no resolution on changing the eligibility for military sexual trauma counseling under Sec. 609, but does not object to its passage. We also note that some of the information called for in reports required under sections 604 and 608 may be available from data already collected by VA. We hope that, to the extent possible, Congress is able to coordinate with VA to obtain the data it requires from existing information resources.

Sec. 612. Grants for women veterans. This program creates a new grant program to assist women veterans with daily living services; (2) income support services; (3) financial counseling services; (4) legal assistance; (5) education supportive services; (6) career advancement services; (7) transportation; (8) child care; and (9) housing. This program would, through grants provided to non-profit providers who work in consultation with state, local or tribal agencies, address many of the unmet needs of women veterans identified in the annual CHALENG report.

While DAV has no specific resolution on this issue, we acknowledge the goal of the proposed program could play in filling gaps in VA programming for women veterans and appreciate its intent. Therefore, we do not object to its favorable consideration.

TITLE VII—OTHER MATTERS

Sec. 701. Prescription of technical qualifications for licensed hearing aid specialists and requirement for appointment of such specialists. DAV has no resolution on the VA's use of licensed hearing aid specialists and thus no position on this section.

H.R. 8005, Veterans Access to Online Treatment Act

This bill would require VA to develop an online pilot program to treat eligible veterans suffering from depression, anxiety, post-traumatic stress disorder (PTSD), military sexual trauma, or substance use disorder, or a combination thereof who are already receiving evidence-based therapy from the Department of Veterans Affairs (VA).

Program participants would be informed about the Veterans Crisis Line and have options for live support, including 24/7 access to mental health providers via chat. The bill requires that the two-year pilot take place at no fewer than three VA facilities in geographically diverse areas and at least two facilities located in rural or highly rural areas. An interim report on the pilot and a final report, including an assessment of any changes in clinically relevant outcomes, would be due to the House and Senate Veterans' Affairs Committees one year after the start of the pilot program and 90 days after the termination of the program.

DAV is supportive of access to a VA online option for a veteran's ongoing evidence-based mental health treatment and services in accordance with DAV Resolution No. 370.

Discussion Draft, Ensuring Veterans' Smooth Transition Act

This draft bill would amend section 1705 of title 38, United States Code, to require VA to enroll all eligible veterans transitioning from military service into the VA health care system, placing them in the appropriate Priority Group based on information provided from the Defense Manpower Data Center (DMDC) no more than sixty days after receiving such information. VA would be required to provide veterans with a notice of enrollment, instructions for "opting out" and access to an electronic version of their certificate of eligibility for VA care.

DAV is unclear about the logistics for automatic enrollment—particularly with regard to VA's ability to make an appropriate determination about a veteran's priority for care based on information sent from the DMDC. While eligibility for health care is easy to determine based upon the characterization of the veteran's discharge, prioritization for care is generally based upon the presence and level of a veteran's service-connected disability, income level, toxic exposures or catastrophic injury or disease, which may be more difficult to assess based upon the information at the agencies' disposal. We suggest a provision be added to the bill requiring VA to provide information about establishing service connection for conditions related to military service, an explanation of VA's system of enrollment including its Priority Groups for health care and its co-payment requirements for each category along with the certificate of eligibility.

Notwithstanding our logistical concerns, DAV endorses the intent of this discussion draft. A general lack of awareness about eligibility and how to apply for VA benefits and health care are often cited as reasons veterans do not seek care and benefits they have earned as a result of their military service. This bill, calling for automatic enrollment into the VA health care system for transitioning service members, could address these issues, help increase awareness about earned benefits and provide a gateway for veterans regarding health care services without requiring them to initiate engagement. Specifically, it could provide an easier more seamless transition from the military to VA thus allowing veterans to have more immediate access to screening, early identification and treatment of common post-deployment issues including post-traumatic stress disorder, military sexual trauma, traumatic brain injury and suicidal ideation.

In accordance with DAV Resolution No. 001, our Statement of Policy, which supports enhanced outreach to ensure veterans receive all of the benefits they have earned as a result of their military service, we are pleased to support the Ensuring Veteran's Smooth Transition Act.

Discussion Draft, VA Research Technology Act

The VA Research Technology Act would allow VA to use accredited commercial institutional review boards (IRBs) to seek approval for proposals that will involve human research subjects along with requiring an annual report to Congress on all approved commercial IRBs. The bill also requires the creation of an Office of Research Reviews within the VA's Office of Information and Technology to perform security reviews for approved research outside the Department and to maintain a list of preferred commercially available software for clinical trials.

We are pleased to support this draft measure in accordance with DAV Resolution No. 133, which calls on us to support improvements to VA's research program that are in conformance with the Common Rule and other ethical and humanitarian constraints to ensure informed consent and safety of all research volunteers, and the efficacy of approved research projects.

Discussion Draft, Access to Suicide Prevention Coordinators Act

This bill would ensure that every VA medical center employs at least one full-time suicide prevention coordinator (SPC), while working with the Office of Mental Health and Suicide Prevention to hire the appropriate number of suicide prevention coordinators as determined by current staffing models.

The bill also requires the Secretary to study the feasibility of reorganizing SPCs within the Office of Mental Health and Suicide Prevention and create a suicide prevention coordinator program office to oversee SPCs and case managers across the VA health care system. The office would be responsible for reviewing current staffing ratios for suicide prevention coordinators and case managers within each VA medical center as compared to mental health providers and for submitting a description of the duties and responsibilities of SPCs to Congress to better define and measure goals and outcomes.

As we continue the battle against veteran suicide, it is crucial that we provide veterans with access to the tools and services they need especially veterans who are in crisis or at high-risk for suicide. These coordinators play a key role at the local, and individual level by helping to destigmatize seeking help for mental health issues, identifying high-risk veterans or those who have attempted suicide and ensuring their care and monitoring is intensified.

DAV Resolution 370 supports improving and enhancing VA mental health programs and suicide prevention efforts. This includes working to fill vacancies or shortages for mental health care support staff. We are, therefore, pleased to support this draft bill.

H.R. 8108, VA Serious Mental Illness Act

This draft bill requires VA to create a workgroup for the purpose of developing clinical practice guidelines for serious mental illness, in conjunction with the Secretaries of the Departments of Defense and Health and Human Services, and other appropriate agencies. Serious mental illnesses includes conditions such as schizophrenia, schizoaffective disorders and mood disorders (including bipolar disorders) in addition to other persistent conditions affecting mental health, emotions or behavior identified by the Secretary. The bill requires the guidelines to include a list of evidence-based therapies, appropriate pharmacological therapies and a plan to implement and disseminate these clinical practice guidelines. The bill also directs the Secretary to reassess the existing clinical guidelines for treating major depressive disorder.

DAV supports this bill for improving clinical practice guidelines for serious mental illness, in accordance with DAV Resolution No. 370, along with the development of a plan to ensure adequate dissemination and training for mental health providers on the use of such guidelines created by VA.

H.R. 8084, Lethal Means Safety Training Act

This bill aims to strengthen VA efforts to reduce suicide in the veteran population. The legislation requires VA to update the training protocol on suicide prevention and lethal means safety training in consultation with other federal agencies, experts and stakeholder groups, including veterans service organizations. The Secretary would be required to ensure that VA's frontline medical staff and staff in the Veterans Benefits Administration, who regularly interact with veterans, are properly trained on culturally appropriate best practices (identified by subject matter experts) for suicide prevention and lethal means safety. The bill requires that such training is updated on an annual basis and would also extend to clinicians with whom VA contracts for medical care in the community, in addition to caregivers participating in the VA's Comprehensive Program of Assistance for Family Caregivers (CPAFC).

While we are supportive of the draft bill, we suggest the Committee extend the number of days that caregivers receiving benefits under the CPAFC program have to complete the mandated training to ensure there is no disruption of payment given their critical role. The Committee may also want to consider requiring VA to conduct a special outreach to caregivers regarding the requirement for completion of the training. Additionally, we suggest that training for non-clinical personnel be appropriate and tailored to their unique interactions with veterans.

Nearly half of all veterans own at least one firearm.⁴ According to VA's 2019 annual report on veterans' suicide, firearms were the method of self-harm selected most frequently by veterans who died from suicide in 2017. Veterans used firearms in 69.4% of completed suicides compared to 48.1% of deaths by suicide in the non-veteran adult

⁴ Emily C. Cleveland, Deborah Azrael, Joseph A. Simonetti, and Matthew Miller, 2015 National Firearm Survey: Firearm ownership among American veterans.

population. Rates of suicide by firearm were higher among male veterans (70.7%) compared to male non-veterans (53.5%) as well as female veterans (43.2%) compared to female non-veterans (31.3%). Use of firearms in suicides are particularly lethal—what might be a “call for help” or attempt using a different method such as poisoning may end life when a firearm is used. Given these findings, training veterans in the safe storage of firearms is a critical component of suicide prevention for veterans that should be a part of any comprehensive public health strategy. A quote from testimony provided by Dr. C. Edward Coffey before this Committee on January 29, 2020, is especially relevant. “Because veterans and service members are venerated in our society and widely acknowledged as expert in injury prevention, they have the opportunity to serve as the model for safe gun ownership in our broader society, and in so doing, catalyze a movement that would save thousands of lives.”

We are pleased to see that VA has already started to develop an outreach and education campaign on lethal means safety, and that this initiative is also included in the President’s suicide prevention campaign—PREVENTS (President’s Roadmap to Empower Veterans and End the National Tragedy of Suicide), mandated by an executive order signed by the President in March 2019. This bill would institutionalize training for providers and other staff to improve their ability and confidence to counsel veterans, especially vulnerable veterans during at-risk periods, about suicide and lethal means safety.

DAV supports this draft bill based on DAV Resolution Nos. 370 and 379. These resolutions support improved training for mental health providers focused on suicide prevention that ensures VA and its community care network of providers offer culturally sensitive treatment and interventions to veterans.

H.R. 8068, American Indian and Alaska Native Veterans Mental Health Act

This bill would require that every VA medical center has a full-time employee who would serve as a minority veteran coordinator (MVC). All MVCs would receive training in delivering culturally appropriate mental health and suicide prevention services to American Indians and Alaska Native veterans.

VA Medical Center suicide prevention coordinators (SPCs) and MVCs would coordinate to develop and disseminate a written plan for conducting mental health and suicide prevention outreach to all tribes and urban Indian health organizations within the catchment area of the VA medical center. The bill requires plans must contain information about: Tribal leadership and tribal facility or Indian Health Service facility; a schedule for and list of outreach plans; and documentation of any conversation with tribal leaders that may guide culturally appropriate delivery of mental health care services.

DAV supports this bill based on DAV Resolution No. 377, which supports the rights and benefits earned by service-connected Native American and Alaska Native veterans.

H.R. 8144, VA Mental Health Staffing Improvement Act

This bill would require VA, in conjunction with the VA's Office of the Inspector General, to submit a plan to Congress to address how it will meet veterans' demand for mental health care services, including filling identified staff vacancies and region-specific incentives that are necessary to attract mental health providers in certain locations.

Adequate staffing is essential to ensure that VA's mental health services meet the Department's own quality and access standards demand for care. We are pleased to support this bill under DAV resolution No. 370, which calls for program improvement and enhanced resources for VA mental health programs and suicide prevention efforts.

H.R. 8130, VA Peer Specialists Act

This bill requires VA, in conjunction with the VA Office of the Inspector General, to assess and report on the number of women it employs as VA Peer Specialists who specialize in peer counseling on mental health and suicide prevention versus non-mental health conditions. The bill requires the report to include geographic distribution of women peer specialists and hours worked to identify if there are areas of the country where more women peers are needed to offer support and help better define and standardize performance goals, duties and outcomes for peer specialists.

Peer support specialists offer an important and personal linkage between veterans, the VA health care system and a veteran's personalized treatment plan. Unlike medical professionals, peer support specialists assist veterans with health-life choices and establishing motivational goals to help them better engage and comply with treatment. For women veterans, in a system in which the patient caseload is predominantly male, it may be particularly helpful to have a same sex peer to navigate the system and aid in their recovery.

DAV supports this bill in accordance with DAV Resolution Nos. 370 and 020, which support improvements in VA mental health services and suicide prevention efforts and enhanced medical services for women veterans.

H.R. 8107, VA Emergency Department Safety Planning Act

This draft bill would require the VA to assess and report on an existing suicide prevention program focused on follow-up engagement for veterans in mental health crisis who present to a VA emergency department or urgent care center.

In 2010, VHA implemented the Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment project (SAFE VET) in five sites to ensure suicidal veterans seen in VA emergency departments, who can be safely discharged, receive

appropriate follow-up care. A 2018 study found that safety planning intervention under SAFE VET was associated with a 45 percent reduction in suicidal behaviors in the six-month period following emergency department care, and more than doubled the odds of a veteran engaging in outpatient behavioral health care.

Beginning in September 2018, VA implemented a suicide prevention program based on SAFE VET, known as the Safety Planning in Emergency Departments (SPED) program. Like SAFE VET, the SPED program includes issuance and update of a safety plan and post-discharge follow-up with veterans to facilitate engagement in outpatient mental health care.

This bill requires VA to provide a report to Congress that includes:

- an assessment of the implementation of the current operation policies and procedures of the SPED program at each VA Medical Center (VAMC);
- an assessment of the implementation of the policies and procedures—disaggregated by gender, race and ethnicity;
- a description of how SPED primary coordinators are deployed to support such efforts;
- an assessment of the feasibility and advisability of expanding the total number and geographic distribution of SPED primary coordinators;
- an assessment of the feasibility and advisability of providing services under the SPED program via telehealth channels, including an analysis of opportunities to leverage telehealth to better serve veterans in rural areas;
- a description of the status of current capabilities and utilization of tracking mechanisms to monitor compliance, quality, and patient outcomes under the SPED program; and
- recommendations, including specific action items, on how the Department can better implement the SPED program.

DAV believes VA efforts to ensure that effective screening, counseling and follow up with veterans who present to its emergency departments in crises are critical to reducing the number of suicides among veterans. Implementation of the VA's evidence-based SAFE-VET model through the SPED program would help VA achieve this goal. DAV strongly supports this bill in accordance with Resolution No. 370, which supports enhancement of VA's mental health programs and suicide prevention efforts.

Discussion Draft, VA Expanded Care Hours Act

This bill would direct the VA to conduct a study on the attitudes of enrolled veterans, to include the opinions of VHA employees, as well as the feasibility and advisability of offering appointments outside the usual operating hours (8:00 a.m. to 4:30 p.m. Monday through Friday) of VA medical facilities.

Service-disabled veterans often have complex health conditions and mental health challenges that require frequent medical appointments. Although many

employed in the civilian workforce receive reasonable accommodations from employers, some veterans still may require more flexible hours to meet all of their health care needs.

Examining the need and desire for extended operating hours could result in removing an access barrier for veterans who need VA health and mental health care services. DAV supports this legislation in accordance with DAV Resolution No. 335, which urges the VA to implement extended operating hours for services such as primary, specialty, and mental health services to enrolled veterans.

H.R. 8145, VA Counseling Act

This draft bill would require VA, in conjunction with the VA Office of the Inspector General, to develop a staffing improvement plan for professional counselors and marriage and family therapists to address strategies for increasing recruitment and addressing vacancies.

The bill requires the plan to include the number of licensed professional mental health counselors and marriage and family therapists needed to meet demand in each medical center and Veterans Integrated Service Network. VA would also be required to provide the steps necessary to address identified shortages, in these positions including a description of any region-specific hiring incentives needed and any local retention incentives necessary to maintain qualified providers.

Marriage and family therapists are often specifically requested by veterans and their availability equates to rounding out a full complement of VA's traditional interdisciplinary mental health care teams, which include VA social workers, psychologists and psychiatrists. DAV supports this bill in accordance with DAV Resolution No. 089, which supports effective recruitment, retention and development of the VA health care workforce.

H.R. 8147, VA Comprehensive and Integrative Health Act

This bill would require VA to assess the implementation of complimentary and integrative health services provided under section 933 of the Jason Simcakoski Memorial and Promise Act (title IX of Public Law 114–198; 738 U.S.C. 1701 note) and identify a plan to expand these services. The bill also calls upon VA to assess the effectiveness of the services delivered including their efficacy for addressing pain, mental health issues and chronic illness in addition to assessing outreach efforts and looking at veterans' experience with the programs.

The bill would also expand the pilot program to include (in addition to yoga, meditation, acupuncture, and chiropractic care already in the pilot) animal therapy, agritherapy, adaptive sports and outdoor adventure at a minimum of five geographically diverse locations and have researchers study the effectiveness of such programs.

DAV supports the intent of this draft bill in accordance with DAV Resolution No. 378, which calls for inclusion of complementary and integrative health (CIH) practices as part of VA's comprehensive health care services continuum. However, we ask the Committee to consider amending the bill to include provisions to ensure complementary and integrative programs are standardized and available throughout the entire VA health care system—as part of VA's whole health model of care. While these services are popular and available at many VA facilities they still vary widely across the system. We concur with the recommendations made in the 2020 report from the COVER Commission (Creating Options for Veterans' Expedited Recovery) that called for uniformity of CIH services in VA and outreach to veterans about these alternative options for the purpose of making informed decisions about their care.⁵

Veterans Burn Pits Exposure Recognition Act of 2020

This draft bill would establish a concession of exposure to burn pits and to the recognized toxins for veterans who served in specific times and countries known to have to active burn pits and guaranty VA examinations for “emerging diseases” claimed due to said exposure.

In reference to Section 2, Findings; Sense of Congress, we agree that the locations of burn pits used by the Department of Defense (DOD) and partnered armed forces, and the possible health effects associated by their use, may never be completely known, as some location and air and soil quality data is fragmentary. The most recent available research involved with establishing links between burn pit exposure and health conditions in most cases, has been inconclusive.

DAV believes that, if it is determined that a veteran was deployed to a covered location during a certain period, the VA Secretary should concede that the member or veteran was exposed to certain toxins, chemicals, and hazards.

In Section 3, Concession of exposure to airborne hazards and toxins from DOD and partnered armed forces burn pits, under covered locations, provides a list of times and countries of recognized exposure to burn pits and airborne hazards. We do note that recently, DOD has acknowledged that Bahrain did not have active burn pits, thus we recommend the removal of Bahrain from the list. DOD has also recently identified additional countries and periods of time that had known active burn pits, therefore we recommend that the following be added to the discussion draft:

- Syria and the period beginning on September 11, 2001, and ending on such date as the Secretary determines burn pits are no longer used in Syria.
- Jordan and the period beginning on September 11, 2001, and ending on such date as the Secretary determines burn pits are no longer used in Jordan.
- Egypt and the period beginning on September 11, 2001, and ending on such date as the Secretary determines burn pits are no longer used in Egypt.

⁵ COVER Commission Final Report. Creating Options for Veteran's Expedited Recovery, Department of Veterans Affairs. January 24, 2020. P. 37.

- Lebanon and the period beginning on September 11, 2001, and ending on such date as the Secretary determines burn pits are no longer used in Lebanon.
- Yemen and the period beginning on September 11, 2001, and ending on such date as the Secretary determines burn pits are no longer used in Yemen.

Under toxins, chemicals, and airborne hazards, the draft identifies and lists the toxins, chemicals, and airborne hazards to which each veteran would be conceded to have been exposed. This list is based on the air sample testing conducted by the U.S. Army in 2008, and mirrors the VA's adjudication manual acknowledged list. DAV supports this inclusion in the draft and it is based on the same recognized and accepted lists by both DOD and VA. We agree that this list can be updated with future evidence and information.

Under medical examinations and medical opinions for emerging diseases, the draft bill recognizes only four diseases that can be considered under this entire draft: bronchial asthma, chronic bronchitis, sinusitis, and constrictive bronchiolitis. DAV does not agree with the limitations of establishing direct service connection for only the established "emerging diseases." The requirement of emerging diseases is too restrictive and would not allow other diseases to be granted on a direct service-connected basis based on the concession of exposure. Thus, veterans with other diseases that could be linked to burn pits exposure, would be denied under this discussion draft.

At the time of writing this testimony, the report from the National Academies, "Respiratory Health Effects of Airborne Hazards Exposures in the Southwest Asia Theater of Military Operations," has not yet been publically released. However, if the report confirms that there is positive scientific evidence of an association between burn pits and the four diseases noted above, we recommend that separate legislation be drafted to establish presumptive service connection based on burn pit exposure.

DAV supports most of the provisions of this draft proposal and recommends that additions be made to update the above noted DOD recognized burn pit locations and time periods. Again, we do not support the idea of emerging diseases as it is too restrictive for burn pit-exposed veterans to establish direct service connection for other diseases and disabilities; however, if the yet-to-be published National Academies report bears out the positive associations as expected, we recommend that separate legislation be introduced to establish presumptive service connection for bronchial asthma, chronic bronchitis, sinusitis, and constrictive bronchiolitis.

H.R. 3450, Second Amendment

This legislation would prohibit the Department of Veterans Affairs (VA) from informing the Department of Justice of information, for use by the National Instant Criminal Background Check System (NICS), based only on the fact that the veteran has a service-connected disability.

Title 38, United States Code, 992(d) governs federal firearms laws and who is prohibited from possessing firearms, including persons who have been adjudicated by a court of law as mentally defective. In 1998, the Bureau of Alcohol, Tobacco and Firearms adopted a new procedure that defined “mental defective” to include someone who “lacks the mental capacity to contract or manage their own affairs due to injury or disease.” Currently, VA reports a veteran to NICS if they are adjudicated as “incompetent” by VA for purposes of managing their money. Current laws, policies, and regulations do not allow VA to transmit any information to NICS unless that veteran is determined to be incompetent for VA purposes.

DAV does not have a resolution specific to this issue and takes no position on H.R. 3450; however, establishment of a specific disability should never adversely be used against any veteran.

H.R. 3788, VA Child Care Protection Act of 2019

H.R. 3788 would prevent VA from making payments with any child care agency that employs individuals that have been charged with a sex offense; an offense against children, a drug felony; a violent crime or other offenses at the discretion of the Secretary, unless the individual charged has been suspended from having contact with children pending resolution of the case.

While DAV supports VA-sponsored child care services or assistance to veterans using VA for the purpose of removing barriers to accessing needed VA health care, mental health treatment and rehabilitative services we have no resolution on this proposal and take no position on the bill. However, in instances where child care services are available at VA facilities, or by contract, we agree those agencies need to be properly licensed and staff fully vetted to ensure that veterans have confidence that their children will be cared for in a safe care environment.

H.R. 3826, Veterans 2nd Amendment Protection Act

This bill would amend title 38, United States Code, by inserting a new section, 5501A, and would preclude the VA from providing any personally identifiable information of a VA beneficiary, to the Department of Justice, for use by the National Instant Criminal Background Check System (NICS), solely on the basis of a VA determination of incompetency for VA purposes without the order or finding of a judge, magistrate, or other judicial authority of competent jurisdiction that such beneficiary is a danger to themselves or others.

Title 38, United States Code, 992(d) governs federal firearms laws and who is prohibited from possessing firearms, including persons who have been adjudicated by a court of law as mentally defective. In 1998, the Bureau of Alcohol, Tobacco and Firearms adopted a new procedure that defined “mental defective” to include someone who “lacks the mental capacity to contract or manage their own affairs due to injury or disease.” Currently, VA reports a veteran to the NICS list if they are adjudicated as

incompetent by VA for purposes of managing their money. DAV does not have a resolution specific to this issue and takes no position on H.R. 3826.

H.R. 7469 – Modernizing Veterans’ Healthcare Eligibility Act

This legislation would establish a “Commission on Eligibility” in order to examine veterans’ health care eligibility rules and regulations that currently exist and make recommendations to change them. The commission would consist of 15 members to be appointed (3 each) by the President, Senate Majority Leader, Senate Minority Leader, House Speaker and House Minority Leader. The President would designate the chair of the commission and at least one member must be appointed from a veterans service organization that represents veterans before VA; one member that has worked for a large private health care system; one representative with experience in a government health care system; and one individual familiar with the Veterans Health Administration, but not currently employed there.

The commission would be required to hold its first meeting no later than 15 days after a majority of its members are appointed and must issue a preliminary report with findings and recommendations no later than 90 days after its first meeting. The commission must issue a final report and recommendations no later than one year from its initial meeting. The president would then be required to submit a report to Congress on the advisability and feasibility of each recommendation, together with executive actions to be taken and legislation necessary to implement them.

Veterans’ health care eligibility and VA’s medical benefits package for enrolled veterans are both clearly defined in title 38, United States Code, and accompanying federal regulations. Because Congress has full authority to modify eligibility requirements or VA’s medical care benefits package through the regular legislative process, it is unclear why a special outside commission is necessary. The legislation does not provide any indication of the types of serious problems the commission should address, proposals it should consider or a compelling rationale for why Congress and VA are unable to properly exercise control under current authorities.

A handful of individuals continue to suggest significantly scaling back eligibility in order to reduce the number of veterans who receive health care from VA as well as limiting the number of medical services VA can provide to veterans. However, these and other similar ideas, including privatizing the VA health care system, have received negligible support and been repeatedly dismissed by Congress as well as by outside experts and panels.

For these reasons, we believe that Congress and this Committee should continue to have the first responsibility to conduct oversight of VA health care eligibility and determine whether legislative or regulatory changes are necessary. Only when Congress is unable to properly exercise these functions should outside commissions be considered.

H.R. 7784, VA Police Improvement and Accountability Act

H.R. 7784 aims to reform the VA police force and would impact more than 4,000 officers across the nation. The bill seeks to ensure accountability among the force, and would authorize working body cameras, along with the tools and training to improve officer's crisis intervention and de-escalation skills.

The bill would improve transparency and accountability by requiring VA Police points of contact at individual facilities and providing public information regarding arrests, use of force, and other key metrics. It would require the VA to issue a report to Congress on its plans for improved police staffing and training and how it is tracking and analyzing police activity such as arrests, ticketing, and use of force. VA police forces would be required to use body cameras and develop best practices to ensure that the use of body cameras is consistent with upholding civil rights and privacy of patients and employees. This measure would address veteran suicide by ensuring that VA police have the training, resources, and appropriate level of staffing for crisis intervention training, crisis de-escalation techniques and other important skills.

DAV does not have a resolution specific to the VA Police Improvement and Accountability Act. However, with millions of veterans receiving care at VA facilities on a daily basis and higher rates of mental health conditions and post deployment readjustment issues in this population—having a well-trained police force is essential for the safety of veterans and VA employees.

H.R. 7964, Peer Support for Veteran Families Act

H.R. 7964 would establish a 30-site, four-year education and peer support pilot program allowing certain family members and friends in caregiving roles to participate in a ten-week program, developed by a non-profit organization, focused on recognizing and managing mental health care conditions of loved ones including techniques for handling crisis situations and for coping with stress. Individuals completing this course of instruction could then be certified and serve as family peer support counselors in another program established by the Secretary. The bill also requires a comprehensive survey and annual report to determine participants' satisfaction with and effectiveness of the program curriculum and peer support program.

DAV has been an early and vocal supporter of programs intended to support veterans' caregivers and include essential training and counseling for family caregivers, and thus we appreciate the intent of this bill. We note that VA already offers telephone and online guidance and support to family care providers. In the wake of the Operation Iraqi Freedom and Operation Endevor Freedom, the Defense and Veterans Brain Injury Center also created a detailed caregivers' curriculum developed specifically for family caregivers who support veterans and service members with moderate to severe traumatic brain injury.⁶ This online curriculum includes specific modules that explain traumatic brain injury and the various ways it may affect individuals, tips on becoming

⁶ <https://dvbic.dcoe.mil/family-caregiver-curriculum> accessed 8/26/20.

an effective caregiver including organizing materials and resources and taking care of oneself, and specifies how to navigate resources and benefits to support a wounded veteran and the family. We believe this curriculum, updated to include new best practices and modified for additional conditions, might offer a preferred model for training for veterans' caregivers.

This bill requires the veteran's permission for their caregiver to attend the training outlined for the program which would likely be beneficial to both the caregiver and veteran. However, we have some concern about the length of the in-person educational program (10 weeks), which would require caregivers to delay or leave their caregiving responsibilities. Additionally, the VA has a comprehensive mental program staff and subject matter experts who are capable of developing and supporting the type of course curriculum and training outlined in the bill.

We believe the bill sponsor or Committee may want to consider amending the bill to require VA to update and expand the existing caregiver online curriculum to include the mental health conditions outlined in the bill and/or consider a shortened hybrid program.

H.R. 8148, VA Data Analytics and Technology Assistance Act

The VA DATA Act would allow VA to pursue contracts with an academic institution or qualified entity for statistical analysis and data evaluation required by law.

DAV does not have a resolution on this matter, but would note it is essential that, when VA deems it is in its best interest to contract for this support, VA build in appropriate protections to ensure veterans' personal data is scrupulously safeguarded.

H.R. 8149, VA Precision Medicine Act

This draft legislation would require the VA Secretary to undertake a research initiative to identify and validate biomarkers associated with mental health and brain conditions in veterans with specific consideration for depression, anxiety and post-traumatic stress disorder, bi-polar disorder, and traumatic brain injury. The bill specifies that data collected is to be used only for research purposes and would also require the Secretary to standardize methods of data collection with appropriate Department of Health and Human Services programs and assess the feasibility of coordinating this initiative under the VA's genomic Million Veterans Program.

While DAV supports improvements for treatment of mental health conditions through rigorous scientific exploration, we want to ensure veterans who participate in research studies are protected throughout the research process. For these reasons, we ask the Committee to consider adding an additional provision to the legislation to ensure that findings from the study will not be used for any purpose other than improving treatment and care for the mental health or brain conditions studied in the research initiative.

Discussion Draft, VA High Altitude and Suicide Research Act

This bill would require VA to investigate if there is a connection or association between living at high altitude and increased risk factors for suicide or depression among veterans. The bill further requires VA to conduct research if such a connection is found, to determine the most likely biological mechanism for a risk factor for depression or dying by suicide and the most effective treatment or intervention for veterans living at high altitude. Because of our commitment to the national priority to eliminate veterans' suicide, we have no objection to this legislation but generally prefer that research proposals are submitted and considered for approval through the conventional merit-review processes.

Again, DAV thanks the Committee for the opportunity to share our views on the legislation being considered at this hearing. We look forward to working with you to improve health services and benefits for our nation's ill and injured veterans. I am happy to take any questions you or Members of the Committee may have.