Association of VA Psychologist Leaders*
Association of VA Social Workers*
Veterans Healthcare Action Campaign
(*An independent organization, not representing the Department of Veterans Affairs)

STATEMENT FOR THE RECORD
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO DRAFT LEGISLATION
Furnishing Mental Health Care to Veterans by Choice Program Providers

WASHINGTON, D.C. October 24, 2017

Chairman Roe, Ranking Member Walz, and Members of the Committee:

On behalf of our organizations, we thank you for the opportunity to submit this statement for the record on draft legislation to direct VA to furnish mental health care to veterans by community providers participating in the Veterans Choice Program (VCP). This statement is in addition to our previous submittal that addressed different draft legislation on a Permanent VCP. We greatly appreciate your unwavering commitment to ensuring that veterans receive the highest quality physical and mental health care.

The Veterans Health Administration (VHA), as many recent evaluations have documented, provides unrivaled mental health (MH) care. That care that would be gravely undermined by this draft bill that allows veterans to obtain mental health treatment with a VCP provider of up to eight visits per episode without any referral from the VHA. Money to pay for this unfettered choice will be siphoned straight from VHA facility budgets, leading to incrementally fewer VHA mental health (MH) providers, with a consequent erosion and disappearance of the high quality VHA mental health services that Veterans now receive.

Below we elaborate on the documented superiority and innovations of the kind of VHA mental health care that is not readily available in the community, including: (1) unique expertise in treating Veterans, and (2) training and adherence procedures that ensure state-of-the art, evidence-based treatment. All of this would be at risk -- as would the benefits of VHA's integration of medical and mental health care -- if funding is diverted from VHA to community care without VHA's referral and oversight.

VHA expertise in treating Veterans with Post Traumatic Stress Disorder (PTSD) and depression is missing in the community.

More than 6,300 VHA MH providers have received extensive training and supervision in the most effective evidence-based therapies (EBP) for PTSD -- Prolonged Exposure and/or Cognitive Processing Therapy. More than 1,800 VA providers have received extensive training and supervision in one of three EBPs for depression.[i] Veterans who received these EBPs in the VA

have experienced clinically meaningful and robust improvement in their PTSD and depressive symptoms.[ii iii iv v vi vii viii]

By contrast, RAND's Ready to Serve[ix] national study of therapists who treat PTSD and major depression found that compared to providers affiliated with the VA or DoD, "a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions" (page 21). Only 18% of Tricare and 6% of non-Tricare community therapists were trained in and used an EBP.

VHA MH patients are more likely to receive recommended psychiatric medication than are patients in the community.

Recent publications comparing the VHA to private sector care's medication treatment for mental disorders found that for all seven indicators, VHA performance was superior to that of the private sector by more than 30%.[x xi] Another study found that only 1-12% of private sector patients treated with antidepressants are treated in a manner that is consistent with American Psychiatric Association guidelines (with care of ethnic minorities tending to be on the lower side of this range).[xii]

The VHA's approach to preventing suicides is more comprehensive than is commonly found in the private sector.

Each of the ~150 VHA medical centers has one or more Suicide Prevention Coordinator (SPC) as dedicated positions. SPCs provide enhanced care coordination for Veterans identified at high risk for suicide and collaborate with VHA's integrated network of care providers and community partners to reduce suicide risk among vulnerable Veterans. VHA Suicide Prevention policies also include follow ups to missed appointments, safety planning, and wraparound services, and for high risk Veterans a medical record flagging and monitoring system that includes mandatory mental health appointments. VHA also uses predictive analytics to identify Veterans at risk for suicide and other adverse outcomes and offers enhanced care to these Veterans according to their needs. Some of these Veterans may not have been identified as at risk based on clinical signs. This novel big data approach – which does not occur with Veterans seen in the community – allows VHA to identify and help vulnerable Veterans before a crisis occurs.

Veterans with Serious Mental Illness (SMI) who use the VHA have greater life expectancy and reduced inpatient bed days of care.

Veterans with SMI conditions who receive VHA care live much longer on average than their counterparts in the U.S. population.[xiii] Veterans with SMI who drop out of VHA health care but then resume have significantly lower rates of mortality than Veterans who do not return.[xiv] Building on this success, VHA implemented the SMI Re-Engage Program, an outreach to Veterans with SMI who have a 12-month gap in VHA service utilization. For Veterans contacted between March 2012 and March 2016, 24% returned to VHA care within 4 months.[xv]

In the VHA's Intensive Community Mental Health Recovery (ICMHR) program, MH staff visit Veterans with SMI multiple times weekly to provide recovery oriented interventions, typically in the Veteran's place of residence, which ensures more routine follow up and alleviates the burden to present to a medical facility. Veterans enrolled in ICMHR services had 27 fewer bed days of care and 1.4 fewer admissions on average as compared to the year prior to admission to the program.[xvi]

VHA's comprehensive and integrated health care response to military sexual trauma (MST) has no comparable program in the private sector.

When screened by a VA healthcare provider, 1 in 4 women Veterans and 1 in 100 men report that they experienced MST.[xvii] Because most servicemembers are men, they constitute 40% of all MST survivors seen in VHA. MST is associated with a wide range of mental and physical health conditions, as well as lasting impairment in occupational and life functioning.[xviii xixxx]

Given that many survivors never talk about their MST experience unless asked directly, VHA's screening, sensitivity and attentive efforts are crucial ways to proactively reach survivors who might not otherwise seek out care. Each VHA facility has a dedicated MST coordinator position, mandatory MST training for primary and mental health care providers, free MST-related treatment and outreach efforts. All Veterans enrolled in the VHA are screened for experiences of MST, and tailored treatment plans are created for survivors in need of mental health care. Over 938,000 outpatient MST-related mental health visits were provided to Veterans with a positive MST screen in FY14.[xxi] Comparable screening and treatment programs do not widely exist in the community, where providers are less likely to have experience or recognize that it is important to even ask Veterans about MST.

The VHA's evidence-based interdisciplinary approach to pain management, which is part of the VHA's care of patients with mental health and substance abuse problems, hardly exists outside of the VHA.

Approximately 50% of Veterans treated in Primary Care report one or more chronic pain complaints, disproportionately higher than American non-Veterans.[xxii] CDC Guidelines[xxiii] specifically recommend avoiding the use of opioids in favor of cognitive behavioral psychotherapy, exercise therapy and non-opioid medications as first-line treatments for chronic pain. Instead of routinely triaging Veterans with chronic pain to specialists, the VHA introduced in 2009 a Stepped Care Model in which patients receive biopsychosocial chronic pain care first within VHA primary care. These interdisciplinary clinics collocate and integrate PCPs, psychologists, pharmacists and/or physical therapists to provide multi-modal pain care. Preliminary results show decreased self-reported pain, opioid risk and daily opioid use.[xxiv xxv]

Interdisciplinary pain management continues to grow in the VHA but is very rare in the U.S. private sector where healthcare tends to be fragmented and truncated. VHA accounts for 40% of the U.S. interdisciplinary pain programs even though it serves 8% of the adult population.[xxvi] The

importance of effective pain management, including behavioral interventions, is further underscored by the fact that pain is the most commonly identified risk factor when analyses are conducted after a Veteran has died from suicide.[xxvii]

In large sections of the country, access to mental health professionals, especially psychiatrists, is quite limited. The bill is unlikely to solve access challenges.

A 2013 SAMHSA report indicated that 77% of U.S. counties had a severe shortage of practicing psychiatrists, psychologists or social workers; 55% of U.S. counties, all rural, have none at all.[xxviii] Even in geographic locations with available private sector psychiatrists, many are unwilling to accept insurance or government payments.[xxix] [xxx] That's a contributing factor to the January 2017 VA OIG Report[xxxi] finding: "Choice's inadequate network of providers created barriers for veterans trying to access care outside of VHA medical facilities" (p. iii). Being unable to find a local Choice provider has been a major source of frustration to our Veterans, as voiced by VHA Veteran-run Mental Health Councils and yearly Mental Health Summit participants. By contrast, VHA actively works against regional shortages with innovative programs reaching out to even the most rural Veterans.

No other healthcare system is as Veteran-centric and Veteran-sensitive as the VHA.

VHA care is Veteran-centric in many ways not found in general community settings. The VHA has hired 1100 Peer Specialists who are Veterans in successful recovery from mental health challenges and are integrated in programs as staff members providing mental health care. Peer specialists are uniquely suited to engage Veterans in ongoing care and to instill hope. Across the system, 31% of VHA employees are Veterans themselves. RAND's Ready to Serve report found that the Veteran and military cultural competency of VHA/DoD providers far outstripped that of community providers. VHA providers' cultural expertise comes not just from required trainings but also from a commitment to the mission of serving those who served and from careers in a system that is by, for and about Veterans. Finally, the VHA has created a community of healing in which Veterans in therapy groups share experiences they have not revealed to anyone else in their lives.

VHA care is superior because it is integrated, monitored and delivered in one location.

The proposed legislation segregates care of veterans, counter to VHA's integrated model that is considered optimal. The VHA also is able to achieve better quality because, as a unified system, it has superior ability to implement and monitor adherence to assessment and treatment standards. As the Commission on Care Final Report recognized: "Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers"(page 28).[xxxii]

The VHA is the main system of preparing our national healthcare workforce.

The VHA is involved in training 50% of all U.S. psychologists, 70% of all U.S. physicians, and 40 other healthcare professions. Significant reductions in the number of VHA attending supervisors would disrupt healthcare education nationally. Given the costs of establishing and maintaining training programs and residencies, the private sector will not be able to compensate for the loss of VHA training opportunities for the next generation of providers.

We recognize that when timely access to VHA services isn't feasible, the VHA should continue to purchase services from outside partners. Future efforts to reform the care of veterans must ensure that funding for high quality VHA mental health services be sustained and strengthened. We thank you again for this opportunity to provide input that describes the impact of allowing veterans to obtain mental health treatment with a VCP provider without any referral from the VHA.

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Notes:

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