Statement for the Record

House Committee on Veterans' Affairs Hearing:
Veteran Suicide Prevention: Capitalizing on What Works and Increasing Innovative Approaches

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Veteran suicide persists as the most pressing issue for the veteran community today. Recent data from the U.S. Department of Veterans Affairs (VA) suggest a modest decline in veteran suicide deaths from the previous two years, yet **rates of suicide within the first year after military discharge are higher now than ever**. Moreover, a study released by researchers at the University of Alabama and Duke University questions the veracity of state-provided death data. While based on data from eight states, the study suggests that the veteran suicide rate could be nearly double what has been previously reported due to undercounting by local medical examiners. Notwithstanding these latest estimates, one theme remains clear: the veteran suicide epidemic is a dire and urgent matter that requires our continued vigilance and action.

Strides taken recently by the House and Senate Committees on Veterans' Affairs offer some degree of hope. The Veterans COMPACT Act, the Commander John Scott Hannon Act, and the Phil Roe and Johnny Isakson Veterans Healthcare and Benefits Improvement Act each represent legislative action and innovation to end veteran suicide. Notably, the VA's latest announcement of the FY22 SSG Fox Suicide Prevention Grant Program recipients and the Phase 1 finalists of the Mission Daybreak grand challenge are demonstrable proof that meaningful steps have been taken. The IVMF commends the Committees' efforts and leadership and remains a committed partner to inform and support innovations that contribute to greater prevention.

This House Veterans Affairs Committee hearing focuses on VA-sponsored suicide prevention programming and research and outside organizations' efforts to prevent veteran suicide within a public health model. We applaud the significant strides that the VA Committees and the VA have already made to advance a suicide prevention strategy that is both clinical and community based. This builds off of an emerging body of research and evidence that suggests integrating health services with social services lead to better outcomes for people in care and reduces costs and strain on the larger healthcare system. We strongly encourage policymakers to continue to double down on this approach.

As the VA makes progress implementing this strategy, we believe it is critical to flag some emerging trends that will be increasingly relevant to our collective efforts to address veteran suicide:

1. **Enhance Coordination Between the VA and the Department of Health and Human Services** – Efforts to integrate health and social services for veterans must be coordinated within the larger context of healthcare in the U.S., starting with the Department of Health and Human Services.

2. **Develop Common Data Standards for the Social Determinants of Health –** Factors that influence health go well beyond traditional indicators of physical and mental health and include social, economic, and environmental factors—often called the social determinants of health. The VA should enhance data collection on health-related social needs and integrate them with health data systems.

3. **Expand "Ask the Question" Campaigns –** Local County health and human service (HHS) departments are a frontline resource in many communities and are currently underutilized as a partner in identifying veterans and connecting them to VA resources. County HHS departments need resources to help them collect data on who in their population are veterans and refer those veterans to life saving VA resources.

4. **Monitor Other Innovative Initiatives Focused on Suicide Prevention –** Currently, there are a few potentially high impact programs being carried out by the VA that should be closely monitored by congressional staff and scaled as evidence suggests is necessary.

Enhance Coordination Between the VA and the Department of Health and Human Services

The movement to integrate health and social services is growing not just in the veteran space but in the broader healthcare sector—including within Medicaid, Medicare, and other large healthcare organizations. To ensure veterans are well represented in this effort, the VA must coordinate further with these relevant agencies.

The newly launched SSG Fox Suicide Prevention Grant Program provides an initial means to support greater integration of health and social services for veterans. Further, the Governor's Challenge to Prevent Suicide among Service members, Veterans and their Families is another promising initiative to drive more collaboration between the VA and broader healthcare partners. However, policymakers in the veteran space must continue to promote greater integration across sectors to effectively advance coordination, and thus prevention-related service delivery.

In recent years Medicaid began spending significant resources to encourage states to facilitate partnerships between hospitals, healthcare providers, and social service providers in communities. In doing so, Medicaid has recognized its ability to incentivize community partners to work with healthcare providers in a coordinated fashion, thus pairing clinical interventions with needed social services that can prevent further deterioration of physical and mental health.

Medicaid is giving states the flexibility to use funding to not only pay for clinical services, but also incentivize partnerships between health and social service providers. For example, states contracting with Medicaid Managed Care Organizations (MCOs) can require coordination between health plans and community-based organizations. Further, Medicaid is using a tool called Section 1115 waivers that allow states to explore new ways to integrate services. California used the waiver to establish a Whole Person Care pilot program which grants dollars to localities to build systems that can link healthcare provision to social services.

These examples may seem irrelevant to the veteran suicide discussion, but they are wholly important for two reasons. First, shifts in Medicaid and broader healthcare policy directly affect veterans. About 1 in 10 non-elderly veterans are currently on some form of Medicaid, and the majority of non-elderly veterans do not use VA healthcare. The Veterans Affairs Committees and the VA must be tracking this movement in broader healthcare to ensure veteran-specific services and care are included in efforts to integrate health and social care. Veterans Affairs committees should be working in concert with their congressional staff partners who oversee Medicaid and Medicare to understand how veteran services are integrated into those efforts.

Second, this trend is important because it signifies innovation that the VA can adopt. While the VA may not wield the same granting authority as Medicaid, it has the means to encourage VA medical centers to work closely with community partners on the ground. Our experiences through the AmericaServes program taught us the degree to which a VA Medical Center (VAMC) is involved in local collaboratives of community services depends greatly on local VAMC leadership. Direction and resources from VA Central Office could encourage VAMCs to work with social service organizations in their communities, much like how Medicaid encourages participating healthcare providers. Once again, these changes should be executed in coordination with the DHHS to ensure integrated care is inclusive of both veteran-specific and non-veteran specific services.

Integrating health and social services for veterans must be a central component of our strategy to end veteran suicide. While providing top notch clinical care, the VA does not operate in a vacuum. Veterans interact with and utilize a whole host of other private and public healthcare programs, and social service providers in communities. The VA must improve its efforts to coordinate its healthcare strategies with those of Medicaid, Medicare, and other healthcare organizations to ensure veterans are not forgotten in a larger movement within healthcare towards health and social care integration. The VA cannot take on the challenge of ending veteran suicide alone and must work together with other relevant federal partners to ensure their strategies are coordinated and effective.

Establish Common Data Standards for the Social Determinants of Health to Enhance Collection and Referrals Between VA and and Community-Based Human Services

The data collected and analyzed to understand the veteran suicide problem—and the set of stakeholders analyzing said data—must grow beyond the clinical arena and government. Suicide

is influenced by several social, economic, and environmental factors known as the social determinants of health. The VA will need to improve the way it collects social determinants of health data and coordinate its practices with those of the Department of Health and Human Services (DHHS) to ensure utmost data interoperability, which underpins effective program evaluation and policy formulation. Further, the VA must recognize its health data must be shared and analyzed alongside the data collected by nonprofit providers of social services. For a full portrait of veteran needs and program effectiveness, the VA needs nonprofit partners who have more robust data on social service utilization than the VA itself.

The data we collect and analyze will greatly impact our success in preventing veteran suicide. Again, the Department of Health and Human Services is making strides towards ensuring better data standards around the social determinants of health. By doing so, the DHHS is setting standards around how social determinants of health data is collected, analyzed, and reported that states and healthcare organizations will follow.

While the VA is beginning to recognize the need for better social determinants of health research (the President's Budget request included a new research program focused on this topic) it **must not** fall behind or out of sync with the data standards being set by the much larger force that is DHHS. The VA only has a small slice of health-oriented data on only a portion of the entire veteran population. To fully understand veterans' social needs and outcomes, and the health needs and outcomes of veterans not in the VA system, it is imperative that the VA prepare its social determinants of health data standards in coordination with the DHHS such that data can be shared and linked down the road.

Similar to the challenges the VA and DoD have struggled with for years in integrating electronic health records, a similar problem is on the horizon for the social determinants of health. The VA and DHHS are both moving in the same direction towards integrated care, but on parallel tracks. If we do not take action to ensure social determinants of health data standards are coordinated, it will undermine long term data interoperability and limit our ability to fully study and understand how social determinants of health impact the veteran suicide problem, tying our hands to improve and adjust policy accordingly.

The VA Veterans Experience Office has provided valuable input to shape the standard Veteran Status definition as part of the Gravity Project, one collaborative focused on integrating social determinants of health data into healthcare data systems. Additionally, the VA Office of Health Equity has piloted the Assessing Circumstances and Offering Resources for Needs (ACORN) Initiative to screen veterans for social needs and offer resources and referrals to VA and community resources. These initiatives present an opportunity for policy leaders in the veteran space to work with broader health service policy leaders and ensure veteran health and social needs are well represented in broader discussions about social determinants of health data. VA Committees, VA researchers, and other VA stakeholders should continue to monitor and contribute to these efforts to set conditions for long-term interoperability and inclusion of veterans and their needs.

Achieving greater standards and interoperability can also facilitate research that includes multiple health and social service systems of care, which can broaden the scope of our understanding of the veteran suicide problem. Currently, data sharing between these systems is generally burdensome and limited to individual partnerships and studies, but the results add valuable insight to the conversation. For example, the IVMF has partnered on a study with the VA's Center for Health Equity Research and Promotion to share data on the economic, social, and wellness needs of veterans from our AmericaServes communities with VA medical records. Findings from our pilot study demonstrate that many veterans are both patients of the VA, users of other VA services, and receive additional care and resources from their communities. The IVMF has found similar overlap between client data from the PAServes network and the Allegheny County (PA) Department of Human Services program enrollment data. Projects like these could be made more feasible, and thus more common, with data standards and interoperability protocols adopted across systems.

Expand "Ask the Question" Campaigns

Better federal agency coordination is necessary, but it is only one part of the larger governmental system with which veterans interact. Connecting new veterans to needed VA resources requires expanding the ways we identify and engage veterans. The federal government can take new steps to empower local and state governments as partners in the effort to prevent veteran suicide by helping to identify and connect services to veterans not yet in the VHA system. By expanding the Governor's Challenge to Prevent Suicide Among Service members, veterans, and their Families to all 50 states, the VA is off to a good start. But there are ways it can go even further in supporting counties and states as partners.

VA data continues to support a longstanding trend; rates of suicide are high among veterans not currently receiving VHA care. A large part of our strategy is and must continue to be focused on connecting veterans into VHA care that haven't yet done so. County Health and Human Services (HHS) departments are an underutilized tool in this area. A popular strategy being deployed by Governor's Challenge Teams is a "Ask the Question" Campaign. These campaigns are focused on helping non-veteran health and service providers, as well as county HHS departments identify who among the population they serve are veterans. As of now, many of these organizations serve veterans but don't know they are doing so as they lack the data infrastructure and expertise to track their veterans' status. Helping these organizations effectively "Ask the question" of veteran status and store that data in an interoperable way, allows non-veteran service providers to identify veterans not currently in the VHA system and connect them to local VHA resources as need be.

Currently, this is a grassroots movement happening in a few states across the country, but resources are still a barrier for counties to carry out these campaigns. A series of small but high impact grants to County HHS departments could help incentivize localities to implement "Ask the Question" Campaigns and identify veterans that are interacting with government services but not the VA and get them connected to the VA before or during crisis. As currently constructed,

local organizations or County HHS departments might be working with a veteran in crisis, but not know their veteran status, leaving the veteran unconnected to life saving VA clinical care.

Monitor Other Innovative Initiatives Focused on Suicide Prevention

There are several small, but potentially high-impact programs growing within the VA that VA congressional committees should be tracking and helping bring to scale where and when appropriate. One such program is the Veteran Sponsorship Initiative, a pilot implementation trial being carried out in a few select cities across the country. The program works by connecting a transitioning service member with a local sponsor (trained and certified by the VA) to help the transitioning service member and their family during their transition experience. This program requires coordination of both the VA, community providers and the Armed Forces to properly ensure the transitioning service member is immediately connected with VA and community resources upon reintegrating into a community.

Currently, this pilot is undergoing an implementation trial evaluation in its Texas location where researchers (including the IVMF) are working to measure its effectiveness. While VA committee staff await the results of this evaluation, they should know it holds potential to be an effective intervention in the larger effort to prevent veteran suicide. Veterans are more likely to experience suicidal ideation in the first year after service than other periods of their life. Connecting the transitioning service member with both clinical VA services and necessary community supports at the critical juncture of transition should be a major part of our whole-of-government solution to the veteran suicide problem.

A similar program run by the VA, the Solid Start Program, makes the connection between a veteran and a VA representative immediately after separation and in the months that follow. This program shows promise too, but its effectiveness should be studied with a formal program evaluation, as recommended by the GAO. Further, its effectiveness will hinge on the program's ability to connect the veterans they reach out to not only to clinical VA resources, but local community social services.

In Closing

We thank the Committee for the opportunity to offer these recommendations and for its continued focus on the target and shared goal of preventing veteran suicide.