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VA MENTAL HEALTH: ENSURING ACCESS TO CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

OCTOBER 28, 2015

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OCTOBER 28, 2015

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VA MENTAL HEALTH: ENSURING ACCESS TO CARE

WEDNESDAY, OCTOBER 28, 2015

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

The Committee met, pursuant to notice, at 2:31 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, Blumenthal, Murray, Brown, Tester, Hirono, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. First of all, I would like to call this meeting of the Senate Veterans' Affairs Committee to order, and I appreciate everybody's attendance today. I particularly appreciate our visitors who are testifying, and I will introduce them in just a second.

This is a critical hearing for the VA Committee. You are all familiar with the GAO report regarding suicide prevention and suicides in the Veterans Administration. I called the first hearing on preventing suicide in the Veterans Administration or Veterans Benefit Services in August 2013 in Atlanta, Georgia, because we had had an inordinate number of suicides in the Atlanta area during that period of time. To Leslie Wiggins' credit, who is the Director of the Clairmont Hospital in Atlanta, a number of things were done to address that subject and greatly reduce, although not totally eliminate, which is a very difficult thing to do, the number of suicides that took place. But, we got our arms around the problem.

I particularly am glad that GAO has focused on the problems that we do have so we can focus on the solutions we must have. As I told a member of the media a few minutes ago outside, failure is not an option, as far as I am concerned. The lives of every one of these veterans is important. They risked that life for all of us and our safety and our security overseas. We have got to make sure they have the comfort and the care and the accessibility to mental health coverage so they do not take their life while they are here at home. That requires a VA that is responsive, a hotline that works, and a program to make sure that veterans can get services when they need them on a timely basis, not a week or two later on.

I am delighted that all of you chose to come and participate today. I appreciate your being here.

With that said, I will introduce the Ranking Member, Senator Blumenthal.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thanks, Mr. Chairman, and thank you for having this hearing on a topic that is supremely important. There is no topic, in my view, that is more important than mental health for our veterans.

As in the civilian world, mental health is often overlooked, given less attention than it should be, an invisible condition that needs to be treated with the same urgency and immediacy as any physical condition would be. In the case of our veterans, it is an invisible wound of war for many and has been often disregarded and neglected until recently.

To its credit, our military now is much more focused on it, particularly when it affects our men and women in uniform engaged in combat, and the same sensitivity and attention have to be given by the VA and our civilian society, not enough that our insurance laws provide parity and require parity in coverage. All too often, incidentally, that law is neglected and overlooked—a separate topic. But, for our military men and women, for our veterans, mental health is as absolutely vital as an arm, a leg, any physical part of the body, and it deserves the same kind of world class, first class health care.

The GAO report that has been issued and is involved in today's hearing certainly documents failures and neglect that need to be remedied, and that is the topic that brings us here today, what more we can and should do right away, not at some distant point in the future, but literally right away.

Thank you, Mr. Chairman, for having this hearing. I look forward to hearing and learning as we listen to this testimony, but also acting on it as soon as possible. Thank you.

Chairman ISAKSON. Thank you, Senator Blumenthal.

I am pleased to introduce our first panel, to which each will have 5 minutes for their testimony and then we will do a round of questioning by the Committee members and then go to our second panel. We thank you for being here.

First is Nick Karnaze, U.S. Marine Corps veteran. We appreciate your being here today and thanks for bringing Lauren along. Lauren used to work for me a long time ago and she is a great lady. I appreciate it.

Dean Maiers, U.S. Navy veteran. Thank you for being here. I married into a Navy family, so I am kind of biased towards the Navy. We are glad you are here.

Mr. MAIERS. Thank you, sir.

Chairman ISAKSON. Roscoe Butler—and Roscoe, you are always with us and we appreciate your being here all the time—the Deputy Director of Health Care for The American Legion.

Dr. Jackie Maffucci, Research Director of Iraq and Afghanistan Veterans of America.

Dr. Debra A. Draper, Director of Health Team, the Government Accountability Office.

We are delighted that all of you are here. We will start with Nick for your testimony, up to about 5 minutes each.

STATEMENT OF NICHOLAS KARNAZE,
U.S. MARINE CORPS VETERAN

Mr. KARNAZE. Mr. Chairman, Members of the Committee, thank you for inviting me here today. It is an honor to be able to share my story with you.

My name is Nicholas Karnaze. I served about seven-and-a-half years in the Marine Corps, both as an intelligence officer and as a special operations officer. I have multiple combat deployments to Afghanistan. I am a graduate of the U.S. Naval Academy and recently completed a veteran program at the Stanford Graduate School of Business.

This is an issue that is near and dear to my heart. I am testifying from the perspective of a veteran who receives all of his health care through the VA.

Many men and women are suffering, as we all well know, from the mental wounds sustained in combat. A lot of them are fearful of coming forward and asking for help because of the stigma associated with it or the impact it could have on their employment. For those that do have the courage to step forward and ask for help, many are met with a lengthy administrative process to gain access to the care that they are asking for and desperately need.

In my personal experience, it took me about a year to get into the VA system upon separation from the Marine Corps. Once I was actually in the VA system, the physical care received was fantastic.

Late last year, in the fall of 2014, I was having some issues with concentration and just the ability to get work done, work that I was compassionate about. I reached out to my primary care physician to get a referral to a mental health specialist. It took me about a month to get that appointment. My first meeting with her was about an hour long, and at the end she asked if I was open to taking medication, because while I did not feel depressed, my inability to concentrate could be a sign of depression.

Wanting to get my head right, getting back and wanting to get back in the game, I agreed. She put me on an antidepressant. We agreed to meet 2 months later and she let me know that it would probably take a few weeks to a month for the drug to start working.

Several weeks into taking that medication, I actually began to feel depressed. I was in a very, very dark place. It was not me. It was not normal. I knew it was not normal. I reached back out to the VA to see my doctor again. She could not see me for another 30 days or thereabouts. So, on my own, I decided to stop taking the medication.

Shortly after I stopped, I was back at my baseline. I started feeling better. Things were good. I went back and I met with her and she said I had made the right choice by stopping the medication, that my body just did not metabolize it properly.

I told her that I would like to speak to a psychologist and maybe get some cognitive therapy, something like that, just because, for

me, I was defining a good year by attending more weddings than funerals. I was losing a lot of friends in combat and I had some guilt associated with that. She said that was a great idea, but she could not provide that cognitive therapy for me. That was my last interaction with a mental health care professional within the VA.

Just this week, I reached back out. I receive my care through the clinic at Fort Belvoir. They have one phone number listed on the Web site. I called that. It went to a recording and gave me another phone number to dial to be referred or to ask for a referral. I called that number, and after waiting for about 15 minutes, I decided to select the option of pressing one to leave a message and have the representative contact me when someone became available. I left my phone number. I left a voice message explaining that I needed to meet with my primary care physician, that I was in search of some mental health care, and to please give me a call back.

Today, I have yet to receive a call back from my clinic. At this time, I am still waiting to at least get an appointment.

I am not the only one in this position. I posted about this on Facebook, that I was going to be speaking before you, sir, and the response that I received was amazing. I received so many e-mails, and I forwarded them along to your staff. I included some of them in my written testimony, as well.

Some of my friends have actually given up hope. My friend, Nathan Lewis, he actually went through his private health care provider with the aid of his employer to receive mental health care. His wife asked him to do so because his issues were putting a strain on their marriage.

I and many veterans like me do not have that luxury. I am a small business owner, and unfortunately, at this time, I cannot afford private health care. Hopefully, that will change, but right now, I am still very much in that startup mode.

A lot of people want help. They need help. As a leader of Marines, I feel it my responsibility to help with that.

I truly believe that when we get the right access to care in a timely manner, we will find that we are going to see a reduction in veteran suicides and we are going to have healthier and happier families.

I am an open book. There is no question off limits for me, I am open and welcome to any questions you might have that might help in this matter. Thank you.

[The prepared statement of Mr. Karnaze follows:]

PREPARED STATEMENT OF NICHOLAS KARNAZE, U.S. MARINE (RETIRED), AND FOUNDER OF STUBBLE & 'STACHE

Mr. Chairman and Members of the Committee: Thank you for the invitation to be here today; it is an honor to be able to share my experiences with you. My name is Nicholas Karnaze, and I served 7.5 years in the United States Marine Corps both as an intelligence officer and as a special operations officer. I served two combat deployments in Afghanistan, and I have a disability rating with the VA. Because of this, I receive all of my health care through the VA. I am a graduate of the United States Naval Academy, and recently received a certificate from the Stanford University Graduate School of Business.

I am testifying today from the perspective of a veteran with service-connected disabilities who has attempted to receive mental health treatment from the VA. As a leader of Marines, I feel it is my duty to share my personal experiences with you so that, together, we can ensure the men and women who honorably served our Nation receive the mental health care that they deserve.

Many men and women are suffering in silence from the mental wounds they sustained during their time in the military. Most know they need help, but some are fearful to ask out of concern that any mention of "mental health" will have an adverse effect on their government security clearance, and ultimately, their jobs. For those who have mustered the courage to reach out, most are confronted with a lengthy and discouraging administrative process in order to gain access to mental health care. There are extremes in mental health—for example if a person is about to commit suicide—but the majority of people seeking treatment have not reached that point.

Often, veterans who are actively seeking help are in the stage in which they experience the feeling that something is not right. While they may know something is wrong, they are not on the verge of suicide, so contacting the VA's widely publicized Veterans Crisis Line seems excessive. So what options do we veterans have in this situation?

Upon leaving active duty, it took me over a year to gain access to the VA healthcare system. Once in the system, the actual physical care I received was fantastic. But, it's the time and process necessary to ultimately receive the care is where the issues lie.

In the fall of 2014 I expressed an interest to meet with a mental health care professional to discuss some issues I'd been having with concentration and memory. Upon referral to a psychiatrist, it took over a month before I was finally able to meet with the doctor. During our hour-long initial meeting, she asked if I was opposed to taking medication, mentioning that while I do not feel depressed, my inability to concentrate could be a symptom of depression. Eager to "get my head right," I said I had no problem trying medication. She then prescribed me an antidepressant, and we agreed to meet several months later to assess my progress. She noted that it could take from several weeks to a month before I noticed a change in my mood.

Two weeks into taking the medication, I began to feel depressed, beyond my initial issue with memory and concentration. Cold, lonely depression took its hold. I felt hopeless. At first I thought I was just having a really bad day, but these feelings persisted. I knew something was wrong. This was not me. I attempted to call the VA to talk with the psychiatrist, but she could not see me for about 30 days. I could not live like this for 30 days. I decided to stop taking the medication. Shortly after I stopped taking the drug, my mood began to improve and I was soon back to my original baseline. When I was able to see the doctor again, she said that I had made the right choice in stopping the medication. She asked if I wanted to try a different drug. I declined. I told her I'd like to try cognitive therapy. She said that was a good idea, but could not provide that for me. I was not referred to a psychologist. I left the clinic and that was the last interaction I've had with a VA mental health professional.

My experience in which the VA deferred to pharmaceutical treatment instead of psychological treatment is not unique. On August 26, 2014, Adam Looney took his own life. Adam was a Marine Corps veteran and brother of my friend Kate Looney, also a Marine Corps veteran. Up until his death, Adam was receiving mental health treatment from the VA in Columbia, MO. According to Kate, the "VA's approach was basically to try every psychiatric medication without really taking the time to counsel the root issue. He used to hate going because it was a long drive and a long wait. I brought him a few times, and he was never in there long. It seemed they were always changing his meds, losing paperwork and switching his counselor."

CURRENT SITUATION

I receive my health care through the VA Community Based Outpatient Clinic at the Ft. Belvoir Community Hospital. Still interested in meeting with a psychologist, I recently attempted to contact my clinic for a referral. The only way I've found to do this is through the one phone number listed on the clinic's Web site. The phone number links to an audio recording that lists another phone number to call for referrals. After calling that number, I was on hold for about 15 minutes before I decided to select the option of having a representative call me back when one became available. To date, no representative has called me back nor responded to the voice message I left requesting help earlier this week.

From a mental perspective, I feel very fortunate. No matter how bad things get, I always have a slight feeling that everything will be OK, that I just need to keep pushing forward. This feeling has been with me through my most difficult days on the battlefield and during my darkest times at home. Because of it, I have always been able to keep moving. But I know not everyone has this internal voice. When a person reaches out for help, especially mental health help, they are extremely vul-

nerable. Not having someone pick up on the other end, someone you have been told will help, is crushing. When you are suffering from a mental wound, you will not have the emotional energy to keep asking for help if your first calls go unanswered.

After learning I'd be testifying before you today, I posted on Facebook asking my friends about their experiences with mental health care from the VA. The responses I received were overwhelming. Alisa Beasley emailed me the following:

> I was medically retired from the Army 28 April 2014. I was just barely holding on mentally, that is how I felt. I saw my primary care provider by May and referred to Mental Health that same day! Then I saw a psychologist in July. Then nothing. I was supposed to be receiving follow up visits and every time I called the Mental Health number it just beeped like it was disconnected. I was so frustrated, and on top of that the VA had sent me a letter stating my benefits would be cut due to two missed appointments for psychiatry and neurology. I didn't miss either of these appointments, they were never rescheduled like I called and asked for. I could literally feel my world crumbling. I had gone through a really tough divorce, he wasn't letting me see my kids * * * I felt like what's the point. I'm done. I was having panic attacks and nightmares and depression. I called and called and there was never an answer from the VA mental health building. It took me calling the patient advocate. By this time I was a sobbing mess and crying and shaking and felt like my world was crashing. She was kind enough to tell me it looks like they literally just dropped me completely off the mental health log. She was able to get me an appointment for February 2015, this call took place in November 2014. I didn't see a psychiatrist to talk about possibility of meds till sometime after June 2015.
>
> This is not the worst-case scenario from the VA and mental health, but this is my story. This can not continue, others are far worse off and need the help they ask for RIGHT NOW not months or even days later. Why is there not a program set up that's 24/7 hours where the Vet can come into the VA mental health building and be treated at that moment. I am going to school now so I hopefully can help another Vet with PTSD. I would like to work with in the VA, efficiently. They cannot continue on this path they are living up to the motto most vets live by now "The VA giving Vets a second chance to die for their country."
>
> The saddest part is it is the truth.
>
> Sincerely,
>
> ALISA HURKMAN,
> *Ret. US Army Vet.*

Like Alisa, I too have had the VA threaten to cancel my benefits for missing an appointment. The problem is that I knew I wasn't able to make the appointment and actively reached out to the VA, but could not get through to an actual person. So, I left a voicemail with my appointment details and that I needed to reschedule. I never heard anything until I received a letter reprimanding me for missing an appointment.

There's a common thread here: the need to be able to efficiently gain access to the right care in a timely and thorough manner. Nathan Lewis, a former Marine Corps Officer, shared this with me:

> After my transition from the Corps my wife suggested I seek help for my challenges related to my two tours in Iraq. I reached out to the local VA hospital and asked for support. I waited months for their response. After three or so months I contacted them again. I was given a list of items I had to complete. It was an admin exercise and I decided to seek help through the assistance of my private sector employer.

But what about those who cannot go outside of the VA for care? As a small business owner, I cannot afford private healthcare at this time. I am aware of several amazing psychologists in the DC area, but I simply cannot afford to pay for treatment out of pocket.

In conclusion, as a veteran seeking mental health treatment from the VA, my biggest issue is gaining timely access to the right type of treatment. For me, the barrier to this is on the VA's administrative side; gaining access to the right providers. I truly believe that streamlining this process and providing veterans with the appropriate mental health care will result in stronger families and dramatically reduce veteran unemployment and the tragic suicides that are plaguing the veteran community.

Mr. Chairman and Members of the Committee, I wish to thank you for this opportunity to present my perspective today.

Chairman ISAKSON. Thank you, Nick.

Mr. Maiers.

STATEMENT OF DEAN S. MAIERS, U.S. NAVY VETERAN

Mr. MAIERS. Good afternoon. My name is Dean Maiers. I am an OEF/OIF disabled veteran. I served in the Navy. I would like to take some time and explain to you about how my peer support specialist has been extremely helpful.

Pretty much when I got out of the military, just like this gentleman to my right said, I had a rough time accepting that I was not right, and it took me numerous years in order to get to the VA and get help. They put me through this program at the Errera Center where all your doctors and peer support specialists are in one building. Ever since I have been going there, my life has changed tenfold.

When I got out of the military. I tried to kill myself twice. I lost my wife, my children, my job. I was homeless for 3 years. This is very important to me, because our fellow veterans really need this help, and if it was not for the VA, I probably would be dead. I have all the thanks and gratitude to the VA, their staff there, and everybody here that has been so helpful.

Every single veteran coming home deserves this program. Every State in this great country needs to have this program implemented. Some veterans, like myself, have too much pride to admit there is something wrong, after it took me 8 years to do it.

Just the fact of knowing that someone is there for you when you need it, or even if you do need it, and I am—I am sorry. I am a little nervous.

Chairman ISAKSON. You take all the time you need to take.

Mr. MAIERS. Basically, I went through some trials and tribulations. I had a very, very rough time when I got out, and I am so grateful for this program and this country, that they are taking care of me now, and it just means the world to me.

I thank you so much for this opportunity and your time. I hope that has been somewhat helpful. Anything I could do to help my brothers and sisters in arms to get the treatment they need and deserve. Thank you very much.

[The prepared statement of Mr. Maiers follows:]

HEARING TESTIMONY OF DEAN S. MAIERS, USN RETIRED

My name is Dean Maiers and I am an OIF/OEF disabled veteran. I would like to take some time and explain how my peer support specialist has been extremely helpful.

I had a very rough time adapting when I got out of the Navy. I pretty much lost everything that was important to me, my wife, children, employment everything seemed hopeless.

Then I found this program. It changed my life in so many ways. Ernest Johnson and the Comprehensive Work Therapy program at the Errera Center in West Haven have been a blessing to be honest. He also introduced me to several other social workers and other programs that have helped me tremendously, by getting me the right support team, and doctors to get me back on track. If it wasn't for my peer support specialist, the program I am in and all the people who are there whenever you need them, I would never have gotten back on track. It gave me a sort of relief knowing that they are always there when I need them.

Every single veteran coming home deserves a peer support specialist. Every state in this great country needs to have this program implemented. Some veterans like myself not too long ago might have too much pride to admit there is something wrong it took me 8 years of failing at everything to give it a try - and now my life has improved in every way possible.

Just the fact of knowing that someone is there for you if or when you need them is a great relief. I am happy to elaborate if you have any further questions for me today.

Thank you so much for this opportunity and your time. I hope this has been somewhat helpful. Anything I can do to help my brothers and sisters in arms to get the treatment they need and deserve.

Chairman ISAKSON. We thank you for your testimony and your service to the country.

Mr. MAIERS. Thank you.

Chairman ISAKSON. Mr. Butler.

STATEMENT OF ROSCOE G. BUTLER, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Mr. BUTLER. Good afternoon. Everyone in this room knows the highest cost of failing to provide mental health care to veterans is losing the life of one of our Nation's defenders to suicide. Even the more mundane stakes are sobering.

Setting aside those who take their own lives, veterans who struggle with untreated mental illness suffer daily with deep and lasting impact to their life, their work, and the lives of everyone that they hold dear. This is a crisis with deep and lasting impact to every facet of life and to every entire community.

That is why ensuring veterans get the right mental health care is and has been a top priority of The American Legion. We are leading the engagement at every level, from VA and DOD officials to veterans and their families in every community. We hold summits. We regularly survey veterans. We are deeply committed to speaking to the folks who are fighting this battle in the trenches to make sure we are providing the voices of those fighters who it comes to look for solutions.

Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee, on behalf of our newly elected National Commander, Dale Barnett, and over two million members of The American Legion, we thank you for the opportunity to testify about ensuring access to mental health care for our Nation's veterans.

The American Legion has conducted detailed examinations of the VA Health Care System for over a decade and as part of our System Worth Saving Task Force. In 2013, we compiled "The War Within," a detailed study of veterans and their experiences with treatment for PTSD and TBI. We followed that up with a survey of veterans' mental health treatment in 2014 and a follow-up survey this fall that are analyzing for patterns as VA adapts their care and treatments.

The survey indicated concerns from veterans about over-medications and a lack of complementary and alternative treatment options, such as art therapy, companion dogs, equine therapy, hyperbaric oxygen treatment, and many more options.

In response to VA's pledge to increase access to those sorts of treatment, by speaking to our members and traveling to VA facili-

ties as part of our System Worth Saving Task Force, has indicated that access to those type of treatments which could be beneficial to treating veterans and mental health conditions varies greatly from location to location. This level of inconsistency is troubling. In fact, one of the more serious problems plaguing the system is not a lack of proper ideals, but inconsistent application of VA guidance.

When we talk to veterans across the country about how well VA implemented a mental health care summit initiative, the responses varied widely. A veteran in Chicago had an outstanding experience with their summit at the Jesse Brown VAMC. The veteran described positive network experiences and a strong level of interaction between VA and the veterans in the community and the applicable stakeholders.

Conversely, a veteran from Seattle had the opposite experience. That veteran experienced summit meetings full of bureaucratic obstacles, mired in a lack of constructive progress, and ultimately was driven to abandon participation, feeling the whole mess was counterproductive.

VA must improve their consistency. No matter how well intended their policies, if they cannot execute them evenly across the country and forge connections with the veterans they serve, they will drive veterans away from beneficial care for their mental health disorders. That must be a consistent and welcoming environment for veterans if VA is going to treat their disorders.

The veterans who provide anecdotal accounts to The American Legion are indicative of larger patterns that even more systemic examinations have revealed. The independent studies of VA health care delivery mandated by the Choice Act found the same problems, troubling inconsistencies in terms of results across VA.

Thank you again, Mr. Chairman, Ranking Member Blumenthal, for ensuring the Committee's attentions stay focused on the critical issues of veterans' mental health care. I appreciate the opportunity to present The American Legion's experience on this topic and views and look forward to any questions you may have.

[The prepared statement of Mr. Butler follows:]

PREPARED STATEMENT OF ROSCOE G. BUTLER, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Chairman Isakson, Ranking Member Blumenthal and distinguished Members of the Committee, on behalf of National Commander Dale Barnett and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising of over 2 million members and serving every man and woman who has worn the uniform for this country; we thank you for the opportunity to testify and for taking on one of the most serious challenges facing America's veterans, that is "VA Mental Health: Ensuring Access to Care."

The mental health of our Nation's veterans is something that The American Legion takes very seriously. One of The American Legion's legislative priorities for the 114th Congress is to ensure Congress and the Department of Veterans Affairs (VA) provide help for veterans struggling with mental health issues and brain injuries and that they dedicate extensive resources to study the devastating effects of Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). The American Legion believes that additional resources and alternative treatments must be provided as options for veterans and servicemembers in need of treatment for brain injuries and mental stress.

The American Legion has helped drive the focus on unprecedented numbers of veterans returning home from Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) with PTSD and TBI which have been known as the signature wounds of these conflicts. To address this problem,

The American Legion convened a TBI and PTSD committee in 2010, to investigate Department of Defense (DOD) and VA existing medical science and procedures, as well as alternative methods for treating servicemembers and veterans suffering with PTSD and TBI as a result of their combat service.[1] In addition to the TBI and PTSD Committee, The American Legion's System Worth Saving Task Force, established in 2003, assesses the quality and timeliness of veterans health care within the VA healthcare system, of which mental health care is a critical component to the overall evaluation.

On August 31, 2012, President Obama signed Executive Order (EO) Number 13625: Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families directing the Departments of Defense (DOD), Veterans Affairs (VA), and Health and Human Services (HHS), in coordination with other Federal agencies, to take the necessary steps to ensure that veterans, servicemembers and their families receive the mental health and substance use services and support they need.

These steps include strengthening suicide prevention efforts across the military services and in the veteran community; enhancing access to mental health care by building partnerships between VA and community providers; increasing the number of VA mental health providers serving our veterans; and promoting mental health research and development of more effective treatment methodologies.[2]

The American Legion applauds VA for the work the department has been engaged in to meet the objectives of the President's Executive order, but much work still needs to be accomplished. The American Legion urges Congress to ensure VA has the funding needed to deliver comprehensive mental health services and to continue to provide the necessary oversight to ensure our Nation veterans receive timely and appropriate mental health services.[3]

VA MENTAL HEALTH HIRING INITIATIVE

Staffing shortages within VA leadership, physicians, and medical specialists within the Veterans Health Administration (VHA) remain a top concern of The American Legion. Since 2003, The American Legion's primary healthcare evaluation tool "System Worth Saving" (SWS) Program has tracked and reported staffing shortages at every VA medical facility visited across the country. The 2014 SWS report found that several VA medical centers continue to struggle with filling critical positions within the VA healthcare system.[4]

In the Spring of 2013, VA attempted to address the increasing numbers of veterans seeking mental health care by announcing the hiring of an additional 1,600 mental health clinical providers and over 800 peer support specialists. VA reported they have exceeded the President's 2012 Executive Order requirements and believe they are on the way to improving veterans access to mental health services. Yet problems with mental health scheduling clearly still exist, as VA's Office of the Inspector General (OIG) found in a June 2015 study of mental health care in Augusta, Maine.[5] VA's continued struggles are indicative of how the lack of available mental health providers can contribute to long wait times for patients. Despite VA efforts in 2014 to hire an additional 1,600 mental health-care providers, time has shown that VA's effort to address the lack of mental health providers still remains a serious problem.

On January 30, 2015, the OIG released a report entitled "Veterans Health Administration's Occupational Staffing Shortages" as required by Section 301 of the Veterans Choice and Accountability Act (VACAA) of 2014. The OIG report determined one of the occupations of critical need within VHA for Fiscal Years 2011 through 2015 for staffing shortages were psychologists.[6]

When The American Legion's System Worth Saving team travelled across the country, medical center staff continues to inform our team that they continue to struggle with recruiting mental health professionals. For example, during a September 1, 2015, SWS site visit one medical center[7] identified the following mental health vacancies:

- 14 mental health psychiatrists,

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[1] The American Legion TBI and PTSD Committee Report: *The War Within*: Sept 2013

[2] Interagency Task Force on Military and Veterans Mental Health: 2013 Annual Report

[3] American Legion Resolution No. 155: Aug. 2014

[4] American Legion System Worth Saving Report: 2014

[5] VA-OIG Report no. 14–05158–377 Mismanagement of Mental Health Consults and Other Access to Care Concerns—VA Maine Healthcare System Augusta, Maine June 17, 2015

[6] VAOIG Report "OIG Determination of Veterans Health Administration Occupational Staffing Shortages": Jan 2015

[7] SWS Site visit, Baltimore, MD, September 1, 2015

• 7 mental health psychologists,
• 15 mental health social workers,
• 1.5 mental health peer support specialists,
• and 1 neuro-psychologist totaling 38.5 mental health vacancies in a single medical center.

On average, a position may be vacant anywhere from 90 days to six months before the position is filled resulting in a significant delay in veterans receiving treatment for their mental health conditions.

The VA has a systematic problem with recruiting talented people to either run their medical centers or to provide front line health care to veterans. The Blue Ribbon Panel, created by VACAA to examine reform of the VA healthcare system, provided a presentation to the VA Commission on Care noting:

• 39 percent of senior leadership teams at VA medical centers had at least one vacancy;
• 43 percent of network directors are in a "acting" status resulting in a severe leadership problem with VHA.
• More than two-thirds of network directors, nurse executives are eligible for retirement, as are 47 percent of medical center directors.

Leaders within the VA healthcare system have to be empowered and more needs to be done in order to grow new leadership.

The American Legion calls on VA to establish a short and long range strategic plan to address their recruiting and retention problems. Whether the problem is pay disparity with the private sector or other disincentives to employment at VA, this needs to be examined and corrected. VHA needs to continue developing and implementing staffing models for critical need occupations, and work more comprehensively with community partners when struggling to fill critical shortages within VA's ranks.[8]

VHA must find a way to fill these vacancies if they are serious about addressing the mental health needs of this nations veterans'. If VHA cannot fill the vacancies, then VHA must determine how they can better allocate the staff and resources they have to maximum effect. Solving the staffing problem requires both short term and long term solutions. In the short term, how can you treat the veterans who need care with the providers you have? In the long term, how can you recruit more providers, and if there are shortages of providers, how can VA help create more mental health professionals?

COMMUNITY MENTAL HEALTH PROVIDER PILOT PROGRAM

On August 31, 2012, President Obama signed Executive Order (EO) 13625: *Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families*. The goal of the Executive Order was to create a vast network of support that had the capabilities of providing quality and timely mental health care services for veterans, servicemembers, and their families. Section 3(a) of the EO directed VA to create partnerships with community providers to decrease veterans wait times and increase the geographical range for veterans accessing mental care treatments and services. Through this action, VA implemented 24 VA/Community Mental Health Clinics (CMHCs) pilot programs with community-based mental health and substance abuse providers across nine states and seven Veterans Integrated Service Networks (VISNs) to enhance veteran access to mental health care programs and services between VA and community mental health care providers.

In June 2013, President Obama directed all 152 VA medical centers across the country to hold Community Mental Health Summits with community-based programs and organizations to support veterans and their families. These summits were established to promote awareness of mental health services, assist veterans to gain access to mental health community programs and services, and to build health communities for veterans and their families to participate in. Annual mental health summits are held at every VA medical center (VAMC) across the country. The VA's goal is to reach all veterans regardless of whether they are enrolled and receiving their health care through the VA.

Communication within the veterans' community is essential. As The American Legion learned from over a dozen community town halls we facilitated under our Veterans Crisis Center program last year, getting veterans in touch with VA to talk about their challenges is a critical tool to solving some of VA healthcare challenges.

[8] The American Legion Resolution No. 101: Department of Veterans Affairs Recruitment and Retention: Sept. 2015

Recognizing the importance of this initiative, The American Legion has been worked to track the experiences of our members with VA's Mental Health Summits.

One veteran told us:

> "A Mental Health Summit was held on September 10th at the Jesse Brown VA Hospital in Chicago. It was moderated by a staff psychologist from the hospital and was attended by many people from various agencies and organizations. We heard from several veterans about their experiences in the VA mental health system and they were all positive. We also had a networking session which was, in my opinion, very positive. I made several good, new contacts that I will utilize in the future. Unfortunately, I understand that not all experiences veterans have with the VA mental health system are positive. But it was good to hear some success stories and speak to the veterans about what they went through."

Another veteran described their experience:

> "I was asked to participate in a mental health focus group at the Seattle VA. The purpose of the group was to provide feedback to VA about promoting awareness, helping veterans gain access etc. I missed the first meeting, attended the 2nd and the 3rd and decided to not participate in the group. Our first task was to adopt bylaws for our group, select a president and a secretary. As I missed the first meeting the group had already selected a leader for the meeting. Staff offered a bylaws template at the previous meeting. The second meeting consisted of taking turns reading the bylaws out loud. Third meeting was even less constructive. Having served on the King County board to end veteran homelessness, served on several other boards in different capacities including President, and being well connected to service organizations such as the Legion, I felt that I had a lot to offer this group. However, most of the group assembled did not have experience in running organizations, access to technology to read documents between meetings. I decided that spending 2½–3 hours driving round trip to attend a one hour lunch meeting progressing at a pace I deemed a snail would find slow a waste of my time. I was Unimpressed in Seattle."

The disparity between these two experiences is representative of perhaps the biggest challenge VA faces in delivering healthcare—inconsistency between locations. Where one veteran in the Midwest can have such a positive experience and another in the Pacific Northwest can have such a negative experience, it's indicative of a system that still has a ways to go to deliver consistent care and results. VA must work harder to achieve that consistency if mental health efforts are going to be effective.

The American Legion is not alone in finding these inconsistencies. The recently completed Independent Assessment of VA healthcare, mandated by VACAA, has similarly illustrated the vast range of inconsistency across VA facilities in the implementation of programs. It is not necessarily that VA is not attempting to implement good policy, it is often that it is executed with disparate results depending on location. That is not a recipe for success.

CONCLUSION

Much of the problems VA faces in delivering effective mental health care revolve around two primary considerations—lack of staff and lack of consistency. The former is something VA and Congress have attempted to address with additional hiring, with mixed results. The latter is something that is completely within VA's realm of control. If they are to change their culture to be better focused on serving veterans, ensuring consistency needs to be at the top of the list of priorities for achieving that goal.

The country's obligation to its Armed Forces and its veterans includes a responsibility for their care and treatment from wounds inflicted upon them while serving their country. The challenge raised by Traumatic Brain Injury and Post Traumatic Stress Disorder demands a dedicated, well coordinated, and flexible response that adapts care and treatment to an individual's needs, not the other way around.

The American Legion thanks this Committee for their diligence and commitment to examining this critical issue facing our servicemembers and veterans as they struggle to access mental health care across the country. Questions concerning this testimony can be directed to Warren J. Goldstein, Assistant Director in The American Legion Legislative Division (202) 861–2700.

Chairman ISAKSON. Thank you very much, Mr. Butler.

Dr. Maffucci.

STATEMENT OF JACQUELINE MAFFUCCI, Ph.D., RESEARCH DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Ms. MAFFUCCI. Chairman Isakson, Ranking Member Blumenthal, and the Committee members, on behalf of Iraq and Afghanistan Veterans of America and our more than 425,000 members, and as IAVA's Research Director and resident neuroscientist, I thank you for the opportunity to share our views today.

In 2014, IAVA launched the Campaign to Combat Suicide, a result of our members continually identifying mental health and suicide as their number 1 issue. This campaign was centered around the principle that timely access to high quality mental health care is critical in the fight to combat veteran suicides.

The signing of the Clay Hunt SAV Act into law was an important first step to addressing this and we thank you for your support on this legislation. But, there is still so much work to be done.

Every year, IAVA surveys our members, and in our most recent survey, half of respondents reported having a mental health injury and about 60 percent of those were seeking care from the VA. Of those, over 70 percent reported satisfaction with that care, but an almost equal percentage reported challenges scheduling appointments.

Bottom line: our members have told us that access to VA mental health care is a challenge, but once in the system, they are satisfied.

No veteran should have to wait for mental health care once they take that difficult step to seek help. Clay Hunt was one of these veterans. Clay sought help at the VA, but was repeatedly frustrated by challenges in scheduling appointments and receiving consistent care. He was a Marine, a son, a friend to many, an advocate, and humanitarian. Yet, despite his proactive and open approach to seeking care, he lost hope and took his life on March 21, 2011. Access to care is critical.

There is a shortage of mental health professionals in this country. The supply is waning while the demand is growing. The Secretary is working to recruit medical students into the VA and into mental health professions, and this is really important. However, there are barriers in place that make it difficult for the VA to hire and to retain these professionals. The Federal hiring process can be confusing and lengthy, and this can be a huge deterrent in attracting and identifying talent.

A recent VA Inspector General report that looked at hiring and loss rates of VA psychologists and medical officers found that a significant percentage of the total gains from hiring was offset by losses. The VA needs to understand and address the reasons that these staff leave as well as how best to attract new talent.

The VA also needs to continually assess and update its staffing models and hiring guidelines. There is an opportunity here for an innovative approach to predict local demand for mental health professionals using real time data. One of the biggest obstacles to this is the current scheduling system, which does not provide this type of data that can inform the VA of usage habits of veterans seeking

VA mental health care. This is just one of the reasons why updating this outdated system and clarifying its policies is so important.

As part of this, we also encourage the VA to get away from grouping mental health professionals as one category and focus on defining the needs for each discipline. Each have a unique skill set. Defining demand and establishing targeted hiring for these professions will help in filling gaps in access, and as these hiring initiatives occur, the need for additional resources is critical.

Outside of staffing, there are three additional areas that warrant focus. Telemental health is one of these areas. VA should be commended for its telemental health program, which can fill gaps in communities that have critical provider shortages and potentially encourage more veterans to seek care. This program must continue to be developed, assessed, and expanded to ensure veterans have access to care.

Vet centers continue to be a highly praised resource among IAVA's member population. We would like to see a comprehensive assessment of the role that Vet Centers play in supporting veteran mental health. It is a critical resource and fills a specific need, particularly for veterans who may be less inclined to seek services at VA health centers or seeking care with their family or are not eligible for VA health. We want to ensure that it is being fully utilized.

Finally, the role of the community providers. The majority of veterans do not seek care at the VA. The care of this Nation's veterans is not the sole responsibility of the VA, but rather the community, and yet as community mental health providers are called upon to serve this population, a recent RAND report suggests they may not be well equipped to address these needs. Pilots such as the VA Community and Mental Health Partnership, or existing and successful programs like the Star Behavioral Health Program, can help to provide a framework for addressing the skills gap.

All veterans deserve the very best our Nation can offer. We look forward to working with you and the administration to address these very real challenges. Thank you, and I am happy to take any questions.

[The prepared statement of Ms. Maffucci follows:]

PREPARED STATEMENT OF JACQUELINE MAFFUCCI, PH.D., RESEARCH DIRECTOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Chairman Isakson, Ranking Member Blumenthal and Distinguished Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members and supporters, we would like to extend our gratitude for the opportunity to share our views on VA Mental Health: Ensuring Access to Care.

In March 2014, IAVA launched the Campaign to Combat Suicide, a direct result of our members continually identifying mental health and suicide as the number one issue facing the newest generation of veterans. This campaign was centered around the principle that timely access to high quality mental health care is critical in the fight to combat veteran suicides. The signing of the Clay Hunt SAV Act into law was an important first step to addressing this. IAVA continues to work with Congress and the VA to fully implement this law, but there is still much work to be done.

Every year IAVA surveys our members on their health experiences, among other issues. In our most recent survey, about half of IAVA's survey respondents reported having a mental health injury, and a little less than 60 percent were seeking care for these injuries from a VA provider. Over 70 percent of those using VA mental health care reported satisfaction with that care, but an almost equal percentage of respondents reported having some level of challenge scheduling VA mental health

appointments. This is compared to only 31 percent of those using non-VA mental health care reporting scheduling challenges. Bottomline, our members have told us both through the survey and anecdotally that access to mental health care continues to be a challenge, but once in care, they are satisfied. No veteran should have to wait for mental health care once they take that difficult step to seek help. And this is where the topic of access becomes so very critical.

Clay Hunt was one of these veterans. Clay sought help at the VA but was repeatedly frustrated by challenges in scheduling appointments and consistent care. He was a Marine who even after being injured signed up to deploy for a second time. Once he separated from the Marines, he became a veteran advocate, working with IAVA, and participated in humanitarian work with Team Rubicon. Despite his proactive and open approach to seeking mental health care, he lost hope and took his life on March 31, 2011. Access to care is critical.

There is a shortage of mental health care professionals in this country. The supply is waning while the demand for mental health services is growing, as highlighted by Clay's story. Specific to the veteran community, almost 30 percent of new veterans treated at the VA have been diagnosed with Post-Traumatic Stress Disorder and 57 percent have some form of a mental health injury. The demand among the new generation of veterans will likely continue to grow as more troops come home and those already home continue transition to civilian life. And we cannot discount potential growth in demand among all veterans. The nation must be prepared to care for these veterans for decades to come, both in and out of the VA.

The Secretary and this Administration are working to encourage medical students into mental health professions, and this must continue to grow the field. However, there are barriers already in place that make it difficult for the VA to both hire and retain these professionals. The application process and the lengthy wait time to be hired into the Federal Government can be a huge deterrent in attracting talented professionals. A recent VA Office of Inspector General Report [1] looked specifically at hiring and loss rates of VA psychologists, determined to be a critical needs occupation. The report found that a significant percentage of the total gains from hiring was offset by losses. Given the amount of training and the continued demand for these professionals, the VA must understand and address the reasons that these staff leave.

The VA also needs to continually assess and update its use of staffing models and guidelines surrounding the hiring of these mental health specialities at the facility level. IAVA believes that there is an opportunity for an innovative approach to develop more predictive models of need that can better inform these staffing models. There are examples of this type of data driven approach to understanding characteristics of the veteran population already in process that could drive this concept, like the Veteran Data Project led by the Center for New American Securities.

As the VA continues to focus on staffing models, it must also get away from grouping mental health professionals as one category when focusing on hiring initiatives, and more specifically focus on the needs for each discipline. Each have a unique skill set and the demand and targeted hiring for these must be determined in their own right.

There are additional constraints that also must be considered. Paramount to all of these recommendations is the need for better data within the VA to define the current demand. This will come as the VA replaces its extremely outdated scheduling system, an initiative in place but not yet fully implemented. Additionally, as demand increases and additional staff are required, there is an impact on resources, including facility space.

Outside of these recommendations, there are three additional areas that warrant focus to address access to care:

1) *Telemental health:* The VA should be commended for its work in introducing and developing its telemental health program. IAVA sees this initiative as one that is able to fill the gaps in communities that have critical shortages in mental health professionals. We look forward to working with the VA to continue to continue to develop, assess and expand this program to ensure that it is providing high quality mental health care to veterans particularly in areas that are geographically isolated and/or experiencing severe mental health staffing shortages in the community and the VA.

2) *Vet Centers:* Since 2003, the VA has expanded the number of Vet Centers, and currently 300 exist. Vet Centers continue to be a highly praised resource among IAVA's member population. They fill a specific need among the veteran population,

[1] Department of Veterans Affairs Office of the Inspector General. *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*. September 01, 2015; Report 15–03063–511.

including serving family members, hosting later hours and serving the veteran population regardless of discharge status. IAVA would like to see a comprehensive assessment of the role the Vet Centers play, the demand for these services and a determination of whether the current number of Vet Centers is addressing that demand. We feel that this is a critical resource, particularly to veterans who may not be inclined to seek services at the VA health centers.

3) *The Role of Community Providers:* Approximately 60 percent of new veterans, and less than 40 percent of the entire veteran population, is seeking care at the VA. The care of this Nation's veterans is not the sole responsibility of the VA, but rather the community at large. And yet, as community providers are called upon to serve this population, a recent RAND report[2] suggests that community providers might not be well equipped to address the needs of veterans and their families, specifically in understanding high quality treatments for PTSD and other mental health injuries. Pilots such as the VA/Community Mental Health Partnership can help to provide a framework for how public-private partnerships can address this skills gap.

At IAVA, we believe our members, and all veterans, deserve the very best our Nation can offer when it comes to fulfilling the promises made to them upon entry into the military. There is no doubt every Member of this Committee has the best interests of our veterans at heart. We look forward to continuing to work with you and the Administration as partners in trying to address these very real challenges with innovative and scalable solutions.

Thank you for your time and attention. IAVA is happy to answer any questions you may have.

Chairman ISAKSON. Thank you very much.

Dr. Draper.

STATEMENT OF DEBRA A. DRAPER, PH.D., DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. DRAPER. Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, I appreciate the opportunity to be here today to discuss veterans' access to VA mental health care.

My testimony today is based on a report released today, and my comments focus mainly on the timeliness of mental health care and VHA's oversight.

Of the 100 medical records for veterans new to VA mental health care that we reviewed, 86 percent received their initial appointment for a full mental health evaluation within 30 days of their preferred date. However, this does not reflect the whole story.

We found that VHA has conflicting policies regarding how long it should take a veteran to receive a full mental health evaluation. One policy says 14 days while the other says 30 days. VHA has not provided guidance on which policy should be followed, which has caused confusion, making it difficult to ensure timely access to mental health care, particularly given the increasing demand for care.

We also found that VHA's wait time calculations do not always reflect the overall time veterans waited for care because these calculations do not account for the period of time prior to establishing the veteran's preferred date, which can be quite lengthy.

VHA disagreed with our overall wait time calculations, which calculated wait time from the initial request for care until the veteran was seen, stating that these calculations did not capture situations that were out of their control, such as when a veteran wants to delay care. While this is sometimes true, we found instances

[2] Tanielian, Terri, Coreen Farris, Caroline Batka, Carrie M. Farmer, Eric Robinson, Charles C. Engel, Michael Robbins and Lisa H. Jaycox. *Ready to Serve: Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families.* Santa Monica, CA: RAND Corporation, 2014.

where requests or referrals for care made prior to the establishment of the preferred date were mismanaged or lost in the system. Gaining a better understanding of veterans' overall wait time experiences provides an important opportunity for VHA to identify and make needed improvements.

Additionally, we found that veterans who receive a full mental health evaluation may experience additional delays in receiving treatment specific to their mental health condition. While VHA disagreed with our findings, stating that the full mental health evaluation should be considered the start of a veteran's treatment, the wide variation we found in the amount of time between a veteran receiving this evaluation and their next appointment presents an additional opportunity for VHA to improve veterans' experiences accessing care.

VHA monitors access to mental health care, but the lack of clear policies contributes to unreliable wait time data and hinders oversight. We found that mental health wait time data may not be comparable over time because VHA has changed definitions used to calculate certain measures. VHA has not clearly communicated the definitions used or changes made, which has created confusion and limits the reliability and usefulness of the data.

We also found that wait time data may not be comparable between medical centers. For example, one of the medical centers we visited referred about a third of veterans seeking mental health care to an open access clinic, which is a type of walk-in clinic, rather than scheduling an appointment. These veterans were tracked using a manually maintained list. Follow-up was inconsistent, and nearly half of those on the list never presented for care. This finding is especially troubling given VHA's past problems with maintaining lists outside of the scheduling system.

We recommended that VHA issue clarifying guidance on its access policies, definitions used to calculate wait times, and how open access appointments are to be managed. We also reiterated our prior recommendation, which calls for VHA to take actions to improve the reliability of its wait time measures.

Very briefly, we also looked at VHA's recent mental health hiring efforts as well as a pilot program to help expand capacity through the use of community providers. We found that while local improvements to mental health care access were reported due to the recent hiring efforts, a number of challenges were also noted, such as the inability to keep pace with the increasing demand for care.

We also found that in 2013, as the result of an Executive Order, ten VA medical centers established partnerships with community providers to improve access to mental health care. A limited number of mental health care appointments resulted from these partnerships, about 2 percent of the total appointments provided by the participating medical centers.

The bottom line is that work is needed to improve veterans' experiences accessing mental health care. Given the vulnerabilities of veterans seeking mental health care, veterans who may be at risk of serious if not life-threatening events, ensuring their timely access to care is critical.

Mr. Chairman, this concludes my opening remarks. I am happy to answer any questions.

[The prepared statement of Ms. Draper follows:]

PREPARED STATEMENT OF DEBRA A. DRAPER, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

United States Government Accountability Office

GAO

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

For Release on Delivery
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VA MENTAL HEALTH

Action Needed to Improve Access Policies and Wait-Time Data

Statement of Debra A. Draper
Director, Health Care

GAO-16-170T

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

I am pleased to be here to discuss our report that is being released today on veterans' access to VA mental health care, the latest review from our extensive work in recent years on veteran's access to care.[1]

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), has seen a 63 percent increase in the number of veterans receiving mental health care between 2005 and 2013. VHA reported a significant portion of this increase was due to an influx of veterans returning from the conflicts in Iraq and Afghanistan, and to its proactive screening to identify veterans with symptoms that may be associated with depression, post-traumatic stress disorder (PTSD), substance abuse disorder, or who may have experienced military sexual trauma. In fiscal year 2014, VHA spent more than $3.9 billion providing outpatient specialty mental health care in its facilities, and more than $34 million for outpatient specialty mental health care provided by non-VA providers.[2]

In recent years, we and others have expressed concerns about veterans' ability to access timely health care, including mental health care, and VHA's oversight of patient scheduling practices, particularly the reliability of reported patient wait times and weaknesses in appointment scheduling

[1]GAO, VA Mental Health: *Clearer Guidance on Access Policies and Wait-Time Data Needed*, GAO-16-24 (Washington, D.C.: Oct. 28, 2015). See also GAO, *VA Health Care: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care*, GAO-14-808 (Washington, D.C.: Sept. 30, 2014); *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012); *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, GAO-12-12 (Washington, D.C.: Oct. 14, 2011); and *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans*, GAO-10-294R (Washington, D.C.: Mar. 10, 2010).

[2]See Department of Veterans Affairs, *Volume II Medical Programs and Information Technology Programs Congressional Submission Fiscal Year 2016 Funding and Fiscal Year 2017 Advance Appropriations Request* (Washington, D.C). The 2014 federal fiscal year ended on September 30, 2014. As a result, recent programs that provide additional options for non-VA care to veterans are not included in this amount.

oversight.[3] For example, in 2012, the VA Office of Inspector General (OIG) reported that VHA was not consistently providing new veterans with timely access to comprehensive mental health evaluations, and had overstated its success in providing veterans with timely appointments for mental health treatment. An August 2012 Executive Order directed VHA to improve mental health care access by, among other things, hiring additional staff and gauging the effectiveness of the use of community-based providers by establishing a community provider pilot program.[4] In addition, the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), enacted in August 2014, provided additional non-VA care options for veterans facing long waits or lengthy travel distances to obtain VHA health care services.[5]

In this context, my testimony today summarizes the findings from our report being released today on veterans' access to mental health care services, which addresses

1. veterans' access to timely mental health care;
2. VHA's oversight of timely access to mental health care;
3. VHA's hiring of mental health staff since 2012 and the effects of that hiring on access to mental health care; and
4. VHA's community provider pilot program's effects on veterans' access to mental health care.

To examine these issues we conducted site visits to five VA medical centers (VAMC) and their affiliated community-based outpatient centers (CBOC), which were selected for variation in mental health utilization, geographic location, and participation in the community provider pilot program, among other factors.[6] For each of the five VAMCs we visited,

[3]See GAO-14-808, GAO-13-130, GAO-12-12, GAO-10-294R. See also Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Review of Veterans' Access to Mental Health Care*, Report No. 12-00900-168 (Washington, D.C.: Apr. 23, 2012).

[4]Executive Order No. 13625, 3 C.F.R. 302 (Aug. 31, 2012): *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.*

[5]Pub. L. No. 113-146, 128 Stat. 1754 (Aug. 7, 2014).

[6]The sites visited were Atlanta VAMC (Decatur, Georgia); George H. O'Brien, Jr. VAMC (Big Spring, Texas); Hunter Holmes McGuire VAMC (Richmond, Virginia); Portland VAMC (Portland, Oregon); and Sioux Falls VA Health Care System (Sioux Falls, South Dakota).

we reviewed a randomly selected sample of 20 outpatient medical records to assess the timeliness in which veterans received mental health appointments. Due to the small sample size of our medical record reviews, the results cannot be generalized across any single VHA facility or to all VHA facilities. We also reviewed relevant VHA policies, federal internal control standards, and other key documents, as well as interviewed staff from VHA's central office, the five selected VAMCs, and the five corresponding Veterans Integrated Service Networks (VISN) that oversee them, among others.[7] We limited our scope to outpatient specialty mental health care, which we refer to as mental health care, because the majority of veterans with either a possible or a confirmed mental illness, about 70 percent and 85 percent respectively, obtain outpatient mental health care through VHA.[8] Additional information on our scope and methodology is available in our report. The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards.

[7]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1999).

For example, we also interviewed staff from Vet Centers and veteran service organizations.

[8]Outpatient specialty mental health care generally refers to mental health services provided by a mental health specialist (e.g., psychiatrist, psychologist, social worker, or counselor) in an outpatient setting (i.e., receiving medical treatment without being admitted to a hospital).

Most Veterans in Our Review Received Care within 30 Days of Their Preferred Dates, but VHA's Method of Calculating Wait Times Does Not Always Reflect Overall Wait Times

The 100 veterans included in our review received a full mental health evaluation in an average of 4 days of the date they preferred to be seen (known as the preferred date). The full mental health evaluation is the primary entry point to mental health care. At the five VAMCs we visited, the average time in which a veteran received this full evaluation ranged from 0 to 9 days from the preferred date.

However, we identified conflicting VHA policies regarding how long it should take a new veteran to receive a full mental health evaluation: (1) a 14-day policy established by VHA's *Uniform Handbook for Mental Health Services*, and (2) a 30-day policy set by VHA in response to the Choice Act.[9] To date, VHA has not provided guidance on which policy should be followed, which is inconsistent with federal internal control standards that call for management to clearly document, through management directives or administrative polices, significant events or activities, such as ensuring timely access to mental health care, to help ensure management directives are carried out properly.[10] A number of VHA officials, including VISN and VAMC officials, told us they do not know which policy they are currently expected to meet, which makes it difficult for them to ensure timely access to care in light of increasing demand for mental health care. As a result, we recommended VHA issue clarifying guidance on the access standard for new veterans seeking mental health care. VA concurred with this recommendation, stating that it is in the process of revising the relevant policy in the *Uniform Handbook* to be consistent with the 30-day wait time goal established in response to the Choice Act. VHA stated that it is targeting issuance of the revised policy and clarifying guidance for March 2016.

[9]Department of Veterans Affairs, *Uniform Mental Health Services in VA Medical Centers and Clinics*, Veterans Health Administration Handbook 1160.01 (Washington, D.C.: Sept. 11, 2008). The *Uniform Handbook* has an expiration date of September 30, 2013, however, VHA officials told us that it is still in effect and no update has been published.

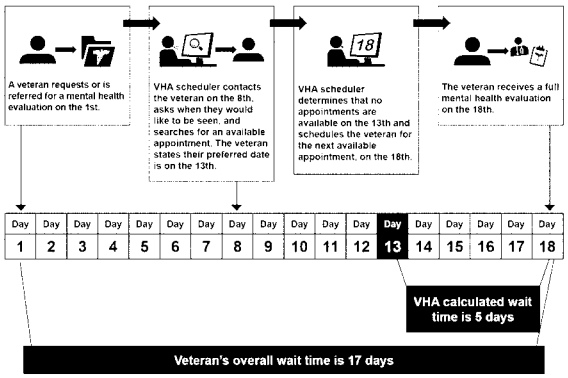
VHA also has a policy that states that veterans who are new to mental health should receive initial assessments within 24 hours to identify those with urgent care needs. VHA officials told us that because these assessments can be completed by a number of providers, including the referring provider, they do not have a way to consistently track them. As a result, VHA cannot determine whether these initial assessments are being completed in a timely manner.

[10]GAO/AIMD-00-21.3.1.

Further, although the average time between veterans' preferred dates and their full mental health evaluations in our review were generally within several days, that time did not always reflect how long veterans may have actually waited for mental health care. Because VHA uses a veteran's preferred date as the basis for its wait-time calculations, rather than the date that the veteran initially requests or is referred for mental health care, these calculations only reflect a portion of a veteran's overall wait time.[11] While some of the delay in care may be attributed to a veteran not wanting to start care immediately, we also found that some delays were because a facility did not adequately handle a referral or request for mental health care. In our review of 100 veteran records, we found that significant delays can occur if the referral or request for an appointment is not processed correctly or in a timely manner. For example, one veteran in our review waited 174 days between the initial referral for mental health care and the veteran's preferred date due to a referral not being appropriately managed. The veteran's primary care provider was to have placed a referral to psychology in March 2014, but our review of the medical record found no evidence of the referral ever being placed. Nonetheless, the veteran's primary care provider alerted a VHA psychologist who reached out to the patient in March 2014, by phone, but did not leave a message. No VAMC mental health provider reached out again until September 2014, after the veteran's primary care provider made a referral (this time appropriately requested). The veteran was then able to schedule a full mental health evaluation approximately 1 week later. On average, our review of 100 new veteran medical records found that a veteran's preferred date was 26 days after his or her initial request or referral for mental health care, though this varied by VAMC. (See fig. 1.)

[11]Most of the veterans whose records we reviewed, 59 of 100, accessed mental health through a primary care referral.

Figure 1: Illustration of How Overall Wait Time May Differ from Veterans Health Administration's (VHA) Calculated Wait Time



Sources: VHA (information) and GAO (illustration). | GAO-16-170T

In commenting on a draft of our report, VHA confirmed that they measure wait times from preferred date to when the appointment occurs. However, they disagreed with our calculations of the overall wait time for veterans to receive full mental health evaluations, noting that these calculations do not capture situations outside of their control, such as when a veteran wants to delay treatment. Our calculations illustrate that the use of the preferred date does not always reflect how long veterans are waiting for care or the variation that exists not only between, but within, VAMCs. During the period of time prior to establishing the preferred date, we found instances of veterans' requests or referrals for care being mismanaged or lost in the system, leading to delays in veterans' access to mental health care. Our current and previous work, along with the work of VA OIG, highlights the limitations of VHA's current scheduling

practices, including wait time calculations.[12] In December 2012, we recommended that VHA take actions to improve the reliability of wait-time measures by clarifying the scheduling policy or identifying clearer wait-time measures that are not subject to interpretation or prone to scheduler error. VHA has not yet implemented this recommendation, and we continue to believe that implementation of this recommendation would improve the reliability of wait time measures.

VHA Monitors Access to Mental Health Care, but Current Policies Cannot Ensure Reliable Data, Which Precludes Effective Oversight

VHA monitors access to mental health care, but the lack of clear policies may contribute to unreliable wait-time data and precludes effective oversight. Among other reasons contributing to the potential unreliability of VHA wait-time data, we found VHA's wait-time data may not be comparable over time or between VAMCs.

- **Data may not be comparable over time.** VHA has changed the definitions used to calculate various mental health wait-time measures, and a number of VHA officials we interviewed, including VAMC and VISN officials, told us they were not sure which definitions for new mental health patients were in effect for calculating wait-time measures or gave conflicting answers about which definitions were being used. VHA has not clearly communicated the definitions used or changes made to these definitions used in its wait-time calculations, which is contrary to federal internal controls standards that call for management to communicate reliable and relevant information in a timely manner. This limits the reliability and usefulness of these data in determining progress in meeting stated objectives for veterans' timely access to mental health care. As a result, we recommended that VHA issue guidance about the definitions used to calculate wait times, such as how a new patient is defined, and communicate any changes in wait-time data definitions within and outside VHA. VHA concurred with our recommendation and stated that it plans to publicly provide an updated data definition document in October 2015 and will issue an information letter in November 2015 that contains sources where both internal and external stakeholders can locate the

[12]Department of Veterans Affairs, Office of Inspector General, *Review of Veterans' Access to Mental Health Care*. The OIG recommended that VHA revise the full mental health evaluation measurement to better reflect the veteran's experience from the point of first contact with mental health care to the completion of the full mental health evaluation.

definitions used to calculate wait times, including how a new patient is defined.

- **Data may not be comparable between VAMC**s. When VAMCs use open-access appointments, data may not be comparable across VAMCs. Open-access appointments are typically blocks of time for veterans to see providers without a scheduled appointment. In these cases, because appointments are not scheduled until veterans come to the medical center, the preferred and appointment dates are the same and wait times are calculated as 0 days, regardless of when veterans initially requested or were referred for mental health care. We found inconsistencies in the implementation of these appointments, including one VAMC that was referring veterans to these open-access appointments after an initial evaluation by phone rather than rather than being given specific appointments. Those veterans who were referred to the open-access appointments were tracked using a manually maintained list outside of VHA's scheduling system. We found that follow-up with these veterans was inconsistent, and nearly half never showed up to the open-access appointments. VHA does not have guidance that clarifies how to manage and track open-access appointments, which is inconsistent with federal internal controls that call for management to clearly document policies for significant activities to help ensure management's directives are carried out properly. As a result, officials at the VAMCs that used open-access appointments said they were unclear about how they could be used, how they should be entered into VHA's scheduling system, and whether local tracking mechanisms were compliant with VHA scheduling policies. Without guidance on how appointment scheduling for open-access clinics is to be managed, VAMCs can continue to implement these appointments inconsistently, and place veterans on lists outside of VHA's scheduling system, potentially posing serious risks to veterans needing mental health care.

As a result, we recommended VHA issue clarifying guidance on how open-access appointments are to be managed. VHA concurred with our recommendation, stating that it conducted training during the summer of 2015 for schedulers based on existing VHA policy that included instructions on how to schedule same-day appointments, which VHA considers to include open-access appointments. VHA further stated its plans to aggressively monitor appointment management and identify areas of local inconsistency in scheduling procedures. However, VHA's description of same-day appointments does not capture the circumstances we observed during our review, in which veterans who would normally be given an appointment were instead referred to an

open-access clinic. We reviewed the training that VHA said was provided to schedulers, but it did not address the circumstances we described. Given differences between types of same-day appointments (e.g., walk-in clinics where no prior evaluation may be required and open-access clinics that include an evaluation prior to referral), issuing specific guidance for open-access appointments would help to ensure veterans are getting their needs served and to improve data comparability across VAMCs.

VHA's Hiring Initiative Met Goals, but VAMCs Reported Continued Challenges in Hiring Mental Health Staff and Meeting the Growing Demand for Mental Health Care

VHA hired about 5,300 new clinical and non-clinical mental health staff between June 2012 and December 2013 for both its inpatient and outpatient programs, meeting the goals of its hiring initiative.[13] Officials at the five VAMCs we visited reported local improvements in access to mental health care due to the additional hiring. For example, officials at one VAMC reported being able to offer more evidence-based therapies. Officials at this VAMC, as well as officials from another VAMC and two CBOCs, cited the ability to provide mental health care at new locations where they were previously unable to do so.

Although VHA considered their hiring initiative a success because it met its goals, the five VAMCs we visited still had mental health staff vacancy rates ranging from 9 to 28 percent, and 4 of the 5 VMACs were unable to meet overall demand for mental health services.[14] Officials at the five VAMCs reported a number of challenges in hiring and placing mental health providers, including

- pay disparity with the private sector;
- competition among VAMCs filling positions at the same time;

[13]VHA increased mental health staff at its facilities nationwide through a two-part hiring initiative: (1) VHA's recruitment effort focused on hiring 1,600 new mental health professionals, 300 new non-clinical support staff (such as scheduling clerks), and filling existing vacancies starting in June 2012; and (2) Executive Order 13265, issued in August 2012, which authorized the hiring of 800 peer specialist positions by December 31, 2013, along with reiterating VHA's goal of hiring 1,600 new mental health professionals by June 30, 2013. VHA officials told us total staff hired does not reflect the total number of staff on board in their positions as of June 30, 2013, as some staff may have left their positions prior to the end of the hiring initiative, necessitating additional hiring.

[14]Vacancies include both inpatient and outpatient staff positions, and only those administrative positions included in VHA's hiring initiative. The director of the VHA office responsible for maintaining the vacancy data told us that these data may include some staff time used for clinical, research, teaching, and administrative activities.

- lengthy VHA hiring process;
- lack of space for newly hired mental health staff;
- lack of support staff to assist providers; and
- nationwide shortage of mental health professionals.

Despite VHA's hiring initiative, additional staff likely will be needed to meet VHA's growing demand for mental health care.[15] In an April 2015 report, VHA projected a roughly 12 percent increase in mental health staff would be needed to maintain the current veteran staffing ratios for fiscal years 2014-2017.[16]

To address some of the mental health hiring challenges, VAMCs reported using various recruitment and retention tools, including hiring and retention bonuses, student debt repayment, and using internships and academic affiliations to find potential recruits. In November 2014, VHA raised the annual salary ranges for all physicians system-wide, including psychiatrists, to enhance the agency's recruiting, development, and retention abilities.[17] Officials at the five VAMCs we visited also described strategies they used to manage demand for mental health care in light of staffing challenges, including (1) increasing the use of telehealth and group therapy (rather than individual therapy); (2) addressing space and staffing constraints by sharing offices or altering provider schedules; and (3) referring veterans to other VA locations when a preferred CBOC was not available.

[15]For example, from fiscal year 2010 through fiscal year 2014, the number of veterans receiving outpatient mental health care increased from 1,259,300 to 1,533,600, a 22 percent increase that also outpaced the general growth in the number of veterans using VHA services overall. VHA attributed the increased demand for mental health care to the influx of veterans returning from the recent conflicts in Iraq and Afghanistan, increased proactive screening efforts, and VHA's increased capacity to provide mental health care.

[16]Department of Defense and Department of Veterans Affairs, *DOD/VA Report to the Congress in Response to Senate Report 113-44, pg. 133, Accompanying S. 1197, the National Defense Authorization Act for Fiscal Year 2014: Mental Health Counselors for Service Members, Veterans, and their Families* (Washington, D.C.: Apr. 17, 2015).

[17]79 Fed. Reg. 56125 (Sept. 18, 2014). See 38 U.S.C. § 7431, which sets forth requirements for setting salary ranges for VHA physicians and dentists.

VHA's Community Provider Pilot Program Expanded Access to Mental Health Care for a Limited Number of Veterans; VAMCs Reported Successes and Challenges

In 2013, 10 VAMCs across VHA participated in a pilot that established partnerships with 23 community mental health clinics (CMHCs), as required by an August 2012 Executive Order in an effort to help VHA meet veterans' mental health needs; these CMHCs provided mental health care to a limited number of veterans.[18] Veterans received approximately 2,400 mental health appointments through the CMHCs, which accounted for approximately 2 percent of the total mental health care provided across the 10 participating VAMCs. Nearly half of the care provided through the pilot program was through partnerships with the Atlanta VAMC. The most common service veterans received was individual therapy or counseling, but other commonly provided services included group therapy, medication management, and treatment for substance abuse. According to VHA's survey of veterans who received care through the CMHCs during the pilot, veterans were generally satisfied with the care they received.

VHA and CMHC officials in our review described a number of successes and challenges related to the pilot program. Successes included improved capacity and communication. For example, officials at one VAMC said they would not have been able to maintain mental health care access at current levels without the capacity provided by the pilot sites. Additionally, officials at three VAMCs said their partnerships allowed them to expand access by providing additional and more convenient care to veterans living in rural areas. VAMC and CMHC officials also said that having a VAMC liaison on site or a dedicated point of contact improved communication, which helped facilitate veterans' access to care.

Challenges with the community provider pilot included a number of administrative issues, including challenges with the timely receipt of medical documentation and payment for services, as well as technical challenges, particularly related to the transfer of medical files and the use of telemental health technology. Other challenges included confusion among some VAMC officials about the different non-VA programs available to veterans and concerns about the appropriateness of care, including whether there were a sufficient number of community providers

[18]While VHA reported that 12 VAMCs established partnerships with CMHCs, the pilot program at one VAMC was never fully implemented and no veterans were referred to care. Similarly, another VAMC identified two potential sites, but never referred any patients for care.

with the necessary training and experience to provide culturally competent and high-quality care to veterans.[19]

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, this concludes my prepared statement. I would be pleased to answer any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Lori Achman, Assistant Director; Jennie F. Apter; Jacquelyn Hamilton; Eagan Kemp; Vikki L. Porter; and Malissa G. Winograd.

[19]Some of the VAMCs in the pilot program extended their partnerships with the CMHCs after the pilot program's ended, but VHA has indicated that the Patient Centered Community Care (PC3) program and the Veterans Choice Program (VCP) are now the primary programs for obtaining non-VA care, including mental health care. PC3 is a nationwide VA program to establish networks of providers that can provide care through the Non-VA Medical Care Program in a number of specialties—including primary care, inpatient specialty care, and mental health care. Under its Choice Act authority, VHA created the VCP with the goal of meeting short-term demand for health care.

Chairman ISAKSON. We will take a round of 5-minute questions for each Member, and I will begin.

Dr. Draper, the VA's representative, Dr. Kudler, is going to testify after this panel, but in reading his testimony with regard to open access appointments, he says, and I quote, "The combination of current policy and training constitutes clear guidance on how to manage and schedule open access appointments."

In the report, open access is discussed quite frequently and is a misleading, in some cases, process in terms of the actual timeliness of veterans being served. Can you comment on that?

Ms. DRAPER. Yes. We actually found two medical centers that were using open access appointments. One facility—there were access audits that were done following the Phoenix issues, and one of those facilities, through that access audit, they were told that they could no longer use the open access appointments without also scheduling appointments. They just could not refer someone to a clinic without scheduling an appointment.

The second medical center that we visited, they were not told that, and they would do a telephone triage. A mental health nurse would do a triage with the veteran seeking mental health care, and at that point, they were referred to an open access clinic, which is a type of walk-in clinic, but they have actually had a triage through a mental health provider, a nurse. It was not the same as a walk-in clinic. VHA did tell us that they provided training, but that is not what we observed in the field. We did not observe the type of walk-in clinic that they were referring to.

Chairman ISAKSON. An open——

Ms. DRAPER. This was basically a list that people were put on. This manual list that maintained outside of the scheduling system, where the policy says that those veterans should have been scheduled for an appointment.

Chairman ISAKSON. Given the problems we had at Phoenix and other areas on appointments and masked, m-a-s-k-e-d, use of lists to show appointments being made in a timely fashion when they really were not, this would have contributed to that. Am I not right?

Ms. DRAPER. It has, and actually, the medical center that was doing this told us that they did this to reduce their "no show" rates, so——

Chairman ISAKSON. I found that to be one of the most disturbing parts of the report, because the last thing we need to do in the VA health services is continue or do anything that perpetuates the memory of what happened in Phoenix in terms of the manipulation of data. So, whatever is reported to us needs to be an accurate reflection of the timeliness of service veterans are getting.

Ms. DRAPER. Absolutely. We found that you really cannot compare the data between medical centers because of issues like that. My question would be, are there other facilities that we did not visit that are also using the open access appointments without scheduling an appointment.

Chairman ISAKSON. Well, the reason we are conducting this hearing today is to get the word out far and wide that we are very concerned about the timeliness of service to our veterans persuing mental health and want to make sure they get the most timely service they can with the very best processes they can.

Mr. Maiers, thank you for your testimony.

Mr. MAIERS. Thank you, sir.

Chairman ISAKSON. In your testimony, and we appreciate your emotion, because I know you care much——

Mr. MAIERS. I apologize about that. To be honest, I did not mean to get that emotional about it. I am trying to stay strong here, you know.

Chairman ISAKSON. I cry at weddings and funerals, too, so do not worry about that.

Mr. MAIERS. I hear you, sir.

Chairman ISAKSON. Your testimony was very compelling, and your services that you receive from the VA, you were complimentary of those services, correct?

Mr. MAIERS. Yes, sir.

Chairman ISAKSON. How long did it take you between the time you knew you had a mental health challenge and you were able to get your appointment scheduled with the VA?

Mr. MAIERS. Well, like I said before, it did take me a while to admit that I had a problem, but the program that was in place—I think I spoke to my psychiatrist and then 2 weeks later, I was referred to this outside place called the Errera Center. It is kind of like a subdivision of the VA where, basically, all your doctors—your primary care, your mental health, your comprehensive work therapist, your peer support specialist—are all in one building. So, instead of waiting at the VA for hours upon end for one appointment, you can knock out all your appointments in 1 day at one place.

If it was not for this, I do not know, honestly, where I would be right now, sir. They have gone leaps and bounds with improving my mental health since the day I admitted I had a problem.

Chairman ISAKSON. What facility was that? What was the name of that facility?

Mr. MAIERS. The Errera Center.

Chairman ISAKSON. The Errera Center.

Mr. MAIERS. In West Haven, Connecticut.

Chairman ISAKSON. Thank you.

Mr. Karnaze, thank you very much for your testimony. I think in your testimony, you said it took you about a year to get into the VA Health Care System, is that correct?

Mr. KARNAZE. Yes, sir, it did.

Chairman ISAKSON. Is that a year from your severance with DOD going into veteran status?

Mr. KARNAZE. Yes, thereabouts.

Chairman ISAKSON. Why did it take you a year?

Mr. KARNAZE. I do not know. After I started receiving health care here in DC—I used to live in North Carolina, which is where I started my paperwork, in the clinic there in Wilmington, NC. I moved up here and was receiving care in the DC office when I actually received a letter from North Carolina—I think it came from Greenville—asking if I was still interested in receiving health care benefits from the VA. I just ignored that letter because I already was.

I am not sure, sir, why it took so long for me to get pulled into the system. I kind of feel like I had an unorthodox entry because I had some symptoms of TBI and they brought me in. I was not assigned a primary care physician first. I actually went to specialists and then kind of went backwards and was assigned a primary care physician.

Chairman ISAKSON. Well, I am not going to abuse my Chairmanship and take extra time, but we will have a second round of questions. I want to delve a little bit further into that particular situation.

Senator Blumenthal.

Senator BLUMENTHAL. Thank you, Mr. Chairman, and thank you for having this hearing.

Thank you, Mr. Karnaze, Mr. Maiers, and Mr. Butler, for your service.

Mr. Karnaze, I noticed in your testimony a reference to the fact—and I do not know whether you repeated it here—that the VA threatened to cutoff your benefits because you missed an appointment, is that correct?

Mr. KARNAZE. Yes, and there was an appointment that I could not make, so I called that number and there was no answer at the other end. I left a voice mail saying I have to cancel this appointment. This is my name. This is what I am being seen for. I cannot make it. I need to reschedule. I did not hear anything back.

Shortly thereafter, maybe a week or two, I received a little postcard in the mail saying that I had missed a VA appointment and if I continued to miss appointments, I might lose my benefits.

Senator BLUMENTHAL. Are you familiar with that practice, Mr. Maiers?

Mr. MAIERS. Yes. I have gotten several of those letters myself. I mean, to be completely honest with you, it is hard working a full-time job and scheduling your time around the VA, because when you go in there, you do not have a choice of appointment. They say, Monday, 2:30, Monday, 3:30. You do not have a choice. If you physically cannot make this appointment, then there is nothing you can do about it. And for us to be held accountable for that, I really do not think it is fair.

Senator BLUMENTHAL. All the more reason for the VA not to threaten you with cutting off your benefits.

Mr. MAIERS. That is correct.

Senator BLUMENTHAL. If you were going to a psychiatrist and you missed an appointment and left a message on the voice machine, the last thing in the world you would expect is for that office to call you back and say, we may not see you anymore, or we will not see you anymore. Absolutely unacceptable.

Mr. MAIERS. I agree.

Senator BLUMENTHAL. I want to thank you, Mr. Maiers, for making the trip here. Just so the Committee knows, you drive for a living and you spent an additional 8 hours on the road to get here——

Mr. MAIERS. That is correct.

Senator BLUMENTHAL [continuing]. Overnight.

Mr. MAIERS. Yes, sir.

Senator BLUMENTHAL. We will forgive you if you nod off——

Mr. MAIERS. Yeah. I am not at 100 percent today.

Senator BLUMENTHAL [continuing]. Which is a temptation that many spectators feel——

Mr. MAIERS. I hear you.

Senator BLUMENTHAL [continuing]. Listening to Senators. [Laughter.]

Mr. MAIERS. I will try not to fall asleep on you, sir.

Senator BLUMENTHAL. Well, I want to thank you for being here. Thank you for your dad, Leroy's, service.

Mr. MAIERS. Thank you. I will let him know.

Senator BLUMENTHAL. And for your strength and courage to be here, as well as to Mr. Karnaze.

On the Errera Center, which I have visited more times than I can count, as I understand it one of the programs available there is the peer program——

Mr. MAIERS. Yes.

Senator BLUMENTHAL [continuing]. The peer-to-peer, veteran helping veteran, program. I have just introduced legislation, with support from a number of my colleagues, to expand that program——

Mr. MAIERS. Good.

Senator BLUMENTHAL [continuing]. In effect, to overcome the stigma, alienation, sometimes shame that veterans may feel seeking mental health care.

Mr. MAIERS. Absolutely.

Senator BLUMENTHAL. It is against their culture, so to speak. I think you have been a beneficiary of the peer program. I wonder if you could tell the Committee a little bit about your experience.

Mr. MAIERS. Absolutely. I would be honored to. Basically, if I can just elaborate on what a peer support specialist is; it is a fellow veteran who, basically, takes the role of a—not so much a psychiatrist, but puts things into perspective for you that only somebody who has been there and gone through what you have gone through can understand and help you with. I have been through at least a half-a-dozen to ten psychiatrists through the VA and I felt was that it was all medicine, medicine, medicine, medicine, with no regard for the way I was thinking.

Ever since I have been in the Errera Center, not only do I have a peer support specialist, I have a primary care physician, and maybe three psychologists. If one does not answer the phone, the other one will call me back in 5 minutes. I mean, what I have going on for me now has turned my life upside down meaning it is 100 percent better and it is all thanks to the Errera Center and the VA Health Care System and I would like to thank them for that.

Senator BLUMENTHAL. And the peer program——

Mr. MAIERS. Peer support specialists, absolutely.

Senator BLUMENTHAL [continuing]. That the Errera Center has helped to pioneer——

Mr. MAIERS. Yes. Absolutely.

Senator BLUMENTHAL. Laurie Harkness has been a tremendous force for good——

Mr. MAIERS. Yes.

Senator BLUMENTHAL [continuing]. In our veterans' community.

Dr. Draper, my reaction on reading this GAO report is I am just more astonished and appalled that the VA has not done better, even after years of records and documentation and all the rest. There still seem to be excessive wait times, inconsistent reporting, inadequate data. Do you have an explanation? Is it a failure of will or resources? Would you give us your sort of from-the-heart assessment.

Ms. DRAPER. Sure. I have been involved with the wait time work for probably 4 or 5 years now. I think that what we have seen, certainly, we see a greater awareness of the need to get wait times under control and a greater awareness of making sure that the information is accurate.

However, we still see data reliability issues, and this goes back to unclear policies. A lot of schedulers enter the data correctly, but the issues that we saw were with the open access appointments. So, you cannot really compare data from across medical centers and the changes in the wait time calculations without providing sufficient definitions.

All of that is not very comparable, and the system itself—I think someone mentioned that the IT system does not support good scheduling practices. We had one facility tell us they go in and check every appointment that is made that day for mental health to make sure that it is done correctly. That is a gross inefficiency of time, where you have limited resources. That is not where people should be focusing their time. The system should support what they are doing.

The policies, ambiguous policies and inadequate oversight are the reasons why we put VHA on the High-Risk List this past year. We still see some of the same issues.

Senator BLUMENTHAL. Thank you. Regrettably, my time has expired, but I hope to come back to this topic with you and GAO and a number of our witnesses and I thank you all for being here.

Chairman ISAKSON. Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman.

I am just curious. It seems strange that the VA would begin their process by announcing an appointment without first conferring with the individual to find out whether or not they could make it. Is that consistent across all of the offices or all of the different locations in the VA? Or, did I misunderstand the statement, that in some cases you are missing appointments because they give you the time and they date. They do not ask you whether or not you are available in the first place. Did I misunderstand?

Mr. MAIERS. Well, what they do is they offer you a couple of appointments, ask which can you make. If you cannot make either one of those appointments, then you are—I do not even know what word I would use—considered an unauthorized absence. You are not there for your appointment. I have received several letters that I have missed appointments, but I missed the appointments because I was in the hospital. So, how am I supposed to go to this appointment when I am in the emergency room? It is very stressful.

It has gotten a lot better and I have the Errera Center to thank for that. I am no longer in the VA hospital. I am in the Errera Center moreso. So, it is a lot different now.

Senator ROUNDS. Dr. Draper, did you find that in your reviews?

Ms. DRAPER. Well, the scheduling policy calls for appointments to be set at what the veterans' preferred date is. However, I think there is a lot of confusion about how that gets operationalized at the local level, because sometimes it becomes, what the next available appointment is. This is really an artificial measure, because a veteran does not know what that means. So, you see this sort of tug-of-war between the scheduler and the veteran. They are pushing the preferred date, but that really does not make any sense to

a veteran. There is still a lot of training and clarification of what all this means.

Senator ROUNDS. Has implementation of the Choice Act increased access to mental health care?

Ms. DRAPER. That was beyond the scope of our work, but we did look at the community pilot program for mental health and it did increase access somewhat. It was pretty limited, and there was a lot of confusion among the provider community with the many different programs that were going on, the PC–3, the Veterans Choice, this program, and they all pay different rates, as well. So, it was very confusing for people as to what the different programs were.

Senator ROUNDS. I know we talked about it and there was a discussion about the "no show" rate. How does that play into this whole discussion? Is it a cascading effect where, number 1, they are making appointments where, in many cases, the veteran is not going to be able to make it in the first place? The veteran did not get there and now they have a no show. So, now they are going to try a different approach, to push the issue. What is with the no-show rates? How are the no-show rates consistent between VA versus non-VA? Have you looked at any of that?

Ms. DRAPER. Not in this particular engagement, but when we looked at wait times back in 2012, no show was a huge problem for VA. At that time, they did not really have a policy. It is called the missed opportunity rate, which includes veterans not showing up for care or a clinic canceling an appointment or a veteran canceling an appointment. So, all that gets factored in. It is really lost productivity for the provider.

The clinic that we talked about, the open access clinic, that was one way they went and tried to resolve their no show issue. They did it incorrectly. It is hard to really understand what each medical center is doing.

The policy says that they are supposed to get the veteran's preferred date and not supposed to schedule without the agreement of the veteran.

Senator ROUNDS. What have we learned from it and is there a new implementation plan that is trying to achieve a better rate than what they have got today? Where are they at right now with it?

Ms. DRAPER. Yeah, that is probably a good question for the VA witnesses that will come up next, but I can say they have done some training. Yet, the scheduler, that is a high-turnover position. The training is just required to be ongoing.

Senator ROUNDS. Are there appropriate specialties available for the different needs? My first thought had been that a veteran would come in and they would be working with a specialist. What I am learning here is that there are multiple specialists that are involved with an individual. Could we talk a little bit about whether or not those specialists are available in the areas where they are needed, or do we have a missing link here somewhere in terms of the professionals, the trained professionals for the different things that a single veteran may need. For anyone who would like to answer.

Ms. MAFFUCCI. Sir, I can take a stab at that. Yes, each mental health professional has their own area of expertise and have their own relevance in providing care. I spoke a little bit to the staffing models, and the way the staffing models go, it is a ratio. There is a preferred ratio of the number of, for example, psychiatrists to X-number of veterans that are seeking care.

The challenge is, at the local level, there is really not a dynamic system that can really qualify what the demand at the local level is, and often, it is left to the local medical centers to really determine that. But without the data to support it, our understanding is it can be really hard to get at that accurately to understand, how many psychiatrists do we really need? How many psychologists do we really need? How many social workers? And that is really where the data aspect comes in, in really defining a more dynamic way of determining the demand at the local level, but being led by the national VA.

Senator ROUNDS. Thank you. My time has expired.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Tester.

HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman. Thank you for holding the hearing. I thank the Ranking Member, also.

I want to thank the folks who provided the testimony. When our men and women go to war, go to battle, we see their courage. We see their sacrifices. When they come home, we never see the wounds that they have acquired when they were in battle, and I think the testimony here points that out more than ever.

We do have a VA panel coming up. Nick, I will just tell you, I apologize. I mean, when you have mental health issues and you call somebody, the last thing you want to hear is a recording. We will take that up with the VA folks. We certainly do not want to be put off and put off, so I appreciate your testimony.

Dean, I appreciate your service and I appreciate your passion. It is good to know that the Errera Center is helping you and moving you where you want to go. I think that is really important.

I guess I am going to ask the first question for you, Dr. Maffucci. To what extent are you seeing the younger generation of veterans? Are they more likely to see mental health care when they need it, or are they like the previous generation of Vietnam veterans, or just tell me.

Ms. MAFFUCCI. Certainly, among our members, we are finding they absolutely are seeking care. Of the folks in our survey who responded that they had a mental health injury, three out of four were getting care, some outside the VA, more of them within the VA. It is really huge that we are seeing that among the younger generation. There are more conversations that are happening. There is a support system in place, a buddy system in place; and in having these conversations, we are seeing a higher demand.

Senator TESTER. OK. Roscoe, regarding The American Legion, you have got some veterans from previous conflicts. Is the stigma still there for them? Are they becoming more willing to go get mental health care, or do they still say, no, that is for somebody else?

Mr. BUTLER. For the Vietnam veterans, they continue to rely on the Vet Centers. They still do not trust the VA system and they want to be separate from the system——

Senator TESTER. Right.

Mr. BUTLER [continuing]. And that the Vet Centers maintain a separate system, so that they believe that the information they share with the Vet Centers remain confidential and entrusted by the Vet Centers.

Senator TESTER. Got you. Got you.

Ms. MAFFUCCI. Sir, if I may——

Senator TESTER. Go ahead.

Ms. MAFFUCCI [continuing]. Just add very quickly, stigma in the post-9/11 generation still does exist——

Senator TESTER. Yes.

Ms. MAFFUCCI [continuing]. And I want to make sure that we are clear about that. But, I think it is improving through the supports that they have established.

Senator TESTER. Well, we have got a long ways to go on the stigma——

Ms. MAFFUCCI. Absolutely.

Senator TESTER [continuing]. Which is why when somebody like these two fellows are willing to step up and say, I know I have a problem, that is a huge step and we owe them—we owe them better——

Ms. MAFFUCCI. Absolutely.

Senator TESTER [continuing]. And they ought not to have to go to a center to get that help, to be honest with you.

Mr. KARNAZE. Sir, if I may, I think one of the reasons why we are seeing more younger veterans look for help is because within the military itself, we are getting better at that.

Senator TESTER. Yes.

Mr. KARNAZE. I know in the special operations community, we do something called third location decompression, where on our way home from the war zone we have to stop for 3 days, a small group of the guys——

Senator TESTER. Yes.

Mr. KARNAZE [continuing]. And we have two required meetings. One is with a psychologist and one is with the chaplain.

Senator TESTER. Yes.

Mr. KARNAZE. That kind of makes it OK. So, we are leaving the military knowing, OK, something is not right. It is OK to ask for help. But, absolutely, the stigma is still there.

Senator TESTER. Yes, and that decompression is good. That is something we have worked on the DOD: to make sure that there is an education process going on, to learn what their benefits are, and to know that it is a big deal if they need to ask for help, because it is curable. We can fix it, like a broken arm; we need to look at it that way.

Dr. Draper, you pulled 100 medical records. I just want to get an idea. Is that an adequate sample?

Ms. DRAPER. Well, they were random—we took 20 each for the five facilities that we visited.

Senator TESTER. You just took them randomly out of the——

Ms. DRAPER. We took a random sample of each facility. These were patients new to mental health care.

Senator TESTER. OK. When you looked at these, did you look at all to see if the problem was in staffing, inadequate staffing, or facilities, or——

Ms. DRAPER. We tracked the date that the patient or the veteran initially requested care, then took it through when they first received their full mental health evaluation——

Senator TESTER. Right.

Ms. DRAPER [continuing]. And the next appointment. Then, we also spoke with the facilities that we had these medical records. They confirmed that our reviews were accurate, and then we talked to them about their staffing needs.

Senator TESTER. What did they say about their staffing needs? Were they understaffed, or did they have extra staff?

Ms. DRAPER. The facilities that we visited, their vacancy rates ranged anywhere from 9 to 28 percent in mental health.

Senator TESTER. Do you know how that compares with general practitioners?

Ms. DRAPER. Yes. The vacancy rate for mental health is, I think it is 14 percent; and 16 percent for VA overall.

Senator TESTER. You are saying the vacancy rate is less in the mental health area than it is in the——

Ms. DRAPER. It depends on—it ranges anywhere from 0 to 28 percent for the facility. So, it varies by facility.

Senator TESTER. OK.

Ms. DRAPER. Some of the rural areas have particularly difficult times recruiting mental health professionals.

Senator TESTER. OK. My time has expired.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you very much. Thank you to those who are here to testify today. Thank you for your service to our Nation. You are once again serving our Nation by your testimony and I am grateful for it.

Dr. Draper, you have been at the GAO for a while.

Ms. DRAPER. Mm-hmm.

Senator MORAN. Do you care to put on the record how many years? [Laughter.]

Ms. DRAPER. I have had two tours of duty, so in total, 8 years.

Senator MORAN. In those 8 years, have you been involved in reviewing the operations of the Department of Veterans Affairs?

Ms. DRAPER. I have been involved probably for the last 5 years.

Senator MORAN. I want to use your experience in an institutional way, because what strikes me today as I sit here is, once again, this Committee—I previously served on the Veterans Committee in the House. We have veterans who come tell us the circumstances they find themselves in. We have GAO and OIG who come and give us reports. We have been doing this for a long time. What strikes me as I listened to the testimony here of this panel, and what I, to some degree, can expect from the Department of Veterans Affairs, I am going to hear something very similar to what I have

heard on previous occasions about mental health or health care or benefits, and how the VA is or is not capable of meeting the needs of our veterans.

My point of that conversation is, it seems to me, not much changes. As someone who has examined the Department of Veterans Affairs for the last 5 years, is that perception correct? What is it that we can do to get out of the cycle of inviting you to come and report on GAO studies? What is it that we can do to get out of the cycle of asking veterans how things are going and to have The American Legion, PVA, VFW and others in front of us telling us about their members and their experiences, then the Department of Veterans Affairs explaining what is going on? How do we get out of the cycle of hearing the same—it is a different topic each time, but it is the same set of circumstances that veterans find themselves in?

Ms. DRAPER. I would love to report something different. I know that we sound like a broken record sometimes, but there are common themes. Going back to the reasons we put VHA on the High-Risk List this past year, there are five common themes and we see them here again in this work. (1) Inadequate policies; (2) things play out differently at the local level, you have got a lot of variation among medical centers; (3) there is poor oversight; (4) data systems or information technology that does not support good practices; and (5) lack of training and resource allocation—identifying what the resource needs are and appropriately allocating those.

One of the issues with agencies that are put on the High-Risk List is that they are in need of major transformation, which I think is certainly true of VA, or VHA. VHA is what we put on the High-Risk List.

Senator MORAN. If I could paraphrase what I think you are telling me, which is those five circumstances are common throughout the VA regardless of what audit report you are preparing, what the topic is. Those failures continue to exist systemwide——

Ms. DRAPER. I would say it is systemwide in VHA.

Senator MORAN. VHA, OK.

Ms. DRAPER. Right.

Senator MORAN. Let me take you to my question again, which is, so what can we do—what can I do as a Member of Congress, what can this Committee of the U.S. Senate do, so that when we have a hearing 6 months from now, or a hearing a year from now, the conversation, the testimony is different than what we hear today?

Ms. DRAPER. To get off the High-Risk List, it calls for the creation of a framework. There are specific criteria to get off the High-Risk List. I think that is a good place to start. There are five criteria which provide a good road map to help frame an action plan to get off the list. The independent assessment that was recently done, that also provides great information. The Commission on Care is going to be issuing a report. All that is information that can be funneled into a framework for transformation.

Senator MORAN. Finally—and perhaps it is the repetition of my questions—there are recommendations, there is a guide plan, a path to reverse the themes that caused you to have placed them on high-risk.

Ms. DRAPER. Right.

Senator MORAN. Is there evidence that it is being pursued, the path to get off the high-risk category?

Ms. DRAPER. We have not seen a lot of progress yet.

Senator MORAN. Mr. Chairman, thank you.

Chairman ISAKSON. Thank you, Senator Moran.

Senator Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Mr. Chairman, thank you, and thank you to all of our witnesses. I share the frustration that I am hearing from all of you and Senator Moran. When I was Chairman of this Committee, we actually held several hearings on mental health care. We asked for several IG and GAO investigations. We demanded that the VA hire more providers and listen to the providers in the field about the barriers they were facing. We even passed into law reforms.

It is really frustrating to be sitting here again today, and I am having a hard time understanding what really has changed since 2012. Why is it that the VA still does not have an accurate picture of wait times? We do not have a staffing model for mental health care at the VA that works and have an alarmingly high number of vacancies still? It is very frustrating, and I think something that we cannot just have a hearing on. We really need to work on this. I really appreciate having this hearing today.

Dr. Draper, thank you to you and your team at GAO for the work you are doing on overseeing VA's mental health care facilities. I am very concerned about the findings. You said in your testimony that you found a medical center with a mental health vacancy rate as high as 28 percent, and as Mr. Butler mentioned, the Legion found, in a site visit to Baltimore, they had a 38.5 mental health vacancies.

What is worse, you mentioned VA projects they will need another 12 percent increase in mental health staff on top of those current vacancies just to keep up the demand through 2017. There is a major shortage of mental health care providers around the country already and VA is struggling to hire. So, I am very concerned about how the VA is going to be able to keep up.

What can the VA do to get enough providers into the system to meet the increasing needs of our veterans?

Dr. Draper.

Ms. DRAPER. I can talk a little bit about this. I think that what we found is that some of the things that they are doing, they are offering hiring bonuses, retention bonuses. I will say, there are real concerns with the hiring process itself. It is a very lengthy process. What we heard from the medical centers that we visited is it sometimes takes up to a year to get a mental health professional on board. During that period of time, they often lose people to the private sector. We repeatedly heard about all the VA medical centers trying to recruit at the same time, so there is a lot of competition between the different facilities.

So, there are a lot of challenges related to trying to get people on board. I think if some of those challenges are addressed, that may pave the way for some smoother transition of people into VA. The lengthy hiring process, we heard that across the board. Some

of that depends on the sophistication of the individual facility. Some have more sophisticated human capital departments than others and it is a real struggle.

Senator MURRAY. If a veteran cannot get into care, if they cannot get in for follow-up appointments, what is the chance they are going to stay in treatment or drop out?

Ms. DRAPER. I will say that of the facilities we visited, there are some very dedicated mental health professionals. Thank goodness they are there, because I think the problems would be a lot worse, because they really work hard to try to make things work with what they have.

We see things like they are spreading out appointments for longer periods of time. They are trying to convert space to put new people in. We have heard stories about converting closets into small offices, trying to do some sharing of space. So, there are a lot of things going on, but there is not a systemic or a systematic approach to how to counter these shortages.

Senator MURRAY. OK. Mr. Butler, I wanted to ask you, in your testimony, you talked about feedback the Legion received from the Seattle VA community mental health summits. I was really concerned by that report. VA hospitals were actually directed to interact with patients in the community to improve communication and awareness of mental health services. Instead, it seems they kind of created pointless bureaucracy, and according to the report, managed to actually make the relationships worse. Tell me what you think the Puget Sound VA ought to be doing to improve communication and interaction with its veterans.

Mr. BUTLER. Our experience varied across the country in terms of who responded to our questions. But in regard to the one service officer who shared that information, he felt that the summit was demeaning and it was not focused in terms of trying to draw the community partners together in terms of what can we do to serve veterans. But it was more talk down from the VA.

I think what they need to do is to reach back out to the community and involve the community in such a way that the community feels that they are valued, that whatever they bring to the table and whatever they can offer, that the VA is being genuine and allow them to provide the opportunity to help the VA in that regard.

Senator MURRAY. I would appreciate if you would ask your members in Washington State to get in touch with me. I would like to work with them and work on helping develop better relationships out there. So, if you could follow up with this, I would really appreciate it.

Mr. BUTLER. Will do.

Senator MURRAY. Thank you.

Chairman ISAKSON. Thank you, Senator Murray.

Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chairman.

First off, I would like to associate myself with the comments that have been made by Senator Murray, Senator Moran, and others about the concern with this continuing dialog. I have only been

here 10 months and I am really becoming frustrated with the lack of progress. I cannot imagine those who have served much longer seeing basically the same thing.

Some of these things speak to systemic problems that we do not seem to be getting at, and Chair, I have lost count. How long has it been since we have had a permanent IG in the VA?

Chairman ISAKSON. A long time. How long has it been? Sixteen months.

Senator TILLIS. It seems to me that when you are looking at root causes to these sorts of problems, the sort of resources that will really focus on it, like the IG's office, like the work that Dr. Draper has done, we need to put every single resource that we can put on it as quickly as possible to get to some of the systemic problems.

Mr. Butler, I wanted to talk to you about something. I apologize for being late. I had a conflict earlier. But, I happened to run into a veteran on a flight, sat next to a veteran and his wife on a flight from Charlotte up here to D.C. a couple of weeks ago, and he is 100 percent disabled, special operator, served for 15 years, and had overcome his own challenges with PTSD and has really found a calling by helping others. He is very well known. He is down in Mississippi.

He had a veteran call him who knew he was in a crisis situation. It was a domestic situation with his wife. He called the VA for help. Now, this is an immediate crisis situation, and the feedback that he got from the VA, it would be 4 days before they could get back with him.

In these crisis intervention scenarios, did he just call the wrong number, or are you reporting back from your members—and anyone can respond to me—a personal experience where this is not just aberration, but something that we should seriously look into?

Mr. BUTLER. I think that the person he spoke to was not trained in terms of the crisis intervention, the crisis hotline. Every facility has a crisis intervention team that should immediately put them in contact with the appropriate people that can—locally as well as at the crisis center—that can address their immediate needs and problems. I think that whichever facility he contacted, they need to provide some remedial training to their staff, because VA——

Senator TILLIS. There should have been an option.

Mr. BUTLER. Right. There should have been an option.

Senator TILLIS. OK.

Mr. BUTLER. They have an excellent crisis——

Senator TILLIS. Well, I think it got worse, because then when he called this veteran and he realized that he needed help and he wanted to remove him from that situation, this man carried him to a hospital, drove him several hours, and they waited in an emergency room setting from about 3 in the afternoon until about midnight before he was actually able to get to a point where he was first able to see somebody that could help him with the intervention. Is that just another breakdown in training or a systemic problem?

Mr. BUTLER. I think that that is a systemic problem with that particular center, because that should never have happened.

Senator TILLIS. Now, I want to get back to Dr. Draper. Dr. Draper, on page six of your opening testimony, I want to get back to—

I have got a lot of questions I could ask you all, and you all know that. I have not figured out how to work in the Camp Lejeune toxic substances comment into this——

[Laughter.]

Senator TILLIS [continuing]. I just figured I will put it out there randomly. I will have the next panel to talk about with that.

This graphic is interesting. Why is it not easy to define what a wait time is? To me, a wait time is when the veteran is waiting when he or she does not want to. It sounds like a part of the questions in your testimony about an objection to your methodology, well, it does not count the times when the veteran really wants to be seen later. Great. Solve for that and then figure out what the real wait time problem is. What am I missing?

Ms. DRAPER. That is really an artificial measure as I mentioned in my opening remarks. You know, a veteran really does not know what it means to have a preferred date, and we found that the time between initial request and getting into, you know, establishing a preferred date, that is done at the time that they actually talk to a scheduler.

Senator TILLIS. I think with this chart you kind of set the context within which you should be able to define something where we can determine whether or not the VA is achieving acceptable wait times or not.

The other question I had for you was why would the data be incompatible in your analysis between the VAMCs?

Ms. DRAPER. The example of the two VA medical centers, or the one that had the open access appointments, they never really scheduled an appointment until the person actually showed up, even though they had talked to them. It may have been months before. When they actually show up, they show a zero wait time, so that is what gets recorded——

Senator TILLIS. And that happens in one and not another?

Ms. DRAPER. It can happen for other reasons that way, but that was a good example of where you might see some zero wait times, which is not accurate. We had a case where someone on that list had called the VA and they were put on that list. A month later, they presented in the emergency room suicidal and they were admitted to an inpatient unit. It is not really a true wait time. There are other things, data entry errors. There are a lot of things where the data just are not comparable between facilities.

The interesting thing is, we did 100 medical records, but that took a lot of work to do because this is a very complicated system to go through. What we know, one of the VISNs is currently doing something similar because they believe that that period of time is also important to identify problems. It is not consistently done throughout VA, and I think if the VA instituted doing audits in their facilities, such as what we did, they would find a lot of areas that potentially could be improved.

Senator TILLIS. Which, again, points back to how I started this conversation. The more people we have auditing the systems and the outcomes, the better off we are. The VA should welcome that as an additional resource, not as some perceived threat.

Thank you, Mr. Chair.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Brown.

HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Thank you, Mr. Chairman.

Mr. Karnaze, I want to understand your personal experience better. Senator Tester and I got on this Committee the same day in 2007, and everywhere I went in my State as I did roundtable after roundtable with veterans, some recently returned veterans, others that had been in the VA system and been treated generally pretty well, we have a number of VA centers, VA hospitals, and we have in my State probably 27 or 28 CBOCs now that serve veterans very well.

But, I heard repeatedly, as you all are aware, that in those days, that if you were home on leave from Iraq and you went to the CBOC in Mansfield, my home town, or you went to a hospital in Dayton or Cleveland, they did not have your medical records. It has been a long-term battle to get DOD interested enough and to have the right interface between DOD and the VA. We still have not made the progress we should yet.

I heard repeatedly from veterans, I remember at Cleveland State and at Youngstown State, there were veterans that were integrating into a classroom, veterans or soldiers that were infantry and they returned home and they are sitting next to an 18-year-old suburban kid and the experiences were so different, all of that. But they also said that when they did not re-up, the DOD just said, see you, without talking nearly enough to the soldier or the Marine or the airman or woman about what VA benefits were. We see all those problems. I think they are improving. They are not there yet.

I want to understand better with you, when you got out, when you came back, when you tried to get access to VA, you said it took a year before you could get in. What does that mean? They had none of your records? Tell me sort of your experience that way.

Mr. KARNAZE. I consider myself quite fortunate in that when I was leaving the Marine Corps in Camp Lejeune, there was actually a nonprofit aboard Camp Lejeune that would help soon-to-be veterans get everything together and submit to the VA. I brought all my medical records to them. We went through it together. They helped me compile the second set of records for me to hold on to.

Then, there was actually a VA center or small office aboard Camp Lejeune where I did my out-processing physical. I went through that whole out-processing physical, I guess, with them. They had all of my records and they set up all of the follow-on appointments for me to go through my screening process so they could determine what was service related and what was not. And then that just went off someplace.

From that point, start the clock, I finally received a letter in the mail with my disability rating and saying that I now had coverage. During that time, I went to the local VA clinic in Wilmington, NC, because I was pretty sick. I had tried to get treatment and I ended up just leaving because they did not have anything in the system. Apparently at that point, I did not receive health care from the VA.

When I moved here to D.C. is when I actually received the letter from the VA with everything like that. And then once I received that letter, I could be a bit aggressive, so I just started burning up

the phone lines, calling the D.C. office here because I wanted some help with some of the concentration issues, and that is when they connected me.

A very wonderful nurse—I forget her name—she took me in. She asked who my primary care physician was. I told her, I do not know. I do not have one. I do not know how to get one. She was, like, OK. Well, let us get this taken care of first. She connected me with neurology. We did a bunch of cognitive exams. That is why earlier when I said I kind of entered in an unorthodox fashion, I feel like I did, because I went through all these specialists before I finally received my primary care physician, who is down at Fort Belvoir.

I am not sure how the process is supposed to work. I just know that is how it was with me, and a lot of that was me being highly aggressive on the phone, in a tactful manner, but until they finally responded.

Senator BROWN. People for a whole host of reasons are not as aggressive as you, because of the stigma, because their personality is not so outgoing as yours, for a whole host of reasons, if they are not as aggressive with you, what happens then? You said partly DOD. Is it all VA? What do we do to get people in the system, and if they want cognitive therapy, that they can make those choices with their provider to go in the right direction?

Mr. KARNAZE. I think, in some cases, they die on the vine. If they do not reach out, I think they are lost and they will not enter the VA system. And for the ones that do, I feel out-processing—because at the time when you are leaving the military, you are pretty excited, or depending on the situation, maybe not so excited, and you are worried about your DD–214, right, free man, free woman. But, the out-processing class that you mentioned, my experience was very poor. It was just a few hours, a representative from the VA saying, hey, if you need a home loan, also, you get health care for 5 years as a post-9/11 veteran. Here is a pamphlet, and their phone number is in there. I was, like, cool. Roger that. Got it. All right. Let us go. And then you are, like, I do not know what to do.

Senator BROWN. That was VA or that was——

Mr. KARNAZE. That was a representative from the VA. We called it TAPS, the Transition Assistance Program. There was a group of us, all ranks, ages, shapes, and sizes at Camp Lejeune and we sat through this class. Most of the people fell asleep in the back of the room. The VA presented first, which I think was great, but again, it was a short, few hour presentation, and then we walked away with a cool little handbook and that was the extent of it.

Senator BROWN. Last question, Mr. Chairman. Thank you.

If that could have been an important discussion, meeting, briefing, how should they have done that TAPS different than that way?

Mr. KARNAZE. I feel that this is such an important issue, that the servicemember at the time does not realize how important it is. If the VA or a representative took the time and fully outlined the process, this is what you need to do, this is where you need to submit your records, this is who you need to engage with aboard this base to get into the system, these are numbers that you can reach out to, expect this timeframe. What is going to happen now is we

are going to review your medical records and then we will get back to you with your disability rating. At that point, you can contact whoever to get assigned your primary care physician.

The process was never outlined to me or any of the Marines that I served with, so we were quite confused about what was going to happen next. I think just explaining it, just communicating to the veteran the way the process works would be of great assistance.

Senator BROWN. To your recollection, Mr. Karnaze, it is basically that they gave you a brochure to tell you that?

Mr. KARNAZE. Yes, sir.

Senator BROWN. Yes, Mr. Butler, sure.

Mr. BUTLER. Senator Tester——

Senator BROWN. He is Tester, I am Brown, but that is OK.

Mr. BUTLER. Oh, I am sorry.

Senator BROWN. Do not ever call me that again. [Laughter.]

Mr. BUTLER. OK. Sorry, Mr. Brown. So, prior to——

Chairman ISAKSON. They look a lot alike.

Mr. BUTLER. Prior to the program changing from TAP to Transition GPS, service officers were allowed to participate in the program. Now, since the program has changed to Transition GPS, service officers are no longer a part of the program. If Veterans Service Organizations were allowed to participate in the program, we could bring a wealth of experience and knowledge and assistance to servicemembers prior to their transition from active military service to the VA.

Senator BROWN. Thank you. Perfect. Thanks.

Chairman ISAKSON. With the indulgence of the Committee, I am going to pass on a second round except for one question that Senator Blumenthal has——

Senator BLUMENTHAL. I have a——

Chairman ISAKSON [continuing]. Because of the importance, I think, that the VA testimony be heard in the context of this testimony. Thank you for being here.

Senator Blumenthal has a question, then we are going to switch panels.

I want to acknowledge for Senator Tillis that although he failed in his 6 minutes and 13 seconds to mention Camp Lejeune, Mr. Karnaze did it four times in 1 minute, so it got done. [Laughter.]

Senator Blumenthal.

Senator BLUMENTHAL. I have a very quick question for you, Dr. Draper. I am looking at your chart on page six——

Ms. DRAPER. Mm-hmm.

Senator BLUMENTHAL [continuing]. Which shows that the VA, at least in some of its facilities, is still vastly under-calculating the amount of wait time, in effect, in this instance, measuring it from not the date of the request for health care, but from the date of the veteran's preferred date, which then was unfulfilled. The veteran had to wait another 5 days, and that is what was measured as the wait time, not the full 17 days that the veteran actually had to wait.

Ms. DRAPER. Yes. The policy is that it is measured using the preferred date as the basis——

Senator BLUMENTHAL. That is exactly the kind of, in my view, wrongdoing that the VA was committing in facilities around the

country that we sought to correct and the VA said it was correcting in the so-called reforms that it instituted after the Phoenix debacle and other revelations, which, in my view, cast doubt on the reliability and trustworthiness of a lot of the data we have been receiving from the VA.

Ms. DRAPER. It is how you define wait times. It can be a wait time is when somebody initially requests care to when they actually receive treatment. Another part of the issue with the way that they are calculating it is their IT system does not support the calculations on that longer wait time. They could do what we did, do some audits. We have one, as I mentioned, one VISN that is doing that, and there is a lot to be learned by doing those types of audits as to what kind of systemic things you see during that period of time before the establishment of the preferred date.

Senator BLUMENTHAL. Well, you know, I think a lot of us are expressing frustration with the apparent finding of your report that the VA may have learned nothing from what has happened in the past. Thank you.

Chairman ISAKSON. For the Committee's information as well as the audience, we are going to have a hearing in December on transition from DOD health care to veterans health care, to focus on that problem, because there is a black hole that everybody seems to fall into from one to the other, and the Warrior Transition Centers at active duty, which are such a good service, kind of do not get transferred to the VA when the veteran is getting ready to transfer, and we want to see if we cannot expedite that process and make it better.

I want to thank our panelists for testifying and ask our second panel to please come forward. [Pause.]

I am pleased to introduce our second panel for the hearing today for testimony, Dr. Harold Kudler, the Chief Consultant for Mental Health Services, Department of Veterans Affairs, who is accompanied by—I think that means they are going to back up his answers if he screws it up, but anyway, Dr. David Carroll, Executive Director, Mental Health Operations, Department of Veterans Affairs, and Dr. Michael Davies, Executive Director, Access and Clinical Administration Program, Department of Veterans Affairs.

Thanks to all of you for being here today. We welcome you to begin your testimony, Dr. Kudler. About 5 minutes, if you will.

STATEMENT OF HAROLD KUDLER, M.D., CHIEF CONSULTANT FOR MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DAVID CARROLL, PH.D., EXECUTIVE DIRECTOR, MENTAL HEALTH OPERATIONS; AND MICHAEL DAVIES, M.D., EXECUTIVE DIRECTOR, ACCESS AND CLINICAL ADMINISTRATION PROGRAM

Dr. KUDLER. Thank you, sir. Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for the opportunity to discuss access and timeliness of veterans' mental health care. I am accompanied, as we say, by Drs. Carroll and Davies.

Just today, GAO reported a need for clearer guidance on access and wait times, and VA is committed to providing timely access

which supports veterans' reintegration into their families and communities. We appreciate GAO's review, concur with its recommendations, and have taken action to address them, and will continue to take action.

GAO found that VA met mental health hiring initiative goals at the national level, but individual VAs continued to face challenges in hiring and in meeting the increasing demands for care. In 2012, VHA began its hiring initiative under Executive Order, and as of June 2013, approximately 5,300 new clinical and non-clinical mental health staff were hired. Almost half of these filled existing vacancies. Nationally, outpatient mental health staffing increased by 25 percent between 2010 and 2014. By December 2013, we had also hired 932 peer specialists. Peer specialists, as Mr. Maiers said, can say, "I have been where you have been and VA can help." GAO documented local improvements in the wake of these hires.

VA has revised and tested its metrics and management process and is now ready to update to a 30-day timeliness standard based on the requirements of the Veterans Choice Act. The target completion date for this is March 2016.

Open access ensures that any veteran can receive urgent mental health care at any entry point in our system within 24 hours. Each facility must have a defined process for warm handoffs to a professional who can conduct same day mental health evaluations and arrange appropriate follow-up. VHA has trained more than 23,000 schedulers this year in support of open access. VHA has simplified access measure methods and definitions and publicly releases wait times for every facility and service every 2 weeks.

In June 2015, we issued clarification to all network directors, saying VHA measures patient wait time using preferred date or clinically indicated date as the first reference point and the pending or completed appointment date as the second reference point. An updated data definition will be posted on our Quality of Care public site this month.

Although excessive appointment delays do exist at specific locations, the recent MITRE-RAND assessment required by the Choice Act found that there were no systemwide crises in access to VHA care. The Altarum-RAND report of 2011 concluded timeliness for mental health or behavioral health care in VHA is as good or better than in commercial and public plans.

VA integrates mental health services into primary care and other settings to minimize barriers to care. By combining effective engagement with systemwide screening, VA produced a 71 percent increase in the number of veterans receiving mental health care between 2005 and 2014, outpacing overall growth among veterans receiving any VA health care. Still more dramatic was an 87 percent increase in the number of mental health encounters during that same period.

Last year, more than 1.5 million veterans—that is 27 percent of all veterans served by VA—receive mental health care in VA, and 200,000 combat veterans, servicemembers, and family members were engaged and served by our 300 Vet Centers and 80 mobile Vet Centers.

Access means nothing, however, without quality. The Altarum-RAND study found that the quality of VA mental health care is as

good or better than that reported for patients with comparable diagnoses who receive care through private insurance, Medicare, or Medicaid.

VA is an innovator in telemental health care and has provided 335,000 telemental health encounters in 2014. Ten thousand of these were by video in the veteran's own home, and new technology and new policy will allow us to expand that tremendously. This is particularly important to the one in four veterans who live in rural areas. Telemental health also allows VA to adjust the supply of providers across the country, even where those providers do not live. VA mobile apps and award winning online services further enhance access and engagement.

The Veterans Crisis Line reaches an ever-growing number of veterans on an urgent basis through voice, chat, and text options. As the number of calls increases, so do referrals to VA.

VA leads the world in the treatment of deployment mental health problems and develops gold standard tools used around the globe. We are developing integrated treatments for depression in veterans with spinal cord injury and for chemical dependents and those with chronic pain.

Our Mental Health Centers of Excellence, including the National Center for PTSD and our MIRECC produced over 1,300 peer reviewed scientific papers per year in the last 3 years.

Mr. Chairman, VA is committed to the care of our veterans, the care they have earned. We appreciate Congress's support, and we are prepared to respond to any questions you may have.

[The prepared statement of Dr. Kudler follows:]

PREPARED STATEMENT OF HAROLD KUDLER, M.D., CHIEF CONSULTANT FOR MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for the opportunity to discuss the important topic of access to and timeliness of Veterans' mental health care. I am accompanied by Dr. David Carroll, Executive Director, Mental Health Operations and Dr. Michael Davies, Executive Director, Access and Clinical Administration Program.

VHA MENTAL HEALTH CARE

The Veterans Health Administration's (VHA) mission is to honor America's Veterans by providing exceptional healthcare that improves their health and well-being. Providing timely access to that care is a critical aspect of our mission. Access enables VHA to provide personalized, proactive, patient-driven health care; achieve measurable improvements in health outcomes; and align resources to deliver sustained value to Veterans. VHA is continually monitoring wait times and making adjustments as needed to ensure that Veterans have access to the best care they rightfully deserve.

Between 2005 and 2014, the number of Veterans who received mental health care from VA grew by 71 percent. This rate of increase is more than 3 times that seen in the overall number of VA users. The increase in the number of mental health encounters or treatment visits, from 10.5 million in 2005 to 19.6 million in 2014, has been even more dramatic—an 87-percent increase. This reflects VA's concerted efforts to engage Veterans that are new to our system and stimulate better access to MH services for Veterans within our system. These include outreach and engagement through 300 Vet Centers, 70 Mobile Vet Centers, Primary Care/MH Integration at VA medical centers, and large community-based clinics. VA Telemental Health innovations provided more than 335,000 encounters to over 108,000 Veterans in 2014. Telemental Health reaches Veterans where and when they are best served. VA is a leader across the US and internationally in these efforts. VA's MaketheConnection.net, Suicide Prevention campaigns, and the PTSD mobile app (which has been downloaded over 208,000 times) add to the increase in MH access

and utilization. These efforts align with VA's interagency activities including the Cross Agency Priority (CAP) Goals and expanding VA MH policy and practice. As a result of these trends, the proportion of Veterans served by VA who receive mental health care increased to more than 1.5 million Veterans. In 2005, 19 percent of VA users received mental health services, and in 2014, the figure was 27 percent.

GAO REPORT

This month the Government Accountability Office (GAO) released a report regarding the need for clearer guidance on access policies and wait time data relating to VA mental health care. VA is committed to providing timely access to high quality, recovery-oriented mental health care that anticipates and responds to Veterans' needs and supports their reintegration into their communities. VA appreciates the GAO review of timely access to mental health care issues at VA medical centers (VAMC) and concurs with GAO's recommendations. We take the findings very seriously and have implemented action plans to address the recommendations.

The GAO report found that the way in which VHA calculates mental health wait times may not always reflect the overall amount of time Veterans wait for care. Specifically, GAO notes that a patient who presents with Mental Health concerns receives an initial evaluation within 24 hours and may not receive a full evaluation until a later date. However, this initial evaluation is the start of treatment. It includes initial diagnostic evaluation and treatment of the most acute problems as appropriate. It may result in a patient being admitted to the hospital, for example, or medication adjustments. At the same time, these patients are often scheduled for a full and comprehensive evaluation at a later time. Of the 100 Veterans whose records GAO reviewed, 86 received full mental health evaluations within 30 days of their preferred date.

The GAO report noted four findings. First, the Veterans' preferred dates were, on average, 26 days after their initial requests or referrals for mental health care, and ranged from 0—279 days. Second, the conflicting access policies for a full mental health evaluation—one which mandates a 14-day deadline versus another which allows for 30 days from the Veteran's preferred date—created confusion among VAMC officials about which policy they are expected to follow. Third, GAO found that data may not be comparable over time as the definitions or updated definitions of new patients have not been communicated with VISN and Medical Center leadership and managers. Fourth, GAO found inconsistencies in the implementation of these appointments; including one VAMC that manually maintained a list of Veterans seeking mental health outside of VHA's scheduling system.

GAO recommended three items for action in response to its findings. First, VA should issue clarifying guidance on which of VHA's policies (14 or 30 days) should be used for scheduling new Veterans' full mental health evaluations. Second, VA should issue guidance on how appointment scheduling for open-access appointments is required to be managed. Third, VA should issue guidance about the definitions used to calculate wait times, such as how a new patient is defined, and communicate this to VISN and Medical Center leadership and managers any changes in wait time data definitions.

INCREASING ACCESS AND HIRING PRACTICES

The GAO report found that VHA met Mental Health hiring initiative goals, but that VAMCs reported continued challenges in ongoing hiring of mental health staff and in meeting the increasing demands for such care.

In 2012, VHA began a two-part hiring initiative under Executive Order 13625 issued in August 2012. The first part focused on recruiting 1,600 new mental health professionals, 300 new non-clinical support staff (such as scheduling clerks), and filling existing vacancies as of June 2012. The second part was the hiring of 800 peer specialist positions by December 31, 2013. As a result of this initiative, VHA hired approximately 5,300 new clinical and non-clinical mental health staff. As of the third quarter of fiscal year (FY) 2013, this included 1,667 new mental health staff, 304 non-clinical support staff, and 2,357 staff to fill existing mental health vacancies and those that opened during the initiative. As of December 31, 2013, VHA had hired 932 peer specialists. GAO found that VAMC officials reported local improvements due to the additional hiring, such as more evidence-based therapies offered, mental health care provided at new locations, and a variety of benefits provided by the new peer specialists such as modeling effective coping, engaging Veterans who are resistant to discussing mental health issues, and providing peer-to-peer counseling. VAMC officials also cited several challenges to hiring mental health care providers such as pay disparity with the private sector, competition among VAMCs, the

lengthy hiring process, lack of space and support staff, and an underlying nationwide shortage of mental health professionals.

At a national level, VHA outpatient mental health staff totals increased from 11,138 full-time equivalents in 2010 to 13,975 in FY 2014. Over the same time period, the number of Veterans receiving outpatient mental health care increased from 1,259,300 to 1,533,600. The increase in Veterans receiving mental health care outpaced both the related hiring and the overall growth in the number of Veterans using VHA services.

The recent rapid growth in the number of Veterans seeking mental health treatment in VA has posed challenges in the area of staffing. In Figure 1 below, the solid line shows the growth in numbers of Veterans using mental health services, from 897,600 in 2005 to 1,533,600 in 2014. The number of patients is expressed in terms of hundreds to show staff and patient numbers on the same graph. For example, 10,000 on the vertical axis represents 1,000,000 patients and 10,000 full time equivalents employees (FTEs).

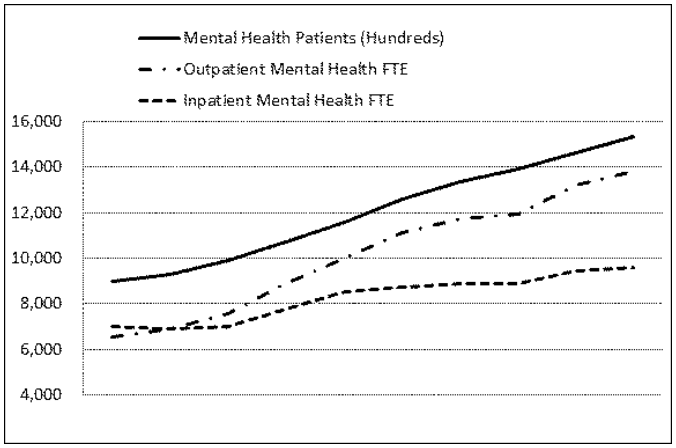


Figure 1. Growth in annual numbers of patients using mental health services and in outpatient and inpatient FTE levels, 2005 to 2014.

This graph also shows the growth in numbers of mental health clinical staff, measured in terms of the FTE providing outpatient and inpatient treatment. Consistent with a shift to outpatient care, the inpatient mental health FTEs began to level off after 2009. Outpatient mental health FTEs began to lag behind the growth in patient numbers in 2012, but as part of the President's 2012 Executive Order 13625, "Improving Access to Mental Health Servicemembers, and Military Families," VA hired more than 1,600 new clinical providers by the June 30, 2013, target date.

In the absence of any national benchmark related to mental health staffing, VA continues to refine a model that is intended to inform local facility decisionmaking about the number of staff necessary to meet local demand for mental health services. In addition, VA is addressing access through the following efforts:

- Veteran-centered operating hours: Extended hours help increase capacity when space is limited and improve the match between available staff hours and the needs of Veterans who are employed or have other competing responsibilities during daytime hours.
- Leveraging trainees and fellows: These professionals provide substantial amounts of clinical care under the direct supervision of appropriately licensed and privileged mental health staff. Training programs also provide ready access to well-qualified candidates for recruitment into vacant positions.
- Support staff, adjunct professions, and peer support staff: VA has hired over 900 peer specialists and is developing a pilot program in response to the President's August 2014 Executive Actions to expand the role of peer specialists into primary care settings.

COMMUNITY PROVIDER PILOT PROGRAM

In 2013, 12 VA medical centers (VAMCs) partnered with 24 Community Mental Health Clinics (CMHCs) across the country to establish Community Mental Health (CMH) pilots. These pilots were created in response to Section 3(a) of Executive Order 13625 which focused on the creation of "Enhanced Partnerships between the Department of Veterans Affairs (VA) and Community Providers" designed specifically to decrease wait times and increase the geographic reach of VA mental health services.

Pilot sites were able to select a model of care to best meet the needs of local Veterans. All sites used one of two broad approaches: Non-VA care or VA telemental health (TMH), with most sites choosing to provide Non-VA care to Veterans. Non-VA care uses community providers that are paid by VA. TMH care utilizes technology to deliver mental health services via modalities such as video conferencing and allows for real-time (or "synchronous") encounters between health care providers and patients who are not in the same location. During the VA/CMHC Pilot partnerships, TMH services enabled Veterans to receive care at designated community clinics that were closer to their homes than the nearest VA medical facilities or clinics.

VA and CMHC staff worked together in determining roles and responsibilities within each pilot partnership. Partnerships using telemental health required space, equipment, a technician, and a protocol for handling emergencies (e.g., a Veteran becoming distressed during a TMH session). For Non-VA care partnerships, there were other responsibilities that needed to be addressed: coordination of care (between VA and CMHCs), billing, and payment. While some pilot site VAMCs developed strong systems for coordinating care, monitoring patients, and billing, other sites, especially smaller ones, experienced challenges in these areas.

Evaluation of the pilots included both gathering data from not only Veterans about their experiences, but also from key staff at each of the participating Veterans Integrated Service Networks (VISN) and VA Central Office (VACO) and a review of key documents associated with the pilots. Results from follow up surveys indicate that Veterans were very satisfied with the services they received via these pilots. When the pilots concluded, each participating VAMC was allowed to determine whether to continue the partnership. Since that time, VA has also moved to Patient Centered Community Care, a centralized contracting mechanism, and has implemented the Veteran's Choice Program. Regardless of how such care is provided, the growing Veteran's need for mental health services will increase the need for efficient leveraging of Non-VA community providers when access to care is not available within the VA system of care. VA is rising to the challenge through its Community Mental Health Summit program which engaged over 11,000 individuals at 144 sites in FY 2014 and continues annually to bring together DOD, VA, State, and Community providers and stakeholders for vital conversations at the local level. VA and DOD developed a joint Military Cultural Competence Training Program as part of the Integrated Mental Health Strategy which is now housed on the public facing TRAIN Web site and which, to date, has provided free training to over 2,000 providers. Whether mental health care is delivered directly by Non-VA mental health care providers, through TMH care at Non-VA sites, or any other means, it is critical for VA to continue to provide Veterans with access to high quality mental health care in coordination with other VA services.

VA RESPONSE LETTER TO GAO REPORT

VA concurred with all of GAO's recommendations in its October 7, 2015, response and added some additional explanation for some of VA's policies.

Regarding the recommendation to clarify guidance on which deadline to use, VA cited VHA Handbook 1160.01, which established that all new patients requesting or referred to mental health services must receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The primary goal of the initial evaluation is to identify patients who require urgent care, such as hospitalization or immediate outpatient care. VHA's policy directs that patients needing mental health care receive clinically indicated care as quickly as possible.

VA explained that the 30-day policy was a result of a goal published in the *Federal Register* as required by the August 2014 Veterans Access, Choice and Accountability Act. VHA has since revised and tested its metrics and management process and is ready to update its policy to the 30-day standard consistent with the published goal, rather than a 14-day standard developed internal to VA for new mental health patients. Once the policy is updated, VHA will announce it on the appro-

priate national calls with key stakeholders. The target completion date for this recommendation is March 2016.

For patients who already have a mental health provider who need follow up care, VHA's policy of less than 30 days wait time from a Veteran's preferred dated is consistent with The Veterans Access, Choice and Accountability Act. Therefore, this policy does not require revision.

MANAGEMENT OF OPEN-ACCESS APPOINTMENTS

Open access, also known as same-day scheduling, is a method of scheduling in which all patients can receive an appointment on the day they call in or walk in. VHA's open access is an essential component of VHA's standard of care for conducting an initial mental health evaluation within 24 hours of a Veteran's request for care. As the identification of a Veteran who may need or request mental health services can occur at several entry points to care, each facility must have a defined process that identifies a "warm hand-off" to a professional who can conduct the same-day initial mental health evaluation and arrange any appropriate follow-up.

Open access scheduling for an initial mental health evaluation ensures that if during a visit to a treatment facility, a Veteran requests or is identified as needing a mental health assessment, it will be provided or at least offered to the Veteran who has the option to accept care prior to the Veteran's departure from the facility.

VHA Directive 2010–027, paragraph 4c(1) established the requirements for documenting same day unscheduled appointments. VHA conducted extensive scheduler training this year. To date, more than 23,000 schedulers have undergone training. VHA finds that the combination of current policy and training constitutes clear guidance on how to manage and schedule open access appointments. Many schedulers are still developing proficiency with the training, and therefore there are still occasional errors. VHA continues to aggressively monitor appointment management and identify areas of local inconsistency in scheduling procedures.

VA agrees with GAO's finding that one medical center was using inappropriate processes for scheduling open access appointments. VA continues to work with this facility to ensure their processes are aligned with VHA.

Mr. Chairman, VA is committed to providing the highest quality care our Veterans have earned and deserve. Our work to effectively and timely treat Veterans who desire or need mental health care and ensure Veterans have access to the counseling and care they need continues to be a top priority. We appreciate Congress' support and look forward to responding to any questions you may have.

Chairman ISAKSON. Thank you, Dr. Kudler.

You are the Chief Consultant at VA, is that correct?

Dr. KUDLER. Yes. That is the policy side of mental health in VA.

Chairman ISAKSON. OK. Are you a contractor or are you an employee?

Dr. KUDLER. I am an employee and I have been for over 30 years.

Chairman ISAKSON. The term "consultant" does not really mean what it does in the private sector, then.

Dr. KUDLER. It is an ancient title. I do not know where it comes from, sir.

Chairman ISAKSON. Very good. You painted a glowing picture, quoting a lot of statistics which I did not have time to write down because they were coming out pretty quick, and I want to acknowledge from the outset that since 2013, when I became interested in this subject, the VA has made some major strides to try to address the problems that were there for mental health. But, I do not think you can totally agree, as you said, with the report done by GAO and then make the defense that you made without recognizing there still are some shortcomings in the delivery of services at the VA, and that is what we are here to talk about today.

You said that the Veterans Administration this year, which is 10 months into the year, has trained 23,000 schedulers, is that correct?

Dr. KUDLER. Yes, sir.

Chairman ISAKSON. In the open access process?

Dr. KUDLER. Yes, sir. It is part of our response to the Choice Act.

Chairman ISAKSON. Right. Do you concur with the findings of Dr. Draper in the report or her comments that were made about the open access process?

Dr. KUDLER. Not entirely, sir. Not entirely. I believe open access is a way of matching supply and demand and drilling down to answer the questions that this Committee would like answered. Do you have enough supply of providers in those places to meet that demand? Open access allows us to do that. I may defer to Dr. Davies, who has some great expertise in that.

Dr. DAVIES. The word "open access" can mean different things to different people.

Chairman ISAKSON. I have learned that.

Dr. DAVIES. I think in the specific facility that the GAO visited, maybe two of them, they were using that term to run a clinic that sort of saved appointment slots and then said to veterans, go over there and try and get one of those. That is a prohibited practice, putting, you know, time slots on a list and saying, go over there. That is a prohibited practice. We appreciate GAO finding that. We contacted the facility as soon as we became aware of that. They have corrected the issue. We hope, and I know Dr. Carroll has done many site visits, that that is a rare or at least an unusual thing.

The word "open access," as a concept, is intended to mean you can get care without delay. It is the entry point. This is what we do in mental health in VA all the time. Whether you are in the emergency room, primary care, or in mental health, if you have a mental health emergency, you are evaluated within 24 hours initially. That is the intent.

We recognize it is a big system. It does not happen every single time reliably. At the same time, we think that most of the time it does.

Chairman ISAKSON. Well, it is a big system, and there are States like Montana and others that are big and where the population is separated by great distances where meeting those standards are very hard.

Dr. DAVIES. Right.

Chairman ISAKSON. We acknowledge that. I think the importance, at least I feel, is having dealt with mental health for a number of years and not being unfamiliar with the problem and the tragedy of suicide, timing of communication upon the first admission by the patient that they have got a problem is probably the most critical time of all.

Dr. DAVIES. Absolutely.

Chairman ISAKSON. The goal of the VA must be to see to it that somebody at risk for their own life, or indicates any tendency for that, gets immediate and fast help as reliably as possible wherever they may come from. And you think open access will accomplish that if it is used in the right way?

Dr. DAVIES. The term "open access" means walk-in first contact, and the system is designed so that when there is first contact, that veteran is evaluated and then referred for a full evaluation later. I must say that there are many veterans inside the system and

people who feel passionately about this who really are working to make the system work.

Chairman ISAKSON. I have no question whatsoever, and I want to thank Dr. Draper for making the statement she said about the many qualified, dedicated employees within VA are working hard. We are not here to castigate VA employees generically, but we are here to see to it that we can help the process improve dramatically to see to it that veterans in need get the services they need.

In terms of open access, if I understand it correctly, most of the open access is with contract providers in the community where the VA is located, is that right?

Dr. DAVIES. "Open access" means you can get care without delay. If we use that definition, then it exists anywhere there is an appointment available——

Chairman ISAKSON. Whether it is in the VA hospital itself, or in the CBOC, or probably not a CBOC——

Dr. DAVIES. Right.

Chairman ISAKSON [continuing]. But in a hospital or a local provider who is under contract with the VA, is that right?

Dr. DAVIES. Or not under contract and just access through Choice. Yes, that is correct.

Chairman ISAKSON. But you do have a relationship with those local vendors so they are willing to provide that service and you know the quality of service they are giving.

Dr. DAVIES. In many cases, we do, yes.

Chairman ISAKSON. In many cases.

Dr. DAVIES. Yeah.

Chairman ISAKSON. OK. Senator Blumenthal.

Senator BLUMENTHAL. Thank you.

Dr. Kudler, why does the VA continue to measure wait times from the preferred date that they express rather than from the date of the request for health care?

Dr. KUDLER. Almost all my years in VA have been years in the clinic, and in that clinic, I see a patient. We agree on a timeframe that is appropriate clinically and that they would like to come back. They go out and meet with a scheduler who sees my electronic order for when that is going to be. The patient and the scheduler take out their independent schedules and figure out, is that going to work for them or not. If it is not going to work, the scheduler calls me up and says, "Doc, that is not going to work. What is going to work best for him and from your medical point of view?" And we come up with a date.

That date is when the patient wants. The patient may want to be seen next week, or the patient may say, I am going to Montana to visit my uncle and I cannot be seen for 3 weeks and that is when it is going to be, and we will work out a plan.

In the meantime, we believe that it is appropriate to measure the date that the patient would like to be seen, not later, but also not sooner than the patient wants to be seen.

Senator BLUMENTHAL. But the patient's preferred date may depend on when she or he is told that there is an opportunity to see someone. In other words, the patient does not say, I am going to see somebody tomorrow. He is told, well, here are the suggested

dates, 2 weeks, 3 weeks from now. What is your preferred date, correct?

Dr. KUDLER. Yeah. That is like a card trick. We do not want to force the card. Here is your card. Is this not what you wanted? We want an honest, open conversation with the veteran. What makes sense for you, and does that make sense clinically, as well——

Senator BLUMENTHAL. I am talking about data, the reliability and trustworthiness of data. When the VA tells us and the world that the wait time is 3 days, how can we trust that when that wait time is the number of days from some date the veteran is given as a possible date and then expresses as a preference. That seems to me inherently unreliable.

Dr. DAVIES. Could I take a shot at that? My answer would be, because VA has a 30-year-old scheduling system, to your initial question, I do not know if you guys realize this, but the current VISTA scheduling system poster child for not working very well is in mental health, because an average psychiatrist in mental health does not have one schedule. They have seven schedules in mental health. That means you have to go to this schedule for PTSD, this schedule for military sexual trauma, this schedule for psychiatry, this schedule for alcohol treatment, and on.

Dr. KUDLER. All with the same provider. That is——

Dr. DAVIES. All with the same provider. Senator Blumenthal, we cannot measure waiting times the same way the rest of the world does, which, by the way, is a very hard thing to do anyway, right? We have invented this time-stamped method of measuring waiting times, which no other health care system that I am aware of uses.

Senator BLUMENTHAL. I apologize for interrupting you, but I have a limited amount of time. I think I get the thrust of your response, which is, to use Dr. Draper's word, this problem is systemic. It is one of leadership and management.

Dr. DAVIES. And IT.

Senator BLUMENTHAL. I will just finish my thought, and then invite yours. We should make sure when we talk about accountability in this body that we are demanding accountability from the right people. Senator Moran and I have talked about this, and other of my colleagues. When we talk about blaming a VA employee, the temptation is to look at that person who is doing the data entry using a messed up system. I could think of another word for "messed up." But, the systemic issues here really have to be overcome. I think we need to focus on an accountability measure that puts the blame and the responses to that fact finding and blame exactly where they should be, not simply having the you-know-what roll downhill, as we used to say.

Now, I want to ask one last question because it relates to the peer bill that I offered yesterday to expand the program that you have commented on, Dr. Kudler. I assume you would agree with me that the peer specialists, the veteran-to-veteran helping each other that Dean Maiers testified about and implemented so effectively at the Errera Center, should be expanded and should be integrated more effectively into the VA Health Care System. My understanding is that that has occurred only at about six to eight locations, and that is the reason why I have offered the legislation that

I have done. I invite you to comment briefly, and unfortunately, it has to be very briefly, on this issue.

Dr. KUDLER. Very briefly, there are 932 peer counselors across the country because we believe in them and we agree with you. It is an incredibly valuable program. It is a next step forward in evolving the VA.

Senator BLUMENTHAL. Thank you.

Thanks, Mr. Chairman.

Chairman ISAKSON. Senator Moran.

Senator MORAN. Mr. Chairman, thank you very much.

Doctors, thank you very much for your presence and testimony.

Let me briefly describe what I think the reason that the Choice Act was passed and ask you how it now works in the delivery of mental health services. I think the belief and the evidence was that the VA was incapable of providing the services that were needed by veterans in a timely fashion, in part because there were a lack of necessary professionals. In addition to that, it was designed to help meet the needs of veterans who live distances from a VA facility. So, two purposes.

If you look at the money, $15 billion got appropriated for the Department of Veterans Affairs, $5 billion of it to go to hire more professionals and $10 billion of it to pay for the services outside the VA in communities. I think the goal here was to alleviate the challenges that the VA has in being able to care for our veterans. It was fully designed to help veterans get the care they need.

My question is, what has transpired on the mental health side of things as a result of the Choice Act that has improved the access for veterans who live distances from a facility and the ability within the VA to have the necessary professionals to meet the needs of those who are within the VA being treated.

Dr. KUDLER. Well, Senator, the Choice Act has provided greater flexibility. It has allowed us to reach out, and with Congress's support, now to combine a number of different programs for reaching out into one and create a new business structure that supports that, which was an essential element and, I think, was the hardest part about implementing Choice, is creating that business piece that allowed us to work with folks.

We have a long way to go, and I want to go back to what was said by the IAVA representative, Dr. Maffucci, that the problem that we face still and that we have a lot of evolution to do, not just in VA but across the country, is it is not just any willing provider can provide this because most providers do not have the military cultural competence or the experience in treating deployment mental health issues that exists in VA.

We connect now with people. We can provide more care closer to the veteran's home. That is wonderful and Choice allows that. But now we have to raise the level of quality and the interoperability of our systems. If we cannot coordinate care with those folks, then we fragment that care instead. There are still challenges, but Choice has started us on a great path.

Senator MORAN. I certainly would not disagree with the need for quality care, but I also know that no care, or care that is delayed, the quality of that care is zero. In my view, the VA ought to be utilizing Choice to meet the needs as best we can of veterans who are,

either because of time or distance, incapable of being currently served within the VA.

You talked about quality care and the business model, so for years, before the passage of the Choice Act, I have been trying to convince the VA that they have an opportunity in my State of Kansas to contract with community mental health centers. These are, I think, 40 across the State. County commissioners levy property taxes to pay for these services. The State legislature and Governor contribute dollars. Across our very rural State, it is the only case in many instances that there is any access to health care. Our efforts pre-Choice and post-Choice have been pretty fruitless in accomplishing that.

I would ask, Dr. Kudler, is there someone that you could direct to meet with me and with representatives of Kansas mental health centers to have a direct conversation about how to accomplish—assuming that you agree with my goal—to put these providers and the VA together in a way that after all these years and in light of the passage of the Choice Act, which gives, I think as you say, more flexibility to you to do that and to pay at Medicare rates, it seems to me that we are missing an opportunity. I thought it was an opportunity years ago. I think it is an even greater opportunity now. I just need you to help me put the puzzle together so that it happens for real.

Dr. KUDLER. Sir, that is an opportunity it sounds like would be very important to develop, and I would gladly do anything I can to help investigate that and make that happen.

Senator MORAN. Please have somebody, you or someone, contact me and let us put the people who know the details of that in front of you.

Dr. KUDLER. There is a special team that has been developing the business rules, and I have a feeling that may be where this belongs, and I will make that happen.

Senator MORAN. I appreciate you saying that. I have 15 seconds only to remind you, Dr. Kudler, we had a conversation about a year ago about the hiring of particular mental health professionals, those being licensed professional mental health counselors and marriage-family therapists, and you indicated in your testimony that you had met with those folks, you had an interest with that. To paraphrase you, it is not happening as fast as any of us hope. But to be absolutely clear, I am dedicated to doing that. Has your dedication resulted in the additional hiring and, therefore, access to these professionals by veterans?

Dr. KUDLER. Not just in additional hiring, but we have actually, with the help of our Office of Academic Affiliations, created training programs internal to VA to actually produce these professionals in our own area so we can actually grow them ourselves and keep them when they have been trained.

Senator MORAN. The statistics would show that those professionals are now available and are being utilized by veterans?

Dr. KUDLER. They will show that, sir, and I still think it could be faster, and it will be faster. But, it is accelerating rapidly.

Senator MORAN. Thank you.

Chairman ISAKSON. Senator Tester.

Senator TESTER. Did I just hear you say that you have incorporated the marriage counselors? The veterans can already see them, not in the VA that you have trained yourself, but in the private sector?

Dr. KUDLER. I am sorry, sir. We have them in the VA and they do exist in the private sector——

Senator TESTER. And have they contracted—have you contracted with the folks outside the VA, the marriage counselors?

Dr. KUDLER. There has been a problem, and I may defer to Dr. Carroll on this. There has been a difficulty because the law stated, and this is not VA regulation, but the law stated that you have to have someone who meets Medicare standards, and my understanding is there is still some bump legislatively about licensed professional mental health counselors meeting Medicare standards.

Senator TESTER. OK.

Dr. KUDLER. This is not our wish.

Senator TESTER. We need to follow up on this, because, quite frankly, if we have to change the rules, we will change the rules. What you have in rural America is you have no service. You have no standard. You have got people who need help and there is nobody there except a marriage counselor, and that is why we put that bill through. We need to follow up on that.

Let me ask you, one of you said, and it might have been you, Dr. Kudler, or it could have been you, Dr. Davies, that mental health emergencies are seen within 24 hours. That is correct?

Dr. KUDLER. Yes, sir.

Senator TESTER. Is that off of the preferred date, or is that when they walk through the door, they are seen that quickly?

Dr. KUDLER. Yes——

Senator TESTER. Or when they call with an emergency, that they are seen——

Dr. KUDLER. If they call in an emergency, they will be seen within 24 hours. If they are actually there physically with us, they will be seen immediately.

Senator TESTER. OK. I would just say that, you know, I mean, I do not like to spend a lot of time, because as the Chairman said, you guys do a lot of things good and we need to reinforce the good, too, but that is not what we are talking about. We have put a lot of money into the VA, I have got to tell you. I mean, we have put a lot, and I have fought for every damn penny of it, and because the fact is, is that our veterans deserve it.

Dr. KUDLER. Yes.

Senator TESTER. To have a model, an IT model, when, by the way, you go down to Silicon Valley, you can go right outside of Bozeman, Montana, and find somebody that is still in college that can make you a scheduling program that will work. It is not that complicated, because they are doing stuff that is complicated.

We ought to be taking care of that, because the wait time, honest to God, the wait time is not the preferred date, and then if that gets moved. The wait time is when I call into my doctor and say I need an appointment, if it takes 2 weeks, I waited 2 weeks. If they do it then, it is immediate.

Dr. DAVIES. Right. What is published in the Federal Register is the method VA uses to measure wait times.

Senator TESTER. I know, and it is not accurate. I do not want to beat you up for it, but the fact, we can debate it, but it is not accurate, because when I call for a doctor's appointment, when I call and they schedule me on the 20th, that is a 20-day wait if I call the first of the money. OK? See what I am saying?

Dr. DAVIES. I do.

Senator TESTER. I got what you have got, and I know you are meeting your metrics, but that is not really giving us an idea——

Dr. DAVIES. I—I——

Senator TESTER [continuing]. Because when I talk to the veteran and they said, you know what, I had to wait too long; then I talk to you guys and you say, well, no, it was only five, 5 days is it. We are not talking about the same standard here.

Dr. DAVIES. You are correct, and I agree with you.

Senator TESTER. Yes.

Dr. DAVIES. I want to point out that we—about 5 percent of all of our 55 million appointments that are completed a year are new patients——

Senator TESTER. Yes. Yes.

Dr. DAVIES [continuing]. And that is a very different experience than an established patient.

Senator TESTER. You are not just kidding.

Dr. DAVIES. We need to measure that——

Senator TESTER [continuing]. We hear about those new patients all the time, because getting through the door is the big problem.

Dr. DAVIES. Right.

Senator TESTER. Let me ask you about something that is what I want to talk about, and that is we heard in the previous panel about Vet Centers and how important those Vet Centers are. Do you guys have any input on when it comes to what the plans are for Vet Centers and increasing the number of Vet Centers?

Dr. KUDLER. Sir, I am not aware of that. Uh——

Senator TESTER. OK. OK. OK. We should. I mean, the truth is, if you are talking to your vets—I talk to vets all the time—they are saying Vet Centers work, and those Vet Centers are not talking to professionals, they are talking to professional soldiers that have been in the field and they can share, you ought to be pushing that kind of stuff. That is all I am telling you. It is important, because in a place like rural Montana, if you can get vets together and they can hammer it out, you might not need some expensive psychiatrist, OK?

Dr. KUDLER. Agreed.

Senator TESTER. All right. I would just encourage you to push.

And, telemental health; what is going on there? What are your plans to expand that, or are there no plans to expand it?

Mr. CARROLL. Sure. We are trying to expand it. It is very important in terms of access——

Senator TESTER. What are you doing to try to expand it?

Mr. CARROLL. We are working on a regulation so that there will be a standard credential, when a provider is in Wisconsin and providing services to a facility in Texas that there can be a national system for credentialing. They do not—and we are also looking at expanding telemental health into veterans' homes——

Senator TESTER. When do you anticipate the credentialing portion of this will be done?

Mr. CARROLL. I do not know, sir.

Senator TESTER. OK.

Mr. CARROLL. It is being handled by our Telehealth Office.

Senator TESTER. OK. One last thing, and then I will go, and that is that I live in Montana. I am in one of the rural States. I farm. I do not compare myself to my neighbors. If I am as good as my neighbor, that is not success. I have got to be better than my neighbor, OK.

When you compare yourself to the private sector, I will just tell you, they have got their problems, too. We have got to be better than the private sector, OK. To say that, you know, our access times are as good and our treatments are as good, that is not good enough. We have got to be better, OK.

The RAND Corporation did this survey for you. I got it. But, the truth is, we are losing a bunch of folks in the private sector, too, that are committing suicide every day. We have a little different standard for the folks who served this country, because if we screwed them up, we ought to fix them, OK?

Dr. KUDLER. Sir, rural Americans commit suicide at the same rate as veterans do——

Senator TESTER. You are exactly right.

Dr. KUDLER [continuing]. And I chose a career in the VA because I believe it is a better system.

Senator TESTER. Got you. We need to make sure it is a better system.

Dr. KUDLER. Yes, sir.

Senator TESTER. When you say we are just as good as the private sector, that is not good enough, OK.

Thanks, guys. Thanks for your work. For the record, I did not get into all the stuff you guys are doing well. You are doing some really good stuff, and we still need to do better.

Dr. KUDLER. Agreed, sir.

Chairman ISAKSON. Senator Tillis, followed by Senator Boozman.

Senator TILLIS. That is where I was going to start, where I think Senator Tester left off. I always try to start by saying you all do a lot of great things. I have gone to all my hospitals in North Carolina and some of the health centers. There are a lot of motivated, dedicated people down there. It is as if we have got these incredibly dedicated workers in a factory that is about 30 years old and that we do not have the right assembly line, we do not have the right systems infrastructures, we do not have modern, in some cases, modern management structures that are needed. Have no doubt about it, I think that there are a lot of good people that are working hard.

Dr. Davies, I wanted to just reinforce your comment about old systems and some of the problems that that creates. Senator Brown and I are working on a bill that over 10 years will provide about $6.2 million in benefits to the families of veterans who died in combat. We found out that in over a year, it is going to cost $5.1 million to modify the system to allow those veterans to receive the benefit. Those ratios are unacceptable. We have to figure out what we are doing from a people process technology perspective to give

you all better tools to do the job I firmly believe you all want to do.

I wanted to go back to Dr. Kudler. On page nine of the written testimony that has to do with the VA letter, or, actually, I guess, the response to the GAO report, I may just be misunderstanding what you are doing to clarify it. It sounds like as a result of the Choice bill, that we are moving from a 14-day standard to a 30-day standard. That seems like it is getting longer. Tell me why that is a good thing.

Dr. KUDLER. Yes. Well, I am glad you asked that question because it is a key question. The 14-day standard was totally arbitrary. It was pulled out of the air some years ago. There was no community standard to go against to say this is a good thing or a bad thing. It was just, what should it be? How about 14 days.

We have been diverting resources from more comprehensive care to trying to meet a standard that has no clinical basis. Instead, when the Choice Act came out, we looked at what the Choice Act said in the Federal Register. Thirty days is the standard for all appointments in VA. And, we said, this is our opportunity to take something that was arbitrary and actually diverting resources.

Yes, emergencies must be seen emergency, and yes, we realize that that does not always happen, and with the help of the two gentlemen on either side of me, we are trying to fix that by drilling down with the data.

But the 30 days is the standard that the Choice Act said. That is what we are going to get to. We are still going to be doing care as it is clinically appropriate. Thirty days does not mean you will now wait 30 days. It means, if you are not seen within 30 days, something is wrong and we will be there asking the questions.

Senator TILLIS. Thank you. Another question really relates to long-term. What we are talking about today are the challenges we have with just the current inflow of potential patients. What sort of modeling have we done? I mean, are we going to have more stress on the system going forward? In other words, do we see a kind of leveling, or how much more stress is going to be placed on the problems you are already trying to address just by an increased patient population?

Dr. KUDLER. Yeah. Great question, and I may ask my friends to help me on this. But, let me start by saying, 22.5 million American veterans, only about nine million of them enrolled in VA. About six million users per year, and that includes veterans of all eras. But, if you look just at the newest generation, roughly three million people have served in Iraq and Afghanistan during these conflicts. Half of them who are already eligible for VA have been to us, and more than half of them have at least one mental health diagnosis, and that is because we are asking about things we never asked previous generations about. This generation is also more vocal, has less stigma, wants help.

Senator TILLIS. A mental health diagnosis related to their service?

Dr. KUDLER. A mental health diagnosis, period, sir. But in most cases, the most common one is post-traumatic stress disorder.

Senator TILLIS. OK.

Dr. KUDLER [continuing]. Followed with depression, substance abuse, problems like this. People are asking us for more. It is more intense. It is a younger generation. It is fresh trauma. It is not looking back 30 years, although that is quite complicated in itself.

There are new demands. They are increasing. They are changing. Our workforce and our training has to shift to meet that balance. But, we are trying to model it. Women veterans are being another issue. Let me pause for my colleagues. Go ahead.

Dr. DAVIES. No, I think that is right.

Mr. CARROLL. That is a good answer.

Senator TILLIS. OK. Thank you.

I will yield back my 5 seconds, Chairman Isakson.

Chairman ISAKSON. Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman.

Dr. Kudler, as you know, on the Committee, there is just a number of us from rural States and the huge challenge is mental health care in these areas, in our rural communities. In 2013, the VA established a pilot program at various VAMCs to partner with local community health care clinics. The pilot is now over. Some of the VAMCs have maintained their partnerships with the community health clinics while others have ended it. Can you talk a little bit about that? I guess, you know, in Arkansas, we have got significant problems. We have got community health care in all of our counties. Can you talk about why if we are using that, if not, why we are not using these resources through the Choice Act or whatever.

Dr. KUDLER. Sir, to keep it short, I think we are using it, but we are not using it as well as we can. I think that these projects were wonderful, including the public-private partnerships. The Choice Act innovations in that, Project ARCH, very big in rural areas, but still a fairly small program overall.

Now, with the chance to roll these together into one program, I think we can get this right, both the clinical and the business end, using geospatial modeling for figuring out where the demand is and how to best match it with the needs of the veterans and what capacity already exists in VA.

Senator BOOZMAN. One of the problems that we have with the outside providers is that the VA does not pay in a timely way. Can you address that? I mean, I guess the question is, why can we not pay our bills on time?

Dr. DAVIES. Well, sir——

Senator BOOZMAN. The problem is, is that many of these individuals do this because of the bureaucracy, because of all the other stuff, they do it because they want to serve veterans. We are a nation at war, and we can get them to do that. But when you have the bureaucracy and you simply do not get paid in a very timely way, it just exacerbates it. My concern is that we are losing providers simply because they get to the point they just do not want to fool with it any more.

Dr. DAVIES. I would just offer that I agree with you. You are right. We have heard that, also. We are in a very dynamic environment with these different changing rules and processes, and I know the business office is working hard to improve it. That is the extent

of it that I could say at this point. It has changed so much that they have not been able to standardize it.

Dr. KUDLER. Well, we will gladly join you in putting our shoulder to that. You are absolutely right. We reduced capacity through a business problem.

Senator BOOZMAN. Right. It is a huge problem.

Dr. Carroll, earlier, Mr. Karnaze testified about his experience at the VA and essentially being prescribed medicine. The medication did not help him. In fact, in his case, as with others, the medication actually made him worse. He quit using it and then again was not offered other forms of therapy that could have helped him. Can you tell us again what we are doing to address that problem, and are we just throwing pills at people in an effort to say that we are doing something?

Mr. CARROLL. That certainly is not our goal or our mission at this point. I think we are priding ourselves in that our standard is to offer a comprehensive continuum of care, and in the outpatient spectrum, that may include medications. But it would include psycho-social treatments, evidence-based psychotherapies. It would involve group. It may involve case management. We are also looking at complementary and alternative medicine options. Our goal is to offer an entire continuum of care.

One of the ways that we are trying to put that in place at medical centers is through creating teams within outpatient mental health clinics, behavioral health, interdisciplinary teams, so that the veteran is not just interacting with one provider who may be a prescriber, or it may be a psychotherapist. The veteran is working with a team and the team can work with that veteran to find the care that is most appropriate.

Senator BOOZMAN. Well, as described by this patient, I mean, that was simply irresponsible. I think we are getting a little bit better at that than we used to be, but it is something that we simply cannot tolerate. Again, it is kind of like why can we not pay our bills on time. I understand that better than I understand this in the sense that it just does not seem like that is standard of care.

Mr. CARROLL. Sir, if I may add one thing, and it goes to something that Senator Blumenthal said earlier in terms of the importance of peer support services in VA, Dr. Kudler has testified that we have increased the number of peer support providers. But the statistic that I think is very promising is that in 2013, we had just under 900,000 visits or encounters with the peer specialists. Last year, we had over 2.7 million. This is an additional resource, and to your question about how can we help providers look at things, if there is a peer support provider on that mental health team in a clinic, it also adds a whole another dynamic.

Senator BOOZMAN. Good. Thank you, Mr. Chairman. Thank you all for being here.

Chairman ISAKSON. Dr. Carroll, just one question. When we had the testimony from Dean Maiers about his experience, I believe you said it was the Arena Clinic, is that right?

Mr. MAIERS. Errera, sir.

Chairman ISAKSON. Errera.

Mr. MAIERS. E-r-r-e-r-a.

Chairman ISAKSON. Are you familiar with that clinic?

Mr. CARROLL. Yes, I am, sir.

Chairman ISAKSON. Is that a quasi-VA facility, or is it a total——

Mr. CARROLL. No, it is a VA facility. It is a center. They have put together their homeless program, their community outreach programs for mental health, their peer support programs, supportive employment programs, all in the same center. It is a remarkable place.

Dr. KUDLER. I just have to mention, Paul Errera was my first teacher when I started training at the West Haven VA, and one reason I took this job is he had this job. He went to take it when I was his student and I thought maybe I could try to follow in his footsteps. I am so glad to hear his name conjured with here.

Chairman ISAKSON. I ran a company and we used a lot of peer challenges and peer support to motivate people to meet higher standards, and it would seem to me if you had something that was that good, based on the testimony of veterans and what you obviously both know yourselves, that ought to be the gold standard in the VA as to how each VA mental health center ought to operate. There ought to be some way we promoted that to give them a role model and an example within the agency of what really can be done.

Mr. CARROLL. Yes, sir.

Chairman ISAKSON. I guess you are ultimately responsible for mental health operations?

Mr. CARROLL. Yes, sir.

Chairman ISAKSON. One day, we will have a chat. I am going to be over there Friday morning of next week. Maybe we can get a chance to talk for a few minutes. I would like to see exactly how you all are organized and how you follow through on that.

Mr. CARROLL. Yes, sir.

Chairman ISAKSON. Thank you very much, Dr. Carroll. Thanks to all of you for your testimony.

Unless there is any other—I guess am next to last. We are—the two most important ones are left, Boozman and me. [Laughter.]

This hearing is adjourned.

[Whereupon, at 4:33 p.m., the Committee was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. VA officials testified that the Department's use of Peer Specialists has increased over the past several years. Please provide the Committee with data on the following aspects of VA's use of Peer Specialists:

Question 1a. The numbers of Peer Specialists staff and encounters with Peer Specialists within VA by location and by assigned unit (e.g primary care, behavioral health, etc.).

Response. Please see attached.

Peer Support Specialist Onboard

Data Source: VHA PAID data via VSSC ProClarity Data Cube excluding Veterans Canteen Service (VCS), intermittent, non-pay, medical residents, and trainees with assign codes T0-T9 current as of 10/31/15

STATION	0101 SOCIAL SCIENCE/18 PEER SPECIALIST	0102 SOCIAL SCIENCE AID & TECHNICIAN/03 PEER SPECIALIST	0102 SOCIAL SCIENCE AID & TECHNICIAN/04 PEER SUPPORT APPRENTICE	
(V01) (402) HCS TOGUS ME		3	2	5
(V01) (405) MROC WHT RIVER JCT VT		5		5
(V01) (518) MC BEDFORD MA		12	1	13
(V01) (523) HCS BOSTON MA		3	4	7
(V01) (608) MC MANCHESTER NH		4	1	5
(V01) (631) MC NORTHAMPTON MA		7		7
(V01) (650) MC PROVIDENCE RI		3		3
(V01) (689) HCS WEST HAVEN CT		25	5	30
(V02) (528) HCS BUFFALO NY		13	8	21
(V03) (526) MC BRONX NY		3		3
(V03) (561) HCS EAST ORANGE NJ		5	1	6
(V03) (620) HCS MONTROSE NY		2	3	5
(V03) (630) HCS NEW YORK NY		6	2	8
(V03) (632) MC NORTHPORT L I NY		4		4
(V04) (460) MROC WILMINGTON DE		5		5
(V04) (503) MC ALTOONA PA		3		3
(V04) (529) MC BUTLER PA		4		4
(V04) (540) MC CLARKSBURG WV		3		3
(V04) (542) MC COATESVILLE PA		7		7
(V04) (562) MC ERIE PA		2	1	3
(V04) (595) MC LEBANON PA		7		7
(V04) (642) MC PHILADELPHIA PA		5		5
(V04) (646) HCS PITTSBURGH PA		8		8
(V04) (693) MC WILKES BARRE PA		5		5
(V05) (512) HCS BALTIMORE MD		11	1	12
(V05) (613) MC MARTINSBURG WV		5	4	9
(V05) (688) MC WASHINGTON DC		8	4	12
(V06) (517) MC BECKLEY WV		3		3
(V06) (558) MC DURHAM NC		9		9
(V06) (565) MC FAYETTEVILLE NC		5		5
(V06) (590) MC HAMPTON VA	1	10		11
(V06) (637) MC ASHEVILLE NC		7		7
(V06) (652) MC RICHMOND VA		4	2	6
(V06) (658) MC SALEM VA		1		1
(V06) (659) MC SALISBURY NC		11		11
(V07) (508) MC ATLANTA GA	1	23		24
(V07) (509) MC AUGUSTA GA		3		3
(V07) (521) MC BIRMINGHAM AL		9	1	10
(V07) (534) MC CHARLESTON SC		12	1	13
(V07) (544) MC COLUMBIA SC		14		14
(V07) (557) MC DUBLIN GA		4	1	5
(V07) (619) HCS MONTGOMERY AL		6	1	7
(V07) (679) MC TUSCALOOSA AL		5		5
(V08) (516) MC BAY PINES FL		20	2	22
(V08) (546) MC MIAMI FL		9		9
(V08) (548) MC W PALM BEACH FL		11	3	14
(V08) (573) HCS GAINESVILLE FL		13	4	17
(V08) (672) MC SAN JUAN PR	2	4		6
(V08) (673) MC TAMPA FL		9		9
(V08) (675) MC ORLANDO FL		14	6	20
(V09) (581) MC HUNTINGTON WV		2	1	3
(V09) (596) MC LEXINGTON KY		4		4
(V09) (603) MC LOUISVILLE KY		6	1	7
(V09) (614) MC MEMPHIS TN		8		8
(V09) (621) MC MOUNTAIN HOME TN		7	1	8
(V09) (626) HCS NASHVILLE TN		9		9
(V10) (538) MC CHILLICOTHE OH		3	1	4
(V10) (539) MC CINCINNATI OH		6		6
(V10) (541) MC CLEVELAND OH		18	3	21
(V10) (552) MC DAYTON OH		5		5

STATION	0101 SOCIAL SCIENCE/18 PEER SPECIALIST	0102 SOCIAL SCIENCE AID & TECHNICIAN/03 PEER SPECIALIST	0102 SOCIAL SCIENCE AID & TECHNICIAN/04 PEER SUPPORT APPRENTICE	
(V10) (757) ACC COLUMBUS OH		3	3	6
(V11) (506) HCS ANN ARBOR MI		7	1	8
(V11) (515) MC BATTLE CREEK MI		12		12
(V11) (550) HCS DANVILLE IL		6		6
(V11) (553) MC DETROIT MI		12		12
(V11) (583) MC INDIANAPOLIS IN		4	1	5
(V11) (610) HCS MARION IN		9		9
(V11) (655) MC SAGINAW MI		6		6
(V12) (537) HCS CHICAGO IL		5	1	6
(V12) (556) FHCC NORTH CHICAGO IL		2		2
(V12) (578) MC HINES IL		8		8
(V12) (585) MC IRON MOUNTAIN MI		3	2	5
(V12) (607) MC MADISON WI		5		5
(V12) (676) MC TOMAH WI		6	1	7
(V12) (695) MC MILWAUKEE WI	1	6	3	10
(V15) (589) HCS KANSAS CITY MO		12	2	14
(V15) (657) HCS ST LOUIS MO	1	16		17
(V16) (502) MC ALEXANDRIA LA	1	2	1	4
(V16) (520) HCS BILOXI MS		12		12
(V16) (564) MC FAYETTEVILLE AR		7	2	9
(V16) (580) MC HOUSTON TX		20		20
(V16) (586) MC JACKSON MS		4	2	6
(V16) (598) HCS LITTLE ROCK AR		5	4	9
(V16) (623) MC MUSKOGEE OK		5		5
(V16) (629) HCS NEW ORLEANS LA	1	4	3	8
(V16) (635) MC OKLAHOMA CITY OK		5		5
(V16) (667) MC SHREVEPORT LA		7		7
(V17) (549) HCS DALLAS TX		21	3	24
(V17) (671) HCS SAN ANTONIO TX		7	1	8
(V17) (674) HCS TEMPLE TX		14		14
(V17) (740) HCS HARLINGEN TX	1	2		3
(V18) (501) HCS ALBUQUERQUE NM		5		5
(V18) (504) HCS AMARILLO TX		4		4
(V18) (519) HCS BIG SPRING TX			2	2
(V18) (644) MC PHOENIX AZ		14	2	16
(V18) (649) HCS PRESCOTT AZ		6	2	8
(V18) (678) HCS TUCSON AZ		7		7
(V18) (756) HCS EL PASO TX		4		4
(V19) (436) HCS FT HARRISON MT		2		2
(V19) (442) MROC CHEYENNE WY		2	2	4
(V19) (554) HCS DENVER CO		16	2	18
(V19) (575) MC GR JUNCTION CO		1	1	2
(V19) (660) HCS SALT LAKE CITYUT		7		7
(V19) (666) HCS SHERIDAN WY		3		3
(V20) (463) HCSROANCHORAGE AK		4	2	6
(V20) (531) MC BOISE ID		3		3
(V20) (648) MC PORTLAND OR		5	3	8
(V20) (653) HCS ROSEBURG OR		10		10
(V20) (663) HCS SEATTLE WA		4		4
(V20) (668) MC SPOKANE WA		3	3	6
(V20) (687) MC WALLA WALLA WA		4		4
(V20) (692) SORCCWHITE CITY OR		7	3	10
(V21) (459) HCS HONOLULU HI		5	5	10
(V21) (570) HCS FRESNO CA		4	4	8
(V21) (612) HCS MARTINEZ CA	1	8	1	10
(V21) (640) HCS PALO ALTO CA		11		11
(V21) (654) HCS RENO NV		4		4
(V21) (662) MC SAN FRANCISCO CA		10	1	11
(V22) (593) HCS LAS VEGAS NV		10	2	12
(V22) (600) HCS LONG BEACH CA		9	4	13
(V22) (605) MC LOMA LINDA CA		12		12
(V22) (664) HCS SAN DIEGO CA		8	1	9
(V22) (691) HCS W/LOS ANGELES CA	1	45	10	56
(V23) (437) HCS FARGO ND		1		1
(V23) (438) HCS SIOUX FALLS SD		2		2

STATION	0101 SOCIAL SCIENCE/18 PEER SPECIALIST	0102 SOCIAL SCIENCE AID & TECHNICIAN/03 PEER SPECIALIST	0102 SOCIAL SCIENCE AID & TECHNICIAN/04 PEER SUPPORT APPRENTICE	
(V23) (568) HCS FORT MEADE SD		2	1	3
(V23) (618) HCS MINNEAPOLIS MN		3		3
(V23) (636) HCS OMAHA NE		20		20
(V23) (656) HCS ST CLOUD MN		2	1	3
TOTAL	11	946	147	1104

Question 1b. The number of female Peer Specialists employed by VA for each of the past three years.

Response. Information attached is provided for fiscal year (FY) 2013–2016.

Female Peer Support Specialist Onboard

Data Source: VHA PAID data via VSSC ProClarity Data Cube excluding Veterans Canteen Service (VCS), intermittent, non-pay, medical residents, and trainees current as of 10/31/15

	FY13	FY14	FY15	OCT-FY16
0101 SOCIAL SCIENCE/18 PEER SPECIALIST		2	4	4
0102 SOCIAL SCIENCE AID & TECHNICIAN/03 PEER SPECIALIST	68	126	168	165
0102 SOCIAL SCIENCE AID & TECHNICIAN/04 PEER SUPPORT APPRENTICE	75	44	35	35
TOTAL	143	172	207	204

Data Source: VHA PAID data via VSSC ProClarity Data Cube excluding Veterans Canteen Service (VCS), intermittent, non-pay, medical residents, and trainees current as of 10/31/15.

Question 1c. The number of female Veterans' encounters with Peer Specialists by era of service.

Response. Information attached is provided for FY 2015.

Peer Specialist Encounters for Females by Era of Service

Period of Service	Encounters
Persian Gulf War	13,3776
Post-Vietnam	76,752
Vietnam Era	28,514
Other or None	1,799
Other Non-Veterans	1,325
Champva—Spouse, Child	829
Post-Korean	423
Korean	356
TRICARE	86
Humanitarian (Non-Vet)	65
World War II	62
Air Force—Active Duty	24
Army—Active Duty	14
Missing	8
Navy, Marine—Active Duty	6
Special Studies (Non-Vet)	4
World War I	4
Coast Guard—Active Duty	1

Question 2. VA has undertaken a campaign for gun safety among veterans including mass media, other messaging, and dissemination of gun locks. Please provide the following specific information regarding VA's gun safety campaign:

Question 2a. General overview and any relevant web links to VA's gun safety campaign.

Response. In FY 2014, VA developed an outreach video to emphasize the importance of recommended practices for safe storage of firearms. In addition to the out-

reach video, VA designed a poster to increase awareness of the importance of gun safety that includes information on acquiring freely-available gun safety locks.

The outreach video is primarily used by VA staff in support of community outreach and education efforts. Simple actions can help individuals and families stay safe, especially during emotional or stressful times, or when someone in the home is in crisis. This video encourages Veterans, Servicemembers, and their families to make sure guns and ammunition are safely secured in their home, particularly when someone is experiencing a period of depression or crisis. Content and messaging for the video was developed with assistance from subject matter experts at the Harvard Injury Control Research Center and the National Shooting Sports Foundation. The video is available on the Veterans Health Administration YouTube page, at http://www.youtube.com/watch?v=-fGHTvTsApg&feature=youtu.be

The poster was created using images and messaging from the gun safety video. The poster provides information on where to watch the video and where to obtain free gun safety locks, which are available at VA medical facilities or from local law enforcement.

GUN LOCKS

The promotion of widely supported practices for storage and use of firearms is a critical public health and safety intervention that has been shown to reduce deaths from intentional and unintentional firearm injury. Research suggests that firearms are present in more than one third of all homes with children. In addition Veterans of military service are more likely than civilian populations to own firearms. Distribution of gun safety locks is an important component of a firearm safety program that seeks to reduce injury and mortality among Veterans and their families.

Gun locks are provided to all VA facilities and VA Suicide Prevention Coordinators as tools to use in patient safety programs and in support of safe gun storage practices, especially for Veterans who may be at high risk for suicide. In FY 2010–2012, VA conducted a gun safety pilot program in partnership with the National Shooting Sports Foundation (NSSF). Through this program, more than 1.5 million gun safety locks and several thousand Project ChildSafe educational brochures were distributed to Veterans and their families. Response to that program was overwhelmingly positive and has led to continued collaboration with NSSF and continued distribution of gun safety locks to VA medical centers and program offices. Gun safety education and awareness materials are also provided in addition to gun locks which are available to Veterans who ask for one.

ONGOING AND FUTURE EFFORTS (FIREARM SAFETY OUTREACH TOOLKIT & TRAINING)

VA has developed a firearm safety outreach toolkit which was disseminated to VA, government and community partners, and the public in June, 2015. The online toolkit helps support teaching of firearm safety by community members, VA clinicians and staff, and the public, and will contain the videos already described as well as printable brochures and materials. VA has initiated discussions with national leaders in the development and dissemination of educational materials promoting safe firearm storage and use. VA has proposed support for the development of a community toolkit that would include educational materials, blueprints for community organization, messages for use with local media, promotional items, implementation support from a recognized leader in firearm safety, and support for implementation in select sites through coordination with Veteran Service Organizations. The proposed toolkit would buildupon existing educational material for programs such as Project ChildSafe, a national education and gun safety lock distribution program designed to increase safe gun storage practices in homes with children.

Question 2b. The number of gun locks that VA has disseminated in its gun safety efforts.

Response. In 2014, VA disseminated 250,000 gun locks to Veterans who requested them. In 2015, 1,038,388 gun locks were disseminated from VA's Suicide Prevention Program to Veterans who requested them with no questions asked.

Question 3. VA officials have noted that they are awaiting analysis of suicide data by the Centers for Disease Control and Prevention before publishing updated veteran suicide data. Please provide a specific timeline for when the new data on veteran suicide rates will be available.

Response. Data for the years 2012–2013 have been transferred to the Centers for Disease Control and Prevention (CDC) for linkage with cause of death information available from the National Death Index. CDC is processing this information and expected to return results from this search within the next 60–90 days. Once received from CDC, VA will process results from the search and calculate rates for these years. The process of data validation and analysis is expected to take an addi-

tional 60–90 days. Barring any unforeseen delays, VA expects updated information on rates of suicide to be available within the next 120–180 days (approximately February-May 2016).

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BILL CASSIDY TO U.S. DEPARTMENT OF VETERANS AFFAIRS

DATA ON MENTAL HEALTH SERVICES AT THE VA

Question 4. Please provide the following information on the mental health services delivered at VHA facilities from 2013–2015 and include:

Question 4a. The number of visits and if this number of visits includes "no shows."

Response. Mental health outpatient encounters (does not include "no shows"):

Fiscal year (FY) 2013: 18,048,772
FY 2014: 19,637,837
FY 2015: 20,797,166

Question 4b. If the number of visits includes the number of no-shows, what is the percent of visits that are "no shows."

Response. Does not include "no shows"

Question 4c. The mean and median wait times for a vet to obtain a mental health appointment at VHA facilities, not including ER visits

Response. The mean (average) waiting times for Primary Care, Specialty Care, and Mental Health (MH) are reported in this data (link) by facility. Veterans Health Administration Support Service Center (VSSC) does not calculate median waiting times. http://www.va.gov/HEALTH/docs/DR34_112015_Retrospective_Wait_Times_Desired_Date_by_Division.pdf

Question 4d. Does the above data vary by VHA facility? What is the range of number of visits per provider, number of visits minus no shows, mean and median wait times to obtain an initial MH visit?

Response. VA cannot provide a meaningful range of the number of visits per mental health provider because the data vary so greatly based on factors such as type of provider, type of service being provided, and amount of time assigned to an outpatient clinic.

The following information is given regarding mean wait times for an initial MH visit in FY 2014 and FY 2015. These data are not available for FY 2013. VSSC does not calculate median waiting times.

	FY14 Average New Patient Wait from Preferred Date	FY14 Average New Patient Wait from Create Date	FY15 Average New Patient Wait from Preferred Date	FY15 Average New Patient Wait from Create Date
(V01) (402) Togus, ME	2.8	14.3	4.9	17.0
(V01) (405) White River Junction, VT	.9	4.8	2.4	5.2
(V01) (518) Bedford, MA	2.9	6.4	4.6	7.8
(V01) (523) VA Boston HCS, MA	4.9	9.9	6.2	11.0
(V01) (608) Manchester, NH	3.3	10.6	2.7	16.7
(V01) (631) VA Central Western Massachusetts HCS	3.1	7.2	4.2	10.1
(V01) (650) Providence, RI	4.3	9.2	5.9	13.0
(V01) (689) VA Connecticut HCS, CT	2.9	7.0	2.2	7.9
(V02) (528) Albany, NY	1.7	8.7	2.0	11.3
(V02) (528) Bath, NY	.5	10.5	3.7	8.7
(V02) (528) Canandaigua, NY	3.0	8.2	5.5	11.0
(V02) (528) Syracuse, NY	1.8	15.1	3.6	15.2
(V02) (528) Western New York, NY	2.5	10.9	3.4	12.7
(V03) (526) Bronx, NY	2.0	10.9	3.6	11.7
(V03) (561) New Jersey HCS, NJ	1.6	13.9	2.7	11.6
(V03) (620) VA Hudson Valley HCS, NY	.9	9.2	2.5	10.6
(V03) (630) New York Harbor HCS, NY	3.8	12.9	5.4	13.2
(V03) (632) Northport, NY	1.8	8.7	1.7	9.3
(V04) (460) Wilmington, DE	4.7	13.7	8.6	15.2
(V04) (503) Altoona, PA	1.7	10.3	1.9	9.5
(V04) (529) Butler, PA	.7	9.9	.6	11.1
(V04) (540) Clarksburg, WV	2.2	10.0	8.0	14.3
(V04) (542) Coatesville, PA	1.9	9.8	2.6	10.3
(V04) (562) Erie, PA	1.0	6.4	.8	7.3
(V04) (595) Lebanon, PA	.5	12.4	8.6	16.9
(V04) (642) Philadelphia, PA	7.2	11.4	9.7	14.2
(V04) (646) Pittsburgh, PA	.7	9.2	2.1	9.7
(V04) (693) Wilkes-Barre, PA	.6	8.8	1.6	14.1
(V05) (512) Baltimore HCS, MD	1.4	9.0	2.1	16.1
(V05) (613) Martinsburg, WV	2.6	10.3	5.2	12.5
(V05) (688) Washington, DC	4.4	10.8	5.9	12.8
(V06) (517) Beckley, WV	2.8	7.5	2.9	5.7
(V06) (558) Durham, NC	1.8	18.7	2.5	14.9
(V06) (565) Fayetteville, NC	5.4	12.4	7.9	15.0
(V06) (590) Hampton, VA	3.2	12.4	5.9	13.4
(V06) (637) Asheville, NC	1.1	8.9	2.2	14.7
(V06) (652) Richmond, VA	2.5	14.9	7.4	15.6
(V06) (658) Salem, VA	.7	12.6	.6	7.8
(V06) (659) Salisbury, NC	4.4	16.6	6.0	15.9
(V07) (508) Atlanta, GA	.5	7.6	.8	7.0
(V07) (509) Augusta, GA	2.0	14.5	3.1	10.8
(V07) (521) Birmingham, AL	2.4	10.0	3.6	11.4
(V07) (534) Charleston, SC	5.0	11.0	3.2	8.8
(V07) (544) Columbia, SC	8.3	13.6	7.9	15.1
(V07) (557) Dublin, GA	4.5	19.5	4.9	15.3
(V07) (619) Central Alabama Veterans HCS, AL	3.2	11.9	7.5	15.5
(V07) (679) Tuscaloosa, AL	.4	9.3	1.3	8.9
(V08) (516) Bay Pines, FL	2.6	8.6	3.7	10.1
(V08) (546) Miami, FL	1.2	8.0	.8	7.8
(V08) (548) West Palm Beach, FL	2.1	13.4	4.0	15.7
(V08) (573) Gainesville, FL	3.4	15.5	5.7	17.3
(V08) (672) San Juan, PR	.4	9.5	.5	8.9
(V08) (673) Tampa, FL	2.8	11.3	2.7	8.9
(V08) (675) Orlando, FL	1.5	12.1	2.5	12.0
(V09) (581) Huntington, WV	1.4	7.5	3.1	9.6
(V09) (596) Lexington, KY	.5	4.9	1.3	8.0
(V09) (603) Louisville, KY	3.0	8.7	4.8	10.7
(V09) (614) Memphis, TN	1.5	13.7	2.7	15.8
(V09) (621) Mountain Home, TN	2.3	10.4	1.9	10.5
(V09) (626) Middle Tennessee HCS, TN	3.9	14.0	5.5	15.8
(V10) (538) Chillicothe, OH	1.2	6.3	2.9	7.6
(V10) (539) Cincinnati, OH	2.7	10.2	3.9	13.1
(V10) (541) Cleveland, OH	.8	7.3	.9	9.1
(V10) (552) Dayton, OH	2.2	10.2	1.8	9.4
(V10) (757) Columbus, OH	2.2	8.8	2.8	10.2
(V11) (506) Ann Arbor, MI	2.3	12.1	1.3	9.8
(V11) (515) Battle Creek, MI	1.5	10.0	3.5	13.5
(V11) (550) Danville, IL	.9	8.3	3.4	9.3
(V11) (553) Detroit, MI	1.2	9.8	1.2	12.3
(V11) (583) Indianapolis, IN	3.7	8.4	5.2	9.6
(V11) (610) Northern Indiana HCS, IN	2.9	10.6	2.7	9.2
(V11) (655) Saginaw, MI	5.3	10.7	6.5	11.4

	FY14 Average New Patient Wait from Preferred Date	FY14 Average New Patient Wait from Create Date	FY15 Average New Patient Wait from Preferred Date	FY15 Average New Patient Wait from Create Date
(V12) (537) Jesse Brown VAMC (Chicago), IL	1.1	11.0	1.0	8.4
(V12) (556) Captain James A Lovell FHCC	.9	5.8	1.3	7.0
(V12) (578) Hines, IL	.9	9.0	2.1	10.3
(V12) (585) Iron Mountain, MI	2.5	28.1	3.8	25.6
(V12) (607) Madison, WI	5.5	9.6	5.6	10.3
(V12) (676) Tomah, WI	.5	9.9	1.2	9.3
(V12) (695) Milwaukee, WI	1.3	12.5	8.5	12.0
(V15) (589) Columbia, MO	.8	10.8	1.1	13.3
(V15) (589) Eastern KS HCS, KS	1.2	14.9	1.5	17.6
(V15) (589) Kansas City, MO	2.6	7.2	1.4	11.2
(V15) (589) Wichita, KS	2.9	10.1	1.4	13.8
(V15) (657) Marion, IL	3.3	8.2	5.1	10.4
(V15) (657) Poplar Bluff, MO	1.7	8.6	3.3	10.0
(V15) (657) St. Louis, MO	3.1	12.8	4.2	16.2
(V16) (502) Alexandria, LA	5.4	13.3	3.7	11.5
(V16) (520) Gulf Coast HCS, MS	5.2	12.4	8.3	13.5
(V16) (564) Fayetteville, AR	1.8	7.0	1.7	7.5
(V16) (580) Houston, TX	1.0	13.5	3.2	13.1
(V16) (586) Jackson, MS	3.4	10.1	5.9	13.1
(V16) (598) Little Rock, AR	2.4	15.6	3.6	14.2
(V16) (623) Muskogee, OK	1.9	9.7	4.9	10.4
(V16) (629) New Orleans, LA	4.5	13.8	6.8	17.8
(V16) (635) Oklahoma City, OK	2.1	10.1	2.9	12.3
(V16) (667) Shreveport, LA	2.0	14.2	4.4	16.9
(V17) (549) Dallas, TX	2.7	8.4	2.5	9.8
(V17) (671) San Antonio, TX	2.8	12.8	4.3	16.4
(V17) (674) Temple, TX	1.3	9.0	3.6	10.2
(V17) (740) VA Texas Valley Coastal Bend HCS	.6	8.6	4.5	9.6
(V18) (501) New Mexico HCS	4.4	12.9	6.7	16.4
(V18) (504) Amarillo, TX	1.7	10.1	1.3	10.7
(V18) (519) Big Spring, TX	8.9	17.1	7.1	12.9
(V18) (644) Phoenix, AZ	5.2	10.9	6.7	11.3
(V18) (649) Northern Arizona HCS	.2	8.5	1.3	8.9
(V18) (678) Southern Arizona HCS	1.6	12.1	3.0	12.4
(V18) (756) El Paso, TX	3.9	10.4	7.2	12.1
(V19) (436) Montana HCS	2.4	12.8	4.2	15.6
(V19) (442) Cheyenne, WY	1.3	10.1	3.6	13.3
(V19) (554) Denver, CO	7.0	15.2	7.2	18.0
(V19) (575) Grand Junction, CO	1.8	8.6	5.2	14.5
(V19) (660) Salt Lake City, UT	8.4	13.8	7.1	13.1
(V19) (666) Sheridan, WY	2.8	16.2	2.5	16.5
(V20) (463) Anchorage, AK	.6	7.1	2.0	9.7
(V20) (531) Boise, ID	1.4	10.5	1.7	6.8
(V20) (648) Portland, OR	2.9	15.1	6.0	17.8
(V20) (653) Roseburg, OR	5.9	16.8	3.9	12.3
(V20) (663) VA Puget Sound, WA	1.0	5.5	.5	4.3
(V20) (668) Spokane, WA	.9	11.0	.8	6.8
(V20) (687) Walla Walla, WA	2.1	10.5	2.4	12.5
(V20) (692) White City, OR	.6	11.6	3.7	13.6
(V21) (358) Manila, PI	6.1	21.9	3.6	23.9
(V21) (459) Honolulu, HI	1.0	9.4	1.3	11.9
(V21) (570) Fresno, CA	2.1	10.3	.4	9.8
(V21) (612) N. California, CA	3.0	9.7	4.8	13.9
(V21) (640) Palo Alto, CA	1.7	10.9	4.1	14.5
(V21) (654) Reno, NV	2.2	11.8	1.7	9.6
(V21) (662) San Francisco, CA	2.1	11.5	4.0	11.2
(V22) (593) Las Vegas, NV	2.7	15.9	4.8	15.4
(V22) (600) Long Beach, CA	1.9	10.6	5.1	13.1
(V22) (605) Loma Linda, CA	2.7	10.2	1.9	15.1
(V22) (664) San Diego, CA	4.7	12.9	7.1	13.7
(V22) (691) Greater Los Angeles HCS	4.5	16.2	8.0	17.0
(V23) (437) Fargo, ND	.7	8.1	1.0	8.3
(V23) (438) Sioux Falls, SD	4.6	16.1	4.5	15.5
(V23) (568) Black Hills HCS, SD	6.1	12.2	4.1	10.5
(V23) (618) Minneapolis, MN	.7	11.1	1.5	9.9
(V23) (636) Central Iowa, IA	3.6	11.3	3.2	9.5
(V23) (636) Iowa City, IA	2.8	13.7	2.4	14.9
(V23) (636) Nebraska-W Iowa, NE	1.5	8.3	2.1	9.3
(V23) (656) St. Cloud, MN	6.5	12.2	7.7	13.3

Question 4e. If there is significant variance, what steps are being taken to correct both wait times and variance among facilities?

Response. MH wait times are regularly reviewed as part of the Mental Health Management System (MHMS) quarterly calls with Veterans Integgrated Service Network leadership and representatives from the Office of Mental Health Operations (OMHO). This call includes review of factors related to access, including staffing ratios, vacancy rates, and productivity. Additionally, MH waiting times are reviewed as part of routine OMHO site visits. Recommendations related to wait time improvement are included as part of strategic action plans reviewed quarterly for progress.

TREATMENT PROGRAMS

According to VA MH Services Public Report (November 2014),

> "The goal of VA mental health treatment is to provide effective care that meets the Veteran's needs and expectations in a timely fashion. No single measure can capture this complex process, so VA monitors programs in terms of timely access to services, the types and quantity of services provided, and patients' satisfaction with care. VA monitors these aspects of the experience of care using various sources of information, such as patient and staff reports and electronic records."

Question 5. Since treatment depends on a good diagnosis, what screening does the VA provide in order to properly diagnose a mental health disorder? Who receives these screenings?

Response. All Veterans engaged in VHA health care are screened for a range of concerns, including: depression, Post Traumatic Stress Disorder (PTSD), alcohol misuse, tobacco use, experience of military sexual trauma (MST), and homelessness or being at risk for homelessness. Depression, problem drinking, and risk of homelessness screenings are completed annually. PTSD screening is completed annually for the first five years following separation from active duty, and every five years thereafter (to restart if reactivated). MST screening occurs once for every activation.

Positive screening results trigger specific follow-up requirements, depending on the condition being assessed, for example:

- Positive screens for depression or PTSD must be followed up with assessment for suicide risk and to determine the most appropriate disposition, which may include referral to specialty mental health services.
- Individuals who screen positive for alcohol misuse or problem drinking must be provided education and counseling about safe drinking limits and health risks associated with drinking above those limits. Individuals with a diagnosis of alcohol use disorder must be offered additional treatment to address alcohol related problems.
- Individuals who screen positive for tobacco use must be provided education and counseling about tobacco cessation, and be offered evidence-based pharmacotherapy to aid in tobacco cessation.
- Veterans who screen positive for homelessness or at risk for homelessness must be offered assistance locating safe and decent housing through collaborative relationships with providers in the community. VA medical staff must ensure that homeless Veterans have a referral for emergency services and safe, adequate temporary housing.
- Individuals who screen positive for MST must be offered MST counseling services.

Question 6. Once a diagnosis is made, does each vet with that diagnosis receive the same treatment protocol including medication? Is there variation? If so, please explain the variation.

Response. VA/Department of Defense (VA/DOD) Clinical Practice Guidelines (CPG) provide clear and comprehensive evidence based recommendations for the treatments that would be effective for a Veteran with a given diagnosis. These guidelines complement and inform the implementation of the array of services to be offered for a given diagnosis as defined by the VA Uniform Mental Health Services Handbook (UMHSH). Further, the UMHSH dictates services that are required to be available based on facility size and complexity.

The initial 24 hour assessment provides an evaluation of need for emergent care for Veterans with a need for immediate inpatient MH hospitalization. For those not requiring inpatient mental health care immediately, a full evaluation occurs to determine the best clinical treatment options to meet the specific needs of the Veteran. If there is a need for a residential level of care, VA Residential Rehabilitation Treatment Program services would be sought. Other options for care are also available including specialized services for Veterans with Serious Mental Illness (SMI) such

as the Mental Health Intensive Case Management Program (MHICM) or Psychosocial Rehabilitation Recovery Center (PRRC), specialty intensive services for PTSD or Substance Use Disorders (SUD), and general MH outpatient services. Some Veterans may benefit from and prefer treatment within primary care and receive services from the Primary Care-Mental Health Integration team and their primary care providers within the Patient Aligned Care Team (PACT).

Within each of these levels of care, there are a number of different treatment modalities available. Veterans have the opportunity to engage in individual therapies, group therapies, and couple or family therapy. Additionally, treatment planning is often informed by engaging the Veteran's family when family involvement is approved of by the Veteran. Last, within each level and modality of care, UMHSH and the CPG identify a range of efficacious services to be offered for a given clinical diagnosis, these may include evidence-based psychotherapies (EBPs) and pharmacological treatment.

Each Veteran's specific diagnoses and needs, along with his or her preferences, are considered during the treatment planning process to tailor treatment to address the unique needs of each Veteran. As a result of this Veteran-centered approach to treatment planning and implementation, there is inherent variation due to a Veteran being offered the choice of efficacious treatments that would effectively meet his/her needs.

Question 7. How many vets complete the treatment program recommended by the provider? Please include the number of visits and medication compliance.

Response. VA monitors the types of mental health services received by Veterans according to specific types of services, such as PTSD or addiction treatment, inpatient admissions, or residential rehabilitation treatment. These monitors allow VA to understand how many Veterans are being served in these clinics or settings, and how much care they are getting measured in numbers of visits or days in a treatment program. However, because MH care is tailored to the clinical needs and preferences of individual Veterans, there is no "one size fits all" regimen that can be applied to all those in mental health care. In addition, even where there are treatment guidelines for particular disorders, those guidelines are not expected to be imposed without regard to individual circumstances. It is therefore not possible to quantify the number of Veterans "who complete a treatment program recommended by the provider." This would require much more nuanced and detailed data about what the provider was recommending than is available in the administrative data.

A P P E N D I X

PREPARED STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Thank you, Mr. Chairman, for holding this critically important hearing, and thank you to the witnesses for appearing here today.

I think everyone in this room agrees that our Nation has a duty to care for its veterans. With so many veterans diagnosed with mental health needs, a significant part of that care is access to mental health treatment.

Veterans face stress and adversity from multiple deployments, and the unique challenges they face during tours of duty that can make it difficult to readjust to life back home. Difficulties with this transition are even worse for those experiencing depression, Post Traumatic Stress Disorder, substance use disorder, or those suffering from military sexual trauma. These invisible wounds of war can be with veterans for many years—but we also have treatments that help, and can get veterans back into their lives.

The VA has a duty to provide the services and foster a culture that actually serves our veterans.

However, I am deeply concerned that despite all of our efforts over several years to address gaps in access to mental health care services, the VA is not making the changes that are needed—and that they have been required to make. As far as I'm concerned, that equates to failing our veterans.

When I was Chairman of this Committee, we held several hearings on mental health care. I asked for several IG and GAO investigations. We demanded VA hire more providers, and listen to providers in the field about the barriers they face in trying to help veterans. We even passed into law reforms designed to improve VA's ability to provide for the mental health needs of our veterans.

But as we sit here today, I'm having a hard time understanding what has really changed since we covered this exact same ground in 2012, and even in 2008.

I'm frustrated that VA:

- still has does not have an accurate picture of wait times.
- still does not have a staffing model for mental health care
- still has an alarmingly high number of vacancies in mental health positions

Now, as the Ranking Member on the HELP Committee, I understand very well the Nation-wide shortage of mental health providers.

But, things need to change. So, I'll be looking for answers on exactly how the VA is addressing two things that we identified as problems years ago:

One, how the VA is making sure there are enough mental health professionals who can quickly and accurately diagnose and treat our veterans; and

Two, how the VA intends to recruit and maintain this crucial workforce. Without proper staffing levels, the VA will never be able to satisfy the demand.

That is a failure we cannot allow.

Allowing veterans to seek care outside the VA is certainly part of meeting this need, but the sobering reality is that half of all U.S. counties do not have a single psychiatrist, psychologist, or social worker. Even if there were enough private-sector providers, it wouldn't solve the problem.

Because of the unique nature of the veteran experience, we need providers specifically attuned to their needs, which include evidence-based treatment and cultural competency. This ultimately means that for far too many veterans and their families, it is unclear where to turn for help.

The VA Inspector General released a report this past August addressing the issue of VA efforts to improve veterans' access to outpatient psychiatrists. This report concluded that the VHA has not been fully effective in its use of hiring opportunities or use of its existing personnel to improve veterans access to psychiatrists.

This is very alarming given that the report also found that 94 out of 140 health care facilities needed at least one additional psychiatrist.

But, most concerning—these problems aren't new. IG and GAO have reported on these same types of failings for years. We need to fix this. And really, it shouldn't take multiple Senate hearings over the course of many years to get this done.

Mental health is just as much of a priority as physical health.

Veterans must have access to see these professionals, without the fear of confusion over where they can go, or lengthy wait times for initial appointments.

The GAO report that was released today discusses some of these above concerns. I look forward to continuing the discussion on what we can do to address scheduling issues, and how to ensure we have accurate information to see where we've fallen short.

The demand for these services is only going to increase as it has been for the last several years. We need to be able to devote the resources to these efforts NOW, so that VA has the ability to respond quickly and appropriately when someone is clearly in, or approaching a crisis.

We also know that the fastest growing group of new veterans are women. Which is why it is extremely important for us to be focusing on the unique mental health needs of female veterans, and I'll continue working to make sure VA is addressing the needs of this growing population.

So, I am deeply appreciative of our witnesses today for their insights, and I hope that this hearing is a step forward in increasing accountability, improving access, quality, effectiveness, and efficiency of mental health services for our veterans and their families.