COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
with respect to the
H.R 5697
The Veterans' ACCESS Act of 2020

from the
American Psychological Association
*Association of VA Psychologist Leaders**
*Association of VA Social Workers**
Veterans Healthcare Policy Institute
(*An independent organization, not representing the Department of Veterans Affairs)

March 31, 2020

On behalf of our respective organizations, we thank you for this opportunity to submit answers to H.R 5697 questions for which you are soliciting stakeholder input. We wish to convey our deepest appreciation for your intention and leadership to ensure the cost-free provision of life-saving services for any veteran at risk of dying by suicide.

Please find our answers below.

1. *a. Should VA allow access to emergency mental health care to any veteran, regardless of discharge status, if they are in imminent risk of self-harm?*

   We support this benefit. However, we recommend changing the wording in the bill from "emergent" to "emergency." Explicitly define the term emergency treatment as used in *38 U.S. Code § 1725 (and Code § 1728)* to mean, "when such care or services are rendered in a medical emergency of such nature that a prudent layperson reasonably expects that delay in seeking immediate medical attention would be hazardous to life or health." Including that explicit wording (minus "medical") in the Definitions section would make clear that the intent of the bill is to provide care for imminent danger to self or others.

   b. If so, is the VCL the best mechanism to make this determination and referral?
   VCL is the best, but by no means the only, mechanism to make this determination.

2. *a. Should VA serve as primary payor for emergency mental health care?*

   We support VA serving as a primary payor for emergency mental health care if the **entirety of added costs is assured by Congress.**

   b. If so, how should limits be placed on the type and amount of care covered?

   More defined limits should be placed on the type of care covered than appeared in the original H.R. 5697 bill. **Covered treatable conditions should be limited to only**

"imminent danger to self/other." Once a non-enrolled veteran is no longer at imminent risk, coverage ceases.

As currently drafted, private sector care well beyond suicidal or homicidal crises is covered in the bill. Veterans who "present at a Department medical facility or non-Department facility with an emergent mental health need, including suicidal crisis." This should be tightened, since the current language would include situations beyond veterans in danger of harming self/other, such as individuals with intensified symptoms of depression, PTSD, schizophrenia, mania, grave disability, drug induced psychosis, etc.

Most importantly, the bill covers 30 days of private sector residential and 90 days of outpatient mental health care which could go beyond imminent risk of self-harm. Therefore, we suggest that **only emergency transport, urgent care, emergency department and inpatient unit services should be covered.** A specific exception for the Mariana Islands could be included that would permit use of emergency transport if inpatient care is required or local residential care if not.

Also, the bill should stipulate that no part of this legislation shall negate health care benefits identified in §1720I.

3. *a. What role should Suicide Prevention Coordinators play in helping to facilitate any follow up care for veterans not enrolled in the VA healthcare system?*

   Suicide Prevention Coordinators would be excellent professionals for this role. However, they are already fully occupied attending to suicide prevention actions regarding enrolled veterans. The bill should indicate that **additional funds for the needed expansion in the number of facilities' SPCs and Member Services personnel, and national VCL staff.**

   b. What other measures may be needed to ensure these veterans receive life-saving care?

   Require non-Department facilities/providers to have the same accreditation and quality standards that VA requires of its own.

   Creating a third lane for furnishing emergency mental health care outside the VA/VCCP severely fragments care and adds extra layers of administration. All facilities providing emergency department and inpatient services under this legislation should become VCCP members.

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

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