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Introduction

I am honored to share my personal story and experiences with the Department of Veterans Affairs (VA) system. In 2003, after serving four years as a paratrooper in the 82nd Airborne, I was medically discharged following an accident during a jump. The subsequent surgeries led to a regimen of heavy opioid use—a path all too familiar to many veterans. Upon leaving the military, I was not informed about the VA or its services. It wasn't until my loved ones intervened due to my addiction that I discovered the VA. In 2004, I began receiving care at the Philadelphia VA Medical Center.

I share this background to frame my testimony, which will draw from my experiences as a VA consumer, Licensed Clinical Social Worker (LCSW), an individual in recovery from substance use disorder, and a community care provider. I believe my diverse perspectives uniquely qualify me to address the current challenges facing VA community care and mental health services.

When I sought help from the VA in 2004, prior to the MISSION Act, I was given a wait time of two to three months for a bed. Today, the VA typically offers a date range of under thirty days. This does not mean the date won't be changed multiple times to a later date. One could say not much has changed in that regard. However, receiving a potential time frame without any guaranteed admission date is devastating when you finally muster the courage to ask for help. I have had multiple stays in VA RRTP facilities over the course of my ten years trying to get sober. During one of these stays, a doctor advised me that saying, "I want to hurt myself," would expedite getting a bed. This practice placed me on the acute psychiatric floor until a bed became available. My stay lasted over three weeks because no beds were available, and I was warned that leaving would jeopardize my chance of getting into the RRTP. Although I knew I didn't belong on a psychiatric floor, I was surprised to find many fellow veterans with substance use disorders similarly confined, waiting for an indefinite period. This practice continues today, raising questions about whether the VA is truly meeting the needs of veterans or merely fulfilling administrative requirements. The next ten years were spent struggling with my addiction as well as trying to get care from an ever-changing complex system.

In 2014, while pursuing my Master of Social Work (MSW), I was enrolled in Vocational Rehabilitation (chapter 31) and my university required VA to purchase commercial insurance for me. They informed VA that having only VA coverage was not sufficient coverage by their standards. I needed SUD treatment and having this insurance allowed me to enter a private treatment facility for opioid addiction, marking my first experience outside of the VA system. The difference was profound. For the first time, I felt genuinely cared for, and the treatment I received was vastly superior to what I had experienced within the VA. I underwent a comprehensive program which included the full continuum of care. This included detoxification, residential care, partial hospitalization (PHP), and intensive outpatient (IOP) services, which took approximately six months to complete. Since December 2, 2014, I have maintained sobriety and achieved numerous personal and professional milestones, including completing my MSW, getting married, becoming a father, earning my LCSW licensure, establishing myself as a community care provider, and a developer of MH/SUD programs around the country. These accomplishments are directly attributed to the quality of care I received outside the VA system.

Becoming a Community Care Provider

In 2020, as the COVID-19 pandemic led to lockdowns and VA facility closures, I was working at a treatment facility outside of Philadelphia. Recognizing the need for continued support, I requested permission to develop a program specifically for veterans affected by the lockdowns. From May 2020 to February 2021, I had the privilege of treating approximately 200 veterans through community care and primarily from VISN 4. During this period, I established relationships with several dedicated VA providers. Together, we developed policies and procedures to meet the evolving needs of our shared veterans, ensuring they received necessary services. While most VAMC providers were collaborative, I was surprised to find that my home VA in Philadelphia was less cooperative. This experience highlighted both the potential for effective collaboration between VA and community providers and the challenges that can arise from inconsistent practices across different VA facilities.

In February 2021, I was approached by a national provider of substance use disorder (SUD) and mental health (MH) services to join their team. They asked me to develop veteran-specific programming at eighteen of their facilities, which provided an opportunity to expand my reach and apply the lessons learned from my previous program on a larger scale. This role also allowed me to engage with VA on a broader level, gaining a deeper understanding of how the entire system operates. Through this experience, I have been able to observe firsthand the complexities and challenges of coordinating care between VA facilities and community providers.

Over the past four years, I have had the opportunity to visit over seventy-five VA Medical Centers (VAMCs), numerous Community-Based Outpatient Clinics (CBOCs), and Vet Centers. Through these visits, I have interacted with a wide range of VA employees, from entry-level positions to executive roles. What I have observed is a significant disconnect between the policies and directives issued by VA Central Office and the realities on the ground at individual facilities. The saying "if you've been to one VA, you've been to one VA" holds true, as each facility operates with its own unique culture and practices. This variability highlights the need for more consistent implementation of policies and standards in mental health across the VA system to ensure that veterans receive uniform quality of care.

During my travels, I identified several areas where the VA lacked adequate services and worked to address these gaps. For instance, I found that there was limited substance use disorder (SUD) treatment available in Alaska, so I established a facility there. Similarly, upon discovering Eastern Colorado lacked SUD treatment options for veterans, I opened a facility in that region as well. Additionally, I developed and implemented an eating disorder program specifically for veterans in Philadelphia.

When VAMCs reached out to me about providing virtual therapy for rural veterans, I was able to meet their needs by establishing programs that served hundreds of veterans. However, when VA decided to cut reimbursement rates for virtual care by 90%, we were forced to close these programs, which had been serving over 800 veterans.

In Alaska, our program was poised to expand services, as there were no detox or residential facilities available in the state. However, the VA cut rates by 60%, and despite our request for a fee waiver, they further reduced the rates. This decision seems counterintuitive, as our services could have supported VA by providing detoxification services necessary for veterans to be admitted into the Domiciliary. I am currently working with a new organization to

bring these essential services to Alaska, and we will figure out how to make it work as our veterans need care.

Community Care Access Across the Country

Through my interactions with veterans and advocates across the country, I have consistently heard about the same challenges. One of the most pressing issues is access to community care for mental health has become increasingly inaccessible. We have witnessed a decline in veterans' ability to receive necessary care, particularly for services not offered by the VA. This problem is not isolated to a specific region; I have observed it in VAMCs from Florida to Alaska. Unfortunately, the situation has worsened following a directive issued last March which limited community care. Since then, I have seen veterans who, like me, sought help but suffered due to inadequate care, with some tragic outcomes. I have documented these experiences in a journal, which is included in Appendix A.

The community care process is intended to be straightforward and veteran-focused, but my personal experience highlights the complexities and frustrations that many veterans face. Last year, I met with my doctor on January 6, 2024, and we decided that I should see a community care provider for dermatology. The consult was placed that day, but it took over four months and forty-four interactions with the VA to get approval. These interactions included two congressional calls, four White House complaint calls, an email to VA Central Office, two handwritten letters to the director of the Philadelphia VA, and numerous interactions with the patient advocate.

The most disheartening aspect was the dismissiveness of the patient advocacy team. When I requested that they follow **VHA Directive 1041**, which outlines the community care appeals process through patient advocacy, they told me it "doesn't apply to our office." Eventually, I received approval for my consult, and I received calls from VISN leadership apologizing for the mistake. However, this raises serious concerns: What if this had been a mental health consult? How many veterans would go to such lengths to resolve their issues? How can a veteran feel supported when their patient advocate seems to be working against them? *(See Appendix B)*

As I have traveled across the country, I have consistently encountered similar issues with community care. For instance, in Massachusetts, I worked with a veteran who was denied entry into a VA Residential Rehabilitation Treatment Program (RRTP) due to past behavior. He then requested community care but was denied without being given a reason. He submitted an appeal through patient advocacy, as the VA was not offering him the necessary services. Unfortunately, the denial was upheld in writing, citing that the VA knew he could obtain a scholarship elsewhere, which they used as justification for not approving community care. I find this rationale puzzling, as it does not seem to be a valid basis for denying community care. I have documentation of this denial, but I would need to obtain a release from the veteran to share it publicly.

In Illinois, I worked with a veteran who resided more than two hours from the Hines VA and required substance use treatment. Fortunately, there was a community care facility located just ten minutes from his home, which was particularly beneficial given the rural nature of the area. Despite meeting the drive time access standard, when he requested that his provider submit a consult for community care, he was informed that this standard did not apply to his Residential

Rehabilitation Treatment Program (RRTP) needs. The veteran appealed this decision but was denied in writing. This case highlights the inconsistencies in applying community care standards and the challenges veterans face in accessing necessary care.

In Texas, I worked with a veteran who was affiliated with the Houston VA. Despite qualifying for a community care consult, he was informed that approval would be contingent on his choosing from list of community care facilities who the Chief of Mental health approved. The veteran submitted an appeal and contacted the White House complaint line. Subsequently, he received a call from the chief of psychiatry, who stated that he could only attend one of three pre-approved locations, as the chief "he was in charge" of what facilities could be used. This same message was conveyed to me via email. We reported this issue to Optum and VA Central Office but were told that they could not control local practices and could only attempt to educate leadership. This experience highlights the lack of continuity in community care process in some regions, where veterans' choices are severely limited by local VA leadership.

In Colorado, we have worked with numerous veterans and non-profit organizations, as there is no VA Residential Rehabilitation Treatment Program (RRTP) available in eastern Colorado. Many veterans in need of RRTP services were told by the Denver VA that they would have to travel to North Dakota or other out-of-state locations to receive care within the VA system. Most VA social workers in Denver will confirm that these services are not offered locally. Given this lack of availability, it seems reasonable that all veterans in need should qualify for community care. What happens to veterans who cannot or will not leave the state? When we inquired about detox services with leadership at the Denver VA, they listed only outpatient options. Upon further questioning, they ceased communication with us. This experience highlights the systemic issues in accessing necessary care and the complete ignorance of the MISSION act.

In Portland, we have worked with numerous veterans who have been consistently told by VA social workers that "we don't use community care." This is particularly concerning given that the Portland VA routinely reports mental health care visits exceeding thirty days on their tracking website. Instead of using community care, most veterans are referred to community providers who accept Medicaid. These providers often operate in large open bay shelters, which can be inappropriate for veterans with a history of Military Sexual Trauma (MST), as they may not feel safe in such environments. If veterans do not feel secure where they are receiving care, the effectiveness of that care is significantly compromised. Furthermore, many veterans are informed that a consult will not even be placed, further limiting their access to necessary services. This practice highlights systemic issues in how community care is utilized and the need for more comprehensive support for veterans.

In Philadelphia, we have encountered numerous veterans who are consistently denied community care. The typical justification provided is that veterans can be accommodated at the Coatesville VA, which is over an hour away from most parts of the city. However, when we have met with the chief of psychiatry, he explains "I cannot send to the community as I won't be able to justify my budget next year". He has cited the MISSION Act, stating that veterans who live within sixty minutes of any VA facility, even if that VA doesn't have the service they won't qualify for community care. According to him, "In the Northeast, where VA clinics are abundant, this disqualifies veterans from receiving community care". It is puzzling that proximity to a VA facility that does not offer the necessary services would be used as a reason to

deny community care. This practice highlights the need for more flexible and service-oriented policies that prioritize veterans' needs over administrative constraints.

In southern California, I have worked with veterans who request community care and are denied. If they are approved, they are only allowed to choose a place within that VA's catchment area. We had veterans from the Long Beach VAMC who wanted to attend a facility in the Loma Linda VAMC catchment, and they were denied due to it being in another VAMC's catchment. This practice also occurs in the Chicago area.

Across the country, I have engaged with Veterans Courts established to support veterans involved in the justice system. One of the primary frustrations these courts face is securing timely access to necessary care for veterans, rather than seeing them remain incarcerated. Communities are coming together to support veterans in need, but a significant barrier remains veterans who rely solely on VA care often struggle to access it in a timely manner. I have met with numerous district attorneys, public defenders, probation officers, and court social workers, all of whom express frustration with the lack of timely access to care for these veterans. The Veterans Justice Outreach (VJO) program is intended to serve as a bridge to facilitate access to care, but it appears that VJOs are often constrained in their ability to secure community care, further exacerbating the challenges faced by veterans in need.

In conclusion, the challenges faced by veterans in accessing community care are widespread and systemic. Across the country, veterans encounter inconsistent application of community care standards, lack of transparency in denial decisions, and restrictive practices that limit their choices. The experiences in Massachusetts, Illinois, Texas, Colorado, Portland, southern California, and Philadelphia illustrate these issues, from being denied community care without clear reasons to facing barriers due to VA facility proximity or “budget” constraints. To address these challenges, it is essential to adopt standardized criteria, such as the ASAM Criteria, to ensure consistency and coordination between VA and community providers. Additionally, streamlining the referral process, educating, and empowering patient advocates, and prioritizing veterans' needs over administrative constraints are crucial steps toward improving access to necessary care. By implementing these reforms, we can ensure that veterans receive timely and effective support, aligning with the principle of acting in their best medical interest.

Community Care Issues

The examples provided are just a few among many (see Appendix A for additional details), and they illustrate that these issues are not confined to a single VA Medical Center (VAMC) or Veterans Integrated Service Network (VISN). Instead, there is a systemic problem with the use of community care, with as many reasons for denial as there are VAMCs. The following list highlights common challenges in accessing community care:

1. **Lack of Written Denials**: In almost every case, VAMCs do not provide written explanations for denying community care, often citing vague reasons.
2. **Discretionary Mental Health Access**: The interpretation of community care access for mental health varies widely among VA facilities, often at the discretion of the Chief of Mental Health.

3. **Patient Advocate Limitations**: Many patient advocates lack knowledge of relevant directives, such as VHA Directive 1041, and find their efforts to assist veterans thwarted by systemic barriers.
4. **Misinterpretation of Residential Care Definitions**: VA providers often define Residential Rehabilitation Treatment Programs (RRTPs) as "extended care," which is used as a rationale for denial based on exclusionary criteria. What is interesting about this point is the definition of residential care in **VHA Handbook 1006.02** states,

Residential care is distinct from VA outpatient, inpatient (acute and psychiatry, medicine, rehabilitation, and surgery beds), and institutional extended care (CLCs).

5. **Process of obtaining a consult:** referral for SUD and MH care through the VA is often arduous, particularly for individuals who are already in a fragile state. This complexity can be attributed to several factors including:
   - **Initial Consult Request**: Many VAMCs require veterans to first see their primary care provider or mental health provider to request a consult. This initial step can delay the process and may not always result in a consult being placed.
   - **Approval Process**: In some cases, the consult is sent to the chief for approval, which can further prolong the process. This bottleneck can lead to significant delays, as the chief may not have the time or resources to review every case promptly.

VA RRTP Application Requirement: Some VAMCs mandate that veterans first apply to the local VA Residential Rehabilitation Treatment Program (RRTP). If the veteran qualifies for VA RRTP but no beds are available locally or within the VISN, the consult may then be sent to the chief for approval. This step can add weeks to the process and may lead to veterans being denied access to community care if they do not meet RRTP criteria. Regarding admission to an RRTP, **VHA directive 1162.02 states** "*Screening with an admission decision must be completed within 7 business days of the referral*". While this is the directive we have seen it take even longer than this just to get a decision.

Admission Review Teams:
Some VAMCs have teams that review potential admissions, but these teams typically meet only once or twice a week. This infrequent review can cause significant delays in the approval process.

Referral to Non-VA Services:
If veterans do not qualify for admission to RRTP, their consults often go unaddressed. In many cases, veterans are referred to seek services through local non-profits or enroll in Medicaid, which may not provide the specialized care they need.

Community Care Approval:
If a consult is approved, it is sent to community care, and a nurse will contact the veteran. While community care nurses often honor veterans' requests for specific facilities only if they align with local VAMC and VISN guidance, many VAMCs have established restrictive rules regarding where veterans can receive community care. This entire process can take anywhere from a week to four weeks to complete, and most VAMCs do not count this time toward MISSION Act access standards. Instead, they may set a clinically indicated date (CID) later,

which technically allows them to remain in compliance with MISSION Act standards but does not reflect the actual date of the veteran's request.

Hospitalized veterans:
When a veteran is hospitalized for substance or mental health-related issues in the community, most Requests for Services (RFS) related to this hospitalization are not processed in a timely manner and often go unconsidered. Technically, these requests should be approved promptly, as the referring provider oversees the veteran's care. However, many VAMCs fail to honor these requests, instead requiring veterans to apply to a VA Residential Rehabilitation Treatment Program (RRTP), which can take several weeks. Community hospitals often lack the capacity to keep a veteran in a bed for an extended period awaiting a VA decision. As a result, many community hospitals have stopped attempting to coordinate with the VA due to the prolonged wait times. This raises a critical question: How many veterans could have been ready to receive care but were instead discharged back to the streets, awaiting an uncertain date for a VA RRTP bed? This situation underscores the need for more efficient processing of RFS to ensure timely access to necessary care.

Best Medical Interest:
A concerning issue is that the "best medical interest of the veteran" access standard is often disregarded. In many cases, providers are willing to write a consult but will inform veterans upfront that it will likely be denied. This practice suggests that the VA's decision-making process prioritizes administrative considerations over the medical needs of veterans. It is crucial that the VA ensures that all decisions regarding community care are made with the veteran's best medical interest in mind, rather than being influenced by factors such as budget constraints or availability of VA services. By ignoring this standard, the VA may inadvertently create barriers to care, which can have serious consequences for veterans seeking timely and effective treatment.

COMPACT Act:
This process needs to be refined as it is not clear to most providers how to work with these veterans and be compensated. Currently private organizations can admit these veterans and it typically takes two to three weeks to find out if the stay will be covered. Organizations cannot function on the hopes and wishes they will be paid. Many providers have issues with veterans who need detox from a substance which could be causing the suicidal ideations, but these veterans are denied in most cases.

Emergent care:
Veterans often present to providers in need of emergent care for alcohol or benzodiazepine withdrawals, but coordinating care with the VA is frequently challenging. According to the Optum CCN provider manual pg.26, "*if a veteran seeks care from a behavioral health provider without a valid referral, the provider must contact the veteran's VA Medical Center to obtain a referral*". However, when we call the local VA, we are directed to the national reporting number. After calling this number, we are given a verification number but often do not receive notification about care approval for weeks. This delay can be critical for patients in need of immediate care. We have collaborated with the directors of VA finance, who process these claims, but they have been unable to identify the root cause of these issues. This lack of timely coordination can lead to significant delays in providing necessary care, highlighting the need for more efficient processes to support veterans in crisis.

In conclusion, the challenges faced by veterans in accessing care through the VA system are starkly contrasted with the streamlined processes available in the private sector. While veterans often encounter lengthy delays and bureaucratic hurdles, the private sector allows individuals to contact a facility, complete an assessment, and arrange for admission on the same day, with transportation sometimes provided. This efficiency highlights the importance of timely action when someone seeks help, as delays can lead to missed opportunities and potentially permanent consequences. The VA must adopt more responsive and efficient practices to ensure that veterans receive the care they need promptly. By doing so, the VA can better align with the principle of acting in the best medical interest of the veteran, ensuring that those who have served receive the timely and effective support they deserve.

Solutions to Community Care Access

As we have discussed, numerous challenges hinder veterans' access to substance use disorder (SUD) and mental health (MH) community care. To address these issues, I propose the following solutions:

1. **Documentation of Denials**: The VA should be required to provide written explanations for denying community care. For instance, when using the DST system to determine drive times, which differ from commercial tools like Google Maps, the VA should provide supporting evidence if a veteran does not meet the drive time standards. Unfortunately, such documentation is rarely provided. It is essential that VA cannot deny community care without clear, documented justification.
2. **Clear Guidance on SUD/MH Access Standards**: There is a need for clear criteria regarding SUD and MH access standards. Adopting the American Society of Addiction Medicine (ASAM) standards would facilitate communication between VA and community providers, ensuring consistency in care delivery. I will discuss this further in the next section.
3. **Appeals Process for Denials**: Pending legislation aims to establish an appeals process for community care denials. However, the issue is not the process itself but rather ensuring that VA staff understand the policies and procedures. Updating the current process to require documentation of initial denials would be beneficial.
4. **Expanded Authorization for Community Care**: Allowing professionals beyond physicians to approve community care authorizations could streamline the process. Currently, the system is often bottlenecked by physicians who may not be fully familiar with a veteran's case. Permitting social workers to approve care, given their familiarity with veterans and existing groundwork, could alleviate backlogs and ensure timely access to necessary care.
5. **Streamlined Process for Mental Health Consults**: A streamlined process for mental health consults requiring Residential Rehabilitation Treatment Programs (RRTPs) is essential. Veterans, their families, advocates, and providers should be able to request RRTPs efficiently. Assessments for these time-sensitive requests should be completed within twenty-four hours.
6. **Efficient Processing of Requests for Services (RFS)**: RFS should be processed through a national notification number rather than local VA facilities. This is crucial for time-

sensitive requests from community hospitals, where delays can be significant. Veterans should have priority access to available beds, whether in the community or VA system, to prevent unnecessary delays and discharges.

7. **Upholding the "Best Medical Interest" Principle**: It is vital to honor the principle of acting in the "best medical interest of the veteran." Decisions made collaboratively between providers and veterans should not be overridden. This includes respecting the professional judgment of social workers, psychologists, and other licensed mental health providers who often have a deeper understanding of veterans' needs.
8. **Emergent Care**: Not every mental health emergency occurs during VA operating hours or near a VA facility, making it unsafe for veterans who are intoxicated, experiencing withdrawals, or in a mental health crisis to travel to a VA facility. Many veterans are reluctant to visit an emergency room due to concerns about being placed on a psychiatric unit. In contrast, community care can offer facilities located where veterans live, with most providing 24/7 admissions. It is essential that the VA adopts a uniform process for handling these situations, removing decision-making from local VA facilities, which often view these decisions as budget issues rather than prioritizing veterans' immediate needs. By doing so, we can ensure that veterans receive timely and appropriate care without unnecessary barriers.

By implementing these solutions, we can improve veterans' access to community care and ensure Veterans receive timely, effective support tailored to their individual needs. VA states, “choose VA”, well it’s not much of a choice when VA is truly in charge of your choice. The above solutions can do just that which is create choice for veterans.

VA’s standard of care for SUD

As a clinician and community care provider who oversees facilities across the country, I would like to highlight concerns regarding communication challenges between the VA and community care providers. These issues stem from differences in standards of care, which hinder effective collaboration and coordination between these entities.

Adoption of ASAM Standards:

The VA has not adopted the American Society of Addiction Medicine (ASAM) standards, despite these being widely recognized and required for community care providers. The ASAM Criteria provide a comprehensive assessment tool that determines the appropriate level of care, specifies minimum treatment hours, and outlines staffing ratios. The VA's reluctance to adopt these standards, citing them as “*they serve as thorough, multidimensional assessments for providers and patients who want to do them”* They found them to be *“long and burdensome for providers to complete and evidence lacking."* (VA/DOD Clinical Practivce guideline for the mangement of substance use disorders, 2021) is puzzling given their widespread use and recognition in addiction treatment. If we want to see an increase in success rates of our veterans, it starts with the proper assessment. “Long and burdensome” should not be terms used when dealing with the lives of anyone let alone veterans.

ASAM Criteria Overview:

The ASAM Criteria are developed by the American Society of Addiction Medicine, a professional medical society dedicated to improving addiction treatment quality. These criteria involve a multidimensional assessment of six dimensions: acute intoxication and/or withdrawal

potential, biomedical conditions, emotional/behavioral/cognitive conditions, readiness to change, relapse potential, and recovery environment. ASAM's guidelines are developed using rigorous methodologies, combining scientific evidence and clinical expertise to establish best practices in addiction treatment.

Benefits of ASAM Criteria:

1. **Comprehensive Assessment**: The ASAM Criteria offer a holistic assessment that evaluates six key dimensions, ensuring treatment plans are individualized and address the full spectrum of a veteran's needs.
2. **Evidence-Based Outcomes**: Research indicates that the ASAM Criteria effectively match patients with the appropriate level of care, leading to improved retention rates and outcomes. Studies have shown that ASAM implementation can increase retention in residential treatment settings.
3. **Standardization and Consistency**: Adopting ASAM would align VA treatment standards with those used by community care providers, ensuring consistency and continuity of care for veterans receiving treatment both within and outside the VA system. This standardization supports seamless transitions between different levels of care and providers.
4. **Widely Recognized and Utilized**: The ASAM Criteria are widely recognized as a standard for addiction treatment, with many states requiring their use for assessments and level of care determinations. The Centers for Medicare and Medicaid Services (CMS) has identified the ASAM criteria as evidence-based treatment guidelines.
5. **Improved Placement in Care**: Adopting the ASAM Criteria would enable better placement of veterans in the appropriate level of care. Currently, veterans are often screened for substance use disorders but not placed in the correct level of care.
6. **Community Care Provider Requirements**: Community care providers are required to adhere to ASAM standards to be part of the CCN network. For veterans in residential levels of care, adherence to these standards is crucial for ensuring consistent and effective treatment.

As per the Optum provider manual which community care providers must follow it states *"The ASAM Criteria was not written for health plans or insurance coverage but was written to improve assessment and outcomes-driven treatment and recovery services. It is used to match patients to appropriate types and levels of care. It defines specific levels of care within SUD services that comprise the care and evaluation within the six dimensions to determine patient placement*". Why is community care held to one standard and VA gets to make its own? If VA was truly the leader in this type of care wouldn't the rest of the industry, follow suit?

By adopting the ASAM Criteria, VA can enhance treatment outcomes, improve collaboration with community providers, and ultimately better serve the complex needs of veterans. This standardization would facilitate more effective communication and coordination between the VA and community care providers, ensuring that veterans receive timely and appropriate care.

Lack of Standards Lead to Negative Outcomes:

In an OIG report from 04Jan2024 titled *VHA Needs more written guidance to better manage inpatient management of alcohol withdrawal*,[i] it was found that approximately 4% of all acute admissions in VA during the years 2020 and 2021 were due to alcohol withdrawal. A survey of 30 VHA healthcare systems by the Office of Inspector General (OIG) revealed that 87% of these facilities lacked written guidance on consulting a substance use disorder (SUD) specialist for managing alcohol withdrawal. It also noted 57% of these systems lacked any guidance on how to determine the appropriate level of care for these veterans. The OIG published reports in 2021, 2022, and 2023 highlighting incidents related to inadequate alcohol withdrawal management, all of which resulted in the death of a veteran. Notably, these reports utilized guidance from the American Society of Addiction Medicine (ASAM) in examining the issues and making recommendations. VHA's response to the OIG report was to concur with the need for written guidance on the management of alcohol withdrawal and asked the local level to provide this guidance. Why not use the industry standard which is accepted and utilized everywhere but VA? These reports outline three veterans who died due to the issues discussed how many veterans could we have lost that we don't know about?

Lack of Standards on the use of Ambulatory Detoxification:

Since VA does not use ASAM criteria, the judgment of who is appropriate for ambulatory detoxification and who is not seems subjective. This was evidenced in all three OIG investigations. According to **VHA directive 1160.06**, "**Management of Admission for Veterans in Acute Withdrawal**," it states, "*Although alcohol and drug withdrawal can often be safely and effectively managed on an outpatient basis, medically monitored inpatient withdrawal management must be available, as needed, for Veterans evaluated to be at risk for moderate to severe withdrawal from alcohol, sedative/hypnotics, or opioids.*" In practice, we have observed veterans visiting the "mental health same day access clinics" for SUD and being provided ambulatory detoxification medication, which is essentially "the management of detoxification on an outpatient basis." Technically, the VA is meeting the veteran's need and fulfilling its requirement to provide this level of care. However, the question remains: Is the VA truly meeting the needs of these veterans in a meaningful way or the needs of the VA?

a. Ambulatory detoxification is best suited for individuals experiencing mild to moderate withdrawal symptoms and having a strong support system at home. This approach is ideal for those requiring flexibility in their treatment schedule and capable of managing symptoms without 24-hour medical supervision. It is particularly suited for individuals with stable mental and physical health, without severe medical conditions or co-occurring mental health issues. However, how can we ensure that veterans have these necessary supports if a comprehensive assessment is not conducted when they present for care? In my experience, I have encountered veterans who consume large amounts of alcohol daily, such as a half-gallon of vodka, and are offered ambulatory detox medications while being placed in outpatient care until a bed becomes available at a VA RRTP. This practice is perplexing because it suggests that the veteran requires residential care, yet they are sent home due to unavailability, highlighting a disconnect between the level of care needed and the care provided. Also based on the above criteria a veteran discharged to a shelter would not be a good fit but it happens all too often.

Lack of Consistency in Continuum of Care:

In appendix F section C of the ***VA/DOD SUD/MH practice guidelines***, veterans who took part in a focus group around VA care "expressed frustration in the lack of coordination and inadequate transitions between inpatient and outpatient treatment settings. Participants reported they had to initiate care and there was a significant time lag in access to outpatient services. ". Participants noted a significant difficulty in transitioning to an outpatient level of care. Participants noted a lack of information from providers as well as a lack of a clearly defined plan.

As stated in my personal journey I was able to take part in a full continuum of care which greatly aided my recovery. RRTP is just a starting point in someone's journey. Research published by the National Institute on Drug Abuse (NIDA) indicates that "individuals who remain in treatment for 90 days or longer have better outcomes, including lower relapse rates, compared to those with shorter treatment durations". This length of stay does not all need to be at the RRTP level of care. There should be a step down to partial hospitalization (PHP) or intensive outpatient (IOP) or outpatient (OP).

1. **VA Continuum of Care: <u>VHA directive 1160.04</u>** defines VA continuum as,

b. The continuum of care for provision of SUD services using a stepped care model.

includes:

(1) ***Level 0.*** *Foundational services including self-care.*

(2) ***Level 1.*** *Interventions in primary care, non-specialty SUD care and general*

mental health clinics.

(3) ***Level 2.*** *Specialty SUD outpatient services, intensive outpatient SUD programs, Opioid Treatment Programs, residential rehabilitation, and acute inpatient services.*

2. **Community Care Continuum of Care:** The following is the standard community care must follow,

ASAM Levels of Care

a. **ASAM Level 0.5**: Early Intervention
   - Assessment and education for those at risk of substance abuse.
b. **ASAM Level 1.0**: Outpatient Services
   - Less than 9 hours per week; for mild disorders or transitioning from intensive programs.
c. **ASAM Level 2.1**: Intensive Outpatient Services
   - 9-20 hours per week; for moderate disorders requiring structured support.
d. **ASAM Level 2.5**: Partial Hospitalization
   - At least 20 hours per week; daily structure for routine living skills.

e. **ASAM Level 3.1**: Clinically Managed Low-Intensity Residential
   - 5 hours or fewer of treatment per week; for relapse management in a group home setting.
f. **ASAM Level 3.5**: Clinically Managed Medium-Intensity Residential
   - For individuals with cognitive function issues; slower-paced treatment.
g. **ASAM Level 3.7**: Clinically Managed High-Intensity Residential
   - 24-hour oversight for those at risk of severe withdrawal or harm.
h. **ASAM Level 4**: Medically Managed Intensive Inpatient
   - 24-hour medical and nursing care in a hospital setting for severe cases.

Comparison:

- **ASAM is More Comprehensive**: ASAM provides a detailed and structured framework that ensures consistency and continuity of care. It is widely recognized and adopted by community providers, which facilitates better coordination and outcomes.
- **ASAM Offers Better Standardization**: The ASAM Criteria are evidence-based and provide clear guidelines for each level of care, ensuring that patients receive appropriate treatment based on their needs.
- **VA Model Lacks Specificity**: The VA's stepped care model, while accessible, lacks the specificity and structure of ASAM, potentially leading to variability in care quality across different facilities.

In summary, ASAM offers a more comprehensive, standardized, and effective framework for substance use disorder treatment compared to the VA's continuum of care. ASAM's detailed criteria and evidence-based outcomes make it a superior choice for ensuring that patients receive the appropriate level of care.

The VA's Intensive Outpatient Programs (IOPs) often fail to meet the standards outlined in **VHA Directive 116.01**, which requires a minimum of nine hours of programming per week. During my visits to various VA Medical Centers (VAMCs) across the country, I have found that only a few meets these standards. Most VAMCs lack nighttime IOP options, leaving a significant portion of the veteran population without access to care. Veterans who work or attend school and require evening services are frequently denied community care consults. VA denies because they offer IOPs, even though these services are often inadequate or not when they can attend. For instance, VA Philadelphia's response to inquiries about their IOP schedule is typically that they have an IOP which offers a one-hour group session five days a week, which is often unrelated to substance use disorder (SUD) treatment. This schedule doesn't even meet VA standards. This is not an isolated case; many VAMCs claim to offer IOPs but, upon closer examination, it becomes clear that they have pieced together services to appear compliant. This practice denies veterans the comprehensive care they need and can lead to further barriers in accessing community care.

Closing Remarks

In conclusion, the challenges faced by veterans in accessing community care are widespread and systemic. Through my personal experiences and interactions with veterans across the country, inconsistent application of community care standards, lack of transparency in denial decisions, and restrictive practices hinder timely access to necessary care. The experiences in Massachusetts, Illinois, Texas, Colorado, Portland, Southern California, and Philadelphia highlight these issues, from being denied community care without clear reasons to facing barriers due to VA's fear of losing veterans to the community. This is a systemic problem and one which is costing veterans their life.

To address these challenges, it is essential to adopt standardized criteria, such as the ASAM Criteria, to ensure consistency and coordination between VA and community providers. Additionally, streamlining the referral process, empowering patient advocates, and prioritizing veterans' needs over administrative constraints are crucial steps toward improving access to necessary care. By implementing these reforms, we can ensure that veterans receive timely and effective support, aligning with the principle of acting in their best medical interest. Our fellow veterans need our help, and this should be a team effort not a battle to justify budgets.

I urge policymakers to consider these recommendations and work toward creating a more responsive and veteran-centered community care system. By doing so, we can honor our commitment to those who have served by providing them with the care they deserve.

Appendix A

The documentation in this section only covers into early 2023. Unfortunately, any documentation afterwards is unretrievable as I no longer work at the organization whose network I had been using. I can assure you the issues outlined here are the same today if not worse.

2021

- **May 2021**: Philadelphia VA is one of the most difficult facilities to deal with. Dr. Oslin, the Chief of Mental Health, is notorious for not signing consults. He told me on a call, "We need to keep our veterans with us, or we will lose resources." After an email from Mary Beckett in Dr. Upton's office about utilizing community care correctly, Dr. Oslin called me to discuss how to help veterans. However, he frequently denied community care consults, which were sometimes approved after I called him.
- **June 2021**: Danville VA - I received a call from Dr. Stephanie Erickson from the Danville VA. She was upset that our team had been calling to help veterans get referrals for the community. I explained to her our team understands the criteria for getting a referral and we explain this to the veterans as well. We have been spoken to several SWs who work for Danville and have said they have "difficulty getting care for their veterans and it's even more difficult for a community referral". I was also told by Dr. Erickson "we don't need your help and all of our veterans will be served here". I also met with several SWs and they expressed their struggle with getting veterans in this region care. They stated, "leadership won't send out as it will cost them jobs in our VA".
- **July 2021**: Hines VA - I have spoken with several providers there, the main one being Erin Magano who is the director of the homeless program. We have a facility in the outer reaches of the Hines VA's area which they would like to use. We have been cleared by their CC department but have yet to get a referral. I had been asked by Erin to connect her with other VA social workers who have gotten auths. I am assuming here but based on the conversations with her and others they want to send veterans to the community but cannot get the auths approved.
- **July 2021**: Togus ME - This veteran did admit to us but only after the following situation: His Psychiatrist Dr. McIntyre at the Togus VA in ME submitted the consult twice, and community care says he is eligible for a community care referral, but they refuse to send him out of their region. They sent the veteran to TX in November. The Chief is refusing to send him out of the region.
- **July 2021**: Houston - We had a veteran request to come to our facility which is part of the CCN but was told we "weren't on the approved list". Apparently, Houston has a list which comes out every Monday of who providers are allowed to refer to.
- **July 2021**: New Orleans- we have had several veterans request services but were unable to get authorizations for them. The patient advocate at this facility was super helpful but as of now none of the leadership has responded. We know the veterans in this area are sent to Arkansas or Biloxi for substance use care. The Patient Advocate stated, "it's almost

impossible to get a veteran a referral here". Haven't had much more interaction to know the validity of this.

- **August 2021**: Boston, MA - An email chain from the Jamaica Plains VAMC discussing community care referrals and wait times for SARRTP.
- **September 2021**: West Palm Beach VA - Initially had a waiting list and did not send veterans out, but later began sending them towards the end of the year.
- **Fall 2021**: Danville VA - There was a dispute regarding a veteran who was asked to pay for his own ticket to travel for treatment.
- **October 2021**: Syracuse VA - They typically sent us 10-15 veterans a month but were later directed to keep as much in-house by sending to other VA's.
- **November 2021**: Togus ME - The veteran was sent to TX for care.
- **December 2021**:
  - **12 December 2021**: Brockton, MA - Any veteran who needs residential MH or SUD must first be interviewed by that VA's program. If and only if they are approved to get services, will they be put on a list. If the wait list is more than 30 days then they will get a CCN referral. If the team does not feel they would be accepted into their program, then they will not get a referral. The providers are fed up and echoed it's the admin who calls the shots.
  - **16 December 2021**: Coatesville is the local SUD/MH hub for this region and has been closed for almost two weeks now. Wilmington VA has sent us sixteen veterans for inpatient SUD care. Philadelphia is much larger and has sent three outpatient who need inpatient care but won't auth inpatient. The other SUD/MH hub Lebanon has closed as well.
  - **23 December 2021**: Coatesville VA was not accepting referrals for the SUD program due to COVID until at least January 5, 2022. Veterans were placed on psychiatric units until SUD beds became available.

2022

- **January 2022**:
  - **Update on Syracuse VA -** They asked us to stop providing care which the veterans like. They said they are having a difficult time getting veterans to engage in VA care because the food is "too good" especially serving them ice cream. They asked if we could stop that. They also asked if we could "stop allowing them to smoke" since veterans don't like that the VA won't allow them to smoke. They also asked if we could not allow them to see what else we offer as the veterans push back against using VA after seeing us. The focus of the call was that veterans don't want to utilize VA care and we are making it "hard for them to compete".
  - **Update on medication issues** - After meeting with the new undersecretary of care in the community (Dr. Flynn), we were able to resolve the issue with injectable

medications like Vivitrol. However, the problem with CVS filling prescriptions persists.

- **Brockton, MA** - The attachments are regarding a veteran from the Brockton, MA VAMC. This veteran requested treatment for SUD and was denied. His SW contacted me and asked if we could help. I asked why he was denied care and she told me he had been a behavior problem in the past and due to this he was not appropriate for their facility. He requested a consult for CCN which was denied. He then submitted this appeal on 19 January 2022 but because the PA didn't log it until 21 January 2022 the time did not start on his appeal. For some reason, his providers supervisor told them they he had a scholarship to our facility if he was denied. They denied him a consult because we offered him a scholarship. I was told by the SW the administration was angry the veteran had "found the law" and put such a request together.
- **20Jan2022-** I was able to connect with the wife of one of the veterans I had been helping who ended up committing suicide. She would be more than happy to share her husband's story with you. He was a Vietnam veteran. The VA had sent him to our facility for substance use disorder but upon arrival it was evident he needed mental health treatment as well as urology. We tried to get him to urology when he was with us, but they would not give a community consult. They originally kept him in the acute psychiatric unit for a few weeks (so technically they were meeting his needs by the VA's definition). Acute needs should not last weeks. They denied his CCN request for urology which was a big contributor to his decline in mental health. His wife's name is (redacted), and her number is (redacted). She asked if someone could call after 430 EST.

We brought him back to the VA to get mental health treatment. After we dropped him off and the VA knew he needed care they left him alone and he fled the VA. The VA initially tried to blame our facility, but his wife had gone up to get him. She met another veteran's wife who was present for her husband being brought in and handed off to VA providers. This contradicted everything the VA told us and his wife. I am working on getting you some more veterans to speak with as well.

- **February 2022**:
  - **2 February 2022**: Met with the Long Beach VA team. They were very open to utilizing our services but did tell us about their procedure. First, a veteran must request treatment and be approved by their SUD program. Once they are approved, the consult is then sent to a committee which determines if they will give approval or not. From the sounds of it, the providers are not part of this committee.
  - **3 February 2022**: Met with the Hines VA who have sent us some eating disorder and mental health veterans. Most providers are unfamiliar with the process of submitting consults as they are not always approved. It was unclear but it sounded like Dr. Nutter was the gatekeeper who would or wouldn't be approve consults. Providers did tell us they are always instructed to search the entire VISN first and then if no care can be found then search other VISNs and if no care can be found there then a consult can be placed.

- **9 February 2022**: This veteran (Redacted) requested a CC referral due to being over an hour from the facility. He was denied and he wrote an appeal letter which was subsequently denied. It took well over two weeks to get a response as well. The VA failed to meet the required three-day response period as well. They did put their own date on it, but he has the initial email. I gave the veteran a free month of treatment at our facility which is close to home.

- **March 2022**:
  - **2 March 2022**: We just got a call from a veteran and his wife who has been trying to get him substance use treatment. The veterans VA provider has expressed her concern as the Hines VA has a full inpatient unit and a full outpatient unit. The only option they can provide him is the acute psychiatric unit at this time. The VA provider, the veteran, and his wife know this is not what he needs. The provider is going to try and place a consult but is unsure as "our (Hines) facility doesn't allow us to refer out". I have connected her with providers who have done eating disorder referrals to help her out.

- **April 2022**:
  - **15 April 2022**: Coatesville VA - A veteran was deemed better suited for our facility, but the VA team could not submit a consult due to computer issues. They suggested we scholarship the veteran instead. When asked why they wouldn't refer out if they couldn't provide the best care, they stated that they do provide care but it wouldn't be ideal for the veteran, and thus they cannot refer out.
  - **13 April 2022**: Seattle VA - A coworker has been working with the director of SUD at the Seattle VA. She was informed they will only give a CCN referral after a veteran has attempted the Seattle VA's program three times and failed. They told her this is the only way someone would be considered for a CCN referral for SUD and even then, it's not guaranteed she will allow them to go to the community.

29April2022

- We had a veteran (Redacted) from the Philadelphia VA be admitted to the Philly VA hospital(23April2022) for alcohol detox complications. He was there for a few days and then discharged home. He had an appointment four days after discharge and asked for SUD treatment and they told him he would be put on the wait list. He asked for a consult to the community, and they told him "no". He almost died from drinking, asked for help, and was sent home. This veteran was readmitted this weekend (30May2022) due to him drinking again while he awaits the VA to send him somewhere. If they would just provide the care when he needs, he wouldn't have to continue to be seen in the emergency room. (05May2022) Veteran was found in the street seizing from alcohol use and again needs to go back to the VA.

- **May 2022**:
  - **5 May 2022**: Houston VA – (redacted) a veteran, was referred to us by a nonprofit program that struggled to find good CCN-approved facilities. They work very closely with the Houston VA and are looking to start utilizing our location to provide services

for veterans. A Dr. Nair at the VA submitted the consult for (redacted) to come to us for services but, at that VA they have created a "special approved list" that provides 10 facilities in which the VA can use for services, and we haven't made it on that list.

- **June 2022**:
  - **8 June 2022**: Hines VA - We have two veterans through the Hines VA. One needs SUD care and has been referred through veteran's court. The Hines VA will not give an auth and has told them it's a 5-6 week wait list for VA RRTP. They offered him to go to Milwaukee which is over four hours away.**10 June 2022**: I was finally able to get consults placed for both veterans after emailing Dr. Flynn the undersecretary of care in the community who then contacted the national patient advocate team.
  - **18 June 2022**: Lyons VA - Veteran (redacted)-he reported he was approved for CC and requested to attend our facility. I spoke to PT and the VA wanted to only send him to Sunrise in NJ. He really wanted to come here but the VA wouldn't allow it. He has intake on Monday at Sunrise.
  - **22 June 2022**: Biloxi VA - Providers have reported the VA has taken the ability of providers to recommend levels of care for veterans requiring MH/SUD treatment. They now have a separate team who has worked with the veteran to make a recommendation which does not always seem to be as beneficial to the veteran.
- **October 2022**:
  - **15 October 2022**: Lyons VA has been sending us veterans but as of recently they have been instructed to search the entire VISN and surrounding VISNs before sending to the community.
  - **20 October 2022**: Veterans in the panhandle of Florida are being sent to Arkansas for SUD treatment.

3 January 2023

- **Tuskegee (AL)**: Met with the community care department, including one of the leads and several nurses, and the patient advocate. The sentiment at this facility with the CC team is they have "no issue placing and getting consults done. The issue is with getting the doctors to sign the consults. They always have some reason as to why they cannot sign the consult". This department struggles with the delays and pushback the doctors give them when trying to get a veteran care in the community. This department also does the authorizations for Montgomery as well.
- **Montgomery**: Met with a social worker (a veteran herself) in the SUD/MH section. She told us she is booked three months out for individual sessions. She says they place community care consults and then it's up to getting a doctor to sign it. The overall sentiment is they can't keep people (employees) because they are "overworked and have a lack of support from VA". The VA system is "not conducive to providing consistent MH care which is integral to providing quality care". She is unable to see veterans on a weekly

basis which at least in the beginning of mental health care would be the standard of care (Very far from “world class care”).

- **Birmingham**: They moved all mental health to a new building. The patient advocate here was helpful and connected us with the directors of the facility, and we are still waiting to hear back from them.
- **North Dakota**: Spoke to the Patient Advocate and head of social work at Fargo. They said they rarely refer to community care providers. When someone requires residential MH or SUD, they send them to the St. Cloud (MN) or Black Hills VA(SD). St. Cloud is a three-hour commute, and the Black Hills, which is in Hot Springs, is a seven-hour drive.

4 January 2023

- **Black Hills**: Has a Dom onsite. They will only refer for specialty programs which they cannot treat.

5 January 2023

- **Hines**: Met with the chief of mental health (Thomase Nutter) and chief of social work (Joe Adder) who were very open to speaking with us. We have worked with them on eating disorder veterans, and they were very open to sending eating disorder veterans to us. We met to discuss how we have SUD services in their area and a treatment center in two areas they cover which are a 90-minute drive from this VA. Dr. Nutter was very open that they cannot send veterans out due to drive time because they have a residential program (12 beds) and SUD residential treatment is “not covered under CCN as it is domiciliary care”. (Considering we offer outpatient services near where the veteran lives, you would think that would qualify) The VISN has been pressuring the chief to open back up to double occupancy rooms, but they do not have the staff and are concerned with COVID. They also said they send to other VA providers anywhere in the country before sending out. This is a sentiment which is echoed over and over to keep veterans in VA healthcare. This VA had an eating disorder team at it, but they all left and there is no one left to treat these veterans.
- **Jesse Brown**: I was invited by the Community outreach team to meet and do a tour of the VAMC. The clinicians we met with were very welcoming and open to collaboration with outside providers. The eating disorder team was very happy to meet with us and had a veteran who would need our services. We spent about two hours speaking with several MH providers. One of the areas of frustration seems to be the “higher ups” decisions to not always provide the appropriate level of care for the veterans. There is a lot of putting people into outpatient levels of care rather than sending them to inpatient or a community provider who can meet those needs. They didn’t come out and say this, but during the conversations, these were some of the comments made. Most were careful with their wording, but it was the lower peer support veterans who were more vocal with their frustrations in the “old way of thinking”.

- **Sheridan**: The patient advocate was not available but spoke to people at the front desks in social work and mental health. Both said they have enough services internally and if they need a higher level of care, they use Black Hills VA for residential use when needed, which is a four-hour drive.
- **Cheyenne**: Spoke to the Veteran Experience Officer in the patient advocate office. They do refer to Black Hills but won't utilize the CCN. They were standoffish and said they couldn't provide much information as they cannot show favoritism towards one provider.

6 January 2023

- **Danville VAMC**: Met with (Josh Friant) to discuss utilizing community care and the services they need for veterans. He said he has seen a change since the last director left. He stated he has had to advocate for at least twelve veterans in the last seven months to get community care consults pushed through. Veterans presented for help, and they had over a 30-day wait list for care in their facility. The veterans were never offered community care until they met with him. He said they have 15 beds, and they are always filled. He was very open to working with us but is aware of the administrators throwing up roadblocks in using community care. He is a veteran himself and very passionate but has echoed frustrations with the VA and the politics involved in getting fellow veterans the services they need.
- **Indianapolis VAMC**: Mental health facility seemed empty, but was able to speak with the person who checks clients in. He said he was familiar with community care and was asking what services we have to offer. He said the MH clinic is always backed up for therapy and currently is booked through April. He said they have a lot of veterans who show up who "need care but can't get it".. Still haven't heard from the chief or get a response from an email.

9 January 2023

- **Palo Alto VAMC**: Was not able to directly speak with anyone, but staff was happy to give me the director's name, phone numbers, and emails.
- **San Jose**: Was able to meet with the program services administrator who met with us to discuss our services. She gave us her email and was willing to send the email to the staff. (She did forward an email with me attached to the entire CBOC).
- **Fremont**: Small CBOC and gave us the director's name to connect with.
- **Oakland**: Mental health was in another building, and there were no MH providers we could connect with.
- **San Francisco**: Went to behavioral health in the main hospital, and there was only one SW, and we were told the rest work remotely. We then went to building 8, the behavioral health building. It was interesting as they are expanding the building, but on all three floors, there was a total of one clinician working. There were more than forty offices with

names but no one working there. We spoke to the front desk, and they said, “providers only come in once a week and there is no set schedule; it is whenever they want to come in”.

10 January 2023

- **Livermore CBOC**: Met with Sean Gibson (MH treatment coordinator) who was interested in the services we offered, especially eating disorders. He told me they just had a meeting about the lack of these services within the VA.
- **Previous Meeting with Dr. Dominguez**: He was not open to our services at first and said they are “not allowed to send to community care and have to keep it within the VA”. They don’t send veterans to detox but rather prescribe them “ambulatory detox” at home. After a veteran detoxes at home, they can go to Menlo Park DOM and receive OP services.
- **Modesto CBOC**: Spoke with the front desk who said they would take my card, but they are not allowed to discuss what services they offer.
- **Fresno VAMC**: Met with Ed, the assistant executive director of the hospital, who then called in the director of the mental health service line. We discussed our services, and they informed us they are going to “stop utilizing the CCN for SUD as they will be keeping everything in house”. They informed me they are at “50% staffing for SUD but will be onboarding and be at 70% capacity soon”. They use one CCN program right now but will be stopping once they have all the staff they need. They agreed they don’t have eating disorder resources and would pass my information along for those services.

11 January 2023

- **Sacramento VAMC**: We have been doing most of this system's telehealth services. They do send about 15-20 veterans a month to CCN provider Akua for residential SUD and MH. We spoke with the nurse manager who has said they “have a need for an eating disorder program” which we do have. They took our information and said they would like to set up a meeting.
- **Mclean CBOC**: Met with the CCN patient advocate who took our information and sent us to social work. They have referred people in the past and don’t have any issues with using CCN.
- **Mare Island CBOC**: Met with the patient advocate who told us they do send veterans to the community when they need help. He did tell us MH services at their facility are “horrible and they get a lot of complaints because none of the providers come in”. They told me the psychiatrists don’t do video appointments but just phone sessions with the veterans, and veterans hate those sessions. Met with the BH nurse who took our information and echoed the sentiment of the PA.

13 January 2023

- **Albuquerque**: Met with community care workers and the supervisor of the department. They were very open to having a meeting with us about our services and what we offer. They have offered to set us up with the CCN behavioral health nurse. They told us they do send many veterans to the community for SUD and MH. They do get many calls from veterans requesting CC because they have long wait lists. They do have a need for eating disorders as well.

17 January 2023

- **Prescott VAMC**: Met with Jason Ramos, the chief of the domiciliary, to discuss our services. He informed us they have 160 beds and don't normally have a wait list or a need to send to the community for SUD. We discussed how he has been getting veterans from all around the country to his program and has been asked to expand his bed count. They do need resources for eating disorders which he has tried to use us in the past. They also provide telehealth and follow-up care, which seems to be the most comprehensive of any VA I have been to. This is only domiciliary care, which is not residential. One thing which does not add up here is they say they have staffing issues and have 160 beds. On the list of providers, there was only eight psychologists who provide care. If this is true, then there is no way they should have 160 clients. Following ASAM staffing standards, you shouldn't have more than 8-12 people on a case load in residential treatment, which would limit this facility to 96 veterans they could serve.
- **Phoenix VAMC**: Met with James Cox, who was the director of the MICU. We discussed how this VA only has domiciliary care and not residential services for SUD. We discussed how a veteran must prove through multiple failures at lower levels of care before they will even be considered for the domiciliary at this facility. We discussed how this VA will not send any veterans out of state as this is what has come down from above. We discussed how there are more than a few veterans falling through the cracks at this VA and not getting the care they need due to resistance in sending to the community. This VA does not have a detox either and he believes they send them to the psychiatric ward for a 72-hour detox. This is not sufficient time for an appropriate detox. I have noticed more than a few of these facilities don't technically offer residential services anymore. What they do is offer "the dom" which they reside at and then get services which are technically outpatient. This allows them to circumvent standards of how many veterans a clinician can have on their caseload. There has been a switch to saying they have domiciliary care and not residential. Technically, the Phoenix VA does not offer residential SUD treatment, and any veteran requesting these services should qualify for a CCN referral.

Appendix B

6 January 2023

- Saw pulmonology for my yearly appointment and it was suggested I see dermatology. I requested a community care consult, and he told me I would have to speak with dermatology when they called. Doctor placed the consult on 6 January 2023.

27 January 2023

- I was contacted by the dermatology scheduler who said they had an appointment on 27 February 2023. I asked for a community care consult to be placed due to the appointment wait time as well as the distance as I live 60 minutes from the facility. The scheduler told me I did not qualify, and she would not request a consult be placed. She informed me "we go by the PID date, and your doctor gave us a PID of 1 March 2023, so we have until 1 April 2023 to get you an appointment". I told her that I still qualified under the distance, and she told me that's "not true since we can get you an appointment in 30 days none of the other criteria matter". I became angry and so did she and she began yelling and telling me "You don't know what you're talking about". (I was not very nice in return). She wouldn't give me her name and hung up on me.
- I immediately received a call back from a Denise Johnson who said she was a supervisor. She wanted to see how she could help me. I told her "I would like a community care consult be placed" and she reiterated what the first woman told me "we go by the PID date and since we can get you in within that time you cannot have a consult placed". She asked me "what will make you happy" and I told her if she could "please get me in writing exactly why I was being denied this request"? I was informed she would need to ask her supervisor and would call me back later in the day or tomorrow.

30 January 2023

- I emailed my primary clinic requesting a community care consult be placed.
- I emailed the patient advocate (for some reason whenever I send a message to the patient advocate appealing my decision or asking about community care they disappear from my sent box within 48 hours) I left a voicemail from patient advocate.

3 February 2023

- I heard back from my primary care that they placed a community care consult for this appointment.

6 February 2023

- I received a call from the nurse in dermatology who informed my "consult was denied because we can give you an appointment within 30 days". I asked who denied the consult and he would not tell me.
- Called patient advocate and emailed.

7 February 2023

- I emailed the provider of dermatology who told me she understands my frustration, but community care said, “based on your address you don’t qualify”. I confirmed the address, and she was using an address I haven’t lived at in 10-15 years. I was confused as I get all my mail from VBA, VHA, Philly VAMC to my current address.
- I called the patient advocate left a message and emailed.
- I called the national VHA hotline in DC and filed a complaint, Case Number: 09467772
- Spoke with the local congressional rep and filled out paperwork for them to get involved.

8 February 2023

- Heard back from dermatology who resubmitted my consult to community care as she said “it appears based on your updated address you do qualify for a community care referral”.
- Called patient advocate left VM and emailed.
- I called the national nursing line and told them what was going on. The nurse was very helpful and said “I am sorry this is happening unfortunately the Philadelphia VA is notorious for not answering the phone, returning calls, or emails. Whose numbers do you need, and I will give you their direct lines, so you don’t get stuck in a main mailbox”.

9 February 2023

- Received a call from the patient advocate who said, “I received your file from the main VHA complaint line and wanted to confirm that you do qualify for community care, and I will make sure the consult is placed”.

15 February 2023

- I called the patient advocate back and this time she told me “Looks like your consult was denied after we reviewed it again. Based on the software we use you don’t meet the time requirement. Someone from CC was supposed to call you to explain.”. I informed her they haven’t and that I would like this in writing so I could appeal it. She took my email and I have yet to hear from her.

28 February 2023

- I called the patient advocate and spoke with Judy who told me Carol was assigned to my case. I was told she would call me back in 10 mins and an hour later I got a message that Carol would connect with me at some point....
- I am filing another complaint with the main VHA hotline to get my denial in writing so I can follow VHA policy to appeal to the VISN. VA hotline 9616278

1 March 2023

- Spoke with Carol S that she is forwarding my concern to CC and will get me the denial in writing. I asked if she needed a copy of the VHA policy and she laughed and said, “I won’t say anything to incriminate myself”.

3 March 2023

- VA responds with written letter (see attached). They essentially said because I refused an appointment it was my fault “drive time and wait time standards could not be met”.

5 March 2023

- My response to the VA letter:

Mrs. Belton,

Thank you for getting back to me. I would appreciate if we could get some clarity on the reason, they are denying me. In this letter it states that "4. VA cannot provide care within certain designated access standards Does not meet criteria as DST (decision support tool built in CPRS) indicates veteran is less than 60 mins drive time and appointments are available at the VA less than 28 days. Veteran has refused multiple appointment date options. In this situation, VA is unable to schedule an appointment that is within both average driving time standards and wait time standards. "

First, I was asking for a community care referral based on drive time which is why I was unwilling to accept an appointment. This is a right afforded me by congress and it has taken two months for VA to reply with rationalization for not providing a CCN referral. I am unsure how my refusal for an appointment takes the onus off VA to not meet the drive time standard? Whether I accept an appointment or not has a bearing on drive time.

I would like a printout of VA DST showing I do not live within the drive time requirements. Using google maps and other civilian maps show the drive time ranges between 85 and 50 mins. The average I have found is 67 minutes utilizing civilian technology. Therefore, I would request that you please include what your system shows as well as a printout. If VA is going to deny me a right afforded me by law, you should be able to provide clear documentation. Please let me know if you cannot do this and why so that I may proceed with my appeal to the VISN level. Thank you again for your time and consideration.

6 March 2023

- Spoke with patient advocate who told me I need to speak with Renee Tucker the manager of CC. The patient advocate told me that is who would need to help me get that information.
- Called and left VM for Renee Tucker. (2158235800 x209390)

7 March 2023

- Called and left VM for Renee Tucker

10 March 2023

- Called and left VM for Renee Tucker

13 March 2023

- Spoke with someone in the patient advocates office who apologized and said she would message Mrs. Tucker to call me ASAP. No one called me.

14 March 2023

- Called patient advocate and no one will answer.
- Emailed the former Undersecretary of CC who then forwarded me to Shaterri Brown who contacted VHA15 for review.

15 March 2023

- Called VHA hotline again and filed another complaint VHA case number- 09739517. I requested to please have my denial with the printout of the DST so I could appeal to the VISN.

20 March 2023

- Received a reply from Shaterri Brown from VISN 4

Good afternoon!

Sharing the update below from VISN 4 Veteran Experience Office.

"This is a VA Hotline Case that was entered on 3/15/2023 with the Request being created on 3/16/2023 under General. The Service Line of Community Care has the Request assigned to them, per National Policy they have 5-7 business days to respond to a general case, leaving the Service Line 5 more days to respond to the Case. "

We will continue to provide updates as they become available.

Thanks!

28 March 2023

- I emailed Shaterri as it was past seven days and still no response....

29 March 2023

- I received this response from Shaterri

Good Afternoon,
Our VISN 4 partners have informed us that a new dermatology consult was created today for you by your Primary Care Provider. Any additional concerns regarding this consult can be addressed by his PACT Team using MHV Secure Messages or by calling (215) 823-4280 Option 5. Furthermore, the team provided Mr. Thompson's contact information in the event further assistance is needed.
POC: Iain W. Thompson, MPH | Supervisor Patient Representative, Veteran Experience Office | office: 215-823-5803
Our office is closing out this inquiry. If you have additional questions regarding this matter, please feel free to reach out to Mr. Thompson directly. Thank you for bringing this matter to our attention.

29 March 2023

- I received a call from Mr. Thompson stating that "after learning of some new information a new consult will be placed and you will be hearing from dermatology". I informed him if this one is denied I would be more than happy to file an appeal in accordance with VHA directive 1041 section 4 and in accordance with procedures in section 5. Once this appeal is

filed, I would like to have the denial in writing per the policy with the printout from the DTS. He told me I could contact him through messaging or his phone number. I informed him that I sent multiple messages to his office in the past and that they keep disappearing. I informed him this has happened multiple times and that all my other messages have been answered by other providers.

29 March 2023

- Congressional response was finally given and signed by the director. This stated, "I did not qualify for CC and my consult would be denied".

4 April 2023

- Scheduler called me to schedule an appointment for the end of June. When I said I wanted a CC referral she told me I could come in tomorrow and therefore don't qualify.

5 April 2023

- Called and left VM for Ian and sent email.

6 April 2023

- Spoke with CC who told me they have never had a consult for me and that they don't approve or deny consults and cannot give me anything in writing.
- Called PA who told me Iain would call me. She told me VHA directive 1041 does not apply to their office and they don't have to give me anything in writing. She told me I do not qualify for CC based on the schedule they have. I asked for it in writing which she would not give me.

10 April 2023

- PA Carol called me back and said a consult had been placed and that VHA directive 1041 does not apply to their office, and they would not discuss it any further.
- Called VHA hotline again. She stated it would best to check back in and ask the next person to escalate it to the VISN level next if it is not resolved.
- Emailed Shaterri Brown

Good morning,
I am back to square one with this issue. Mr. Thompson called me one day and assured me he would be my POC. I have called and emailed him and no response. The scheduler called me and offered me an appointment at the end of June or the next day. I told them I was out of state and couldn't make it the next day. She told me that I didn't qualify for CC since they could get me in the next day and refused the appointment. The patient advocate also told me VHA directive 1041 doesn't apply to them, and CC must provide me a denial in writing. CC told me they don't approve or deny any consults and that the someone else would have to do this for me. I informed that VHD directive 1041 covers CC appeals and states their office is responsible for this, but they said I was wrong and would not discuss it anymore. I had to call the patient advocates office since last Tuesday before anyone even got back to me. I have no idea where to go from here as I am following VHA policy and VA is not doing the same. I would appreciate any guidance on

this as I am stuck and just want to follow the rules to get the services I should be getting. Thank you for your time and assistance with this matter.

11 April 2023

- Mr. Thompson called me to apologize for the delay in getting back to me. He confirmed that a CC consult has never been placed for me and he will work on it. He asked if "we can get you in within thirty days would that be good for you". I asked him "if an organization had treated you the way the VA has treated me would you come in"? His response was "No I wouldn't and that's why I have private insurance and don't use the VA". We discussed the drive time and how he knows where I live and agreed it should be in the drive time access standard. He agreed this "need to end and we need to get you the care you deserve". He told me he would get to work on it and get back to me.

14 April 2023

- Was called by someone in CC who told me my CC consult was approved and a scheduler would call me in a few days to get me scheduled. I informed them I knew where I wanted to go and they told me to "get the NPI and have it ready" when they call back.

18 April 2023

- Called CC and spoke with Adele who was very helpful. She said she would get this assigned to the lead of the green team and let them know my preference. She said someone would reach out to me to get me scheduled.

19 April 2023

- CC called me and we called the place I want to go and have an appointment on 20 April a block from my house.

References

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https://www.vaoig.gov/sites/default/files/reports/2024-02/vaoig-21-01488-44_0.pdf
https://www.vaoig.gov/sites/default/files/reports/2024-02/vaoig-21-01488-44_0.pdf

https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/6-duration-treatment
https://www.vacommunitycare.com/doc/ccnProvManual/ccnPrManual
VHA Directive 1160.04, VHA programs for Veterans with Substance Use Disorders

VHA Directive 1160.02, Mental Health Residential Rehabilitation Treatment Program

VHA Directive 1006.02 VHA site classifications and Definitions
(VA/DOD Clinical Practivce guideline for the mangement of substance use disorders, 2021)