Advisory Committee on Disability Compensation (ACDC/the Committee) Meeting

Tuesday, August 22, 2023 – Wednesday, August 23, 2023

10AM – 3PM & 9AM – 4PM Eastern

EXECUTIVE SUMMARY

Transcription Services: Provided by Jamison Professional Services

Veterans Benefits Administration (VBA) Staff Present:

- Jadine Piper, ACDC Lead Designated Federal Officer (DFO); Chief, Compensation Service (CS), Veterans Benefits Administration (VBA)
- Lisa Lotts, Alternate DFO, ACDC; Program Analyst, CS, VBA
- Claire Starke, Alternate DFO, ACDC; Program Analyst, CS, VBA
- Jesse Burgard, PsyD, Senior Consultant, Suicide Prevention, Interventions Office of Mental Health and Suicide Prevention
- John Capozzi, Assistant Director, Quality, Medical Disability Examination Office
- Kyle Timmons, Chief, Quality, Medical Disability Examination Office
- Nicole Dumas, VA Schedule of Rating Disabilities (VASRD) Acting Assistant Director
- Pat Mackin, Contractor – Sr. Economist, SAG Corporations
- Sarah Prenovitz, Contractor - Sr. Analyst, Abt Associates

ACDC Members Present:

- Evelyn Lewis, Chair
- Bradley Hazell, Vice Chair
- Patt Maney
- Eloisa Taméz
- Frank LoGalbo
- Steven Wolf
- Al Bruner

Meeting Summary

Purpose: The purpose of the Advisory Committee on Disability Compensation is to provide advice to the Secretary of Veterans Affairs on establishing and supervising a schedule to conduct periodic reviews of the VA Schedule for Rating Disabilities (VASRD).

The purpose of the meeting is for the Committee to receive presentations on various topics relating to their job as a Committee, as well as discuss the submitted biennial report and future meetings.

The committee met in an open, public session on Tuesday, August 22, 2023, and Wednesday August 23, 2023.

Tuesday, August 22, 2023

Opening Remarks

Ms. Claire Starke called the Committee to order at 10:00 a.m. Role was called, and seven members were present. She noted the requirements were met for quorum and turned the floor over to the lead DFO, Jadine Piper.

Ms. Jadine Piper welcomed the Committee to the meeting and reviewed the rules of engagement for speaking. She then turned the meeting over to the Committee's Chair, Dr. Evelyn Lewis.

Chair Lewis thanked the Committee for attending the meeting and began member introductions.

Member Introductions

After self-introductions by members, Chair Lewis turned the floor back to Ms. Piper.

May & June Debrief

Ms. Piper explained that with the survey results from previous meetings, they took the feedback given by the Committee members to help improve future meetings. She also discussed how it was their first in-person meeting all together, and that she would be looking for real-time feedback from the Committee members as well as any questions.

In May, Executive Director Beth Murphy and other presenters from Compensation Service had discussed the PACT Act and highlights from Compensation Service. Ms. Piper asked the Committee if they had any comments or questions for future presentations to be given to the May presenters.

Chair Lewis suggested that since the work Compensation Service does ties directly into the work of the Committee, it would be important for the Committee to receive continuous updates of information from Compensation Service so they can stay up to date on anything new being done. She shared her experience of hearing from a friend who had served, as well as his father, and neither of them had heard of the PACT Act. She suggested that the messaging being sent out to Veterans about the PACT Act is not enough, as there are still many who don't know what it is or how it could help them.

Ms. Piper asked what types of suggestions they had for outreach, as the VA has information on VA.gov, messaging, nationally, commercials, et cetera. Patt Maney suggested that remote geographical areas may have a harder time receiving that information, as the area he lives in only has a Community Based Outreach Clinic (CBOC). He did say there was a PACT Act event being run at the JAG as patients were there, so it was well attended and included screening and preparation of filing claims. However, he said there was no outreach into his area or further east for the people

more than two hours away. He shared that these communities have multiple military bases and many Veterans without outreach, including no emails, mailers, signs in CBOCs, et cetera.

Chair Lewis suggested that people be placed in the CBOCs specifically to reach out to Veterans about the PACT Act and other eligibility items. Steven Wolf suggested that more outreach is done through radio or local television stations instead of just national ones.

Ms. Piper shared that for the month of May, they consolidated all the comments from the Committee. For the Compensation Service Leadership Overview, only one comment was received which stated their appreciation for the overview and information provided to the Committee.

For Topic 2, Federal Advisory Committee Act (FACA 101), the consolidated comment received stated how they enjoyed the review and materials provided on FACA, as well as a great overview.

Topic 3, VA Schedule for Rating Disabilities (VASRD) Updates, the commentor expressed their appreciation for the update and requested information for a better understanding of Iteration 2, incorporating the Earning and Loss Study (ELS) in the review of the body systems.

Ms. Piper asked for comments from the Committee about the VASRD Updates or any other items that the Committee felt needed to be addressed. Mr. Hazell suggested they look into the impact of the loss study and support of medical documentation and nexuses. He asked how best to show the level of impairment lost versus the disability percentage and medical evidence so they can have a better understanding and ensure that the ratings are applied properly.

Chair Lewis asked specifically with the ELS data about the design and how they decided what questions they were going to ask and what information they needed to come to the conclusions they currently have. She shared how the presentations in the past didn't share as much about what has come out of the information gathered and what the numbers are. She requested more background information about how the information was reached, and not just what the final information is.

Ms. Piper requested they take a lot of notes in the next day's meeting so they can see if the information Chair Lewis was requesting had been given and they could move from there. Mr. Hazell concurred with Chair Lewis, sharing that he also felt that the presentation given by VASRD in the previous meeting had been one of the more comprehensive presentations they had been given, so he appreciated the amount of information shared and hoped that future reports would have as much detail as the last report.

Ms. Piper moved on to the next topic, Electronic Health Record (EHR) presentation. Comments showed that the presentation was enjoyed, and they understood it was a very complex topic and takes a lot of time to complete. She asked if there was any further discussion about the EHR. Chair Lewis agreed that the process is complex but felt it was taking an incredibly long amount of time to be completed.

The next topic was the Integrated Disability Evaluation System (IDES) briefing. Mr. Hazell shared that they are still seeing transitioning service members not getting separation health assessments on time. He said the VA is not providing the exams that they said they would do in a timely matter, causing the service members to have to rush to get a physical through the Department of Defense (DoD) instead. Mr. Wolf felt the DoD needs to take more responsibility on making sure the service members who are transitioning are getting what they need done in a timely matter.

Ms. Piper asked if anybody had comments or suggestions around the Military Sexual Trauma (MST) presentation. Chair Lewis said her comments are similar to those about the PACT Act, that there are countless people who do not know they can get care for MST.

With no further comments or discussion, the Committee took a brief break before returning for the next presentation.

Medical Disability Examination Office (MDEO) Deep Dive: Quality and Error Trends

John Capozzi, Assistant Director, and Kyle Timmons, Chief from MDEO began the presentation. Mr. Capozzi explained that the MDEO quality team conducts random quality audits/reviews on Disability Benefits Questionnaires (DBQs) completed by vendors. Vendor quality performance is assessed through accuracy and consistency of DBQ reviews, to include vendor's adherence to exam request instructions, DBQ instructions, and internal MDEO guidance provided in the form of Vendor Guidance Memorandums (VGMs). MDEO uses a quality checklist to score the accuracy of a DBQ, and the aggregate score of reviewed DBQs in a quarter determine the overall score for a vendor's DBQ quality performance for a contract.

Mr. Capozzi shared that MDEO also is in contact with vendors on a monthly basis, providing monthly Error Citation Reports (ECR). These allow MDEO to provide the vendor notification of inaccuracies identified in DBQ audits, identify error trends for all vendor contract regions, provide vendors with opportunities to avoid future errors, and inform vendors how to accurately report findings that are required for DBQs.

In addition to the monthly ECRs, MDEO also has monthly quality calls with the vendors to share current quality results, training issues related to errors cited during audits, responses to questions on established expectations for completing DBQs accurately and assess the vendor's improvement efforts. MDEO also conducts annual corporate onsite visits with each vendor to discuss quality error trend data with the vendors in a formal visit as well as present trend error analysis and focus on needed actions to improve the vendor's quality.

Mr. Capozzi shared a graph that showed combined vendor quality over time, showing that the quality has improved from 95.9% in Fiscal Year (FY) 2022 Quarter (Q) 1, to 97% in FY23 Q3. In terms of errors, he showed data about the top error trends from October 2022 to June 2023. These error trends include not completing all applicable questions in the DBQ, DBQ/VGM instructions not being followed, discrepancies within

the DBQ findings without clarification, incorrect documentation of diagnostics testing results to include testing completed in conjunction with the exam, and necessary medical opinion elements not being provided, and/or conflicts with other evidence/findings within DBQ or evidence of record. Having reached the end of the presentation, the floor was opened for questions.

Mr. Wolf asked if they were taking quality from the DBQs or the actual examination, the doctors. Mr. Capozzi answered that they assess what is reported on the DBQ.

Chair Lewis asked, when the errors and trends are identified, how are they corrected? Once they are corrected, what is the impact of the correction on the process the Veteran has to go through? Mr. Capozzi answered that if there is a deficiency within the DBQ report, the decision maker gets the report and sends back to the vendor for a correction for anything that is missing.

Chair Lewis asked if there is information missing but the person making the decision does not send the DBQ back to be corrected but instead continues to make their decision, if there is a way to identify and correct that action by the decision maker? Mr. Capozzi said the VBA would be the one to identify and correct the issue.

For corrections on the errors and trends, they have found in the past affect the process for Veterans, Mr. Capozzi answered that errors found in the claims process are fixed for that individual for whom the error was found. Chair Lewis clarified that she was wondering if anybody has tracked how much of an impact it has had on the Veterans filing the claims. Mr. Capozzi said that in correcting the issues, it makes the vendors be more compliant with the rules set forth for DBQs, which would positively impact the Veterans. However, tracking for that particular item would be done by Compensation Service.

Frank LoGalbo asked if MDEO is taking steps to collaborate with Compensation Service in order to track these types of metrics and ensure that errors made by a review specialist are identified and ensure the contractors are maintaining the standard based on that information. Mr. Capozzi said they do have a monthly call to have someone look at active claims to identify and fix issues.

Chair Lewis asked if MDEO had any data they could share about the errors that had been identified and what steps were taken to fix them. Mr. Capozzi said they did, and he would have the information sent to the Committee.

With no further questions or comments, Ms. Piper thanked Mr. Capozzi for his presentation and time.

Survey Results Discussion Continued

Ms. Piper showed the Committee the questions asked in the last meeting and the results of those surveys. She shared that they made sure to ask in what way each person was joining, so if they were experiencing issues if they joined via telephone, it would be known to address that for the telephone attendees and not needed for the rest of the attendees.

The next topic Ms. Piper reviewed was based on the VA Suicide Prevention Program. The comments for the last presentation included a request for more information to have a better understanding of how all of the programs work together as well as how the impact was measured; wanting to see more focus on current programming and less on statistics; asking if there was a website where the data could be reviewed.

Chair Lewis shared that she had been on two committees with the National Academies and that the VA had contracted with them to workshop on things like Veteran Suicide and what the community's role is to help, how providers can ensure the Veteran is getting the help they need, et cetera. She was unsure of how everything comes together, stating that they are doing all of these different things but why aren't they looking at the big picture to see what it looks like together.

The next topic Ms. Piper brought up was Veterans Experience. Some comments included asking for the slides to be easier to read, as some had very small font; personally appreciated a good news story from VA; transition options; would like to know how VEO is working with VBA based on the HDC model. They also wanted to know how the character of discharge issue is being addressed for Veterans who are looking to change their character of discharge.

Ms. Piper then brought up Exams Quality, and how they had just heard from MDEO and will hear more after their lunch. The comments included wanting additional information and metrics to do with information submitted on last report; asking for continuous updates on efficiency; preferring more detail about how quality review is performed; wanting more concrete information on how concerns are responded to. Chair Lewis suggested that for the next presentation from MDEO, they ask questions based on the reports so the presentation can address the concerns they had from previous presentations.

The next topic involved the end of the COVID-19 National Emergency. The comments were positive with no additional information needed. Chair Lewis shared that she doesn't feel they need another full brief on the status, and that any updates can be sent with a few slides, especially with new variants of COVID flaring up.

Military Environmental Exposures presumption research was the next topic mentioned. Continuous updates as well as more information and slides were requested.

For Part 3 regulation changes, many commenters requested the information to be clearer with more slides, less acronyms, and more links to further information as well as a summary of regulation changes and possible dates for regulations being changed. Chair Lewis suggested that more information be shared with those who were discharged as other than honorable but have Post Traumatic Stress Disorder (PTSD) or MST and are able to receive some benefits. She felt these groups weren't receiving enough information and they may not know what benefits they qualify for.

Ms. Piper shared the next topic, Veteran Service Officer (VSO) Applications. The comments asked for more information about specific efforts or changes and an updated brief on the short-, and long-term plan for the applications.

At that point, a county-wide power outage occurred and the meeting was adjourned until the next day.

Wednesday, August 23, 2023

Opening Remarks and Committee Member Introductions

Ms. Lisa Lotts, opened the meeting at 9:00 a.m. She informed the attendees that the meeting would be recorded and transcribed. Role was called and Ms. Lotts indicated quorum was met and the meeting can continue. She then turned the floor over to Ms. Piper.

Ms. Piper welcomed the Committee and others attending the meeting and reviewed the rules of engagement. She informed the attendees that the previous day's power outage caused their last presentation to not be given on the site visit overview. She shared that they would present during that day's meeting if there was enough time for them to do so. She asked that members of the public hold their questions or comments until the allotted time for them to do so. She then turned the floor over to Chair Lewis for member introductions. Each member introduced themselves with a brief background.

VASRD Status Update

Ms. Piper introduced the first speaker of the day, Nicole Dumas, Regulations Chief, VASRD Program Management Office (PMO), Compensation Service.

Ms. Dumas informed the Committee that she would be speaking about the VASRD, and after a break, contractors will speak to the Committee about the ELS. She began by giving a brief overview of the history of VASRD beginning in 1988, when (Government Accountability Office) GAO advised VA to develop a plan for reviewing and revising the body systems and going to 2019, when VA created the VASRD PMO.

She then spoke about VA's goal for the VASRD, which included VA's commitment to updating its disability rating criteria to accurately reflect medical advancements and improved technology, allowing VA to ensure its disability evaluations more accurately compensate Veterans based on impairments in average earning ability. In addition, the Secretary shall from time to time readjust the schedule of ratings in accordance with experience. Ratings shall be based, as far as practicable, upon the average impairment of earning capacity resulting from such injuries in civil occupation.

Finally, VA is in the process of performing its first complete update of the VASRD since 1945. To date, VA has finalized 10 of the 15 VASRD body systems. The VA will publish final updates for the remaining systems in four rulemakings within the next two years.

The 10 body systems finalized and published include Dental and Oral; Eye; Gynecological Conditions/Breast; Endocrine; Skin; Hematologic and Lymphatic;

Infectious Diseases, Immune Disorders/Nutritional Deficiencies; Musculoskeletal; Genitourinary; and Cardiovascular.

The status of the final body systems are as follows:

- Digestive: Estimated final rule publication date 7/12/23. Status: Final rule in VBA concurrence.
- Respiratory/Ear Nose Throat (ENT)/Audio: Estimated final rule publication date 10/02/23. Status: Final rule in VBA Concurrence.
- Mental Disorders: Estimated final rule publication date 10/02/23. Status: Final rule in VBA Concurrence.
- Neurological: Estimated final rule publication date TBD FY24. Status: Proposed rule pending VA Office of General Counsel concurrence.

Ms. Dumas then shared the VASRD Concurrence Dashboard (1st Iteration) which showed where the final body systems are specifically in a specific level. She also showed the release schedule of when each body system should be added into the Veteran Benefit Management System (VBMS) and the target effective date after experiencing some delays.

She noted the importance of the concurrence process and what the benefits are behind the process. One reason for the process is to ensure accuracy of the VASRD updates, including bringing things into law that are legally sound. They also want to ensure that they are considering the impact to other VA organizations such as Veterans Health Administration (VHA), and properly account for the impact to stakeholders. It also creates confidence in the final product and increases timeliness of Under Secretary for Benefits (USB) and Secretary of Veterans Affairs (SECVA) signatures.

Ms. Dumas showed a flowchart of the concurrence process and how long it may take at nearly 4 years. She shared that VBA is committed to updating all VASRD Body Systems on perpetual reoccurring cycles, with update implementation coinciding with VBMS release/ Office of Information and Technology (OIT) development cycle. A drafted proposed rule can take approximately 19-28 months to reach concurrence, while the final proposed rule concurrence takes approximately 17 months.

She stressed that their goal is to make sure the VASRD accurately reflects current medical science and reviewed some of their risk and mitigation strategies. One risk involves rule review delays with concurrence partner, and they are trying to mitigate that risk by CS communicating due dates with concurrence partners, discussing pass backs, and following up with each partner throughout the concurrence process, as well as encouraging senior leaders to engage when necessary. In addition, they will consider creating rules with fewer DC updates.

The second risk she shared was delays in approving required changes to the DBQs to incorporate VASRD updates. To mitigate this risk, they are working to convene the Change Control Group (CCG) meetings more frequently to expedite concurrence and postpone the effective date of the regulation, in addition to ensuring CCG participants are included in initial workgroups.

Ms. Dumas moved on to speak about goals for future iterations. She shared they were going to continue modernization efforts based on medical data, economic data, and internal reviews. Medical data includes updating medical terminology, removing obsolete conditions, and incorporating medical advances that have occurred since the last review of each body system. Economic data helps determine if VA can use ELS data to update criteria within the VASRD. Internal reviews will help create updates to ensure terminology throughout VASRD is consistent.

She shared the lessons learned to date with the VASRD updating process, including ensuring proper staffing, minimizing number of updates within a single rule, maintaining contact with workgroup SMEs, and prior planning for concurrence around election periods. The floor was then opened for questions.

Dr. Eloisa Taméz expressed her concern about the length of time to get new body systems processed since medical data could be already different from when the review was done by the time a body system is finished and finalized. Ms. Dumas shared that they do have governance boards that are aware of the problem, and some of the delays happening are unavoidable, especially with the large number of entities involved in the process.

She also said that with the length of time, cost is associated and the delay can cause more cost that needs to also be updated. She assured the Committee that they are taking notes and taking everything into consideration at the end of Iteration 1 as they move into Iteration 2 to ensure the process is more expedient.

Chair Lewis also expressed her concern about the delays. She was trying to understand how the delays are going to be resolved or mitigated as they continue forward. She asked when the process first began, and Ms. Dumas answered that it began in 2009. However, much of the process was not started until 2012, and there have been offices working on the VASRD update that had other tasks so they could not focus 100% on the updates. That is why the VASRD office was created in 2019.

She also pointed out that because the office is new and nobody had previously focused 100% on VASRD updates, everything they are doing is completely new so they are having to learn as they go. They have implemented strong training programs to ensure their employees are able to finish things like drafts within the time period they predicted.

Chair Lewis requested that the Committee receive timely updates with what is happening for what the department needs to minimize the delays that occur. She shared that the Committee could help address these issues in their biennial report to the Secretary of the VA.

Mr. Hazell asked to view the slide that showed where each body system was in the concurrence process. He asked if it was possible to see when the respiratory and mental body systems moved from the comment period to analyzing, and then to drafting the final rule, as far as those processes.

Ms. Dumas said that for respiratory/mental, they opened February 15 and closed April 18. She shared she was analyzing for respiratory and on day one, they hit 200 public comments where they usually only get 10 to 20 for an entire comment period, which did

add time to processing it. The goal was 90 days but with over 2,000 comments in full, they didn't get a draft for concurrence created until the beginning of October 2022. Mr. Hazell then asked if she could tell the Committee if the drafted final rule was different from the proposed rule based on public comments. Ms. Dumas was unable to say.

Judge Maney asked what it meant when GAO added VA to the High-Risk List. Ms. Dumas answered that it meant the VASRD was high risk of not being properly aligned with current medical science and not updating as it should be updated. Judge Maney commented that the craft of the early timeline of processing stated that General Counsel should take about 120 days to complete their part of the process, which moved to 180 days, then showing the body system that has been sitting in the General Counsel's office for 18 months.

He asked what could be done to help that body system move along. He also asked for clarification on what it means to plan concurrences around election periods. Ms. Dumas answered that they want to get the concurrence done so it is not sitting still during an election period and might have to start over again if new people are placed into office, so they want to publish 3-6 months before the election period starts.

Ms. Dumas also shared that the Office of General Counsel (OGC) has had staffing issues and have been understaffed, which significantly delays processes going through that office. They also have other rules that take precedence, like the PACT Act, and other rules in general that they are working on at the same time.

Mr. LoGalbo asked what steps are being taken to address training quality to become more efficient. Ms. Dumas said they don't have a quality assessment since they have the concurrence process, but they developed a training program and have staff who volunteered to be a training officer. Ms. Dumas is also looking into doing annual training and working on effective research.

Chair Lewis asked if Ms. Dumas has a document that lists the things that the VASRD team need more training on. Ms. Dumas answered that they, the program management office, has a full training program for new employees based on prior experience and background. They are also working on having reoccurring training so that all employees are up to date on any new processes or rules.

Earnings & Loss Deep Dive – VASRD

Dr. Pat Mackin, a project manager and senior economist for SAG Corporation on the ELS program, introduced himself and told the Committee they could jump in with a question when they had one, if needed. He explained that they would be reviewing the project overview, a summary of ELS 3 progress, using ELS results in VASRD review, and ongoing and future work.

He began with the project overview of the multi-phase effort to develop quantitative evidence on the loss in earning capacity associated with individual disabling service-connected conditions. ELS 1 estimated for a preselected set of diagnostic codes and matched VA data to American Community Survey data at Census, demonstrated

viability of estimates for individual diagnostic codes (DCs), and identified sample size as a critical limitation.

ELS 2 refined the methodology developed in ELS 1 and pursued more data sources, and also estimated basic models for all diagnostic codes to assess sample sizes and estimate precision. This helped to demonstrate the importance of improving data to obtain useful results. ELS 3 is estimating earnings losses for hundreds of DCs using refined methodology from ELS 2. They are introducing improved data and modeling techniques to increase precision and enhance usefulness of results for policy applications.

Dr. Mackin continued, giving a summary of ELS 3 progress to date. In the base year (ELS 3.0), they reviewed the 100 most prevalent DCs, finding 92 to have enough data to produce estimates. They also conducted pseudo panel and panel estimates, as well as first estimates using administrative earnings data.

Option Year 1 (ELS 3.1) had them reviewing an additional 163 diagnostic codes, with 161 of those having enough data to produce estimates. They created first-level rating estimates and examined dispersion of losses around average values.

In Option Year 2 (ELS 3.2), they reviewed another 127 diagnostic codes, created rating-level estimates in baseline estimates, and made improvements in model specification based on previous research.

Dr. Sarah Prenovitz, a senior analyst and economist for Abt Associates working with the ELS 3 program, showed the Committee an example of ELS 3 estimation results on a graph, showing “Estimated Effects by Time Period, Diagnostic Code 5156: Little finger, amputation of.” She explained the y-axis showed Earnings Gain (+) or Loss (-), 2016 Dollars. The x-axis showed years to onset. The graph showed the gain and loss both before and after onset of the disability, showing an increased amount of earnings loss for each year afterwards. It also showed their confidence level that the data is accurate for their estimates.

Dr. Mackin explained their methods for interpreting the estimates from the data they collect. He shared that loss estimates provide multiple pieces of evidence which relate to average loss, percentage change in earnings, timing of loss, persistence of loss, loss relative to other rating levels and conditions, and the precision of their estimates.

Dr. Prenovitz then reviewed several other charts with the Committee. One showed the standard path of earnings over time versus age. The next, earnings after onset of service-connected disease (SCD), with earnings loss being the gap between potential earnings and observed earnings. Then estimating earnings losses, using the earnings of Veterans without SCDs to estimate counter factual earnings. They also make sure to review data about the influence of other SCDs, for if they do not control for other DCs, they could overestimate the earnings loss. They use information on other ratings to account for effects of other DCs.

The next graph showed their estimated earnings loss for DC 9434 (major depressive disorder) which estimated the earnings loss in the year of rating as around $6,000. Another graph, showing the earnings loss by rating level for DC 7913 (diabetes

mellitus), showed how estimated losses increase with rating level for that specific DC. However, the earnings loss by rating level for DC 6100 (hearing loss) didn't show that the estimated losses always increased with the rating.

A graph showing earnings loss over time for DC 9434 (major depressive disorder) showed that losses are already observed at one to two years before the rating decision to grant service-connection to the Veteran. The changing earnings loss over time for DC 5237 (intervertebral disc syndrome) graph asked if estimated losses for this DC fall over time, or was the change due to the changing sample used? For the graph showing earnings loss versus benefits payments for DC 7913 (diabetes mellitus), they asked if estimated losses align with benefit payments.

Dr. Mackin continued the presentation by explaining how the ELS results are used in VASRD review. They first need to consider implications of imprecise estimates such as large confidence intervals, which could signal the need to improve data or models; could reflect variation in earnings impacts of medical conditions; and could reflect imprecision in rating criteria. They can then do a dispersion analysis of the data, which can reveal when earnings-loss experience varies widely across Veterans, and if there are clinical or other differences among similarly rated individuals.

For the rating-level results, they ask the question of what it means when estimates overlap or do not follow their expected patterns. They also consider the effects of presumptive conditions with the concern that Veterans newly rated with a change in presumptive service connection policy may not experience the same earnings loss as a "typical" Veteran with the same condition prior to the policy change.

Chair Lewis asked that when using ELS results in the VASRD, with such wide confidence intervals for some of the data shown earlier, what does it do to the accuracy of integrating that information into the decisions made with VASRD? Dr. Mackin answered that in some cases, it may be indicative of variations in the severity of the condition as it affects the ability to work, earnings, so they are able to review the data more closely to ensure it aligns with the decisions made for VASRD.

Chair Lewis asked if the variations would be examined prior to looking at using ELS results for VASRD so they would understand the information to be more accurate or precise. Dr. Mackin said the ELS evidence may show three to five years after the benefits were granted to a person, so once they review all the other information being taken as a whole, they can put together the data in due process.

Dr. Mackin then explained the ongoing work being done to enhance the estimates. They are working to refine the modeling approach for better approaches to handle rating changes, as well as working on shrinkage estimators. They are also investigating the potential to incorporate data from Unemployment Insurance records, which would produce working paper that discusses the results. In addition, they are creating supplemental resources to assist using evidence for VASRD review, including supporting documentation and clinical analysis of data.

Dr. Mackin opened the floor for questions at this point. Mr. LoGalbo asked if Dr. Mackin could share the annual working papers with the Committee so they can better

understand how they are reaching the estimates. He also requested the five data analysis plans to increase accuracy that was mentioned earlier to be shared with the Committee.

Ms. Dumas answered that with the working papers, they would have to wait for leadership to clear them to provide the papers to the Committee. She shared that they still have to make sure that the data is viable with current economic data, which Dr. Mackin and his team are working on with regard to updating models. They have to ensure that it would be valid to make adjustments based on the ELS findings so they can support the changes that they're making.

Chair Lewis shared that the data would be useful for them to receive as they can then decide on what they need to interpret from the data using the Committee's varied experiences. They would then be able to know what questions to ask from the VASRD updates and ELS data in the future.

Mr. Hazell asked with the possibility that the data may not be viable, what currently could cause that? Ms. Dumas answered that the estimates being too varied based on different elements could cause data to not yet be viable until it is determined why the data is varied and if it accurately reflects the earnings loss of the DC and not other disabilities the Veteran might have that could change the data.

Mr. LoGalbo asked if they would have access to any of the peer-reviewed studies used by the ELS. Ms. Dumas confirmed that anything like that would be available.

When it comes to the ELS 3 detailed analysis plans, Dr. Prenovitz shared that they plan to deliver five detailed analysis plans per year. Examples include testing the equality of earnings loss for shared rating criteria; examining how labor market disruptions and recessions affect earnings loss; investigating how changes in policy/law affect estimated earnings loss; exploring how educational attainment affects earnings loss; and analyzing how changes in presumptive laws/regulations affect their estimates of earnings loss and how it changes the population characteristics of Veterans with service-connected disabilities.

Mr. Wolf asked about analyzing changes in presumptive law and for Dr. Prenovitz to expand on what they mean with changes to the population characteristics of Veterans with regards to presumptive. Dr. Prenovitz responded that some people who receive service connection may not have received service connection the same way another Veteran received it, as in they received service connection before their DC became presumptive or if they were denied and then when it became presumptive, they were granted. They don't know for sure that there is a difference in earnings loss, but they are researching to see if there is and why.

Dr. Prenovitz went on to share the planned directions for future work. They plan to add estimates for at least 100 Diagnostic Codes each year. They will continue to adopt enhancements to main specification, which includes estimation techniques and data improvements to produce more precise and accurate estimates, particularly for less prevalent conditions.

They will implement detailed analysis plans from current and past years. Dr. Prenovitz shared that the priorities of these might include estimates of how receiving benefits affects earnings; using clinical data to identify onset of symptoms, variation in symptoms, presence of other non-service-connected conditions, therapeutic benefits, and therapeutic compliance effects on earnings; re-analysis of data from the Benefit Offset National Demonstration (BOND); and an analysis of variation in earnings losses by participation in other programs. In addition, they will develop additional detailed analysis plans.

Dr. Taméz was curious about the direction of the diagnostic codes because some of the experiences they have had with consultants outside of the VA is that sometimes the VA finds conditions differently. She suggested they keep that in consideration when reviewing data.

Follow-up Overview of Suicide Prevention Program

After a lunch break, Ms. Piper introduced the next speaker.

Dr. Jesse Burgard, Senior Consultant for Interventions, Suicide Prevention Program for VA Suicide Prevention and the VA Office of Mental Health and Suicide Prevention (11MHSP) began his presentation with a follow-up overview of the status of the Suicide Prevention Program.

Dr. Burgard began by explaining that suicide is complex but preventable and requires everybody's support. There is no single cause of suicide. Suicide is often the result of a complex interaction of risk and preventative factors at the individual, community, and societal levels. Risk factors are characteristics that are associated with an increased likelihood of suicidal behaviors. Protective factors can help offset risk factors. To prevent Veteran suicide, we must maximize protective factors while minimizing risk factors at all levels and throughout communities nationwide.

He reviewed the current programs that are part of the Suicide Prevention Program. For interventions, the programs include field operations, Suicide Prevention (SP) 2.0 Clinical Telehealth, and community-based interventions. On the operations side, there is data and surveillance; grants; research and program evaluations; partnerships, training, and innovations; and policy.

Dr. Burgard shared information regarding the Suicide Prevention 2.0 Vision for the Distance: Combining Community & Clinical Interventions. Community-based prevention strategies include: Veterans Integrated Service Networks (VISN)-Wide Community Prevention (community coalition building); Together with Veterans (Veteran-to-Veteran building); Governor's/Mayor's Challenge (state-driven suicide prevention planning).

These three together are considered Community Engagement and Partnership Coordinators (CEPCs). Clinically-Based Interventions include: Evidence-based psychotherapies and interventions implemented through clinical video telehealth. These involve: Cognitive Behavior Therapy for Suicide Prevention (CBT-SP); Problem-Solving Therapy for Suicide Prevention (PST-SP); Dialectical Behavior Therapy; and Safety

Planning Intervention. Currently, there are 7.72 outpatient mental health full-time equivalent employees per 1,000 Veterans in outpatient mental health.

Dr. Burgard continued, sharing more in-depth explanations of each of the above-mentioned programs. He began with Community-Based Interventions for Suicide Prevention (CBI-SP), which serves as a unifying model from national to community levels for all community-based efforts to end Veteran suicide.

The Governor's Challenge is a collaboration with VA and the Substance Abuse and Mental Health Services Administration (SAMHSA) where state policy makers partner with local leaders to implement a comprehensive suicide prevention plan.

Together with Veterans is focused on Veteran-to-Veteran coalition building and Veteran leadership development for suicide prevention.

Community Engagement and Partnerships for Suicide Prevention (VISN Expansion) is focused on facilitating community coalition building for suicide prevention. There are now more than 1,300 local coalitions, and 50 states and 5 territories working in suicide prevention under a unifying, evidence-informed model.

Dr. Burgard moved on to explaining clinical-based interventions, which strive to identify risk early, reduce risk/enhance protection, provide access to effective treatment, and promote holistic recovery. VA's expansive network of more than 400 VA Suicide Prevention Coordinators, along with their teams located at every VA, connect at-risk Veterans with care and educate the community.

VA's REACH VET predictive model allows VHA the ability to identify Veterans across the healthcare system at high statistical risk for suicide. REACH VET providers review opportunities to enhance care to Veterans in the top 0.1% tier of highest risk. Early assessment of suicide risk across emergency, urgent, and ambulatory care settings is an essential strategy for reducing overall Veteran suicide. VA's Risk ID strategy implemented universal screening standards for suicide risk to ensure that all Veterans receiving care in VHA are screened and/or evaluated annually.

The SP 2.0 Clinical Telehealth Program spans nationwide to provide direct access to specialized, evidence-based, suicide prevention treatments via VISN Clinical Resource Hubs (CNH). Safety planning intervention is typically a one-time 60-minute intervention, though the provider may meet with the Veteran multiple times to continue working on the safety plan.

CBT-SP involves 12 weekly sessions or 6 weeks of sessions twice a week. PST-SP is 6 to 12 weekly sessions and includes the safety planning within the PST-SP protocol. Dialectical Behavior Therapy (DBT) combines weekly individual and group therapy for one year, and includes phone coaching, including how to use the VCL after hours.

Dr. Burgard paused for questions. Chair Lewis asked about VA working with National Academies of Sciences, Engineering, and Medicine (NASEM) and was wondering about the integration and outcome of workshops and if there have been things published around those. How are they viewed versus what they're doing to help prevent Veteran

suicide. Dr. Burgard said they were just talking about NASEM that morning in a leadership meeting. He attended last year's NASEM meeting about lethal means safety.

His understanding of NASEM is they are an independent entity that works with them to identify a topic or area that VA is interested in learning more about, and perhaps due to the nature of it, they may benefit from an external third-party perspective. He said that generally speaking, working with NASEM allows them to have an independent eye to look at an issue that VA can then get a report with the outcomes of NASEM's study to use for strategic planning moving forward. He said the most recent topic focused on was lethal means safety, particularly in the community and how that can be promoted in community partners as well.

Chair Lewis clarified that her question was more focused on if they take the information that was discovered from the process of conducting the workshops as a third-party entity, and review the information, do they find it to be impactful and what was accomplished by integrating the third-party review information. Did it actually have an impact on decreasing Veteran suicide rates? Dr. Burgard said that her last question is a challenging one, particularly when you look at things that are still upstream. It's difficult to quantitatively tie an action to prevention of suicide because it's hard to know what was prevented. However, once enough data comes out on the number of suicides per year, they may be able to see if it's decreased, but not necessarily if it was decreased due to a specific program or study.

He shared that they do have a research department that they curate on a regular basis as far as what literature shows, so that's another source for them to learn from as to what they know works in micro-cases, if there's a study done with a certain group of individuals. He said he would have to get back to Chair Lewis specifically about the NASEM studies but that they continue to have conversations with third parties who work with the community care networks around how to bolster training for community are.

Chair Lewis then brought up how many Veterans don't receive VA care but rather get their care in the community, and so how do they liaison with community providers to make them aware of best practices and tools when working with Veterans? Dr. Burgard said that VA does publish Clinical Practice Guidelines for Suicide Prevention which is an open-source document available to anyone which were created through a collaboration between VA and DoD.

He shared that they had recently had a meeting to revise and review the document to ensure the information is all current. They also provide training to community providers through VA Train, which is an online open source training program, which was one of the things they leveraged around the lethal means safety training.

Dr. Burgard shared that they also have been meeting to try to promote more community providers to take the course themselves. For modalities, he shared that they are looking in the future to leverage Veterans portals to utilize the services, like cyber oriented psychotherapy. For example, CBT-SP, they are working on creating a computer based online portal that they can do independently without needing to make an appointment with a therapist. They are also looking to scale up a model for non-VA providers on some of those modalities.

Dr. Taméz said that mental health providers are already deficient throughout the country but especially when it comes to medically underserved areas. How does the information being gathered about the needs of the Veterans go towards and influence decision makers about how to provide more services to the underserved areas?

Dr. Burgard shared that he was a mental health chief for several years in West Texas and so he understands her question. One advantage the VA has is systems such as Telehealth where providers are more widely available via Telehealth than they are in person, and so that helps the Veterans to gain access to beneficial Telehealth treatment with a specially trained, suicide prevention-oriented therapist. In that way, they can leverage the technology to help more Veterans. It is a national question and issue of how to make the modalities more readily accessible, such as the self-help online oriented course mentioned.

Judge Maney asked why Vet centers and readjustment counseling had not been mentioned in the presentation. Dr. Burgard answered that Vet centers are a key partner and the presentation isn't finished, so there are more slides to go through, but not about readjustment counseling. They do partner with Vet centers. As an example, they perform virtual site visits to every region of the country in VA around suicide prevention. This gives them the opportunity to meet with leadership level hospital staff and have conversations about how the programs are going and what their barriers are. They do have a distinct section specifically for meeting with Vet centers.

Just a month ago, they visited Vet centers in Michigan, Indiana, and Ohio in VISN 10. They know the importance of having distinct sessions because of important linkage, and they understand the Vet Center are key partners, especially on high-risk Veterans. So, part of the conversation with them asks how they work with Veterans that they recognize have suicidality, and encourage them to have the Veteran link with the VA medical center for suicide specific programs that wouldn't be offered at the Vet center.

Judge Maney asked if they have Memorandums of Understanding (MOU) between the medical centers and Vet centers. Dr. Burgard shared that there was a national MOU a few years back but most Vet centers and medical centers don't have written MOUs to his knowledge. However, there are structural ways they overlap monthly where VA medical center staff go out to Vet centers every month to do case consultations on high complexity cases. Vet centers are also represented on the medical center's mental health executive council.

Judge Maney then asked if any improvements had been made since June 2022 when VHA shared a report stating that the Suicide Prevention Coordinators (SPC) need more training. Dr. Burgard said that's an area that their office under interventions supports directly, so they have a team with the primary role of supporting SPCs. On a monthly basis, they liaison with them at the national level through conference calls and supply them with ongoing training. They also have published a lot of policy guidance and guides and have a specific suicide prevention program guide (SPPG) which is a manual for the role of SPCs that is updated on a regular basis.

Dr. Burgard said that in recent years, they have also created regional leaders in SP, so VISN or regional leads for SP who serve as a middle tier between front line folks at the

hospital and his office to support local, regional SPCs. He acknowledged that an SPC's job is complex and it's a fast-moving area in VA with updated training and programs being released on a regular basis.

Judge Maney asked if there are any strategies VA is using to get more mental health specialists and therapists into the system for training. Dr. Burgard said that VA is competing to recruit, though it's a broader question than what he himself is involved in. He gave a general answer that VA trains a great amount of mental health providers and are working to bring more in. He did talk about how they track for each hospital how many staff they have hired with the number of Veterans being served. There is an initiative within their department to work on constant recruiting, and there are recruiters who attend job fairs and other events with tables to bring in new providers.

Judge Maney shared that he has heard from Veterans who express reluctance to go to the VA because they don't want to lose possession of their firearms. What can he tell the Veterans when they come to him with this information? Dr. Burgard said that they do know that Veterans disproportionately use firearms when they attempt commit suicide, upwards of 70 percent versus the national average of around 50 percent. He said that they know that having ready access to a firearm can and do elevate the risk of suicide in Veterans that are at risk. He also acknowledged that for Veterans, firearms and having access to them is an important right and value they hold.

He suggested that Judge Maney tell the Veterans that the VA is not in any role or position to separate Veterans from guns. They just make sure to talk a lot about secure storage to create time and distance between them and their firearm, particularly if they are at increased risk. He said those conversations are always with respect to the Veteran's desire so there is no action the VA is taking to create the time and distance. They want Veterans to understand the risk, because they may also think of their firearm as a method of safety and they should understand the risk of that as well.

Judge Maney asked if the SP hotline calls law enforcement to go and seize someone's weapon. Dr. Burgard said that if a Veteran calls in an imminent, acute situation where they say they have a firearm and plan to use it on themselves, then yes, the action that needs to be taken to save that Veteran's life may be for the law enforcement to seize their weapon.

In any other situation, for the purpose of seizing weapons, there's nothing to his knowledge that VA does to that regard. He said that state laws may also have a factor, so there are complexities in certain instances. He noted that his colleague had shared resources in the chat for the meeting on how to talk to Veterans about this exact issue.

Dr. Burgard said in the second part of the presentation he was going to run through the operations department, and the last part will review some resources available. He asked what would be the best use of their remaining time set aside for the presentation? Ms. Piper requested that he continue his presentation in case it will answer any remaining questions.

Dr. Burgard then explained the operations side of suicide prevention. He began with Data and Surveillance, sharing that in 2006, the Serious Mental Illness Resource and

Evaluation Center (SMITREC) began comprehensive suicide surveillance for the VHA patient population. In 2013, this expanded to joint work by SMITREC and the Center of Excellence (COE) for Suicide Prevention (SP) to gather data for the entire Veteran population, which established the VA/DoD Mortality Data Repository.

The first annual suicide report was released in 2016, with the goal of advancing VA's understanding of the scope of Veteran suicide, the distribution of suicide rates across Veteran subgroups, and trends over time.

He told the Committee about the Staff Sergeant Parker Gordon (SSG) Fox Suicide Prevention Grant Program (SPGP). Following priorities set forth in §201 of the John Scott Hannon Veterans Mental Health Improvement Act, on 9/19/22 VA announced awarding $52,500,000 to 80 grantees in 43 states, the District of Columbia, and America Samoa.

Awards are issued one year at a time. In the initial three-year pilot phase, not every VAMC will have a grantee in their catchment area. The 2023 Awards are due to be announced in September 2023. The eventual goal is to obtain Congressional support for a permanent and expanded program. SSG Fox SPGP enables VA to focus on community-based suicide prevention efforts that meet the needs of Veterans and their families through outreach, Suicide Prevention services, and connection to VA and community resources.

Dr. Burgard explained that Research and Program Evaluation (RPE) involves two sections. Research focuses on grounding all actions in the science, and Program Evaluation supports and informs process/outcome evaluation, quality improvement, tracking and reporting on SP efforts, programs, and initiatives.

He moved on to Partnerships, Training, and Innovations. Partnerships focuses on the establishment and maintenance of strategic Public Private Partnerships (P3); non-binding, non-monetary relationships focused on offering goods or services in kind to Veterans at no cost. Other considerations are PILOT programs that are directed at fulfilling the Secretary's goal of ending Veteran suicide.

Education & Training promotes the inclusion of knowledge and skills related to suicide prevention in educational materials and trainings across VA offices and with external stakeholders. Innovations supports various projects as project managers and contract management to further the mission.

The Suicide Prevention Policy workstream serves as the primary consultants for VA leadership through management of all suicide prevention related policy, legislation, regulatory and/or oversight actions and initiatives. He explained that this includes: Policy, Congressional and Oversight tracking (i.e., Policy Tracker, Congressional Tracker, Oversight Tracker) and consultation (i.e., coordination of Technical Assistance, Legislative proposals, NOT QFRs, Letters to Congress, Request for Information). This also involves assigned program development and strategic planning actions, such as Caring Letters.

Dr. Burgard explained that the programs within Suicide Prevention Program work together seamlessly daily on various initiatives, including but not limited to: P2A,

STRONG Act, COMPACT Act, NOW Plan, Charters and Interdisciplinary Workgroups, and Communications and Campaigns.

Impact is measured in different ways. The Suicide Prevention Program, Interventions and Operations, utilizes multiple dashboards and tools to measure impact such as Strategic Analytics for Improvement and Learning (SAIL) Mental Health Domain Composites, and the SPPARTA dashboard.

Dr. Burgard then shared that there are many ways for Veterans and those who care for them to find different types of resources for Suicide Prevention. These include VA.gov and the Veterans Benefits Administration Financial Literacy page, which contains financial-related resources and links to help Veterans and their family manage, secure, and protect financial resources and well-being. He explained that there have been studies that show how alleviating financial strain can reduce suicide risk. He then opened the floor for questions.

Mr. LoGalbo asked if SPP is getting any data about transitioning service members about suicide risk from the Getting Results in Transition (GRIT) program, and Dr. Burgard answered that they are not, though he has attended workshops by them in the past.

With no further questions, Ms. Piper thanked Dr. Burgard for his presentation and helping answer their questions.

Committee Discussion & Planning

After a brief break, Ms. Piper shared that they would now discuss FY 2024 site visit planning. She said that it would be in Reno, Nevada and that they have been speaking with the Reno, Nevada regional office to plan the site visit.

Ms. Lotts asked who would be able to attend the site visit in person, and who would be attending virtually. She said it would be September 18 through 22, with the 18th and 22nd being travel days and the actual meeting being the 19th through 21st. They had a short discussion about who would attend and how.

Ms. Lotts then explained that the visit would not have briefings but instead would be a chance to talk to people at the Reno regional office. The plan would be meeting with Reno and getting an idea of how they operate. They would have a chance to speak with employees, VSOs, and congressional and senatorial staffers for the state. There will also be a Veteran town hall so they can speak with Veterans as well. She said each meeting would start with a five-minute introduction about the meeting.

She asked the Committee to help develop prompt questions so they can ensure the questions that the Committee want to be asked, are asked, and requested they get back to her as quickly as possible with their questions.

Some topics suggested by the Committee were Veteran’s relationships with mental health, if they knew about certain suicide prevention programs or other programs that were available to them, and if they had experienced having a DBQ where the examiner

did not complete the DBQ in full or had not asked any questions to do with their specific disability for the exam. It was also suggested that they talk about potentially creating an MOU between the Vet centers and medical center. Ms. Lotts said they would also be touring the Vet center as well as the regional office in Reno.

Ms. Lotts shared that they have requested if one of the top three such as Deputy Secretary or Chief of Staff could meet with and speak to the Committee, and they would also be speaking prior to the Veteran town hall.

Public Comments

Ms. Piper invited any members of the public who which to speak to do so at this time. No members of the public came forward to comment.

Final Thoughts and Adjournment

Ms. Piper thanked everybody for attending and adjourned the meeting.

Elizabeth Alice Roy
Jamison Professional Services
Preparer of the Executive Summary

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