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."
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> Further specifics in the policy are as follows:
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> "When can a Veteran be referred to COMMUNITY CARE:
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> - 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:
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> - 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.