

**LEGISLATIVE HEARING ON H.R. 3495;
AND A DRAFT BILL TO ESTABLISH A PILOT
PROGRAM FOR THE ISSUANCE OF GRANTS
TO ELIGIBLE ENTITIES**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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C O N T E N T S

WEDNESDAY, NOVEMBER 20, 2019

	Page
OPENING STATEMENTS	
Honorable Mark Takano, Chairman	1
Honorable David P. Roe, Ranking Member	4
WITNESSES	
Honorable Robert Wilkie, Secretary, U.S. Department of Veteran Affairs	6
Accompanied by:	
Dr. Richard Stone, Executive in Charge, U.S. Department of Veterans Affairs	
Dr. David Carroll, Executive Director, Office of Mental Health, U.S. Department of Veterans Affairs	
Mr. Adrian Atizado, Deputy National Legislative Director, Disabled American Veterans	34
Mr. Blake Bourne, Executive Director, Veterans Bridge Home	36
Mr. Sherman Gillums Jr., Chief Efficacy Officer, AMVETS	38
Ms. Melissa Bryant, National Legislative Director, The American Legion	40
APPENDIX	
PREPARED STATEMENTS OF WITNESSES	
Honorable Robert Wilkie Prepared Statement	57
Mr. Adrian Atizado Prepared Statement	59
Mr. Blake Bourne Prepared Statement	62
Mr. Sherman Gillums, Jr. Prepared Statement	66
Ms. Melissa Bryant Prepared Statement	70
STATEMENTS FOR THE RECORD	
American Federation of Government Employees	73
Veterans of Foreign Wars	75
Paralyzed Veterans of America	77
Iraq and Afghanistan Veterans of America	79
National Organization of Veterans' Advocate, Inc. and Partners	80
Institute of Veterans and Military Families	83
Union Veterans Council	86

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COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
Washington, D.C.

The committee met, pursuant to notice, at 9:59 a.m., in room 210, House Visitors Center, Hon. Mark Takano (chairman of the committee) presiding.

Present: Representatives Takano, Lamb, Levin, Brindisi, Rose, Pappas, Luria, Lee, Cunningham, Cisneros, Peterson, Allred, Underwood, Roe, Bilirakis, Dunn, Bergman, Barr, Meuser, Roy, and Steube.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN

The CHAIRMAN. The hearing will come to order. Without objection, the Chair is authorized to declare a recess at any time.

Good morning, everybody. This legislative hearing is an opportunity for stakeholders to make their comments and concerns public following last week's closed door roundtable. Today's hearing follows months of meetings and discussions with veteran service organizations, mental health professionals, experts in suicide prevention, suicide prevention policy, union leadership, and other stakeholders. I am grateful for their responsiveness and willingness to work toward improved language that delivers VA's finite resources to the communities that need the most.

In order to mitigate veteran suicide, in order to reduce veteran suicide, we need new solutions. We all acknowledge that VA has the ability to provide top level mental health services, but that only works for veterans connected with VA.

Today, we will hear about two measures that attempt to address veteran suicide: H.R. 3495, as it stands in its current form; and my discussion draft. While I agree with the underlying intent of H.R. 3495, I do have significant concerns.

First, this bill would allow VA grants to fund community based clinical care and would clearly circumvent the MISSION Act that streamlined clinical care under one program. We worked awfully hard in this committee to streamline the many different lines of community—care in the community, and the way I see H.R. 3495 as currently written, it would create a lane outside of the MISSION Act.

This legislation creates a separate lane for care in the community without critical safeguards and accountability measures in place. I will oppose any language that authorizes use of VA grants to provide clinical care, clinical mental health care.

At the roundtable, the coordinating groups or hub organizations that we heard from said that they had the ability to make clinical services available to veterans ineligible for care at VA. Veterans, with other than honorable discharges, can already receive mental health care at VA facilities. Current law allows that to happen.

Furthermore, grant funding for clinical health care does not solve the problem of underresourced and underserved geographic areas suffering from a general shortage of providers. I am going to repeat that. Allowing grant funding for clinical health care will not solve the problem of underresourced and underserved geographic areas suffering from a general shortage of providers. That is a whole other problem.

Clinical care paid for with VA dollars should be subject to accountability and we should ensure that any such clinical care be culturally competent, be provided by a clinically competent providers in the community. And these providers should be part of VA's community care network created under the MISSION Act. There is no reason why this should not be possible. That is the responsibility of the VA leadership to make the MISSION Act work in this particular case.

The urgency of addressing the crisis of veteran suicide should not be the pretext for allowing VA money to go to providers who are not held to account for measurable outcomes or for providing culturally competent care, and who are not subject to any oversight.

Second, H.R. 3495, as introduced, would provide direct temporary cash assistance to veterans, their families, and anyone else who may live with them. My understanding is that cash assistance to veterans needs further, more careful consideration, and should be taken up in separate legislation. Third, H.R. 3495, as introduced, would also distribute VA's limited funds to community partners without any controls in place to ensure that those funds are properly utilized.

H.R. 3495, as introduced, authorizes the VA Secretary to award grants to organizations unbound to any performance criteria and irrespective of whether there is demonstrated local need for the services provided by these organization.

I believe, and I think—well, we believe, funding decisions should be driven by local coordinated organizations, otherwise known as hubs, who have the pulse on their communities and regions. The coordination should be as local as possible. There are many examples—many, many examples of such excellent organizations, which are known also by the term hubs, by many who do the work.

Funding grants through hubs promotes accountability through widely recognized metrics and effectiveness through local funding determination. Without local need and metrics tied to the award of grant funding, this is not consistent with a policy goal of reaching the 60 percent of veterans at risk for suicide, who are not connected with VA.

Now, all this being said, I am very grateful for General Bergman's commitment to ensuring we work together to ensure

vital accountability measures are in place and my concerns on H.R. 3495, as introduced, are addressed. I am very pleased that he is addressing my concerns.

My legislation presented today as a discussion draft delivers a public health solution focused on upstream intervention. The idea that if we provide wrap around services to addressing housing, and security, unemployment, and social isolation, we can better prepare veterans to deal with life stressors that may lead to suicidal ideation itself.

We want to intervene far upstream before even a crisis occurs. That is the public health model. My discussion draft seeks to channel Federal grants into local community organizations, through local coordinated organizations that mirror the recommendations embedded in the president's own executive order. I do not believe the Office of the Secretary, with an advisory committee in Washington, D.C., meets the intent or spirit of the president's executive order, especially Section 5, establishing metrics and coordination of local resources are emphasized in Section 5 of that executive order.

Veterans' daily lives do not solely revolve around VA. The veterans frequent small businesses. They attend classes at community colleges and universities. They volunteer in their neighborhoods and participate in the local workforce, just like everybody else.

My draft legislation aims to leverage these deep ties already existing in the community by using the hub model, which can help connect veterans with existing community based partners, already working to serve veterans and their families. Hubs are similar to the vet centers, resource centers, and case managers VA provides. They also can coordinate services, make referrals, and track effectiveness, demand, and capacity across a network, in a sense creating that network for service that already exist. I underscore "already exist."

I realize in some parts of the country, they may not exist. My discussion draft goes beyond doling out cash to unestablished organizations and ensures key accountability measures are in place that require organizations with a demonstrated track record of providing services to veterans. It creates an opportunity for coordination. It creates an opportunity for communities as a whole to surround and support veterans with the services they wish to access most often.

My draft legislation would authorize VA to provide grants, up to \$500,000 in the first year, matched by—well, matched 100 percent by the organization for up to 10 community based coordinating organizations each year. Qualifying organizations are those that provide social services, that mitigate known life stressors like employment counseling, family counseling, debt forgiveness, higher education assistance, housing services, legal counseling, and recreational therapy.

We must create a public health infrastructure. If we fail to provide our communities with the support they need in order to assess, increase, and leverage community-based services to better serve veterans, then veterans will not be able to access these services.

By allowing VA to responsibly partner with community organizations already serving veterans, while at the same time protecting VA's expertise and providing clinical care—culturally competent clinical care, I believe we can reduce the overall number of veteran suicides.

These hubs already have their fingers on the pulse of their communities and have collectively served hundreds of thousands of veterans. They speak to veterans and their families every day. They do not care about Veterans Health Administration (VHA) eligibility or disability ratings. They just care about offering solutions to life's problems, and when and where veterans need it.

Focusing VA's limited funds to fill gaps in resources will provide the most sought after services based on recommendations from local stakeholders in the community, not from politicians in Washington, D.C. We have long been debating how to address the crisis of veteran suicide. My draft—my discussion draft is a clear solution that will direct resources to those who need the most increased coordination in our own communities, improve the quality of life for veterans and their families, and help reduce veteran suicide as a result.

With that, I would like to recognize Ranking Member Dr. Roe for 5 minutes for any opening remarks that he may have. Dr. Roe.

OPENING STATEMENT OF DAVID P. ROE, RANKING MEMBER

Mr. ROE. Thank you, Mr. Chairman. I am glad today that we are having this hearing. I very much appreciate it. Since this bill was introduced in the House on June 26th, so 148 or so days ago, 2,960 service members and veterans have died by suicide. There is undoubtedly a lot to discuss about this bill today, but I want to ask all committee members, and all of our witnesses, and all of those watching not to lose sight of that number, 2,960. That 2,960 families that will not have all of their loved ones around for their Thanksgiving tables or Christmas this year or ever. That 2,960 lives are forever lost.

That is what this bill is about, finding the lost and saving their lives. The stakes could not be higher. Of the 20 service members and veterans who die by suicide each day, 14 did not seek care from the Department of Veterans Affairs in the 2-years prior to their death. We do not know much about those men and women, except they are not VA users. Some of them are not likely—are not eligible for VA benefits and services, others likely unfamiliar or uninterested in them.

The Improve Act would give VA the means to identify and support those veterans. The ones who do not will not or cannot seek VA out for themselves. By assisting the organizations and entities caring for them in their communities so that the VA can meet them where they are and offer them whatever help they might need to save their own lives.

There are precious few things Elizabeth Warren and I agree on, but we are both co-sponsors of the Improve Act. We are joined by more than 200 of our colleagues in the House and more than 27 of our colleagues in the Senate, with widespread bipartisan support that this bill is received from Representatives and Senators across the political spectrum is rare and evidence of both the seriousness

of the impact, the national suicide crisis having on our Nation's veterans, and the wisdom of the broad public health approach to suicide prevention the Improve Act embodies.

The Improve Act would significantly expand the reach of VA suicide prevention programs and give more veterans the opportunity to be indirectly served by VA, and to learn about VA benefits and services they may be entitled to. It would also provide a necessary mechanism to deliver care and supportive services to veterans who are at risk and who are living outside the VA's influence.

It is not a threat to VA, much less to the health and well being of our Nation's veterans, as some have alleged. It is a lifeline. As you know, we will hear shortly from Blake Bourne, with the Veterans Bridge Home, one of my fellow Army veterans. No single entity can adequately meet the needs of every veteran in every community in every instance. Not even the second largest department in the Federal Government with a budget and staff that grows every year.

Because the Improve Act is based on a legislative proposal in Fiscal Year 2020 budget submissions, specific funding has already been allocated for it in the Department's Fiscal Year 2020 budget request. That funding would compromise far less than one half of 1 percent of the total mental health budget, and yet it has the potential to reach 70 percent of service members, veterans, who die by suicide every day without being known to the VA.

Mr. Chairman, after last week's roundtable, which was very good, I might add, you asked that I draft a compromise proposal that addressed the concerns that had been raised by you and others about the bill as written, especially with regard to provision of clinical care, the provision of temporary cash assistance, and the provision of grant funding to direct service providers.

I believe the draft proposal I produced and shared with you and our witnesses preserve the life serving intent of Improve Act as introduced, and effectively addresses those three areas of concern by: number one, putting specific mechanisms in place to connect veterans with VA medical facilities so that if possible, any ongoing care of veteran requires is provided by VA; two, allowing grantees to assist veterans struggling with common risk factors, but prohibiting them from provided direct cash assistance to veterans and their families; and number three, requiring VA to prioritize grant funding to so-called hub organizations, but not limiting grants only to those organizations which do excellent work, but may not effectively serve at-risk veterans in rural or remote areas where I live.

My compromise language is truly a compromise. Accepting it would require concessions from both of us, Mr. Chairman. It includes many of the suggestions that were made during our roundtable last week by our veteran service organization partners. I look forward to discussing that language today and hope that we can soon come to an agreement on it and commit at last to marking it up as soon as we return to D.C. in December.

I am grateful that Secretary Wilkie is with us this morning to participate in the discussion. It is his leadership and foresight on the Improve Act has been steadfast. I am also grateful for the many Veteran Service Organizations (VSOs) who are testifying here today, and those who have submitted statements for the

record, and those who appeared at our closed door roundtable just last week. Their input and support are invaluable and I appreciate their willingness to engage with me and my staff to make sure that we are on the right track with respect to this bill and all of our work.

I am also grateful to Mr. Bourne for being here to discuss the great work that the Veterans Bridge Home does for veterans and their families in North Carolina, and the wonderful life saving opportunity we have with the Improve Act to sustain that work across the country.

Just, Mr. Chairman, a couple of comments, and why I want to do this and I why I think this is important. We have had accountability. We have had metrics. We have call centers. We have quality measures. We have all of those things, and guess what? Still today, 20 veterans are going to commit suicide. So we have to reach out and try to find those 14 who never get to the VA, never get the care. I know as a clinician, if I am seeing someone in extremis, I am going to worry a whole lot less about when I get paid then to take care of that person in need right then. We do it all the time in health care. We take care of the patient and then figure out who all gets the money.

I think certainly with this small amount of investment, it is not a large investment. I agree with you on that. The money is in a different silo anyway. We have gone from 2 and a half billion in 2005 to a \$9 and a half billion budget and our suicide rate is exactly the same. We have to start doing something differently. With that, I yield back.

Mr. Chairman, thank you for holding the hearing today.

The CHAIRMAN. Thank you for those kind words, Ranking Member Dr. Roe. I have to say that I understand that the minority staff and the majority staff have been, I think, in meaningful dialog, something that I did not perceive to be happening before the last markup. I am—so I am pleased that there is discussion going on about the concerns that I have, the three main concerns that I have with H.R. 3495, as introduced.

Appearing before us today, and we are delighted to welcome Hon. Robert Wilkie, Secretary of the U.S. Department of Veterans Affairs. Welcome, Mr. Secretary.

Secretary WILKIE. Thank you, sir.

The CHAIRMAN. I recognize you for 5 minutes for your opening statement.

STATEMENT OF ROBERT WILKIE

Secretary WILKIE. Thank you—thank you, Dr. Roe. I am going to pick up on Dr. Roe's theme. While we are here, two veterans will take their lives. Since the first shots were fired at Lexington, 41 million Americans have put on the uniform, and well over a million have paid the ultimate price. This issue, the issues that we faced in dealing with the incommunicable experience of war and its aftermath is not new.

In the 1890's, President Benjamin Harrison, who was not known for much other than being in between non-successive terms of Grover Cleveland, was alarmed at the reports he was receiving from the Department of War, that suicides among the officer corps were

spiking. He was the first president to order statistics to be gathered on the trends and the costs of suicide amongst those in uniform.

In the last 2 years, we have been the first to finally come to the table and say, "This is a crisis that needs to be addressed." As Dr. Roe said, every day 20 veterans take their lives; 60 percent of those have no contact with us, and the majority of those are from the Vietnam era. I saw through the eyes of the child the residue and the cost of that conflict. My own father, three purple hearts, after 3 years of recovery from his last wounds returned to the 82d airborne division, the most decorated combat unit in the armed forces of the United States, and because of the times was not allowed to wear his uniform off post.

It is his comrades who have been suffering the most. To put that into a timeline, Lyndon Johnson left Washington 50 years ago in January. That is how long the problems that our Vietnam veterans have faced, have been going on.

The idea that General Bergman has presented, and the ideas that have been supplemented by Dr. Roe are not new. In fact, the idea came from the Speaker of the House many years ago in her attempt to combat veterans' homelessness. What General Bergman and Dr. Roe have done, they have substituted the word homelessness with suicide in an attempt to get the entire community of the United States engaged in finding those 14 veterans that we do not see.

This is not an attempt to circumvent VA health care. This is an attempt at triage on the streets and in our rural areas, to help us find those veterans we cannot touch, and perhaps save them from the consequences that they have experienced as a result of their service.

I want to get to the argument that I believe was made in the roundtable, and that is privatization. Let me put this in context. The budget for this department set aside \$18 million for these programs. \$18 million is not a lot of money for us. We have a \$9 and a half billion mental health budget, inside of a \$220 billion VA budget. Only in Washington, D.C. would someone say that using \$18 million to get community partners engaged in the lives of veterans is a pathway to privatization and the degradation of services. It will not happen.

As the Chairman and the ranking member have said, we have been in contact with the VSOs and both sides of this committee in the last few weeks to hammer out a way forward, a way forward that Dr. Roe just articulated.

We recognize that we need help, that we need help in finding those veterans. I will not sit here and tell you that I am going to give you a metric and that we will eliminate veteran suicide. Human life is not linear. I will give you an example of some of the problems that we faced this year.

In Ohio, a 69 year old veteran took his life on one of our grounds. He was facing life changing surgery, cancer surgery that would have removed his left eye, his jaw, and his vocal cords. He made a decision to take his life, but he left us a note asking us to take care of his mother. That is the kind of tragedy that we see on a

daily basis, the ones that we do see. It is those 14 we do not see that are the crux of this legislation.

This is an important step forward in a time—and I am considered a pretty good historian by some—in a time when Washington, D.C. is divided as it has not been certainly since Vietnam and perhaps the Civil War. This is an opportunity to say when it comes to warriors, that enough is enough. This legislation has brought together conservatives. It has brought together liberals. It has brought together moderates on both sides of the House.

It is our way of supplementing what this committee has already done with the MISSION Act, with accountability, in letting us get out to those communities and say, "Please help us find these warriors." As I said at the beginning, it started in the 1890's, and we are sadly finally getting around to addressing this as a Nation. We have an opportunity here and this is a very good first start, and I thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF ROBERT WILKIE IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Secretary, for your comments. I also want to recognize that we have with us today Dr. Stone, the executive in charge of the U.S. Department of Veterans Affairs. He is in charge of the VHA. Dr. David Carroll, executive director, Office of Mental Health, the U.S. Department of Veterans Affairs. Welcome, gentlemen, to the committee as well.

I will begin by recognizing myself for 5 minutes, and I will begin. Mr. Secretary, first of all, I want to—does your bill or does H.R. 3495 require funds to be directed only toward organizations with a history of improving well being?

Secretary WILKIE. Well, the compromise legislation that Dr. Roe talked about and I know—

The CHAIRMAN. Mr. Secretary, I just want to know, regarding 3495 as currently written—

Secretary WILKIE. Well, 3495 has evolved. I am a—

The CHAIRMAN. I know it has evolved, but I just want to know, as it stands now, it does not require that funds be directed toward organizations with a history of well being. Is that—

Secretary WILKIE. Well, it requires funds to be directed to those organizations that have an impact in the community.

The CHAIRMAN. It does not have—does not require that they be spent only toward organizations with a history of improving well being.

Secretary WILKIE. Well, I will ask—I will say that that is probably right.

The CHAIRMAN. Okay, thank you.

Secretary WILKIE. Because—because—

The CHAIRMAN. Thank you. I want to move on to my next question. Does H.R. 3495, as introduced, require organizations seeking grants to show evidence that there is a waiting list of veterans seeking their help?

Secretary WILKIE. No.

The CHAIRMAN. It does not. Thank you.

Secretary WILKIE. No, no, you—

The CHAIRMAN. We will move on.

Secretary WILKIE. Okay.

The CHAIRMAN. Does H.R. 3495, as introduced, ensure the expenditure of funds provided to these organizations are used directly to serve veterans in the communities in which they live?

Secretary WILKIE. The only place we should be spending money is in the communities with veterans—

The CHAIRMAN. I am glad we agree on that. Does H.R. 3495, as introduced, ensure the expenditure of funds provided to these organizations—

Secretary WILKIE. Mr. Chairman, I think—

The CHAIRMAN.—used directly to serve veterans in the communities in which they live?

Secretary WILKIE. Mr. Chairman, I think you know the answer, that the intent of that is yes.

The CHAIRMAN. The intent is yes, but is there language that ensures that the expenditure funds—in other words, it prohibits the expenditure of funds if they are not spent on veterans that are serving committees directly where they live.

Secretary WILKIE. General Bergman's legislation creates a mechanism within the Department of Veterans Affairs that will take these grants and give them to groups that we approve, that we know can reach out to veterans. Let me just say, legislation—

The CHAIRMAN. Secretary—

Secretary WILKIE. I have got to respond. Legislation is not static. General Bergman, Dr. Roe, and your staffs have been working—

The CHAIRMAN. Reclaiming my time, Mr. Secretary. I understand—do not—you tell me a legislation is not static, but I am just asking you questions about the legislation that you have relentlessly been pushing through your department without discussion with me, as the Chairman—

Secretary WILKIE. But that is—

The CHAIRMAN.—never meeting with me. I want to make clear what is in the legislation as introduced—

Secretary WILKIE. The—that legislation is no longer relevant.

The CHAIRMAN. Mr. Secretary. Reclaiming my time, Mr. Secretary.

Secretary WILKIE. Yes.

The CHAIRMAN. Reclaiming my time. It is my time to ask a question.

Secretary WILKIE. I hope you give me time—I hope you give me a chance to respond.

The CHAIRMAN. I have, and you have answered very succinctly and honestly so far, but the legislation intends, but does not—but I am telling you it does not require. When I ask you a simple question, does the—does H.R. 34, as introduced, require the expenditure of funds provided to these organizations that are used—that these organizations are used to directly serve veterans and their communities. Your answer was, "That is the intent." I am telling you, the legislation as written does not require that.

Secretary WILKIE. Well, I will say, and I am a—you and I had this discussion in front of the Speaker. The legislation that you are talking about is no longer relevant in the discussion, because you have compromise legislation that has been offered by the author. You have compromise legislation that has been worked on by the ranking member.

That base bill is no longer—will no longer be passed into law.

The CHAIRMAN. I want to make clear—

Secretary WILKIE. We are going beyond that—

The CHAIRMAN. What I want to make clear, Mr. Secretary, is relentless this legislation was pushed. You have pushed out op-eds in advance. That meeting with the Speaker was arranged with the Speaker. I was an add on. You have never sought a meeting with me to discuss my problems with this bill. In fact, there is a major shortcoming in terms of there is no inadequate accountability for how this grant money is going to be spent. Your legislation, as written, the legislation H.R. 3495, as written, does not even require that funds be spent on organizations that directly serve veterans in their own communities.

Secretary WILKIE. Well, let me say, you are giving me much too much credit. This legislation was around long before we had a President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) task force. This legislation was put forward by members of this committee. The only thing that I did was support the efforts by members of this committee to finally address suicide.

The CHAIRMAN. Okay. My time has—

Secretary WILKIE. That is my job as the Secretary of Veterans Affairs.

The CHAIRMAN. My time has expired, Mr. Secretary. I now call on Dr. Roe for 5 minutes for his questions.

Mr. ROE. Thank you, Mr. Chairman. Let me get us back on track here. This is not—this discussion today should have been 3 months ago. This is not about who got asked what. This is about preventing—helping prevent veteran suicide and finding those veterans out there who have not been able to get into the VA, and then get them in to where they can get care. I think that is what this is about.

Secretary WILKIE. That is right.

Mr. ROE. Let me ask a question, Mr. Secretary, and please feel free to answer. The compromise language, and again that is what I thought the roundtable was for was to go past the base bill. We were asked—and I want to thank the minority staff for working with the majority staff during this past week. We were asked to do that. We brought our VSO partners in, had their comments, and we did exactly what we were directed to do, and that is provide a compromise bill to address those misgivings that the Chairman had.

The compromise language that we worked on, we prepared, would prohibit the provision of direct cash assistance from grantees to eligible individuals and their families. Are you supportive of that? Why or why not?

Secretary WILKIE. Yes. Let me take a step back with your indulgence, Dr. Roe. I have the legislation that General Bergman presented. The provision in Section 2, it says, "The Secretary shall give preference in the provision of financial assistance under this section to eligible entities who have demonstrated the ability to provide assistance and suicide prevention services." General Bergman's legislation answered all of your questions, Mr. Chairman, in that one paragraph.

What I have been saying is that the questions that you asked are not relevant as we speak now in that that compromise legislation is now the vehicle for that presentation. I would also add, legislation that at its base has the support of 220 members of this body. The answer to Dr. Roe's question is yes. I want to thank the Chairman for bringing this bill forward, and hopefully we can get this thing done and out of here by Christmas so the bipartisan group of Senators who are backing this can get it done and have us get the ability to get out on the streets and find those veterans we do not see.

Mr. ROE. Mr. Secretary, the compromise language that we worked on in the past week would require the VA to give preference to so-called hub organizations when awarding grants. It would not preclude grants to smaller, non-hub organizations where appropriate. Are you supportive of this change?

Secretary WILKIE. Absolutely.

Mr. ROE. Yes. I looked at my own State, and we have a thing called the First Tennessee Development District. It is 8 of my 12 counties I represent. All—the board of this organization are all the mayors of the counties and the municipalities. They have access to all kinds of services that you could go out. This would be a perfect organization.

I looked at Guard Your Buddy in Tennessee for the Tennessee Guard that we have used. I think they should be included in this type of thing to help find veterans that are out there. We have a program that actually works. We know it has worked in Tennessee.

I think, again, to get our discussion back on track, really, we have gone past the base bill because that is what we were asked to do. Mr. Chairman, when you had the roundtable, which was very good, I thought, last week, it really sparked us to say, "Hey, what can we do—" You had some misgivings and I appreciated that misgivings and tried to address those misgivings. The staffs did, I thought, did a great job. I think we have a good compromised bill, and I think we need to move forward with light speed.

Secretary WILKIE. This is the last I will say about this. This is too serious a matter to worry about who gets credit for the final product. We have been ignoring suicide amongst warriors for over 200 years in this country. We are finally getting around to it. I saw what impact it had growing up at Fort Bragg. I have seen it now in spades as the Secretary of this department.

I think that what we have seen play out in the last few weeks with members coming together is an indication that members of this body and the other body have also said, "Enough is enough, and let us get something done."

Mr. ROE. Secretary, I want to finish my saying General Bergman served in Vietnam. I served in Korea at the same time. I would not pick up a coat that had Vietnam written in it. I would hang it back up. I would not even put it on. If they gave it to me, I would not take it. It has taken me a while to get over that, and I have. You have veterans out there that feel the same way about the VA. They would not walk in there for a certain reason. We have got to get to these men and women and help them. I yield back.

The CHAIRMAN. Mr. Secretary, I am—I just want to make clear that my concern here is not about who receives credit. My concern

all along has been to engage with minority staff and to get even your office to even respond. You have never taken the opportunity to respond to my draft, which has also been out there for quite a while. We just received—majority staff never received and never worked on this so-called compromise legislation. It was sent after 7 p.m. last night.

It has taken this long to even get people, you know, the minority staff to respond. Since you are raising this issue of 212 co-sponsors on H.R. 3495—

Secretary WILKIE. Two hundred twenty.

The CHAIRMAN. I guess the number has gone up.

Secretary WILKIE. Yes.

The CHAIRMAN. Well, since you have raised this issue, Mr. Secretary, I hope you can clarify a point for me. Did anyone in your office, or the Office of congressional Affairs, contact House member offices asking members to sign on to H.R. 3495?

Secretary WILKIE. Well, I am sure we did.

The CHAIRMAN. Okay. Well, then you can—then, I should not be surprised when I see a note that we have printed out, actually an e-mail, “Wanted to shoot you an e-mail today because I was reviewing the status of H.R. 3495 and noted that bot Reps X and Y were co-sponsors, but your boss has not signed on yet. I thought I would reach out and provide some info and let you know that it would be great to add Representative Pocan as a co-sponsor.”

This is highly inappropriate. I think—and you seem to be very proud of the fact that your office has been engaged in this sort of stuff, and this way of operating. This is what has caused so many members to sign onto the bill. I want to read you 18 U.S. Code 1913, which states, “No part of the money appropriated by Congress shall be used directly or indirectly to pay for any printed or written matter, or other device intended to or designed to influence in any manner a Member of Congress to favor, adopt, or oppose by vote, or otherwise any legislation, whether, or before, or after the legislation of any bill proposing such legislation.”

The way I read that section of the U.S. Code, your actions were—actions of your office, and people who work in your office, were inappropriate and public funds should not have been used in that way.

Secretary WILKIE. Well—

The CHAIRMAN. That can explain why so many members have signed onto this bill.

Secretary WILKIE. Well, Mr. Chairman, you are—I do not think you are giving credit to the 220 members who signed on. Second, in my professional experience, I have been the Assistant Secretary of Defense for Legislative Affairs at the Department of Defense, I have also had that job at the National Security Council. The section of the law that you cite is about corruption. It is not about the offices of the Federal Government educating, and informing, and supporting legislation that support the activities of that particular Federal department. If that were the case, then we would not have any Legislative Affairs Office—

The CHAIRMAN. Mr. Secretary, I can tell you—

Secretary WILKIE. We would not have an effort by any department of the Federal Government to do something as simple as pro-

mote the President's budget and try to get sponsors to support the President's budget. I think I will say that we are doing our due diligence to help veterans. Again, I go back. I really do not care who gets credit. I do not care what went on before. We have got 20 veterans who are dying, 2 have died in the time that it has taken for you to drop that gavel and me to answer your questions. That is what is more important here.

The CHAIRMAN. Do not imply, Mr. Secretary, I care any less about the veterans who are committing suicide. I have declared suicide prevention to be the No. 1 priority of this committee. We have worked diligently on that priority, and we want to get it right. There are high stakes in terms of getting it right, and there are high stakes in terms of getting it wrong.

With that, Mr. Secretary—and by the way, in my 7 years of being on this committee, I have never seen anything like the solicitation of co-sponsorships as indicated in this e-mail occur during my watch on this committee. I would now like to call on Representative Lamb for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman. I just want to reiterate the feeling of all members of this committee about the urgency of this situation and the determination to get it right, whatever decision that we reach. I do not believe there is a single member of this committee that does not feel that this is the most urgent priority in front of us. Mr. Wilkie, I just had the pleasure of finishing Secretary Mattis's new book, and I know you are an admirer of him as well. He reminded me of one of the lessons of the basic school, which is that time spent doing reconnaissance is almost never wasted time.

Secretary WILKIE. Absolutely.

Mr. LAMB. I think that is what we are doing here. I would like to focus, if I could for a moment, on the—what I see as the strengths of the Chairman's hub proposal. First of all, I just want to ask up front, the hub proposal that is being suggested in the alternative, do you think that VA could make that work if that ended up being the decision at the end of the day?

Secretary WILKIE. Absolutely. We have seen it work with homelessness. That is why I referenced the Speaker at the beginning of my remarks. What the hub proposal did—what the hub model did was go out in the communities and find groups like Catholic Charities, who have deep tentacles into all areas of a community and say, "Go out and help us find homeless veterans."

I think the addition that General Bergman has made augments that by trying to find those groups, even small ones, that can be more creative when it comes to helping us find those veterans on the street. Yes, I think it has worked before, and I think it would work again.

Mr. LAMB. I appreciate that. I think it is important for people to know that this is actually already working in some communities in the country. Not everybody has an America Serves hub already, but I am sure you are familiar with the America Serves program?

Secretary WILKIE. Yes. Yes, sir.

Mr. LAMB. We are fortunate enough to have one in three counties of the roughly ten counties of southwestern Pennsylvania and it is—you mentioned Catholic Charities. This is overseen by the Pitts-

burgh-Mercy Health System, which is an off-shoot of the Sisters of Mercy.

Secretary WILKIE. One of the best in the country.

Mr. LAMB. Definitely one of the best. The program administrator of that is an artilleryman from the Pennsylvania National Guard. The team leader was an engineer in the Pennsylvania National Guard with deployments to the Middle East. The intake specialist served in the 1st and 23d infantry division in Iraq from 2003 to 2004. The other intake specialists served as a military police woman in the Army Reserves. The other intake specialist was an Air Force enlistee for 11 years with deployments to Iraq. The overall head of it is a 11 year—10 year social worker with expertise in community health for Pittsburgh-Mercy.

This staff in Pittsburgh knows the community. They are veterans. They know mental health treatment. They already are coordinating with dozens of local groups all around our area. From what they tell me, they could expand their reach beyond those three counties and serve a higher number of veterans if they had additional funding and support.

My question, I guess, is if we have hubs like this already in existence that already know the difference between a good provider and a bad provider—or I should not even really say provider, but I guess recruiter of veterans and agency that encounters veterans, I think we share the goal of going out and finding these people.

Secretary WILKIE. Absolutely.

Mr. LAMB. It is often a conservative principal to shift decision-making down to the lowest level. From where I am sitting, why is the PA Serves network not a better decisionmaker and better distributor of funds than someone in your office, in Washington, D.C.?

Secretary WILKIE. Well, I do not think that there is a yes and no answer to that. I do think that as stewards of the Federal dollar, we do have to go out and investigate and determine who is good and who is not, and that is just routine cost of doing business. Certainly what—and you and I know, I was just in Pittsburgh, what is going on in Pittsburgh is a model for the country. It is a model for veterans. I think that an organization like that would be at the top of the list.

Mr. LAMB. Thank you. Mr. Chairman, I—one last question. Dr. Stone, I did ask you last week about the vacancies in vet centers and mental health providers. Do you have that number?

Mr. STONE. I do. At this time, we have over 24,000 providers. Our vacancy rate is just over 2,400 or just over 10 percent.

Mr. LAMB. Twenty-four hundred on the mental health provider?

Mr. STONE. Right.

Mr. LAMB. Would that include—that would be like docs, nurses, social workers, all inclusive?

Mr. STONE. These are mental health providers. They are psychiatrists, psychologists, psychiatric social workers.

Mr. LAMB. Got it. Okay. On the vet center side?

Mr. STONE. The vet center side I do not have in front of me, and I promise you I will get that.

Mr. LAMB. Okay. Thank you. Mr. Chairman, I—

Mr. STONE. If I could just add one other thing. The administrative overhead as part of this bill is about 20 employees in central

office, but specifically, their job would be to seek those organizations like you listed with relationships in the community that could act in the hub manner in order to distribute throughout the community. There is not a large administrative overhead anticipated within central office.

Mr. LAMB. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Lamb. I call on Dr. Dunn for 5 minutes. General Bergman.

Mr. BERGMAN. I will be glad to take Dr. Dunn's and my 5 minutes. Let's get to the point. Number one, Chairman Takano, thank you to you and the majority staff for all the efforts that you have put in, especially collectively with the minority staff, Dr. Roe's office, and as we have gotten some communication line open with the VA. This is what truly in military terms in any operation, if you do not have good communications, your chance of mission failure is greatly increased or your chance of mission success is greatly decreased. The communications that are driving us here today, I thank you all.

You know, we always quote different authors and different entities. I am a big Steven Covey fan, and begin with the end in mind. I believe we are all here with the end is that we are going to do everything we can to reduce veteran suicide. Period. Especially in a group that we have not made any dent in those suicides in the last several years, because pure and simple one reason. We do not have any communications with them. We do not have any connection with them. They are out there alone.

You know, one of Covey's other habits is seek to understand before trying to be understood. What Congressman Lamb talked about as far as General Mattis's quote on reconnaissance, I would say seeking to understand is just a different form of reconnaissance. You usually develop your understanding through your ears, not through your mouth.

The point is, as my mother would have said, you have got two ears and one mouth, so you do the ratio for what you use. Veterans have long been part of laboratory experiments. I can remember the shotgun, for giving the vaccinations that did not really work as well as it should have on the right—you know. Bottom line is we all got vaccinated. I could go on with different experiments.

I can think of no better laboratory experiment than to figure out ways that we are no currently doing to reach that target market of those 20 veterans a day.

We have heard a lot of things repeated here and I would just like to repeat what I believe I heard, and what I see on the paper in front of me is that we have gone past the initial bill. We have exhibited compromise. We have exhibited discussion first, back and forth. We are at a point where now the State of this bill as the proposed language that talks about, you know, the hubs versus smaller/specialized organizations compromise that Secretary Wilkie, you will prioritize the hubs. The grants can also be given to non-hub direct providers. Clinical services compromise, eligible veterans must be referred to the VA for clinical care, but grantees can provide some services if urgency needed.

I guarantee if you are on the battlefield, you really do not care, if you are a soldier, if it is a Navy corpsman who treats you. You

know, if you are in my case in Northern Michigan in January and you are in a ditch alongside the road, you really do not care who stops to pull you out. I mean, you need help when you help it. I think on the, I know on the cash assistance compromise that, you know, we are going to—that will be prohibited directly to veterans, but the grantee can acquire needed service on behalf of the veteran.

With that, Secretary Wilkie, just one question here. We know very little about many veterans who take their own lives but are outside the VA system. In my bill, we are working to put parameters in place to ensure proper use of grant dollars and track their success. Where do you see is the proper balance between such parameters in ensuring that the legislation allows VA and the community partners to proper—the proper flexibility to help at-risk veterans wherever they are and with whatever problems they might be facing?

Secretary WILKIE. Well, I think your base bill actually gives us the guidance. This part of the bill has not changed. It says, and you wrote it, that we assist those who have demonstrated the ability to provide or coordinate suicide prevention services or other services that improve the quality of life of veterans.

I think that is—that is the prime directive. We know, as Congressman Lamb just said, what works in Pittsburgh. I know what works in New Orleans and North Carolina. You know what works in Michigan. I think the beauty of the hybrid model that you have come up with, and again, it is not the base bill that we are dealing with. It is dealing with this compromise. It allows for the ability to innovate by allowing us to go out and seek organizations that may not be old. They may not be hierarchical in their organization. They may be able to reach somebody in far rural Montana or Alaska.

I will give you an example as to the other way. I spoke—I have been to Alaska twice to speak to the Federation of Natives to ask them to double the number of tribal representatives that they have dealing in veterans issues to go out into the wilderness of Alaska and help us find them. What you have done is allowed us the broadest aperture when it comes to finding people in diverse communities who can go out and help. I think that is a benefit that is long overdue.

Mr. BERGMAN. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, General Bergman. I appreciate the work we have done with each other, and I appreciate your legislation. Again, the intent was never—this hearing is not about credit. I would love to—and I do not believe you think it is about credit. I just assume using—but we will give it to you. Thank you so much.

I would like to now recognize Mr. Levin for 5 minutes.

Mr. LEVIN. Thank you, Mr. Chairman. Thank you for being with us today, Secretary Wilkie. As you know, I am very grateful for all the good work of the VA and San Diego, generally, and in my district specifically. I think we all here share an objective to deal with the crisis of veteran suicide.

Your staff had circulated a white paper in support of H.R. 3495, which states, and I quote, “We acknowledge there needs to be a

clear line of referral from the grantee to VA.” My understanding of H.R. 3495 is that it allows grantees to provide clinical care to veterans without referring them to VA. Could you clarify, Mr. Secretary, the department’s position on whether grantees should refer veterans to VA?

Mr. STONE. If I could take that, sir. We think that for all chronic mental health issues ought to come back to the VA. We do recognize the fact that in our work with organizations like the independence fund that brings formations back together that have had difficult times, that there are emergent crisis situations that those organizations ought to have the ability to treat the crisis situation and diffuse it.

We also know from our roundtable where a number of hub-type organizations spoke, that about 85 percent of veterans that engaged with those community organizations then enrolled—the veteran then enrolled in VA health care. We really believe that through the use of these organizations, we will have enhanced enrollment in VA health care for chronic conditions. The line is between acute, crisis situations, diffusing, and then coming to VA.

Mr. LEVIN. How do you anticipate that creating a new communication pathway disconnected from VA could impact enrollment, impact coordination of care. You have addressed that a bit, but if you care to expand.

Secretary WILKIE. Let me, as the non-medical person, address what I know the intent of General Bergman has been. We need to find people. If we find people in crisis, then it is imperative that if that crisis is acute, it does not matter where the care is. If you cannot get to a VA, the matter needs to be dealt with quickly and efficiently.

I am confident that in a chronic—in an acute situation, the imperative will be to get that person to the nearest care, and then we can take over.

Mr. STONE. Let me add to that. At the current time, we have our eight categories of eligibility. We also have the ability to take humanitarian cases and then figure out their eligibility after we are already treating them.

We expand that another step within our vet centers. It is why Congressman Lamb’s question was so important. What is the staffing of our vet centers? Because we have enhanced expandability. What—the difficulty today in the 14 that we are losing is that we cannot see them. I cannot sit here and tell you that we exactly understand the barriers, except we do know, as the Secretary has articulately stated, that 50 years after Vietnam, there are a number of veterans that still prefer to be lost from us.

And we need to identify them through community partners and then come back to you and say, “We need this additional criteria in order to bring them into the system.”

Mr. LEVIN. The one-pager also states, and I quote, “Grant funds will be restricted for the direct use of veterans.” Yet, I believe the bill allows the provision of services, including clinical care, to a veteran’s family members or housemates. Can you clarify the department’s position on using its resources to care for civilians?

Mr. CARROLL. The care that we want to provide is focused on the veterans. I think family members are an integral part of their com-

munity, and to the extent that family members can support the veterans, or maybe if the family dynamic is the dysfunctional component, that that needs to be addressed in order to reduce that person's crisis at that time.

Secretary WILKIE. I would add, an example of that, Congressman, would be childcare. If we found a veteran in crisis, and took that veteran to an acute service, the import of General Bergman's legislation and Dr. Roe's compromise would be to allow that community-based organization to support that veteran by taking care of childcare. That is an example.

Mr. STONE. Let me move away from sort of the mental health answer. We have veterans in crisis because they cannot get to a job. It may be paying a family member to drive them to their job because they do not have a driver's license. There is—if we begin to move away from all the causes of crisis, from simply mental health care, you begin to identify areas needing support that this bill attempts to get at.

Mr. LEVIN. Thank you. I am out of time. Again, thanks for your hard work on behalf of our veterans and I hope we are able to achieve a favorable outcome from all this.

Secretary WILKIE. Thank you, sir.

Mr. LEVIN. Thank you.

The CHAIRMAN. Thank you, Mr. Levin. I now recognize Mr. Meuser. Is he here? Mr. Meuser is not here. Mr. Steube, not here. Mr. Barr, 5 minutes.

Mr. BARR. Thank you. Thank you, Mr. Chairman, and thank you very much for holding this hearing on this very, very critical issue facing our veteran population.

Secretary Wilkie, Dr. Stone, good to see you all again. Thank you so much for your attendance this morning at today's hearing.

I want to thank General Bergman for his service to this country and for his leadership with the Improve Act. I am proud to cosponsor it, General, and I thank you for your leadership on this.

I am very heartened that there is bipartisan support for this bill and it deserves bipartisan support. I hope that this innovative approach of engaging the VA's community partners to fight this heartbreaking epidemic will ultimately succeed, I am confident it will, and I am confident that we will come together in a bipartisan way to address this issue.

I want to personally thank you, Mr. Secretary, for your active engagement on this. Not only do I not think it—not only is it not inappropriate for you to be actively soliciting support for this endeavor from Members of Congress on both sides of the aisle, I would respectfully submit that this is your job, it is your job to do it. I thank you for doing your job in soliciting support for an effort like this.

To the extent we need to work out and iron out some differences, I think we can do that, and I know the chairman is committed to that and I thank the chairman for his interest in that. I thank the chairman also for his desire to create accountability, and maybe that is what is animating this hub concept and I think we can get there.

As you all know—and, Dr. Stone, you and I have talked about this quite a bit, I have asked you about equine-assisted therapy; it is a major priority for me and veterans in my district.

Since the Lexington VA began offering equine therapy in 2016, hundreds of veterans in the mental health resident rehabilitation treatment program have been able to take advantage of this therapy, really important work that is being done to prevent suicide. We can all agree that effective mental health rehabilitation is key for avoiding veteran suicide. Would any of you all be able to confirm if both bill versions would allow for equine therapy groups in my district and other districts who already work with veterans, like in my district, Central Kentucky, Riding for Hope, the Life Adventure Center, would they be able to directly apply for grant funding to help serve veterans?

Mr. STONE. To my understanding, the answer is yes.

Mr. BARR. In both versions?

Mr. STONE. In both versions.

Mr. BARR. One thing I am a little worried about this hub concept is that it would cut out equine-assisted therapy and some of these smaller groups—and, let us face it, a lot of these equine-assisted therapy groups are small organizations, there are two, three people involved—they would not be a hub, so to speak.

Secretary WILKIE. I can answer that. That is why this hybrid model that General Bergman has come up with almost revolutionary, because it allows us to find groups like that who provide unique services, things that are not run-of-the-mill, that we have not engaged in the past.

Mr. BARR. Right. I would just say, Mr. Secretary, as I read the Improve Act, there is a lot of accountability features in the bill that impose on the VA a responsibility to ensure and certify that these groups have a track record, there are reporting requirements—

Secretary WILKIE. Yes.

Mr. BARR.—there is application criteria, there is data collection, there is evaluation, you are helping these groups to make sure that they qualify, and that they are qualified and have experience. They are not fly by-night—

Secretary WILKIE. That is right. I would also say, sir, that many of these small groups are owned and operated by veterans and, to me, that is—to use a Kentucky term, that is the trifecta, because you have people who understand the culture and speak the language and they are on the ground, and it is these unique ways—I mean, look at what we are doing now, equine therapy, art therapy, music therapy, things that were unheard of even when I was a young officer. I am an older officer now and these things are now accepted.

Mr. BARR. Dr. Stone, final question. If this bill were to become law, we already have an adaptive sports grant program, can you explain how the Improve Act grants would interact with the existing Associated Student Government (ASG) grant programs?

Mr. STONE. I think you have to recognize the fact that these grants are to bring people that are not participating into the system and, once you begin to bring them into the system, then the adaptive sports pieces can kick in right away. When we go to various adaptive sports events, over and over again we hear from vet-

erans, "I was isolated, I was alone, these types of activities brought me in."

Mr. BARR. Well, my time has expired, but I would agree with that these groups, including equine-assisted therapy groups, they are out in the community, they interact with veterans who have no interaction with the VA, especially in rural places like Kentucky, and that is why this is so important.

Mr. STONE. That is correct.

Mr. BARR. I yield back.

The CHAIRMAN. Thank you, Mr. Barr.

Mr. Brindisi, you are recognized for 5 minutes.

Mr. Brindisi is not here? Mr. Pappas.

Ms. Luria.

Ms. LURIA. Well, thank you, Secretary Wilkie and Dr. Stone, for joining us today. Thank you, Mr. Bergman, for introducing this legislation.

I would have to say that I reiterate my colleagues that this is one of the issues of utmost importance to this committee and to our Nation, because those men and women who have served and who are suffering need to have access to the care.

Secretary WILKIE. No more so than in your district.

Ms. LURIA. Thank you.

I really appreciate a comment that Ranking Member Roe made in his opening statement. I wrote this down. It says, "It is not a threat to the VA, it is a lifeline to the VA."

In research for this, I went through and I looked at the wait times within my district's general geographic area to receive mental health care and this is just drawn from VA websites. At the clinic in Virginia Beach, 33 days; at Chesapeake, 23 days; Hampton VA Medical Center, 13 days; and Elizabeth City, North Carolina, 34 days.

For veterans who are in crisis, they need a resource in the community and I think that this bill gets after the fact that there are more partners within the community that can provide an immediate resource. I have been listening and observing the debate as to whether clinical services should be provided, but I think that where I would like to see us go with this is that it is a gap. I mean, 34 days when you are in crisis and you are thinking about taking your own life is too long.

I think that the intent of having these additional services within the community—and we can debate how they are delivered, whether hubs or a hybrid system—I think the hybrid is important and, as Mr. Barr said, there are organizations out there that can provide these services immediately and they may or may not be clinical care, they could be equine therapy, there can be all types of things that change someone's outlook on life when they are suffering and contemplating hurting themselves that can be helpful, and I think we should expand that.

The reference that you gave earlier to equating this to what we did for veterans homelessness, we went to the community and said, who out there can help and how can we give you the resources to help you help our veterans. That is the direction I would like to see this go.

And I appreciate that there are details within the bill. It is very important to me that we do have, you know, accountability for where the money is going, that those organizations who receive the funds should be able to show us back that they are effectively using those funds to serve veterans in the communities. I am very confident, you know, between Mr. Bergman's efforts and the discussion that we have had here that, you know, we can get from the original text to something that provides those opportunities for our partners in the community to provide more service.

I do not necessarily have a question, I just want to say that, taking in everything that we have considered here today, I think that we can get to a yes on this, and I really appreciate you personally appearing before the committee today to be part of the discussion.

Secretary WILKIE. Well, I thank you for your kindness to me in the time that you have been serving. I have a lot of familiarity with your district, having gone to school in Norfolk when my father was at Joint Forces Staff College, it was the Armed Forces Staff College then, and then in my naval service at Little Creek and Dam Neck. No other district in the country has as many servicemen and women as yours does and I think that is the one place where we better get this right, because of the impact that this issue has on the people that you live next door to.

Mr. STONE. Congresswoman, thank you. Thank you also for the visits that you have made to our facilities in your region and your engagement in helping us change and deal with, frankly, what is a very concentrated area of veterans, but also a geographically challenging area because of tunnels and bridges.

I would like to say one thing for those veterans that are listening to us today. If a veteran is in crisis, we will see you today; if there is an urgent need, we will see you today. The numbers that you listed were numbers for our wait time for routine care, for non-emergent care, and they are accurate numbers. It can take us sometimes 3 weeks to get people in for a routine visit, for changing a provider. If there is an urgent need, we will see you today.

Ms. LURIA. Well, I appreciate you clarifying that, and I also did hear that from the providers at the Hampton VA, that the doors are open, if you are in urgent condition, come on in and we are here to help, and they can provide that triage, that immediate assistance. I think the purpose of this bill is to provide more partners in our community who also can be that conduit to get people into the care.

The last thing that I would like to highlight in my last few seconds is that I am very concerned that the Hampton VA has gone from the watch list to the high-risk list. We look forward to working very closely with you, with the new director, Mr. Collins, to find the resources and the tools to, you know, get them back on track and in a better ranking relative to other VAs, and to provide the best service to our constituents.

Secretary WILKIE. I will visit with you and we will walk those halls. As I mentioned, your district is unique among unique districts in that part of the world.

I will add one thing—

Ms. LURIA. I think we are out of time, but—

Secretary WILKIE. If I could ask the indulgence? I have talked a lot about America never having a national conversation about mental health, the only person who ever did that was Rosalind Carter, God bless her for that, and nobody was listening. We have had to change the culture, to begin to change the culture, both on the active side and now at the VA side. We do have those same-day mental health services, as you noted. We are now screening every veteran for mental health issues.

As the former Under Secretary of Defense for Personnel and Readiness, General Bergman's former leader General Mattis and I plotted out how we begin allowing our recruits in basic training and in their basic individual training to start hearing the cadence of mental health talk. What do you see in yourself, what do you see in your comrade? That by the time they get to VA, at whatever stage they had in their military career, they know, they have a base knowledge with which to move forward and that to me, the culture will change, is the most important step that we can take in getting our arms around this national issue.

Ms. LURIA. Well, thank you. I know we have already run over, but, you know, both being on the Military Personnel Subcommittee and Veterans' Affairs Economic Opportunity, I think that there is a link from active to veteran where we can make that continuum happen and would love to work with you in both capacities. Thank you for your attention to the Hampton VA.

The CHAIRMAN. Thank you, Ms. Luria.

Thank you, Dr. Stone and Secretary Wilkie, for emphasizing that same-day access to mental health care, urgent mental health care, is the policy at the VA and, as emphasized, I am very pleased that you clarified that point.

I would now like to recognize Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Thanks for holding this hearing. I thank the ranking member and of course the General for offering this bill, and the ranking member for offering the compromise.

Mr. Secretary, I really appreciate the fact that you are thinking outside the box. I went to a vigil, a candlelight vigil when I got off the plane this past Friday, a veteran in my community committed suicide, and there were several members of the community that were there that did not know him personally, but wished they had, because they would have done everything they possibly could. You know, I did not know the veteran, but it did not necessarily mean that he had a mental health issue, like you said, sir, but it could have been—I know he was having a hard time in life as far as relationships are concerned, as far as getting a real, well-paid job, as far as having an automobile to drive him to work. I understand he was riding a bicycle to work the last few weeks of his life.

Again, this is so very important, bringing in the alternative therapies. The VA does a great job, but thanks for recognizing that we need the community involvement as well and we need experts in the community. I am in the Tampa Bay area and we have terrific nonprofits that do a wonderful job, but the funding is not always there, so they cannot see all the veterans. Of course we want to make sure that they are experts and it is science-based.

I do have a couple questions, if that's Okay.

Secretary Wilkie, can you explain the relationship, if any, between the grant program that the Improve Act would create and the PREVENTS Task Force work which is ongoing? If the Improve Act is enacted, how would you ensure that it is implemented in accordance and collaboration with the PREVENTS recommendations?

Secretary WILKIE. Thank you, sir. I can certainly attest to what goes on in Tampa. As you know, my sister is a constituent and I am in the Tampa VA hospitals quite often. You and I are going to go to one of the dinners—

Mr. BILIRAKIS. Absolutely.

Secretary WILKIE.—at the hospital this coming year.

The PREVENTS Task Force came after this legislation. This legislation was here before, but I have said across the country that the PREVENTS Task Force is our first attempt at a national roadmap, a national health roadmap on suicide. Let me put that in perspective too.

Growing up, the leading cause of death for teenagers during my era was automobile accidents; today, the leading cause of death for teenagers is suicide. The New York City Police Department is ravaged by suicide. We have seen a 56-percent rise in the last 10 years in youth suicide. The point of that is, PREVENTS, I believe, will provide an opportunity for forward movement in terms of veteran suicide that will give the rest of the country an opportunity to think more deeply about what is going on.

The first goal, it presents a national roadmap, second is to open the aperture to the community. This is the first step. I do not have to wait until the report is done in March to move out on what this committee is doing. That is the vital part of this, that we start bringing small, medium hubs into our family, so that we can have a greater reach than we have ever had. I do believe that in the end the public health benefit of what we are doing at both PREVENTS and here will offer America a way forward during a very tragic time.

Mr. BILIRAKIS. Thank you.

The next question, Mr. Secretary, is the grant program that the Improve Act would create is based on this Supportive Services for Veterans' Families, SSVF. Why do you think that that model has been effective at addressing veteran homelessness and why do you think it will be effective at preventing veteran suicide?

Secretary WILKIE. Well, the key word is "community." What that model did was allow us to reach into the community with non-traditional partners, with hubs as well. A few years ago, there were 400,000 veterans and families on the streets of America every night, we are down to about 40,000 now. That is 40,000 too many, but that is a heck of a lot better than 400,000. The reason this is modeled on that approach is that we know that approach works.

We know that getting into the streets with the people who know the streets is the key not only to finding homeless veterans, but it can be the way forward on suicide. It is one of the most under-appreciated Federal-private partnerships that we have and its success rate is palpable going from, as I said, 400,000 down to 40,000 just in the last few years. We need to focus on success and that gives us a way forward.

Mr. BILIRAKIS. Thank you. We have St. Vincent de Paul Catholic charity that does an outstanding job in the Tampa Bay area and has reduced homelessness, but if there is one homeless veteran out there, that is one too many. This is so very important.

Again, you talked about the Haley Tampa VA—and I know my time has expired—you know, they think outside the box and they are making a great deal of progress, but we have got to do more.

Thank you very much, Mr. Chairman. I yield back.

Mr. STONE. Mr. Chairman, with your indulgence for just a few seconds. We will be in Tampa tonight to cap that new Patient Care Tower in Tampa and we appreciate it, but I had an opportunity a number of weeks ago to talk to your Governor's team about exactly these kind of programs in the Tampa area and their demonstrated effectiveness. It is exactly these kind of programs, sir, that you refer to that we want to get our arms around. We thank you for your leadership in this area.

The CHAIRMAN. Thank you, Mr. Bilirakis.

I now call on Ms. Lee for 5 minutes.

Ms. LEE. Thank you, Mr. Chairman.

Thank you for being here today. You know, when I think about just today sitting here that 20 men and women are going to take their life by suicide, men and women who have fought for our freedom, it is completely unacceptable and I do think it is the number one issue facing this committee. I thank you for your work on this issue.

I have a history of running non-profit organizations and I am an advocate for public-private partnerships. I think that issues like this that, as you said, Mr. Wilkie, are not linear require that type of unconventional approach. You know, knowing that what we are doing right now is clearly not working, that 14—or we can debate the number—of these veterans who are not currently accessing services, so clearly trying to find ways to get them to access services and get services to them is important. I am also a big proponent of accountability and not throwing a ton of money at problems and, you know, throwing everything and the kitchen sink and then not really having any accountability.

I do want to get to issues about data, and I want to know, what data do you have that indicate that veterans who are currently not connected to the VA are likely to use these programs under this bill?

Mr. STONE. I do not think we can say absolutely we can see this veteran population and, therefore, this is an effort—and that is why it starts at an \$18 million investment and then bringing you data back before we allow it to grow over a decade. We have got to be able, as I said in my previous answer, to see this veteran population and get them from, no, I do not want anything to do with you to yes, and the greatest chance is with using the types of non-profits that you have talked about and represented in bringing them in, we have to use their neighbors in order to get them to yes.

Ms. LEE. Thank you.

One other question I have is with respect to cash assistance and, you know, these veterans who died by suicide, but were not connected to the VHA in the 2 years prior to their death, is there any data that suggests—I mean, like what is the rationale behind pro-

viding cash assistance—or that suggests that access is or lack of access is a significant factor in suicide?

Mr. STONE. Yes, it is from the SSVF Program that has been so effective that it is identified that at-risk families present that I have lost my job, I cannot pay my rent, I think we are going to be homeless, and it is that reason that we need to get at this type of cash assistance. Clearly, we do not want to become an ATM, but what we need to do is to recognize the fact that my failure to be able to get to work because I have lost my driver's license for whatever reason places me and my family at risk both of homelessness, as well as at risk for possible suicide.

Ms. LEE. I want to turn now to a different issue that concerns. The VA's 2019 National Suicide Prevention Annual Report says that in 2017 70.7 percent of male veterans and 43.2 percent of female veteran suicide deaths resulted as a result of firearm injury. In my home State of Nevada, that number is a staggering 75 percent of veteran suicide deaths by firearm. I know other western states and states with high rural populations face those similar challenges.

Mr. Wilkie, what policies or programs has the VA proposed or created to address this issue of death by firearm?

Secretary WILKIE. Well, we will start with we are dealing with a population that by its profession has expertise in firearms. We have educational programs, particularly through our Vet Centers for—and I point to the Vet Centers, because you have to have been in combat to get into a Vet Center—we provide gun locks. There was some controversy with some of the groups that we did that, but I am four-square behind us providing tools to our veterans and their families to promote that kind of safety.

Right now, it is the form of education and material like that that we use to address these matters.

Mr. STONE. We also recognize the decision to commit an act of self-harm is also an impulsive act and, therefore, the presence of the gun lock helps, but also we talked in previous testimonies over these last few months about freezing the keys in a glass of water that has got a picture of one of your children on it, so that it slows down the distance between decision and the ability to execute the act of self-harm.

These are incredibly emotional decisions in this society. Look, I am a gun owner. I spent more than two and a half decades in the military around weapons, I am comfortable with weapons, I am a hunter, but I recognize the fact that safe handling of those weapons, especially with those people struggling the tumult of life and loneliness, are things that we have got to get around. We have handed out 2 million gun locks, but the discussion that goes on between our providers and patients is important. This bill allows us to reach an enhanced population and, therefore, this dialog will continue.

Ms. LEE. Thank you. I just would encourage that, obviously, organizations that are eligible for support through this program be encouraged to implement those programs. Thank you very much.

The CHAIRMAN. Thank you, Ms. Lee.

I now recognize Mr. Roy for 5 minutes—is he still—Mr. Roy.

Mr. ROY. Thank you, Mr. Chairman. I appreciate it. I thank all of you for taking your time to come down here and visit with us here today.

A couple questions, Mr. Secretary. Do you agree that the MISSION Act was clear that the VA is the primary coordinator of care for the enrolled veterans receiving care through the VA health care system?

Secretary WILKIE. Yes, sir.

Mr. ROY. Do you agree that there is a gap, as evidenced by the fact that 14 of the men and women who die by suicide each day have not been in contact with the VA or have not been receiving VA services for the past 2 years?

Secretary WILKIE. Yes, sir, a tremendous gap.

Mr. ROY. It is a gap of service, care, and suicide prevention that the VA is unable to meet or fill on its own at this time?

Secretary WILKIE. Yes, sir, yes.

Mr. ROY. Do you agree that it is incumbent upon us as compassionate human beings to figure out how to fill that gap regardless of who does it: the government, non-profit organizations, private groups, faith-based entities, et cetera?

Secretary WILKIE. Absolutely.

Mr. ROY. Anything to add to that?

Secretary WILKIE. Well, sir, I cannot agree more with that sentiment. I do not care where the care comes from. If we are finding a veteran in need, we get that veteran to the closest possible effective care to save a life.

Mr. ROY. Thank you. Do you agree that it would be wrong for us to be, as Washington often is, arrogant in our wisdom as to think that the Government and its selected representatives, a bureaucracy, is the only institution equipped to intervene in the most dire of circumstances, and capable of mitigating suicide and related deaths?

Secretary WILKIE. Sir, the most effective care is that care that is closest to the veteran.

Mr. ROY. Got it. Do you agree that the stakes are so high, life and death that we are talking at here, that the statistics have remained constant for so long, at least 20 years or so, despite budget increases for mental health that are greater than 250 percent since 2005, that it would be irresponsible for us to not allow others to come in and to participate in a highly structured grant program to bring other possible life-saving solutions to the table?

Secretary WILKIE. Yes, sir, absolutely.

Mr. ROY. Mr. Secretary, are you aware of the compromise language that Dr. Roe has prepared on behalf of some of my colleagues here on the committee that would require the VA to give a preference to so-called hub organizations when awarding grants, but would preclude grants to smaller, non-hub organizations where appropriate, are you supportive of that change?

Secretary WILKIE. I am supportive of Dr. Roe's and General Bergman's compromise that allows us, as you said in an earlier question, to open that space up to unique services and unique partnerships. I think we can do both.

Mr. ROY. One more question. Do you believe that some veterans—and do you agree with me that some veterans, and many

that I have talked to in Texas 21—and I am proud to represent Fort Sam Houston, Army Futures Command, and upwards of 80,000 veterans in and around San Antonio, Central Texas—it is a great place for people to move to, so we get a lot of veterans—do you agree with me that some veterans, though, do not seek care out of concern that they might lose their Second Amendment rights—whether they have got a legitimate concern or not, but do you believe and agree with me that some veterans do not seek care out of concern that they are going to have their record submitted to National Instant Criminal Background Check System (NICS) and that it would be good for us to make clear that the sole reason for getting a veteran's information to NICS should not be just because of suffering from conditions related to Post Traumatic Stress Disorder (PTSD) and their service, and that we should try to make it clear so we can attract as many people to get care as needed?

Secretary WILKIE. I will say that I do not know any data along those lines, but we are not in the business of impacting someone's fundamental rights. We are in the business, as I mentioned to Ms. Lee, of making sure that we have all of the means available to make life safe for that veteran.

Mr. ROY. Would it surprise you that many veterans in Texas 21 that I talk to have said to me that they do not seek care out of that concern?

Secretary WILKIE. I would not be surprised by that, no, sir.

Mr. ROY. Okay, thank you.

No more questions, I yield.

The CHAIRMAN. Thank you, Mr. Roy.

I just want to point out, I mean, Mr. Secretary, you have had time to analyze the compromise language proposed by Mr. Bergman and the minority staff, but you have offered no comments or taken no time to analyze the discussion draft that I have put forward that has been available for quite some time.

Secretary WILKIE. Sir, I just got that legislation from your staff last night.

The CHAIRMAN. That is not true, no. Mr. Secretary, this is—

Secretary WILKIE. The compromise legislation I just got last night.

The CHAIRMAN. Okay. That is not our—I am just saying that you have had a chance to—you have a chance to respond to the compromise language, which is fine, but you have not been able—you have issued op-eds and not been able to—

Secretary WILKIE. Well, those op-eds have been on the original legislation, which I am understanding from your comments is no longer valid, that General Bergman and Dr. Roe are going to put forward that compromise that I have been talking about as their base legislation. I think that is right.

The CHAIRMAN. All right. Well, Mr. Secretary, I mean, you have issued op-eds decrying the draft Amendment in the Nature of a Substitute (ANS) that I have had made available. My whole frustration is the lack of any attempt between your office to reach out to mine and to, you know, deal directly with the committee chairman.

Secretary WILKIE. Well, sir, we have never been asked by your staff for any technical assistance on your legislation. I am not pre-

sumptive enough to interject where I have not been asked, having—as you and I talked in front of the Speaker. I learned this business from the person she called the master, Mr. Lott. I am not in the position of doing that.

The CHAIRMAN. Yes, you went to the Speaker, but you chose not to—

Secretary WILKIE. Well, I am just telling you about—

The CHAIRMAN.—engage me. Anyway, I—

Secretary WILKIE. You were not ask—

The CHAIRMAN.—I want to call on—I want to call on Mr. Rose—or Mr. Cisneros for 5 minutes, please.

Mr. CISNEROS. Thank you, Mr. Chairman. Thank you, Secretary Wilkie and Dr. Stone and Dr. Carroll for being here today.

Like my colleagues, this is an important topic for me and, for me, it is also very personal. I had a good friend of mine in college who was an Iraqi and Afghan vet, who I served also with in the Navy, who had come back and, you know, as friends do lose sometimes, we lost contact, and when I tried to get back in contact with him I found out that he was deceased and had died in a car accident. After talking to his wife following his death, you know, she had said that he had kind of suffered from problems coming back from his service overseas, and it got me to thinking that maybe it was not so much a car accident as it was him kind of choosing to make a decision to take his life.

It is something and we do need to make sure that we go and serve our veterans.

I want to ask you really about staffing first with the VA. Would filling the nearly 50,000 vacancies reported by the VA help expand the VA's own capacity to provide high-quality, effective psychotherapy, family counseling, medication, treatment, mental health assessments, and other forms of clinical care?

Mr. CARROLL. We have, as Dr. Stone said earlier, we have roughly 24,000 mental health providers in VA. Over the last year and a half, we have hired—we have backfilled around 3 to 4,000 vacancies and actually added over 1,000 mental health providers to the workforce. The vacancy rate is currently around 10 percent. We continue to look at mental health staffing, we have a staffing model that we work with facilities to make sure that they—it is a dynamic model, because it is based upon demand. It is not just a fixed number, you need X number, but it is really based upon the number of veterans who are coming to us for care and, therefore, it always changes and increases. As we have staffed up, we have seen a greater demand for mental health care within VA.

Mr. CISNEROS. You said you are about 10 percent undermanned, about how many people is that?

Mr. CARROLL. It is around 2400 vacancies, but the vacancies are dynamic. There may be retirements, people moving on, people taking a different job. It is just part of the workforce that we have.

Secretary WILKIE. I would add, sir, that we are not immune from the pressures of the rest of society. America has a shortage of mental health workers, America has a shortage of primary care physicians, America has a shortage of mental health workers, and we suffer in that sense.

I will say, though, that our vacancy rates in those categories tend to be lower in the private sector because people want to serve veterans.

Mr. CISNEROS. Secretary Wilkie, like your father, my father is also a Vietnam Veteran. You know, one thing I do take exception to is that you said, Dr. Stone, is that, you know, only about 6 out of every 20 are seeking care from the VA, so that is an assumption that you kind of made that the other 14 do not want to seek VA care. I would kind of make the argument that a lot of times our veterans just do not know. It took my dad 30 years before he went to the VA, he knew that was even an option for him, when he was suffering from diabetes. Then later on, after he started receiving his treatment from the VA, he was also diagnosed with PTSD.

I have run into numerous veterans in my district who have said—you know, I asked one guy who was actually my Uber driver one day, you know, another Vietnam Veteran, he knew he was eligible for his VA loan, the VA home loan, but did not know about any other services that he was eligible for.

How are we going to—you know, rather than just kind of turning this over to the other individuals to say, okay, here, take care of this problem, we want to integrate these people into the VA, we want to make sure they are getting this holistic-approach health care from the VA. I will say the health care my dad receives is—it has been good and it has taken care of his eyes, it has taken care of his diabetes. How are we getting the word out there to make sure that these people are getting in, because I do not think it is people just do not want to receive their health care from the VA, I think there are the people they just do not know what they are eligible for.

Secretary WILKIE. I certainly think that the world has changed. I can tell you that this is not the VA that we saw in 2014, 2015, 2016. The statistics that I have presented show that in the last year we have had almost 3 million more appointments than we did the previous year. That is 1.7 within VA and another 1.3 in terms of the MISSION Act referrals. Veterans are voting with their feet.

The most recent VFW survey, 90-percent satisfaction rate with VA health care amongst VFW members and, more importantly, to get to the second part of your question, those 90 percent of VFW members recommend to those who are not in VA to get themselves to us. That is the best way to do it, by word of mouth and by going to a place that is in a much better position than it has been in the last few years.

Mr. CISNEROS. I am out of time, but I would make the argument too, right, the VFW, the American Legion, these VSOs may be pushing that, but how many actual veterans are actually serving in those organizations? It is very few. We need to have a better approach that we are making sure that we are getting out to our veterans.

With that, my time has expired.

The CHAIRMAN. Thank you, Mr. Cisneros.

Ms. Underwood, you have 5 minutes.

Ms. UNDERWOOD. Thank you, Mr. Chairman for holding this important hearing, and thank you to our witnesses for being here.

I know we all share the same goal of halting the veteran suicide crisis and ensuring that our veterans' access to high-quality suicide prevention services is critical to that goal. As a public health nurse, I also know firsthand how important it is to build in robust accountability and quality assessment measures when designing programs that provide these services, which is why I introduced the Veterans Care Quality Transparency Act, which passed the House earlier this year. My bill helps ensure that outside entities that VA partners with for suicide prevention and mental health services are providing effective care.

I appreciate the additional guardrails included in the chairman's draft of H.R. 3495, which I think go a long way toward addressing concerns that some of the accountability metrics in the bill were overly broad.

I wanted to clarify at the beginning something that you said, Mr. Secretary, at the beginning of this hearing. You said that there was \$18 million set aside by VA for these grant programs, can you just clarify that number and what specifically you were referring to?

Secretary WILKIE. We set aside moneys in our budget for new grant programs; however, we need authorization to take those moneys and use them for programs that are part of the legislation. We have to have specific legislative authorization, which is what this bill does, it allows us to spend that \$18 million on the hub, and also on the small and medium providers.

Ms. UNDERWOOD. Right. Absent that \$18 million, which then I would imagine because you do not have the authorities outlined in this type of a bill, then how much are you spending currently on community-based outreach for veterans who are not connected with the VA services?

Mr. STONE. We have no authority today, Congresswoman, to spend that \$18 million. It is sitting, waiting for authority to spend.

Ms. UNDERWOOD. So—

Mr. STONE. Because we have been talking about a public health approach for a number of years, we thought this was the year that we would get authorization passed and, therefore, it is in the budget for this year. Should this bill not pass, we will not have the ability to spend that \$18 million.

Secretary WILKIE. That is only a part of our nine and a half billion dollar mental health budget. I mean, that is what is out there.

Ms. UNDERWOOD. Okay, I am going to take this offline. That is a little inconsistent with what we had heard previously, which is how our legislation was generated. I mean, the VA has been spending millions to contract with outside groups to reach people doing—and maybe outreach is different than clinical care coordination or a clinical service provision, but it is our understanding that there has been outreach to these veterans who are not connected with the VA, which is why we passed this legislation earlier this year to take a look at some of those contracts.

We will be following up with you all separately.

My question for Dr. Carroll is that, from a clinical perspective, what do you believe defines a successful suicide prevention service?

Mr. CARROLL. It has to be individually tailored. We have to look at the individual person and we want to find the healthy balance of risk and protective factors. Everyone has risk and protective fac-

tors and the successful outcome is to have a response to that individual given their situation in life, given the demands that are placed upon them, that works for them in that situation.

I think we certainly want to preserve life, but we do not—that is not the end. We want to help people thrive in their communities and we want people to live well. Our mission in VA is to use a whole-health approach—

Ms. UNDERWOOD. Right.

Mr. CARROLL.—to engage veterans in life-long health, well-being, and resilience, and that is really the focus of this and everything that we do.

Ms. UNDERWOOD. Again from a clinical perspective, then how would you determine an organization eligible to receive grant funding from this bill as one that is successful at providing services that reduce veterans' risk of suicide?

Secretary WILKIE. Well, the legislation is very clear, in Section 2 it says that we have to see evidence from the group, that we have to verify that they have an established track record of reaching out and helping veterans who are in danger of suicide. The standards are already written in the legislation.

Ms. UNDERWOOD. Okay. Well, again, based on our review, it does seem that that definition of success might be a little inconsistent given an organization that might not have a track record of that type of clinical success. It is one thing to be able to do outreach, it is very different to be able to successfully say that you have prevented a suicide.

Secretary WILKIE. Well, I mean, the language I think is indicative here, it says that the only people who are eligible are “those who have demonstrated the ability to provide and coordinate suicide prevent services or other services that improve the quality of life of veterans and their families to reduce factors that contribute to suicide.”

That is the benchmark that we have to go off based on the legislation as presented.

Ms. UNDERWOOD. Okay. We will be following up with you separately about the money. Thanks for appearing here today.

I yield back.

The CHAIRMAN. Mr. Secretary, that language that you were quoting, is that from the original bill or is that the so-called compromise language?

Secretary WILKIE. I think it is in both.

The CHAIRMAN. All right. Well, thank you.

I now call on Mr. Rose for 5 minutes.

Mr. ROSE. Thank you, Mr. Chairman.

Mr. Secretary, thank you, and thank you to the rest of you for coming today, and thank you for your service.

First off, Mr. Secretary, you should not be so hard on yourself; you are not an old warrior.

Secretary WILKIE. Thank you, sir.

Mr. ROSE. Okay.

Secretary WILKIE. No, you are the warrior, I am the staff officer.

Mr. ROSE. Still your best years are ahead of you.

I trust we all agree that we have got to get this over the finish line, and let's not forget that we are serving warriors who put their

differences aside and just tried to get the job done. We just honored them on Veterans Day, but rather than just thanking them for their service, I do think it is important that we try to emulate their service and their values.

Now, with that being said, I would like to just briefly transition the conversation to that of the Post-9/11 veterans. The active duty soldiers of today are the veterans of tomorrow. Yes, we have to serve them as best as possible once they become veterans, but I also think it is important that we not unnecessarily put them through hardship during their active duty time which can produce trauma that can ultimately lead to suicide.

In line with that, Dr. Robert Usano [phonetic] of the Uniform Services University of Health Sciences did a study of a group of soldiers, 593 men and women in the United States Army who had been deployed twice and who attempted suicide between 2004 and 2009. He found that those who served 12 or fewer months before their first deployment were approximately twice as likely to attempt suicide during or after their second deployment compared with those who had more time to train and acclimate to the military before initial deployment. They also found that those that re-deployed within 6 months or less were 60 percent more likely to attempt suicide.

We have asked soldiers post-9/11 to do something that we have never asked soldiers to do in the history of this country—I deployed once, it is nothing—four, five, six, seven times our soldiers have deployed, sometimes with minimum dwell time.

My question to you is this. These stats are shocking, do you believe that every General in the United States military today, every Colonel in the United States military today, is aware of these statistics?

Mr. STONE. I cannot tell you whether everyone is aware. Certainly, rotational and dwell time is something we talked about when I was on the Army staff and as the major ground force participating—

Mr. ROSE. Mr. Stone, let us—this is an incredibly large system and when we want them to be aware of something we put a system in place. Let me refine my question, is there a system in place right now whereby Generals and staff officers are made aware of these statistics whereby a soldier is two times as likely to commit suicide or attempt suicide if they are deployed before an initial 1 years of training or dwell time, or if they are deployed rather quickly?

Secretary WILKIE. I will answer that as the former Under Secretary for Personnel and Readiness, I was aware of them, General Mattis was aware of them. I left a year and 3 months ago. I would argue that that is policy that should not be left up to the Generals and Colonels, that has to be policy that comes from the Secretary of Defense himself and the service secretaries. I know General Mattis was deep into dwell time, I was. I have got to confess, I don't know what they have done since then.

Mr. ROSE. We have got to figure out how we can have a better answer to my question, we have to. Would you agree with that?

Secretary WILKIE. Oh, I agree with you wholeheartedly.

Mr. ROSE. Do I have your commitment that we can implement some type of policy and procedure whereby our United States military officers are made aware of the significant health ramifications to multiple deployments and minimized dwell time?

Secretary WILKIE. Well, you have my commitment that I will again raise an issue that you and I have talked about, that I was once responsible for, with the proper leadership over at DOD. I think you are on target.

Mr. ROSE. Okay. Thank you, Mr. Secretary. I give back the rest of my time. And thank you again for your service.

Secretary WILKIE. Thank you, sir.

The CHAIRMAN. Mr. Secretary—well, thank you, Mr. Rose, for that very incisive questioning about dwell time and it gives us all pause, and to think that we have sent so many people on multiple deployments and what we have asked of our men and women.

I thank you, Mr. Secretary, for your testimony today. Thank you, Dr. Stone—

Secretary WILKIE. Thank you, sir.

The CHAIRMAN.—I appreciate your being here. If you have time, I hope that you will stay and listen to the testimony of our VSOs and get their response to the legislation.

Secretary WILKIE. Well, I think in the current climate, if I stayed, which I would love to do, I would probably be held in contempt of Congress for not appearing at another hearing.

The CHAIRMAN. I see. I see, Mr. Secretary. Well, we do not want that to happen, sir.

Secretary WILKIE. No, sir.

The CHAIRMAN. As you know, I have told you that I appreciate having a permanent Secretary in place, not an acting Secretary, that we need the continuity of leadership and that is one of the biggest problems I have seen with this Department is that we change leaders so often. We hope to get Dr. Stone in some sort of a, you know, confirmed situation. I do not like this Executive in Charge business.

Secretary WILKIE. Well, I will add to that, sir, you are absolutely right about the qualities of General Stone sitting next to me. As the Colonel, I have to acknowledge that. I will also say, I have been privileged to be in this seat now for a year and 3 months, I did not expect it—Mr. Lamb and I have talked about this, it came out of the blue—I have never had a better professional or emotional experience than being part of this VA family and it is the one place—and after all of the back and forth about process, it is the one place where it does not matter where you are on the spectrum, we all have a goal of taking care of those who have borne the battle, and thank you all for your courtesy to me.

The CHAIRMAN. You are welcome, Mr. Secretary. Let me just say that I think we both find enormous satisfaction in the work we do, it is a tremendous privilege to serve our veterans and I see your sincere commitment to it. I just make a plea for there to be more extensive and more frequent communication directly between you and I—between you and me, excuse me—I am English teacher, I caught myself there—

Secretary WILKIE. You are the school teacher—

The CHAIRMAN. Yes, I am.

Secretary WILKIE.—you are the teacher.

The CHAIRMAN. It is you and me, between you and me, object of the preposition. So let me just say that I am responsible for making sure that the statutes we enact are not just about your tenure, because I believe you to be an honorable and well-intentioned public servant, but I have seen in this administration people switched and changed, and I never know when we are going to get somebody who is not so well-intentioned and will exploit a weakness in the statutes we pass, that is my concern.

I do not really care about the credit and I do want to get this legislation passed before the end of the year, because I believe it is vital that we build out our infrastructure, our public health infrastructure, so they can reach these veterans, the 16 veterans that are not connected to the VA, and we have got to reach them and I agree with you.

Secretary WILKIE. Well, I thank you. I thank you for your passion and your commitment too, sir.

The CHAIRMAN. All right, thank you.

With that, you are excused, and I do not want you to be held in contempt.

Secretary WILKIE. No, sir, I do not want to be part of that parade.

The CHAIRMAN. Okay, thank you.

Let me take a brief recess while we get our second panel assembled.

[Recess.]

The CHAIRMAN. The committee will come back to order.

I now invite our second panel to the witness table, and seated at the witness table are Mr. Adrian Atizado, Deputy National Legislative Director for Disabled American Veterans. Welcome, Mr. Atizado. Mr. Blake Bourne, Executive Director, Veterans Bridge Home. Welcome, Mr. Bourne. Ms. Melissa Bryant, National Legislative Director, American Legion. You are kind of not in the same order, I went to that side. In between Ms. Bryant and Mr. Bourne is Mr. Sherman Gillums, Chief Efficacy Officer of AMVETS.

I want to begin the second panel with the opening statements. Mr. Atizado, you are recognized for 5 minutes.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Mr. Chairman, members of the committee, and General Bergman, I want to thank you for inviting DAV to testify at today's legislative hearing on the majority's discussion draft, as well as H.R. 3495, the Improve Well-Being for Veterans Act.

First, I want to make sure I get this on record, Mr. Chairman, that Disabled American Veterans (DAV) believes that one suicide is too many and every one is a tragedy.

These two proposals, which seek to address the extremely complex issue of suicide in the veteran population, is in fact needed. The veteran population is at an elevated risk compared to the civilian population in terms of suicide. Such complexity will likely require a multi-faceted response using a public health approach, as evidenced by the establishment of the PREVENTS Task Force, which in March 2020, just a few months from now, will recommend strategies to integrate private partners into the Federal inter-

agency effort on suicide prevention. DAV believes the task force's guidance should provide the strategic direction for any new interventions on suicide prevention, including the bills being considered today.

The heart of any public health strategy lies in the metrics used and the measurements at baseline, and periodically thereafter, to determine effectiveness of the intervention. Mr. Chairman, we believe both bills in the discussion draft would benefit by distinctly stating the purpose of this grant program, and that is to reduce suicide in a target population, not just to simply provide suicide prevention services. At the very least, suicide reduction should be included at its core in whatever compromise legislation comes out of this committee.

Accordingly, grants should be concentrated to entities serving a distinct catchment area with a well-defined target population. We believe the grant program should contribute to the base of evidence, which is scarcely limited, for community-based interventions targeting veterans at risk for suicide and to reduce population-level suicide rates. Thus, a grantee program should be replicable, so that effective programming at one site can be used elsewhere for a similar population.

DAV continues to believe that it is in the best interest of veterans that these grantees make some connection to the closest VA, which offers several advantages for suicide prevention based on a myriad of interventions the Department has deployed. We are talking such things as the VA-DoD Clinical Practice Guideline for Suicide Prevention; the Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) Program, a risk-identification strategy using predictive modeling; as well as comprehensive medical record data and each suicide prevention coordinator at every VA medical center. DAV firmly believes that without VA's efforts we would be looking at an even worse scenario than what we have today.

To this point, both proposals before us appear to operate from a perspective of veterans not using the VA, want nothing to do with it, which is, in DAV's view, a flawed assumption.

Based on VA's surveys and independent evaluations, veterans are often unclear about their eligibility for VA services or even their veteran status, a clear barrier to suicide prevention.

Mr. Chairman, we similarly appreciate the broad scope of services that would be offered through both a discussion draft as well as H.R. 3495, but we are concerned that without more structure and a detailed plan with regard to the cash assistance, we want to make sure that such a proposal does not promote fraud, waste, and abuse.

DAV is also concerned with the clinical care services offered under H.R. 3495 outside the new Community Care Program enacted by the VA MISSION Act. The bill provides no assurance that clinical care funded through the grant has the additional safeguards provided under the VA Community Care Program on access, as well as quality. If the committee desires to use these grants to reach out to veterans not using VA services, it should ensure that the grantees are in areas where VA has low market penetration and presence, including its Community Care partners. This

would ensure that grantees are filling gaps in coverage and reaching veterans who do not have good options for care and support services.

Finally, Mr. Chairman, DAV believes VA should be required to conduct active monitoring of this grant program, as contemplated under the draft proposal.

In closing, DAV sees the benefit of this approach, both bills. The committee has our commitment, as we have done, to find a final compromise that will go forward from this committee, and hopefully something that the Senate will be able to pass themselves.

Thank you, Mr. Chairman. This concludes my testimony and I am happy to take any questions you may have.

[THE PREPARED STATEMENT OF ADRIAN ATIZADO APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Bourne. I now call upon—not Mr. Bourne, Mr. Atizado.

Mr. Bourne, you have 5 minutes to make your opening statement.

STATEMENT OF BLAKE BOURNE

Mr. BOURNE. Thank you, Mr. Chairman, Ranking Member Roe, General Bergman, and the remainder of the committee members. I would like to start by thanking you for your work on behalf of America's veterans and their families, and for the opportunity to address you today on the subject of H.R. 3495 and the chairman's discussion draft.

According to the VA's 2019 Suicide Prevention Report, we have lost nearly 6,000 veterans to suicide every year for over a decade. We must address this challenge and engage leaders at all levels of the government, but especially in the communities where our veterans live.

Dr. Eric Caine from the University of Rochester Medical Center recently presented on suicide prevention and mentioned, "Preventing suicide is a public health and clinical care challenge. Suicide prevention and caring for suicidal people are not the same. Prevention and clinical interventions must be woven into the context of communities and families, as well as the lives of individuals."

I am here to represent Veterans Bridge Home, one of the longest standing and most successful hub organizations in our country, and we could not agree more with Dr. Caine's assessment.

VBH is focused exclusively on the connections between veteran families and the communities where they live. We work to ensure the long-term health and success of our veterans via a robust, accountable, and responsive community of employers, providers, and fellow community members.

Our organization's geographic footprint is across the Charlotte, North Carolina region, including ten surrounding counties, we have had the honor of working alongside 5,000 families, providing nearly 15,000 unique services addressing the social determinants of health of veterans of every age, era, gender, branch, race, and socioeconomic group.

This experience has taught us that there are critical elements to effectively act as a hub of a community on behalf of veterans and

their families, the most important of which is a servant-leadership role by putting the community's strengths at the forefront and matching them with the needs of our veterans who live here.

If we do this, we are able to collectively address the complexity of post-service life alongside our veterans in their community. This approach is holistic, adaptable, personal, and sustainable.

As I have submitted in my written testimony, we have highlighted three veterans that we have recently served just this year, to include a 39-year-old Army helicopter pilot who came to us 10 years ago when we first started the organization, and we have supported his family and a myriad of needs over those 10 years, to include most recently his getting his MBA and receiving employment and financial services.

We recently helped a 50-year-old cold war-era veteran who moved to Charlotte and had experienced homelessness. We connected him to over ten separate community organizations and addressed needs across the spectrum of social determinants of health.

Finally, a 42-year-old single mother serving in the Air National Guard initially came to us looking for social connectivity, as she was new to the Charlotte area, and upon meeting her and her family identified a need of transportation. She did not have a reliable way to get to work and we were able to find a community partner who provided her a nearly new car that we presented to her earlier this year.

Each of these veterans are just a few of the representatives that we have been able to support over the last 10 years. Each of them is at a different point in life, with different goals and different challenges, but the one common thing that they are looking for is connection in their community.

Our role as the hub is to meet veterans where they are, triage their needs, and find local accountable resources and solutions within the cities and towns and communities which they live. We have been doing this from the four families we first helped in 2009 and now to the over 5,000 since then.

Our team has worked to connect 62 public and private organizations via seamless technology platform. We engage over 200 local employers to hire veterans. We have connected over 8,000 community members through social fitness and volunteer events. This is done at a local level on a daily, weekly, and monthly basis to provide personal relationships with each of these organizations. This direct approach ensures that the relationships and connectedness that we are building and facilitating in our community are tangible resources for our veterans who call Charlotte home.

The health and human services in our community are fragmented. A recent Institute for Veterans and Military Families (IVMF) study showed that the majority of veterans' biggest challenge is navigating their community. These hubs, as you have coined them, make this navigation easier. Effective care coordination across the social determinants of health cannot only save lives, but contribute to thriving leaders that have the capacity to invest in building healthy communities. Barriers associated with navigating these resources across variegated community landscapes within these complex systems can prolong service delivery and

compromise desired outcomes at the individual and community level.

The language and financial support of Chairman Takano's draft would allow us to increase our capacity to address the needs of veterans and manage the relationships with providers, thus increasing efficiency and improving outcomes by working with both groups.

The VA has been a critical partner in this work since we have been here and we look forward to continuing to work with them.

Thank you for allowing us to share our experience with the committee and including it in your consideration the support of this suicide prevention. With respect to Chairman Takano's draft legislation, we appreciate and applaud the committee's efforts to address the systems-level work at the community level, and will welcome the opportunity to more formally work alongside our VA partners and this legislation would allow us to do so.

Thank you.

[THE PREPARED STATEMENT OF BLAKE BOURNE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Bourne.

Mr. Gillums, you have 5 minutes to give your opening statement.

STATEMENT OF SHERMAN GILLUMS, JR.

Mr. GILLUMS. Chairman Takano, members of the committee, thank you for this long-awaited opportunity to speak on the issue of veteran suicide that touches far too many families and communities.

I have had the heartbreaking privilege of assisting and representing the spouses and parents of veterans lost to suicide for over 15 years. For me, these veterans are not numbers expressed as decimals and percentages. Each human being who dies by suicide has a complex story with multiple dimensions, a set of seemingly insurmountable circumstances that made the permanent solution more desirable than continuing to face hardships such as relationship breakups, financial issues, poor health, and social isolation.

There is not a single person within earshot of my voice who does not understand how vexing the problem of veteran suicide is and has been for quite some time. After all, we are talking about human behavior that is motivated by factors both seen and unseen, fairly controllable and beyond anyone's control. For these reasons, we cannot simply legislate our way out of a problem that has no clear, absolute fix in the usual partisan manner.

Veteran suicide is hard to predict, much less to stop. We get that. And while there is little we can do to get to absolute zero suicides, we have to define some measure of success.

This begs the question, what does success actually look like on the issue of veteran suicide? How about we start with the ambitious goal of cutting them by half in the next year? Fifty percent fewer suicides per year among the veterans who exhibit the signs of crisis, who cry out for help, who try to access care, but cannot for one reason or another; who have loved ones that see the signs, but have no answers; who are geographically and socially isolated; or who are more likely to reach out to a peer-based group like AMVETS and the other veterans service organizations here than

the VA. We have a responsibility to turn over every stone within our reach to find a way to connect them with the help they need. So let us focus on those stones.

The first one examines how Federal funding for local programs should be distributed and to whom. One idea contemplates the establishment of hubs that currently provide intervention services to veterans in need and would work over the course of a year to build networks of local service providers who receive funding through their respective hub. The upside would be tighter control and oversight of funding; the downside would be delayed action masquerading as additional time needed to lay out another bureaucratic layer and restrictive policies, as veterans have to demonstrate yet again the patience of a saint to await the help they need.

The issue goes even deeper as questions persist regarding which eligible entities and service providers ought to be recognized and funded under H.R. 3495. AMVETS certainly appreciates the importance of maintaining traditional intervention such as psychotherapy and pharmacological treatments, but we also support veteran access to nontraditional interventions such as equine therapy, warrior retreats, canine companionship, and therapeutic recreation opportunities. It also past time to have mature discussions about cannabis and the role it could play in healing.

Short of that, we cannot say with a clear conscience that we are absolutely doing all we can to find solutions in saving lives. Too many decisionmakers presumably know what works and what does not work with no basis in empirically derived fact.

For example, are fishing trips effective? Ask veterans. Do retreats work? Ask veterans.

What turned my life around after suffering a spinal cord injury while serving in the Marine Corps was not a pill or a therapy, it was sitting in a bar—and, as a Marine, that should come as no surprise—surrounded by 300-plus other severely disabled veterans in Aspen, Colorado during the National Veterans Winter Sports Clinic and seeing the light, seeing hope through their lived experiences.

It is veterans, with all due respect, not health care professionals, bureaucrats, or lawmakers who can ultimately decide what works and what does not, in my opinion. Any compromise must give great weight to those pathways that veterans have chosen for their healing, not simply those that were offered or appear to be effective to those who have not walked in their combat boots.

Many of these veterans vote with their feet in terms of accessing preferred services based on what is available when they need it.

Case in point. What is the best treatment for a veteran with a drinking problem who was recently divorced, receives a threatening collection notice for a medical bill he cannot pay, because he quit his job due to a disabling condition of cancer he believes is linked to his Blue Water Navy service in Vietnam, for which he has been awaiting a VA decision and benefits for a year and a half? Most might say a pill of some type is what he needs to help ease his anxiety, but I disagree. This veteran needs to get out of the hole, not something to help him forget about the hole in which he finds himself. What the veteran needs is the holistic, multi-faceted approach we take with our Healthcare Evaluation, Advocacy, Legislation

(HEAL) Program, where we address the underlying precipitating factors that lead to crisis.

You reach these veterans not by going down familiar paths; rather, you go where there is no path and you create one, through organizations you might not have previously considered or pathways to relief that might run counter to conventional sensibilities.

We cannot keep shooting first and then drawing a bull's eye around the impact point by relying on one-dimensional approaches that serve a few and only point to those successes. As I earlier said, it is time for game-changing ideas that test our assumptions and raise expectations.

I fully appreciate that Congress through this committee understands its responsibility to scrutinize how taxpayer dollars are spent, but analysis paralysis is what happens when Congress over-thinks and under-works. It is far better to make mistakes than to fake perfection. There are risks and problems that require a trial-and-error approach, not unlike what we presently see with homeless veteran and adaptive sports grants from the VA.

I will leave you, our elected leaders, with these questions. Is it worth having compromise? Is it worth one side or the other getting the lion's share of the credit? Is it worth potentially losing the next election to solve this problem to the best of our collective ability? The answer is yes. You know why, because you live to fight another day when you lose a political tug of war, but when our veterans lose so that one side can win, the grand prize for the winner is 20 more bodies a day.

Thank you for giving the veterans who died by suicide and the families they left behind the opportunity to be heard through my testimony, Mr. Chairman.

[THE PREPARED STATEMENT OF SHERMAN GILLUMS, JR. APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Gillums.

Ms. Bryant, you are recognized for 5 minutes.

STATEMENT OF MELISSA BRYANT

Ms. BRYANT. Thank you, Chairman Takano, Ranking Member Roe, and distinguished members of the committee here today.

On behalf of our National Commander, James W. Bill Oxford, and the nearly 2 million members of The American Legion, we thank you for the opportunity to testify on H.R. 3495, the Improve Well-Being for Veterans Act, and the veteran suicide crisis in the United States.

As the largest patriotic service organization in the United States with a myriad of programs supporting veterans, The American Legion appreciates the leadership of this committee in focusing on the critical issue of suicide prevention and improving veterans' overall well-being.

We all know the numbers, we all know the data. I have lost soldiers and friends to suicide, I have personally intervened with a soldier who was attempting suicide. We know the human cost and we know that we need to act now.

The American Legion stands behind VA in its efforts to collaborate with partners and community nationwide to alleviate this public health crisis, of which veterans and military are a microcosm of

a far greater epidemic. It is imperative that the full committee, VA, and other stakeholders work together from the outset to tackle this complex issue whenever new proposals arise. We are all in this together, and the The American Legion stands by as a trusted adviser and partner, now and always, to help navigate toward safe and effective suicide prevention solutions.

As I stated at last week's roundtable and in written testimony for this hearing, we believe that all suicide prevention efforts must be in accordance with the PREVENTS Executive Order (EO). I will not belabor further on that; I think my colleagues have well covered that throughout the course of today's hearing.

The American Legion supports providing funds to both hub organizations and providers of non-clinical services if they are subject to a rigorous vetting process based on clear metrics and evaluation criteria. The American Legion believes that a diversity of quality organizations providing non-clinical social services would be useful in combating veteran suicide, particularly in rural and highly rural locations. However, further questions on the mechanics of how to administer said funds and/or clinical care to support veteran suicide prevention through non-VA entities should be coordinated through the existing VA programs.

As several partner organizations and VSOs have echoed either in testimony today or in discussions that served as a prelude to today's hearing, we are happy to support ancillary services by community providers or hub organizations in the fight against suicide among veterans, but we feel that creating a whole new lane outside of VA and the community care network will result in fragmented care and will not help those veterans who do not use the VA services for care.

The American Legion does not support the provision of clinical care to veterans and their families through non-VA providers outside of the VA community care network. VA is the most qualified and reliable source of long-term clinical care for veterans, and non-VA providers should refer veterans to the VA should they need clinical care and should they receive the expert care offered by the VA community care network.

The American Legion also opposes the provision of direct temporary cash assistance to veterans and their families. There are already numerous mechanisms in place to aid veterans such as the Supportive Services for Veterans' Families, SSVF, and VSO grant programs, as we have discussed earlier throughout this hearing. Giving cash directly to veterans is not an effective use of limited resources and it provides unique challenges in the oversight of such temporary cash assistance. Again, that is what the VSOs are here for and that is what we have stood for decades.

We are thankful that the majority and the minority staff, as well as the VA Office of Congressional and Legislative Affairs (OCLA) office have consulted with us in the past couple of weeks to get closer to reconciliation of these various proposals, and we are pleased to have received the compromise language from the minority last night that seems to address our aforementioned concerns, and we hope that said language creates a basis for ongoing discussions.

In closing, The American Legion appreciates the leadership of this committee and remains committed to reducing veteran suicide. We are further committed to working with VA and this committee to ensure that America's veterans are provided with the highest level of support and health care.

With that, I yield back my time.

[THE PREPARED STATEMENT OF MELISSA BRYANT APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Bryant.

I now recognize myself. I just want to say that we have very few members left and we can be somewhat flexible with the response time. That being said, I do want to keep my time brief. I recognize myself for ostensibly 5 minutes.

I would like to get a baseline on where each of your organizations are on the major discussion points. Some of you have already answered these questions, but I would ask you to answer them again. I am not really trying to pin you down, but I think it is important for us, it is important for our discussion today to understand where you are, more or less. I would like to run through quickly some questions and they are really yes-or-no questions. If you feel compelled or you need to answer some more, we might have some time later on in a second round of questioning, or you can revise and extend your remarks through written testimony.

The first question I have for each of you is, should VA provide grants directly to providers of non-clinical social services without any information, without any information about the veteran-specific needs or what services are available within their communities?

We will begin with—we will just start with Mr. Atizado and go down the panel.

Mr. ATIZADO. Mr. Chairman, I appreciate that question, but I think not doing an assessment of need is—I do not even know how a service provider would be able to engage a patient or an individual that comes through their door without doing some sort of assessment. I suppose it would really depend on what that assessment is.

The CHAIRMAN. It sounds like you would say probably no, I mean that VA should not provide grants directly to non-clinical social services without any information about the veteran-specific needs or what services are available within their community?

Mr. ATIZADO. It would be a no. I would be suspicious of any service provider that does not.

The CHAIRMAN. Okay, thank you.

Mr. Bourne?

Mr. BOURNE. Yes, Mr. Chairman, I would agree with my colleague Adrian that, no.

The CHAIRMAN. Thank you, thank you.

Mr. Gillums.

Mr. GILLUMS. I feel like I have to peel that question a little bit. Are you saying that the information about a specific veteran does not go to VA first?

The CHAIRMAN. What I am saying is—

Mr. GILLUMS. What is the process we are kind of—

The CHAIRMAN. The question is, should VA provide grants directly to providers of non-clinical social services without any infor-

mation about the veteran-specific needs or what services are available within that veteran's community?

Mr. GILLUMS. Right, I feel like everything up to "without" is a yes until the "without" and——

The CHAIRMAN. Yes.

Mr. GILLUMS.—I would say no——

The CHAIRMAN. No, Okay.

Mr. GILLUMS.—with that qualification.

The CHAIRMAN. Ms. Bryant.

Ms. BRYANT. I would agree with my colleagues in saying no. Essentially, if you have a veteran that is referred to one of these hubs or an outside provider, that should be a triage point and, from that triage point, it should go forward to whether they know what is available to them through VA and wrapping around back to VA, or within the community care network, but it should not go into clinical provision.

The CHAIRMAN. All right, thank you.

The second question. Should VA provide grants to allow the provision of clinical care to veterans and their families through non-VA providers outside of the community care network, outside of a CCN, yes or no?

Mr. Atizado.

Mr. ATIZADO. Mr. Chairman, I will say yes, but there has to be a caveat to this answer, Mr. Chairman. As was discussed earlier by this committee and by the previous panel, we are talking about acute situations where an individual has to be stabilized if they are in fact in that critical State. In those particular circumstances, stabilizing, I think it is critical that services, even clinical, be provided at that time.

The CHAIRMAN. You are saying yes, but in very limited, carefully defined situations?

Mr. ATIZADO. Yes, Mr. Chairman.

The CHAIRMAN. All right. Mr. Bourne.

Mr. BOURNE. Thank you, Mr. Chairman. At this time, I would say no. In the 894 health care requests that we have received in the last 4 years, we have been able to address the clinical needs of veterans both at the VA and in non-VA without this payment method. At this time, without further standards of care and especially with the work that has come out of the MISSION Act, my answer is no.

The CHAIRMAN. All right, thank you.

Mr. Gillums.

Mr. GILLUMS. Could you repeat the question, just so I have the full context?

The CHAIRMAN. Should VA provide grants to allow—should VA grants allow for the provision of clinical care or should they go to clinical care to veterans and their families through non-VA providers outside of the community care network?

Mr. GILLUMS. I can see why it would be dangerous to go in that direction, but I know the reality and veterans are already doing that, they are already accessing programs and services outside of the VA's view. I think that having some way to coordinate this, and maybe through this grant process that would be one way to do it, but veterans are going to go, for example, if they want to explore

cannabis as a possible healing option, and the VA is pretty dogmatic about that, they are going to go do that.

I think it really depends on, you know, what the treatment is, but I will remain open to the idea that there may be instances where a veteran needs to be empowered to explore care where he or she desires to get it.

The CHAIRMAN. Okay. Thank you.

Ms. Bryant.

Ms. BRYANT. So I am clear, Mr. Chairman, you are asking if grants should be provided through non-clinical—non-clinical services should be provided by the VA through to the veteran, correct?

The CHAIRMAN. Yes, should VA provide grants, should VA money be used for the provision, to allow for the provision of clinical care to veterans and their families through non-VA providers outside of the community care network?

Ms. BRYANT. I will refer back to my first answer and the answer is no with a but. The but being that we understand that points of entry for care, we are okay with any point of entry in which a veteran raises their hand and says, “I need help.” It is OK to not be okay. If they come in through a point of entry that is a triage point that then refers for clinical care after an initial assessment back to the VA, then that is what we are in favor for.

The CHAIRMAN. All right, thank you.

Should VA grant—I have just two more questions here for everyone and if you can answer as close to a yes or no, I can get through this faster—should VA grant money be used for providing temporary cash assistance directly to veterans, their families, and their housemates under the pilot program as currently written?

Mr. Atizado.

Mr. ATIZADO. No, Mr. Chairman. I think probably the best way to tackle this issue is actually have it flow through SSVF, who happens to be a very high-risk—a population at high risk of suicide.

The CHAIRMAN. Thank you.

Mr. Bourne.

Mr. BOURNE. Mr. Chairman, our answer is no, because there are several local community resources that provide temporary financial assistance, in addition to the SSVF programs that already exist, and local hubs should know those.

The CHAIRMAN. Mr. Gillums.

Mr. GILLUMS. I would say no, but there should be a consistent, predictable standard for how it is applied, how you would disseminate those dollars.

The CHAIRMAN. Ms. Bryant.

Ms. BRYANT. I concur with my colleagues in saying no.

The CHAIRMAN. Okay. Thank you.

Finally, do you currently support H.R. 3495 as drafted, not—I mean as drafted, the language in the introduced bill, not whatever version of compromise language is out there?

Mr. Atizado.

Mr. ATIZADO. Thank you, Mr. Chairman. At this time, as both the sponsor of the legislation and the minority committee staff know, we are working with them to improve that underlying bill.

The CHAIRMAN. Okay. Thank you. I will take that as no, but go ahead.

Mr. BOURNE. Mr. Chairman, I would agree with my colleague Adrian that, yes, the answer would be no on the former version. By the previous testimony and your version, those compromises sound like they are moving in the right direction based on our conversation last week.

The CHAIRMAN. Mr. Gillums.

Mr. GILLUMS. No, and I think the compromise language speaks to some of the concerns we have with the original language.

The CHAIRMAN. Okay. Thank you.

Ms. BRYANT. No to the underlying original bill as written. We believe, again, in the compromise language from both your staff, as well as from the minority that we have worked with, has been taken into account in that language.

The CHAIRMAN. We are moving—and I think you are saying we are moving in the right direction?

Ms. BRYANT. We are moving in the right direction between the two compromises.

The CHAIRMAN. Okay. Thank you. I went over 3 minutes and, Dr. Roe, you are welcome to do what you want.

Mr. ROE. I will not.

Mr. Gillums, you mentioned fishing, if you decide you want to come fishing for therapy, I have a fish hatchery in my district, I can guarantee you big trout. So if you want to come.

Let me just say that I wish we had done this a little sooner. We have an opportunity and I got my marching orders at the roundtable. We had a lot of hiccups and starts with this, but the three things I want to bring up are the following.

The clinical care, the compromise draft, which is what we are really talking about now, would allow grantees to provide an initial assessment, a triage, then require them to refer eligible individuals to VA for subsequent or ongoing care; such care would be provided by VA pursuant to existing authority. We agree on that.

Number two, I know Mr. Atizado had mentioned this at the roundtable, the temporary cash assistance, that is the second thing that was discussed. The draft compromise proposal would prohibit direct cash assistance from the grantees to eligible individuals for their families. The hubs, the draft compromise—and we worked on this and I agreed to this, because I think the hubs in many cases are great ideas—the draft compromise proposal would require VA to give preference to hub organizations who are referred to as organizations that have demonstrated the ability to coordinate suicide prevention services in awarding grants, but would not prohibit grants to non-hub organizations.

I think that is what I heard everybody say and we agreed on this, and I think this is very simple what we ought to do.

The other concern that I have is—look, I had guys that I was in service with 40-something years ago and many of them just will not go to the VA. They are Vietnam Vets, they just will not go. We need to not forget these guys and gals, number one. The VA is not meeting all the needs, otherwise the suicide rate would not be 20 a day and staying there.

I think this idea about casting a bigger net—Mr. Bourne, I really like what you guys are doing—cast a larger net to bring these people in and then we will get them in, if they qualify; if not, we will

find someplace for them that is proper for them to get care. I think that is what the whole idea of this is.

I guess a question I have very simply, and then I will yield back my time, is did you hear what I heard during the roundtable? We went straight to work on that. We have included, by the way, all of these things, and we have emails back and forth to the majority staff, letting them know exactly when we sent to the staff what we have, do you all—are you all comfortable with what we have done in the compromise?

Mr. Atizado, I will start with you.

Mr. ATIZADO. Thank you, Ranking Member Roe, for that question. Like was mentioned, we got the draft late last night—or I was able to look at it late last night and a little bit this morning. I am not comfortable right now to give our organization's position on that, but I do—I must point out to you that you did, your staff and this compromise that was provided last night, did include some of the recommendations that were spoken to in the roundtable, and I really appreciate your work and the committee staff's work in doing that. There are some minor issues in the draft that we have identified and we are still working with your staff to cure some of those. I think, and my colleagues I think will agree, that we would like here is that both at least on a committee staff level are working very hard to come to a compromise here and meet the chairman's deadline of having a markup here real soon for us to be able to push and implement to veterans out in the community.

Mr. BOURNE. Sir, thank you for your kind words of support earlier and then just more recently about the work we do. I think based on, again, as Adrian said, the limited time we have had to look at the compromise version, I think that based on the discussions we had last week during the roundtable and that I have heard today that, yes, we are on the same page and headed in the right direction.

Thank you.

Mr. GILLUMS. I consulted with our staff who was in attendance at the roundtable, I think we are headed in the right direction. The one caution I would have is it seems like we think we have so much time, you know, this idea of building a process where you have this hub, take about a year to figure out to build these networks, we do not have that kind of time. I think if we make it too hard, too stringent, we are going to block out more people just by virtue of the fact that it is just too hard to deal with the VA on these things.

I would like to see a shorter time line between these hubs and when they are supposed to deploy these networks. I think that is the only area where I think there needs to be some refinement.

Mr. ROE. I think some people are locked and loaded and ready to go right now; I agree with you.

Ms. BRYANT. Dr. Roe, I want to thank your staff, as well as the majority staff, and also to my colleagues here from the VA, I think all three entities have had meetings, calls, conference calls, I have lost count of how many we have had in the last couple of weeks, to try to move this across the goal line. And from what I have seen so far, notwithstanding having had a chance to review with my full

team just yet, I think that the compromise language that we received last night is moving in the right direction.

I also want to note that I share your concern for the Vietnam era. My father is a Vietnam Veteran, nothing scares me more of him losing another friend or me possibly losing him to the stressors of suicide, just as I have experienced as an Operation Iraqi Freedom (OIF) veteran.

Mr. ROE. Thank you all.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Roe.

Mr. Lamb, you are recognized for 5 minutes, more or less.

Mr. LAMB. Thank you, Mr. Chairman.

I want to reiterate something I said in the last panel, which is that nobody on this committee on either side needs to be lectured about the urgency of this situation, we all understand it very well. I have been a member of this committee since April 2018, which means I have served under both a Republican majority and a Democratic majority, and I want to thank the chairman for making this the first hearing we have had in that time on this particular subject, and he has committed to getting a bill moved forward by the end of the year.

When you see disagreement between the two parties about how actually to get that done, that is so that we can strike, we strike fast and hard and effectively. And our debate is about how to do this, not whether to do it and not how fast. That is what our constituents elected us to come here and do, to be sure that every dollar is spent responsibly and that it is spent to accomplish the actual mission.

The reason that the issue of hubs has been such a focus is that these are at least 17 to 20, by my count, existing networks that already know the local players in their geographic region, and know who is good and who is bad at providing these services, and have some experience working together.

Mr. Bourne, I would like you to maybe confirm a couple of things. Are you part of the AmericaServes network or are you guys separate?

Mr. BOURNE. No, we are, sir. Yes, we are the second community.

Mr. LAMB. It seems similar then the work you all have done to what PAServes is doing, and just confirm for me if this is a similar level of services that you coordinate.

PAServes, if you look at their list of providers, meaning all the places that they can refer out a veteran who comes in front of him, you have got Action Housing; you have got Advantage Credit Counseling; you have got the Red Cross of Western Pennsylvania; you have got Boulder Crest Retreat for Military and Veteran Wellness, which is an organization we have a ton of respect for; you have got the Community College of Allegheny County; you have got Corporate America Supports You, which is an employment organization to get rid of unemployment for veterans; you have got the Duquesne University Psychology Clinic, which can get people into direct care very quickly; you have got the Goodwill of Southwestern Pennsylvania, Hire Our Heroes; you have got Interim Healthcare and Hospice; you have got Leadership Pittsburgh for building leadership skills for people who are looking to get back in the work-

force; you have got Neighborhood Legal Services Association for someone maybe who is facing eviction or other some kind of immediately legal action.

These are just examples, but would you say that your hub organization is comprehensive like that as well where it is dealing with financial, legal, health care, employment, all those things?

Mr. BOURNE. Yes. Thank you very much, Representative Lamb, it absolutely is. I know Gene and Matt and Aaron and that team well at PAServes, we have had the opportunity to work together for over 4 years. We have actually supported families that have crossed our boundaries, that have moved from Pittsburgh to Charlotte, Charlotte to Pittsburgh.

Yes, our network is just as comprehensive as theirs are, and I think many of the same or similar partners. Our Goodwill of Southern Piedmont, they have Goodwills, you know, our community colleges and local universities like Queens University, our county Veterans Services office.

When you map and you overlap communities and these partnerships, these networks, they begin to look very similar, they are similar actors. They might be sitting in a different, they might have a different brand, but they are doing very similar roles in specifically the key areas that we focus on, which are employment, education, housing, health care, benefits, and then social enrichment.

Mr. LAMB. Like PAServes, is your staff—does it have many veterans on it as well?

Mr. BOURNE. Yes. Everyone on our staff is either a veteran or a direct family member of a veteran of the 12 total.

Mr. LAMB. In your time there, have you ever encountered an organization that wants to be part of the hub network that you guys are that you thought was going to be pretty good at providing some service, whatever it was, and then time and experience showed that they were not a reliable partner or someone maybe you did not want to do business with?

Mr. BOURNE. Yes, absolutely. We started the network in 2015 formally—we had been operating as an organization since 2010, but formally with this network, with the help of AmericaServes, in 2015 we went live with 32 organizations, that has grown to 62. We were at one point as high as 78, but we have shrunk some of those. Some were national partners that wanted to have a presence in Charlotte, but were not a reliable source to be able to deliver care in our local community and it was not something that our veterans were really asking for.

Mr. LAMB. Yes, we have seen a similar thing back in Pittsburgh where there are just good players and bad players, and sometimes there is even bad players that are already doing business with the VA. I mean, we had this one experience recently where a local veteran who is a retired Marine, First Sergeant, and will not take no for an answer from anybody, came across a homeless veteran and it took him 15 phone calls to get the guy a bed at the VA, which was okay at the end of the day, and they kept him and treated him well. Then when it came time to get the veteran in housing using SSVF funds, the organization that was contracted for that was terrible. They would not pick up the phone, nobody was at the office,

it took days and days and tons of delay, and it was only this Marine First Sergeant's persistence that ended up getting the homeless veteran in his home, and now there are serious questions about whether that non-profit group should be continuing to receive these Federal funds based on the record we knew.

It was just an important example where I think it has been suggested that SSVF is somehow a perfect model for what we want to do. That program does not always work out perfectly anyway and a lot of times it is the person with the local know-how who is really able to kind of assemble the team of resources that you need to get this done.

I think we think the hub programs are strong for that reason and it is, in my view, really more about who is making the decision here. Organizations like yours have years of experience figuring out who is good and who is bad at the ground level, I am just not certain that people in the Secretary's office, however well-intentioned they are, would have the same level of expertise or knowledge compared to the existing hub networks.

With that, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you, Mr. Lamb.

I now call on General Bergman for 5 minutes.

Mr. BERGMAN. Or so?

The CHAIRMAN. Or so.

[Laughter.]

Mr. BERGMAN. Great to be last—and I say that seriously. Well, I know, because the chairman always gets the last word.

A quick question, and we will start with Mr. Atizado and just go down the line. What percentage—looking now at your organizations that you are here representing, okay? What percentage of your eligible membership population, so those who are eligible for membership in your particular organization, do you think you are currently reaching through your current communications efforts?

Mr. ATIZADO. General Bergman, that is a great question, something that I am sure my other—

Mr. BERGMAN. Can you give me a bandwidth? Half?

Mr. ATIZADO. Well, I wish I could. We have a number of platforms, like other organizations here. We have our mail-out magazines, we have social media, we have our Facebook, we have our website—

Mr. BERGMAN. Let me ask the question a different way. Would anybody like to offer a percentage before I ask you the derivative of that question?

Mr. BOURNE. Ours is approximately 4 percent, sir.

Mr. BERGMAN. You are reaching 4 percent of the eligible population?

Mr. BOURNE. Our eligibility require if you have served in the military or are an immediate family member of someone that served in the military, we will address the needs that you have.

Mr. BERGMAN. Of that eligible 4 percent, what do you think, how many are you reaching?

Mr. BOURNE. Oh, no, I am sorry, the 8,000—excuse me, the nearly—

Mr. BERGMAN. If your target population is 4 percent of the total military having-served population, did I hear that right?

Mr. BOURNE. No, sir. I apologize, I might have not been clear. Of the families that we have served, we have reached about 4 percent of the total eligible population in our geographic catchment area.

Mr. BERGMAN. Okay, Okay. 4 percent.

Mr. BOURNE. Four percent.

Mr. GILLUMS. I will not even venture a guess, because I think we have the most liberal membership eligibility criteria. 20 million point 2 veterans could theoretically join our membership. We have about a quarter million members and, if I had to venture a guess—you see, here is where the failure of communication is assuming that it has occurred—we can reach out, but whether they get it, whether they have heard us, whether they engage, it is kind of situational.

As Adrian said, there are many platforms. We venture out in social media more than ever and we gauge reach by responses often-times and how much engagement we get. We will have peak engagement on things like maybe this hearing and then we will have not that much on other things.

Mr. BERGMAN. All right.

Ms. BRYANT. I would have to say, General Bergman, that 100 percent of our Legionnaires at least receive our magazine. If you want to talk, like my colleagues have, on platforms, I am sure you have probably received a copy as well—

Mr. BERGMAN. I get your magazine.

[Laughter.]

Mr. BERGMAN. I get all the—as, you know, member of the Legion, member of VFW, member of—

Ms. BRYANT. Absolutely.

Mr. BERGMAN.—you know, okay—

Ms. BRYANT. But it is hard to capture, as my colleagues have said.

Mr. BERGMAN. Well, the point is, the point is—and I am glad you brought up the point of the magazine—regardless of what percentage of your target population that you are trying to reach, are you trying different ways? Do you have, you know, meetings amongst your leadership to say, okay, we think we are doing this well, here is what we may try to improve? Anything like that going on in your organizations just as a matter of routine business?

Mr. ATIZADO. General Bergman, thank you for that question. Yes, so a part of our business, a part of our strategy as an organization is to in fact saturate the target population. I think I may have misunderstood your original question when I answered. Our population, membership for DAV are all those veterans that were injured during military service—

Mr. BERGMAN. Yes, you have specific criteria—

Mr. ATIZADO. Very much so.

Mr. BERGMAN.—for it to be eligible.

Mr. ATIZADO. Our members at the most local level, down to our chapter level, actually have—are driven through incentives to reach out to veterans that they may have heard were injured or believe was injured in military service. That is part of the leadership at the local levels—

Mr. BERGMAN. The point is, in fact you all said it in different ways, you are all trying through your organizations to get your

message out. You are not sure if your message is being heard, because sometimes you do not get that sonar ping back that there was—you know, that they have received the message, and when you send a magazine out, you never know if someone read it, okay? Unless somebody looks at a number or an email in your Legion magazine and calls and says, hey, I saw it in your magazine.

Why—

Ms. BRYANT. We do have other programs, of course, sir.

Mr. BERGMAN. Well, you do, of course you do, we all—but the point is, the point is, when I heard earlier when Mr. Cisneros talked about the need for the VA to communicate with the veterans, communication is not a perfect art. Just because you say something or write something does not mean it is heard. Even if it is heard, it does not mean it is understood. This is communication is a two-way street.

What I have seen across the board is, if we are not looking for new ways to communicate, especially utilizing social media, different venues, avenues that may be available today that were not decades ago, then we are not doing our job to adjust to the changes necessary to get our message out. To get the veterans informed about what is going on in the VA, but also get that feedback.

I kind of—what I see in all organizations is you are all trying, including the Veterans Administration. I am on all their lists as a veteran, so I know exactly what they are doing and what kind of communications that are out there.

Now, here is the challenge, because what we are talking about here by and large is reaching out to veterans who we are not getting to now, that is the reason we are sitting here today. We have urban, we have suburban, we have—I hear the term ex-urbs, I have not figured out that one yet—we have rural, but I happen to live in a district that is less than rural, it is remote.

I have a couple of maps here of the United States that show two things, it shows basically the percentage of veterans that are in a district, reflecting the current percentage of the population, but also as you look at the geography of the map it shows the difference between remote, rural, urban, and suburban.

When I think about reaching out to veterans in my particular district—and there are others, this is not the only district in the country that has this remoteness—that our challenge going forward in reaching out to these veterans who are at risk and are vulnerable, if we do not try different methods—in some cases they may not have Internet, they may not have a cell phone, they may not have a lot of things, so how do we, you know, bring the message to them?

In some cases it is going to be—and I think—Mr. Gillums, did you mention the bar? Yes, it could be the local bar, it could be the local church, it could be something where there is a community care group that is specific to that area. When we think about just doing things one way and that is going to hit 100 percent of the target, we know it is not.

The point is—well, I guess I am probably not asking you too many questions right now, am I? okay, here is the last question. Is it better to have an 80-percent plan aggressively executed or a perfect 100-percent plan never executed? That is a rhetorical ques-

tion. You know, the fact is we are all, everyone who is in this room today wants to reach out to those vulnerable veterans.

Now, I look at things in a Marine Corps way, okay, but I also look at things as a pilot and making decisions when you have to make decisions to ensure the safety of the people whose lives I am responsible for and it may be different than the book said at a time, but I had to make that decision to keep everybody safe. So when I look at a nice, tidy solution set that is perfect bureaucratically, it scares the bejesus out of me.

Having said that, Mr. Chairman, you have indulged my extra words and I appreciate your efforts here, and I look forward—is anybody here adverse to the word “compromise”? Good. I think we have got a good compromise on the table. And I yield back.

The CHAIRMAN. Dr. Roe, closing comments?

Mr. ROE. I will be briefer than the General.

[Laughter.]

Mr. ROE. I appreciate all of you all being here and I think we have made great progress. Simply my only concern was, I wish we had done this a little sooner, but I think we are moving in the right direction. I think we sat down and listened very carefully to the roundtable and said what do we do to get everybody to the same or as close to the same place as we can. I think we have hit that with a few little minor things. Basically what Mr. Gillums said was we cannot wait; the wait is over, it is time to do this and get it done.

What General Bergman also said was, you know, with all the metrics and good intentions and all of that, the suicide rates have not changed, so we need to do something different.

To Mr. Bourne, who has a very mature there in Charlotte—I feel like I am a resident of Charlotte, I fly through there twice a week, so I feel like I should be a taxpayer there—

Mr. BOURNE. You should come visit, sir.

Mr. ROE.—do not send me a notice—but you have a very mature, sophisticated organization in Pittsburgh. Those are big, mature cities. I have to go to Sneedsville, Tennessee that has 2,000 residents and they are across Clinch Mountain. There are veterans that live there, they are very patriotic people, and there are veterans in Mountain City, Tennessee that I have to get to. Where General Bergman was talking about in the UP, that is a whole other piece of territory up there.

We are trying to cast a wide net to bring in more people to get care, that is what we are trying to do. I do not think we need to get all hung up on the minutia, to look at the goal that we all have, I think everyone here has, and not get hung up on one little thing or the other.

I would encourage us to—I think we are just about there and I see a solution coming, I really do, if we keep the staffs working together, and you guys can tell us the few little things that you have that—but do not let a little thing derail a big things, I think is what I am saying, do not get hung up on one little thing.

It was easy for me last week when I was listening to the roundtable and we talked about the cash assistance. Look, that makes perfectly good sense what you guys are talking about, provide the service with the cash. I had no problem with that, but I think also

having people in an emergent situation—I can tell you as a doctor, if someone comes in to me and is in extreme, I am going to take care of them and I am going to worry about who pays for it later. I am not even going to be worried about that. Let us get the problem taken care of and then get this person where they need to be. I think that is the way most people feel.

Mr. Chairman, I thank you for having this. I think this has been a great hearing and I see a solution. I think we can meet our deadline of before we get out of here for Christmas, at least this Congress. It has not done much, I can say that, to my frustration, but this we can and should do.

With that, I yield back.

The CHAIRMAN. Okay. Before I adjourn today, I would like to extend my appreciation to the VSOs, the mental health professionals, the union leadership, experts on suicide prevention policy, and stakeholders who have assisted committee staff in helping to improve legislation to help veterans.

Last April, following three veteran suicides in 5 days on VA campuses, this committee rededicated itself to working toward solutions to help our veterans in crisis. We called members together for an emergency hearing, convened the press. I recall that Ranking Member Roe and all the members, most of the members of the committee came together for a bipartisan press conference to draw attention to the issue. We passed five bipartisan bills and held multiple roundtable discussions. These efforts have led us here again today to find solutions.

Now, I pulled this legislation from the markup, the last markup we had, because I did not feel it was ready, I did not feel that the staff engagement was earnest at that point, and I did not feel that we were going to get where we needed to get to in the markup.

We established a roundtable, which Dr. Roe and I think everybody who was present felt it provided information that allowed us to, I think, start talking in earnest.

General Bergman, I really want to thank you. You on the floor said, let us talk as member to member without interference from the staff. We, the members, are the ones in charge. I give you a lot of credit, I give you the credit for making that real, asserting the power of the member and to remind staff that they serve members and members' intent as they author the bill. You have precipitated, I think, the earnest discussions we have had today. In the end, I would like to see it be your bill that passes.

I am appreciative that our concerns, even though in the majority we could make those concerns the concern, but that is not the way I want to do things here. I have been frustrated that the Legislative Affairs operation at the Department of Veterans Affairs has orchestrated a press effort—we have not done that on the majority side, we have been restrained, mainly—all in the service of doing something about reducing veteran suicides. It was more important to me that we arrived at a compromise, arrive at an agreement. In the end, I think a good compromise, everybody walks away feeling that they did not compromise, that we have reached a mutual understanding.

Look, I have a high regard for Secretary Wilkie. He served, I think, a great Secretary at the Department of Defense before he

came over to the Department of Veterans Affairs, but, as I said, my job as the chairman of a committee is to make sure that the legislation that comes out of this committee is not written just for a good public servant, a well-intended public servant. I have seen parts of this administration spend money that has not been appropriated for certain purposes and that I have seen a pinhole be made wide enough for a Mack truck to be driven through, and the intent of Congress is not met unless we carefully craft the language and carefully put language that does not allow the intent of Congress to be somehow twisted.

With that, I say that I implore the staff to work hard at hammering out the details, drawing those fine distinctions. We have worked hard to create a MISSION Act that is a lot simpler than the many lines and many channels of care, community care in the community that used to have to be funded by the VA.

I say to the VA, and the administrators and leadership at the VA, that they need to make sure that we engage the culturally competent providers of mental health care, bring them into our community care networks, and thereby grow our capacity, whether we do it internally or whether we do it through care in the community, but care in the community that is connected, that is accountable, and that is competent to deliver the urgent care and the urgent mental health care needs that veterans may find themselves in, that we arrive at that place where we can do all of the above.

With that, members will have 5 legislative days to revise and extend their remarks, and include extraneous material.

Again, I thank, my thanks to all of the witnesses appearing here today. As we head into the Thanksgiving Day holiday, may all of us be blessed with wonderful family time, and thanksgiving for our country and thanksgiving for what our veterans have done for us.

Thank you.

[Whereupon, at 1:04 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Robert Wilkie

Chairman Takano, Ranking Member Roe, and Members of the Committee, thank you for inviting us here today to present our views on two bills regarding the establishment of suicide prevention grants. Joining me today are Dr. Richard Stone, Executive in Charge for the Veterans Health Administration (VHA), and Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention.

Mr. Chairman, in the House Veterans' Affairs Health Subcommittee hearing on September 11, 2019, VA presented on its own initiative views on H.R. 3495, which are reproduced below. Regarding the second bill on the agenda, the Draft bill to establish a pilot program for the issuance of grants to eligible entities, VA only received the bill last Thursday, November 14, and thus was not able to include written views on it today. However, we will follow up with the Committee soon with a views letter on that legislation.

H.R. 3495 Improve Well-Being for Veterans Act

H.R. 3495 would require VA to provide financial assistance to eligible entities approved under this section through the award of grants to provide and coordinate the provision of services to Veterans and Veteran families to reduce the risk of suicide. VA would award a grant to each eligible entity whose application was approved by VA. VA could establish a maximum amount to be awarded under the grant, intervals of payment for the administration of the grant, and a requirement for the recipient of the grant to provide matching funds in a specified percentage. VA would ensure, to the extent practicable, that financial assistance is equitably distributed across geographic regions, including rural communities and Tribal land. VA also, to the extent practicable, would need to ensure that financial assistance is distributed to provide services in areas of the country that have experienced high rates or a high burden of Veteran suicide and to eligible entities that can assist Veterans at risk of suicide that are not currently receiving health care furnished by VA.

VA would have to give preference in the provision of financial assistance to eligible entities providing or coordinating (or who have demonstrated the ability to provide or coordinate) suicide prevention services or other services that improve the quality of life of Veterans and their families and reduce the factors that contribute to Veteran suicide. Each grant recipient would have to notify Veterans and Veteran families that services they provide are being paid for, in whole or in part, by VA. If a grant recipient provided temporary cash assistance to Veterans or Veteran families, the recipient would have to develop a plan, in consultation with the beneficiary, to ensure that any beneficiary receiving such temporary cash assistance is self-sustaining at the end of the period of eligibility for such assistance.

VA would require each grant recipient to submit an annual report describing the projects carried out with VA's financial assistance; VA would also specify to each recipient the evaluation criteria and data and information to be included in the report, and VA could require entities to submit additional reports as necessary. An eligible entity seeking a grant would submit a form to VA containing such commitments and information as VA considers necessary to carry out this section. Each application would have to include a description of the suicide prevention services to be provided, a detailed plan describing how the entity proposes to coordinate and deliver suicide prevention services to Veterans not currently receiving care furnished by VA (including an identification of community partners, a description of arrangements currently in place with such partners, and identification of how long those arrangements have been in place), a description of the types of Veterans at risk of suicide and Veteran families proposed to be provided suicide prevention services, an estimate of the number of Veterans at risk of suicide and Veteran families that would be provided services (including the basis for the estimate and the percentage of those Veterans not currently receiving VA care), evidence of the experience of the applicant (and the proposed partners) in providing suicide prevention services (particularly to Veterans at risk of suicide and Veteran families), a descrip-

tion of the managerial and technological capacities of the entity, and other application criteria VA considers appropriate.

VA would be required to provide training and technical assistance to eligible entities under this section regarding the data that must be collected and shared with VA, the means of data collection and sharing, familiarization with and appropriate use of any tool to measure the effectiveness of the financial assistance VA provided, and how to comply with VA's reporting requirements. VA would have to establish criteria for the selection of eligible entities that have submitted applications. In establishing these criteria, VA would have to consult with Veterans Service Organizations (VSO), national organizations representing potential community partners of eligible grant recipients, organizations with which VA has a current memoranda of agreement or understanding related to mental health or suicide prevention, State Departments of Veterans Affairs, national organizations representing members of the reserve components of the Armed Forces, Vet Centers, organizations with experience in creating measurement tools for purposes of determining programmatic effectiveness, and other organizations VA considers appropriate.

VA would have to develop measures and metrics for grant recipients in consultation with the same group of entities or organizations. Before issuing a Notice of Funding Availability under this section, VA would have to submit to Congress a report containing the criteria for the award of a grant under this section, the tool to be used by VA to measure the effectiveness of the use of financial assistance provided under this section, and a framework for the sharing of information about entities in receipt of financial assistance under this section. VA could make available to grant recipients certain information regarding potential beneficiaries of services, including confirmation of the status of a potential beneficiary as a Veteran and confirmation of whether a potential beneficiary is currently receiving or has recently received VA care.

VA's authority to provide financial assistance would end on the date that is 3 years after the date on which the first grant is awarded. Not later than 18 months after the date on which the first grant is awarded, VA would have to submit a detailed report on the provision of financial assistance under this section. Not later than 3 years after the date on which the first grant is awarded, VA would have to submit to Congress a follow up on the interim report containing the same elements and a final report on the effectiveness of the financial assistance provided through this authority, an assessment of the increased capacity of VA to provide services to Veterans at risk of suicide and Veteran families as a result of this financial assistance, and the feasibility and advisability of extending or expanding the provision of financial assistance.

Eligible entities would be: (1) an incorporated private institution or foundation that is approved by VA as to financial responsibility and no part of the net earnings of which incurr to the benefit of any member, founder, contributor, or individual and that has a governing board that would be responsible for the operation of the suicide prevention services provided under this section; (2) a corporation wholly owned and controlled by an organization meeting the same requirements; (3) a tribally designated housing entity (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)); or a community-based organization that is physically based in the targeted community and that can effectively network with local civic organizations, regional health systems, and other settings where Veterans at risk of suicide and the families of such Veterans are likely to have contact. Suicide prevention services would be services to address the needs of Veterans at risk of suicide and Veteran families and includes outreach; a baseline mental health assessment; education on suicide risk and prevention; direct treatment; medication management; individual and group therapy; case management services; peer support services; assistance in obtaining any VA benefits for which the Veteran or Veteran family may be eligible; assistance in obtaining and coordinating the provision of other benefits provided by the Federal Government, a State or local government, or an eligible entity; temporary cash assistance (not to exceed 6 months) to assist with certain emergent needs; and such other services necessary for improving the resiliency of Veterans at risk of suicide and Veteran families as VA considers appropriate. Veteran family would mean, with respect to a Veteran at risk of suicide, a parent, a spouse, a child, a sibling, a step-family member, an extended family member, or any other individual who lives with the Veteran. VSOs would be those organizations recognized by VA for the representation of Veterans included as part of an annually updated list available online.

VA strongly supports this bill. VA's efforts to reduce the incidence of suicidal ideations and behavior (and suicide completions) among all Veterans could be complemented by partnering with community-based providers who are able to replicate VA's suicide prevention programs in the community and to connect with Veterans

that are currently beyond VA's reach. This novel approach would assist VA in reaching more of the 14 of the 20 Veterans dying each day by suicide who are not under VA care at the time of their deaths; effective partnering with eligible grantees would be key to our being able to reduce, if not prevent, the number of these tragic occurrences. Additionally, the legislation aligns with VA's proposal submitted with the President's Fiscal Year 2020 budget. This proposal has been identified as the Secretary's top legislative priority and the legislation provides the necessary authorities clinicians believe will help the Department combat suicide among Veterans. Last, we note that the legislation is aligned with the President's strategic taskforce to combat suicides in the Nation. The taskforce will assist in planning and providing strategic guidance with our stakeholders allowing VA to operate and implement the grant program. The need for this legislation is evident and will enhance and increase the suicide prevention measures the Department is currently taking to combat and reduce suicides in the Nation.

We offer one comment for the Committee's consideration, but we emphasize that this is not an issue that would alter VA's position on the bill. The definition of "risk of suicide" in section 2(k)(4) would include exposure to or the existence of any of the specified conditions. We believe this definition is overly broad and recommend instead allowing the Secretary to implement this definition by regulation to include the addition of a process for determining degrees of risk of suicide based on consideration of the factors set forth in section 2(k)(4). Risk is obviously variable, ranging from no risk to high risk. Even without this recommended change, the bill would give VA sufficient authority to prefer applicants that ensure their services go to those Veterans who have the highest risk of suicide.

We estimate the bill would cost \$19.10 million in Fiscal Year 2021, \$28.36 million in Fiscal Year 2022, and \$37.70 million in Fiscal Year 2023, for a total cost of approximately \$85.16 million over the 3-year period of the program.

This concludes my statement. Thank you for the opportunity to appear before you today. We would be pleased to respond to questions you or other Members may have.

Prepared Statement of Adrian Atizado

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the House Committee on Veterans' Affairs. DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Thank you for inviting DAV to testify about the majority's discussion draft and H.R. 3495, the Improve Well-Being for Veterans Act today.

Everyone in this room understands that suicide is an extremely complex issue that will not be successfully addressed by any one proposal, idea, or intervention—particularly for the veterans' population, which is at elevated risk for suicide and suicidal ideation. In response, the bills before us today are multifaceted attempts to respond to this extremely difficult issue by reaching outside of the Department of Veterans Affairs (VA) to allow community providers to develop new and innovative programs that may be more accessible to veterans who have traditionally not used VA and their family members—specifically, those 14 out of 20 suicides by veterans who do not seek care in VA, which the Department estimates will occur each month.

We can also agree to the urgency of the situation. It's clear that the 20 veterans we need to reach this month cannot wait long for Congress and VA to act. But in this case, the Government has taken steps to address this critical issue with the establishment of the President's Roadmap to Empower Veterans to End a National Tragedy of Suicide (PREVENTS) interagency task force (or Task Force), which has been charged with identifying a public health strategy that will bring all the resources of the Federal Government to bear on this epidemic affecting our Nation's veterans. The Task Force will also recommend strategies to integrate private partners into suicide prevention efforts. The PREVENTS recommendations are due in March 2020—just a few months from now. DAV believes the Task Force's guidance should provide the strategic direction for any new interventions in suicide prevention.

The Task Force is concentrating on several lines of effort including lethal means, partnerships, research strategies, State and local action, workforce and professional development and communications aimed at universal, selective and indicated audi-

ences to change the culture of treatment seeking. VA also has a public health suicide prevention strategy developed for 2018–2028 that focuses on empowerment, clinical and community prevention, treatment and supportive services, and research and surveillance. While we have expressed some concerns about VA's readiness to take on this public health mission, it is in keeping with public health models that rely upon awareness, and changing the culture by addressing stigma and perceptions to increase the likelihood individuals affected will seek or encourage others in need of care to get the help they need, and above all—measuring against clearly defined goals.

The heart of any public health strategy lies in the metrics it establishes and measures at baseline and periodically during and after an intervention. DAV is gratified that both bills make use of work groups that would include veterans' service organization representation among other subject matter experts to establish such metrics. Looking at grantees' effects on the population they target will require them to tightly define their catchment area and the types of veterans they will serve. They will also have to make some well-founded assumptions about those they do not reach and measure changes in the whole population throughout the intervention. If grantees do not see evidence of positive changes from their programs, they will have to recalibrate their strategies. As much as possible, the programs should also be replicable so that effective programming taking place at one site could be used elsewhere for a similar population.

DAV continues to believe that it is in the best interest of veterans that these grantees make some connection to VA. VA and the Department of Defense (DoD) have reviewed evidence-based practices that have been deployed throughout both systems including at points of entry to screen and capture at-risk service members and veterans. These practices are—at least—holding the line on rates of suicide among veterans that may be among the most complex and severely affected. VA has created risk identification strategies, such as the REACH VET program, which uses predictive modeling and medical record data to identify and target intervention for veterans that are at high risk of suicide and most likely to act. Additionally, VA uses appointed suicide prevention coordinators at every VA medical center to help identify the resources that can help them recover. VA has identified evidence-based practices such as cognitive behavioral therapy to treat conditions tragically linked to suicidal behavior such as post-traumatic stress disorder, depression, substance use disorders and homelessness. The Veterans Crisis Line has intervened in thousands of instances to forestall tragedies and refer our veterans to local resources for care. While DAV shares the frustration many in Congress have expressed about not being able to move the needle and lower the rate on the staggering rates of suicide in the veteran population, we believe that without VA efforts we could be looking at an even worse scenario.

The bill and discussion draft before us today offer two contrasting options that create a role for private or other public providers to stem the tide. Both H.R. 3495 and the discussion draft, however, seem to operate from the perspective that veterans not using the VA want nothing to do with it, which in DAV's view is a flawed assumption. We understand from VA's surveys that veterans are often unclear about their eligibility for services or even their veteran status. In its most recent report, 2010 National Survey of Veterans: Understanding and Knowledge of VA Benefits and Services (November 2011), the National Center for Veterans Analysis and Statistics found lowered rates of understanding of health care eligibility among non-enrollees, varying from 15 percent to about a third who claimed to understand the health care services for which they were eligible.¹ In 2018, National Academies of Sciences, Engineering and Medicine Evaluation of the VA Mental Health Services also found 40 percent of veterans not using VA mental health were unsure of their eligibility for services. Lack of awareness of VA and eligibility is clearly still a barrier to many veterans who may be eligible and greatly benefit from VA's specialized health care and mental health services.

VA has had real success publicizing the Veterans Crisis Line, which has responded to hundreds of thousands of veterans' calls, texts, and emails. We believe it is successful because there is a **clear source all veterans can access for help** while eligibility and lack of awareness have obscured veterans' access to VA. DAV would be in favor of Congress allowing VA to serve as an initial point of contact for any individual in crisis who has served in the military, Reserves or National Guard. If VA medical facilities find they are ineligible, and they are not in immediate crisis they could refer them to other partners, including possibly grant providers. But clear "no wrong door" messaging that would allow those in immediate

¹ https://www.va.gov/vetdata/docs/SpecialReports/2010NSV_Awareness_FINAL.pdf accessed November 15, 2019.

need a place to go for help. Using VA as the entry point to grant providers would better ensure its ability to make appropriate referrals and coordinate care and services for veterans at risk of suicide.

We believe both the bill and the discussion draft would benefit from aiming interventions at more targeted patient populations. While both bills are clearly drafted to incorporate all of the risk factors that might be present in veterans with suicidal ideation, these risk factors should not define eligibility for services. DAV would argue that even the most resilient among us have one or more of these risk factors, histories or life events. For example, the 2015 National Firearm Survey found almost half of the veterans' population (44.9 percent) owns one or more firearms—most often for protection, but sometimes for sports and recreation such as hunting.² A quarter of all Americans will divorce. Almost all of us will suffer through the loss of loved ones and have stressful life events. Yet, as drafted, exposure to any one of these factors would define a veteran as “at risk” of suicide. Using these overly broad factors to target veterans, effectively targets no one. While it is important to understand these factors and build risk identification strategies and treatment plans around them, DAV believes, for these initial grants, the presence of any of the defined health risk factors (mental health challenges, substance use disorders, serious or chronic health conditions or pain and traumatic brain injuries) would create a big enough umbrella to allow almost anyone in need of services to participate.

Mr. Chairman, we similarly appreciate the broad scope of services that could be offered both through a bill similar to the discussion draft and that of General Bergman. But we are concerned that without more structure and a detailed plan, the cash assistance program in H.R. 3495 may be prone to waste, fraud and abuse. It has been attested that this program was modeled after the Supportive Services for Veterans Families (SSVF) grant assistance program. We agree that SSVF has been effective in combating and sometimes preventing homelessness as one program within a constellation of other programs and services that provide veterans who are homeless or at imminent risk of homelessness. Because it is a homeless service, veterans have also met certain qualifications—including demonstrating fiscal need, and there are established protocols for administering and monitoring the program and veterans in receipt of services.³ The cash assistance program in General Bergman's bill requires no qualifications for cash awards, and offers no assurances that the individual is even a veteran to qualify for cash assistance. The language in the bill states that the Secretary **may** make information about veteran status and use of VA medical care available, but it does not require the grantee to ask for or use this information to provide cash assistance. DAV believes many veterans in fiscal circumstances dire enough to affect suicidality may qualify for the SSVF program. We also know homelessness is a risk factor for suicide so building out this existing program may also assist in suicide prevention in the homeless population. DAV recommends that Congress simply add more resources to the existing SSVF program—an application for this funding could be coordinated through the grantee if a veteran's need dictated and the eligibility criteria, financial and managerial controls for this program are already established.

DAV is also concerned with the clinical care services that are outlined in General Bergman's bill. These services would provide a confusing overlay to the new Veterans Community Care Program, just as VA medical centers have finished market plans and are beginning the process of establishing their community provider networks enacted through the MISSION Act of 2018. DAV has recommended using best practices, such as VA's maternity care protocol, to manage care for veterans as they transition between VA and private sector facilities.⁴ VA's maternity care coordinators administer the protocol to ensure VA remains in contact with veterans throughout labor and delivery process in private sector facilities and assure that veterans are receiving necessary and timely care and receive access to other VA services for which they are eligible, such as pharmaceuticals, prosthetics and mental health care. Suicide prevention coordinators should establish similar protocols as veterans identified at risk of suicide access community care through VA partners. The Community Care Network providers will also have additional criteria to better assure access and quality for veterans. We would have no similar assurances of access or quality of providers receiving grant funding for suicide prevention services.

If the Committee wants to use these grants to reach out to veterans not using VA services, it should ensure that the grantees are in areas where VA has low market penetration and that are distant from VA health care resources including med-

² Cleveland, E. , et al. “Firearm ownership among American veterans: findings from the 2015 National Firearm Survey.” *Inj. Epidemiol* 2017 Dec; 4:33.

³ VHA Directive 1162.07 Supportive Services for Veterans Families (January 23, 2018).

⁴ VHA Handbook 1330.03, Maternity Health Care and Coordination

ical centers, community-based outpatient centers, Vet Centers and community network providers. This would ensure that grantees are filling gaps in coverage and reaching veterans who do not have good options for mental health care.

I'd like to give you an example of a grant program that is working to reduce suicides among veterans. DAV's Charitable Service Trust, an affiliate of DAV, which strives to meet the needs of injured and ill veterans through financial support of direct programs and services for veterans and their families, is funding a local DAV chapter making a difference in the lives of veterans in a remote and rural Arkansas county. Learning of the high rate of suicide among veterans in their county, DAV's chapter commander and deputy commander, a licensed clinician, set a goal lowering the rate of veterans' suicide in the area. They began by exploiting or establishing community ties to other veterans' groups, churches, business leaders, and health care providers, and providing personal outreach, individual or group counseling, to veterans who identify a need for these services. They refer a few veterans with the most complex needs to the VA. The County coroner's office is working with this DAV chapter, identifying veterans' deaths from probable suicides so they measure the effects of their interventions. According to feedback, their efforts are working, with rates of suicide having dropped since their efforts began. These two local heroes happen to have the requisite skills and personal means to allow them to devote countless hours to this program without compensation, which creates an extraordinary circumstance in this area that may not be replicable elsewhere. While there are some extraordinary features of this program, other features adding to their success are:

- Deep community ties to health and supportive resources and ongoing relationships with veterans in the area.
- A public health strategy that measures and monitors its efforts on an ongoing basis.
- High-touch services that counteract isolation and work to integrate veterans into their communities.
- Lack of other health providers, including VA medical centers in the area, making their services a critical resource to the community.

In closing, DAV sees the benefit of this approach and supports the concept of assisting groups or supportive networks that can make a positive difference in the life of at-risk veterans and hopes that the Committee takes our views into account when considering these bills.

Thank you Mr. Chairman. This concludes my testimony I will be happy to respond to any questions you or the Committee may have.

Prepared Statement of Blake Bourne

Chairman Takano, Ranking Member Roe, and the Members of the Committee, I'd like to start by thanking you for your work on behalf of America's veterans and their families, and for the opportunity to address you today on the subject of "HR 3495: the IMPROVE Well-Being for Veterans Act."

I'm here today representing Veterans Bridge Home, one of the longest standing and most successful "hub" organizations in the country, focused exclusively on the connection between military connected families and the communities which with they live after their service. Our organization geographic footprint is across the Charlotte, North Carolina region including the 10 surrounding counties. We have worked alongside over 5,000 families providing nearly 15,000 unique services. This firsthand experience of supporting the transition of military connected families began in the home of our founders, Tommy and Patty Norman in 2009, focusing on one family at a time. Identifying their unique goals and needs, finding the most appropriate local resource to address that need, and then matching the family and the resource together ensuring both parties understood the role and opportunity of working together to achieve long lasting sustainable success. The Normans were able to support four families in 2009.

Ten years later, Veterans Bridge Home is still focusing on one family at a time, but our team is working with approximately 175 families each month. With a staff of 12 we have formally connected 62 public and private organizations via a seamless technology platform, we engage with and educate 200 local employers, and have connected over 8,000 community members and veterans through social, fitness and volunteer events. This is all done at a local level on a daily, weekly, and monthly basis via personal relationships with each of these organizations ensuring that the rela-

tionships and connectedness that we are building and facilitating in our community are a tangible resource for the families who call Charlotte home.

When they take off their uniform our service members leave a hyperconnected, purpose driven, and globally supported community inside of the Department of Defense. In many cases, for the first time in their adult lives, they must address the professional, social and service needs of themselves and their family on their own, in a new community, without the guidance and support systems of the DoD. The reality is daunting and the stress of transition is real.

Health and human services in our country are fragmented. Our community, like many across the country, has an abundance of services, programs and opportunities to ensure the success of our Veterans and their families. IF you know where to look, if you know what to ask, and if you are able to be patient. That isn't always the case and can exacerbate any existing challenges, service connected or not.

Recent studies suggest that 44 percent to 72 percent of Veterans experience high levels of stress during transition to civilian life, including difficulties securing employment, interpersonal difficulties during employment, conflicted relations with family, friends, and broader interpersonal relations, difficulties adapting to the schedule of civilian life, and legal difficulties (Castro et al., 2014; Morin, 2011). This appears to predict both treatment seeking and the delayed development of mental and physical health problems, including suicidal ideation. Effective care coordination across top social determinants of health—Employment, Housing, Healthcare, Social Enrichment, Benefits/Finances, and Education—cannot only save lives but contributes to thriving leaders that have the capacity to invest in building healthy communities. Barriers associated with navigating resources across a variegated community landscape within and between complex systems can prolong service delivery and compromise desired outcomes at the individual and community levels.

Since 2011, Veterans Bridge Home has been working around the clock to grow a system that builds community capacity to welcome and integrate Service Member and Veteran Families successfully into its fabric. This “Community Integration” or “Collective Impact” model is meant to leverage the strengths of a community and utilize the best first use of services for the families that need them. We take a care coordination approach, engaging partners, community members and the Veteran in holistic relationships. Key components of effective care coordination services for Service Member and Veteran Families include outreach, triage, ongoing provider network engagement and cultivation, and measurement and evaluation. An effective “hub” organization must be able to connect with and manage relationships with not just the Veteran, but with community partners as well. It is not enough to only know the Veteran and their needs. You must know who, locally, can address those needs, what their eligibility criteria are, how to make the match and what to expect from the service delivery.

VBH continues to refine its growing care coordination program. In the past four years alone, our community partner network, has been able to connect over 4,800 unique families with over 12,800 unique services across multiple service domains. We continue to build this program as we do this meaningful work, refining as we go to meet the demand signal with the staff and partners willing and able to assist. We work with our partners to continuously improve our processes and measurement and expect to optimize program protocols and practices that build capacity across the network and implement program enhancements that boost shared outcomes.

Routine and targeted outreach is essential to meeting program goals to include 5 percent new client reach annually, 120 eligible clients for SSVF grant funding aiding housing attainment and/or retention, and increased support of suicide loss survivors with local and national resources as well as participation in Operation Deep Dive Suicide Prevention Study. Effective community engagement / outreach activities result in increased help-seeking behaviors and health coping attitudes and behaviors, a primary public strategy for suicide prevention. Additional goals related to outreach activities include increased social connectivity as evidenced by engagement with other veterans through workouts, chill time, play, and volunteer opportunities. Routine outreach activities include monthly coffees and luncheons, weekly workouts, community and partner resource fairs and events, etc. Targeted outreach includes working alongside key partners within their organization(s) or locations/ events with Veterans with known needs. A “hub” organization must have healthy existing relationships with those partners and understand their keep capabilities. Charlotte is fortunate to have several incredible local partners addressing specific needs such as Liz Clasen-Kelly at the Men's Shelter and Urban Ministry, who specifically serves individuals who are experiencing homelessness. Or Janene McGee at the Mecklenburg County Veterans Service Office who has a team of 13 benefits officers who help navigate the State and Federal benefits for Veterans and families. Or finally Noel McCall, who leads Patriots Path, an incredible career development

course which provides 20 hrs of training for Veterans and spouses to finding meaningful employment opportunities.

VBH works with each of these organizations and leader in unique and specific ways to ensure the Veterans they serve have access to the full domain of local, State, and Federal resources and we are all working together as a team to address their needs. No one single organization can address everything a Veteran might need today or will need over their lifetime. We are creating a system of services, seamless and connected the Veteran and their family can benefit from all the community has to offer and we reduce the duplication, underlaps and lack of effectiveness from outcomes that are not shared amongst the community.

This work also allows for more effective gap analysis. After our Outreach, engagement and connection efforts-measurement and evaluation play a critical role in understanding the needs of our Veterans and the effectiveness of our partners. We have a variety of measures which capture:

What are the demographics of the Veterans or family member asking for support?

What is the military service of the individual requesting support?

What service type(s) are they specifically interested in accessing?

Does that service exist? Is it available? What are the eligibility criteria?

How long it takes to match the individual with the program or organization?

What occurs once they are connected and how long does it take to deliver the service?

What is the outcome of that service delivery and how sustainable is the Veteran?

These are important questions that help us measure the needs of our Veterans, the gaps and overlaps in our community, the efficiency of our partners and the ultimate outcomes we are trying to collectively deliver.

Consistent client data capture is not only critical to quality metrics but also to effective bi-directional communication between providers in the business of triaging needs and delivering health and human services. Important components of triage involve identifying target population—Service Members and Veteran Families—as well as person centered goals and needs across social determinants of health, prioritizing critical services, and referring individuals to trusted and competent providers in the community in the least amount of time possible. As the demand signal has increased, screening practices have been refined from a more intensive five page / 60+ minute intake form to a 22-question screening instrument to a six question screening instrument to address holistic needs. We recognize a need to evaluate effectiveness of screening tool to effectively address identification of holistic needs, prioritization of those needs, mitigate risk for complex clients, and improve expeditious responsiveness to priority needs across social determinants of health. Currently individuals who make contact with our network report 2.6 unique needs.

We are able to conduct these measurements via a technology platform called UniteUS. UniteUS has not only helped transform care for Veterans across the Carolinas, thanks to the AmericaServes initiative from IVMF, but is not being adopted by health and human service providers across the State of North Carolina to address the Social Determinant of Health needs of all North Carolinians.

UniteUs metrics indicate that Veterans Bridge Home has a 96 percent accuracy in making smart referrals (effective matching with providers who provide the service requested and have capacity to serve the client) and takes on average 9.17 days to positively match client with service provider. We suspect processes, protocols, and communication can be optimized within coordination center and across partner organizations to meet goal of ≤5 days time to match and contribute to overall increased client satisfaction and well-being. At this time, primarily two staff members are triaging the majority of clients who make contact along with the 252 additional network users.

A diverse, engaged, and efficient provider network is essential to effectively care for those who have worn the uniform, especially for those with complex care needs. Provider engagement is a key variable to this community integration model's success and sustainability. Current data indicate that 37 percent of providers are utilizing Unite Us platform to connect clients to other providers and resources with a network goal of 70 percent of providers adopting technology to make and receive referrals. Provider engagement strategy needs to be evaluated to improve effectiveness to reach targeted goals. In-depth qualitative interviews with our top ten providers identified provider priorities—technology needs, process improvements, professional development, and improved communication. At this time, two Veterans Bridge

Home staff are dedicated to provider engagement with substantial support of approximately six additional staff members. An area of opportunity is leveraging technology to optimize strategic and targeted provider engagement efforts to meet outlined goals above.

The language and financial support of H.R. 3495 would allow us to increase our capacity to address the needs of Veterans and manage the relationships with providers, thus increasing efficiency and improving outcomes by working on both sides of the equation.

Outputs like 72 percent of service requests have been successfully closed by the network since launch help us know that we are moving in the right direction with respect to desired outcomes like improved health and well-being of military and veteran families in our community and increased cultural competency and expert companion skills across service providers. At this time, we recognize the need to integrate a holistic self-report measure that can be administered at program entry, during service episode(s), and post service completion to better understand program impact and inform program enhancements. Veterans Bridge Home is equipped with diverse talent, time, information, technology and capacity to engage in program evaluation with further assistance and funding. With strong existing funding partners at the local, State and national levels as well as generous community goodwill, we believe we will be able to garner the kind of support and funding needed to sustain measurement and evaluation capacity built through partnership with the VA and Federal partners as outlined in the proposed legislation.

Since 2010, Veterans Bridge Home has provided ongoing leadership to shape and/or create six existing collaboratives across stakeholders which are directly aligned to the top six needs our SMVF request in the Charlotte market—Social Enrichment (14 percent), Employment (27 percent), Housing (20 percent), Education (2 percent), Benefits (9 percent), and Healthcare (8 percent). The Charlotte Veteran Network / Vet-Charlotte is a network of over 6,000 Veterans that spans 12 organizations and 34 corporate affinity groups. Founded in 2010, this network connects socially and in service through networking, fitness and volunteer events. Since 2012, the Carolinas Alliance for Veteran Employment has grown to engage over 200 employers and 12 organizations in the service of getting an average of 14 veterans employed monthly. Housing our Heroes was established in 2014 to end Veteran homelessness and consists of 12 organizations that have worked together to see a significant decrease in homelessness. NCStrive also stood up in 2014 and involves over eight organizations to support the resiliency and transition of Veteran students attending two and 4 year public and private institutions of higher education in the region. A VA Community Veteran Engagement Board was established in Charlotte in 2017 to improve communication between the VA and community stakeholders on behalf of the Veteran families it serves. In 2018, a SMVF Suicide Prevention Workgroup was launched and has grown to include over 150 people across 12 VHA Programs, 19 Healthcare Entities, and 23 community organizations. This group has aligned itself with State and Federal strategies to reduce suicide among military and veteran families. VBH staff hold key leadership positions across these six collaboratives and work tirelessly with strategic partners to break down silos and be a bridge across systems to support military and veteran families holistically.

These are all examples of the amount of services, resources, and efforts that are happening at the local level. VBH and similar hubs must engage with and facilitate relationships between these disparate groups to improve the overall population health outcomes of our Veterans and their families.

Veterans Bridge Home is one of 17 AmericaServes networks in the Nation and has been leading the way in working to align national non-profit, local non-profit, county, State and Federal resources to address the needs of Veterans. We work closely with the State of North Carolina's Governor's Working Group to support State wide initiatives to support North Carolinian Service Member and Veteran Families, especially in the areas of Employment, Benefits, Education, Healthcare, and Suicide Prevention. Veterans Bridge Home staff have professional subject matter expertise in a variety of areas including, but not limited to health and human service delivery, healthcare, housing, employment, community engagement, public relationships. Staff are well positioned in a variety of key leadership roles to utilize and leverage further program refinement and enhancements and learning to influence and impact over 63 organizations in this community as well as State and national communities of practice.

There are similar "hub" organizations in our region doing this critical work who know the Veterans in their area of operation as well as the partners and act as objective and accountable servant-leaders. This work requires facilitation, education, relationship management and continuous process improvement. Two great examples are Charlie Hall and the UpState Warrior Solution team in The Greenville-

Spartanburg region doing incredible work and Scott Johnson and his team at The Warrior Alliance in Atlanta. Both orgs are similarly built and similarly acting as a bridge between their military connected families and the communities within which they operate. Strong relationships between our three markets and developing standards of care ensure that Veterans that move between markets are well cared for and connected as they are in our local market.

With respect to the proposed legislation, we appreciate the Committees efforts to address the systems level work at the community level and would welcome the opportunity to more formally work alongside the VA and this legislation would be a conduit to do so. With two deployments to Iraq and over 13 years in the military and Veteran space, I have had to honor of working alongside of some of the most dedicated and well-trained individuals our country has to offer. I have seen a myriad of individuals step forward to serve those who have served and never back down from what is needed to make sure they are as successful out of uniform as they once were in uniform. The commonality between my time in the Army and my time in the community is that relationships make all the difference. Ensuring that the leaders closest to the problems have the resources, tools and training they needs as well as the connectivity to their fellow Soldiers or providers than amazing outcomes can be achieved. Without investing in that system and setting standards of care, we will not adequately combat the realities our Veterans and their families are facing in dealing with communities that are not aligned and

Thank you for the opportunity to address you and share our experience on this critical challenge facing our country.

Prepared Statement of Sherman Gillums, Jr.

Chairman Takano, Ranking Member Roe, and honorable members of the House Committee on Veterans' Affairs, I appreciate the opportunity to present AMVETS' views on H.R. 3495 and the draft "amendment in the nature of a substitute" (ANS) under consideration.

As the largest veteran service organization that represents the interests of our Nation's 20 million veterans, we have prioritized addressing the mental healthcare crisis and suicide epidemic in our country. We signed a Memorandum of Agreement with the VA Mental Health and Suicide Prevention Office in 2018 for the purpose of better coordinating access to care and averting personal crises for the veterans we serve through our HEAL Program. Also, this month we made our scenario-based online crisis intervention program available to the public. Finally, AMVETS has steadily raised alarms regarding VA's approach to mental health that has fundamentally failed too many veterans and their families, as evidenced by statistical data.

Our Past National Commander provided emotional oral testimony in March as he told the story of an AMVETS Post Commander who took his life in the parking lot of his post. This issue is not abstract for us. Nor is it driven by numbers that cast human lives as averages and percentages. It is very raw and real for our AMVETS family.

In the past decade, we have lost more veterans to suicide than those who died in the Vietnam War. Since the start of the wars in Iraq and Afghanistan, we have spent more than \$70 billion on VA mental health programs, a cost that has only grown year after year, with no correlating drop in the number of suicides.

As we stated in March of this year, we must continue to confront the inescapable reality: VA's current efforts to curb suicide and expand access to mental health services have not measurably decreased the incidence of suicide among at-risk veterans.

After a statistical correction led to a decrease from 22 to 20 suicides per day, the number of veteran suicides per day remains stagnant. While some have chosen to view this as favorable when compared to the non-veteran populations, AMVETS will not subscribe to this tortured logic.

Despite billions of dollars spent, new legislation proposed and passed, and a considerable amount of pledges and lip service in the form of speeches, executive orders, and other initiatives, too many veterans are dying by suicide at an unacceptable rate.

Moreover, significant research has highlighted the need for new and more effective approaches. Yet Congress and the VA appear to have either turned a blind eye to this research, such as that involving genomic studies, peer retreats, and medical cannabis, or suffered from a collective failure of the imagination while doubling down on methodologies that have gotten us nowhere fast.

"These findings point to the ongoing crisis in PTSD care for service members and veterans. Despite the large increase in availability of evidence-based treatments, considerable room exists for improvement in treatment efficacy, and satisfaction appears bleak based on low treatment retention...we have probably come as far as we can with current dominant clinical approaches."

The Journal of American Medical Association (JAMA) 2017

Thankfully, Congress has prioritized H.R. 3495. AMVETS is supportive in principle of both the proposed bill and amendment under consideration, mainly, for the sake of progress. At a time when thousands of veterans continue to die by suicide, Congress cannot justifiably stay the course or allow partisan deadlocks to win the day. The expanded use of care in the community, in both traditional and non-traditional forms, is not a job-protecting union issue, a pro/anti-privatization issue, or a political issue—it is literally a matter of life and death. Put simply, AMVETS believes this bill needs to be a bipartisan game changer in the effort to curb veteran suicide.

In general, there appears to be three points of acute interest on the current proposals: direct cash assistance, non-VA clinical treatment, and decisionmaking authority for grants. A brief discussion on these three points follows.

Direct Cash Assistance

Providing cash payments directly to veterans who are in the midst of personal crises has pros and cons. Many veterans find themselves in dire financial straits because of their inability to manage their finances. Giving them money could serve to deepen their despair. Other veterans find themselves in financial trouble due to circumstances beyond their control, such as those facing mounting medical expenses or unemployment due to barriers to opportunities.

Regardless of the reason, financial hardship is a common precipitating factor among many in suicide cases, so the focus must remain on saving lives first and foremost, not treating the situation like a credit application evaluation. Whether the moneys are given directly to veterans or expenses are paid on their behalf by an eligible entity, the focus must remain on eliminating the key contributory cause of suicide—lost hope.

That could mean making financial counseling, employment assistance, and/or other supports that offer sustainability-focused solutions a part of the process. The point is helping at-risk veterans address short-term financial woes is an approach that must be explored, whatever the form happens to take. Reasonable compromises in this area should be made to move the bill forward.

Non-VA Clinical Treatment

The problem with “suicide” is that the word itself catches everyone’s attention. But it is the actions that lead up to it or effectively stop it that go unnoticed. There are myriad clinical and non-clinical interventions that have proven effective in achieving mental wellness for at-risk veterans. Many veterans suspect they are being taken through a generic checklist of protocols that fail to take into account their specific needs. This “process over people” approach to treating a patient population with unique needs often rewards VA clinicians for following standards while disincentivizing novel or nontraditional approaches that could prove more effective, in the view of many veterans and advocates.

Within the context of the proposed bill and substitute amendments, AMVETS remains concerned that a failure to compromise and allow for innovation in how “clinical care” is defined and coordinated at the local levels will only serve to exacerbate the problem. If eligibility for funding under H.R. 3495 is too tightly defined by traditional approaches, such as cognitive processing therapy and prolonged exposure, amongst other common treatments, then nothing will markedly change. However, the riskiest thing we can do is to just maintain the status quo.

There’s a difference between what veterans have gotten and what they’ve needed and deserved, starting with access to all possible pathways to wellness, not just those that fit within the boundaries of convention. This means offering non-traditional and alternative treatments, to include those that involve the intervention of non-clinicians and experts in peer engagement outside the clinical setting, which needs to be a key aim of the legislation.

VA already spends the vast majority of funding on tradition methodologies, the efficacy of which has been subject to debate in the Journal of the American Medical

Association and other studies. As such, AMVETS supports using this funding to support alternative, effective, multi-pronged, and impactful approaches that expand beyond limited and costly standards of care.

Decision-Making Authority for Grants

This may perhaps be the most critical issue in terms of reaching a compromise on the language in the bill. In the proposed amendment in the nature of a substitute, AMVETS reads the intent to be funding provided by VA to “hubs,” presumably using pre-established screening and selection criteria, that will manage funding given directly to service providers. The alternative would be for VA to make the decision on funding and provide funds directly to service providers.

Like many aspects of the bills, both approaches bear pros and cons to weigh. Lying anterior to the question of who will disseminate funds is the question of what standards will be used to decide who should get the funds, specifically in terms of program or service quality. All programs that purport to serve veterans are not created equal. Some services might appear ineffective but render better results than first anticipated while others seem effective but only because they’re common, which is why outcomes matter most.

Some veteran non-profits and organizations have done excellent work in measuring their outcomes and effectiveness while others are better at marketing intent than making impact. Not only should outcomes drive decisions about who gets funding, they also serve as the absolute best measure for judging whether the suicide problem is being adequately addressed. We can no longer allow delusions of adequacy to persist in a system that treats lives lost to suicide like the “dog bites man” stories they have increasingly become over time for the public and our government. The lion’s share of any funding under the measure must go to programs that can demonstrate sustained effectiveness in preventing suicide among the veterans within their reach, particularly in areas of the country with the highest risks, such as tribal lands and rural regions.

Further, we are also concerned about the 1-year period that will be reportedly needed to determine needs/gaps, as well as what entities will qualify as the “hubs” that will manage funding and decide who will receive it for the provision of services that have yet to be fully determined. The number of veteran suicides exceeded 6,000 each year from 2008 to 2017, and the numbers have not decreased in subsequent years. Staring the problem in the face without meaningful action for another year as we, once again, focus on process instead of the people that are dying is unacceptable. This process needs to be as streamlined and free of red tape as possible so that organizations are incentivized to participate and veterans do not need the patience of a saint to deal with the system and receive potentially life-saving benefits.

We understand that someone will have to serve as gatekeeper for the funds in the interest of fiscal responsibility, which means, in plain terms, deciding who receives funding based on a given criteria. But the best approach is that which does not build into the process more rules, contingencies, and reporting requirements than are necessary to attract the best and most effective non-VA service and support providers to augment VA’s efforts.

Conclusion

Chairman Takano, Ranking Member Roe, and members of the committees, I would like to thank you once again for the opportunity to present the issues that impact AMVETS’ members, active duty service members, as well as all American veterans. We believe we’ve only seen the tip of a huge iceberg that hides many more issues beneath the visible surface. But we can no longer stand for allowing a glacial pace of change to continue. As debate on H.R. 3495 continues, we urge you to imagine that the lives of those you love depend on your votes and your actions reflect the urgency that millions of spouses, parents, caregivers and peers live with every day—and tens of thousands of survivors can only wish had existed before they lost their loved ones.

Sherman Gillums Jr., Chief Advocacy Officer, AMVETS

Sherman Gillums Jr. began his military career in the U.S. Marine Corps at age 17, a month after his high school graduation. During his 12 years of active service, he advanced from the junior enlisted ranks to a commission as an officer. He completed his career at the rank of Chief Warrant Officer 2 and received an honorable discharge after suffering a career-ending injury while preparing to deploy to Operation Enduring Freedom with Headquarters Battalion, 1st Marine Division.

In 2004, Gillums began his journey in veteran advocacy as an accredited representative for veterans, dependents, and survivors seeking VA benefits in Southern California. He later worked as member of Paralyzed Veterans of America's Field Advisory Committee and an appellate representative at the Board of Veterans' Appeals in Washington DC. Shortly thereafter, he accepted the position of Associate Executive Director of Veterans Benefits in 2011 and Executive Director in January 2016. Gillums joined AMVETS National Headquarters in January 2018 and currently serves as the Chief Strategy & Advocacy Officer for AMVETS.

Gillums Jr. collaterally serves as the vice chairman for the Federal Advisory Committee for Veterans' Family, Caregiver, and Survivor. He had previously served as a member of the Federal Advisory Committee on Prosthetics and Special Disabilities, adjunct faculty for the State of the Science Symposia hosted by Pittsburgh University, and a research reviewer for the Defense Department's congressionally Directed Medical Rehabilitation Program in the areas of Technology Development & Devices, Clinical Trials, Qualitative Research, and Early Acute Care and Assessment in Neuroprotection.

Gillums has testified before Congress as an expert witness and appeared on CNN, Fox News, CBS News, and CSPAN as a voice for veterans. His opinion editorials in The Hill, Military Times, Washington Times, and other prominent print publications have proven influential in shaping policy and discourse on veterans' issues. His manuscript, "Paving Access for Veterans Employment through Holistic Transition: Practice Implications when Working with Veterans," was published in the Journal of Applied Rehabilitation Counseling in the Spring 2016 issue.

Gillums is a graduate of the University of San Diego School of Business Administration and completed his executive education at Harvard Business School.

About AMVETS

AMVETS is America's most inclusive congressionally chartered veterans service organization. Our membership is open to both active-duty, reservists, guardsmen and honorably discharged veterans. Accordingly, the men and women of AMVETS have contributed to the defense of our Nation in every conflict since World War II.

Our commitment to these men and women can also be traced to the aftermath of the last World War, when waves of former service members began returning stateside in search of the health, education and employment benefits they earned. Because obtaining these benefits proved difficult for many, veterans savvy at navigating the government bureaucracy began forming local groups to help their peers. As the ranks of our Nation's veterans swelled into the millions, it became clear a national organization would be needed. Groups established to serve the veterans of previous wars wouldn't do either; the leaders of this new generation wanted an organization of their own.

With that in mind, 18 delegates, representing nine veterans' clubs, gathered in Kansas City, Missouri and founded The American Veterans of World War II on Dec. 10, 1944. Less than 3 years later, on July 23, 1947, President Harry S. Truman signed Public Law 216, making AMVETS, the first post-World War II organization to be chartered by Congress.

Since then, our congressional charter was amended to admit members from subsequent eras of service. Our organization has also changed over the years, evolving to better serve these more recent generations of veterans and their families. In furtherance of this goal, AMVETS maintains partnerships with other congressionally chartered veterans' service organizations that round out what's called the "Big Six" coalition. We're also working with newer groups, including Iraq and Afghanistan Veterans of America and The Independence Fund.

Moreover, AMVETS recently teamed up with the VA's Office of Suicide Prevention and Mental Health to help stem the epidemic of veterans' suicide. As our organization looks to the future, we do so hand in hand with those who share our commitment to serving the defenders of this Nation. We hope the 116th Session of Congress will join in our conviction by casting votes and making policy decisions that protect our veterans.

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

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

Fiscal Year 2018—None

Fiscal Year 2017—None

Fiscal Year 2016—None

Disclosure of Foreign Payments—None

Prepared Statement of Melissa Bryant

Chairman Takano, Ranking Member Roe, and distinguished members of the Committee on Veterans' Affairs, on behalf of National Commander, James W. "Bill" Oxford, and the nearly two million members of The American Legion, we thank you for the opportunity to testify on H.R. 3495, the "Improve Well-Being for Veterans Act," and the veterans suicide crisis in the United States. As the largest patriotic service organization in the United States with a myriad programs supporting veterans, The American Legion appreciates the leadership of this committee in focusing on the critical issue of suicide prevention and improving veterans' overall well-being.

Background

The latest data on veteran suicide shows more than 6,000 veterans have died by suicide every year from 2008 to 2017, and in 2016, the suicide rate was 1.5 times greater for veterans than non-veteran adults.¹ Veteran (and military) suicide is a national issue which far exceeds the ability of any one organization to handle alone. The American Legion stands behind the Department of Veterans Affairs (VA) in its efforts to collaborate with partners and communities nationwide to alleviate this public health crisis, of which veterans and military are a microcosm of a far greater epidemic.

The American Legion launched an online mental health survey in support of VA's public health approach to reducing veteran suicide.² It is part of the American Legion's continuing research and efforts on mental health issues impacting our Nation's veterans. The survey was created by the American Legion's TBI/PTSD Committee and was designed to collect data that will help The American Legion bring local resources related to TBI, PTSD, and Suicide Prevention to veterans and their families. In a yet to be released report, the data collected indicated only 10.29 percent of participants were "very confident," they could connect a veteran in crisis to the appropriate resources. No veteran should be lost to suicide because an individual who identified them as "at-risk," was unaware of available resources. The survey identified that 84.23 percent of respondents never sought mental health care from Vet Centers. Vet Centers are community-based counseling centers and are part of the VA. More than a third of respondents (39.73 percent) were unsure of the veteran's eligibility for VA mental health services.³

Again, it is clear that there is a mental health and suicide crisis in the United States, and that veterans are an "at-risk" subset of the ongoing crisis. This makes it all the more important that Congress and VA take steps toward combatting this issue and continue looking for new tools to accomplish this goal. However, this does not mean rushing to pass legislation before it has been fully fleshed out. There is more work and due diligence to be done between the Committee, VA, and VSOs to ensure that H.R. 3495 is truly a bill which will improve the well-being of veterans across the Nation. To that endeavor, The American Legion wants to highlight two critical issues before discussing the ongoing debate on the proposed legislation: First, in whatever form H.R. 3495 becomes, it must be coordinated in concert with Executive Order (EO) 13861, the President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS), in order to ensure that there are no duplicative programs which cause unnecessary confusion or obstruction of services to veterans.⁴ Second, it must also have clear metrics and evaluation criteria to not only choose grant recipients, but to also ensure the quality of care being given to veterans and the outcomes of their programs.

Position and Recommendation

The main point out of three questions recently raised in several discussions regarding this bill is whether VA should provide financial assistance directly to providers of non-clinical social services or should these funds be funneled through "hub organizations," which coordinate services between community-based resources.

The American Legion supports providing funds to both hub organizations and providers of **non-clinical** social services if they are subject to a rigorous vetting process based on clear metrics and evaluation criteria. The American Legion believes that a diversity of quality organizations providing **non-clinical** social services would be useful in combatting veteran suicide, particularly in rural and highly rural locations. However, any further questions on the mechanics of how to administer said

¹ The 2019 National Veteran Suicide Prevention Annual Report

² Legion launches online mental health survey

³ Report to be released March 2020

⁴ Executive Order on a National Roadmap to Empower Veterans and End Suicide

funds and/or clinical care to support veteran suicide prevention through non-VA entities should be coordinated through existing VA programs.

Conclusion

In closing, The American Legion appreciates the leadership of this committee and remains committed to reducing veteran suicide. Further, The American Legion is committed to working with the Department of Veterans Affairs and this committee to ensure that America's veterans are provided with the highest level of support and healthcare. Chairman Takano, Ranking Member Roe, and distinguished members of this committee, The American Legion thanks this committee for holding this important hearing and for the opportunity to explain the views of the nearly 2 million members of this organization. For additional information regarding this testimony, please contact Mr. John Medin, Legislative Associate of The American Legion's Legislative Division at (202) 263-5756 or JMedin@legion.org

STATEMENTS FOR THE RECORD

Prepared Statement of American Federation of Government Employees

Chairman Takano, Ranking Member Roe, and Members of the Committee,

The American Federation of Government Employees, AFL-CIO and its National Veterans Affairs Council (AFGE) appreciate the opportunity to submit a statement for the record on H.R. 3495, "Improve Well-being of Veterans Act" and the draft bill to establish a pilot program for the issuance of grants to eligible entities. AFGE represents more than 700,000 Federal and District of Columbia government employees, 260,000 of whom are proud VA employees.

H.R. 3495, the "Improve Well-Being of Veterans Act"

AFGE strongly opposes H.R. 3495, the "Improve Well-Being of Veterans Act." Outsourcing clinical care services for veterans at risk of suicide through this proposed grant program will undermine veterans' well-being, not improve it. The most appropriate source of clinical care for at-risk veterans is the VA's world-class health care system, including its highly regarded telemental health program and its Community Care Network (CCN). These clinical care services include direct mental health treatment, individual therapy, group therapy, family counseling, medication management and substance use reduction programming.

Clinical care provided by grantees will be fragmented and lack the specialization, provider competency, coordination and accountability of care provided through the VA. It would be unprecedented to fund clinical care for veterans without any prior authorization from the VA but that is exactly what this grant program would do.

AFGE welcomes the opportunity to share its ideas with the Committee on new ways to connect eligible veterans to the VA and expand access to ineligible veterans through new administrative and legislative initiatives. We should draw on the expertise of mental health experts who have studied this veteran population and the barriers to care they face, with the goal of ensuring that every veteran receives comprehensive, coordinated, world-class VA care.

We also oppose bill provisions that give the VA Secretary the primary role in administration and coordination of the grant program. The most effective way to reach and support at-risk veterans through the provision of non-clinical wraparound services is by strengthening the role of the VA's Readjustment Counseling Service (RCS) Vet Center Program. RCS has the proven track record and established relationships in communities across the country to select grantees, oversee grantee outreach activities and coordinate these wraparound services with other community entities and VA facilities.

AFGE has a number of other significant concerns about H.R. 3495, including: lack of geographic requirements, lack of fiscal controls and the absence of any role in the grant process for employee representatives of VA personnel caring for our wounded warriors.

VA funds should never be used to duplicate or supplant existing, high quality VA health care services but that is exactly what could occur under this grant program. There are absolutely no geographic restrictions on the location of grant organizations. Under this bill, a grantee right next door to a VA medical center could provide the same clinical care services a veteran could get (and at much higher quality) at the VA. While this bill may claim to be targeting hard to reach veterans in remote areas, it would also allow a grant to be awarded in a major city.

The lack of fiscal controls in this bill are also very troubling. There are two major areas of concern. First, the maximum grant amount is left totally up to the discretion of the Secretary. This would allow a large national organization that can exert a lot of influence in the grant selection process to receive a large share of the grant funds even though they would be better allocated to a greater number of small community-based organizations. Second, the bill does not place any caps on the percentage of funds than can be spent on large CEO salaries and other indirect costs instead of on direct veteran services. This potential CEO slush fund is contrary to the requirements of Federal contracts which have strict caps on indirect costs. Veterans'

well-being, not CEO pockets, should always be the priority of VA suicide prevention services.

Finally, absent from the long list of entities who the Secretary shall consult under this bill are the labor representatives of the very people who are on the front lines of the VA every day providing clinical care and wraparound services to veterans. More than one-third of the VA workforce are veterans, including many who use VA health care themselves. Their unique expertise, personal perspective and their ability to hold the VA accountable for mismanagement make them and their labor representatives essential to any grant oversight group.

Draft bill to establish a pilot program for the issuance of grants to eligible entities

AFGE commends Chairman Takano for his draft bill to establish a grant program for at-risk veterans. It addresses significant concerns already addressed. Most important, it would fund a wide array of non-clinical services while prohibiting the use of any funds on clinical care or cash assistance. The VA, its telemental health program and CCN should be the sources of clinical care for all veterans, and we should work together to ensure that more veterans use and are eligible for this far superior care. Similarly, cash assistance is already available when appropriate through community-based programs that have proven track records with Vet Centers.

We also strongly endorse the draft bill's provisions that make the VA's Readjustment Counseling Services and its Vet Centers the grant program administrator and coordinator. Veterans across the country already turn to Vet Centers for direct care and wraparound services, and the longstanding relationships between Vet Centers and community-based organizations will ensure quicker program startups, the provision of better services and greater accountability for the use of grant funds.

The draft bill encourages more effective allocation of grant dollars and provides safeguards against misuse of grant funds. The draft bill also sets a dollar cap on first year and second year grant and requires organizations to have matching funds which is a valuable screening tool for identifying entities with a strong financial track record. In addition, grant applicants are required to specify the amount of grant funds to be made available to community partnerships and the financial controls that will be put in place to track the expenditure of grant funds. The draft bill includes critical reporting requirements regarding the use of funds for executive compensation, overhead costs and other indirect costs.

AFGE also appreciates that the draft bill includes labor representatives of front-line VA employees in the working group that will consult with Readjustment Counseling Services on administration of the grant program.

Conclusion

AFGE has discussed the aforementioned concerns with the Committee and we hope to continue to work together to ensure that the best interests of at-risk veterans are well served. AFGE urges the Committee in the strongest possible terms to oppose H.R. 3495 as drafted.

In addition, AFGE wants to work with the Committee to identify the most effective, least risky ways to fill existing gaps in direct care and wraparound services. The VA has already expanded access to those with other than honorable discharges; it can do more to fund and expand these services. The VA is the Nation's leader in telemental health; it can do more to increase use of its unique services to veterans who face challenges coming to VA facilities. The VA already has a strong family counseling program and clinician training program; it can do more to expand services to family members by adding spouse-only therapy and filling the over 40,000 unfilled VA health care positions. The VA's Vet Centers already work with strong community-based organizations to reach out to isolated at-risk veterans; a strong grant program administered by Vet Centers themselves will make outreach more effective. VA mental health professionals and researchers already work with other experts to identify and address barriers that keep veterans from seeking care at the VA; with the help of well-managed community-based outreach groups, they can do more.

Fragmented care and unrestricted grants to unknown providers and outreach organizations through H.R. 3495 are not in the best interests of veterans and will cause us to miss the opportunity to work collaboratively and creatively to save more lives. The VA treats the whole veteran and is the national model of integrating primary care and mental health care; every veteran deserves that high level of care. The VA is by far the most cost-effective source of health care in our country.

Thank you.

Prepared Statement of Veterans of Foreign Wars

Chairman Takano, Ranking Member Roe, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide views on H.R. 3495, *Improve Well-Being for Veterans Act*, and related amendments.

Suicide among America's veterans is a serious and stubbornly persistent issue. Tragically, 16.8 veterans completed suicide in 2017, which was an increase from previous years. We also know that there are undoubtedly more who attempt but do not complete the act. Thanks to recent Department of Veterans Affairs (VA) efforts, we have data that gives us a better picture of what populations of veterans are completing suicide. Veterans represent approximately 22 percent of U.S. suicides; younger veterans have a higher rate of suicide but veterans over 60 years of age account for the most suicides; veterans over 50 years of age account for 65 percent of veterans completing suicide; around 62 percent of veterans completing suicide have not been seen by the Veterans Health Administration (VHA) in the year or year preceding their suicides.

The VFW is supportive of the intent of H.R. 3495, *Improve Well-Being for Veterans Act*, to utilize non-VA affiliated community programs to reach veterans not currently being seen by VA. This concept has been advocated by VA in the National Strategy for Preventing Veteran Suicide promulgated by the VA Office of Mental Health and Suicide Prevention, to wit "A wide range of community partners also have an important role to play in delivering prevention programs and services to Veterans at the local level."

The VFW does not agree, however, with the inclusion of clinical care in the services covered under the grant program established by H.R. 3495. Suicide prevention efforts are often focused on clinical factors that lead to veteran suicide, such as drug or alcohol dependency, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and others. We know that veterans who use VA health care have access to such clinical programs, but do not know if lack of access to clinical care is a contributing factor in suicides among veterans who do not use VA health care.

We do know that VA, other public health care options, and private sector health care providers do not always provide access to services and programs that address the non-clinical factors of suicide, such as life skills, financial instability, housing instability, and emotional issues that frequently need to be addressed. These factors often coincide and a suicidal act is the culminating event in a chain of issues that have developed over time. The National Strategy for Preventing Veteran Suicide (National Strategy) recognizes as much, saying, "In addition, many risk factors related to suicide are influenced by community and societal factors outside the bounds of VA's influence. This will require VA to reach beyond the health care setting, through which it has traditionally supported Veterans' health, and empower actors to prevent Veteran suicide in other sectors."

The VFW has recognized the need to cast a broad net in the community as well. The VFW is proud to have partnered with VA and community and corporate partners through the VFW Mental Wellness Campaign. The campaign raises awareness of mental health conditions, fosters community engagement, improves research, and provides intervention for those affected by invisible injuries and emotional stress. Since September 2016, more than 300 VFW posts around the world and 13,000 volunteers have successfully reached 25,000 people in three "Day to Change Direction" events hosted in partnership with Give an Hour's Campaign to Change Direction.

The purpose of the VFW's Mental Wellness Campaign is to teach veterans and caregivers how to identify when they or their loved ones are experiencing the signs of emotional suffering—personality change, agitation, being withdrawn, poor self-care, and hopelessness—as well as promote emotional well-being. In an effort to destigmatize mental health, participants learn that mental health conditions such as PTSD are common reactions to abnormal experiences.

The VFW's worldwide cadre of VFW-accredited Veterans Service Officers helps veterans and their families as they seek care or benefits from VA, and navigate issues and roadblocks. The VFW's Unmet Needs program also assists active-duty service members, veterans, and their immediate families to assist with basic life needs by providing grants and referrals to other organizations. However, those assisted do not receive cash directly; the Unmet Needs program makes payments directly to creditors. The VFW National Home for Children provides active-duty military personnel, veterans, and relatives of VFW and VFW Auxiliary members case management services to help families set up their plans and goals for the future; educational, recreational, and enrichment opportunities; community resources and counseling; and free housing and daycare.

The VFW does not receive Federal funds for any of these programs. However, these are among the types of programs that H.R. 3495 must support, and the VFW believes in the efficacy of these programs to alleviate stressors on veterans and their families. These kinds of emotional, financial, housing, and familial stressors are cited as potential precursors to suicide attempts. Complementary and integrative health programs that have shown evidence of improving the non-clinical stressors that contribute to suicide, such as mindful meditation, must also be included. We believe that the programs mentioned above are of the kind envisioned in Objective 1.4 of the National Strategy for Preventing Veteran Suicide: “Promote the development of sustainable public-private partnerships to advance Veteran suicide prevention. In addition, VA encourages creation of public-private partnerships that focus specifically on preventing Veteran suicide at the local, state/territorial, and national levels.”

The broad nature of the services eligible for grants under H.R. 3495 will allow for grants to many programs and organizations not previously seen in the VA pantheon. Because of the new territory being covered, the VFW believes that the legislation creating any community grant program and regulations implementing such a program must:

- Focus on non-clinical social factors of suicide prevention and protective factors for suicide to include positive coping skills, having reasons for living or a sense of purpose in life, and feeling connected to other people.
- Facilitate access to mental health care, excluding clinical care except in case of emergency.
- Complement and supplement VA suicide prevention efforts.
- Accord with VA’s focus on evidence-based suicide prevention programs.

The grant program as written in both bills is still too amorphous. The VFW urges the committee to amend the scope of the grant program to:

- Define the population the grant program will target, to include service members who do not meet VA’s definition of veteran.
- Restrict funding of clinical care solely to emergency care.
- Identify clinical care options, if necessary, for the population engaged, including a warm handoff to VA for those eligible or to other health care options for those not eligible.
- Require the establishment of strong metrics before VA awards grants that capture definable measures of success and can serve as indicators of therapeutic modalities that should receive further funding and study.

Without both strong, well-defined criteria for programs that will receive grant awards and strong, well-defined metrics of success, the program envisioned under H.R. 3495 risks conflating a flurry of activity with achievement.

The Supportive Services for Veteran Families (SSVF) grant model upon which H.R. 3495 is based has very clearly defined success criteria. From the VA’s website, SSVF “support[s] outreach, case management and other flexible assistance to rapidly re-house Veterans who become homeless or prevent Veterans from becoming homeless.” Put more simply, the success criteria for SSVF is that formerly homeless veterans are no longer homeless. That is a straightforward metric. Because one cannot prove a negative, services that are meant to ameliorate suicide factors and prevent suicide cannot be measured against an obvious, simple standard. However, the stated goals of H.R. 3495 are to alter negative circumstances and connect with veterans who are not engaged with VA. Therefore, success must be defined through effectiveness in addressing the supportive factors identified, and facilitating connection to and utilization of continued services provided by VA or other entities as appropriate.

VA has done excellent work on clinical factors that contribute to suicide, such as genetic markers, PTSD, TBI, and even insomnia. The grant program proposed under H.R. 3495 should not be used to research clinical topics, but for the goal stated by VA leadership and the bill’s sponsors—to reach the oft-cited 10-veteran cohort not engaged with VA and those who have served and are commonly viewed as veterans but who are ineligible to use VA. That is why the VFW opposes the use of grants under H.R. 3495 to provide clinical care, except in an emergency. VA has an established health care system. With the MISSION Act, VA has a standardized process to appoint eligible people to providers in the community. The VFW believes that eligible people should use VA care programs—either VA direct care or VA community care—as a matter of course. For consistency and clarity of purpose, VA must use these resources as intended.

If the goal of H.R. 3495 is to “catch” veterans in the community who are not using VA with a safety net of VA grant-supported community programs, the question becomes what to do with the cohort once they have been identified? For the VFW, the answer is obvious—connect them with VA or health care options for which they are eligible, such as TRICARE, Medicare, or employer-sponsored insurance. VA has wraparound services that already exist and are funded. H.R. 3495 must not set up a parallel track of community providers that supplant VA in provision of services. The grants distributed under H.R. 3495 should complement VA capabilities to deliver supportive services where applicable and supplement VA capabilities where necessary. A grantee that encounters a veteran in need of routine mental health care should connect that veteran to a local VA medical facility or help the veteran to find health care options under a health plan for which the veteran is eligible.

To summarize, the VFW applauds and accepts the stated goal of H.R. 3495 to engage eligible people who are not utilizing VA services through resources in their communities. The purpose of the program, criteria for grants, and metrics for success must be strong and clearly defined. H.R. 3495 cannot create an alternate path for clinical care or supportive services in the community for those eligible to use VA. Community services should complement and supplement VA efforts and services, and serve as an entryway to VA benefits accompanied by a warm handoff. Grants established by H.R. 3495 should not be clinically focused, but focused on the protective factors for suicide identified by the VA Office of Mental Health and Suicide Prevention: positive coping skills, having reasons for living or a sense of purpose in life, feeling connected to other people, and others (such as housing, financial, and relationship stability and access to education and training), as well as access to mental health care through appropriate channels.

The VFW stands ready to assist in the reduction of veteran suicides and helping veterans connect and thrive in their communities through service. The VFW is willing and able to share its experience in assisting veterans through our well-established programs such as Unmet Needs and the VFW National Home for Children, and the activities of our National Veterans Service.

Prepared Statement of Paralyzed Veterans of America

Chairman Takano, Ranking Member Roe, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on the pending legislation impacting the Department of Veterans Affairs (VA) before the Committee today. PVA is proud of its rich history and no group of veterans understand the full scope of care and benefits provided by the VA better than PVA's members—veterans who have incurred a spinal cord injury or disorder (SCI/D), such as Amyotrophic Lateral Sclerosis (ALS).

We also thank the Committee for last week's roundtable discussion on H.R. 3495, the “Improve Well-Being for Veterans Act.” Too many service members and veterans are dying by their own hand; so, we applaud you and the VA for trying to provide veterans with additional treatment options to meet their needs and combat their struggles. However, we remain concerned that unless veterans are offered evidence-based solutions, many of the programs funded by this legislation will have little effect on the problem, and waste precious resources.

To be clear, PVA supports the intent of having VA coordinate with Federal, State, and local agencies, as well as private and not-for-profit organizations, to combat the epidemic of veteran suicide. We believe that legislation focused on assisting veterans at risk for suicide should concentrate on identifying those who are not enrolled in the VA health care system and assessing their needs. Unfortunately, the language in H.R. 3495 is too broad and it needs to be constricted to ensure limited resources are directed toward quality programs with proven results that can be monitored and assessed on a periodic basis. Furthermore, the lack of detail in this legislation makes it difficult to gauge its potential benefit for our membership. For example, are these programs going to be accessible to veterans with significant disabilities? If they are, what is the referral process if a community provider encounters a veteran with a spinal cord injury or disorder (SCI/D) who is in crisis?

With this in mind, PVA makes the following recommendations which we believe will strengthen the legislation.

1. PVA does not believe extending clinical care to veterans through non-VA providers outside of the Community Care Network is appropriate at this time. Instead, there should be greater effort by VA to increase its internal capacity to provide mental health care services in accordance with Section III of P.L. 115–182, the VA MIS- SION Act of 2018.

2. Many organizations claim to have programs that are designed to reduce veteran's risk of suicide, but they lack the empirical data to support their assertions. Before an eligible entity can receive a grant, they should be required to provide evidence-based, scientific data that shows how any services being offered will reduce rates of suicide.

3. The goal of the grant program should be to identify veterans who are not connected with VA, assess and assist them with their immediate needs, and if they meet eligibility requirements, to help reconnect them with VA, which is better equipped to address their long-term health care, economical, and educational needs. We do not believe that the provision of temporary cash assistance through grantees is an appropriate use of resources.

4. Before a grantee is approved to participate in the program, they should be required to submit a detailed plan that addresses the following:

- a. The kinds of assistance the grantee is offering.
- b. The number of staff supporting the program.
- c. The number of veterans they can assist at any given time.
- d. A demonstrated capability to assist catastrophically disabled veterans and those with significant disabilities. The plans should also State how referrals for these individuals will be handled.
- e. How the assistance being offered will meet the veteran's needs, and most importantly, help them achieve and then sustain a healthy lifestyle that can lead to a fulfilling life.
- f. The length of time that services will be required, e.g., up to 12 visits over a 6-month period.
- g. A detailed plan on how they intend to conduct one-on-one engagement with veterans.
- h. A plan for documenting each veteran's progress that increases the likelihood that services being provided can/will meet the agreed upon objectives.
- i. In the event the services offered did not meet the veterans's expectation, what (if any) avenues of recourse they have.

5. Because VA is the payer of these services, they retain the responsibility to ensure that care and services being provided by grantees meet pre-established standards. PVA believes each beneficiary should be assigned a VA case manager who will be required to monitor the beneficiary's progress. When the case manager determines the desired outcomes are not being met, they can make recommendations to include terminating the services, if necessary.

We readily stand behind any effort to improve health care for all veterans but remain concerned about the ability of VA to continue to meet the health care needs of the most vulnerable veteran populations, such as those with SCI/D and polytrauma. Specialized services are part of the core mission and responsibility of VA. As the Department continues its trend toward greater utilization of community care, Congress must be cognizant of the impact these decisions may have on veterans who need the level of complex care that only VA can deliver. Under no circumstances should funding the programs in H.R. 3594, the proposed amendment, or other similar legislation undermine VA's ability to provide foundational care and services for all veterans with serious disabilities. VA must receive a dedicated, robust funding stream to ensure its core functions are not impaired in any way.

PVA would once again like to thank the Committee for the opportunity to submit our views on the legislation considered today and are committed to working with you to develop a package that will improve the health and well-being of all America's veterans.

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

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

Fiscal Year 2020

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

Fiscal Year 2019

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

Fiscal Year 2018

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

Disclosure of Foreign Payments

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

Prepared Statement of Iraq and Afghanistan Veterans of America

Chairman Takano, Ranking Member Roe, and Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members worldwide, thank you for the opportunity to share our views, data, and experiences on the pending legislation today.

The Campaign to Combat Suicide is an incredibly important part of our work. It is the top priority in our Big Six Priorities for 2019, which also include: Defense of Education Benefits, Support and Recognition of Women Veterans, Government Reform for Veterans, Support for Injuries from Burn Pits and Toxic Exposures, and Support for Veteran Medicinal Cannabis Use.

Unfortunately, IAVA members know this issue all too well. According to our latest Member Survey, 59 percent of our respondents knew a post-9/11 veteran who died by suicide. Additionally, 65 percent knew a post-9/11 veteran who attempted suicide and over 75 percent believed that the Nation is not doing enough to combat military and veteran suicide.

This is why for nearly a decade, IAVA and the veteran community have called for immediate action by our Nation's leaders to appropriately respond to the crisis of over 20 military and veterans dying every day by suicide. Thanks to the courage and leadership of veterans, military family members, and our allies, there has been tremendous progress. The issue of veteran suicide is now the subject of increased media coverage, there is a reduction in stigma for seeking treatment, and there is a surge of government, non-profit, and private support. Despite this progress, however, we are not seeing improvement in the numbers. We are still losing an astonishing number of veterans to suicide each day and that needs to change urgently.

IAVA thanks the committee for bringing both H.R. 3495 and the *Discussion Draft* forward for discussion today. Grants can be powerful tools for VA to use to reach populations of veterans that they would be otherwise unable to reach. The majority of veterans that die by suicide each day are not currently connected to the VA system; grants are another means to bring those veterans into VA and ensure that they are getting the care that they have earned and deserve. That is why IAVA worked closely with Senate Veterans Committee Ranking Member Jon Tester to create a provision in the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (S. 785) that would allow a grants program, much like the ones proposed here today. It is also important to note that while we are supportive of grant programs, we believe that VA must remain central to the care of the veteran. VA is uniquely structured to provide care for veterans, and more importantly, veterans like the care that they receive from VA. According to our latest Annual Member survey, a resounding 81 percent of IAVA members rate VA health care as average or above average. This program should enhance the capability and capacity of the VA, not undermine it.

While IAVA is supportive of grant programs to increase veteran outreach and care, IAVA also understands that these programs must be carefully administered in order to ensure that grant funds are being received by those most in need. It is to that end that while IAVA fully supports the intention of the *Discussion Draft* in front of the Committee today, we also have some concerns over the current language.

First, IAVA is concerned with the ability of Vet Centers to administer the grant program. While Vet Centers are uniquely positioned inside communities and can currently offer referral services to other community providers, they are not set up to provide grants to their community partners. IAVA is concerned that their administration of grants could potentially harm their relationship with those important community partners. While the administrator of these grants could and should work with local Vet Centers, by elevating that authority out of the Vet Center we can also ensure that the program is administered by officials with experience in dealing with the intricacies of grant programs.

Additionally, IAVA is concerned by starting a pilot program as laid out in the *Discussion Draft* with only 10 organizations. While we appreciate the intent behind the

low number to start, IAVA has concerns that with only 10 organizations receiving grants, coupled with the application requirements, there may be too high of a barrier to entry for emerging or less established hubs that wish to work in this space to receive these important grants. IAVA believes that a potential fix for this issue would be to create two separate funding streams, one for established hubs that are already providing services outlined in the *Discussion Draft*, and another funding stream to support organizations that wish to create the necessary technical and developmental expertise in areas where they might otherwise not exist, such as rural states. IAVA believes that this would serve to both support organizations that are already established, but also truly expand the number of hubs available as viable resource centers around the country. IAVA believes that by providing two separate funding streams VA could support both small, emerging hubs, and large hubs simultaneously.

IAVA also suggests that an addition of a universal data sharing platform would ensure that all hubs and community partners are able to share best practices and also identify veterans that might be at high-risk of suicide, similar to the highly successful Supportive Services for Veterans Families (SSVF) grants. SSVF grants were created to address the national veterans homelessness crisis. When VA partnered with local programs that are currently working with homeless populations 'on the ground,' they were able to significantly reduce veteran homelessness. IAVA believes that similar models can be created to not only identify, but also increase the VA's ability to reach high-risk veterans, and in turn better address the veteran suicide crisis. By creating similar data sharing platforms for veterans at risk of suicide, organizations working with high-risk populations would better understand where to refer veterans in crisis if they themselves are unable to help, ensuring that no veteran in crisis is ever turned away.

IAVA thanks the committee for their commitment to helping solve the veteran suicide crisis. The time to act is now. However, we also understand the need for data in order to make the most informed decisions. IAVA urges any grants program to have robust metrics in order to track outcomes and ensure that VA is using their limited resources in the best possible way. The goal of any grant program to address this epidemic should be a focus on simplicity, accessibility, and accountability.

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

Biography of Travis Horr

Travis Horr serves as Director of Government Affairs, assisting in IAVA's advocacy efforts in Washington, D.C. Prior to IAVA, he worked at a consulting firm, as well as political campaigns in both Maine and Delaware. Travis served in the Marine Corps Infantry for 4 years and was stationed at Marine Barracks 8th & I in Washington D.C., and Camp Pendleton, CA. He deployed to Helmand Province, Afghanistan in 2010 in support of OEF. Travis is a Maine native and graduated from the University of Southern Maine with a B.A. in Political Science with Honors utilizing the Post-9/11 GI Bill.

Prepared Statement of National Organization of Veterans' Advocates, Inc. & Partners

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

On behalf of our organizations, we thank you for the opportunity to submit a statement for the record on the Improve Well-Being for Veterans Act. As a collective group who has previously presented statements for the record to your Committee, we want to convey our appreciation for your leadership on this issue and the Committee's commitment to ensure the provision of life-saving services for our nations' veterans.

The Improve Well-Being for Veterans Act would provide pilot funds to non-VA entities to offer suicide prevention services to veterans who are not using VA healthcare and/or live in geographic areas where the risk of suicide is high. It emphasizes a Public Health Model to prevent suicide by attending to the full spectrum of social needs—housing, employment, relationships, transportation, finances and legal. We concur that expansively addressing social risk factors may substantively reduce suicide.

However, the same is not the case for clinical care. Establishing a mental health care delivery lane outside of the VA and Community Care Network (CCN) would have multiple deleterious impacts, as we identify below. We also provide recommendations that could enhance suicide prevention efforts.

The Consequences of Establishing An Outside Lane to Provide Clinical Care.

Under MISSION Act directives, non-VA providers may join the CCN to deliver clinical care to at-risk veterans and their families. Since CCN is already a pathway for providers, eating another outside system for the provision of clinical care would potentially have three deleterious consequences:

1. It would duplicate and erode the mental health care offered by VA and CCN.

Funding non-VA clinicians outside the CCN to provide direct mental health treatment, individual therapy, group therapy, family counseling, medication management and substance use reduction programming duplicates the **clinical mental health care offered by VA and CCN.**

Care is targeted in the same geographic locations as VA facilities. There is no requirement that entities focus efforts in locations beyond the geographic reach of existing VA facilities where care is scarce. On the contrary, providers can be located close to VA Medical Centers, VA Community Based Outpatient Clinics, Vet Centers and CCN providers.

For those veterans who distrust the government or are reluctant to seek mental health help at a VA facility, there are over 300 Vet Centers and 80 mobile Vet Centers available throughout the country. More can be added if there is a need.

2. It would lower the bar for outside providers' qualifications, quality of treatment and tracking of relevant outcomes.

There is **no requirement that entities be held to comparable (or any) standards** of mental health or suicide prevention training, provider qualifications or documented best practices to which VA holds itself.

It does not require entities to render services in a timely manner, which is mandated in the VA and is crucial for responding to at-risk populations.

Critically important is the fact that there is **no requirement that entities track and report on suicide attempts** of veterans who receive their services, as is mandated in the VA, and is the stated purpose of the legislation.

There is **no requirement that, in order to receive grants, entities have to show a previous track record for measuring successful outcomes** of their services. They only have to demonstrate throughput.

Non-VA entities are not capable of using VA's big-data predictive analytics REACH VET to prospectively identify individuals who are at the very highest risk of suicide.

3. It would undermine VA's model of providing health care.

Private sector clinical care would not require VA pre-authorization. That plan begins to replace **VHA as a health care provider system, transforming it into an insurance provider.**

With no parameters for co-payment responsibility, clinical care is permitted to be provided for free. While that's laudable, it competes with and **subverts the basic VA system for veterans' priority group eligibility and co-payment.**

By creating a third lane of providing clinical care outside of VA and CCN, providers in the community would be incentivized to leave the CCN or never join it in the first place. That **erodes the whole intent of the MISSION Act to create one overarching, coordinated program.**

It covers some veterans/families receiving mental health services in the community but not at a VA facility. If the goal is to ensure that mental health care is available to all veterans/family members (including Priority Category 8), the VA should be allowed to open its doors to these veterans/families as has occurred with transitioning service members (Presidential Executive Order 13822), military veterans who served in combat, and Other Than Honorable (OTH) administrative discharged veterans.

Further Recommendations to Improve Delivery of Mental Health Care and Suicide Prevention Efforts for At-Risk Veterans

1. Better understand the veterans who die by suicide.

Very little is understood about the 11 of 17 veterans who die by suicide daily who do not use VA. It is not known whether they are already receiving mental health care in the private sector, lack knowledge about VA eligibility, or would refuse care in or outside the VA even if offered. To be better able to target interventions for veterans not using VA who die by suicide, perform a Behavioral Health Autopsy of every veteran suicide, especially veterans who don't use the VA.

2. Facilitate greater access to VA.

a. Educate and assist newly separated service members. Veterans who do not seek VA mental health care were studied extensively last year in the National Academies of Sciences, Engineering and Medicine *Evaluation of the Department of Veterans Affairs Mental Health Services*.¹ It found that the top reasons that veterans with a mental health need do not seek VA care include that they (a) lack knowledge of how to apply for VA benefits (42 percent of survey respondents), (b) lack certainty whether they are eligible for or entitled to mental health care (40 percent), (c) lack awareness that the VA offers mental health care (33 percent), or (d) did not feel they deserved to receive mental health benefits (30 percent). We support implementing the National Academies' recommendations for facilitating greater access to VA mental health care by eliminating barriers to accessing care, expanding outreach efforts, enhancing awareness campaigns of VA eligibility criteria and mental health care services, setting up initial VA health appointments as part of the Transition Assistance Program and providing liaisons to assist throughout the transition process.

b. Enhance capacity. For locations where VA/CCN mental health services capacity is lacking, build more capacity.

c. Correct myths that hinder veterans seeking VA care. Veteran suicide would be significantly reduced by correcting the false belief among many veterans that "the VA wants to take away our guns." If that misperception were replaced with an accurate message, more at-risk veterans would seek out mental health care. Establish a workgroup that includes gun constituencies to champion such a shift.

d. Increase the number of video-reception sites where veterans could access care via VA telemental health, particularly in rural areas (e.g. VFW posts, Community Mental Health Centers).

3. Establish suicide outcome measures.

Entities should be required to track and report suicide attempts of veterans receiving their services, including for 6+ months post-treatment.

4. Measure success of referring veterans to VA care.

Entities should be evaluated for their success in referring at-risk veterans to the VA for clinical care. VA suicide prevention services remain the best in class.²

5. Ensure quality across the system.

Require that provider qualification and service delivery standards in non-VA entities be equal to those used in the VA.

Conclusion

The provision of grants that address social risk factors may substantially help prevent veteran suicide. However, clinical care for at-risk veterans is best provided by utilizing and expanding VA/CCN's existing infrastructure. Non-VA mental health care providers should be encouraged to join CCN. Creating another outside care delivery system for non-VA providers would have multiple deleterious effects.

We thank you for the opportunity to provide our perspective on this urgent matter.

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¹ Evaluation of the Department of Veterans Affairs Mental Health Services. The National Academies of Sciences, Engineering and Medicine. The National Academies Press, Washington, DC. 2018 <http://nationalacademies.org/hmd/Reports/2018/evaluation-of-the-va-mental-health-services.aspx>

² Veteran Suicide Prevention Annual Report, (September 2019). U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

Prepared Statement of Institute of Veterans and Military Families

The Institute for Veterans and Military Families (IVMF) at Syracuse University is grateful to Chairman Takano, Ranking Member Roe, and the Members of the Committee for the opportunity to submit written testimony on the subject of H.R. 3495 and related Draft bill, to establish a pilot program for the issuance of grants to eligible entities to provide and coordinate the provision of suicide prevention services for veterans at risk of suicide, and in support of veteran families.

The research and programmatic efforts of the IVMF, over the past decade, have generated actionable insights into the social and economic determinants of veteran health and wellness, particularly as impacted by the service member's lived experience navigating the transition from military to civilian life. Since 2014, the IVMF has been meaningfully engaged in work aimed at improving the coordination of services for veterans and military families. Through the AmericaServes initiative, over 1,000 participating organizations in 17 communities across the country have helped over 30,000 veterans, transitioning service members, and spouses with over 65,000 requests for services, resources, and care. Given that the average client seeks assistance with at least two service requests, it has been essential for communities to have hubs empowered with the responsibility to facilitate efficient and appropriate referrals among a network of organizations spanning health and social service domains.

Central to the mission of the IVMF is the idea that the lived experiences of those who undergo transition from military to civilian life are critical to the long-term health and happiness of veterans and their families. Veterans and families who undergo successful transition are more likely to experience post-service health and prosperity. Conversely, a negative transition experience is highly likely to set a veteran and the veteran's family on a compromised trajectory from which it is difficult to recover.¹ Additionally, circumstances and events occurring before, during, and after service may contribute to the stressors associated with suicidal ideation (financial instability, social disconnectedness, etc.).

With this context in mind, it is the belief of the IVMF that robust and well-coordinated support systems should underpin any efforts to improve the well-being of veterans and their families, and to reduce veteran suicide. This testimony will elaborate on three core ideas and practices that the IVMF has identified through the depth and scope of its AmericaServes work supporting and evaluating a diverse range of community coordination efforts across the country:

1. Criteria that position organizations to effectively coordinate service provision in communities;
2. Shared measures are critical to establish data-driven interventions to improve well-being;
3. Communities and coordination efforts benefit when given opportunities to share learning and receive ongoing technical assistance and evaluation support.

Criteria that position organizations to effectively coordinate service provision in communities

There are a number of important factors that may be used to identify appropriate locations for grant program funding to flow as part of a pilot program-concentration of veteran population, utilization of VA services and/or VA spending, suicide rates, etc. It has been the IVMF's experience that there is no shortage of need for more robust systems of care; rather, there are other more qualitative conditions that should be in place, at least initially, when determining whether a community is "ready" to undertake efforts to coordinate resources and services. "Ready" is best assessed by two key considerations: 1) strong local leadership committed to changing how services are delivered, and 2) dedicated philanthropic resources to support (or supplement) coordination infrastructure. Grant dollars have the risk of being ineffective if applied to communities with stakeholders unwilling or unable to collaborate in a transparent and accountable way.

Additionally, as policymakers address the role of organizations who offer direct service provision or the coordination of service provision, the IVMF encourages a focus on organizations that demonstrate proof of the ability to take on *hub-like activities*. Across 17 AmericaServes communities, 17 unique organizations have taken on a hub role. These organizations are diverse in size, age, mission, and direct service offerings-making it apparent that successful hubs can be supported by any orga-

¹ Sonethavilay, H., Maury, R. V., Hurwitz, J., Linsner Uveges, R., Akin, J., De Coster, J. L., & Strong, J. D. (2018). Military Family Lifestyle Survey. Blue Star Families. Retrieved from <https://bluestarfam.org/survey>

nization; however, not every organization has the capacity to support a successful hub.

The IVMF has adopted a set of important criteria organizations should meet in order to ensure efficient and effective service coordination and delivery to veterans and military families. These are:

- **Expertise about benefits and resource eligibility**-Comprehensive understanding of eligibility requirements for certain benefits and program will ensure clients get to the right provider(s), and conversely that clients are not referred to provider(s) who can't help them.
- **Referral management across resources**-Experience coordinating services across agencies. Alternatively, demonstrates strong organizational history, staffing, and ability to stand-up and operate a coordination center within a community.
- **Trusted relationships with community organizations**-Established history of collaboration, partnership, and/or participation in local efforts to serve population needs. Also, local reputation and trust among providers and within broader community.
- **Holistic intake of clients for needs spanning social determinants of health**-Understands how certain needs co-occur and can assess and triage clients based on a spectrum of potential needs.
- **Outreach to connect with veterans less likely to access care** - Demonstrates track record and openness for connecting with hard to reach veteran subpopulations.

Organizations that have held these roles, or that exhibit clear potential and willingness to build capacity to do so, represent grantees well-positioned to make best use of Federal dollars. In the experience of AmericaServes, these organizations do not necessarily provide an extensive list of service offerings spanning the social determinants of health (i.e., not one-stop shops). Rather, community hubs are most effective if there is a strong incentive to refer clients to partner organizations better suited to meet specific needs.

Importantly, coordinating services in a community helps create a no-wrong door approach to care that early evidence suggests is welcoming for difficult to reach populations. For example, AmericaServes disproportionately serves women veterans and minority veterans. Both are groups more likely to experience greater challenges at transition and beyond. Creating systems that are welcoming to underserved veteran populations increases the likelihood that they receive the services they need, and by extension, ideally contribute to suicide prevention.

Further, finding the right organization to steward Federal grant dollars puts both Federal and community resources to the first and best use. An example of this comes from our PAServes-Greater Pittsburgh network and one of the network's most committed providers, Defenders of Freedom Pittsburgh (DOF).

DOF provides emergency financial assistance for transitioning Post-9/11 veterans. In 2018, DOF served 78 veterans and spent approximately \$145,000. This year, DOF is on track to serve 20 percent more veterans yet spend 20 percent fewer dollars. This efficiency is due to the network's ability to connect many of the veterans they served with other programs for which they were eligible, prior to utilizing limited philanthropic dollars through DOF. Pittsburgh Mercy's ability to serve as a hub has fostered a healthy network that makes better use of programs like LIHEAP, SSVF, and disability compensation, while also leveraging the resources found in the community.

This example is one of many that demonstrates how creating a hub role within a community can serve to connect veterans to the programs that best suit their needs-which typically means existing public and VA programs first, reserving philanthropic dollars to fill in gaps and to provide support to veterans and military-connected clients not eligible for VA programs.

Shared measures are critical to establish data-driven interventions to improve well-being

A fundamental tenet of collaborative models that adopt shared systems is the commitment to identify shared measures, in order to use data analytics to track outcomes, reflect on the insights derived from those data, and adapt community priorities based on the evolving needs of the population. The IVMF supports this legislation's inclusion of a key data collection and analysis component, in order to monitor progress, create responsive service delivery networks, and develop a common understanding of veteran well-being.

In the IVMF's experience, once a common language and set of metrics are established, a phased approach has been an effective method to building community (local) and aggregate (national) measurement systems. Additionally, communities need tools that prevent data collection from being overly burdensome.

The first phase represents community-oriented measures. These are interim outcomes that help provide a more accurate/near-real time needs assessment and gap analysis for the community. These measures illustrate critical outputs such as service utilization by category, referral volume to providers, clients served, timeliness of care, and provider-reported service outcomes. This data would also offer insight into the needs and quality of services for understudied populations, such as military families.

Subsequent phases of measurement design should establish and monitor long-term improvements in quality of life. In addition to survey instruments to assess client well-being over time, evaluation activities may include collecting data with the potential of being connected to other rich Federal datasets such as those produced by the Census Bureau, the Department of Health and Human Services, and the VA. In combination, these data can shed insight into outcomes associated with the physical, psychological, and social determinants of health that affect suicidal ideation.

Ultimately, the measure of success for this bill will be the long-term trends of veteran suicide. If the rate is reduced, especially in locations funded by this legislation or in locations with existing care networks, it would represent preliminary evidence of the efficacy of coordinated approaches in communities.

Communities and coordination efforts benefit when given opportunities to share learning and receive ongoing technical assistance and evaluation support

Improving the way veterans and their families connect with services, resources, and care is challenging work. Doing so requires an ongoing commitment of both financial and human resources across hundreds of stakeholders in each community, and the ability to continuously evaluate progress.

Platforms that support ongoing lines of communication between organizations and communities can be powerful mechanisms to address these types of challenges—creating space to share best practices and solve common problems to help advance the quality and effectiveness of care coordination across the country.

In AmericaServes, this infrastructure is called the Community of Practice (CoP). The activities and resources in the CoP provide a backbone for communities to work through complex cases, establish shared minimum standards of care, and collectively solve problems faced by multiple networks. Additionally, CoPs create opportunities for exchange between practitioners and analysts around insights derived from community data. The IVMF model to embed evaluation support into its programs has facilitated faster learning and the adoption of evidence-based practices due to open dialog around the interpretation of data.

As this legislation is finalized, the IVMF recommends considering creating a robust technical assistance model, for example something similar to the offering within the Supportive Services for Veteran Families (SSVF) program, or to the cohort model utilized in the Institute of Museum and Library Services' (IMLS) Community Catalyst Initiative. The IMLS program, in particular, offers an infrastructure for grantees to connect, increase capacity in key areas, and learn from their experiences.

These technical assistance models should also include evaluation and analytics support. Even if provided with tools for data collection, many community organizations do not have the internal capacity or expertise to analyze or report on required measures. The IMLS grant helpfully included direct evaluation support to complement whatever level of in-house effort could be applied.

Conclusion

Veteran suicide prevention efforts begin by ensuring that veterans have positive post-military experiences. These efforts require supportive solutions that build on the extensive fabric of organizations that already exist in the communities military families call home. The best data available, while likely incomplete, tell us that 17 veterans take their lives every day. 11 of those veterans are not in VHA care. This legislation importantly prioritizes and seeks to empower communities to connect veterans who are falling through the cracks of our existing care systems to the services they need, which helps the VA enhance its ability to meet its mission.

Prepared Statement of Union Veterans Council



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Dear Members,

The Union Veterans Council, AFL-CIO, which represents over a million Union working veterans nationwide, including the tens of thousands that work at the Department of Veterans Affairs (VA) would like to voice our support for Chairman Takano's Amendment in the Nature of a Substitute (ANS) to H.R. 3495, the "Improve Well-Being of Veterans Act." This amendment would address the largest concerns that a large number of Veterans, Veterans Service Organizations, and Professional organizations have expressed regarding the original text of H.R. 3495.

The crisis that the veterans' community faces from suicide and mental health issues is one of our leading concerns, that is why we must oppose H.R. 3495 in present form. This bill is simply the wrong bill at the wrong time, it is very concerning to us that it does not require VA to be the primary provider and manager of care provided outside the VA. This will lead to fragmented care, a lack of accountability when it comes to private providers, and will divert much needed resources from building the VA's internal capacity when it comes to deliver clinical care services for mental health. Along with preempting the White House/VA PREVENTS Task Force (Executive Order 13861) findings.

This Amendment would allow us to support the many positive aspects of the IMPROVE Act that will undoubtedly improve the veterans' community while addressing the major concerns that have been stated by many in the VSO community.

There is always room for improvement when working to meet the healthcare needs of veterans. Every resource afforded to the VA should first go to improving and building the VA's internal capacity to provide timely, quality services to veterans. With privatization bills like H.R. 3495, it will become harder for the VA to expand its capacity to do so. Veterans deserve better than uncoordinated care from unproven entities given open-ended grants with virtually no oversight.

We ask you to please support the Chairman's discussion draft to H.R. 3495, the "Improve Well-Being of Veterans Act." The Union Veterans Councils, AFL-CIO looks forward to working with you and the VA to improve and expand VA mental health and suicide prevention programs.

For additional information or questions, please contact Will Attig at wattig@unionveterans.org.

Respectfully,

A handwritten signature in black ink, appearing to read "Will Attig".

William Attig

Executive Director

Union Veterans Council, AFL-CIO