COMBATTING A CRISIS: PROVIDING VETERANS ACCESS TO LIFE-SAVING SUBSTANCE ABUSE DISORDER TREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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C O N T E N T S

TUESDAY, APRIL 18, 2023

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TUESDAY, APRIL 18, 2023

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

The subcommittee met, pursuant to notice, at 10:20 a.m., in room 390, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Van Orden, Luttrell, Kiggans, Brownley, Budzinski, and Landsman.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Good morning again. This oversight hearing for the Subcommittee on Health will now come to order. Our country has been experiencing a substance abuse and overdose epidemic, and we are seeing historic highs in overdose deaths and our Nation's veterans are not immune. One death from substance use disorder is one too many. It is a somber reality that many lives are taken by this treatable mental disorder. One hundred sixty-five million people in the United States alone struggle with drug and alcohol abuse, and over 100,600 Americans died from drug overdose in 2021.

As a 24-year veteran, I have seen the unique challenges that many of my fellow service members and veterans face. Among the veteran population, we have sadly seen a 53 percent increase in drug overdose mortality rates from 2010 to 2019. Four in 10 veterans struggle with illicit drug use, seven in 10 struggle with alcohol use, and one out of eight struggles with both.

This is an enormous obstacle that we need to address. Had the VA sent us testimony in a more timely manner, let me emphasize that, had the VA sent us testimony in a more timely manner, I would have liked to have addressed the initiatives they are talking about today. In spite of that, I would like to acknowledge the VA Mental Health Residential Rehabilitation Treatment Program, also called MHRRTP, that provides rehabilitative and clinical care to veterans that need intensive specialty treatment for mental health and substance use disorders. The MHRRTP continuum includes more than 70 programs for the treatment of substance use disorder and more than 40 programs for the treatment of posttraumatic

stress disorder, with the expectation that all programs provide integrated, concurrent treatment for co-occurring substance use disorder and mental health treatment needs.

That being said, veterans through the Mission Act should be eligible to receive in and outpatient substance abuse treatment in the community when it is appropriate course of action.

I am very concerned about how the VA has interpreted and differentiated between institutional and uninstitutional extended care. It is becoming increasingly clear that once again bureaucracy has overcome intent. VA continually repeats that there is no wrong door for veterans seeking substance abuse care. However, we will hear from our witnesses on the second panel that that is inaccurate and bureaucratic hyperbole with that statement.

I would like to point out three instances where the VA has not embodied their no wrong door declaration. First, we have heard from a specific veteran who struggles with Post Traumatic Stress Disorder (PTSD) and alcohol abuse. After many attempts and 3 months of trying to receive care, this veteran was not able to get the help they needed. This was essentially a locked door. This veteran spoke with multiple congressional offices and with the VA central office. They were eventually referred to community care. However, it was rescinded as the VA ensured that this veteran could receive the care they need. This veteran still struggles with their sobriety today.

Next is an example of the VA presenting no door to a veteran. As we will hear during our second panel, there was another instance where a veteran sought care in the community. However, VA noted that they could not refer this veteran to the community if a VA bed was available within 30 days. Veterans can and should not have to wait 30 days to receive care that they desperately need. The program attempting to assist this veteran was told that veterans must first go to a domiciliary, then grant per diem programs such as VA homeless shelter, and then to the Salvation Army. Then after all of these options have been exhausted, they could be referred into the community.

That is a disgrace. As a state senator, I specifically introduced legislation to get rid of preauthorization for medicated assisted treatment. So, within immediate. To find that this is existing with our VA system is unacceptable.

Finally, we have heard from a veteran who has struggled with PTSD, substance use disorder, and a history of traumatic brain injury. This specific veteran was searching for a residential program for substance use disorder at the VA. However, this veteran was denied because they did not have a history of seeking help through the VA. Because this veteran had not been to the VA since 2017, their record was closed and they were never contacted about receiving care. This appears to be a case where a veteran experienced a missing door. Luckily, a Veterans Service Organization (VSO) paid for a treatment program for this veteran.

There is no excuse for any of the neglectful and harmful care that these veterans are experiencing and we need to hold the VA to a much higher standard. I am saddened and I am frustrated that this is how VA has been managing care for those who have selflessly served our country. Thank you all for being here and I

look forward to our discussion on both panels to best identify ways to improve access. With that, I yield to Ranking Member Brownley for her opening statement.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Madam Chair, for holding this morning's important hearing. As of Fiscal Year 2022, more than 550,000 veterans receiving VA healthcare, or about 8.5 percent of all veterans using VA healthcare services, had substance use disorder diagnoses. Often, veterans have turned to alcohol or drugs to try to relieve stress or symptoms of PTSD and other co-occurring mental health disorders. As a result, substance use disorder is a significant challenge among the veteran population. This challenge was only compounded by the COVID–19 pandemic, which increased feelings of social isolation, anxiety, and depression, and caused many adults to start or increase their use of alcohol or drugs.

At the same time, access to intensive residential treatment at VA and in the community declined as providers limited admissions and placed residents in single occupancy rooms in an effort to minimize the spread of COVID–19. I am perplexed by the two very different stories that were told in the written testimony of VA and the other witnesses we will hear from today. If we are to take VA at its word, veterans receive timely access to residential treatment, admission within 72 hours for veterans requiring priority admissions, and within 30 days for routine admission. The VA Office of the Inspector General, however, has found that VA "faces significant challenges in meeting the needs of individuals with substance use disorders."

This finding is echoed in the testimony of our second panel of witnesses. I hope today's hearing will help us better understand the true state of veterans' access to residential treatment for substance use disorder. I do not doubt that there are instances where veterans would benefit from referral to residential treatment from community providers, particularly when there are excessive wait times for beds in VA programs, or when veterans can access timely care in the community closer to home. However, we must ensure that veterans receive high quality evidence-based care when they are sent to the community.

I hope today's hearing will also shed some light on the extent to which VA ensures that the community providers to which it refers veterans meet clinical practice guidelines and accreditation standards for delivering such care. While we will focus much of our attention today on access to residential treatment, I hope we will also take some time to consider the full continuum of care, including the extent to which veterans are successfully transitioning from residential care to outpatient treatment and independent living.

As the VA Office of Inspector General points out in its testimony, care coordination between VA and community providers is critically important for high-risk patients like those receiving treatment for substance use disorder. When patients receive care in the community, they are not always as easily able to access other VA benefits, such as housing and employment support as they would if receiving care at a VA facility.

In 2019, I visited a truly impressive program operated by the VA Boston Healthcare system called the Women's Veterans Trust House, which provides excellent care, coordination, and continuity of care for women veterans who had completed residential treatment for substance use and posttraumatic stress. The typical stay is about 12 months, during which time women veterans participate in individual and group psychotherapy, compensated work therapy, and recreational community outings. Through this program, they are learning how to develop healthier coping mechanisms and constructive interpersonal relationships. Unfortunately, at the time I visited, the Trust House could accommodate just seven women at a time, and they were traveling from all over the country, first to participate in VA's residential treatment program and then this transitional program. Undoubtedly, more women veterans, indeed all veterans, would benefit from greater access to transitional programs like this.

I hope that we can learn more today about the extent to which VA is trying to expand its capacity in this area as well. I have legislation that aims to do just that, and I hope today's hearing will help inform my planned reintroduction of the bill. Thank you again, Dr. Miller-Meeks, for organizing this important hearing and I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. I would now like to introduce the witnesses. Joining us today from the Department of Veterans Affairs is Dr. Tamara Campbell, who is the executive director of the Office of Mental Health and Suicide Prevention (OMHSP). Accompanying Dr. Campbell today is Dr. Sachin Yende. I apologize for any mispronunciation. The chief medical officer in the Office of Integrated Care. We also have Dr. Julie Kroviak, the Principal Deputy Assistant Inspector General of Healthcare Inspections in the office of the Inspector General. Dr. Campbell, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF TAMARA CAMPBELL

Ms. CAMPBELL. Good morning, Chairman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee. Thank you for the opportunity to discuss VA's mental health, substance use disorder, residential rehabilitation treatment programs, and community care referrals. Accompanying me today, as mentioned, is Dr. Sachin Yende, Chief Medical Officer, Office of Integrated Veteran Care.

Over the past decade, potent and dangerous drugs became more widely available and misused in the United States. In response to the rise in substance use morbidity and mortality, prevention and treatment efforts have been established. VA is making a positive difference in veterans' quality of life by enhancing motivation and building confidence in their treatment and recovery process. Veterans receiving treatment for their substance use disorder in VA are experiencing benefits in terms of their mental and physical health across many other aspects of their lives that impact social determinants of health. VA's mental health Residential Rehabilitation Treatments (RRTPs) are a critical component of VA's broader

efforts to address the needs of veterans with substance use concerns.

Mental health residential programs are institutional extended care and are not subject to designated access standards. They do, however, have access requirements that inform when consideration for referral to the community should occur. These access requirements are defined by Veterans Health Administration (VHA) Directive 1162.02 and more recently by implementation of the Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act for Crisis Residential Care.

The ability to pay for community care mental health residential treatment has resulted in an increase in the number of programs available to veterans. From Fiscal Year 2021 to Fiscal Year 2022, referrals to the community increased from 7,000 to 11,000 uniques, with expenditures exceeding 1.2 billion since 2021. Concurrent with these increases, VHA has observed instances of community programs marketing directly to veterans and providers, resulting in confusion by veterans when informed of the availability of VHA to meet their needs. We believe the solution to this lies with increasing familiarity with the process and with VA's mental health residential resources, while also addressing concerning marketing practices when they are identified.

Timely access to residential treatment has been a priority area of focus for VHA. This has been critical as the residential programs experienced significant reductions in capacity early in the pandemic. I am pleased to share that today MHRRTP capacity is rebounding, with wait times decreasing and census increasing.

Recognizing a need to ensure access to this critical level of care, OMHSP worked collaboratively with the Office of Integrated Veteran Care to verify authority, to provide residential treatment in the community, and to provide a mechanism by which VHA could pay for such care. VHA policy requires that when a veteran is assessed as requiring residential treatment and the program is unable to meet the veterans' needs, an alternate treatment program must be offered. Alternate treatment may include treatment within VA or within the community. VA is thankful for the independent investigation of the Office of Inspector General in the review of the Domiciliary Substance Use Disorder (SUD) Treatment Program and residential community care referrals.

The ability to refer to mental health residential treatment in the community is a relatively new process with the first Standard Episode of Care for the Mental Health Residential Treatment, released in October 2020, and updated in August 2021. OMHSP worked collaboratively with Veterans Integrated Services Networks (VISNs) during this time to clarify requirements and expectations for when referrals for mental health residential care in the community may occur. These efforts have continued with targeted efforts to ensure awareness of requirements and processes for ensuring access to residential treatment in the community when indicated.

In conclusion, we appreciate the committee's continued support and partnership in this shared mission. Nothing is more important to VA than supporting the health and well-being of our veterans and their families. This critical work is lifesaving, and my col-

leagues and I are now prepared to respond to any questions you may have. Thank you.

[THE PREPARED STATEMENT OF TAMARA CAMPBELL APPEARS IN THE APPENDIX]

Mr. LUTTRELL. [Presiding] Thank you, Dr. Campbell. Dr. Kroviak, you are now recognized for 5 minutes to deliver your opening remarks.

STATEMENT OF JULIE KROVIAK

Ms. KROVIAK. Thank you. Ranking Member Brownley and subcommittee members, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of VHA's substance use disorder treatment program. The OIG's Office of Healthcare Inspections reviews the quality and safety of healthcare provided across VHA and communicates the findings through public reports. We are unique in the IG community because of our ability to conduct this oversight. With over 250 clinical staff, the majority having significant experience providing direct care to veterans, our reports can provide in-depth clinical analyses and identify issues that impact healthcare delivery.

Take our mental health team, staff with board-certified psychiatrists, psychologists, and licensed clinical social workers. They are proactive and vigilant in conducting oversight work that supports veterans in need of mental health treatment. We are in the last stages of developing a new cyclical review that will initially focus on VHA's inpatient mental health units. These units treat acutely ill psychiatric patients. And our teams have developed tools to evaluate the safety and efficacy of these settings to ensure veterans are receiving the high-quality care they need and deserve.

Substance use disorders have devastating effects on veterans, their families, and caregivers, and often require intensive, multidisciplinary interventions to support a meaningful recovery. In addition, veterans with substance use disorders often have additional mental health diagnoses that can place them at higher risk for suicide. Given that VHA's top clinical priority is to reduce veteran suicide, evidence-based, substance use disorder treatment programs are critical to addressing these clinical needs.

To meet the increasing demand for these services, VHA depends on community care. When VHA and community care providers are comanaging these patients, the coordination must be seamless and collaborative. The OIG has identified persistent administrative errors and communication failures among VHA, its third-party administrators, and community care providers, as well as between the care providers and their patients. These deficiencies challenge the efforts of VHA personnel to ensure that seamless experience for veterans.

Many OIG reports have described the challenges and, most importantly, the risks when patients are referred to the community. These risks are amplified for patients with high-risk mental health issues or complex disease. For example, my written statement details our January 2023 hotline inspection that substantiated the allegation that in 2020 and 2021, VA North Texas staff did not follow VHA policy requiring that patients be offered alternative options for care within VHA or the community when the wait time for a

needed service exceeds 30 days. This practice potentially delayed treatment for these veterans and has the long-term potential to fracture trust between patients and the healthcare system upon which they rely. We also determined that the VISN's chief mental health officer lacked authority to ensure staff adherence to these policies.

We made five recommendations, with one specifically ensuring that staff comply with community care referral requirements and another recommending a review of the facility's management of community residential care referrals. All of these recommendations are open, and we will begin the follow-up process with VHA at the end of this month.

While this report highlights issues with offering community care to veterans, it does not provide a complete picture of the concerns we have found when veterans are receiving community care. Our office has published reports related to community care detailing delays in diagnosis and treatment, lack of information sharing or miscommunication between providers, and significant quality of care concerns. While we recognize the importance of VHA staff consistently informing and offering veterans all options available to meet their care needs, ignoring that the current community care framework does not adequately address critical gaps in coordination will further increase risk to patients. We are piloting a new community care review that will provide data to support VHA's leaders' efforts to reduce these risks.

The OIG will continue to provide meaningful oversight to support and improve the quality of healthcare provided to our Nation's veterans. We also recognize the need to enhance and adapt our work to best support this dynamic healthcare system. We remain grateful for the participation and cooperation of VHA staff across the country, and we commend their commitment to caring for those who have served. Members of the subcommittee, this concludes my statement. I would be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF JULIE KROVIAK APPEARS IN THE APPENDIX]

Mr. LUTTRELL. Thank you, Dr. Kroviak. We will now proceed to questioning. I now recognize the ranking member, Ranking Member Brownley, for any questions she may have.

Ms. BROWNLEY. Thank you, Mr. Chairman. The first question I have is to Dr. Campbell. I understand VA currently has two dedicated residential substance use disorder treatment programs for women veterans. Is that correct? Two?

Ms. CAMPBELL. I did not hear, I am sorry, the first part of the question.

Ms. BROWNLEY. I understand that VA currently has two dedicated residential substance use disorder treatment programs for women veterans. Is that true?

Ms. CAMPBELL. We have 13 programs across nine locations specializing in treatment for women at the residential level.

Ms. BROWNLEY. I had difficulty finding those. Where do I go to find those?

Ms. CAMPBELL. You can locate them on our website. They are in VISN 110, and I believe 17.

Ms. BROWNLEY. I understand that all of these are not substance use disorder treatment programs.

Ms. CAMPBELL. There is a mixture, and thank you for that question, of substance use disorder as well as PTSD. We understand that those diagnoses typically coexist, and so we ensure that our programs are treating both the PTSD and substance use at the same time.

Ms. BROWNLEY. Just to get back to my original question, there are currently two dedicated residential substance use disorder treatment programs for women veterans. True or false?

Ms. CAMPBELL. I would have to go back to get that exact number. What I have is 13 programs across nine locations, five programs that specifically focus, and two additional that are in for implementation for Fiscal Year 2024.

Ms. BROWNLEY. Okay. I also understand the Fiscal Year 2024 budget request indicates the Department has two additional women-only residential programs in development. Is that correct?

Ms. CAMPBELL. Yes, ma'am, that is correct.

Ms. BROWNLEY. In what locations will they be?

Ms. CAMPBELL. I will have to get back about those locations.

Ms. BROWNLEY. How did you decide where the locations should go?

Ms. CAMPBELL. We are in the process now of making that determination.

Ms. BROWNLEY. Okay. In my opening comments, I talked about transitional programs and the continuity of care for our patients. Does the VA, you know, I know today we are focusing much more on intensive residential treatment, but wanted to know how many transitional programs across the VA do exist. I mentioned one in Boston.

Ms. CAMPBELL. Thank you for that question. I would have to get back with you about the specific numbers. In terms of transitional programs, we have compensated work therapy and community reentry programs within all of our domiciliary programming. Is that what you are referring to?

Ms. BROWNLEY. Yes, I mean, for those kinds of services. In a transitional, you know, in a transitional space environment, you know, where women would be co-located going through with these particular kinds of services offered to them. The one I referenced in Boston lasted for almost a year of transition. That is what I am looking for. Apparently we do not have the answers to that. I will have to wait until you can get back to me on several of these questions about numbers of residential treatments for women and the two additional women clinics, where they are and how they were decided upon in terms of location.

My last question to Dr. Kroviak. In terms of veterans being referred to in the community, what are some of the hallmarks of quality residential substance use disorder treatment programs? How does coordinating this kind of care in the community differ from coordinating a medical procedure such as surgery?

Ms. KROVIAK. There are some accrediting bodies that are important to the residential programs, like are for Joint Commission. VA is required to ensure that when they are referring a patient to this type of treatment, that those facilities are certified by one of the

two institutions as well as the state in which they are operating. In terms of referrals, the referral process is quite similar. You know, a patient can self-refer. Any provider can refer a patient when they are appropriate and engaged in that level of care.

Ms. BROWNLEY. Just this accreditation process or, you know, approval from these outside agencies and as far as you are concerned, the VA is adhering to those requirements?

Ms. KROVIAK. We have no concerns that VHA is not, meaning that we have not heard allegations on that front. Those are appropriate accrediting standards to ensure.

Ms. BROWNLEY. Thank you. I yield back, Mr. Chairman.

Mr. LUTTRELL. Thank you, ranking member. The chair recognizes Congresswoman Kiggans.

Ms. KIGGANS. Thank you, Mr. Chair. Thank you committee members just for being here, our board members. Just a question about reimbursement for community care providers. We got to hear from them and just some of their struggles with why are they not accepting some of our patients that we are referring to. They had concerns about their reimbursement rates and about the time it was taking for them to be reimbursed. Can you tell how competitive we are when looking at community care compared to the VA system? Is the compensation competitive or do we look at that even when we are thinking about compensation?

Mr. YENDE. Thank you for that question, Congresswoman. In terms of processing claims in general, VA has been pretty good about processing clean claims. I believe over 95 percent of these clean claims are processed within 30 days. I do not have the exact numbers for RRTP programs, but we can get back to you if needed.

In terms of a reimbursement, we follow Medicare rates in general, but there are lots of nuances about reimbursement. I believe we are competitive. If there are specific questions about a particular Current Procedural Terminology (CPT) code or those kind of details, we are happy to work offline and try to clarify those questions.

Ms. KIGGANS. It was just a comment that I have heard more than once about why they can not take VA or they do not want to contract with the VA because our reimbursement rates were not competitive for them. There is such a shortage of mental health providers in the community and throughout the country that, you know, I just want to make sure we are prioritizing staying competitive so that they are incentivized to be able to see our patients.

I represent Hampton Roads and recently got to talk to and visit the Hampton VA, which is doing a great job. Their two complaints were that they wanted more space and they needed more people, which I think is kind of are universal complaints. Their mental health department, I think they are doing good work. Overall, I just want to say thank you, you know, to them. I know it is a hard job. I know that as a nurse practitioner, I know nurses especially have been asked to do a lot during the pandemic, especially in the mental health field and all providers. I want to thank them because they are doing good work out there.

One of the things I hear about and that I am concerned about as well is when we have these great inpatient programs that we send our veterans to for substance abuse for any mental health as

depression, anxiety, suicidal ideations, we stabilize them and have them there for however long it takes, and then we release them back to the community, back to their homes. That continuity of care piece, you guys talked about it a little bit, but, you know, we see it. I saw it, you know, in my practice. It is like we lose them to the community, right? How are we ensuring that when these patients are discharged, I am sure there is a discharge planner that makes sure they have a follow-up appointment, that make sure they go home with their meds. On the State House level, I know we were pushing for things like home health to actually visit the home because leaving the motivation just with this patient and they are already probably struggling, and their family, and a lot of questions, new side effects of medication, transportation issues, all those things.

My desire was to have someone actually visit the home. There is so much benefit. We can get to see what that home environment looks like. That continuity of care piece, whatever that looks like, is it home health? What is the VA doing to just ensure that? Is it utilization of nurse managers, you know, to make sure that we are really thinking of all the issues that veterans struggle with once we get them stabilized so that we do not lose them to the community?

Ms. CAMPBELL. Thank you for that question. We do have full comprehensive continuum of care that includes, as we mentioned, inpatient, which is the most restrictive all the way to outpatient services, as well as leveraging our peer specialists and that provide a lot of coaching. The uniqueness about VA peer specialists is that they have a veteran lived experience and so they are able to rapidly build rapport with our veterans.

We certainly are able to leverage telehealth services so that when the veteran reintegrates in the community and is competitively employed, we can utilize that service so they do not have to spend time away from a job that they have been newly employed to. Then we have multiple award-winning apps that can be downloaded for the veterans use. Thank you.

Ms. KIGGANS. They are utilizing those things. Someone is going behind them and making sure they are utilizing one of those great services.

Ms. CAMPBELL. Yes, we are.

Ms. KIGGANS. Thank you. Thank you, I yield back.

Mr. LUTTRELL. Thank you. Congresswoman Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman and thank you, ranking member. Thank you to the panel for being here today. I represent a predominantly rural district in Central and Southern Illinois. I just got back from a 2-week recess working at home in-district and heard from many of the veterans while I was in-district that are struggling still in accessing VA services, specifically in our rural areas. This is very concerning to me as the rate of veterans with substance use disorders continues to climb, especially post pandemic. Rural vets simply do not have the access to as many SUD treatment programs and facilities as they do in urban areas.

My first question is really two-part and it is for Dr. Campbell. What are the steps the VA is taking to ensure rural veterans with

substance use disorders are able to access high quality VA treatment programs? What is being done to address the infrastructure and access shortages for our rural vets?

Ms. CAMPBELL. Thank you for that question. We do realize that that is a challenge for our rural veterans. Whenever we can, we leverage our telehealth services. Sometimes we know that there could be bandwidth problems with that. Veterans are still able, certainly, to see individuals face to face as needed. The Office of Mental Health and Suicide Prevention has partnered with rural health and our clinical pharmacy service to help us leverage additional prescribers for medication assistant treatment for our veterans.

Ms. BUDZINSKI. Thank you. I wanted to add on to what Ranking Member Brownley had just asked about some of our women veterans in particular. As you know, the number of women in the military is increasing and women are the fastest growing demographic within the VHA. It is why within my district I am going to be specifically assembling a women's veterans council so I can hear specifically from the women veterans in the district because female veterans are experiencing many of the same problems as males.

There is emerging evidence showing that women veterans may be more likely to experience substance use disorders than their male counterparts. This is due to additional factors for women veterans tending to experience such as higher chances of experiencing sexual assault, and harassment, rape, and intimate partner violence. Again, my question is for Dr. Campbell. The VA has acknowledged it needs to improve VA services for women veterans, but what are some specific steps that the VA is taking to improve and expand specialized care for women veterans experiencing substance use disorders?

Ms. CAMPBELL. Thank you again for that question. Wherever we can in terms of our full continuum of treatment, we are making sure that those individuals who are specialized to address women health needs are right in those clinics, such as the primary care mental health integration clinics, certainly on our residential treatment programming clinics. Then we are also ensuring that our women's advocacy is shored up that they have the time to devote to make sure that there is seamless flow of treatment for women within VA.

Ms. BUDZINSKI. Okay, thank you. Since I have a little bit more time, I am actually going to shift to residential rehabilitation treatments. To just note, you know, I understand some of the concerns my colleagues have voiced regarding access standards for residential SUD treatment, as this can lead to longer wait times and longer travel times for our vets, which I know we have been talking about. The ability to have all levels of SUD treatment available, including outpatient, residential, and hospital inpatient services is still strained for all veterans. However, more so again concerning for women veterans and for rural veterans.

I also understand that we need to ensure our veterans have protections from fraudulent community providers who have taken advantage of vulnerable patients seeking treatment and who have prioritized profits over the safety of their patients. Veterans deserve, as I believe, high quality evidence-based care if they are sent to community providers for SUD treatment.

Dr. Campbell, I know not all veterans have a substance use—require a substance use disorder residential treatment. For those who do, how can the VA help to ensure those veterans are able to access the intensive SUD care they need while also making sure they are protected from fraudulent providers or entities? Thank you.

Ms. CAMPBELL. Thank you again for that question. We are in the process of continuing to educate within our own organization, and certainly with the community, the standards that we expect in terms of particularly SUD treatment. We have completed regional conferences to make sure that our staff is aware of the policies as it pertains to community care, as well as holding quarterly meeting with our VSO stakeholders to make sure that they understand where our programs are and to listen and learn regarding the concerns they have.

I wanted to mention another certainly concern of our women veterans is that they need to feel safe when they come to our facilities. Within our residential units, we have secured wings just for female veterans with closed circuit TV monitoring at exit entrances so that we can keep monitoring as closely as we can. Dr. Yende can——

Mr. YENDE. Just to add to Dr. Campbell's point, from a community care side, in addition to the accreditation requirements that Dr. Kroviak mentioned, we also have standardized processes where our Transition Patient Advocates (TPAs) are expected to review LEIE list. If a provider has engaged in fraudulent activities and that has been confirmed, they will be part of the List of Excluded Individuals and Entities (LEIE) list and they are expected to be excluded from that.

Ms. BUDZINSKI. Thank you. I think we are overtime. Thank you for your generosity, Madam Chair.

Ms. MILLER-MEEKS. Thank you. The chair now recognizes Representative Luttrell for 5 minutes.

Mr. LUTTRELL. Thank you, Madam Chairman. Dr. Campbell, I understand—I am going to go off what the ranking member asked. The VA currently has two dedicated residential substance use disorder treatment programs for women veterans. Then the question was asked, there are two additional residential programs in development. Where are they and are they admitting patients? How did the VA decide on these location programs because the budget itself is already out?

I do respect and appreciate the weight that you have to carry, but we have to go back to our district. When these questions come from our constituents. The fact that you were not able to answer those questions in front of us today is disheartening, because now we have to go back and tell them that the VA does not know. You want to respond to that?

Ms. CAMPBELL. I would. Thank you again for that question. I certainly understand the responsibility that we all have to our veterans for these answers. I will certainly get that answer to you as quickly as I can regarding where the two additional programs will be located. The other programs that I mentioned specific to women are in VISN 110 and 17. I will check that, though, to make sure that that is accurate.

Mr. LUTTRELL. Thank you, Doctor. I appreciate it. Dr. Kroviak, are you familiar with VHA Policy 1162.02 regarding mental health residential rehabilitation treatment programs?

Ms. KROVIAK. I am somewhat familiar. I certainly did not draft it, but I would be happy to take your question.

Mr. LUTTRELL. What do you know about it? Give me the wave top.

Ms. KROVIAK. I am sorry?

Mr. LUTTRELL. Can you give me what the wave top description is? The way you think that is?

Ms. KROVIAK. The referral time you mean?

Mr. LUTTRELL. Well, I will just go this way. It states, the directive states that any veteran with a scheduled wait time of greater than 30 calendar days must be offered alternative residential treatments on another level of care to meet the veterans needs and preferences at the time of screening. Where did 30 days come from?

Ms. KROVIAK. That was legislated to my understanding.

Mr. LUTTRELL. Do you think that that is a good——

Ms. KROVIAK. Oh, I am sorry. I might be confusing with the Mission Act. I think the 30 days was just a measurable metric developed to assess progress toward providing the care that was not available at the time of the referral.

Mr. LUTTRELL. Given the issues that we see in suicide and substance abuse, the psychiatrists, and psychologists, and doctors in the VA still think 30 days is a reasonable timeframe?

Ms. KROVIAK. I would have to defer that question to VHA in terms of the 30-day standard of what their providers assume is appropriate.

Mr. LUTTRELL. As the Inspector General, I would assume that you were digging into this problem.

Ms. KROVIAK. In terms of the 30-day standard, that was not established by the IG.

Mr. LUTTRELL. No, I know.

Ms. KROVIAK. We just do oversight to hold——

Mr. LUTTRELL. I guess my question——

Ms. KROVIAK [continuing]. VHA accountable.

Mr. LUTTRELL [continuing]. is, do you think that that timeframe is too long?

Ms. KROVIAK. I think it depends on the diagnosis that you are describing. I think it is a clinical decision. I think 30 days is somewhat arbitrary for a lot of these issues that veterans are referred for specialty care.

Mr. LUTTRELL. Some do not like the Community Care Network. However, the intent of the new COMPACT Act is to provide immediate access to those services anytime, anywhere, largely expanding access to community care. What is the view of the VA on implementing the COMPACT Act? Is there any rulemaking to write directives and policy to implement the act itself?

Ms. CAMPBELL. Thank you for that question. COMPACT has been implemented, as you mentioned, that it allows the veteran to be treated for an acute suicide episode at any community facility or within VA. I will defer to Dr. Yende for more information on COMPACT.

Mr. YENDE. Congressman, implementation started in January of this year. Implementation of the COMPACT Act started in January of this year. To date, we have provided care for over 11,000 veterans since the program started.

Mr. LUTTRELL. Eleven thousand?

Mr. YENDE. Yes. This is both on the direct care side as well as on the community care side.

Mr. LUTTRELL. Okay, final question. I am just going to throw this out to the three of you. Are any of you aware of a new VA community care policy or process and/or guidance within the last 10 months surrounding a mental health residential rehabilitation treatment program that restricts, inhibits, or deters community care referrals? I say that because I actually have verbal and written statements by VA employees that State that they are under this new policy.

Mr. YENDE. To our knowledge, Congressman, we have no policies that would restrict. If they meet criteria for referring the patient to alternative treatment facilities for RRTP programs, which includes community care, they should be referred in a timely manner.

Mr. LUTTRELL. My time is up, ma'am. I would like to preserve the opportunity to submit additional questions.

Ms. MILLER-MEEKS. So recognized. The chair now recognizes Representative Landsman for 5 minutes.

Mr. LANDSMAN. Thank you, Madam Chair, and thank you all for being here. My district, which includes the city of Cincinnati, Southwest Ohio, is home to a great VA. We offer, you know, some of the best veterans care in the country for PTSD, suicide prevention, and other mental health issues.

When I have spent time with folks at the VA in Cincinnati, they talk a lot about the evidence-based programming, and it is really compelling. When it comes to specialty treatment for substance use disorder, veterans across the country are not getting the care they deserve. This may have already come up. I have seen statistics that suggest more than 550,000 veterans diagnosed with substance use disorder last year, of those, 62 percent received outpatient treatment. Those numbers drop off drastically as the level of services increase. Less than 25 percent received specialty care and even fewer received intensive care at 4 percent. You see, there is a drop off in terms of if a veteran needs additional treatment outside of the outpatient treatment.

I have two questions. One has to do with, you know, do you have a sense as to the drop off? What you know, have you seen, is it staffing, is it other issues? Then the second has to do with a general question as it relates to all of the VA services. This is true for a lot of public services, nonprofit services, and that is that we really do struggle to get to folks who are not getting to us. You know, this is particularly true for veterans, particularly veterans who are just not coming in, you know, and have real issues.

I have been pushing in these hearings for the kind of programming outreach that gets the VA to where folks are. I am curious what you think has worked, could work in terms of meeting veterans where they are, and connecting those who are currently dis-

connected. Two questions, one has to do with the drop off and the second outreach. Thank you.

Ms. CAMPBELL. Thank you, sir, for those questions. I will take the first question in terms of the dropout. The dropout may not necessarily mean that that veteran is not in some type of other care. I think what you were referring to is a drop off when it concerns more intense care, such as residential treatment. The veteran may still be involved in an outpatient treatment, may be involved with teleservices, and sometimes, for various reasons, the veteran has elected a later date to come into treatment. That decision regarding the level of care is always between that individual veteran patient and the provider that is helping with the medical disposition and clinical decisionmaking. We do realize, especially where community care is concerned, because SUD is such a specialized treatment, that it may not be available in every location where that veteran is.

In terms of your second question regarding being able to touch veterans who are not already in our care, we are certainly hoping that the legislation that has been passed with COMPACT, allowing veterans to be treated wherever the need is without any cost to them will help with that. We have fantastic media campaigns, Don't Wait Reach Out, where we are utilizing veterans to help veterans understand what it is like to come into VA for care. Then certainly leveraging everywhere we can our peer support specialists who have that lived experience that can help us bring in care.

Mr. LANDSMAN. Thank you very much. I have additional questions if I can submit them. Thank you.

Mr. VAN ORDEN. Dr. Campbell, good afternoon. How long has your office been in existence? I know you have been there since 2022, but how long has the Office of Mental Health and Suicide Prevention been in existence?

Ms. CAMPBELL. I am sorry, sir, I did not hear the entire.

Mr. VAN ORDEN. How long has the Office of Mental Health and Suicide Prevention been in existence?

Ms. CAMPBELL. Been getting?

Mr. VAN ORDEN. Been in existence?

Ms. CAMPBELL. Oh, been in existence. At least 34 years.

Mr. VAN ORDEN. Thirty-four years. Very well, thank you. How many people work for you?

Ms. CAMPBELL. I have about 140 people within my office.

Mr. VAN ORDEN. Got it, thank you. Do your reporting numbers reflect, for veteran suicide, do they reflect overdoses?

Ms. CAMPBELL. That is a separate report in terms of overdoses that we hope to be able to publish the end of June.

Mr. VAN ORDEN. In your opinion, Doctor, if someone kills themselves by overdose or gunshot wound, are they still dead?

Ms. CAMPBELL. They are still dead, sir.

Mr. VAN ORDEN. Okay. Do your metrics for veteran suicide include overdose?

Ms. CAMPBELL. The metrics that we reported recently on our annual report does not include overdose.

Mr. VAN ORDEN. Okay. That is a problem. What are your established metrics of success for your Office of Mental Health and Suicide Prevention?

Ms. CAMPBELL. We have various metrics depending on the service that we are looking at in terms of outcomes. We have hundreds of metrics that we use. It depends on specifically what you are asking about in terms of outcome.

Mr. VAN ORDEN. Do you think, and please take this as it is intended, Morgan and I have had multiple friends commit suicide. Over 21 now, for me personally. Veterans have committed suicide. Do your metrics include veterans that do not commit suicide? I know it is kind of hard to prove a negative. What I am wondering is, after 34 years of existence with over 140 employees, if your office ceased to exist, would more veterans be alive tomorrow? I mean, is your office preventing veterans from committing suicide or not? Or are we just spending money and hiring people so that they can get together, come to these committee meetings, talk a bunch, submit reports, metrics that can not be defined? Are you moving the needle?

Ms. CAMPBELL. Sir, we do. Thank you for that question. I certainly can understand the frustration. This is a very complicated area. We are certainly ourselves saddened by any——

Mr. VAN ORDEN. Doctor, please——

Ms. CAMPBELL [continuing]. suicide.

Mr. VAN ORDEN.—I have a limited amount of time.

Ms. CAMPBELL. I do believe we are moving the needle on this. We have a full public health approach where suicide prevention is concerned. The field of mental health and psychology, psychiatry has evolved over the past 30 to 40 years. As we continue to evolve, we are learning new things, new methods, new evidence-based approaches that we can use.

Mr. VAN ORDEN. Thank you. That leads to my next question. How many non-evidence-based treatment modalities do you guys support, specifically religious and faith-based programs similar to the incredibly successful Mighty Oaks Foundation? How many faith-based nonevidence programs are currently being administered by the Veterans Administration?

Ms. CAMPBELL. Thank you again for that question. Within VA, we certainly value scientifically based evidence-based programs. That does not mean, however, that we do not collaborate with our chaplain services that certainly help us with specifically the moral injury side of PTSD and other mental health disorders.

Mr. VAN ORDEN. Doctor, what I am hearing from you is that the Veterans Administration is not helping these wildly successful programs that can quantify, like, actually quantify the amount of veterans lives that they are saving because they are faith-based, which, according to you guys, are non-evidence-based. Living veterans, that is evidence of a program's functioning.

I just want to be real clear. You are telling me the Veterans Administration is not allowing non-evidence-based, specifically faith-based programs like the incredibly successful Mighty Oaks Warrior Foundation to function within your organization, even though they have proven to save thousands of veterans lives? Is that accurate?

Ms. CAMPBELL. Sir, we are certainly willing to sit down and have a conversation with this organization to see how we can partner with them.

Mr. VAN ORDEN. Thank you very much for your time, ma'am. With that, I yield back.

Ms. MILLER-MEEKS. Thank you. The chair now recognizes herself for 5 minutes of questioning. The Independence Fund will testify that in the past 23 months, their case workers intervened for 110 veterans who ran into issues accessing complex mental health care and 59 of those required substance use care. In fact, in the last Congress, we passed a bill, the Brandon Act, because a veteran in my district went to the VA Center, was denied care, and 5 hours later committed suicide. Would you agree that these veterans, frustrated by access to critical care, would be at elevated risk for suicide? Dr. Campbell, yes or no, please?

Ms. CAMPBELL. Yes, I would agree that they are at high risk, and veterans at high risk certainly would be at high risk for suicide.

Ms. MILLER-MEEKS. Dr. Yende.

Mr. YENDE. Yes, chair, Congresswoman.

Ms. MILLER-MEEKS. Dr. Campbell, the committee has been made aware of a policy that was supposedly rolled out internally, as was mentioned, that required that if a VISN's Veterans Administration Medical Center (VAMC) could not meet the 30-day appointment availability window, it must confer with other VISN VAMCs for VA residential substance use disorder bed availability before leveraging community care in order to keep care in house. I certainly have experienced these complaints in my own district in Iowa. It was also reported that five VAMCs must be contacted to fulfill the directive. Can you either confirm or deny this policy?

Ms. CAMPBELL. There is no policy, Madam Chairwoman, denying veterans access to community care. The Standard Episode of Cares (SEOCs) regarding residential treatment were newly established. SEOCs is a standard episode of care for community care in October 2020. The process is somewhat new for us. We understand there are challenges in making sure that people are educated about the appropriate referrals to community care. We do not have a policy denying people community care access.

Ms. MILLER-MEEKS. Would you call these veterans liars?

Ms. CAMPBELL. No, I would not call the veterans liars. What I would say is that we need to do a better job of educating our veterans, our staff, and the community about the appropriate procedures for referrals to community care.

Ms. MILLER-MEEKS. Well, I can certainly say as both a physician who has taken care of veterans through the community care system, the Mission Act, and as a veteran myself, that it is unacceptable. When people report and come to the decision to obtain substance use disorder treatment, they should be addressed and acknowledged and get care immediately. This also goes for complex mental health. I can tell you the family of our veteran who committed suicide 5 hours after being at a VA hospital, would also agree with that.

Dr. Campbell, we have heard of multiple instances where veterans have been approved for a community care referral, as I said, only to have that referral overruled by administrative or other senior staff. Can you explain why a decision for a specific course of medical care as determined between the veteran and their provider would be reversed by an official outside of their clinical chain?

What recourse does the referring physician have when their clinical judgment is overruled? How are you going to address this deficit?

Ms. CAMPBELL. Thank you for that question. Each case, as we mentioned, is an individual case that is a decision between that provider and the patient or veteran. I am not aware of policies where decisions are being overturned. I will turn to Dr. Yende to see if he has more information regarding community care.

Mr. YENDE. Congresswoman, if the provider determines that the veteran should go to the community, then that decision should be followed through. Our policies do not require that that care should be provided in the VA in that instance. If there are instances, we are happy to look into it.

Ms. MILLER-MEEKS. Let me just speak for the entire committee. We expect better of the VA medical care system. Our veterans deserve better. Through this oversight, you know, some of the comments that have been revealed are really astonishing. We hold oversight because what is occurring at the VA Medical Center and what is occurring in referrals for community care when veterans are in need, especially complex mental health and substance use disorder, needs to be addressed and addressed rapidly. We will continue to ask for both collaboration and verification, as we have said. What you have learned today should in fact put you on notice and on record.

On behalf of the subcommittee, seeing that there are no other Representatives who wish to ask questions, I want to thank you for your testimony and for joining us today. You are now excused. We will wait for a moment as the second panel comes to the witness table.

Welcome, everyone, and thank you for your participation today. On the second panel, we have Dr. Daniel Elkins, the chief of staff with the Independence Fund, Mrs. Jen Silva, chief program officer with the Wounded Warrior Project, Mr. Thomas Sauer, chief executive Officer and owner of Miramar Health. Accompanying Mr. Sauer is Mr. Brendan Dowling. Mr. Elkins, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF DANIEL ELKINS

Mr. ELKINS. Good morning Chairwoman Meeks, Ranking Member Brownley, and members of the subcommittee. On behalf of Sarah Verardo, Chief Executive Officer (CEO) of the Independence Fund, we would like to thank you for your kind invitation to provide testimony at today's hearing. As a currently serving Green Beret in the National Guard and the chief of staff of the Independence Fund, I have seen firsthand my brothers and sisters in desperate need be denied access to care, fall through the cracks of bureaucracy, and suffer alone with the wounds from war. It is this denial of access and subsequent isolation that often culminates in death by suicide, a death that could be prevented.

This hearing could not be more timely as our casework staff have been receiving a significant number of inquiries nationwide who are experiencing frustration and hardship when seeking the most critical services for acute mental health conditions. The geographic dispersion and similarity of factors presented in many of the cases indicate that these cases are not merely anecdotal but may be indi-

cators of a more widespread problem for mental health within the hospital network. We would like to thank VA's VSO liaisons for their support and assistance and help with these cases. However, there is work that needs to be done.

In our written testimony, the Independence Fund has provided extensive case study examples of the inconsistencies currently present within VHA care. Each of these cases involves a veteran who was in acute need and required priority treatment for substance abuse disorder in PTSD. These veterans were denied access to care, even community care referrals, in direct conflict with the spirit. In some cases, incidents of the letter of the law of Mission Act. We have found that the Veterans Health Administration was unable to provide these veterans with proper continuity of care, failing to meet the most basic of industry standards.

Indeed, it was not until October 2021 that the Independence Fund discovered that VHA does not consider the access standard authorities of Mission Act when veterans are seeking help for substance use disorders. Yes, you heard that correctly. Veterans do not have Mission Act's regulatory protections for wait times, travel distance when seeking treatment for substance use disorders as these treatments fall within VHA's residential rehabilitation treatment program.

According to the VA, this program is instead under the authority of VHA Directive 1162, which requires that VA admit a veteran seeking inpatient residential care within 72 hours for priority patients, and no more than 30 days after a VA assessment for any patient needing residential care. Based on our experience, however, that is not unusual. It is not unusual for veterans to wait beyond this time limit. Furthermore, it has been our observation that even after those time limits are exceeded, VHA exercises latitude to further delay access to treatment when looking for an available bed in another VA facility, even if that facility is several states away.

More troubling, the Independence Fund has found that some VHA administrators or senior clinical staff overrule referrals of care for the community, in spite of VA-appointed providers for the veteran. There have also been some cases where our casework team were told by an administrator that community care was not offered. At times, the administrative staff did not understand community care was even a lawful option. In certain circumstances, VA staff do not discuss community care options with the veteran without prompting or until a case worker inquires a VA administrator or patient advocate.

It is important for us all to keep in mind that many veterans do not know their full care options and have already taken a monumental step in seeking help. More work needs to be done. In our written testimony, we offer six recommendations to the subcommittee on how to resolve these issues that create barriers to care for veterans seeking treatment for substance use disorder and PTSD and other conditions that are highly indicative of death by suicide. I will highlight what we believe should be the foremost priority for this subcommittee.

We must ensure that all criteria for community care wait times, travel distance, and access standards under Mission Act govern VHA Directive 1162 or eliminate VHA Directive 1162 entirely and

defer to Mission Act's original authorities and intent to support all levels of specialty care, including rehabilitation services. Once this goal is achieved, it will substantially improve the quality, timeliness, and effectiveness of care for veterans in acute need of treatment for substance use disorder, whether that be in a VHA provider or community care provider.

Thank you for this opportunity to share with you all the struggles of our Nation's heroes, and I look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF DANIEL ELKINS APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Elkins. Ms. Silva, you are now recognized for 5 minutes to deliver your statement.

STATEMENT OF JEN SILVA

Ms. SILVA. Thank you, Chairwoman Miller-Meeks, Ranking Member Brownley, and the distinguished members of the Health Subcommittee for this opportunity to speak before you. Since our founding 20 years ago, Wounded Warrior Project has been helping post-911 wounded, ill, and injured veterans address their biggest challenges and reach their highest potential through impactful no cost programming and advocacy. Today, those two paths intersect to highlight how veterans who need inpatient care for mental health or substance use are not receiving access to the prompt and in some cases, lifesaving care that they need and deserve.

The VA Mission Act was signed into law with broad support in the potential to provide veterans and their advocates with clear, useful, and timely information that could inform their health care decisions. In January 2019, VA published access standards that included limits on wait times and travel for mental health care. However, as time has passed, it has become clear that these access standards have a critical gap for veterans seeking care in inpatient programs, most specifically VA's mental health residential rehabilitation treatment programs, or their community-based equivalents.

As discussed in our written statement, VA's Mission Act derived access standards do not extend to these crucial inpatient mental health programs. Instead, veterans and their advocates are left to interpret a VHA directive that we have discussed. In our experience, this directive provides little predictability about the course of their treatment and their options for care along the way. Unless Congress or VA act to address this policy gap, many of these veterans will continue to face obstacles in connecting to the care they need, placing them at heightened risk for negative outcomes the longer they wait.

My remarks today are largely informed by Wounded Warrior Project's Complex Case Coordination Team, or C3. This team offers a high touch service to warriors with complex challenges that are often multifaceted and require urgent action. The team connects warriors to our internal support programs and to VA and community care treatment options, all with the goal of providing immediate assistance and case coordination.

In just the last four years, our team has helped nearly 1,200 warriors with complex cases navigate VA and community treatment options. However, our support simply cannot reach the scale re-

quired to assist all veterans who need this heightened level of care and intervention. The team's single biggest challenge since inception has been helping veterans access VA inpatient mental health care. The lack of a consistently applied access standard has essentially resulted in no true access standard for residential treatment. Local policy variations have resulted in unpredictable referral decisions. Wait times are not uniformly calculated and can be impacted by inconsistent policies about a veteran first having to complete significantly less intensive treatment options. Staffing challenges can also limit communication and bed availability. Alternative treatment options that would result in a community or even intra-VA referrals and faster access are not uniformly accepted by VA administrators.

In totality, many veterans are not accessing the care they need when they are ready to receive it. Delays in finding appropriate care in a timely manner not only fails to capitalize on the veteran's desire to change their life circumstance, but in some cases causes further damage to their mental and physical health, declines in family and social relationships, and even involvement with the justice system. As illustrated in VA's most recent National Veterans Suicide Prevention Annual Report, substance use disorder continues to be a significant factor in veteran suicide. While the report showed overall reduction in the veteran suicide rate, subpopulations struggling with opioid, cocaine, cannabis, and stimulant disorders showed increased suicide rates.

To mitigate the risks associated with inpatient care access and ensure consistent VA help throughout the enterprise, we believe that Mission Act access standards must apply to the delivery of inpatient mental and substance use disorder care. We want and we need the VA to be successful in this. Simply put, for us, VA is our most critical partner in connecting veterans to the inpatient care they need. In closing, I want to thank the subcommittee for this invitation to testify, and I welcome your questions.

[THE PREPARED STATEMENT OF JEN SILVA APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Silva. Mr. Sauer, you are now recognized for 5 minutes to deliver your opening statement.

STATEMENT OF THOMAS SAUER

Mr. SAUER. A broken record here, all right. Thank you very much. Chairman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, my name is Tom Sauer, and I am honored to testify before you today. I am a Navy and Marine Corps veteran, and for the better part of my life, I have been wearing the cloth of the Nation. I am a former listed Marine infantryman, a 2006 Naval Academy graduate, and a former Navy explosive ordinance disposal officer. Today, however, I am the owner and CEO of Miramar Health, a veteran-owned and operated community care provider for intensive substance use disorder and mental health treatment exclusively for America's veterans.

Mental health and addiction treatment are deep passions of mine because depression and addiction killed my dad. Five days before I graduated from high school and 3 weeks before I shipped out for the Marines in 1999, a methamphetamine overdose took his life

after decades of struggle, just like so many millions of Americans suffering from our country's disastrous mental health and addiction crisis. I would also like to point out that 4 days ago, my father-in-law died of addiction. He was an Air Force veteran.

Thanks to recent legislation, thousands of veterans have enhanced access to lifesaving mental health care and addiction treatment within the VA's Community Care Network. We provided intensive, custom tailored, world class mental health and addiction treatment for nearly 250 veterans from a dozen VA medical centers across the western United States, typically for 30, 60, sometimes 90-plus day stays. This treatment is for our veterans who are truly suffering, in crisis, and often near death from suicide or overdose resulting from this disastrous mental health and addiction crisis.

In 3–1/2 years, we have grown from one small clinic with six employees to eight residential facilities and one large outpatient facility. These facilities are staffed by nearly 100 phenomenal physicians, nurses, psychologists, therapists, medical technicians, case managers, and support staff, many of whom are veterans themselves. One is sitting right to my left as well. I could not be any prouder of them.

I did not come all the way out here just to tell you all this, just so I could pat myself on the back, but rather to simply convey the sincerity of our intentions and to lay out how important this challenge is. Miramar believes in our partnership with the VA by bridging both capability and capacity gaps within certain VA medical centers and in being an advocate to veterans in need, all while providing them with the highest quality of care. In other words, we do not consider ourselves to be just another government contractor. We are partners and we are teammates with the VA, and we are here asking for your help to ensure our Nation's veterans receive the lifesaving care they need and deserve by helping us to strengthen that partnership.

The overwhelming majority of frontline, boots on the ground VA personnel we directly interact with are fantastic, dedicated, lifesaving public servants. Some of these guys deserve medals and parades. There are many who deserve medals and parades. I am here to add today to advocate for veterans in need to be able to access care anywhere immediately and we can figure out that paperwork later.

The current VA policy of 30 days to wait to find a bed in a given region does not meet the urgent level of this crisis. I think you have been hearing this before, a recurring theme. Specifically, we have encountered several occasions where, despite community care being available for a veteran in crisis, they are either put on a waiting list for up to 30 days before receiving care when they do not have 30 minutes without becoming a very real risk to suicide or overdose. Chairwoman Miller-Meeks, I think you have highlighted such a case. We have cases that can highlight that as well too.

I have firsthand knowledge of these suicide and overdose deaths since I have owned Miramar, so I can understand the devastation this policy can cause. We believe this issue could rather be easily corrected through either through a legislative carve out for community care eligibility, as with urgent care, or when it comes to urgent

care for community care, when it comes to mental health and addiction treatment. This could be done by clarifying ensuring the COMPACT Act is being implemented as intended and that veterans are aware of this option for receiving care.

We urge you to seek to ensure that our veterans have access to care they need when they need it through the Community Care Network. We appreciate your consideration of this matter, and we are willing to work with you to address these issues to ensure that our guys and gals get the care they need so desperately. Thank you, Chair, and members of the subcommittee, each of you, your staffers, and the committee staff are champions for America's veterans. I am exceptionally grateful to you and to your commitment to serving them and that you are holding this important hearing today. In conclusion, thank you so much for addressing these issues, and I am more than happy to answer your questions.

[THE PREPARED STATEMENT OF THOMAS SAUER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. On behalf of all the committee, Mr. Sauer, our condolences on the loss of your father, and I thank you for your testimony. I will go last in the lineup of questions. I now recognize Ranking Member Brownley for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair. Ms. Silva, I just wanted to stay on a theme of women veterans for a minute, and I know we are talking about access, so I was wondering if you could speak at all to your experiences in trying to get women veterans the gender specific care that they need programs, inpatient programs, and if you could speak to that within the VA and within the community.

Ms. SILVA. Well, thank you for the question. I believe the women specific care adds an element that complicates this already kind of urgent action approach to this. We have a very short window for care. If a veteran comes to us and needs that—we are talking, specifically mental health and substance use disorder—the co-occurring with either military sexual trauma makes them at a heightened risk, as we talked about in the previous panel for this.

I have a vignette that I think is a pretty interesting one, where a female veteran was trying to get care for Military Sexual Trauma (MST) and substance use disorder, so co-occurring, and the opportunities were not available. They were available in that Community Care Network area. Unfortunately, in this situation, the VA said it seemed too resort-like and were not able to get her into that care. They did not allow for that.

What she did, but they did have an intra-VA option and she moved her entire family across a couple of states in order to get into that care. She was into VA care. I think in my experience, once they are in the care, so all those barriers of maybe females not being comfortable, once they are in there, it has been very productive and the outcomes are fantastic. We have got to work on—it does not have to be that difficult where you have got to move across states. Maybe it had to work in this situation. I think we can do better though.

Ms. BROWNLEY. Well, I think it is true for men as well as women, but I think for particularly women, I think you just highlighted one of the, I think, big obstacles to access, and that is a woman to get

the proper resources and treatment that she needs, many times has to travel outside of her state in order to receive that within the VA. You know, what does a woman do with her family? All of that. It becomes a tremendous burden for them to, you know, to leave family, to leave responsibilities in order to get the appropriate treatment. I feel like we need to address some of those issues as well.

As a consequence, we need more, I believe, more gender specific programs for women. I wonder if you could just comment a little bit. I know we are talking more about access, but just in terms of your experiences with getting referrals inpatient within the VA and within the community, can you speak to—it is my sense that when I have spoken to people, once they get into the VA and inpatient care, it is pretty good and the success is there. Can you talk a little bit about quality of care compared to, you know, inpatient VA versus community care? Can you give any kind of conclusions?

Ms. SILVA. Ma'am, I actually agree with what you said. Once they are into care, whether it is in the VA and in the community, it has been very positive overall. It is the connective tissue in order to get them into that care is lacking. They are willing oftentimes they have to go to a less intensive program before they are—even if the clinical decision is that they need this inpatient approach, it needs to be quick. That window of opportunity, especially when we are talking about these complex cases, most of them co-occurring or the substance use disorder it is a really short window. You have got to act as everyone would agree.

You have to have that availability. There is a shortage, et cetera. If the community can provide that, then that is the best way to go, in my opinion, because ultimately the veteran has a positive experience. It is still a VA referral. I think from a customer perspective, it actually keeps your customer, if I can use that term, happy with the overall care, even if it is not within the VA Medical Center.

I know within—back to the military sexual trauma or women specific care, we have found within our Warrior Care network, it is extremely important to many of the women that are served through our intensive outpatient program that they receive it outside of the VA or outside of maybe if they are still active duty. That is a gigantic barrier to care. If that is the best option for that female veteran, then let us do it. We have VA liaisons there that can get them back into VA care. It is really not outside. It is just the connective tissue is a really positive experience for that veteran.

Ms. BROWNLEY. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. I now recognize Representative Luttrell for any questions he may have.

Mr. LUTTRELL. Thank you all for your service to this country and your continued service to our veteran community. I really appreciate that. Sir, I am very sorry for your loss.

Given the previous testimony on the previous panel's testimony, Mr. Sauer, can you just explain to us as a veteran why it is you do what you do today?

Mr. SAUER. Well, thanks for the question, Mr. Luttrell. I found really no higher calling than helping fellow service members. That is what it comes down to. When it came down to all this. I realized

that there is a bigger crisis, you know, especially you two gentlemen up there on the dais, that we probably lost more friends and colleagues to suicide and addiction than we did on the battlefields overseas. I saw this as an incredibly growing problem.

The opportunity for a TriWest contract was presented. I did not know this was something that was even available. I like looked at this phenomenal opportunity that serves this growing dramatic public need. When one of my partners, who is my Naval Academy classmate, and I work with folks like Mr. Dowling here from the special operations community, like what a phenomenal group of people. Just to absolutely save lives.

I can tell you right now that, you know, as a former Navy Explosive Ordnance Disposal (EOD) officer, I spent a long time in uniform, that the work that we are doing herein today is far more valuable and to the Nation, and to the country, and frankly, for the world at large than anything I ever did wearing the uniform.

Mr. LUTTRELL. Congressman Van Orden brought up a very valid point. He said that the Suicide and Prevention Office in the VA has been in place for 34 years. My question that I did not get to ask then was has the suicide rate gone up in those 34 years? It has, absolutely. I think that lends itself to the efforts that this panel is making to protect our brothers and sisters in the veteran space.

If there were one change that you could make that would increase veteran access to lifesaving substance abuse and mental health inpatient care, what would that be?

Mr. SAUER. I think it is a pretty simple one right now is that to change that wait time from 30 days. When they do not have 30 minutes, ordinarily I would suggest 24 hours. You know what, to kind of be—to be a little understanding of the VA, 72 hours, that is one business day. When a veteran shows up to their VA provider in a mental health or addiction crisis that the VA is, you know, their standard must be that they put that veteran into a bed, get them off the X, so to speak, because lots of—we do not know exactly that the severity of the need of care. Get them off the X and they have the opportunity to be in a residential treatment program, whether or not that is in an in-house VA facility. If those facilities are full, not available right away, then you get them into a community care facility within 72 hours, one business day, preferably 24, frankly.

If we can do that right there, because obviously, one, we need to be able to ramp down the level of care as far as like if somebody has to wait 30 days, but then they can do telehealth, like that is ramping up the level of care. You need to get them off the X right away, get them into a highly intensive level of care, and then you can assess and start ramping down those levels of care. However, I would say that is what you got to do right there, just immediately get them off the X in that care, 72 hours. Yes, I think that is it right there. I mean, in a simple word, is not 30 days. You have got 72 hours, whether it is in the VA or outside with community care.

Mr. LUTTRELL. For us on the panel and having dealt with the VA at multiple levels, is it in your professional opinion that the referral process is failing at a lower level or at the higher leadership level, at the higher level?

Mr. SAUER. Absolutely. It is not the social workers we deal with. I have encountered many who have told me, you know, over the phone, told people like Brendan over the phone as well, or even over email saying, this program looks fantastic. I would love to write you referral. You know, instead they would say, however, the residential rehabilitation care has a different Mission Act eligibility criteria than other specialty services and then they cite 1162.02. In that particular case, I took that particular veteran on scholarship. He was a retired Marine, spent a long—former infantryman—and we took him on scholarship. We also have a former Navy Seal who is in our facility today on scholarship as well, because he was denied care and denied access. We saw we had to do the right thing.

We know when I speak to these social workers nearly every single time, they are the ones who say we would love to be able to refer them, but we can not. They will not let us.

Mr. LUTTRELL. If you do not mind, I would like to circle the wagons and get those names and the positions they hold so I can address them directly. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Luttrell. I now recognize Representative Van Orden for 5 minutes.

Mr. VAN ORDEN. Dr. Campbell, I see you in the back there. I want to thank you for staying here. Just so you are aware, I think Brendan, you are an enlisted guy, right? Yes, you did not go bad like, you did not go bad like Sauer?

Mr. DOWLING. Yes, I was.

Mr. VAN ORDEN. Yes, yes, noted. Ma'am, so as enlisted people, we need to make the rubber meet the road. Although those questions appear to be harsh, they are for a very specific reason so that we can quantify a problem and then move forward. Our purpose here, my sole legislative agenda as the chair of a Subcommittee for Veterans Economic Opportunity is to prevent veteran suicide. I thank you for staying here. I appreciate that greatly.

What I have noticed, gentlemen and gentlewoman, is that the issue is not with the Veterans Administration in many cases. It is with the Department of Defense (DOD). What I would like to ask you specifically is what is your access to the Transition Assistance Program? We will just start with Mr. Elkins, the Green Beret.

Mr. ELKINS. Well, as an enlisted guy, it is always a pleasure to be in the company of other enlisted, as well.

Mr. VAN ORDEN. Okay. I did not realize that. I thought you went bad too. Go ahead.

Mr. ELKINS. Working with the Transition Assistance Program at many levels, having gone through it multiple times, we will have to go through it again in the next several months, as I am about to transition out of my role to deploy for the third time in the last several years. There is definitely gaps that need to be addressed.

Mr. VAN ORDEN. Let me ask you something specifically, does your organization have access to the Transition Assistance Program so that you can speak to active duty service member as an upstream solution to prevent them from committing suicide and having drug and alcohol addiction issues after they retire?

Mr. ELKINS. Yes.

Mr. VAN ORDEN. You do?

Mr. ELKINS. Yes.

Mr. ELKINS. Okay. Ma'am, Ms. Silva.

Ms. SILVA. No, we do not.

Mr. VAN ORDEN. You do not. Okay. Mr. Sauer.

Mr. SAUER. No, sir, we are not. We are dealing usually directly with VAs, and by the time a veteran comes to us or we are made aware of a veteran that in need, that they have already gone down. They are already in a bad spot.

Mr. VAN ORDEN. Then, Brendan, what class were you in?

Mr. DOWLING. I was in Buds Class 242.

Mr. VAN ORDEN. New guy. Oh, with you? OK. When you went through the Transition Assistance Program, were you made aware of any of these external organizations that may help you bridge the gap from being active duty service member to becoming a productive veteran?

Mr. DOWLING. No, I was not. My Transition Assistance Program experience was unremarkable. I did not really pull anything from it——

Mr. VAN ORDEN. Okay.

Mr. DOWLING [continuing]. of use.

Mr. VAN ORDEN. Then just for everybody across the board, do you feel like you have access to the Department of Defense and ready access to the Veterans Administration on a coequal basis because we have to get upstream solutions. Do you guys have points of contact that you can call? Do you feel like the DoD is responsive to your guys' inquiries? If you needed to, can we help? If you do not, can we facilitate that for you so that we can start up here and then work our way to the veteran status?

Mr. ELKINS. We do have access. In some cases, it is very timely, and other times, we will use you and your office for assistance.

Mr. VAN ORDEN. Okay. That is absolutely open at any time. Ma'am?

Ms. SILVA. I would say we have developed, on the DoD side, we have developed relationships with different commands. We have heavy involvement in Alaska due to the increased suicide rates there, and we have been able to be part of that solution, working with the community there. And then different—it is very command-related. That is the difference, in my opinion, between DoD and VA. Most of the warriors that we serve are already on the veteran side of the equation, and so our bigger contacts are with the VA. We certainly would love more collaboration with the transition piece of DoD.

Mr. VAN ORDEN. Okay, excellent. Mr. Sauer.

Mr. SAUER. Miramar is contracted with TriWest Healthcare Alliance, which, you know, currently has the sole contract with the Department of Veterans Affairs. We have no formal relationship with DoD. However, as you may be aware, TriWest Healthcare Alliance won the contract for Tricare West, so we will, beginning next year, it is my understanding we will be able to treat active duty and their families, which we look forward to. We are close to Camp Pendleton. There is a large population of active duty there, and we welcome the opportunity to strengthen those relationships for that transition.

Mr. VAN ORDEN. Okay. Hey, my time is expiring. I just want to tell you that my office is yours. I know that there is no one on this

panel, Democrat or Republican, who is unwilling to step out to make sure that we can facilitate your organizations to work in conjunction with Dr. Campbell back there to help prevent veteran suicide. With that, God bless you, and thank you for your work very much. Ma'am, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Van Orden. I thought about removing your time because I take offense as a former enlisted who became an officer.

Mr. SAUER. Same here.

Ms. MILLER-MEEKS. Ms. Silva, who is a West Point grad, that I did not go to the dark side when I got pinned my lieutenant bars. I now yield myself 5 minutes for questions.

You know, this is a very sobering hearing in many ways. Let me just say that as a veteran and as an ophthalmologist and I did both care, active duty military. I did Veterans Administration care. I was an assistant professor in academic medicine and as well as private practice, and I was an ophthalmologist. Let me just say that when I would get calls from a patient for a red eye, I would see that patient that same day. That is a red eye. Nowhere near the gravity of what we are talking about now. That was my personal standard. It was not a standard imposed upon me by an insurance company, by the institution for which I worked, nor by Members of Congress.

Mr. Elkins and Mr. Sauer, in both of your testimonies, you mentioned being made aware of a VA policy stating that the VA has 30 days to place a veteran with substance use into an inpatient mental health residential rehabilitation program when working cases for veterans in crisis. Can you explain further your experiences with the VA when policy is not adequately or inaccurately conveyed?

Mr. ELKINS. Thank you for that question. Thirty days is too long to ask a veteran to wait on the availability of an RRTP facility or care in the community. In a 30-day period, the risk of suicide or destabilization can drastically increase. We recommend a clinically sound, lesser number of days because PTSD in conjunction with SUD require swift intervention and services. Additionally, in some cases, veterans lack trust with the VA based on past experiences and the mere fact that you have to go through an RRTP facility first and fail and then afterwards go to the community care, needs to be addressed.

Ms. MILLER-MEEKS. Thank you. Mr. Sauer, I will just kind of dovetail on that and then go to you. Both of you in your work with veterans, have you heard anything about a recent direction from the VAMC that if they can not meet the 30-day appointment availability, they have to confer with other VISNs. They have to try to get them into care at another location. Or that five VAMCs must be contacted to fulfill the directive. Have you all heard that?

Mr. SAUER. Yes, we have. A matter of fact, Mr. Dowling, to my left is the one who directly dealt with that when after speaking with a VAMC therapist who was one who also managed many community care referrals or made the consults that would later become referrals. Brendan can definitely speak about it in more detail if you have questions. It was that if a VISN's VAMC—it went to effect on I think October 1 is what they were told. We were told this

verbally. This was not in a writing or policy, that if a VISN's VAMC cannot meet the 30-day appointment availability window, it must confer with the other VISNs for bed availability before leveraging community care in order to keep the care "in house." He further reported that five VAMCs must be contacted in order to fulfill the directive. He advised this new policy would highly impact referrals throughout the community. Is there something else you wanted to add, if I may? Is it is all right, to Mr. Dowling? It is Okay if not. Understood.

Ms. MILLER-MEEKS. Have you experienced the same thing?

Mr. ELKINS. Yes, we have experienced the same thing in multiple cases over the last several months. As of January, we have seen a significant increase in the amount of cases we are seeing where there are unnecessary delays.

Ms. MILLER-MEEKS. Thank you. It is surprising then that our bureaucracy has not heard the similar thing.

Mr. Sauer, we often hear that the VA care is the best care because those who work at the VA understand the veteran. I am going to refer to a community organization I have in one of my largest cities in my district in Davenport, where an entirely volunteer veteran organization assisted a veteran who had not seen their family or come for any kind of care for 20 years, had not seen their family. The veteran showed up there to this total voluntary organization, no one taking a salary, and contacted his family for the first time in 20 years. How does your experience and the experience of your staff, such as those with Mr. Dowling's background, equip you to serve our Nation's veterans?

Mr. SAUER. It is a big question, ma'am. I would say that we are incredibly honored for this opportunity to do this. I will say that there is nothing that is more rewarding. I know that when Brendan joined the team last year, he saw the mission we were doing. I mean, he can speak for himself on that one. Most certainly we go pretty far out of our way for a number of cases. We have taken, for what it is worth, as well, when we have cases where a veteran has for any number of reasons, but usually due to the reasons that we are here for which we are here today, they are unable to get care, we take them on scholarship.

Now, I still have 100 employee—nearly 100 employees. I have to make payroll to keep the lights on. I can not do that continually, but I am happy to do that, you know, in certain situations. We have done that about seven or eight times that I can think of in the past year or two. We just do it because it is the right thing to do, that is it.

Ms. MILLER-MEEKS. Thank you. I yield. Ranking Member Brownley, would you like to make any closing remarks since I see no other members here?

Ms. BROWNLEY. Yes. Thank you, Madam Chair. Really, thank you very much for having this hearing. It is very much an important hearing of which I still feel like we need to do even a deeper dive on it to really get down to the bottom of things. I really thank this panel for your testimony. This is one of these hearings where I wish we had panel two first and the VA second, because there is so much that you have raised that now I would like to ask the VA. I think there is clearly a disconnect between the VA's testi-

mony and your testimony, and we need to get to the bottom of that. I have a feeling that some of the problem has to do with how VA really addresses access and how they account for access and missing some data points, perhaps.

I do want to acknowledge that what I am hearing from panel two as well is that the quality of care within the VA once the veteran gets into the VA is very good. I want to, you know, applaud the VA for the quality care. The access piece and when we are talking about suicide and other kinds of things, that getting, you know, when someone is in crisis and they come to the VA or come to any of you, if there is not a bed, they still need to be in a room. They do not get to leave the hospital at that particular point. They are in the care of the VA. Never should a veteran walk out of that VA in crisis. I think clearly something has to be done here around these access points.

Mr. Sauer, too, I want to congratulate you, too, on, you know, the quality of community care that you are providing in your area. We thank you for that. Again, my condolences to you with regards to your father. With that, I will yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. I would like to thank everyone for their participation in today's hearing and for their productive conversation. I would like to especially thank our most recent panel for submitting their witness testimony in a timely fashion so Members of Congress could read it.

As a veteran, as a doctor, as a former director of the Department of Public Health, and someone who is very active in mental health and substance use disorder, it is one of my top priorities. I know the same goes for my colleagues on both sides of the aisle to take care of all veterans and to ensure that they have timely care, especially for those who are struggling with complex mental health issues and substance use disorder. No one here on this panel—witness up on the dais today has impugned the quality of care delivered at the VA. The most important metric, not hundreds of metrics, the most important metric of success is whether the suicide rate has gone down, and unfortunately, it has gone up. No veteran should be turned away when a decision is made to seek help.

I look forward to working on these issues. I look forward to working with my colleagues on the other side of the aisle and many more with the department, stakeholders, and my colleagues on this subcommittee.

The complete written statements of today's witnesses will be entered into the hearing record. Questions will be submitted, and we will ask that they be responded to in a timely fashion. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material. Hearing no objection, so ordered. This meeting is now adjourned.

[Whereupon, at 12:03 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESSES

Prepared Statement of Tamara Campbell

Good morning, Chairman Miller-Meeks, Ranking Member Brownley and distinguished Members of the Subcommittee. Thank you for the opportunity today to discuss VA's substance use disorder treatment programs through Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) and through community care referrals. Accompanying me today is Dr. Sachin Yende, Chief Medical Officer, Office of Integrated Veteran Care (IVC).

Veterans are increasingly struggling with substance use disorders (SUD). From fiscal year (FY) 2018 to FY 2022, the number of Veterans diagnosed with a SUD and receiving treatment in the Veterans Health Administration (VHA) increased from 522,544 to 550,412. This increase also reflects an increase in Veterans with a diagnosis of alcohol use disorder receiving care in VHA which increased from 393,531 to 411,615 over the same time period. Of the over 550,000 Veterans receiving care from VHA in FY 2022, or 8.5 percent of all patients who received care from VHA, received treatment for a substance use disorder. While the annual number of Veterans receiving treatment from VHA for opioid use disorder has stabilized at about 67,000 patients per year, a rising number of VA patients are receiving treatment for cannabis use disorder and amphetamine stimulant use disorder, which includes methamphetamine use disorder. The number of patients treated in VHA for amphetamine stimulant use disorder has climbed by almost 8 percent over the previous 5 years to more than 40,000 patients annually, while the number of patients treated in VHA for cannabis use disorder has increased by more than 12 percent to more than 139,000 patients annually. The number of Veterans who have been diagnosed with an alcohol use disorder over the same time period has increased by nearly 5 percent. Together with each of you, VA is totally committed to providing a wide range of interventions that are supported by evidence to cater to the requirements of every Veteran.

Care for Veterans who have co-occurring SUD and mental health issues is a crucial component of general health care. Because it has an integrated health care system, VA is in a unique position to meet the requirements of Veterans with SUD by offering assistance for co-occurring medical, mental health, and psychosocial issues, including by providing supports for employment and housing. Due to the complexity of SUD, neither a single remedy nor solely clinical or VA interventions will suffice to solve address the issue. To reduce the burden of SUD in the veteran population, it is important to use broad-based national preventative and treatment strategies. To achieve its goals, VA uses both whole-of-Government and whole-of-Nation approaches. These are exemplified by VA's interagency collaborations. As an illustration, the Department of Defense (DoD) and VA collaborated to produce clinical practice guidelines for the management of substance use disorders. To meet the needs of Veterans with or at risk of substance use disorder, VA also collaborates closely with several other Departments and agencies, including the Departments of Health and Human Services, Energy, Justice, and Housing and Urban Development.

Also, VA is incorporating Oak Ridge National Laboratory data into predictive models for targeted prevention programs so we can better identify Veterans with the greatest challenges to recovery and get them the additional support they need. Through collaborations with the Lawrence Berkeley, Los Alamos, and Sandia National Labs, VA is making better use of medical record information to identify high-risk VA patient populations. Through work with JJR Solutions in Dayton, Ohio, a service-disabled Veteran-owned small business, VA has found that provider education sessions on opioid safety practices lead to more effective treatment for Veterans in primary care and reduction in overdoses.

Overview of SUD Treatment at VA

There has been an upsurge in morbidity and mortality from substance use disorders during the past 10 years or more as powerful and hazardous illicit drugs have become more widespread in the United States. Federal, State and community

prevention and treatment efforts have been developed in response, particularly aimed at reducing overdose deaths and addressing the opioid epidemic.

Within VA, patients with at-risk alcohol use or the SUDs of mild severity may be treated with evidence-based brief interventions and/or medical management in primary care or general mental health. For those with more severe disorders impairment, specialty SUD treatment programs provide intensive services including withdrawal management, evidence-based psychosocial treatments, SUD medication, case management and relapse prevention provided in outpatient, intensive outpatient and residential settings of care. VA has developed services specifically focused on engagement in care for vulnerable Veteran populations. VA efforts include universal screening for at-risk alcohol use, urine drug screening for at-risk Veterans, the provision of peer support services, integration of SUD treatment within homeless programs, and collaboration with Veterans' courts and the work of our re-entry specialists to engage Veterans with SUD involved with the legal system.

These efforts also have required close collaboration with other Federal partners in support of priorities defined by the Office of National Drug Control Policy (ONDCP). In alignment with ONDCP's National Drug Control Strategy, VA is working to expand access to evidence-based treatment for SUDs and enhancing evidence-based harm reduction efforts aimed at reducing overdose fatalities. VA offers a comprehensive continuum of specialty SUD services for Veterans. Our VA/DoD Clinical Practice Guidelines,[1] updated in fiscal year (FY) 2021, provide the foundation for evidence-based treatment within VA and have positioned VA to respond to emerging drug use trends. Current policy requires facilities provide access to a comprehensive continuum of SUD treatment services ranging from early intervention and harm reduction services through intensive outpatient and, when needed, residential or inpatient treatment for SUD. In addition, current policy requires facilities provide same day outpatient access for Veterans with emergent substance use treatment needs. This care may be provided in several settings including general mental health, primary care mental health integration clinics, and SUD specialty clinics. Core characteristics of SUD services include timely same day triage, a no wrong door approach, concurrent treatment for co-occurring needs and Veteran-centered and individualized treatment based on the needs and preferences of the Veteran.

With national initiatives like Stepped Care for Opioid Use Disorder, Train the Trainer, and the Psychotropic Drug Safety Initiative, VA emphasizes access to evidence-based treatments for SUDs. These initiatives also aim to increase access to both evidence-based pharmacotherapies and evidence-based psychotherapies for substance use disorders. According to the National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration, only 22 percent of the general population with opioid use disorder received medication for opioid use disorder in 2021. In calendar year 2022, VA more than doubles that rate, with over 47 percent of patients with opioid use disorder receiving medications for opioid use disorder from VA within the last 12 months. Appropriate use of FDA-approved medications for opioid use disorder can lower the risk of illicit opioid use, overdose, suicide, and other mortalities.

In 2022, VA provided psychosocial or behavioral therapy for SUD to almost 172,000 Veterans. VA is using national training initiatives to ensure that these treatments are as effective as possible, expanding access to highly evidence-based cognitive behavioral therapies and contingency management programs. Notably, contingency management is the most effective, evidence-based treatment for stimulant use disorder and has shown success in treating cannabis use disorder, two substance use disorders that are increasingly common in the VHA patient population. More than 6,200 Veterans have received contingency management treatment since 2011. Over 90 percent of the nearly 80,000 urine samples that those Veterans submitted tested negative for the target drugs, which are frequently stimulants and occasionally cannabis (THC). For Veterans with alcohol use disorder, VA offers both evidence-based medications as well as evidence-based psychotherapies separately or in combination depending on the shared decision-making between each Veteran and his/her treatment provider.

VA recognizes that not all Veterans with SUD will embrace abstinence among their recovery goals. Furthermore, SUD, like hypertension or diabetes, is a chronic, relapsing condition; even Veterans who are striving to abstain from substances may not always be consistently successful. Because any exposure to substances can be fatal for individuals with SUD, VA provides Veterans with evidence-based interventions to protect them from harms, like overdose or infectious diseases like HIV and hepatitis, that could otherwise lead to their death. In just the past year, VHA equipped over 70,000 Veterans with naloxone to reverse potentially fatal opioid

[1] https://www.healthquality.va.gov/guidelines/MH/sud/.

overdoses. Furthermore, nearly 1 million naloxone prescriptions have been provided to Veterans since 2014, when we launched our Overdose Education and Naloxone Distribution (OEND) initiative. This initiative has led to more than 3,700 overdose reversals. As part of this effort, VA uses data-driven modeling to identify Veterans at high risk of overdose and conducts clinical case reviews to inform their customized treatment plans. Support from Congress has been critical for the success of VA's overdose prevention efforts with passage of the Jason Simcakoski Memorial and Promise Act allowing VA to provide naloxone at no cost to Veterans at risk for overdose.

In support of its comprehensive approach to the treatment of SUD, VA has developed a wide array of substance use education programs in its efforts to expand SUD education and outreach. The programs are being implemented across the Department and can be classified as follows:

- Initiatives to educate primary care practitioners on the diagnosis and treatment of alcohol use disorders.
- Harm reduction approaches to reduce negative consequences of substance use including planned/developed mobile and internet-based treatment to expand VA's efforts related to SUD treatment, education, and outreach.
- Programs developed for Veterans and Veterans' families.
- Clinician training and consultation programs to improve their knowledge, skills, and abilities to treat Veterans with SUD.
- SUD training programs for trainees participating in clinical training with VA.

In addition, VA is supporting SUD training for our future workforce and is implementing novel harm reduction approaches including the development of mobile and internet-based applications. Beginning with the President's Budget for fiscal year 2022, VA has requested support to directly respond to national priorities defined by ONDCP. The plan directly addressed the unique needs of Veterans with substance use concerns within the context of broader national priorities.

VA honors Veterans' autonomy in determining their recovery goals, and our providers support them with evidence-based treatments and subject matter expertise. Consequently, VA is making a positive difference in Veterans' quality of life by building confidence in their treatment and helping motivate them in their recovery. Indeed, Veterans receiving treatment for their SUD in VA are experiencing benefits in terms of their mental and physical health and across many other aspects of their lives such as housing stability, employment, and improved interpersonal relationships (See DeMarce et al. for an example of such impact).[2] These are the goals VA is pursuing. We want to help Veterans do more than just survive – we want to help them learn how to thrive.

FY 2024 President's Budget Expands Access to Treatment for Substance Use Disorders (SUD)

President Biden's FY 2024 Budget proposes continued support for initiatives started during FY 2022, with over 1,100 additional staff awarded enterprise-wide to help meet VA's SUD treatment priorities to include the following:

- Stepped Care to expand access to evidence-based treatment for SUD in settings outside specialty SUD Care;
- SUD Residential Treatment to reduce wait times and improve the quality of SUD care with expansion of staff and programs;
- SUD Telehealth to expand access to evidence-based SUD treatment via telehealth;
- Homeless Program SUD Treatment Coordinators to engage Veterans with SUD into VA SUD outpatient and residential services;
- Supported Employment Specialists to expand access to employment opportunities for Veterans in recovery; and
- SUD Peer Specialists to increase engagement and retention in evidence-based SUD treatment.

As of March 7, 2023, over 55 percent of the more than 1,100 positions have been filled or are in the final steps of the hiring process. VA continues to respond to emerging illicit drug threats to ensure the needs of Veterans experiencing substance

[2] Josephine M. DeMarce, Maryann Gnys, Susan D. Raffa, Mandy Kumpula & Bradley E. Karlin (2021) Dissemination of cognitive behavioral therapy for substance use disorders in the Department of Veterans Affairs Health Care System: Description and evaluation of Veteran outcomes, Substance Abuse, 42:2, 168–174, DOI: 10.1080/08897077.2019.1674238.

use concerns are met. VA will establish program management leads for harm reduction and will work collaboratively to develop policy and national tools to support implementation of targeted harm reduction strategies throughout VHA addressing critical issues such as stigma and the need for technical assistance for the field to support implementation.

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

VA's MH RRTPs are a critical component of VA's broader efforts to address the needs of Veterans with substance use concerns. With origins that date back to the National Homes for Disabled Volunteer Soldiers, the Domiciliary Care programs have evolved over time to meet the changing needs of Veterans. Today, residential treatment for mental health and substance use concerns in VA is provided through Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) located throughout the country. The MH RRTP continuum includes Domiciliary Care (SUD, Posttraumatic Stress Disorder (PTSD), General and Domiciliary Care for Homeless Veterans – DCHV) as well as Compensated Work Therapy-Transitional Residence programs, which provide transitional housing for Veterans actively engaged in vocational rehabilitation and participating in either transitional work or supported employment. There are currently more than 250 MH RRTPs across 121 locations of care with more than 6,700 operational beds. This includes more than 70 programs for the treatment of SUD and more than 40 programs for the treatment of PTSD with the expectation that all programs provide integrated, concurrent treatment for co-occurring SUD and mental health treatment needs (dual diagnosis services) as more than 90 percent of all Veterans served by the MH RRTPs have a SUD diagnosis.

All Domiciliary Care programs within VHA provide 24/7 professional and peer support with comprehensive services addressing mental health, medical and psychosocial needs provided by an interdisciplinary team; these programs are accredited by The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities. VHA Directive 1162.02 defines expectations for clinical services within the programs with the Domiciliary SUD (DOM SUD) programs expected to adhere to the VA/DoD Clinical Practice Guidelines for the Management of SUD. Given the nature of the care provided in the residential programs, VA's MH RRTPs often are at the forefront in implementation of critical services for Veterans. For example, efforts to support implementation of OEND within VA have their origins with work that was started by the MH RRTPs in 2012, as part of the first Culture of Safety Stand Down, which was established in response to concerns about opioid overdose. At that time, only 11 percent of Veterans served by the MH RRTP received medications for opioid use disorder. During FY 2022, more than 40 percent of Veterans received medications to treat opioid use disorder during their stay. Further, during FY 2023 to date, more than 70 percent of Veterans with an opioid use disorder have received a prescription for naloxone[3] during their MH RRTP stay. Several studies have demonstrated the impact of VA residential treatment.[4] Studies completed within the SUD residential programs have shown sustained reductions in substance

[3] We note that U.S. Food and Drug Administration (FDA) recently approved the first nonprescription naloxone product. See FDA Approves First Over-the-Counter Naloxone Nasal Spray, U.S. FOOD &DRUG ADMIN. (Mar. 29, 2023), https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray#:?:text=Today percent2C percent20the percent20U.S. percent20Food percent20and,for percent20use percent20withoutpercent20a percent20prescription

[4] Smith, N. B., Sippel, L. M., Rozek, D. C., Spangler, P. T., Traber, D., Straud, C. L., Hoff, R., & Harpaz-Rotem, I. (2020). Courses of suicidal ideation among military veterans in residential treatment for posttraumatic stress disorder. Depression and anxiety, 37(3), 273–284. https://doi.org/10.1002/da.22993 Holliday, R., Smith, N. B., Holder, N., Gross, G. M., Monteith, L. L., Maguen, S., Hoff, R. A., & Harpaz-Rotem, I. (2020). Comparing the effectiveness of VA residential PTSD treatment for veterans who do and do not report a history of MST: A national investigation. Journal of psychiatric research, 122, 42–47. https://doi.org/10.1016/j.jpsychires.2019.12.012 Cook, J. M., Schnurr, P. P., Simiola, V., Thompson, R., Hoff, R., & Harpaz-Rotem, I. (2019). Adoption by VA Residential Programs of Two Evidence-Based Psychotherapies for PTSD: Effect on Patient Outcomes. Psychiatric services (Washington, DC.), 70(7), 553–560. https://doi.org/10.1176/appi.ps.201800338

use and changes in other factors related to recovery (e.g., Blonigan & Macia, 2021;[5] Boden & Moss, 2009;[6] Lash et al., 2007,[7] 2013[8]).

Access to Mental Health Residential Treatment within VHA

VHA affirms the critical importance of timely access to residential treatment for mental health and substance use concerns and has taken steps to remove barriers to care. Veterans may self-refer or may be referred by their provider (internal or external to VHA) to mental health residential treatment. In accordance with nationally defined admission criteria, Veterans must be screened for appropriateness for admission with a decision provided within 7 business days. VHA's goal is to admit Veterans as quickly as possible, and the admission date should take into consideration the Veteran's preference. Timely access to residential treatment has been a priority area of focus for VHA with several efforts underway to ensure Veterans have access to residential treatment when clinically indicated. One such effort included development of a process to facilitate access to residential care in the community. Prior to the time of enactment of the VA MISSION Act of 2018 (June 6, 2018), residential treatment in the community was not readily accessible, with a limited number of care providers and no direct pathway to authorize and pay for such treatment. When care did occur, it was provided either through inpatient programs for the treatment of substance use disorder or through contracts with community care providers. Recognizing a need to ensure access to this critical level of care, VA worked to verify authority to provide residential treatment in the community and to provide a mechanism to pay for such care. The Mental Health Residential standardized episode of care (SEOC) and the technical mechanism to place a consult for this care were released to VA medical centers in October 2020.

VHA's formal guidance to facilities defined how and when referrals for residential care in the community should occur. This guidance was informed by VHA Directive 1162.02, which defines requirements for ensuring timely access to residential treatment. While the MH RRTPs are considered institutional extended care and not subject to the designated access standards established by VA at 38 CFR § 17.4040, which can establish eligibility to elect to receive care in the community, access standards for MH RRTPs still do exist. VHA policy requires that when a Veteran is assessed as requiring residential treatment and the program is unable to meet the Veteran's needs (72 hours for Veterans requiring priority admission and 30 days for Veterans assessed as appropriate for routine admission) an alternate treatment program must be offered. Alternate treatment may include another MH RRTP in the Veterans Integrated Service Network (VISN), a comparable program appropriate to meet the Veteran's needs (e.g., a homeless grant and per diem program) or referral for care in the community. The policy in question does not reflect a new policy requirement but rather was the first step to provide a clear expectation for provision of residential treatment within the community and a mechanism to facilitate access.

Through the second quarter (Q2) of FY 2022, the average time between screening and admission for all Veterans admitted for residential treatment was 23 days, with half of Veterans admitted within 12 days of being screened for admission. For the DOM SUD programs the average time was 24 days, but with half of Veterans admitted within 9 days of being screened for admission. It is important to note that a small subset of Veterans request or require a later admission date (18 percent for DOM SUD programs during FY 2022). VHA is committed to ensuring timely access to care with a focus on moving toward same day/next day admission consistent with priorities defined by the National Drug Control Strategy. Through Q2 of FY 2023, 40 percent of Veterans were admitted either directly from an inpatient mental health stay or within 1 day of screening.

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[5] Blonigen, D. M., & Macia, K. S. (2021). Personality change during substance use disorder treatment is associated with improvements in abstinence self-efficacy post-treatment among U.S. military veterans. Journal of Substance Abuse Treatment, 120, 108187. https://doi.org/10.1016/j.jsat.2020.108187

[6] Boden, M. T., & Moos, R. (2009). Dually diagnosed patients' responses to substance use disorder treatment. Journal of Substance Abuse Treatment, 37(4), 335–345. https://doi.org/10.1016/j.jsat.2009.03.012

[7] Lash, S. J., Stephens, R. S., Burden, J. L., Grambow, S. C., DeMarce, J. M., Jones, M. E., Lozano, B. E., Jeffreys, A. S., Fearer, S. A., & Horner, R. D. (2007). Contracting, prompting, and reinforcing substance use disorder continuing care: A randomized clinical trial. Psychology of Addictive Behaviors, 21(3), 387 397. https://doi.org/10.1037/0893–164X.21.3.387

[8] Lash, S. J., Burden, J. L., Parker, J. D., Stephens, R. S., Budney, A. J., Horner, R. D., Datta, S., Jeffreys, A. S., & Grambow, S. C. (2013). Contracting, prompting and reinforcing substance use disorder continuing care. Journal of Substance Abuse Treatment, 44(4), 449–456. https://doi.org/10.1016/j.jsat.2012.09.008

Further, since the publication of the MH Residential SEOC, the number of Veterans receiving residential care in the community has increased rapidly. During FY 2021, there were more than 7,000 referrals for mental health residential care in the community using the new SEOC, with that number increasing to roughly 11,000 unique referrals during FY 2022 and exceeding 6,800 to date during FY 2023. Expenditures for residential care in the community since 2021 have exceeded $1.2 billion. By comparison, during FY 2022, VA's Domiciliary Care programs overall served more than 20,000 unique Veterans with the DOM SUD program serving more than 9,800 Veterans.

Community care residential treatment programs are critical resources when a facility is unable to furnish residential treatment for a Veteran within the VISN. Facilities are actively working with community providers to ensure that when a Veteran is referred to a residential treatment program, the program meets quality standards and that there are clear processes for referral and for engagement in post-discharge continuing care with VHA. Collaboration with community providers also has allowed VISNs to communicate about specific treatment needs where residential treatment options may be limited in VHA.

Beyond ensuring that mechanisms exist to ensure Veterans have access to community residential treatment when applicable, VA is committed to addressing internal access challenges. The MH RRTPs were significantly impacted by the pandemic with many programs reducing capacity to ensure both Veteran and staff safety. VA began communicating on the importance of ensuring access to MH RRTP services as early as July 2020, with a focused effort to resume MH RRTP services and increase capacity initiated in February 2021. Since that time, VA's Office of Mental Health and Suicide Prevention (OMHSP) has been working collaboratively with the VISNs to increase capacity and reduce wait times with the average number of days between screening and admission approaching pre-pandemic levels. However, VHA recognizes the need to establish accelerated targets informed by Veteran feedback. Beginning in August 2022 and concluding in December 2022, VHA conducted regional meetings specifically focused on access to residential care emphasizing a goal of providing same day or next day admission when clinically indicated. Since the start of those conversations in August 2022, the average daily census has grown from around 3,300 Veterans to just over 3,800 Veterans in March 2023.

In addition to efforts to return MH RRTP capacity to pre-pandemic levels of operation, several new DOM SUD programs have recently been established or are under development and expected to open within the next few years. During FY 2022 and FY 2023 year to date, 55 DOM SUD beds have been established at 3 new locations of care with 14 additional beds at 2 additional programs projected to open during FY 2023.

Compliance with Community Care Referrals for Substance Abuse Residential Treatment

VA is grateful for the independent investigation of the Office of Inspector General (OIG) in the review of the DOM SUD treatment program and residential community care referrals.[9] As noted in VHA's response in the OIG report, the ability to refer for mental health residential treatment in the community is a relatively new process with the first SEOC for mental health residential treatment released in October 2020 and updated in August 2021. OMHSP worked collaboratively with VISNs during this time to clarify requirements and expectations for when referrals for mental health residential care in the community may occur. These efforts have continued with targeted efforts to ensure familiarity with access requirements and processes for ensuring access to residential treatment in the community when indicated.

Specifically, in response to recommendations in the report, VA has taken several steps to ensure a clear understanding by all programs of access requirements and when referrals for mental health residential treatment in the community should be completed. Further, in response to the OIG report, VA has ensured clarification on the existing guidance regarding the role of the mental health treatment coordinator and expectations for engagement with the coordinator as part of the referral and admission process for Veterans requiring mental health residential treatment. Further, VA has several efforts currently underway to address access for MH RRTP services, with a workgroup convening to determine potential changes in national policy responsive to access challenges that have been communicated by stakeholders with the expectation that a formal plan and path forward would be finalized within 45 days of the workgroup convening. In addition, OMHSP is working to put in place

[9] Department of Veterans Affairs Office of Inspector General. "Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System". Report No. 21–03864–34. January 31, 2023.

a process that leverages existing monitoring efforts to inform procedures for notifying VISN leadership when there are concerns with conformance to national policy.

Implementation of Veterans COMPACT Act, Section 201

The Veterans COMPACT Act created a new authority in 38 U.S.C. § 1720J for VA to provide emergent suicide care to eligible individuals in acute suicidal crisis at no cost both in VA and in the community. This authority increases access to care, including residential care, and is in full alignment with VA's National Strategy for Preventing Veteran Suicide.[10] Building upon VA's comprehensive public health approach, this new emergency suicide care and treatment health care benefit enhances our ability to provide critical treatment for eligible individuals experiencing a suicidal crisis. Eligible individuals in suicidal crisis can go to any VA or community health care facility for emergent suicide care. VA is responsible for providing, paying for, or reimbursing for this care, depending on the setting it is provided in, and therefore, this care is provided to eligible individuals at no cost. Eligible individuals receiving emergent suicide care will also have the costs of ambulance transportation and related prescriptions covered. Emergent suicide care can be provided in multiple settings, including inpatient or crisis residential care for up to 30 days and crisis-related outpatient care for up to 90 days. The access standards for mental health residential treatment outside of an acute suicide crisis (72 hours for priority admission and 30 days for routine admission) would not apply. This health care benefit has the potential to increase access to acute suicide care to an additional 9 million unenrolled Veterans and reduce the number of Veteran suicides by offering immediate care when Veterans are most vulnerable.

On January 17, 2023, VA published an interim final rule outlining eligibility for emergent suicide care and immediately began providing this new benefit to eligible individuals. As part of implementation, VA developed a robust communications plan targeted toward eligible individuals, Veterans, and community providers. VA continues to aggressively address critical cross-platform information technology enhancements to ensure that multiple administrative and clinical systems work seamlessly together to ensure timely and efficient care at no cost. The Veterans Crisis Line serves a critical role in the coordination of life-saving resources, such as emergency dispatch for Veteran crisis care. VHA provided external resources for Veterans and providers, as well as internal resources and training for VA staff on section 201 of the COMPACT Act. We are committed to ongoing education and training efforts within VA and in the community as we deploy this new, life-affirming benefit in our ongoing suicide prevention efforts.

Conclusion

We appreciate the Committee's continued support in this shared mission. Nothing is more important to VA than supporting the health and well-being of the Nation's Veterans and their families. VA has employed broad, evidence-based strategies to address the opioid epidemic, including patient and provider education, pain management and access to non-pharmacological modalities, risk mitigation strategies, and addiction treatment for Veterans with SUD. This critical work saves lives.

My colleagues and I are prepared to respond to any questions you may have.

Prepared Statement of Julie Kroviak

Chairwoman Miller-Meeks, Ranking Member Brownley, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Veterans Health Administration's (VHA) domiciliary substance use disorder treatment program. The OIG's Office of Healthcare Inspections reviews the quality and safety of health care provided across VHA and communicates the findings through a variety of public reports. These include results from hotline inspections, national reviews, comprehensive healthcare inspections, vet center inspections, and Veterans Integrated Service Network (VISN) reviews. For each of these reports, OIG clinical review teams provide recommendations for improving processes or further reducing risks to the veterans who entrust their health care to VHA.

VHA faces significant challenges in meeting the needs of individuals with substance use disorders. The devastating effects on veterans, their families and caregivers, and communities cannot be overstated. Veterans with substance use disorders often have co-occurring mental health issues that can place them at higher

[10] U.S. Department of Veterans Affairs. (2018). National Strategy for Preventing Veteran Suicide. http://www.mentalhealth.va.gov/suicideprevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

risk for suicide. Given that VHA's top clinical priority is to reduce veteran suicide, evidence-based substance use disorder treatment programs are imperative to addressing the clinical needs of these high-risk patients. When both VHA and community care providers are engaged in managing these patients, the coordination must be seamless and collaborative.

This testimony focuses on OIG reports that have identified challenges with community care access and coordination for high-risk patients. The OIG believes the findings and recommendations should be considered by all VHA providers and leaders managing patients with complex mental health needs including substance use disorders.

NONCOMPLIANCE WITH COMMUNITY CARE REFERRALS FOR SUBSTANCE ABUSE RESIDENTIAL TREATMENT AT THE VA NORTH TEXAS HEALTH CARE SYSTEM

In August 2021, the OIG hotline received allegations that staff for the domiciliary substance use disorder treatment program (DOM SUD) at the VA North Texas Health Care System (VA North Texas) placed patients on waitlists for two to three months and failed to offer non-VA community residential care referrals for substance use disorder treatment.[1] The complainant also alleged that VA North Texas staff denied patients' requests for community residential care referrals, whereas patients from another VISN 17 facility, the Central Texas Veterans Health Care System (Central Texas VA), received community residential care treatment. During the course of the OIG staff's review of the allegations (including examining 15 VA North Texas DOM SUD consults (referrals) and electronic health records for 10 patients), the team identified additional concerns related to compliance with required scheduling procedures and the assignment of mental health treatment coordinators to patients awaiting admission. To understand the context for the resulting report's findings, it is important to consider VHA's program goals and requirements.

Background

Mental health residential rehabilitation treatment programs (MH RRTPs) provide 24-hour treatment and rehabilitative services to patients with a range of treatment needs and include domiciliary substance use disorder programs. MH RRTP is an umbrella term for the range of residential programs that provide treatment to patients experiencing homelessness, substance use disorders, posttraumatic stress disorder, as well as other medical and mental health conditions. To be eligible for an MH RRTP referral, veterans must need a higher level of care than an outpatient program but not be at imminent risk to themselves and others, and not meet criteria for a medical or acute mental health admission. VHA requires that each facility provide access to care at MH RRTPs through service agreements with other VA facilities or through referral to non-VA community residential care facilities.

VA North Texas, part of VISN 17, includes a 40-bed DOM SUD at the Dallas VA Medical Center and a 69-bed DOM SUD at the Sam Rayburn Memorial Veterans Center in Bonham, Texas. The Central Texas VA is in Temple, Texas, and has a 169-bed general domiciliary that offers substance use disorder treatment as a "track."

According to VHA's requirements, patients referred to MH RRTPs must be screened within seven business days by a team that includes a licensed mental health professional and a medical provider to determine whether admission is appropriate. If accepted, the patient must receive a tentative admission date and a point of contact at the MH RRTP.[2] So VHA can track admission wait times, the patient must be added to the pending bed placement list.[3] Since 2018, VHA has required staff to include information in the patient's electronic health record to improve tracking of program wait times and capacity.[4]

Community Care Program Eligibility Criteria

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018

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[1] VA OIG, *Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System*, January 31, 2023.

[2] VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, July 15, 2019. Tentative admission date refers to the MH RRTP staff's expected date of bed availability.

[3] VHA Directive 1002, Bed Management Solution for Tracking Beds and Patient Movement Within and Across VHA Facilities, November 28, 2017.

[4] VHA Deputy Under Secretary for Health for Operations and Management (10N) memo, "Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) CPRS Note Templates Implementation," July 30, 2018.

(MISSION Act) mandated changes to VHA's community care program.[5] Those changes led to VHA's Office of Community Care issuing implementation guidance stating that "wait time and drive time access standards are only applicable to primary care, specialty care, and non-institutional extended care services." The guidance further said MH RRTPs "are considered institutional extended care services" and do not follow the same wait-time standards.[6] When MH RRTP care is not available within VA facilities for an eligible patient who "elects to receive care in the community," VHA will authorize community residential care. Further, for MH RRTP admission wait times greater than 30 calendar days, facility staff must offer the patient alternative care that addresses the patient's needs and preferences including a referral to community residential care or another VHA program. Additionally, facility staff should discuss outpatient care options with the patient while the patient awaits MH RRTP admission. It is important to note that the COVID–19 pandemic put additional stresses on VHA and that the Texas facilities were not alone in facing long wait times. In February 2021, VHA estimated that 3,500 patients nationally were pending admission with an average wait time of more than 150 days. At that time, VHA required MH RRTP staff to provide alternatives, including community residential care, if unable to admit patients within 30 days.[7]

VA North Texas DOM SUD Wait Times Exceeded Requirements and Staff Failed to Refer Patients to Community Residential Care as Required

The OIG team reviewed 15 VA North Texas DOM SUD consults to determine admission wait times and evaluate whether staff offered community residential care. The team substantiated the allegation that VA North Texas staff placed patients on waitlists for two to three months and failed to offer community residential care referrals during most of fiscal years 2020 and 2021, inconsistent with VHA requirements. It is important to note that the OIG did not identify any adverse clinical outcomes due to the patients' delayed access to residential care.

In March 2020, due to the pandemic, facility leaders restricted access to the Dallas DOM SUD to local veterans, in accordance with VHA guidance. The Dallas DOM SUD subsequently reopened to a broader group of patients but still with reduced capacity in September 2020. The Bonham DOM SUD remained open during the pandemic at reduced capacity until January 2022, when admissions were halted until June 2022 due to COVID–19 concerns. VHA data indicated that the Dallas and Bonham DOM SUDs' average wait time was 30 days or greater from the third quarter of fiscal year 2020 through the second quarter of fiscal year 2021, likely due to pandemic-related restrictions.

Of the 10 North Texas patients' records the OIG reviewed, five had one DOM SUD consult placed and the other five had two consults placed during the review period, resulting in a total of 15 consults examined. Of the 15 consults, 13 were referrals to the Bonham DOM SUD and two were referrals to the Dallas DOM SUD. Seven consults were closed when the patient was admitted within 30 days, declined screening, or was not approved for admission. Among the eight remaining consults, two were closed when the patients declined admission and six resulted in patients waiting an average of 79 days before VA North Texas staff offered DOM SUD admission or removed the patient from the pending bed placement list. For seven of the eight consults, staff documented that the "anticipated admission date exceeds 30 days; however, there is no available alternative to consider at this time."

The OIG determined that the VA North Texas chief for Patient Administration Services, who oversees community care, misinterpreted community care guidance and provided inaccurate information to VA North Texas leaders and staff. Specifically, the Office of Community Care's guidance states that community care wait time standards were not applicable to MH RRTP. Facility staff should have instead followed VHA policy requiring a patient with a schedule wait time of greater than 30 days be offered alternative residential treatment or another level of care. Alternative residential treatment could include a referral to a community program, another program in the VISN, or another program in another VISN.[8]

However, the Patient Administration Services chief told the OIG team during the review that MH RRTPs are "excluded from the MISSION Act" and not eligible for

[5] MISSION Act, Pub. L. No. 115–182, 132 Stat. 1393 (2018).

[6] VHA Office of Community Care, "Field Guidebook: Specialty Programs," updated November 3, 2021. The Office of Community Care determines a patient eligible for community mental health care when the wait time is greater than 20 days or the drive time is greater than 30 minutes for a VHA outpatient mental health appointment.

[7] VHA Assistant Under Secretary for Health for Clinical Services memorandum, "Ensuring Access to Residential Treatment for Veterans with Mental Health and Substance Use Disorders during the Pandemic," February 11, 2021.

[8] VHA Directive 1162.02.

community care based on access standards—reflecting an inaccurate understanding of the Act. In contrast, the national director of the MH RRTP reported that although drive time and wait time standards do not apply to DOM SUDs, community care referrals are expected when a patient is determined to require a residential level of care and VHA is unable to provide treatment within the required timeframe.

In September 2020, the MH RRTP national program office released guidance that included instructions for community care referrals. In February 2021, VHA provided guidance that VISN chief mental health officers and facility leaders must ensure that patients who require a residential level of care are offered a VA MH RRTP bed or community residential care. VHA further required that each facility provide the operational status of MH RRTP beds and "information on the availability of community based residential treatment options."[9] VISN 17's response to the February 2021 guidance indicated that the Dallas and Bonham DOM SUDs were not making community residential care referrals.

In December 2021, the OIG informed VISN 17 and VA North Texas leaders of staff's failure to comply with community residential care referral expectations and requested corrective action be taken to address staff education and potential patient treatment needs. VA North Texas leaders communicated referral requirements to Office of Community Care and Mental Health Services staff and reviewed all community residential care consults placed from October 1, 2019, through November 30, 2021. Additionally, in response to the OIG's request, VA North Texas staff completed a clinical review to ensure appropriate follow-up for patients referred from October 1, 2019, through December 31, 2021, to the Dallas and Bonham DOM SUDs whose wait times were greater than 30 days.

The OIG made a total of five recommendations in this report.[10] The first recommendation is for the VA North Texas director to ensure that staff provide alternative treatment options, including community care when MH RRTP admission wait times exceed 30 days. The second recommendation calls on the director to conduct a comprehensive review of the management of community residential care referrals. They concurred in principle with this recommendation. The remaining three recommendations are described below.

VA Central Texas Compliance

In contrast to the VA North Texas's failures, the OIG's review of two patients referred to the Temple DOM SUD by VA North Texas staff indicated the VA Central Texas staff placed consults and scheduled patients in accordance with VHA policy. Further, VA Central Texas developed procedures for community residential care referrals when MH RRTP wait times were greater than 30 days.

Inadequate VISN Oversight

The OIG determined that VISN 17 leaders did not ensure VA North Texas leaders' adherence to the national MH RRTP policy. According to the MH RRTP directive, each VISN mental health lead is responsible for ensuring that all VISN MH RRTPs collect data sufficient for oversight related to VHA policy implementation.[11] Additionally, the national director of the MH RRTP confirmed the VISN has oversight responsibility to ensure eligible patients have access to a residential level of care, although there are not defined expectations related to community care utilization monitoring. The VISN 17 chief mental health officer provided guidance to VA North Texas leaders on three occasions in 2021 regarding the use of community residential care. However, she reported that the VISN role did not have the authority to ensure policy adherence or "direct oversight" because "oversight is at the local facility management level." The third report recommendation is for the under secretary for health to make certain that VISN leaders provide adequate oversight to ensure that access to care for MH RRTPs is provided consistent with VHA policy.

Bonham MH RRTP Nonadherence with VHA Scheduling Requirements

During the inspection, the OIG team also identified that the Bonham MH RRTP standard operating procedure was inconsistent with VHA's minimum scheduling effort requirements, as it instructed schedulers to close a consult after three failed

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[9] VHA Assistant Under Secretary for Health for Clinical Services memorandum.

[10] The OIG considers all five recommendations currently open pending the submission of sufficient documentation that would support that adequate progress has been made on implementation to close them. The OIG requests updates on the status of all open recommendations every 90 days, which are then reflected on the recommendations dashboard found on the OIG website. For this report, the OIG will request the first update on or about May 1, 2023.

[11] VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, July 15, 2019.

scheduling contact attempts rather than the four required. Since 2016, VHA has required providers to document a request for other services in the referred patient's electronic health record. The second attempt must use a different method of contact and can be completed the same day as the first attempt, while the third and fourth attempts must be on different days. To allow the patient time to respond, staff must wait a minimum of 14 calendar days from the second contact attempt before determining the action on the consult request, such as closing the consult. Additionally, the Bonham MH RRTP staff were attempting to contact patients by phone and not using other modes of contact. Failure to adhere to VHA minimum scheduling requirements may hinder efficient patient scheduling and contribute to the barriers patients experience in accessing DOM SUD services. The fourth recommendation is for the VA North Texas director to ensure that Bonham MH RRTP scheduling procedures are consistent with VHA minimum scheduling effort requirements.

Mental Health Treatment Coordinator Assignment

Finally, the OIG found that VA North Texas policy did not include information about the requirement for MH RRTP staff to assign a mental health treatment coordinator for patients awaiting admission to a residential program. Since 2012, VHA has required facility staff to assign a mental health treatment coordinator to patients who are receiving treatment in an outpatient mental health setting, have been admitted to an inpatient mental health setting, or are "waiting to engage in a different level of care" including an MH RRTP bed. However, in an interview, the national director for the MH RRTP acknowledged not having an assignment process for patients pending MH RRTP admission. This failure to develop a national-level process likely contributed to the VA North Texas MH RRTP leaders' lack of knowledge that the VA North Texas policy should address the identification and assignment of a mental health treatment coordinator for accepted patients awaiting admission. This lack of policy awareness may not only contribute to a coordinator not being assigned but can also diminish the likelihood of patients' engagement in outpatient care while awaiting admission. The fifth report recommendation relates to strengthening coordinator assignment procedures for patients waiting for an MH RRTP bed.

OTHER OIG REPORTS CITING CONCERNS WITH COMMUNITY CARE COORDINATION OF VETERANS WITH COMPLEX MENTAL HEALTH NEEDS

Coordinating medical care between the VHA care system and community providers remains a challenge, particularly for managing patients with complex mental health needs. The OIG has identified persistent administrative and communication errors or failures among VHA, its third-party administrators, and community care providers, as well as between the care providers and their patients. These deficiencies challenge the considerable efforts of VHA personnel to ensure a seamless experience for veterans. Many OIG reports have described the frustrations and, most importantly, the risks associated with patients referred to the community. The following reports exemplify the consequences that poor care coordination contributes to for high-risk patients.

In a report on the deficiencies found in the care and administrative processes for a patient who died by suicide, the review team found that administrative errors and confusion in the Phoenix VA health care facility's community referral process delayed specialized psychological testing for a veteran. The veteran died by suicide never having received the appropriate testing and resulting targeted treatment.[12]

Another oversight report focused on a patient who ultimately died by suicide after not receiving several authorized community care counseling sessions. This was due to deficiencies in the coordination of the patient's care between the Memphis VA facility's community care staff, providers in the community, and the third-party administrator.[13] In addition, the patient suffered from hyperthyroidism, a condition that can aggravate anxiety. The patient declined a referral to endocrinology at the facility, due to the distance from home, but was never offered a referral to the community.

CONCLUSION

High-quality care demands that patients receive the necessary care provided by qualified clinicians in a timely manner. This is even more critical for individuals deemed to be at high risk due to their mental health and substance use conditions.

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[12] VA OIG, *Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System*, Arizona, March 31, 2021.

[13] VA OIG, *Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee, September 3, 2020*.

The pandemic disrupted healthcare delivery in all settings, including addiction treatment, yet at the same time increased the demand for such interventions. VHA will continue to rely on community providers to deliver care when a veteran's needs cannot be met within VA's own facilities. The reports highlighted in this testimony call attention to the risks introduced when that care is not offered and even more concerning, when the care is not coordinated.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, this concludes my statement. I would be happy to answer any questions you may have.

Prepared Statement of Daniel Elkins

Testimony of Daniel Elkins

Chief of Staff

The Independence Fund

House Committee on Veterans Affairs

Subcommittee on Health Hearing

"Combatting a Crisis: Providing Veterans Access to Life-saving Substance Abuse Disorder Treatment"

April 18, 2023

Daniel Elkins

Mr. Elkins is the Chief of Staff at The Independence Fund (TIF), the leading Veteran Service Organization in helping America's most severely wounded Veterans. TIF serves the Warfighter Community by providing innovative programs and services to support the physical, mental, emotional, and spiritual independence and dignity of our Service Members, Veterans, Caregivers, Families, and Service Allies. Mr. Elkins works directly with TIF CEO, Sarah Verardo, to ensure the Fund's mission success, tracking completion of objectives, as well as coaching and motivating staff in order to elevate overall productivity.

Mr. Elkins is a subject matter expert on Special Operations, national security, covert and clandestine capabilities, military transition, preservation of the force and family, the National Guard, suicide prevention, military and veteran healthcare, student veterans, the Post-9/11 G.I. Bill, Federal Tuition Assistance, and for-profit and nonprofit education policy. Mr. Elkins maintains strong relationships with the White House, multiple Veteran Service Organizations, Congress, and the Departments of Defense, Education, and Veterans Affairs. These key relationships often place him at the forefront of policy decisions that impact members of the Special Operations community.

Mr. Elkins is also a currently serving Green Beret in the National Guard and proud recipient of multiple military awards and decorations, including the Combat Infantryman Badge, Parachutist Badge, Special Forces Tab, Military Free Fall Parachute Badge, and the Afghanistan Campaign Medal with Campaign Star.

Prior to serving with TIF, Mr. Elkins founded the Special Operations Association of America (SOAA), the only Veterans Service Organization in Washington D.C that engages in policy and legislation advocacy on behalf of all of the men and women in the Special Operations community and their families. In his role at SOAA, Mr. Elkins frequently engaged Congress, the White House, the Department of Defense, the Department of Veterans Affairs, and other key stakeholders in the Administration on behalf of the Special Operations Forces (SOF) community.

Before SOAA, Mr. Elkins had served as the Executive Director for the Veterans Education Project (VEP) where he directed nationwide grassroots outreach to ensure the protection of military benefits. He was also responsible for monitoring all legislative activities on Capitol Hill, with a focus on oversight and implementation of policy. His day-to-day responsibilities included developing new relationships with key stakeholders on Capitol Hill, maintaining relationships with the Administration, and serving as an expert witness to both congressional and federal offices.

Mr. Elkins serves as a board member for Equinox Innovative Systems, a company specializing in the integration of drone technology into Special Operation Forces for low intensity conflict. Furthermore, he retains positions on the boards of both SOAA and VEP where he serves as the president of the board. Prior to working as an advocate for Veterans and serving in the military, Mr. Elkins spent five years working overseas with nonprofit organizations to solve complex issues related to human trafficking across South America, Sub-Saharan Africa, Europe, and the Middle East.

Mr. Elkins is a proud life member of the Special Forces Association, the Enlisted Association of the National Guard of the United States, and Veterans of Foreign Wars. Mr. Elkins is originally from Western Maryland, and primarily splits his time between Charlotte, NC, and Washington, DC.

Dear Chairwoman Meeks, Ranking Member Brownley, and Members of the Subcommittee:

On behalf of Sarah Verardo, CEO of The Independence Fund, we would like to thank the Subcommittee for your kind invitation to provide testimony at today's hearing, "Combatting a Crisis: Providing Veterans Access to Life-saving Substance Abuse Disorder Treatment." My name is Daniel Elkins and I joined TIF, the leading Veteran Service Organization (VSO) in helping America's most severely wounded Veterans as the Chief of Staff in 2022. I also currently serve as a Green Beret in the National Guard. For over a decade I have fought on behalf of the Warfighter Community to support the physical, mental, emotional, and spiritual independence and dignity of our Service Members, Veterans, Caregivers, Families, and Service Allies through Advocacy. I am also a Veteran of Operation Freedom's Sentinel. As a result of my many years of Advocacy within the Military and Veteran Community, I maintain strong relationships with the key leaders from the White House, multiple Veteran Service Organizations (VSOs), Congress, and the Departments of Defense, Education, and Veterans Affairs and am a Subject Matter Expert on a wide array of issues including military and veteran healthcare and suicide prevention. Prior to my tenure with TIF, I founded the Special Operations Association of America (SOAA) and Veterans Education Project (VEP) helping the Special Operations community and their families and Veterans with their higher education goals. As a combat Veteran, I have experienced firsthand the transformative and vital role the VA plays in healing the seen and unseen wounds of war. It is through this testimony that I would like to share our perspective, experiences and recommendations to ensure the often touted "worldclass healthcare" of the Department of Veterans Affairs (VA) is caring for our most vulnerable and at-risk Veterans.

TIF has been, and is, intimately involved advocating for and advising Veterans across the Nation when they encounter difficulties accessing appropriate care for mental health (MH) treatment and substance abuse disorder (SUD) and seek our counsel and intervention with the VA. This hearing could not be timelier because our Casework staff have received a significant number of inquiries from Veterans in the past two years that involve obstacles to timely and clinically appropriate care for their MH conditions. The geographic dispersion and similar factors present in many of these cases lead us to surmise these cases are not merely anecdotal rather they may be indicators of a more widespread access to care and care coordination problem for MH within the Veterans Health Administration's (VHA) hospital network.

TIF was founded in the halls of Walter Reed National Military Medical Center to provide greater mobility and independence for severely wounded and injured military personnel returning from Iraq and Afghanistan. We began by providing motorized all-terrain wheelchairs, fitted with treads, to Veterans for easier movement across everyday wheelchair barriers, like a playground or the backyard, and to also give disabled Veterans a chance to get back to the unpaved outdoors, whether it be the beach, the woods, or mountain trails. We just ordered our 2,640th chair this month, representing more than 42 million dollars alone for track chairs to America's severely disabled Veterans. We have also been centrally involved in the evolution of the Caregiver program because our CEO, Sarah Verardo, is the wife and caregiver to Sergeant Michael Verardo, U.S. Army (Retired). Michael was catastrophically wounded in Afghanistan by an IED blast, his left leg and left arm were severely injured, and he suffered burns, complex polytrauma, traumatic brain injuries, and a host of other wounds. Michael is alive today because of the great care he received from the Army and the care he continues to receive from VA.

As a result of Michael Verardo's experiences and those of his fellow soldiers from the 82nd Airborne Division, many of whom returned from multiple deployments with invisible wounds like Traumatic Brain Injury and Post Traumatic Stress, TIF has been sharply focused on MH and suicide prevention. The need for peer-to-peer engagement and compassionate care led to the establishment "Operation Resiliency," a multi-day event where combat units are reunited under the formation they deployed under for fellowship and candid discussions concerning their MH. We conduct these reunions with the support of VA MH professionals.

Our Casework team, based in Charlotte, North Carolina, is led by a Licensed Clinical Social Worker who is an Air Force Veteran with prior service in Afghanistan. Her team focuses on the individual Veteran at the center of each unique case, conducts due diligence on the case, and acts as a liaison to VA and Community providers. This quick-response care model assists Veterans, Caregivers, and their families in finding solutions to issues that are beyond their ability, knowledge, or experience to solve on their own at the local level. TIF provides assistance in the areas of service-connected benefits, VA medical eligibility, Caregiver assistance, upgrading discharge status, Community resources, medical referrals to Community providers, Vocational Rehabilitation, unresolved medical issues, access to medical care, and legal resources. Our team of professionals frequently provides case management services to support and aid individuals in navigating the complexities of VA policy and regulations while routinely interacting with VA leaders and employees in medical facilities and program offices to develop and cultivate strong community relationships and ensure the right resources are available for a Veteran's care in a timely manner. The team fields calls daily from Veterans across the Nation seeking advice and aid with problems or impediments they are experiencing with access to VA care relative to a MH diagnosis or an emergent MH concern, substance use, traumatic brain injury, and suicidal ideation.

Casework Observations on Residential MH Care Access Related to SUD:

In the past 2 years, our Casework team records indicates we received 1,304 cases for action with 110 of those, or 11.8%, stemming from a problem a Veteran was experiencing seeking timely access to complex MH care from VA through Intensive Outpatient care or Residential Inpatient care and requesting help from our Casework team to obtain a resolution that involved either VA-based care and/or a referral from VA to Community-based care. Fifty-nine of those 110, or 53%, were Veterans with SUD. Twenty-one of those 59 have been recorded since January of this year. It is important to note that MH cases and SUD cases specifically consume the vast majority of our Casework team's time and energy due to the sometimes-fragile condition of these Veterans, and difficulties they have comprehending the intricacies of VA regulations and processes. These 59 cases spanned 26 states and involved 29 VA medical facilities.

The casework narratives for these cases frequently depict, to varying degrees, multiple laudatory and concerning aspects with local VA facility responsiveness to Veterans' needs and conditions. In many cases the Veteran has taken what is for them a major step by voluntarily asking for care in a structured setting or program. When they are met with a sense of urgency and responsiveness that can make a significant difference in how they respond to treatment, but when they experience a lack of empathy and an inability to listen from VA employees, or a lack of clarity and consistency regarding the care process, a Veteran's trust in VA can decline rapidly. That is often when our Casework team is contacted by a Veteran, while they are seeking admittance to a VA facility or a program or soon after they are admitted, and they begin to feel unheard or receive contradictory direction and expectations from VA clinical staff. Our Caseworkers understand there are often many sides to how human interactions are perceived, so they tread carefully and try to understand all sides.

Until October 2022 our Caseworkers operated under the assumption VA's MH care in a residential/domiciliary setting - which includes SUD treatment - in what VA calls MH RRTP or the MH Residential Rehabilitation Treatment Program, was covered by the access standard authorities in the 2018 MISSION Act for travel distance and wait times. It was only by accident that our caseworkers discovered this law does not apply to MH RRTP access standards and practices. A copy of the MH RRTP policy was sent to us by a senior clinician at a facility that could not provide care to a Veteran and that facility had denied a referral to an approved and willing Community Care provider.

This VHA Directive #1162 requires that VA admit a Veteran seeking inpatient, residential care within 72 hours for priority patients and no more than 30 days after a VA assessment of any patient needing residential care. Based on our experience, it is not unusual for Veterans to wait beyond 72 hours or 30 days for care and it has been our observation that even after those limits are exceeded, a facility has the latitude to continue to seek an available bed in another MH RRTP facility,

sometimes several states distant, rather than approve a referral to a Community provider with those services in the Community Care Network (CCN).

In some interactions with VA administrators at local facilities, our Casework team has found that the primary care provider for the Veteran, a VA physician, has approved a referral to a CCN provider, but that referral is overruled by administrative or senior clinical staff. There have also been some cases where our caseworkers were told by an administrator that Community Care is not offered for residential MH treatment and other interactions where the VA administrative staff do not understand Community Care is a lawful option and are unfamiliar with how a referral is generated. In certain circumstances VA staff have not discussed CCN care options with a Veteran without prompting or until a caseworker inquires of a VA administrator or patient advocate.

It is important to emphasize that the VA healthcare system is often complex and confusing to many Veterans who do not understand their care options or their rights. Our caseworkers work diligently to educate them in real-time and advocate for appropriate and timely care, regardless of whether that care is to be provided by VA or a CCN provider. Given the staffing and capacity limitations in MH RRTP, it is not unusual for our caseworkers to attempt to identify an available and qualified CCN provider that can render necessary care in order to avoid the Veteran waiting beyond the limits of the MH RRTP policy or to request a referral before those limits are reached, if the Veteran is in crisis and the VA facility concedes it hasn't found an available bed for the Veteran.

Another key concern with the MH RRTP policy of 73 hours and 30 days is the difficulties our caseworkers have encountered determining when the "clock starts" for those prescribed time limits and who in each facility is designated to monitor the elapse of time relative to the policy and ensure the process is being adhered to by VA clinical and administrative staff. This opacity has often lead to frustration and distrust. In one instance of delayed and poorly coordinated care, it was discovered that the VA staffer responsible for entering patient communications with RRTP staff into the electronic record had not done so, leaving significant gaps. Consequently, when our casework staffer attempted to reference those communications there was no way to reference them to help reach an informed and timely resolution of the case.

Casework Narratives:

The following casework narratives are provided for a more detailed understanding of what our caseworkers encountered with a range of SUD, MH RRTP cases and how the cases were managed. Some were resolved within days, others in weeks or months, and some remain unresolved:

Case #1: OIF Combat Veteran, PTSD/SUD, Maine; October 2021 (RESOLVED)

History: Veteran needed dual treatment, detox, and experienced suicidal ideations. Veteran had to leave a facility in Florida due to reports of abuse (to date, Caseworker received three reports of abuse from different Veterans). Veteran is from Maine, used heroin, history of six overdoses, suicidal ideations, and chronic pain. Veteran contacted Caseworker and asked for support leaving the facility on Thursday evening.

Case Coordination: Caseworker reached out to VHA staff and left a message. Veteran became dangerous to himself during detox. Veteran wanted treatment and Maine VA stated they could not provide referral in the VHA network within 60 days.

Resolution: Caseworker discussed the case with Provider and Community Care authorization was issued to support the Veteran's continued treatment.

Duration of Case: six days to resolution.

Case # 2: OEF Combat Veteran, SUD, Houston, TX; January 2022 (RESOLVED)

History: Veteran sought MH therapy at the Debakey Clinic for post-traumatic stress disorder (PTSD) related to combat experiences in January 2022. Veteran was told he could only receive an appointment for April 2022.

Case Coordination: Caseworker reached out to provider team and was told that Veteran was indeed eligible for Community Care for local services. Scheduler subsequently reached out to the Veteran and said he could stay in the VA system if he wanted services. Caseworker reached out to the Patient Advocate, and the Patient Advocate stated that this was a huge oversight and that the Community Care team dropped the ball and could not believe he was getting issued referrals, only to have them stopped twice by Community Care staff. Caseworker called the Community Care department and discussed Veteran's need to see a provider. Community Care scheduler called Veteran and finally scheduled appointment only after MH Provider had to place another referral in the system.

1. Miscommunication on Veteran's need for therapy; had a referral to Community Care canceled twice while Veteran had over three-month wait to receive inside VHA services.
2. Lack of accountability with Houston/ Debakey staff meant that Veteran's case continuously was being dropped, referral was canceled, and no communication was made on behalf of VHA to explain to Veteran.

Duration of Case: took four weeks to receive Community Care after schedulers initially refused to offer Community Care.

Case #3: OEF Combat Veteran, PTSD/SUD, February 2022 (RESOLVED)

History: Veteran needed dual treatment, detox, and was unable to work or support family financially or physically as he was continuously intoxicated and making poor choices. MH

condition escalated to the point of considering ending his life. The Veteran was previously involved in Operation Resiliency. Reached out to Casework to ask for support getting access to treatment quickly after driving to children's school and falling asleep intoxicated.
Case Coordination: Caseworker reached out to VA Patient Advocate and discussed the previous attempts of the Veteran to stabilize with therapy and medication. VHA staff agreed that a dual diagnosis facility would be the best option and considered Veteran's preference in the request.
Resolution: VHA issued Community Care referral and Veteran was admitted in less than a week.
Duration of Case: seven days to resolution.

Case #4: Post 9-11 Veteran, SUD, Mountain Home, TN; March 2022 (UNRESOLVED)

History: March 2022 Veteran requested Community Care for inpatient MH treatment as he frequently drank to the point of blacking out and went through the evaluation process to assess SUD at VA. Veteran was told to wait 45 days until May 2022 for appointment.
Case Coordination: Caseworker called and spoke to SUD MH team and scheduled and advocated for Community Care.
Duration of Case: No resolution. Veteran dropped Casework services due to relapse and inability to get into MH services.

Case #5: Post 9-11 Veteran, SUD, Mountain Home, TN; May 2022 (UNRESOLVED, INCARCERATED)

History: May 2022 Veteran was denied inpatient SUD support after VHA stated he should receive VA care. Admission date was two months away and Veteran presented in a dangerous cycle of blacking out, PTSD, and using methamphetamines.
Case Coordination: Casework attempted to advocate with local recovery coordinators (LRC). LRCs denied ability to admit sooner and denied the possibility of Community Care services.
Resolution: No resolution. Veteran ended up in jail for possession after two weeks of asking for inpatient Community Care referral.
Duration of Case: No resolution.

Case #6: OEF/OIF Combat Veteran, PTSD/SUD, Texas and New York; July 2022 (RESOLVED)

History: Veteran needed dual treatment, detox and experienced suicidal ideations. Family and friends took him to a VA community partner, concerned that without immediate intervention the Veteran would succeed in ending his life.
Case Coordination: Veteran was from NY, stayed with family in TX as he struggled to overcome his suicidal ideations associated with PTSD triggers and depression with SUD withdrawal. The family contacted Caseworker and asked for insight; stated over the weekend Veteran became dangerous to himself. Family consulted a Community Care partner and asked if they would have

a bed available; they did. Veteran was admitted. The family stated that insurance would still charge $6,000 co-pay. Asked Caseworker for support with any VHA coverage.
Resolution: Caseworker reached out to the provider at NY VAMC. VHA Primary Care Physician (PCP) reported that she would do everything to assist Veteran and was very supportive of dual diagnosis program based on Veteran's history. PCP initiated referral and authorization, and Veteran was supported financially throughout his treatment.
Duration of Case: three days to resolution.

Case #4: OEF/OIF Combat Veteran, PTSD/SUD, Salisbury, NC; July 2022

History: Veteran needed dual treatment, detox, and was incarcerated due to drug use and destructive behavior.
Case Coordination: Veteran was from NC, struggled with SUD. Veteran contacted Caseworker wanted assistance with seeking support related to his PTSD and SUD. Stated he experienced anger issues and couldn't control it without help.
Resolution: Caseworker reached out to Salisbury VAMC MH team who promptly issued a Community Care referral observing his needs for dual diagnosis.
Duration of Case: five days to resolution.

Case #5: OEF Combat Veteran, PTSD/ SUD/MST; July 2022

History: Veteran needed support for combat PTSD and SUD use of heavy narcotics and fentanyl. Veteran reported blacking out, overdosed numerous times, and knew he was "going to die" if he kept using.
Case Coordination: TIF partner contacted the team and put Caseworker in touch with Veteran. Veteran badly wanted help but reported that he could only stay sober in the mornings. Veteran reported that military sexual trauma (MST) had never been discussed with his VHA MH team, but he had been gang raped by male Veterans on his squad. Caseworker reached out to Social Worker at VHA. Discussed the MST and concern for Veteran reporting feeling unsafe around male Veterans.
Resolution: Social Worker worked quickly to obtain Community Care referral. Veteran was able to receive treatment in a safe environment and is now a leader in peer support.
Duration of Case: ten days to resolution.

Case #6: Post 9-11 Veteran, PTSD/SUD, Togus, ME, July 2022 (RESOLVED by 3rd Party)

History: Single-amputee combat, Army Veteran who received his amputation after service due to an infection incurred by service and, in his own words, "ignored" by Military doctors.
Case Coordination: Casework originally began working with him in June 2021 with other familial support. Recently reached out on July 2022, asking for help to obtain residential treatment for alcohol substance use and combat PTSD. Veteran has been under the care of a VA Psychiatrist and MH counselor at the Togus, ME VAMC but had only recently admitted that his challenges

were significant enough to seek treatment in a residential setting. Presented to caseworker identifying that his psychiatrist was supportive and recognized his need for a higher level of care. The psychiatrist placed the referral for inpatient help through the national nonprofit Warriors Heart; however, it was denied by Community Care leadership. This triggered a complex and evolving call to advocacy on his behalf.

1. **An Extended Delay:** Since Veteran contacted us in July, Veteran and TIF Casework have worked to advocate for support for SUD and PTSD residential support. At almost 90-days since the request, Veteran was told he could not receive Care through a Community partner, but had to seek VA care first. When he elected to seek care in a VA facility, he was told he could not get approved for a facility in Sarasota, FL, close to his family.
2. **Stress on the Veteran:** Veteran attempted suicide in September due to inaccessibility to treatment and support. He prepared a noose and ingested large volumes of alcohol preparing to hang himself, his wife walked in on him during the attempt.
3. **Failure to Care:** Veteran was discharged from VA after a 72 hour hold without a follow-up treatment plan.
4. **Policy Conflicts:** Contact has been sporadic with Togus VAMC staff, and the goal posts continued to move. Even with the combined Advocacy of TIF, Rep. Jared Golden's (D-ME) office, and the VA Central Office, there was no resolution. Togus VAMC's leadership challenged the MISSION Act, stating that Community Care is not warranted unless the Veteran completes VA first and fails out of it. They further asserted that residential treatment did not fall within the MISSION Act rather fell under different criteria specified in the VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook Specialty Programs.
5. **Care Implementation Timeline:** VA leadership at Togus VAMC asserted that Veteran should seek VA Care first- but when pressed, has no known timeline of when a VA bed could be available.
6. **Communication / Documentation Errors:** VA leadership stated that when Veteran requested Care through Sarasota, it was never documented in the system and was never mentioned internally as a discussion for options for Veteran's treatment.

Resolution: Veteran received financial support from a nonprofit partner paying for his admission at Warriors Heart in October 2022.
Duration of Case: three months to resolution.

Cases # 7 & # 8:

Veteran One, OEF/OIF Combat Veteran PTSD/SUD (Alcohol), St. Cloud, MN; August 2022 (RESOLVED)

Veteran Two, OEF Combat Veteran PTSD/ SUD (Heroin); St. Cloud, MN; August 2022 (UNRESOLVED)

History: Both cases presented as referred to TIF on August 2022, before Labor Day weekend, by a Community Care partner. Veterans one and two were staying in a non-VA, community sober living facility where a friend and fellow Veteran recently died by suicide. They reported finding him after the deceased Veteran asked for help multiple times, having disclosed to them that he was in an intimate relationship with the facility director and it had become abusive. Veterans one and two reported feeling unsafe remaining at the community facility under the present circumstances, but had no place to live otherwise. Both Veterans stated their safety and well-being concerns to St. Cloud VAMC Staff. They were advised by VA staff that they would have to wait through the Labor Day weekend to receive a VA assessment for care and were advised to go to an Urgent Care outlet for any immediate health concerns. Veteran two subsequently left the community facility on a weekend pass and used heroin. Veteran one was assessed by VA on 8/31/2022 and Veteran two was assessed by VA on 9/1/2022. Veteran two reported that he felt the urge to use heroin again and was having memories of the corpses he had retrieved in Iraq. Veteran one was experiencing reported panic attacks.

Case Coordination: TIF Caseworker contacted VAMC Director prior to the Labor Day weekend and requested an expedited referral to Community Care via #1162, under a criterion of unsafe living conditions (which allows 72 hours to treat veterans per the Directive) and given that a VA Community Care partner with qualified and parallel programming was willing to admit both Veterans immediately. Facility director stated to Caseworker there was no provision for Community Care in those circumstances within St. Cloud VA System.

Resolution: Veteran one was admitted to St. Cloud VAMC on 9/6/2022; delay for VA care did not exceed the post-screening, 72-hour limit as stipulated in #1162. Veteran two relapsed and lost contact with VA and local casework partners. Veteran one and Veteran two reported to TIF they felt they were being "forced" to accept VA care and were told by VA staff that Community Care options were not something their local VA considers when referring for MH and addiction treatment.

Additional Information: Dr. Nichole Welle, Director of CBOC issued the following authority on St. Cloud's willingness/ ability to provide MH community services:

> "Veteran and I discussed the limitations for VHA Care in the Community (CITC) covering the cost of MH residential programs in the community. Minneapolis VAHCS CITC leadership clarified that VHA does not fund MH residential programming outside the VHA system when VHA provides the service."

Case # 9: OIF Combat Veteran, PTSD/SUD, East Orange, NJ: September 2022 (RESOLVED)

History: Veteran needed support for combat PTSD and SUD use of heavy narcotics and fentanyl. Veteran was engaging in high-risk behavior as a cry for help.

Case Coordination: Casework partner contacted the TIF team to discuss Veteran's case. Veteran was hospitalized for OD and nearly died. Upon discharge home, Veteran's parents told him to "go f*cking die" and set the Veteran off again. Veteran went missing for 24 hours. TIF Casework staff notified VHA staff and discussed the case. Veteran called into Casework two days later and asked for help. VHA staff worked quickly to support a Community Care referral to dual facility in TX. The veteran was admitted two days later after discussion with Caseworker and VHA staff.

Duration of Case: five days to resolution.

Case # 10: OEF Veteran, SUD, Portland, OR; September, 2022 (RESOLVED)

History: Veteran was, at the time of contact with TIF, homeless, in need of inpatient treatment and receiving care through the Portland VAMC. The Veteran was sent to detox by Portland VAMC, but was told he did not have priority to receive authorization for residential substance abuse treatment, which is typically provided immediately following detox to eliminate possibility for a relapse. Veteran disclosed to TIF he was discharged on 9/12/2022 from detox and had already used drugs since then while calling the Portland VAMC multiple times to request treatment; Veteran's SUD was service-connected.

Case Coordination: On 9/16/2022 TIF Caseworker and Veteran had a conference call with an employee at the Portland VAMC-Substance Abuse Department. VA employee shared that Veteran's appointments were on 11/3/2022 and 11/23/2022 for the initial Substance Abuse Evaluation. Veteran expressed his need for earlier appointments. Caseworker asked the VA employee if there were cancellations to allow an earlier date or dates. VA employee shared that there are rarely cancellations and that most individuals didn't show up with any notice. Veteran and TIF Caseworker inquired about the Community Care program as an option. The VA employee stated that "substance abuse does not qualify for the care in the Care in Community program and recommended the Veteran call VA MHMH RRTP - Vancouver, WA. Veteran said he had done so and MH RRTP did not have an opening until January 2023. The VA employee said there was nothing else she could do to assist the Veteran prior to his appointments in November 2022.

Resolution: Portland VAMC initially provided a wait time of four months for this Veteran to be admitted into a residential program and Portland VAMC staff stated Community Care was not an option at their location. This Veteran was homeless and at higher risk which should have initiated a priority request for care within 72 hours, per the VHA regulation. After TIF contacted the VA MH RRTP Program director, the Veteran was admitted within seven days, but still outside of the 72-hour limit stipulated in #1162.

Additional Information: While conducting Casework, Advocacy and Research to assist one of the Veterans cited above, The Independence Fund was provided a VA policy excerpt by a VAMC

employee that explains the referral process to a Community Care provider for inpatient MH treatment.

The policy states, in part:

> "By national policy, MH RRTPs are Veterans Integrated Service Network (VISN) resources. VISNs should ensure adequate access to MH RRTP care across the VISN. When the care cannot be provided by a MH RRTP, and the Veteran meets the eligibility standards for MH RRTP care and elects to receive COMMUNITY CARE, VA will authorize that care to be provided by a community provider with whom VA has contract for the provision of the necessary services."
>
> Further specifics in the policy are as follows:
>
> "When can a Veteran be referred to COMMUNITY CARE:
>
> - A Veteran who meets criteria for a priority admission (within 72 hours) that cannot be accommodated by a MH RRTP. Referrals to an alternate MH RRTP should be exhausted before a community referral.
> - A Veteran who must wait greater than 30 days for admission to a MH RRTP. Referrals to an alternate MH RRTP should be exhausted before a community referral.
>
> General requirements for MH RRTP/Community Residential Care referrals:
>
> - Veteran is assessed as not meeting criteria for acute psychiatric or medical condition(s).
> - Veteran has attempted a less restrictive treatment alternative, or one was unavailable.
> - Veteran is assessed as requiring the structure and support of a residential treatment environment.
> - Veteran is assessed as not being a significant risk of harm to self or others.
>
> Wait time and drive time access standards are only applicable to primary care, specialty care, and non-institutional extended care services. MH RRTP services are considered institutional extended care services and therefore these standards are not factors that require consideration for a community referral."

Case # 11: Post 9-11 Veteran, SUD, Columbia, SC; September 2022 (UNRESOLVED)

History: September 2022 Veteran has attended VA directed MH RTTP four times and Intensive Outpatient Program (IOP) seven times. VA Chief of Substance Abuse clinic refused to offer community services citing that there were VA options with beds available to Veteran. The Veteran was not considered in previous attempts to attend VA care. Veteran is still unserved after six months. The Veteran completed MH RRTP and believed it did not help through the VA and wanted to explore other options.

Case Coordination: Caseworker reached out to clarify the Veteran's interest in Community Care options and the VA Chief stated that there were four VA systems the Veteran could use. Veteran reported that those programs did not help him as evidenced by his inability to stay sober. Veteran refused to attend VHA care again and Chief of MH at Columbia VAMC, Dr. Brian Apple refused to offer Community Care referral. Dr. Apple was adamant he would not consider it as indicated below:

- "He has received outpatient care with the VA in the past. We can offer this service again, including Suboxone. We can refer him to a Methadone Clinic if he desires that service on an outpatient basis.
- The VA has an inpatient program we can send him to. He can pay for other services outside the VA if he wants, but we need to try the Residential programs within the VA first.
- He was approved for admission to the Salisbury VA, but they could not contact him in March of this year (he was incarcerated). We can place a consult there again.
- We can also place consults to Asheville, Atlanta, Dublin, and Augusta. Previous inpatient treatment in the VA was found in his records. There is no indication he was not successful.
- He was in the Buffalo VA RRTP in 2020; he was in the Asheville VA RRTP in 2019; he was in the Salisbury VA RRTP in 2013 and 2014.

Resolution: No resolution.

Case # 12: OIF Combat Veteran, PTSD/SUD, Columbia, MO; October 2022

History: Veteran needed support for combat PTSD and IOP program. Veteran attempted to get IOP through VA, but the nearest in person program was 2.5 hours away in another state. Veteran completed MH RRTP and needed to follow up with IOP services to remain successful.
Case Coordination: The Veteran called Caseworker and requested support to navigate and get IOP. Caseworker called Social Worker at VHA and Social Worker agreed based on PTSD related presentation, Veteran would be better in an in-person IOP.
Resolution: Referral was issued shortly after discussion with Social Worker.
Duration of Case: three days to resolution.

Case # 13: OIF Combat Veteran, PTSD/ SUD, East Orange, NJ; October 2022 (RESOLVED)

History: Veteran needed support for combat PTSD and SUD use of methamphetamines. Veteran was in trouble after passing out with meth on person within a vicinity of school zone. Veteran needed assistance getting into treatment facility but was told he would have to wait over thirty-days locally or travel out of state.
Case Coordination: Veteran reached out to Caseworker for legal support and was also connected with Veterans Justice Initiative (VJI), a TIF Program that works with law enforcement to avoid

the unnecessary criminalization of mental illness, substance abuse, and incarceration of veterans. An advocate from VJI was able to discuss Veteran receiving treatment in lieu of incarceration as there was no intention to distribute.
Resolution: Casework team reached out to VHA staff and discussed treatment options to ensure probation was facilitated. The Veteran was connected with a referral for Community Care in the local community which allowed him to adhere to restrictions issued in court by the magistrate.
Duration of Case: nine days to resolution.

Case # 14: Post 9-11 Veteran, SUD, St. Louis, MO; October 2022 (RESOLVED)

History: Veteran requested MH services and was denied access to care within 30 days. Casework staff subsequently reached out and assisted Veteran in obtaining Community Care services within the month.
Case Coordination: VHA staff stated it could take over 30 days to receive MH RRTP services. Nationally recognized CCN provider offered specific dual diagnosis resources within thirty minutes of Veteran's home, other VHA options would take Veteran hours away. Lack of urgency to provide a referral to Veteran even though screened as needing MH RRTP support.
Resolution: Veteran was able to obtain referral after discussing the urgency and severity of struggle with symptoms and after conference with VHA MH staff and Caseworker.

Case # 15: Gulf War Era Veteran, SUD, Dallas, TX; October 2022 (UNRESOLVED)

History: Veteran was sexually assaulted by male counterparts in service. He was using heroin, fentanyl, and drinking to escape the memories of his trauma. Wife threatened to leave him if he didn't stop using. The Veteran reported if he didn't get help soon he was going to likely "die" and "destroy" his life. Numerous attempts to contact the MH staff and ask for support, but the VHA wanted him to travel a minimum of four hours to Dallas to receive services. Veteran had been to treatment twice within VHA before and requested a Community Care referral.
Case Coordination: Caseworker and Veteran reached out to VHA staff regarding Veteran's need for support. Both Veteran and his Peer support person reported the Chief of MH, screamed at him, and stated Community Care was not an option she would consider. Chief of MH never responded to Caseworker's emails or telephone messages asking for support.
Veteran reported that the Chief of MH called him again and told him if he denied VHA care, he was declining care. Veteran responded he could not travel and did not want to be around other Veterans due to the culmination of his experiences (Veteran has complex sexual trauma). Veteran reported he was not being considered at all in his own treatment.
Resolution: No resolution.

Need for New or Revised Regulations and Policy for SUD and Mental Health Access to Care and COMPACT Act:

Based on past and ongoing casework interventions TIF has undertaken on behalf of Veterans with SUD and other MH needs and our Casework team's interaction with VHA administrators and clinicians, there appears to be a lack of uniformity, consistency, and adherence to VHA Directive #1162 across several VHA facilities in different VISN regions. The administrative barriers and impediments to receiving timely care within an MH RRTP or a timely referral to a CCN provider with the same services are incongruent with trauma-informed care and unaligned with the intent of the MISSION Act's "best medical interest" proviso. The following recommendations are provided in an effort to revise and align #1162 with the MISSION Act and ensure the processes and procedures for access to care are focused first and foremost on the Veteran who is seeking that care within the original spirit and intent of the MISSION Act:

1. Include all criteria for Community Care wait time, travel distance, and access standards under MISSION Act in #1162 to govern residential rehabilitation programs or eliminate #1162 entirely and defer to MISSION Act's original authorities and intent to support all levels of VHA provided specialty care, including residential rehabilitation services.

    a) Mandate patient assessments be conducted within a uniform window of time after care is first requested by the Veteran or his/her primary care provider. Require no more than 72 hours to conduct that assessment.

    b) Reduce the maximum wait time for access to a facility. Thirty days is too long to ask a Veteran to wait on the availability of MH RRTP or residential Community Care. In a thirty-day period, risk can rise and a Veteran's condition destabilize. Recommend a clinically sound, lesser number of days because PTSD and SUD require swift interventions and services.

2. Rescind any formal or informal VHA guidance or directives that require a Veteran to complete a program in an MH RRTP and "fail" before they can be referred to a CCN provider. In some cases, Veterans lack trust in VA based on past experiences. If a Veteran has a fear or concern about an inpatient MH program or has attended a program in the past and indicates they do not want to return, there is potentially diminishing value for the Veteran to be required to enter MH RRTP again. That is not trauma-informed care.

3. Expand COMPACT Act to cover non-suicidal crises like SUD and allow civilian providers inside and outside the CCN to authorize care for SUD residential services.

4. Conduct outreach and education on COMPACT Act authorities and the request for the approval process to the following:

a) All Executive Directors for the Veterans Service Organizations in The Military Coalition based in Washington DC.

b) All local Veterans Service Organization leaders for the localities where a VAMC is located and the catchment area for those VAMCs.

c) All CCN and non-CCN hospitals and all CCN providers in the catchment areas of the VAMCs participating in the COMPACT Act.

5. Educate and train VHA staff to recognize what is in the "best medical interest" of the Veteran. Further empower leaders, clinicians, and administrators to align themselves with the Veteran's needs to build and sustain trusted relationships.

   a) Case management for Veterans seeking SUD treatment must consider all the treatment modalities and options that are necessary for full recovery, with no gaps in that care. A Veteran assessed at an elevated risk should never be discharged from a detox facility for a period of time while they wait to be admitted to MH RRTP and other appropriate programs, inside or outside VHA. These gaps can increase the probability of a relapse between treatments.

   b) VHA administrators should not have the authority to override a physician's recommended referral to a CCN provider under "best medical interest." Regulations and procedures need to be clear and precise that irrespective of the statutory wait time standard, if a physician recommends treatment within a shorter time frame and VHA cannot meet that time frame, the Veteran must be referred to a CCN provider of same services whenever a CCN provider can admit the Veteran before direct VHA care becomes available.

6. Veterans should be notified without delay of CCN eligibility in all appropriate circumstances when VHA is approaching a deadline to determine if VA care is available, including an explanation of how to request a Community Care referral and the process by which a Veteran can appeal a CCN denial decision. When a CCN referral is denied and the Veteran appeals the decision, the VA must provide a response outlining the justification for the denial and appeal instructions following the decision in a timely manner not to exceed 10 days from the date the appeal is submitted. When MH RRTP is considered as a treatment option for cases of mental illness or SUD, urgency is required to ensure the Veteran receives timely and appropriate access to care.

7. Require the VA Office of the Inspector General (OIG) to audit each VAMC's ability to advise Veterans on CCN eligibility, inform Veterans of their right and ability to seek CCN

services, deliver CCN referrals in a timely manner and appropriately approve and coordinate CCN referrals for Veterans. The OIG will submit a report to Congress annually on its findings.

Again, on behalf of The Independence Fund, and all the Veterans we have helped access the care they deserve and earned, we appreciate the opportunity to testify before the Subcommittee. We hope the examples we provided shine a light on the exemplary work being done by many VAMCs across the country to offer timely and urgent service to struggling Veterans, and also highlight where there is inconsistency, miscommunication or failure to adhere to directives which hurt the people it is our privilege and duty to honor and serve.

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WOUNDED WARRIOR PROJECT

Statement of
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On

"Combatting a Crisis: Providing Veterans Access to Life Saving Substance Abuse Disorder Treatment"

April 18, 2023

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs Subcommittee on Health – thank you for inviting Wounded Warrior Project (WWP) to submit this written statement for the record of today's hearing on veterans' access to Department of Veterans Affairs (VA) substance use disorder (SUD) treatment.

For 20 years WWP has worked to fulfill our mission to honor and empower wounded warriors. In addition to our advocacy before Congress, we offer more than a dozen direct service programs focused on connection, independence, and wellness in every spectrum of a warrior's life. Our organization has grown alongside the warriors we serve and we remain committed to tailoring our programming to the evolving needs of a post-9/11 generation of warriors that has become increasingly diverse.

In this context, assisting warriors with their mental health challenges has consistently been our largest programming investment over the past several years. In Fiscal Year 2022, WWP spent more than $82 million in mental and brain health programs – an investment consistent with the fact that more than 7 in 10 respondents to our 2022 Annual Warrior Survey self-reported at least one mental health condition.[1] As diagnoses of post-traumatic stress disorder (PTSD), depression, and anxiety have consistently ranked among the top five most self-reported conditions across previous editions of our Annual Warrior Survey, our Mental Health Continuum of Support has developed over the last decade and now allows us to engage each individual based on their unique needs.[2] In Fiscal Year 2022 alone, WWP provided warriors and their family members with nearly 55,000 hours of treatment for mental health conditions, including PTSD, traumatic brain injury, SUD, and other mental health conditions.

[1] WWP's 2022 Annual Warrior Survey can be viewed at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.
[2] More information on WWP's Mental Health Continuum of Support can be found at the end of the document.

Our specific focus on assisting warriors with substance abuse has followed a similar evolutionary path. In 2020, WWP recognized a gap in mental health services for veterans struggling with a substance use disorder and a co-morbid mental health disorder (e.g., PTSD). An increasing volume of veterans connected with our Mental Health Continuum of Support programs were sharing similar stories about their difficulty accessing clinical treatment. Providers were telling veterans that their SUD had to be treated independently before receiving PTSD care, or vice versa. Delays in finding the appropriate care in a timely manner would not only fail to capitalize on the veterans' desire to change their life circumstances, but in some cases cause further damage to their mental and physical health along with declines in family and social relationships. Hearing these stories, WWP committed to investigating further and commissioned the RAND Corporation to conduct a landscape study on the most effective way to treat post-9/11 veterans with co-occurring mental health and substance use disorders.

The resulting report, *Improving Substance Use Care: Addressing Barriers to Expanding Integrated Treatment Options for Post-9/11 Veterans*[3], has helped guide WWP's programming and advocacy before Congress. Data provided in WWP's 2019 Annual Warrior Survey, in combination with findings from the literature on SUDs and mental health disorders in veteran populations, revealed the high level of need for both substance use and mental health care among post-9/11 veterans. Among their key findings, RAND concluded that:

- Veterans screening positive for PTSD or depression are almost 20 percent more likely to screen positive for hazardous alcohol use or a potential SUD;
- Mental health treatment facilities typically specialize in treating one type of disorder or the other;
- Mental health treatment facilities often require veterans to abstain from substance use, but veterans may be using substances to manage their mental health symptoms;
- Veterans who receive substance use treatment alone may be at risk for failing to meet their treatment goals if their mental health symptoms are not addressed; and
- Integrated, evidence-based approaches that address both substance use disorders and mental health disorders concurrently and provide ongoing support for recovery can improve outcomes for this population, but it is critical that veterans are able to access programs and facilities that are equipped to treat the veteran population.

The RAND report includes a number of recommendations for improving options for and access to treatment for veterans with co-occurring SUDs and mental health disorders. One of these recommendations is to decrease barriers to accessing treatment.[4] They write, "given the difficulty of engaging the veteran population, it is essential to reduce barriers to care to help veterans not only initiate care but also to reduce dropout once enrolled."[5] The report also emphasizes the importance of ease of access to services and "limited delays in setting up initial and continuing care appointments."[6]

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[3] ERIC R. PEDERSON ET AL., RAND, IMPROVING SUBSTANCE USE CARE: ADDRESSING BARRIERS TO EXPANDING INTEGRATED TREATMENT OPTIONS FOR POST-9/11 VETERANS (2020).
[4] *Id.* at 150.
[5] *Id.*
[6] *Id.* at 154.

For these reasons, WWP has committed itself to ensuring that veterans who seek help are connected quickly to clinical programs that meet their needs. The Department of Veterans Affairs (VA) is a critical resource and partner for accomplishing those goals, and as discussed below, their collaboration with two key programs has helped lead to more successful outcomes for warriors who have engaged WWP for help. Our work has also spotlighted gaps and efficiencies that inform specific calls to action for this Subcommittee focused on accelerating access to care, addressing provider shortages, enhancing data reporting, and strengthening case management services.

ADDRESSING ACCESS CHALLENGES THROUGH WWP PROGRAMS

Currently when a warrior reaches out to WWP for mental health support, their first step to finding care is a conversation with our Triage team. The Triage team conducts screenings of a warrior's mental health history, provides the warrior with information about our various mental health offerings, and refers the warrior to the most appropriate mental health program within WWP or an external resource. In FY 22, our Triage team received 12,610 referrals to find warriors appropriate treatment, placed 10,634 referrals for mental health support (including 5,630 referrals to external outpatient care providers), and made their first connection with interested warriors an average of 1.04 days later. Warriors assessed as needing SUD treatment were most often either referred to WWP's Warrior Care Network or Complex Case Coordination (C3) program.

Warrior Care Network

Wounded Warrior Project's Warrior Care Network is a two-week intensive outpatient program where warriors are helped to minimize the interference of mental health issues in their everyday lives. WWP partners with four academic medical centers across the country to provide this treatment to help warriors manage their PTSD, TBI, SUDs, and other mental health conditions.

Since publication of WWP-commissioned RAND report on co-occurring SUD and mental health disorders, WWP has invested additional resources to ensure that the Warrior Care Network is providing this integrated treatment for veterans through our academic medical center partners. Warriors who complete the Warrior Care Network program have seen significant improvements in their PTSD and depression symptoms and improved functioning and quality of life. Most significant to today's hearing, treating mental health and SUD concurrently has led to reduced substance use habits. For those being treated as part of Warrior Care Network's SUD program, the pre-treatment average of 6.1 days of substance use per week was reduced to 1.6 days after treatment. After six months, warriors' substance use remained reduced at an average of 4.1 days of substance use per week.

While Warrior Care Network academic medical center partners provide veteran-centric comprehensive care, aggregate data, share best practices, and coordinate care in an unprecedented manner, partnership with VA has helped create a broad continuum of support that has been critical. In 2016, the VA and WWP created a first-of-its-kind partnership, signing a Memorandum of Understanding (MOU) aimed at ensuring continuity of care and successful

discharge planning for Warriors receiving treatment from both WCN and VA. This partnership included providing VA staff to assist part time at each AMC, facilitating coordination of care and integrating the AMC care team.

The MOU and partnership were expanded and enhanced in 2018, establishing four full time VA Liaison positions, embedded at each AMC. The VA Liaisons are responsible for ensuring that medical records are seamlessly shared between VA and WCN, that warriors are fully registered with VA, and that they get follow up care appointments after WCN graduation at the VA. In 2022, the VA renewed the MOU for a third time, continuing to fund one VA Liaison at each AMC site. Each VA liaison facilitates national referrals throughout the VA system as indicated for mental health or other needs. During 2022 alone, VA Liaisons served 708 warriors. Over the FY 18-22 period (beginning when VA Liaisons were assigned):

- 88% of veterans served by Warrior Care Network took advantage of connecting with a VA Liaison.
- 53% of veterans that met with a VA Liaison discharged from Warrior Care Network with a VA appointment scheduled.
- More than 3,000 referrals for VA care were opened. Among the most requested appointments were mental health care, VA benefits, and primary care.
- More than 19,000 hours of collaborative hours between VA Liaisons and academic medical center employees and veterans.

In sum, Warrior Care Network results and collaboration with VA has validated our belief that community-based, veteran-centric, intensive mental health and substance use care can lead to exceptional health improvements and increased engagement between veterans and VA when properly structured and managed.

Complex Case Coordination (C3)

Wounded Warrior Project's C3 team serves warriors with complex challenges that are often multi-faceted and require urgent action. They connect warriors to internal and external resources and treatment options to provide them with immediate assistance. When working with warriors, the C3 team assesses each of their unique needs and works with them to develop an individualized plan. They work to identify the resources that will best meet the warrior's needs and often act as a liaison between VA, the Department of Defense (DoD), and private community resources throughout the course of the warrior's treatment.

All facilities that the C3 team directs warriors to are carefully vetted by a WWP Clinical Psychologist for modality review while the C3 Director conducts on site vetting for a review of their operations. These facilities must participate in the VA Community Care Network or provide a specialty care need. C3 has established a menu of facilities that offer different types and modalities of care including PTSD, SUD, dual diagnosis, MST, grief, serious mental illness, and eating disorders. These facilities vary from inpatient, residential, partial hospitalization, intense outpatient, and treatment with residential capabilities.

The C3 team works a case in three phases. First, they work to stabilize the warrior, conducting an assessment and determining their needs. The second is to maintain the situation while they work to build an action plan, mobilize resources, and advocate for the warrior's needs. The third is the transition, where the team coordinates wrap around services and conducts follow-up. By pursuing these phases with nearly 1,200 warriors to date, the C3 team has developed significant history referring veterans to VA's Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) and provides the most significant perspectives on the access to care challenges facing warriors who pursue that care through VA.

ADDRESSING ACCESS CHALLENGES THROUGH ADVOCACY

As previously stated, WWP's most significant partner in meeting the needs of veterans with SUD and other mental health disorders is VA. Among its most intensive care options are its MH RRTPs, which provide residential treatment services to veterans with mental health issues, SUDs, medical concerns, or those dealing with homelessness or unemployment. There are currently 249 MH RRTPs throughout the country, and they are often an important resource for warriors experiencing co-occurring SUDs and mental health diagnoses. MH RRTPs offer a range of services and evidence-based psychotherapies.

Unfortunately, veteran access to MH RRTPs has been frustrated in several instances by the current access standard landscape. The *VA MISSION Act* (P.L. 115-182 § 104) required VA to establish access standards for community care and VA subsequently established these standards for primary care, mental health, non-institutional extended care, and specialty care. However, VA did not include a specific access standard for residential care, and they do not consider MH RRTPs to fall within their access standards for mental health or specialty care.

Access Standards under VHA Directive 1162.02

Instead, VA uses VHA Directive 1162.02 ("Mental Health Residential Rehabilitation Treatment Program") to define the admission criteria for MH RRTPs and to establish when a veteran is eligible for residential care in the community. The Directive states that all admission decisions must be completed within 7 business days from the referral. Veterans requiring priority admission must be admitted within 72 hours. For all other veterans, they must be admitted as soon as possible after a decision has been made. If they cannot be admitted within 30 calendar days, they must be offered alternative residential treatment or another level of care that meets the veteran's needs and preferences. Alternative residential treatment can be a program in the community, another program within the VISN, or another program in another VISN.

Whenever there is a gap of greater than two weeks for any veteran accepted into a mental health RRTP, providers must maintain clinical contact with the veteran until the time of admission, and address any urgent mental health care needs that arise.[7] Under the Directive, this responsibility should generally fall to the Mental Health Treatment Coordinator (MHTC). The MHTC is responsible for ensuring a veteran's continuity of care while receiving mental health treatment. They are to be the veteran's Point of Contact, clinical resource, and member of the

[7] *See* VHA Handbook 1160.01 ("Uniform Mental Health Services Handbook").

veteran's assigned outpatient general mental health team, except under certain circumstances. The MHTC is also supposed to be notified when a veteran is not accepted for care, and they are supposed to be included in the discharge and transition planning process.

Unfortunately, VA's admission goals seem aspirational when compared to its most recent admission data. According to a VA briefing provided to veteran service organizations in February 2023, only 38 percent of veterans assessed as needing priority MH RRTP admission in the first quarter of FY 23 were admitted within 72 hours. While 17 percent requested a later date, this leaves many veterans outside of the window required by the Directive. Similarly, data published by the Government Accountability Office in February 2023 showed that, in Fiscal Year 2021, health care systems with mostly rural veterans had an average waiting time above 30 days for MH RRTP programs.[8] Health care systems with some (~27 days) or few rural veterans (~23 days) were only slightly faster.

Wounded Warrior Project's assistance for warriors seeking MH RRTP access, while positive in many instances, has shown similar shortcomings. The lack of a consistently applied access standard has essentially resulted in no true access standard for MH RRTP. Local policy variations have resulted in unpredictable referral decisions. Wait times are not uniformly calculated and can be impacted by inconsistent policies about completion of other, less intensive treatment options. More specifically, some VA facilities will require a veteran to exhaust all outpatient programs before considering them eligible for a MH RRTP program. For patients with co-occurring mental health and substance use disorders, some VA facilities will utilize partial treatments (e.g., SUD care only) while waiting for dual-diagnosis treatment (e.g., treatment for SUD and PTSD) beds to open, satisfying the access standard but not getting the veteran to the appropriate program more promptly. Transparent staffing challenges have limited communication and bed availability. Identifying alternative treatment options that would result in community – or even VA – referrals and faster access to care consistent with Directive access standards are not uniformly accepted. Consequently, some warriors will only pursue care after asking for assistance of a trained and passionate advocate like WWP, or even worse, decided to stop pursuing care altogether.

WWP Access Issues Validated by VA Office of the Inspector General (OIG)

In January 2023, the OIG released a report on noncompliance with community care referrals for MH RRTPs within the VA North Texas Health Care System.[9] The report found a number of instances where the VA North Texas Health Care System failed to follow VHA Directive 1162.02. Throughout most of fiscal years 2020 and 2021, veterans were put on waitlists for two to three months to receive care at the local VA North Texas domiciliary substance use disorder program (DOM SUD) and were not offered referrals for care in the community. Requests by the veterans for community care referrals were inappropriately denied.

The OIG specifically reviewed 15 VA North Texas DOM SUD consults placed for 10 patients as part of their investigation. Seven consults were closed when the patients were

[8] GOV'T ACCOUNTABILITY OFF., VA MENTAL HEALTH: ADDITIONAL ACTION NEEDED TO ASSESS RURAL VETERANS' ACCESS TO INTENSIVE CARE 31 (Feb. 2023).

[9] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, NONCOMPLIANCE WITH COMMUNITY CARE REFERRALS FOR SUBSTANCE ABUSE RESIDENTIAL TREATMENT AT THE VA NORTH TEXAS HEALTH CARE SYSTEM (Jan. 2023).

admitted within 30 days and two were closed when patients declined admission. Unfortunately, the remaining six consults ended after an average wait time of 79 days before the patient was offered a DOM SUD admission or after being removed from the pending bed placement list. Although VA North Texas staff knew the wait time to admission for care was over 30 days, no community care options were offered to these patients.

The OIG report concludes that the VA North Texas chief, Patient Administration Services, misinterpreted VA policy on MH RRTP care and community care referrals and provided inaccurate information to staff and patients. The report goes on to say that "failure to discuss alternative resources or treatment options, including community residential care, may have contributed to patient's increased risk of negative outcomes due to delayed access to DOM SUD services."

This report found other instances of VA North Texas failing to follow VHA policy. The Bonham MH RRTP failed to follow VHA's minimum scheduling requirements to contact veterans four times to schedule a requested service before closing a consult. The OIG wrote that this "failure to adhere to VHA minimum scheduling requirements may hinder efficient patient scheduling and contribute to barriers to accessing DOM SUD services." VA North Texas also failed to follow the VHA requirement that staff assign a mental health treatment coordinator to patients that are either receiving outpatient mental health treatment, have been admitted to an inpatient mental health setting, or those that are waiting to receive a different level of care, such as those waiting for placement at an MH RRTP.

In their response, VA North Texas noted that this time period was during the peak of the COVID-19 pandemic and that VA North Texas had the highest COVID-19 census in the VA system for several months in 2020 and 2021. They also point out that some community care facilities were not accepting admissions during this time. VA North Texas argues that staff were doing the best they could with difficult circumstances and that while VA guidance was misinterpreted, very few patients were ultimately affected. While this may be true in this specific instance, WWP has seen a pattern of these types of issues reported at VA North Texas around the country.

Action in Progress

As WWP has consistently raised the problems with MH RRTP access over several months, we appreciate that Congress has taken important steps to address the mental health and substance use crisis amongst our veteran population in recent years. The *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (P.L. 116-171 § 201) required VA to develop a clinical provider treatment toolkit and accompanying training materials for comorbid mental health conditions, comorbid mental health and substance use disorders, and comorbid mental health and chronic pain. That toolkit is now publicly available on the VA website.

The *Support the Resiliency of Our Nation's Great (STRONG) Veterans Act* (P.L. 117-328, Div. V § 303) included provisions related to SUD and mental health. Section 503 requires VA to conduct a study on inpatient mental health and substance use care at VA, including if there are sufficient geographic offerings for inpatient mental health care, sufficient bed spaces, and wait times. The study must also include recommendations on new locations for RRTPs and

where new beds can be added. Section 504 also requires a study on treatment at VA for co-occurring mental health and SUDs. The study must include information on the availability of treatment programs, geographic disparities in access to these programs, and average wait times. WWP is eager to see the results of these reports and use them to inform future advocacy.

Moreover, to the extent access issues are created by staffing shortages, WWP is grateful for recent congressional action to improve VA's mental health staffing capabilities. The *STRONG Veterans Act* (P.L. 117-328, Div. V) also includes provisions that will expand the Vet Center workforce (§ 102), create more paid trainee positions in mental health disciplines (§ 103), and offer more scholarship and loan repayment opportunities for those pursuing degrees or training in mental health fields (§ 104).

Recommendations for Future Action

While WWP applauds the work Congress and VA have already undertaken, there is much more work to be done. Based on the data we've outlined and our experiences attempting to place warriors into residential care for co-occurring mental health issues and SUDs, WWP provides the following recommendations:

VA access standards must ensure prompt access to residential mental health and substance use services

The access standards contemplated by the *VA MISSION Act* (P.L. 115-182 § 104) and memorialized in the Code of Federal Regulations (38 C.F.R. § 17.4040) do not, in practice, extend to mental or substance use disorder care provided in a residential setting. VA has maintained adherence to access standards for this type of care through VHA Directive 1162.02, which establishes a priority admission standard of 72 hours and, for all other cases, 30 days before a veteran must be offered (not necessarily provided) alternative residential treatment or another level of care that meets the veteran's needs and preferences at the time of screening.

Due to this approach, veterans seeking mental or substance use disorder care provided in a residential setting are not subject to the access standard protections assigned under law. VA is not required to inform these veterans of their expected wait time. *See* P.L. 117-328, Div. U, § 122. Veterans are not guaranteed the soonest possible starting time before a community referral must be made. *See* P.L. 117-328, Div. U, § 121; 38 U.S.C. § 1703(d)(4). The access standards used are not applicable to community care network providers who receive referrals for these veterans' care. *See* P.L. 117-328, Div. U, § 125; 38 U.S.C. § 1703B(f).

Most importantly, if appropriate community-based providers are identified and available to provide treatment, veterans waiting beyond VHA's policy-backed access standards have no dependable, consistent recourse to be referred for that care. VA has presented data suggesting that only 38% of veterans meeting priority admission criteria were admitted to VA within 72 hours, and that the average wait time before admission among all veterans receiving MH RRTP care was 24 days – just 6 days less than the 30-day access standard and among a population where 53% were admitted within 14 days (information on admissions within 30 days was not provided in the presentation).

At least two approaches show potential to address this problem. First, 38 U.S.C. § 1703(d)(1) can be amended to specifically include access standards for residential mental health or substance-use services.[10] Second, 38 U.S.C. § 1703B can be amended to ensure that residential mental health or substance-use services are included as part of the extended care service access standards that VA must prescribe. Either path would help provide certainty that access standards are not left to VA policy and carry the same opportunities and predictability that are extended to other medical services as part of the *VA MISSION Act*.

Advance policies that promote a stronger mental health and substance use treatment provider base across the United States

In January 2023, the U.S. Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) released the results of its 2021 National Survey on Drug Use and Health (NSDUH), which contains fresh evidence of the extent of mental health and substance use challenges across the country.[11] Results from the survey show that while veterans may be at heightened risk for these health challenges and more likely to experience them, the broader national context must be considered to help adequately address access to care issues that exist and may continue to arise.

Among the findings most pertinent to today's hearing, 29.5 million people aged 12 or older showed alcohol use disorder, 24.0 million showed a drug use disorder, and 5.6 million showed an opioid use disorder.[12] These findings run parallel to findings that nearly 1 in 4 U.S. adults with a mental illness[13] and are particularly striking within the context that more than 150 million Americans live in a federally designated mental health professional shortage area.[14]

One way for Congress to act outside of the VA health system – but nevertheless helping veterans, particularly those in underserved areas – is to pass S. 462, the *Mental Health Professionals Workforce Shortage Loan Repayment Act*.[15] This bill would authorize the federal government to repay up to $250,000 in eligible student loan repayment for mental health professionals who work in mental health shortage areas. As written, this bill requires an annual commitment to full time employment in substance use disorder treatment. Although the *STRONG Veterans Act* enhanced and expanded VA's internal staffing capabilities, we believe that policies to help address a nationwide shortage of medical personnel will bring stronger assurance that mental health and substance use services are available to veterans regardless of whether it is initially pursued at VA.

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[10] *See, e.g.*, S.5348 (117th Congress).
[11] SUBST. ABUSE AND MENTAL HEALTH SVCS., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2021 NATIONAL SURVEY ON DRUG USE AND HEALTH, *available at* https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf.
[12] *Id.* at 32.
[13] *Id.* at 39.
[14] BUREAU OF HEALTH WORKFORCE, HEALTH RES. AND SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS STATISTICS, FIRST QUARTER OF FISCAL YEAR 2023 (Jan. 2023) (as of December 31, 2022).
[15] Federal regulations stipulate that, to be considered as having a shortage of providers, a designation must have a population-to-provide ratio that meets or exceeds a certain threshold. Mental health designations may qualify for designation based on the population to psychiatrist ratio, the population to core mental health provider ratio, or the population to both psychiatrist and core mental health provider ratio.

Ensure more consistent reporting on the relationship between SUD and veteran suicide

According to VA's National Veteran Suicide Prevention Annual Report for 2022, the prevalence of alcohol use disorder among "Recent Veteran VHA Users" who died by suicide was 19.6%, cannabis use disorder 8.3%, and opioid use disorder 4.9%.[16] Overall, while suicide rates fell from 2019 through 2020 for those with any mental health or SUD diagnosis, suicide rates rose for those with substance use disorders.[17] Insights like these are helpful for policy-making; the data above is particularly compelling for the subject of today's hearing. Yet even though access to mental health and substance use disorder services is a VHA priority and part of VA's National Strategy for Preventing Suicide, comparable data was not presented in the 2021 report. In 2020 and 2019, mental health and substance use disorder discussion covers periods dating back to 2005[18]; however, no comparable data can be found in the September 2018 report.

While we appreciate the earnest efforts of VA to report on veteran suicide data, WWP supports the laudable goal of more comprehensive and consistent annual reporting. The *Not Just A Number Act* (S. 928) would create several annual reporting requirements for VA, including an examination of trends in suicide rates or deaths among veterans who have a diagnosis of substance use disorder. In addition to creating expectations about consistent reporting on health data and trends, this legislation would go considerably further by looking at trends related to Veterans Benefits Administration usage that have not been addressed in prior annual reporting. In sum, passing this legislation would create more potential for VA and the broader veteran support community to make more informed decisions about where to focus resources to help prevent veteran suicide.

Make case management services more accessible

Wounded Warrior Project's approach to helping warriors find care for co-occurring SUD and mental health disorders has been successful thanks in part to strong case coordination and communication. As discussed previously, VA Liaisons co-located at Warrior Care Network's partner academic medical centers have been an indispensable tool in creating a stronger continuum of care for warrior patients. Between FY 2018 and FY 2022, that collaboration has resulted in over 9,000 cases consultations by VA staff at academic medical centers.

Similarly, our C3 program has also delivered more positive results for veterans on account of close collaboration with VA. Among nearly 1,200 veterans served though C3, 30 percent of those enrolled for care at VA stated the VA is not aware of their current mental health situation. Because C3 works to identify community-based providers that are in the Community Care Network, our advocacy on the veteran's behalf often results in significant communication with local VA mental health leaders once veteran permission is acquired. Subsequent VA-provided referrals for care result in lower out-of-pocket expenses for the veteran than what may

[16] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2022 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 27 (Sept. 2022).
[17] *Id.*
[18] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2020 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 27-28 (Sept. 2020); OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, 2019 NATIONAL SUICIDE PREVENTION ANNUAL REPORT 12-13 (Sept. 2019).

have been sought independently (or without WWP assistance) and closer coordination of care before and after community-based treatment.

This positive engagement with VA can go even further when considering the typical presentation of a warrior who works with our C3 program. For example, 16 percent of warriors did not have an appointed primary care provider at VA before working with WWP and subsequently established a point of contact for current and ongoing referrals. 78 percent had been unemployed for 6 months or more and could surely benefit from more streamlined support from Veterans Benefits Administration programs like Veteran Readiness and Employment. An equivalent number of veterans also reported unstable housing as a barrier to care. Future care for other conditions would appear more likely as well given that these veterans often present with multiple medical diagnoses (1,149 clinical diagnoses among 422 warriors in a recent sample).

One program that may warrant closer inspection is VA's Mental Health Intensive Case Management program. These programs are required at Veterans Health Administration health care systems serving 1,500 or more veterans identified on the National Psychosis Registry. Designed specifically to optimize the health status, quality of life, and community functioning of veterans diagnosed with serious mental illness who frequently utilize VA mental health inpatient and emergency services, perhaps a complementary program can be made available to veterans with less severe medical diagnoses.

Given how the veterans we serve often present with complex needs, inspiration for improvements to case management can be found in the Federal Recovery Coordination Program (FRCP) that previously assigned recovering Service members with recovery care coordinators responsible for overseeing and assisting the Service member in their course through the entire spectrum of care, management, transition, and rehabilitation services available from the federal government. The program also called for assignment of medical care managers and non-medical care managers who were responsible for, among other tasks, helping resolve problems involving financial, administrative, transitional, and other matters that arose during recovery and transition.

In 2018, the FRCP transformed into the Federal Recovery Consultant Office (FRCO) in response to the Presidential Executive Order, "Comprehensive Plan for Reorganizing the Executive Branch." While this shift may have created some efficiencies, WWP encourages a fresh assessment of whether the FRCO can serve as a similar hub for veterans seeking more assistance with complex cases involving SUD and/or mental health disorders. WWP's experience has shown that veterans are likely to benefit from a heightened level of support often present with co-occurring SUD and mental health disorders.

CONCLUSION

Wounded Warrior Project thanks the Subcommittee on Health and its distinguished members for inviting our organization to submit this statement. We are grateful for your attention and efforts towards addressing this critical issue of substance abuse amongst our nation's veterans. We look forward to continuing to work with you on these issues and are standing by to assist in any way we can towards our shared goals of serving those that have served this country.

MENTAL HEALTH CONTINUUM OF SUPPORT

The Wounded Warrior Project® (WWP) Mental Health Continuum of Support is composed of a series of programs that address mental health care needs of warriors. These programs allow us to engage with warriors based on their unique needs. The continuum is made up of internal resources and programs to assist warriors on their journey to recovery. WWP uses the Connor-Davidson Resilience Scale® (level of resilience), the Rand QoL Scale (psychological well-being), and other validated scales and measurements to determine the appropriate level of care for each warrior.

The continuum of support doesn't define an exact, prescriptive path to recovery, rather the individual needs of each warrior to determine the order and frequency of appropriate program engagement. For example, a warrior in acute psychological distress may be referred to a number of clinical intervention programs. Another warrior with less severe mental health issues may participate in only one or two programs. Subsequently, any warrior who has a setback may be re-evaluated and referred back to one or more programs for additional care. The goal is to provide the appropriate amount of care a warrior may need to get to his or her highest possible level of resilience, psychological well-being, and healing.

INPATIENT CARE
Clinical Intervention

Inpatient care is reserved for warriors in severe psychological distress who have exhausted all other resources. WWP may be able to fund inpatient services in order to stabilize warriors so that they can be engaged with other mental health programs in the continuum. The goal is to sustain and facilitate movement in the continuum through other programs.

WARRIOR CARE NETWORK
Clinical Intervention

To accelerate the development of advanced models of mental health care, WWP partners with four world-renowned academic medical centers to form Warrior Care Network®, leveraging our collective commitment and expertise. The Warrior Care Network treatment model delivers a year's worth of mental health care during a two- to three-week intensive outpatient program (IOP). This unique veteran-centric approach increases access to treatment and improves outcomes. Warrior Care Network provides a path to long-term wellness, improving the way warriors are treated today and for generations to come.

PROJECT ODYSSEY
Engagement Intervention

Project Odyssey is a 12-week mental health program that uses adventure-based learning to help warriors manage and overcome their invisible wounds, enhance their resiliency skills, and empower them to live productive and fulfilling lives. Based on their unique needs, warriors can participate in an all-male, all-female, or couples Project Odyssey. The program starts with a five-day mental health workshop, where warriors are challenged to step outside the comfort of their everyday routines. This opens them up to new experiences that help develop their coping and communication skills. After the workshop, participants work together with WWP to stay engaged, achieve their personal goals, and make lifelong positive changes.

★ PROGRAMS WITH MULTIPLE STAGES OF ENGAGEMENT ★

Within the continuum of support there are additional programs/resources that can be engaged at nearly any point in the continuum. These are WWP Talk and outpatient therapy. The Independence Program, which also encompasses multiple stages of engagement, is a unique component of the continuum. The resources provided by the Independence Program allow the most severely wounded warriors the ability to lead a full life at home instead of a long-term facility.

OUTPATIENT THERAPY • *Engagement and Clinical Intervention*

An additional clinical resource available to warriors across the stages of the continuum is outpatient therapy. Here WWP funds external partners to provide individual, family, or couples therapy delivered by a culturally competent therapist in the closest geographic location to the warriors as possible. With multiple funded clinical partners, warriors are able to engage in traditional outpatient sessions or, if in a remote location, engage in virtual therapy.

WWP TALK • *Engagement and Coordination Intervention*

WWP Talk is a telephonic emotional support program that breaks down the barriers of isolation and helps both warriors and family members plan an individualized path toward their personal growth. Participants work one-on-one with a dedicated team member during weekly emotional-support calls. Together, they set tangible goals and develop skills that lead to positive changes, like increased resilience and improved psychological well-being.

INDEPENDENCE PROGRAM
Engagement, Coordination, and Clinical Intervention

The Independence Program provides long-term support to catastrophically wounded warriors living with injuries such as: a moderate to severe brain injury, spinal cord injury, or neurological condition that impacts independence. The program is designed to support warriors who, without high-touch services, would struggle to live day to day due to the severity of their injuries. The Independence Program increases access to community services, provides rehabilitation through alternative therapies, and empowers warriors to achieve goals leading to a more independent life. Because every journey is different, we work as a team with warriors, their family members, and their caregivers to set goals to live a fulfilling life, at home, with their loved ones.

★ LIVING THE LOGO ★

WOUNDED WARRIOR PROJECT

The WWP logo is much more than a trademark — it is what we see as the ultimate goal for all warriors engaged with the continuum of support to achieve. It is the collective goal of the continuum of support (through resources and teammates) to empower warriors to make it to this final phase and live our logo. The logo, one warrior carrying another warrior, represents a peer assisting a fellow veteran — in essence, carrying him through the recovery process until he can walk of his own accord (through heightened resiliency and psychological well-being). Eventually, as resiliency reaches the highest levels in the continuum, warriors are empowered to help carry fellow veterans, essentially becoming force multipliers as they are engaged as peer mentors.

Prepared Statement of Thomas Sauer

Chair Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee:

I am honored to testify before you today. My name is Tom Sauer, and I'm a Navy and Marine Corps Veteran, having spent the better part of my adult life wearing the cloth of our Nation. I'm a former enlisted Marine infantryman, a 2006 Naval Academy graduate, and a former Navy Explosive Ordnance Disposal officer. Today, however, I'm the owner and CEO of Miramar Health, a Veteran-owned and operated Community Care Provider for intensive substance use disorder (SUD) and mental health treatment, exclusively for America's Veterans.

Mental health and addiction treatment are deep passions of mine, because depression and addiction killed my dad. Five days before I graduated from high school, and three weeks before I shipped out for the Marines in 1999, a methamphetamine overdose took his life after decades of struggle, just like so many millions of Americans suffering from our country's disastrous mental health and addiction crisis.

Thanks to recent legislation, thousands of veterans have enhanced access to life-saving mental healthcare and addiction treatment within the VA's Community Care Network (CCN). We've provided intensive, custom-tailored, world-class mental health and addiction treatment for nearly 250 Veterans from a dozen VA Medical Centers across the Western United States, typically for 30, 60, and sometimes 90+ days. This treatment is for our veterans who are truly suffering, in crisis, and often near death from suicide or overdose resulting from America's disastrous mental health and addiction crisis.

In three and a half years, we've grown from one small clinic with six employees, to eight residential facilities and one large outpatient facility. These facilities are staffed by nearly 100 phenomenal physicians, nurses, psychologists, therapists, medical technicians, case managers, and support staff, many of whom are Veterans themselves. I could not be any prouder of them.

I didn't come all the way out here to tell you this just so I could pat myself on the back, but rather to simply convey the sincerity of our intentions and to lay out how important this challenge is. Miramar believes in our partnership with the VA by bridging both capability and capacity gaps within certain VAMCs and in being an advocate to Veterans in need, all while providing them with the highest quality care.

In other words, we do not consider ourselves to be just another government contractor. We are partners and teammates with the VA, and we're here asking for your help to ensure our Nation's Veterans receive the lifesaving care they need and deserve by strengthening that partnership.

The overwhelming majority of front-line, boots-on-the-ground VA personnel we directly interact with are fantastic, dedicated, and lifesaving public servants. There are many who, in my mind, deserve medals and parades for saving the lives of Veterans.

I am here today to advocate for veterans in need to access care ANYWHERE, IMMEDIATELY, and we can figure out the paperwork later. The current VA policy of having 30 days to find a bed in a given region does not meet the URGENT LEVEL of this CRISIS.

Specifically, we've encountered several occasions where, despite community care being available for a Veteran in crisis, they're either put onto waiting lists for up to 30 days before receiving care, when they don't have 30 minutes without becoming a very real risk to suicide or overdose. I have first-hand knowledge of these suicides and overdose deaths since I've owned Miramar, so I understand the devastation this policy can cause.

We believe this issue could be rather easily corrected through a legislative carve-out for Community Care eligibility, as with Urgent Care, when it comes to urgent and emergency mental health and addiction treatment.

This could be done by clarifying and ensuring the COMPACT Act is being implemented as intended and that Veterans are aware of this option for receiving care.

We urge you to ensure that our veterans have access to the care they need when they need it through the Community Care Network.

We appreciate your consideration of this matter, and we are willing to work with you to address these issues and ensure that our guys and gals get the care they so desperately need.

Thank you, Chair and members of the Subcommittee. Each of you, your staffers, and the committee's staff are champions for America's Veterans, so I am exceptionally grateful to you and your commitment to serving them, and that you are holding this important hearing today.

In conclusion, thank you for addressing the issues we raised today. Veterans' lives depend on it. Thank you again for the opportunity to appear, and I look forward to answering your questions.

Prepared Statement of Brendan Dowling

Good morning, Chair Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee.

My name is Brendan Dowling, and I am currently Miramar Health's Veteran Outreach Manager.

I am formerly a Navy SEAL that served in multiple military campaigns for the Global War on Terror from 2001–2014. My service spanned across numerous deployments in multiple combat zones.

Since last summer, I have had the pleasure of visiting over 141 VA facilities that provide medical, clinical, counseling, or VBA services to Veterans across the Western US.

This includes 94 VHA facilities; 18 Medical Centers, 74 Community Based Outpatient Clinic's, and 35 Veteran Centers.

I look forward to answering any questions you may have.

STATEMENT FOR THE RECORD

Prepared Statement of Cohen Veterans Network

Cohen Veterans Network

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Cohen Veterans Network
Statement of Dr Anthony Hassan
Chief Executive Officer
On
"Combatting a Crisis: Providing Veterans Access to Life Saving Substance Abuse Disorder Treatment"
April 18, 2023

Dear Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Subcommittee Members,

On behalf of the 50,000 veterans and family members that we have served in our network of 24 outpatient mental health clinics across 15 states, thank you for the invitation to submit a statement for the record to the Subcommittee on Health, Committee on Veterans' Affairs Legislative Hearing. We appreciate the opportunity to address the importance of access to outpatient mental health care, especially substance use disorder treatment for our veterans. Effective early intervention is vital in prevention of chronic and severe behavioral health conditions and related alcohol and substance use comorbidities which may develop as a consequence of escalating biopsychosocial challenges and attempts to self-medicate in its absence. Moreover, it is instrumental in managing risk for subsequent suicidal behaviors and overdose which unfortunately, are increasingly endemic within our veteran population.

Cohen Veterans Network, Inc. (CVN) is a not-for-profit philanthropic organization [501(c)(3)] founded in 2016. CVN is focused on delivering mental health services for post-9/11 veterans, service members, and their families. Cohen Military Family Clinics are committed to improving mental health outcomes through a network of customized, outpatient clinics in high-need communities, in which trained clinicians deliver client-centered, evidence-based care. Additionally, CVN is committed to removing barriers to care and advancing the field of mental health.

CVN provides accessible outpatient behavioral health care for veterans and their family members. Services are provided without regard to the clients' ability to pay or characterization of discharge. Family is defined broadly, including veteran's spouses but also parents, siblings, adult children, and others as defined by the veteran. The CVN model is client centered, evidence based, and targeted. Core services include psychotherapy using evidence-based protocols and industry best practices, medication management, and case management.

Evidence based protocols and practices are utilized to address mental health adjustment and family issues which may be contributing factors in the veteran's care. Approximately 53% of CVN clients are veterans or active-duty military members with 47% family members including adults and children. Top presenting problems include family concerns, anxiety, adjustment disorders, depression, and posttraumatic stress disorder (PTSD). All clients receive a comprehensive screening including the Columbia Suicide Severity Rating Scale (CSSRS) and a full biopsychosocial assessment prior to beginning treatment. CVN conducts comprehensive screening for alcohol and substance misuse, abuse, and dependence as they are frequent co-occurring conditions for individuals seeking mental health treatment. Given the complex needs presented by many veterans, medication management and case

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management are readily available to all clients seen in our clinics. This extra support is vital to decrease self-management, link veterans to more support and guide them through healing and recovery.

The Criticality of Accessible Upstream Intervention for Veteran's Coping with Mental Health Issues

The US is currently facing a national crisis in mental health and mental healthcare, however rates of mental health disorders among post 9-11 veterans remain significantly higher still. Suicide risk for both male and female veterans are dramatically above those of their civilian counterparts. In the VAs (Veterans Affairs) 2022 annual report the rate was cited as 57.3% above the rate for non-veteran adults. Furthermore, research indicates that current substance use disorders (SUDs) signal increased suicide risk among veterans especially among women, and that co-occurring psychiatric disorders partially explained associations between SUDs and suicide.[1] Alcohol and Substance use disorders (AUD/SUD) have been reported to occur at a rate of approximately 11% in veterans seeking care from the VHA (Veterans Health Administration) and onset of SUDs can emerge secondary to and comorbid with other mental health problems such as post-traumatic stress disorder (PTSD) and depression.[2] Comorbidity of SUD (substance use disorder) among those with PTSD has been reported between 35-50% and these patients have been found to have greater drug use severity and worse treatment outcomes.[3] Additionally marital and family issues have been identified as significant factors among veteran families due to a range of military specific challenges including frequent relocations and deployments over the course of a military career with spouses reporting higher rates of mental health issues including depression than their civilian counterparts.

Women veterans report the highest rates of PTSD among post 9-11 veterans and per VA data, one in three women veterans have experienced military sexual trauma (MST). The incidence of lifetime SUD is significantly higher for women veterans with a history of sexual assault. Moreover, needs assessments suggest that their unique service needs may not be ideally met within the VA, and many are unaware of or fail to take advantage of their VA benefits based on their failure to identify as veterans

Access and Eligibility Within the VA

Challenges related to access and wait times within the Veterans Health Administration have been well established but perhaps more germane to the current discussion is the rates at which veterans receive care through the VA. Based on the agencies own estimates about two thirds of veterans receive their

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[1] Bohnert, K. M., Ilgen, M. A., Louzon, S., McCarthy, J. F., and Katz, I. R. (2017) Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction*, 112: 1193– 1201. doi: 10.1111/add.13774.

[2] Teeters, J. B., Lancaster, C. L., Brown, D. G., & Back, S. E. (2017). Substance use disorders in military veterans: prevalence and treatment challenges. *Substance abuse and rehabilitation*, *8*, 69–77. https://doi.org/10.2147/SAR.S116720

[3] Boden, M.T., Kimerling, R., Jacobs-Lentz, J., Bowman, D., Weaver, C., Carney, D., Walser, R. and Trafton, J.A. (2012), Seeking Safety treatment for male veterans with a substance use disorder and post-traumatic stress disorder symptomatology. Addiction, 107: 578-586. https://doi.org/10.1111/j.1360-0443.2011.03658.x

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healthcare outside this system. This is due to a multitude of factors including not only wait times but also eligibility, awareness, and preference. As a result of this a robust network of accessible and culturally competent services is necessary to serve these veterans who are unlikely to be seen within the VA. Current VA access standards require a veteran to be seen within 30 days but may seldom be met. VA uses VHA Directive 1162.02 ("Mental Health Residential Rehabilitation Treatment Program") to define the admission criteria for MH RRTPs and to establish when a veteran is eligible for residential care in the community. This Directive states that all admission decisions must be completed within 7 business days of the referral. Veterans requiring priority admission must be admitted within 72 hours. In all other cases, the veteran must be admitted as soon as possible after the decision has been made. If a veteran cannot be admitted within 30 calendar days, alternative residential treatment or another level of care that meets the veteran's needs and preferences must be offered. Alternative residential treatment can be a program in the community or another program within the VA. In cases where there is a gap of two weeks or more for a veteran accepted into a mental health RRTP, clinical contact must be maintained until the time of admission, and urgent mental health care needs that arise must be addressed. The MHTC is responsible for ensuring a veteran's continuity of care while receiving mental health treatment.

Given these limitations and the relatively small proportion of veterans who receive their care through the VA, the case is easily made that other community providers and Veteran Service Organizations play a key role in meeting the needs for essential services for mental health and SUD care. Accessible community-based care may function as a stopgap or interim resource or an alternative to VHA where access is insufficient, or services are unavailable. In recognition of these realities funding and coordinating with these services becomes imperative. Additionally restrictive policies related to duration of services or payment to these community agencies needs to be addressed in light of the need for robust partnership vs. competition in providing desperately needed care in an expeditious, deliberate, and coordinated manner.

How CVN Services Address Upstream Drivers of Low-Density High-Cost Residential Care

At CVN we have diagnosed and managed over 1,659 veterans with AUD/SUD since 2018. Early and upstream intervention for depression, anxiety and post-traumatic stress pave demonstrable impact on the trajectory of veterans through the care system. Comorbidities with other mental health disorders in veterans treated at CVN were identified at elevated levels with approximately 78% of SUD diagnoses occurring in conjunction with 1 or more comorbid disorders, including depression (47%), anxiety (26%) and PTSD (46%). Evidence based interventions to address symptoms and enhance quality of life, reduce subsequent levels of care required, hospitalizations and emergency department visits. Early outpatient mental health intervention, especially in conjunction with case management services may prevent development of severe symptoms, build coping skills, and address marital and family conflict reducing risk of suicide, as well as further health and mental health crises, overdose and even homelessness among veteran populations.

CVN provides focused intervention through episodes of care averaging 8-12 sessions over a typical course of 120-180 days with rates of remission and clinically significant change which rival those reported in comparable samples based on an independent validation study. Few veterans who receive care require referral to a higher level of care and average improvements on quality of life (QLES-SF) and Dyadic Adjustment are considerable. Wait times for care vary across clinics with a goal of < 14

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days and a typical wait time of under 30 days to receive biopsychosocial assessment with subsequent initiation of therapy within 7-10 days thereafter. CVNs goals are not only to save lives but to change lives. Early intervention is critical for success and is robustly supported by the business case as compared with higher levels of care which are associated with the increased severity and chronicity of symptoms and disorders which develop when these issues are not identified and treated at an early stage.

On the issue of SUDs, the VA would be well served to enhance its existing Community Care Network (CCN) to ensure that access standards are met and that veterans in crisis are not being maintained on waiting lists or managed at levels of care inadequate to their assessed treatment needs. With the standard set for 72 hours for priority admission to residential/inpatient SUD care, the VHA will need additional purchased care options in most if not all localities on a continuous or recurring basis and the standard should not be violated to accommodate patients in VA direct care to improve VA metrics at any level. Embracing community partnerships and ensuring effective coordination of care must guide the future direction in terms of SUD/AUD treatment for the benefit of veterans and their families.

At CVN we are committed to doing our part to address veteran mental health needs and supporting the larger effort currently undertaken by the VHA in conjunction with our partner veteran serving organizations (VSOs) to assure effective and timely care is being provided to veterans experiencing SUD/AUD. Our 24 clinics will continue to support their communities by addressing relational and adjustment challenges and common comorbidities which predispose veterans to or lead to more significant mental health concerns concomitant with greater disruptions in functioning and requiring higher levels of care

Looking forward, CVN will continue to strongly support the existing CVN-VAMC partnerships and do our utmost to foster new ones. We are eager to continue to work with VA, VHA as part of the VA Community Care Network to continue to expand the support available to veterans to treat the comorbidities which frequently occur with substance abuse disorders and to improve veterans' quality of life. CVN thanks Chairwoman Miller-Meeks and the other distinguished members of the Subcommittee on Health for their tireless and essential life-saving efforts on behalf of our US veterans. We look forward to continuing to work with you on these vital issues.

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Mental Health Care for Veterans, Service Members, and Their Families

Cohen Veterans Network

Cohen Veterans Network is a not-for-profit network of mental health clinics delivering **accessible**, **confidential**, **high-quality** care to veterans, service members, and military families.

Contact your local Cohen Clinic: **cohenveteransnetwork.org**

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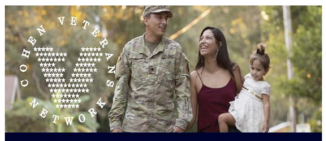

WHO WE SERVE

- **POST-9/11 VETERANS** including those from the National Guard/Reserves, regardless of occupational specialty, discharge status, or service length.
- **SERVICE MEMBERS** of all branches including the National Guard/Reserves, regardless of activation status.
  *Active Duty need TRICARE referral.
- **MILITARY FAMILY MEMBERS** of post-9/11 veterans and service members, including spouse or partner, children, parents, siblings, caregivers and families of choice.

All sexual orientations/genders welcome.

HOW **WE HELP**

- **PERSONALIZED THERAPY** for individuals (adults and children), couples, and families. Care is available for a **variety of mental health** concerns including:
  - PTSD
  - depression
  - transition challenges
  - anxiety
  - stress
  - trouble sleeping
  - relationship and family difficulties
  - anger

  Our high-quality care is **evidence-based**, which means we use treatments that are supported by research and considered to be among the best, most **effective** practices available.
- **RESOURCE CONNECTION**
  We connect clients to local resources and provide referrals for related needs such as finances, legal, education, employment, housing.
- **CVN TELEHEALTH**
  Video therapy delivered online makes it easy to access the same high-quality, confidential care without having to visit the clinic. Stable internet connection and device with audio / video capabilities needed.

Learn More: **cohenveteransnetwork.org** @CohenVeteransNetwork @CohenVeterans