Veterans Healthcare Policy Institute

Policy Analysis of
Joint Action Plan for Supporting Veterans
During Their Transition from Uniformed Service to Civilian Life
(Dated April 18, 2018)

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In an effort to reduce the heightened risk of veterans dying by suicide in the year following their discharge from the military, the Departments of Veterans Affairs, Defense and Homeland Security recently issued an interagency "Joint Action Plan for Supporting Veterans During Their Transition from Uniformed Service to Civilian Life." The plan contains many innovative ideas that can be life saving, including early and consistent outreach to transitioning service members and enhanced veterans' connection to peer supports. However, the plan also contains provisions that are extremely problematic. The plan will drain the VHA of existing resources needed to maintain its level of high quality care, expand community care that may be substandard to quality mental health care and effective suicide prevention services pioneered by the VHA, and alter eligibility criteria that lead to further VHA privatization. These shortcomings, delineated below, are all the more troubling given the absence of additional funding needed for the successful implementation of suicide prevention efforts.

1. **The plan would drain the VHA of existing resources needed to maintain its level of high quality care.**

   The Joint Action Plan estimates that roughly 245,000 servicemembers will transition out of the military every year. The plan requires that each one of them be contacted within 90 days of their separation and at subsequent times over the year. Peer supports must be available for warm handoffs throughout the year. These are only some of the tasks – all of them essential – that must be accomplished if the plan is to be successful. However, there is no stipulation for Congressionally approved supplemental VHA staff or budget allocations needed to effectively fulfill these new mandates. If there is no funding allocated, these tasks will be conducted by shifting VHA staff from other duties and/or by eliminating other VHA positions.

   The plan also estimates that 32,000 veterans will seek mental health treatment in their year following discharge. They will be entering a VHA mental health system where caseloads are already extremely high, because twice as many veterans receive VHA treatment as a decade ago. Increased allocations for VHA mental health provider staffing is urgently needed to accommodate transitioning veterans, especially in locations where they tend to settle. Without additional resources, these veterans will have to be referred to the community, and funding for that community care will be offset by reductions in existing VHA budgets.

Recommended solutions:

a. Provide emergency mandatory supplemental funds for expanded peer support duties with the 245,000 transitioning servicemembers.
b. Provide emergency mandatory supplemental funds to hire VHA mental health providers to treat the 32,000 veterans who will avail themselves of this benefit.
c. Provide emergency mandatory supplemental funds for space and infrastructure needed for (a) and (b) above.

2. **The plan promotes expanded use of private sector providers who may not deliver the kind of quality mental health care and effective suicide prevention services that have been pioneered by the VHA.**

   The Joint Action Plan's promotion of veterans' expanded use of community care disregards the fact that VHA's suicide prevention program is far more advanced, coordinated, comprehensive and successful than private sector efforts. That superiority is true as well for the entire spectrum of mental health conditions, as a recent review in the Federal Practitioner comparing VHA to outside care convincingly documented.

   The plan wisely recommended (Action 2.7) expansion of the VHA's successful REACH Vet program, (which uses systemic data to predictively identify and intervene with VHA-enrolled patients who are at the very highest risk of suicide.) However, veterans receiving care in the community will be beyond range of the REACH program, and there are no programs in the community that are comparable. We save veterans lives by encouraging connection to the VHA.

   The stand-alone mode of community care runs completely counter to the VHA's best practice integrated care approach. Veterans have more complex problems and need greater, not less, integration of mental health, physical health, and social services across the continuum.

   Recommended solutions:

   (a) Wait to accept new providers as community partners until the June 4, 2018 GAO Report recommendation #8 is implemented: *"The Secretary of Veterans Affairs should establish a system for the consolidated community care program VA plans to implement to help facilitate seamless, efficient information sharing among VAMCs, VHA clinicians, TPAs, community providers, and veterans. Specifically, this system should allow all of these entities to electronically exchange information for the purposes of care coordination."*
   (b) Increase staffing recommended above.

3. **In altering eligibility criteria, the plan will lead to further VHA privatization.**

Action 3.4 states, “Transitioning Service members who need mental health care, but who are barred from VA care, otherwise ineligible or not interested in VA care can be referred to Vet Centers when appropriate or to other community providers.” The key clause is “not interested in VA care.” This new language for VHA offering supplemental care goes beyond previous eligibility standards for community referrals in the Veterans Choice Program or recently enacted VA MISSION Act. Up until this point, the VA would offer community options if a veteran had to wait too long or travel too far for services, or there was a clinical reason to refer out. This clause represents a radical revision that has long been the priority of privatizers like Concerned Veterans for America.

The plan’s allowance of choice without regard to impact sets a dangerous precedent for the rest of the system, jeopardizing its ultimate existence. Pressure to open up private care options was a prime reason that Secretary Shulkin was fired, following his ominous warning last year to the Senate Committee on Veterans Affairs: “Just giving veterans a card, a voucher, and let them go wherever they want to go... is appealing to some but it would lead to essentially the elimination of the VA system altogether. It would put veterans with very difficult problems out into the community with nobody to stand up for them and to coordinate their care, and the expense of that system is estimated to be at the minimum $20 billion dollars more a year than we currently spend on VA healthcare.”

There are many problems with this provision. Of great concern is the fact that transitioning veterans may not “be interested” in VHA mental health care because they are unaware of the high quality of services that they would receive in the VHA. This creates or exacerbates resistance to getting care in general and from the VHA in particular.

An interconnected problem is that all community care elected by preference is paid for out of local VA facility funds. This then leads to vacant VHA positions not being filled and VHA mental health services eventually being curtailed. As the availability of VHA services diminish, more veterans will be channeled into private sector care, leading to a vicious cycle of further VHA cuts. Permitting veterans to choose non-VA care may sound good in principle, until the unintended consequences are considered. One of these inevitable side effects is depriving other veterans of high quality VHA choices.

It is, of course, true that effective mental health treatment depends on a good working relationship between the patient and provider. Veterans should have the prerogative to obtain a new provider if the fit between them and their current provider is problematic. The right solution already exists: a veteran can appeal to the VHA patient experience coordinator for reassignment to another VHA provider. Only if another provider is not available, and the Vet Center cannot accommodate, should a voucher for private sector care be issued. That’s the operative model used in every fully integrated healthcare system.

Recommended solutions:

a. Inform separating service members of their 12 months of mental health benefits in a way that assures that they get needed information about the superior nature of VHA's mental health services.
b. Establish a metric for measuring the percentage of service members apprised of VHA's superior care.
c. Change language of Action 3.4 to "Transitioning Service members who need mental health care should be offered VHA in-person or telemental health care, and when that is not readily available, referred to Vet Centers. In instances when neither is available, care from community providers can be offered."

A fuller Joint Action Plan implementation framework, including the expected costs of the initiative, will be issued in a July 9, 2018 status report. That would be an ideal time to address the issues raised above.

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