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CONNECTIONS TO CARE: IMPROVING SUBSTANCE USE DISORDER CARE FOR VETERANS IN RURAL AMERICA AND BEYOND

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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CONNECTIONS TO CARE: IMPROVING SUBSTANCE USE DISORDER CARE FOR VETERANS IN RURAL AMERICA AND BEYOND

WEDNESDAY, JUNE 14, 2023

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Brown, Blumenthal, Manchin, Sinema, Hassan, Moran, Boozman, Cassidy, Tillis, Sullivan, and Tuberville.

OPENING STATEMENT OF CHAIRMAN JON TESTER

Chairman TESTER. I want to call this hearing to order. Good afternoon. I want to thank the panelists here. We got another panel after this one. I want to thank them for being here, too.

And I want to thank my friend, Senator Tuberville, for filling in for Senator Moran, at least for the first part of this Committee.

Senator TUBERVILLE. Yes.

Chairman TESTER. Many veterans deal with the invisible wounds of war. For some, that may mean challenges with their mental health. For others, they may turn to substances in order to cope with the burdens that they bear. And for many, these are linked. According to the latest data, about 1.1 million veterans suffer from both substance abuse/use disorder and mental health conditions.

Today, we have gathered leaders from the Department of Veterans Affairs as well as researchers, advocates, and oversight officials to discuss how we can improve veterans' access to high quality treatment for SUD.

We know barriers exist, whether it be stigma, wait times, or finding the right treatment option, and for veterans in rural communities, like so many veterans in Montana, it can be even harder to access care. Rural areas often have shortages of healthcare professionals, and the VA is no stranger to that challenge. Almost 70 percent of primary care health professionals shortage areas across this country are in rural or partially rural areas, and a recent study found that 136 hospitals in rural communities closed between 2010 and 2021.

Improving access to care for rural veterans by purchasing care from community care may not be the answer because rural areas are relatively underserved generally. You cannot buy it if it ain't there.

That is why it is so important to bolster the VA's workforce. I am proud to say that through resources Congress has provided VA has added some 1,100 positions nationwide since FY '22 to improve SUD care veterans. That is good work, and they need to be thanked for that.

VA provides coordinated care to veterans with an understanding of the unique life experiences and conditions that the veterans face. However, there is work to be done to ensure all veterans have timely access to that care. I have heard numerous issues with veterans not being able to readily access VA's residential care for mental health and SUD, the RRTP program. That is why I included a provision in my STRONG Veterans Act enacted last December to study RRTP wait times and availability to better inform the development of additional RRTP sites and bed spaces.

Building off that effort, I will be introducing legislation very soon to make community care really work for veterans, and that includes being able to access residential SUD and mental health care in the community when that care is needed. For veterans who need this level of care, there is no time to waste, and we need to ensure they are given all the options available.

I want to thank you all for being here today. I look forward to your testimony. I look forward to the discussion. With that, I will turn it over to Senator Tuberville for his opening statement.

OPENING STATEMENT OF SENATOR TOMMY TUBERVILLE

Senator TUBERVILLE. Thank you, Mr. Chairman, and thanks for the witnesses being here today to discuss this very important topic and a top priority of mine, which is veterans' access to substance use treatment.

On behalf of Ranking Member Moran, I would like to give a special welcome to Chelsey Simoni who is here with us today. She is Co-Founder and Executive Director of HunterSeven Foundation. Ms. Simoni is an Army veteran, flight medic, clinical nurse researcher, and advance practice provider. She continues to serve her country by advocating for her fellow veterans to get the care that they deserve.

We are here this afternoon to determine if the VA is meeting the needs of veterans, specifically veterans who reside in rural and highly rural areas, when they need treatment for substance use disorders. The VA continues to claim suicide prevention is their top clinical priority. Therefore, ensuring veterans have prompt access to high quality treatment for mental health conditions and addictions is critical in achieving our shared goal of combatting veteran suicide.

As overdose deaths are increasing across America and especially in our rural areas, so is the need for high quality mental health care and addiction treatment. That is why I continue to wonder why the VA will not use the tools and authorities Congress has given them to save the lives of veterans who are most at risk. When veterans make the decision to seek treatment for their mental health conditions or addictions, VA must ensure that they are met with high quality care that provides veterans with timely access choices and no red tape.

I look forward to hearing from each of the witnesses today on this important topic, Mr. Chairman.

Chairman TESTER. Thank you, Senator Tuberville.

Now, for our first panel. And I want to thank you all for having names that I should be able to pronounce. Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services at the Department of Veterans Affairs, she is accompanied by Dr. Tamara Camel—Dr. Tamara Campbell, I guess I was wrong, Executive Director of the VA Office of Mental Health and Suicide Prevention, and Dr. Bradley V. Watts, Director of the Veterans Health Resource Center at the VA's Office of Rural Health. I thank all three of you for being here.

Dr. Scavella, the floor is yours.

PANEL I

STATEMENT OF ERICA SCAVELLA ACCOMPANIED BY TAMARA CAMPBELL AND BRADLEY V. WATTS

Dr. SCAVELLA. Thank you. Good afternoon, Chairman Tester, Ranking Member Tuberville, and distinguished Members of the Committee. Thank you for the opportunity today to discuss VA's substance use disorder treatment programs in rural America. Accompanying me today are Dr. Tamara Campbell, the Executive Director of the Office of Mental Health and Suicide Prevention, and Dr. Bradley Watts, Director, Veterans Rural Health Resource Center.

For the past decade, there has been an increase in morbidity and mortality from substance use disorders as powerful and illicit drugs have become more widespread. For fiscal years 2018 through 2022, the number of veterans diagnosed with a substance use disorder and receiving treatment in VA increased from 522,000 to over 550,000.

VA is committed to ensuring all veterans have access to treatment for substance use disorder regardless of where they live. Core characteristics of substance use disorder services include timely same-day triage, a no-wrong-door approach, concurrent treatment for co-occurring needs, and veteran-centered and individualized treatment based on the needs and the preferences of veterans.

Over the last decade, VHA has worked to mitigate risk factors associated with overdose and suicide among veterans related to opioids and stimulants, including launching a national Opioid Safety Initiative and Stimulant Safety Initiative. Beyond treatment for substance use disorder, VA provides primary and secondary prevention specific to opioid use disorder in addition to efforts specific to the risks associated with substance use in general. As an integrated healthcare system, VA is uniquely positioned to address the needs of veterans diagnosed with substance use disorder.

Current policy requires facilities to provide access to the comprehensive continuum of care of substance use disorder treatment services ranging from early intervention and harm reduction services through intensive outpatient and, when needed, residential or inpatient treatment. Current policy also requires facilities to provide same-day outpatient access to veterans with emergent sub-

stance use treatment needs. This care can be provided in person or via telehealth in several settings, to include our general mental health clinics, our Primary Care-Mental Health Integration clinics, and substance use disorder specialty clinics.

VHA national policy explicitly states that veterans cannot be denied care due to their use of a substance. Further, both national and the VA DoD Clinical Practice Guideline for the Management of Substance Use Disorders define expectations that veterans be retained in care and that programs do not use criteria that would automatically discharge them from treatment.

VHA offers comprehensive care in Mental Health Residential Rehabilitation Treatment Programs, or MH RRTPs, to veterans with co-occurring mental health, substance use, medical, and psychosocial needs. Today, more than 70 domiciliary substance use disorder programs are in operation, with over 1,700 beds. We are focused on specifically providing intensive residential substance use disorder treatment.

VHA recognizes the importance of timely access to the Mental Health Residential Rehabilitation Treatment Programs for veterans and requires this intensive level of care to be available to them. We will continue to review our policies and address concerns from many stakeholders related to the concerns you mentioned.

Veterans living in rural communities often face unique characteristics that limit their access to health care. Barriers such as long distances to clinical facilities and a shortage of qualified providers can put rural veterans and their families at risk. To overcome these challenges and reach rural veterans with critical health care needs, VA has expanded access through telehealth programs and leveraging the skills of our existing clinicians. This includes the development and ongoing expansion of Clinical Resource Hubs, which are a network of VA centers in large urban settings that are skilled in delivering their services to veterans in rural areas at medical centers, VA Community Care Clinics, and in the home through the telehealth services.

In conclusion, we appreciate the Committee's continued support with this shared mission. Nothing is more important to VA than supporting the health and well-being of the Nation's veterans and their families. VA has employed broad evidence-based strategies to address the opioid epidemic. This critical work saves lives.

My colleagues and I are prepared to respond to any questions you may have and look forward to working with you on some remaining barriers that make it challenging for us to meet this mission. We are committed to providing world-class care to our Nation's veterans. Thank you.

[The prepared statement of Dr. Scavella appears on page 43 of the Appendix.]

Senator TESTER. Thank you, Dr. Scavella. To the second, I might add, on that testimony.

So I will start out with a few questions that I have. I come from a State that is pretty darn rural. In fact, in some departments, the whole State is considered a rural State. Even our most populated areas are considered rural.

We have a treatment facility at Fort Harrison. It is a 24-bed—by the way, Fort Harrison is a long ways from Plentywood, Montana. Okay? And so it is our State capital. It is where we have our VA hospital. And they have a 24-bed residential treatment program for veterans' mental health, eight beds for SUD, eight beds for co-occurring SUD, and then eight beds for PTSD.

I have got two questions. The first question is: What makes VA unique and able to provide residential care for veterans that have comorbidities like SUD and PTSD?

And then the second question is: How common is it—because in my world there is not a lot of treatment centers out there. There is just not a lot of treatment centers. So how common is it in rural America that the only choice they have is the VA for a veteran that has these issues?

Dr. SCAVELLA. Thank you, Chairman Tester, for that question. So to answer your first question related to why VA is uniquely able to provide the care to the veterans with these substance use disorder diagnoses and other co-occurring comorbidities, the first is that we are the largest integrated healthcare system in the United States. We provide comprehensive care for our veterans from primary care through pain management, general mental health, as well as substance use disorder. And so we treat the whole patient, and we are able to see that due to the fact that we have an integrated record. We can communicate with our colleagues to provide that care. So that is one of the reasons why we are certain that we can communicate internally, do warm handoffs when required to pass patients' information along, to make sure we are providing that care.

The second question that you asked, which is related to the availability of services in rural locations, you recounted your statistics in your State very well. We know that we have challenges, but we do have facilities in Montana specifically for substance use disorder.

And our commitment is from the time of identified need to make sure that we are bringing those veterans in if they need inpatient or residential services, to start that referral and to get the care provided as soon as possible, preferably on the same day but within 72 hours if it is for priority needs.

Chairman TESTER. Okay.

Dr. SCAVELLA. Yes.

Chairman TESTER. So I talked to you about the distances. So when you are referring to community care, oftentimes you have no choice. Oftentimes, it is a long ways away. What role does that figure in your decision-making, distance from home?

Dr. SCAVELLA. So distance from home is important to us to consider. The average patient may have to drive an average of 185 miles or greater to get the residential inpatient—the residential services that we would like to provide to them. So distance is a consideration.

What we want to do is provide the soonest care possible in the best way possible. If we can keep them within the VA system to provide that care, we will. If distance is prohibitive, and/or the time between the appointment referral and the time that the appointment is going to be given, we can make a referral to the commu-

nity, and we do that through some of the authorities provided in legislation.

Chairman TESTER. Okay. So what is the wait time for RRTP, typically?

Dr. SCAVELLA. Thank you for that question, Chairman Tester. The first question that you are asking about the wait times, we have a goal of getting our patients in within 72 hours if it is for a priority care. If it is for routine residential care, the goal is 30 days. We are able to meet that need in over 50 percent of our patients, but if there is a concern voiced by the veteran or the family, we can work with our community partners.

I am going to turn it to Dr. Watts to see if there is anything he would like to add to that answer.

Chairman TESTER. Sure.

Dr. WATTS. I think, as you indicated, the challenge is often that there are not community resources available for the most vulnerable rural veterans even if we do want to make those referrals. So the action could end up causing the veteran to need to travel many hundreds of miles in order to achieve that care in a timely way. So it is often a sense of tradeoff between those two.

Chairman TESTER. Okay. So before I turn it over to Senator Tuberville, you said 50 percent of the time you are hitting the 72. Fifty percent you are hitting the 30 days for routine, too, or are you making the 30 days more often than that?

Dr. SCAVELLA. Our average time, Senator Tester, for the referrals is between eight to 20 days when we look at our data, so we are hitting that. However, we are also being very aggressive with making sure that we are staying engaged with those patients, making sure that if something changes that we are able to adjust our plan. If something changes in the acuity of that veteran, their situation changes, we can make those adjustments.

And again, I will turn it over to Dr. Campbell to see if there is anything she would like to add to that answer.

Dr. CAMPBELL. Thank you again for that question. I just want to reiterate that many of our veterans choose to stay within VA, and so if they choose to stay within VA, we will keep them in VA and engage them in other forms of treatments. We have stepped care models. So we may be engaging them in telehealth services or outpatient treatments while they are waiting for residential care because they have chosen, or they choose, to stay within VA.

Chairman TESTER. Okay. Thank you.

Senator Tuberville.

Senator TUBERVILLE. Thank you, Mr. Chairman.

Dr. Scavella, is that how you pronounce it? Scavella? I know people mispronounce my name all the time, too.

Chairman TESTER. Never.

Senator TUBERVILLE. Never, right? Doctor—and this is for all three of you. I would like to kind of get to the bottom of this. I just recently reviewed a memo issued on May 24, 2021, signed by the Assistant Under Secretary of Clinical Services, which recommends all VA medical centers establish syringe service programs, also known as clean needle exchanges, for veterans enrolled in VA health care experiencing substance use disorders.

Now Federal law prohibits taxpayer funds to be used to purchase needles or syringes for the injection of illegal drugs. Why do we believe that the VA is above this? I do not understand that. Doctor, could you start out? And if anybody has got any—just all we are looking for is information.

Dr. SCAVELLA. So thank you for that question, Senator Tuberville. One of the things that we understand from looking at the research is that veterans who participate in a syringe exchange program, or people in general, are more likely to seek care from the entity providing those services for their substance use disorder. So in addition to reducing the passing, the contracting of other infectious diseases through those syringes, we also know that there is a greater likelihood that they are going to look toward us, look toward that entity to get overall help with their substance use disorder.

I will turn it over to Dr. Campbell for some additional.

Senator TUBERVILLE. Okay.

Dr. CAMPBELL. Just to reiterate—and thank you again for that question—our job is for the protection of veterans and also for the protection of the public. So the comorbid and co-medical issues that present with IV drug use, HIV and hepatitis C, we are able to help reduce that with this program.

Senator TUBERVILLE. Dr. Watts, you got anything to add to this?

Dr. WATTS. Nothing to add.

Senator TUBERVILLE. Okay. I just do not know who authorized this, number one. I know if Secretary McDonough did it, he is not a doctor, and so you know, it is very concerning to me that we are giving out needles, you know, for drugs and when it is illegal. You know?

So what authority does the Assistant Under Secretary of Clinical Services have to issue guidance to every VA medical center given the priority VA has had on care and pain management? You know, why is the memo not signed by the Secretary himself? He did not even sign this. I mean, do you know? Do you have any follow up on that?

Dr. SCAVELLA. So thank you for the question, Senator Tuberville. That memo was drafted, as you stated, in May 2021 through the authority that the Assistant Under Secretary for Health for Clinical Services had, which is to oversee the clinical care provided as a chief medical officer for the Department of Veterans Affairs.

Senator TUBERVILLE. Ms. Campbell, do you know anything about that?

Dr. CAMPBELL. Just to add that within the Federal guidelines within the hospital we provided them within our hospital setting.

Senator TUBERVILLE. Yes. Dr. Scavella, I wonder why the Secretary did not sign this himself. Do you know?

Dr. SCAVELLA. Senator Tuberville, I cannot answer that question.

Senator TUBERVILLE. Okay.

Dr. SCAVELLA. I do not know.

Senator TUBERVILLE. I will ask him myself, but it is pretty concerning.

Do you know who is administering this program at facility level? Do you know who has the authority?

Dr. SCAVELLA. Thank you. I will ask my colleague, Dr. Campbell, to provide an answer to that question. Thank you.

Dr. CAMPBELL. So each facility—thank you. Each facility certainly has a "quad member," medical director, as you know, chief of staff, and the SUD coordinator or manager over that program would assist in overseeing it.

Senator TUBERVILLE. Is this person also in charge of care management plans; do you know that?

Dr. CAMPBELL. So they would have a team, a multidisciplinary team, sir, to help them with the planning, with the entire care team planning for this.

Senator TUBERVILLE. All right. Is the VA managing data surrounding these programs; Dr. Scavella; do you know? Do we have data on where this is headed?

Dr. SCAVELLA. So we do have some data on outcomes related to our veterans and their ability to successfully engage with us for substance use disorder. We know through all of our multidisciplinary care plans related to substance use disorder that we have reduced the number of veterans who are starting opioids for the first time, that are taking opioids in combination with other medications such as benzodiazepines. We also know that we are seeing fewer deaths from accidental and intentional overdoses. So there are some improvements with the overall comprehensive substance use disorder program that we are very proud of as far as ensuring that our veterans are improving.

Senator TUBERVILLE. Do you know if we are handing—if we are just handing out syringes to newly—I guess new patients from the VA that come in first off? And are we just handing out needles, or are we putting them in some kind of detox plan?

Dr. SCAVELLA. So thank you for that question, Senator Tuberville. We would be bringing our patients in for comprehensive care. It would not be provided in a vacuum. But I will rely on my colleague, Dr. Campbell, to add some details to that answer.

Dr. CAMPBELL. Thank you again. Dr. Scavella is absolutely correct. It is an entire team that works with these patients. They are not in isolation. And that team includes—medical practitioners are included in that team, and we emphasize certainly the biopsychosocial approach to treatment.

Senator TUBERVILLE. Well, just a quick statement on it, I think this is pretty concerning when we are really not following the law here, and I hate that we fall back on an easy plan when we should be really, really helping these veterans because we got a huge problem. You know, the fact that the VA is the country's largest integrated healthcare system and it is administering a clean needle exchange program when they should be creating treatment plans for veterans experiencing substance use disorders, to me, it is not very common sense and it is really—you know, I do not think we are doing the veterans—I do not think we are doing them right.

So I think, to me, it is poor use of taxpayer money and again it is really a disservice, you know, when we have got all these veterans out there and a lot of them have huge problems, that we do not treat the problem immediately and we are just kicking the can down the road in some of these situations.

So hopefully—and I am going to write a letter to Secretary McDonough and get some answers from him. It is pretty concerning that, you know, we just do not make it—we do not want to make it easy on ourselves. We want to make it tougher, you know, to make sure that we give good health care.

Dr. Watts, I am sorry I did not have a question for you, but if you have got anything to add to that.

Dr. WATTS. Nothing to add, thank you.

Senator TUBERVILLE. Okay. Thank you, Mr. Chairman.

Chairman TESTER. Do you guys want to comment on the statement as far as treatment plans and furnishing needles? Is there a treatment plan involved before needles are furnished?

Dr. SCAVELLA. So thank you for that question, Chairman Tester. As Dr. Campbell stated, veterans would be engaged in a comprehensive care program to identify all of the underlying comorbidities including mental health concerns, serious mental illness, also pain management, to work on a comprehensive plan to reduce the use of substances and reduce the substance use disorder in that veteran. So, yes, those veterans would be engaged in a comprehensive care plan with very specific goals in place.

We would also be using incentives to encourage them to change their behavior. And, we are providing comprehensive care for veterans before they get into a situation where they are using substances and identifying risky behavior very early on, if possible, but then when they are in a situation where they need assistance with substance use disorder, we are providing comprehensive care.

Chairman TESTER. Thank you for the clarification.

Senator Brown.

SENATOR SHERROD BROWN

Senator BROWN. Thank you, Mr. Chairman. Thank you. As some on this Committee know because I have mentioned it fairly ad nauseam, I have been doing roundtables. And Senator Tester has written, also by many others on this Committee, the PACT Act. I have done roundtables in almost half of Ohio's counties now, and what I hear—I will do it at a VFW or a Legion or a DAV hall, and I will hear over and over the difficulty of transition from the military to civilian life and hear generally the most—many people I talk to, many former soldiers, marines, or sailors will say that their commanding officers and the military does not really care that much about that safe, that easier, handoff to the point that veterans organizations and the VA do not know where these veterans, these recently become veterans, live.

So, Dr. Campbell, one question to you and then a comment. And thank you, Mr. Chairman, for your time. Talk about the VHA proactive outreach to servicemembers transitioning back to civilian life, especially on mental health and potential substance use disorders.

Dr. CAMPBELL. Thank you for that question, Senator Brown. So we have strong collaborations with the Department of Defense and interagency collaborations through our Domestic Policy Council. We are involved with the Transition Assistance Program, where we are interfacing with the Department of Defense, with those veterans who are going to be discharged. We know that that first year

is a vulnerable year, and so we provide them with resources regarding the benefits that they have as well as all the services that can be provided, not just mental health services but medical services as well.

Senator BROWN. I hope that—thank you, Dr. Campbell. I hope that suggests that the VA continues to work with us on the Adam Lambert Improving Servicemember Transition to Reduce Veteran Suicide Act. It is important that we do more there, and I am hopeful that you will continue to work with us on that.

Dr. CAMPBELL. Absolutely, sir. We have very strong suicide prevention outreach workers at every VAMC, and we are leveraging our Governor's Challenge as well as Mayor's Challenge to help us.

Senator BROWN. I understand you are doing that at the VA and you work for the VA, but do you believe we are finding those men and women returning home, or the VA is finding them, local veterans organizations are finding them? Ohio has one in each—at least one in each—county, veterans service officers in all 88 counties, who work for veterans. Are these entities finding these veterans when they are coming home?

Dr. CAMPBELL. We are certainly collaborating with them. We know we can do a better job. We have quarterly meetings with the VSOs, and so we are leveraging every opportunity we have to find them.

Senator BROWN. Is it better than it was 10 years ago?

Dr. CAMPBELL. We are trending better than it was 10 years ago.

Senator BROWN. Okay, one comment. I want to quickly mention the Chillicothe VA, southern Ohio. The Secretary has come out at my request, seems perhaps unusually interested in that. It serves—it is the only rural VAMC in Ohio. It is important in Appalachia. The past year, my office has worked with community leaders and local VA staff to ensure that the facility is resourced in a way that continues to serve Ohio veterans.

During the Trump administration, it looked like it was slated for closure. Secretary McDonough and all of you and my office were working with the union, in essence, saved it, but there still is not the attention paid. I do not think it is as dedicated to the future of this facility as the veterans in southeast Ohio. And it is mostly AFSCME members, I am sorry, AFGE members and AFSCME are believing it should be.

It is essential that access to treatment for substance use disorders, particularly including inpatient treatment, remain available for local veterans. So I just want to say VA must listen better than it has to Chillicothe, to me, to those advocates, that this VA, which is I think probably the biggest employer in town, as it often is in smaller communities, but most importantly, a very, very, very important focal point for serving veterans. Just wanted to let you know that, how important that is, and remind you.

Dr. CAMPBELL. Yes, sir. Thank you.

Chairman TESTER. Senator Tillis, if you are ready. If not, I will go to Blumenthal.

Senator TILLIS. I am ready.

Chairman TESTER. You are up.

SENATOR THOM TILLIS

Senator TILLIS. Thank you all for being here. I know that when we talk about veteran suicide we always, I think appropriately, point out how many of those who are committing suicide have no connection to the VA. What do we know about the population of veterans who have substance abuse problems? I know it is hard to know what you do not know or take a roll by asking everybody that is absent to raise their hands, but do we have any data that would give us an idea of just how many, how big the problem is, and what the ratios are between people who have a connection to the VA and do not?

Dr. SCAVELLA. So, Senator Tillis, thank you for that question. We know that we are actively treating approximately 6.2 million of our veterans of the 9 million that are enrolled, and we know that there is approximately another 9 million that are not enrolled. We know that within our system for this most recent fiscal year that we have approximately 550,000 that are dealing with substance use disorder. So if we extrapolate those numbers to the population that is not coming in, it may be around the same number since we are essentially touching half.

We do—as we previously stated, we have lots of outreach that we are doing to try to make sure we are meeting veterans where they are, working with our community partners to bring them in to service, and also just letting them know that we are here for them when they are ready to come in.

Specific to data that is outside of our catchment area, I can check with my colleagues, but I do not believe we have that readily available, but we would be happy to get that to you.

Senator TILLIS. The reason I ask the question is that we have to find more ways to make more connections and I believe that we are in a time-sensitive, unique position to do that as a result of the Camp Lejeune Toxics Act. I do not know if you all have noticed, but there is a few of those annoying ads that come on about every 30 seconds on whatever TV outlet you are watching. And there has been some debate here about capping legal fees and doing those kind of things for people that are signing up for law firms.

One of the things that I wanted to do was to simply put out—and we are going to file a bill. I am going to talk with members about co-sponsorship. But, something I have told them to call the Patriot Bill of Rights, and that is simply an informed disclosure before you sign a retainer with an attorney who is going to help you with a case for Camp Lejeune, to say: Did you know that you could call your—did you know you could call this 1–800 number to the Department of Navy? If you are not connected to the VA, here is the number for the VA. Here is the number of your Congressmen and Senators who do casework all the time and prevent you from having to pay legal fees. And then here are these Veterans Service Organizations that are building expertise around this area, who can also provide you help at a far lower cost than the legal fees. Have them fully understand all the tools that many of them would not have.

But just imagine, even if they decide to sign the retainer, if we can just get them to make the call and get connected, what benefit that has for the population. And we have got a free sort of oppor-

tunity here to increase awareness because the trial lawyers are trying to go out there and sign everybody. Why wouldn't we want to formally or fully inform them and potentially create a relationship that does not exist today?

I mean, we could have hundreds of thousands of veterans make a contact they have never made before. We can save their life. We can determine whether or not they have substance abuse problems and actually get them into care that you all do an extraordinary job of.

So I am hoping we are going to speak with more Members about it, but it seems like it ends the debate of capping legal fees. It gives us an opportunity to touch a number of veterans who for the first time that they may ever be connected is through a law firm that is trying to make money, and hopefully, get a benefit for the veteran.

But it seems to me to be a fairly sensible approach. What is wrong with my idea?

Dr. SCAVELLA. Senator——

Senator TILLIS. I am not trying to poison the well by positioning it as a sensible approach, but——

Dr. SCAVELLA. Yes, I will say that since this is the first time that any of the three of us on this panel have heard about this and since the Secretary has not had an opportunity to weigh in, we would be happy to review——

Senator TILLIS. We are going to send the text over to you. It is literally as simple as I have described it, so I will be very interested to see what the Department's position is on the bill fairly soon here. Thank you all.

Thank you, Mr. Chair.

Dr. SCAVELLA. Thank you.

Chairman TESTER. Senator Blumenthal.

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman. You know, I have believed for some time that one of the challenges is outreach, whether it is through the media or person-to-person contact.

In Connecticut, we have a partnership between the Connecticut VA health system and a group that is called Connecticut Harm Reduction Alliance run by a very able young man named Mark Jenkins, and they have established what is called a Rover Program since RVs, literally, recreational vehicles, provide harm reduction supplies to communities. I have gone around with some of them, and they are stocked with all the stuff that is necessary to provide what people suffering from substance disorder need. And the program in Connecticut has been tremendously successful, now has over 35 of these rovers serving 26 communities, and it plans to expand nationally.

As I mentioned, outreach partnership with the VA—the VA cannot operate in isolation. It has to seek partnerships with community groups like the Connecticut Harm Reduction Alliance. What plans do you have to try to seek to provide more access to substance use disorder treatment programs in the non-VA community?

Dr. SCAVELLA. So thank you for that question, Senator Blumenthal. We clearly understand within the Department of Vet-

erans Affairs that substance use disorder, especially considering opioid use disorder, is a whole-of-government and whole-of-nation approach that is required. We do need to continue to leverage those community partnerships, as Dr. Campbell stated earlier, to make sure that we are reaching veterans where they are, especially if they are not engaged in our care.

We do have several programs in place to address veterans who may be at risk, to include our Overdose Education and Naloxone Distribution program, to make sure that we are providing tools and education, to give both veterans and their families and caregivers the signs and symptoms to look for if someone is potentially getting close to overdosing, and then giving the tool, the naloxone, to actually do the reversal. So that is one of the things that we are doing.

We are also engaged with many different community partnerships, to include the Governor's Challenge and others, to really identify veterans who may be at risk. The Hannon Act provided for the ability to engage with veterans within the first year of post-separation from the Department of Defense. So we are leveraging that as well, making sure that we are reaching those veterans where they are, participating in their TAP classes, to make sure that we are giving them the tools that they need to engage with us, perhaps not immediately but hopefully when they think of it and realize that they have that benefit and they are entitled to that care.

Senator BLUMENTHAL. I may have missed it in your testimony, but do we have—you know, we use these figures, 21 veterans every day commit suicide. Is there an accurate, up-to-date number?

Dr. SCAVELLA. Senator Blumenthal, I am going to turn that over to Dr. Campbell, but we do have some updates on that number.

Dr. CAMPBELL. So thank you for that very important question. We all know one suicide is one too many, and so we really are leveraging everything we can. That number has trended downward to 16.8 according to the last annual report, and we continue to review those numbers daily.

Senator BLUMENTHAL. According to which report?

Dr. CAMPBELL. The last annual suicide——

Senator BLUMENTHAL. Oh, the last annual report.

Dr. CAMPBELL. Yes, sir.

Senator BLUMENTHAL. And how do you—what data do you—how do you access data on veteran suicide? What kind of data is available?

Dr. CAMPBELL. Sure. Thank you for that question. So we work with the Centers for Disease Control and World Health Organization, and we use scientific methodology utilizing their definitions of what a suicide is to develop that report and to look at those numbers.

Senator BLUMENTHAL. And did they have—how did they define suicide? In other words, is there a definition of suicide?

Dr. CAMPBELL. So that——

Senator BLUMENTHAL. Substance use disorder taken to a certain level can constitute a form of self-destruction?

Dr. CAMPBELL. That definition certainly is determined by the coroner's office, and they look at each individual case and determine that.

Senator BLUMENTHAL. Thank you. My time is expired, but I will want perhaps to follow up on this issue. Thanks.

Chairman TESTER. And there will be opportunities for questions for the record, Senator Blumenthal.

That concludes our first panel. You got off lucky because there usually is more people than that here, but there is a vote going on right now. Thank you guys for your testimony. I appreciate it very much. You are certainly welcome to stay for the second panel if you choose.

And now I will introduce the second panel. I would like to welcome Dr. Julie Kroviak, Principal Deputy Assistant Inspector General in the Office of Healthcare Inspections at the VA's Office of Inspector General. Then we have Dr. Jonathan Cantor, who is Policy Researcher at the RAND Corporation. Then we have Naomi Mathis, who is Associate National Legislative Director of the Disabled American Veterans, and we have Chelsey Simoni, Co-Founder and Executive Director of the HunterSeven Foundation.

Dr. Kroviak, you have the floor.

PANEL II

STATEMENT OF JULIE KROVIAK

Dr. KROVIAK. Thank you, Chairman Tester and Committee members. I appreciate this opportunity to discuss the OIG's oversight of VHA's substance use disorder treatment programs.

The OIG's Office of Healthcare Inspections reviews the quality and safety of health care provided across VHA and communicates these findings through public reports. The majority of our healthcare inspection staff have significant experience providing direct clinical care to veterans, and such experience adds unique insight to our oversight work. This is particularly true of mental health teams staffed with board-certified psychiatrists, psychologists, licensed clinical social workers, some of whom are combat veterans. These team members have cared for veterans facing the very issues we are discussing today.

VHA faces significant challenges in meeting the needs of individuals with substance use disorders, and rural settings can pose additional obstacles in addressing these patients' needs. In that veterans with substance use disorders often have additional mental health diagnoses that place them at higher risk for suicide, seamless and timely care coordination is critical. The Committee's focus on rural veterans is appreciated as veterans living in highly rural areas are 65 percent more likely to die from suicide than those residing in urban settings, an unsettling statistic that VHA faces in addressing their top clinical priority, to reduce veteran suicide.

Our oversight is much broader than just major medical centers. We reach out into rural communities with our VISN and CHIP reviews that analyze VA rural facilities, including the most highly rural CBOCs, and our Vet Center reviews will review the Mobile Vet Centers, important outreach units for many of our rural communities.

To meet the increasing demand for services, including mental health and substance use disorder treatment, VHA depends on

community care. The OIG has identified persistent administrative errors and communication failures among VHA, its third-party administrators, and community care providers, as well as between the care providers and their patients. These failures amplify risks for patients with high-risk mental health issues and complex disease. My written statement details two reports that provide insight into the complexity of coordinating care for patients with substance use disorder at two distinct stages of treatment needs.

Earlier this year, we substantiated the allegation that in 2020 and 2021 North Texas staff did not follow VHA policy requiring that patients be offered alternative options for residential substance use disorder treatment within VA or the community when the wait time for this service exceeded 30 days. This practice not only potentially delayed the treatment for these veterans but also has the potential to fracture trust between patients and the healthcare system upon which they rely.

The second report describes the mismanagement of a patient at the Tomah VA, a rural facility in Wisconsin, who was suffering from acute alcohol withdrawal and subsequently died at another VA hospital. We found failures in the clinical management of this veteran that likely contributed to their death. Assessments and stabilization efforts for patients at risk for life-threatening consequences of alcohol withdrawal leave no room for error, especially in rural settings when transfers to higher level care must be anticipated early.

To improve the quality of administrative and clinical practices in rural facilities and across the system, VHA frontline staff need policies and guidelines that are clear, standardized, and current. For example, just last month, our office published an advisory memo alerting the Under Secretary for Health that VHA's Mental Health Handbook had not been recertified as required by 2013. Handbooks support frontline clinical decision-making, and such direction must be clear, accurate, and current. Standardizing the oversight of frontline performance can also support consistency and accountability.

Additionally, while it is important for VHA staff to inform veterans of all care options available for their needs, ignoring that the current community care framework does not adequately address critical gaps in coordination may further increase the risk to patients. Our office has published reports related to community care, detailing delays in diagnosis and treatment, lack of or miscommunication between providers, and significant quality of care concerns.

The OIG will continue to provide meaningful oversight to support and improve the quality of health care provided to our Nation's veterans. We also recognize the need to enhance and adapt our work to best support this dynamic healthcare system. We remain grateful for the participation and cooperation of VHA staff across the country and for their commitment to caring for those who have served.

Chairman Tester, this concludes my statement. I would be happy to take any questions you may have.

[The prepared statement of Dr. Kroviak appears on page 53 of the Appendix.]

Chairman TESTER. Thank you, Dr. Kroviak.

Next up we have the policy researcher from the Rand Corporation, Dr. Jonathan Cantor.

STATEMENT OF JONATHAN CANTOR

Dr. CANTOR. Chairman Tester and Members of the Committee, I want to thank you for your invitation to testify today on what is a pressing and urgent public health problem. My name is Dr. Jonathan Cantor, and I am a policy researcher at the nonprofit and nonpartisan RAND Corporation. I have conducted extensive research on the geographic availability and accessibility of substance use disorder treatment for veterans, military servicemembers, and the civilian population.

In my testimony, I will discuss three main issues: first, the complexity of substance use disorder treatment for veterans given the frequent existence of co-occurring mental health disorders. Second, a brief overview of the geographic accessibility of substance use disorder treatment for veterans. Third, why it is difficult to assess disparities in access.

And then finally, I have a few recommendations to enhance data collection and reporting to improve our understanding of the geographic availability and accessibility of substance use disorder treatment for veterans.

In 2020, around 12 percent of veterans 18 years or older had a substance use disorder, and approximately 1.1 million veterans suffered from both a substance use disorder and mental illness. Less than 10 percent of veterans with a substance use disorder in 2020 received any treatment.

There are a multitude of reasons for why a veteran would not receive the necessary care. First, some veterans who use substances do so to self-medicate their post-traumatic stress disorder symptoms. Second, many veterans fear seeking mental health or substance use disorder treatment because it could negatively affect their career advancement. Third, co-occurring disorders often go unidentified. A practitioner may identify a substance use disorder or a mental health disorder but not necessarily both. Fourth, the appropriate treatment for an individual with a substance use disorder and co-occurring mental health disorder is more complex than treating one or the other alone.

A key determinant for whether an individual receives substance use disorder treatment is how far they have to travel for care. To date, there have been very few studies that have examined distance to substance use disorder treatment as a barrier to care for a national sample of veterans.

In 2019, the Wounded Warrior Project partnered with RAND researchers to understand geographic accessibility of co-occurring substance use disorder and mental health treatment. Our calculations indicated that, on average, Wounded Warrior Project alumni were around a 10-minute drive time from the nearest substance use disorder or mental health treatment facility with a co-occurring program. In contrast, for these veterans, the closest VA medical center with a co-occurring program was around a 60-minute drive time from where the veteran lived.

Our results were encouraging. Most Wounded Warrior Project alumni veterans were able to access treatment programs for co-occurring substance use disorder and mental health disorders within 60 minutes.

Almost one-quarter of U.S. veterans reside in rural communities. There is a concern that it is more difficult for rural veterans to receive care given they must travel farther than veterans that live in urban settings. The geographic accessibility of substance use disorder care could also vary based on the race and gender of the veteran.

Our study did not focus on these potential disparities because there are extensive data challenges in quantifying these differences. Such analyses should require at least detailed data on the addresses or the ZIP codes of the veteran, as well as data on their race, ethnicity, age, sexual orientation, and gender. Finally and perhaps most challenging, the data would need to include whether the veteran suffered from substance use disorder only or substance use disorders and mental health disorders.

Drawing on my research and existing work, I provide several recommendations in my written testimony. I want to highlight two.

First, the Substance Abuse and Mental Health Service Administration's Behavioral Health Treatment Locator could include additional information on specific treatment approaches available for veterans.

Second, either the Substance Abuse and Mental Health Service Administration or VA should consider conducting regular audit studies among non-VA facilities to get a more accurate understanding of the forms of treatment offered, approximate wait times to the next appointment, and total capacity of the facilities for substance use disorder treatment, and they should vary the calls based on the sociodemographic characteristics of the veteran.

Far too many Americans, especially veterans, fail to receive treatment for substance use disorder each year. I am confident that we can increase the number of veterans who receive treatment and reduce the number of drug overdoses. However, that will require an infusion of funding to improve current data collection systems and ensure that veterans can access the information necessary to make treatment decisions.

Thank you for your time, and I am happy to answer your questions.

[The prepared statement of Dr. Cantor appears on page 64 of the Appendix.]

Chairman TESTER. Thank you for your statement, Dr. Cantor.

Next, we have Naomi Mathis, Associate National Legislative Director of the Disabled American Veterans. Naomi?

STATEMENT OF NAOMI MATHIS

Ms. MATHIS. Chairman Tester, Ranking Member Moran, and Members of the Committee, DAV is grateful for the opportunity to appear before you today to address concerns with access to the VA substance use disorder treatment program.

DAV members are injured and ill, service-disabled, wartime veterans that utilize the VA healthcare system at extremely high

rates, which many depend on as their sole source of health care. Our one million-plus members live throughout the country and provide us with an insight into their unique struggles with access to care.

Our written testimony provides our entire position. However, I will focus on the challenges, barriers, and our recommendations.

First, rural veterans face issues accessing health care similar to those faced by the general population, including a lack of transportation. In rural communities, distance to a healthcare facility, time, cost of fuel, and access to transportation are all exacerbated and known barriers to care. Veterans who lack access to public transportation or are no longer able to drive because of age, health, or driving restrictions rely on family, friends, or community service organizations.

To help such veterans, DAV operates a fleet of vehicles around the country to provide free transportation to VA medical facilities for injured and ill veterans. While this program is highly successful and beneficial for the veterans we serve, we continue to face administrative challenges with expediting volunteer driver examinations. Specifically, there is a breakdown in the onboarding process for our volunteer drivers.

For example, our transportation coordinator in Montana told us they had 30 applications for volunteer drivers. However, by the time VA completed the onboarding process, a year and a half later, only two applicants remained interested in volunteering. During my recent trip to New Hampshire, our coordinators there expressed similar concerns. By contrast, we are hearing of other facilities that can onboard in as little as 3 days.

We recommend VA standardize and expedite the volunteer driver onboarding process VHA-wide.

Next, the Philippines is the only foreign country in which there is a VA outpatient clinic to serve eligible veterans. In October 2022, we began receiving complaints from our members who indicated VA Manilla had completely stopped dispensing controlled medications, including those undergoing mental health and substance use disorder treatments. Options faced by this population of veterans are to either stop the medication, utilize the community, travel to Guam or to the United States whenever a refill is needed.

Guam, American Samoa, Puerto Rico, U.S. Virgin Islands, and the Northern Mariana Islands face even greater challenges due to limited or poor infrastructure. Veterans living in these areas often have to take commercial aircraft, which are not disability-friendly, to get to medical appointments or fill prescriptions. Not one of the VA OCONUS has a specialty SUD program.

We recommend VA conduct a needs assessment to determine if adding substance use disorder programming for outside community—outside CONUS communities is warranted.

Mr. Chairman, an additional barrier facing veterans residing outside of the United States is the Beneficiary Travel Self-Service System, which was designed to automate the travel reimbursement claims process. However, there continue to be complaints regarding the slow processing of payments and improper payments made to beneficiaries. VA must fix and modernize this system in consulta-

tion with stakeholders on the Beneficiary Travel Self-Service System.

Lastly, as we celebrate the 75th anniversary of the integration of women into the Armed Forces, we must remember that women veterans are the fastest growing cohort in the VA system. Therefore, VA must continue to accommodate this growing population and their gender-specific needs.

As a combat woman veteran, I experience longer wait times for specialty care at VA than my male counterparts, including mental health care. VA reports fewer than half of all residential facilities have separate dorm space for women veterans and only 13 programs have gender-specific services for women veterans compared to 27 programs exclusive to men. I will note that none of them are located in rural areas.

Additionally, women veterans with substance use disorder who experience longer wait times for treatment could have an increased risk of suicide. This may be due to VA's lower capacity to address women's needs.

We recommend VA conduct a nationwide analysis to determine if expanding gender-specific substance use disorder inpatient care is warranted.

This concludes my testimony, and I look forward to any questions you and the Committee may have.

[The prepared statement of Ms. Mathis appears on page 76 of the Appendix.]

SENATOR JERRY MORAN

Senator MORAN [presiding]. Thank you very much.

Now, Ms. Simoni, we look to you for your testimony. Ms. Simoni is the Co-Founder and Executive Director of the HunterSeven Foundation.

STATEMENT OF CHELSEY SIMONI

Ms. SIMONI. Senator Moran, Senator Hassan, thank you so much for sitting here and listening today. This story is very personal to me as it is a lived experience, so I appreciate it.

Today, I speak before the Committee as a licensed healthcare provider with advanced medical degrees, including public health and epidemiology as well as specialty certifications. I have spent over 15,000 hours working in emergency medicine, long- and short-term substance use settings, and military veteran-specific mental health clinics. I have published in numerous academic journals and presented at conferences nationwide.

However, I speak to the Committee today as a sister of a combat-wounded marine losing his battle with addiction, as the child of an alcoholic mother and heroin-addicted father. I speak today as a disabled Army veteran dealing with constant, debilitating pain and the uninterrupted emotional burden I face daily. The testimony I share today is, unfortunately, entirely true.

By 14, I had a job, I skipped school, and I never got my homework done. I got into fights and did everything I was not supposed to do, so I failed my freshman year of high school.

At 15 years old, I lost my oldest brother to an overdose. My mother told me my 24-year-old brother planned to enter substance

abuse treatment the following Monday. He did not make it. He had shot up the night before with friends of my father's, and he had fallen asleep and began to choke on his throw-up. Instead of calling 911 and keeping him awake, those he was with had moved his body into the hallway where he choked on his vomit and died.

Shortly after his death, I was expelled from school. My behavior was self-destructive, and I lacked structure and discipline. It was difficult to talk about my situation at home with those who did not understand, especially those who had just thought I was a bad kid but never figured out to ask why.

By 16, in 2007, my youngest brother had signed up to serve as an infantryman in the Marine Corps. We wrote each other often. And while he was in boot camp at Parris Island, he loved it. He loved every single minute of it. And I had just graduated high school when my brother told me he was going to be deployed as one of the first marines into Marjah, Afghanistan, under President Obama's surge to disrupt Taliban forces. He spent 7 months in southern Afghanistan.

While he was deployed, I would sit at night and watch the evening news and keep to myself in the loop about what was going on in the war. Every time I heard an unnamed marine casualty occurred, my heart sank. It was almost daily. In total, 68 marines were killed in action during that 7-month deployment, and 694 marines were wounded in action. In turn, I enlisted in the Army.

In August 2011, he redeployed to Sangin, Afghanistan, for 8 months. Thirty marines had been killed in action while 582 marines were wounded in action. Of those wounded marines was my brother. While he was on—while he had lost men he considered brothers and witnessed his closest friend suffer near-death amputations from hidden explosive devices and others who had been physically ripped apart by RPK machine gun rounds, my brother felt lucky. He had sustained outrageous blast injuries from explosions and rocket-propelled grenades, one blast so severe that an MRAP vehicle had flipped over on top of him, throwing him from the turret, causing him to break four ribs, fracture his skull and sections of his lower back.

He came home, but the physical pain was mute compared to the emotional guilt and moral injury he tried so hard to hide. Over the next year, he struggled with pain, physical, depression, and guilt overwhelmed his life. What began as a short-term Vicodin prescription for pain management became a full-blown addiction where he would steal fentanyl patches from the regiment's Navy corpsmen.

He had kept his habit under the radar until a random drug test had found opioids in his system. Sixteen days later, he was discharged under other than honorable conditions for illicit drug use, and he was homeless, jobless, emotionally and physically unstable, and addicted. He was too embarrassed to seek help and suffered in silence.

Around the same time, I suffered a severe spinal cord injury while serving in the Army. I remember the electrifying pain. It was like no pain I had ever experienced before, but my adrenalin was high, and the mission made the pain seem nonexistent. It was not until later that evening I lost control of my bladder, and pins and needles drove up my leg, causing debilitating painful paralysis.

At 21 years old, I was told my injury led to the discs in my lower back partially paralyzing my spinal cord and I needed surgery. My military career was placed on hold, but that was not the case for the rest of my team.

In the months leading up to the major surgery I was scheduled for, I was given more than 300 pills of the mild opiate, hydrocodone-acetaminophen, better known as Vicodin. I was told to take them every six hours for pain. In case the Vicodin was not working, I was given 100 pills of tramadol, a synthetic opioid that reduces the pain felt through the central nervous system. To lessen the right-sided leg numbness and severe neuropathy and muscle spasms, I was given 100 pills of Flexeril. My anxiety was front and center, so I was given 30 pills of Lorazepam, the anti-anxiety benzodiazepine to take as needed for anxiety.

Two weeks later, I received a call that one of my closest friends that I had known since I was 14 was killed in Dawlat Shah, Afghanistan. I felt hopeless, motionless, and stuck in time, and I could not move. The pain had gotten worse. And the more pills I took, the pain I had was less and less, and as time went on everything became easier to deal with or at least what I thought.

I went through a three-hour surgery and was on the road to recovery. The first few nights were hell. I had severe nightmares, dreams I would never wish on anyone. I would wake up covered in sweat and unable to move, and the pain worsened. I was given 60 pills of oxycodone-acetaminophen, also known as Percocet, and was told to stop taking the Vicodin as it may have been an adverse reaction.

I could not swallow the pills without vomiting, worsening my post-operative pain. I was sent home with an eight-ounce bottle of Oxydose, liquid oxycodone. It helped with the pain. Eventually, it subsided as I healed.

I felt great. Looking back, I cannot remember a time in my life where I felt that relaxed or carefree. I could sleep. My mind stopped overthinking, and my heart stopped racing. I was not sad, and I was not worried about the future. I was enjoying the present. And when I started to feel myself come back to reality, I grabbed the medicine bottle, and I would take another sip.

Like most 21-year-olds, I did not have a way to measure the amount I was taking, instead, relying on my balance to let me know if I had taken enough. I do not remember much besides laying in bed, thinking, isn't life great. I loved how I felt in those moments. It was an unmatched feeling.

I took medication not for the physical pain but to cover my emotional pain, which worked very well until it almost killed me. Late one night, I was laying in bed, and I had drank too much. I laid back and felt a sudden sickness. I went to get up and felt my legs get weak. Using the side of my bed, I slowly slid to the ground, and I do not remember much afterward as I woke up a few minutes later covered in vomit. I cried as I knew what had happened.

The next day, I knew I had to get rid of it, which was not easy, but what kept me motivated was returning to uniform and being with my team again. There is a reasonable probability that this is what kept me alive today. To this day, I know I cannot take Percocet as I enjoy it too much.

While dealing with my situation, my brother battled something similar. He figured out his steps, and he ended up staying with my aunt on her couch. He was addicted to prescription opiates. When those ran out and he could not get more, he turned to heroin.

He was alone one night and had shot up heroin, and it was discovered later that it had traces of fentanyl. He passed out on her couch, and when our aunt found him he was covered in vomit and not breathing. She called 911 and began CPR. His lips were dusky and cold. He was given Narcan, intubated, and rushed to the emergency department where the medical team worked to save his life. The doctor said it was a miracle he was alive.

While my brother faced his battles, I received medical clearance to remain in the Army despite having a life-changing surgery. My provider told me that the chances of another injury occurring were highly likely. As mentioned and as predicted, years later, I suffered a reinjury, this time equally as painful, but I could still move and manage. For me, long story short, my career was over.

It was always—it will always be the most dangerous time in any servicemember's life when you are leaving a tight-knit group and leaving a feeling of belonging and reintegrating into a society that could not care less about you, your service, your situation, or your struggles. There is no team or tribe that you can turn to or fall back on. There is no safety net or mirroring experience in a fellow veteran for you to voice your feelings on.

I went to bed as a servicemember and woke up the following day as a civilian. My pain had become increasingly worse. My temper was short, and my frustration grew.

I woke up one morning my senior year of college, and it was like a trap door falling underneath me. I had a commemorative military pistol from my unit, a Sig Sauer P250 .45 ACP under my bed, and I laid down on my bedroom floor, looking up at the ceiling, with my pistol in my right hand. I pointed the gun toward myself and put the barrel in my mouth. I can still remember the cold feeling and taste of steel.

The only reason I am still here today is twofold. I could not kill myself in my grandparents' house, and I reached out to somebody who served in the military, and I said to them, I am not okay, and got the help I received.

In short, I invite you to read the remaining of my testimony as this is something very personal to me, and I appreciate the time. I know I went over, so thank you very much.

[The prepared statement of Ms. Simoni appears on page 84 of the Appendix.]

Senator MORAN. Ms. Simoni, thank you very much.

SENATOR MARGARET WOOD HASSAN

Senator HASSAN. Thank you, Ranking Member Moran.

And, Ms. Simoni, thank you so much for your testimony. Just a couple of things, I was Governor of New Hampshire as we began to see what had been an increasingly bad opioid and heroin epidemic turn to a fentanyl epidemic. The thing that gives me hope and the thing that has made some progress possible although we have much more work to do, as your testimony indicates, is that

people like you have spoken up about their experience, about the fact that opioids, and particularly this new class of opioids and fentanyl, is extraordinarily addictive and that we have to treat substance use disorder as the disorder that it is.

And we have a lot of work to go, both to help people get into recovery and stay in recovery and recognize that sometimes relapses happen, right, and treat it like an illness that way. We also have to go after the unbelievably insidious cartels that are trying to drive up demand for this drug that is so cheap for them to make and easy for them to transport.

I also want to thank you for talking about the difficulty of the transition period for servicemembers because what I hear from especially servicewomen and women veterans in New Hampshire is how difficult this period is and how alone people, veterans feel, especially women veterans, especially women veterans in rural areas.

So I thank you for giving voice to that. I thank you for being brave enough to do it. And I know that everybody on this Committee, both sides of the dais, want to work with you and veterans throughout the country to make progress on these issues and to make sure that veterans understand how deeply we appreciate your service.

With that, I am going to turn to a couple of questions to Dr. Cantor just because I want to—what I want to do is not only recognize the problem but talk about what is working and what is not and what we still need to do.

And with that, Dr. Cantor, as we are talking about veterans and particularly veterans who fall through the cracks as they transition out of service, or as they are dealing with substance use disorder, or whether they are dealing with mental health challenges, we now have the 988 Suicide and Crisis Lifeline that veterans in crisis can call, and they can be connected to the Veterans Crisis Hotline for help just by pressing option 1. What impact has 988 had on connecting veterans to the Veterans Crisis Hotline?

Dr. CANTOR. Thank you for the question. I do not know of any specific research at present that has discussed or looked at the linkage between the 988 lifeline to the veterans crisis line as of yet.

Senator HASSAN. Okay. Is it an area that you think we need data about and explore, yes?

Dr. CANTOR. Yes, I would agree with you.

Senator HASSAN. Okay. And I want—part of my reason for asking the question is just so that any veterans who may follow this hearing know that now this crisis hotline is there and the wait times are relative—you know, I think they are averaging about 40 seconds, if I have got my data correct, and that there is this option for people. And so I hope veterans will take advantage of this.

The other thing I would want veterans watching to know is that there are a couple of programs, the Buddy Check program, our Solid Start program, that are really intended to lift up Veterans Service Organizations as they reach out to their peers to provide support.

I also, Dr. Cantor, wanted to talk about telehealth. My colleagues and I have worked together on a bipartisan basis to expand access to opioid treatment. Last year, we passed into law the Mainstreaming Addiction Treatment Act, which I led with Senator

Murkowski. That removed unnecessary barriers for doctors to prescribe lifesaving medication-assisted treatment for people struggling with opioids, including veterans.

However, veterans in rural areas may still have limited access to in-person healthcare providers to initiate and monitor substance use disorder treatment. So we are going now from about 150,000 docs nationally who could prescribe buprenorphine to opioid addiction to 1.8 million now that we have removed this barrier, but we still have to be able to get people in front of a doctor to get that treatment.

So, Dr. Cantor, can you discuss the role of telehealth in expanding veterans' access to lifesaving medication-assisted treatment?

Dr. CANTOR. Thank you for the question. I think since the COVID–19 pandemic there has been this drastic increase in telehealth availability.

Senator HASSAN. Yep.

Dr. CANTOR. And I think that it is an outstanding question. There has been some research that has examined the telehealth utilization rates.

Senator HASSAN. Yep.

Dr. CANTOR. I think it is still under review as to whether or not the effect of the quality of care that veterans receive differs between inpatient and telehealth.

Senator HASSAN. Yep.

Dr. CANTOR. And I think without that being answered first I think we just need more information, data.

Senator HASSAN. Yes. Well, one of the things that I am trying to drill down on here is if you have veterans in a rural area who do not have a primary care doctor in the area or a doc who is expert in treating substance use disorder. We need to get people in front of a doctor and begin that relationship.

I am going to continue, Mr. Chair, to push for telehealth resources when it comes to treating opioid abuse disorder because if we are expecting people to drive hours for this kind of treatment I think it is going to be an effective denial of access to them. Thank you for letting me go over.

Senator MORAN. A Kansan can relate to what you say.

Senator Cassidy.

SENATOR BILL CASSIDY

Senator CASSIDY. Thank you all. I have been pulled every which way, so if I sound like I am asking something which others have already asked, I apologize because I probably am.

Ms. Simoni, your statement that military veteran care should be less about the VA and more about the veterans themselves, what a powerful statement. And we know, oftentimes, it becomes the other way around; it becomes more about the institution than it is about the veteran. So can you just say what should we be doing to make sure that the VA provides the services that veterans need, when they need it, in a location which is convenient?

Ms. SIMONI. Sure. I appreciate that. Yes, I have noticed from being a veteran myself and utilizing the VA, but also being a healthcare provider, that we start to come to these hearings and we hear more about the actual—you know, the VA more, less about

the veteran. And so you know, for a lot of these veterans, Post-9/11 specifically, less than 40 percent are enrolled in VA care.

So when you look at the rural health aspect and you look at somebody who is (a) suicidal or has a dual diagnosis of, you know, TBI, chronic pain, mental health disorder, you have got to look at it holistically. You can treat one thing. You can treat substance use the day of, sure, within 48 hours, but if you do not have something to back that with—you know, physical pain, such as myself, or emotional pain. I was discharged honorably but medically retired. I was without my team.

So mental health is lacking. You know, polytrauma, substance use, dual diagnosis, we have nothing to do that with.

So when a veteran comes to me and says, I am in crisis, I know my time is limited. If that veteran is addicted to substances and they are wanting treatment, you have to meet the veteran where they are at. You cannot expect them to drive hours away or wait days, hours. Hours is too much. It takes 10 minutes from the time you have a thought of suicide to the action itself. Ten minutes. That is a short amount of time.

And if you cannot help a veteran when they say, I am ready—because you can spin your wheels and you can say, hey, you know, we have treatment available, but if they are not ready, if they are not committed, they are not going to do it.

You know, you have to bring health care to them. And with all due respect, as somebody who has telehealth and virtual care, I can tell you right now as a provider that is not the right route to go for substance use because you cannot physically assess that patient. You cannot physically determine if they have injection marks on their arms. You cannot see if they are currently struggling. You cannot see below, my legs, where I cannot stop moving my legs.

So we need to meet the veteran where they are at, and it does not matter the extent of how that is. You just make sure you get it done. You know? And that is—these are people I served with. If I have to stay awake 24 hours a day and make sure that they are okay and they do not kill themselves, I will do that because——

Senator CASSIDY. So as a doc who greatly knows the advantage of being in the room with somebody to give me information, I can totally relate.

Dr. Cantor, you kind of put the statistics on this, that your testimony is showing that less than 10 percent of veterans with a substance use disorder in 2020 received any treatment and a key determinant is whether an individual receiving SUD, how far they have to travel.

Now Ms. Simoni, a health provider, finds telehealth as a poor substitute for in-person health. Any comments on that?

Dr. CANTOR. I think that we just basically need more research in terms of the quality of care for telehealth, and I have already stated that previously. I think that there is not enough known currently in terms of actually to determine whether or not one provides better care versus the other. I just think we need more information.

But to your point about veterans in general, about not receiving care, I think it is a persistent issue across the healthcare system; it is not just veterans. A large, significant proportion of the country

does not receive care for substance use disorder as well. So I would not just say it is just a veterans' issue in terms of the lack of care.

Senator CASSIDY. So is the issue specific—we know about the deaths from despair and how that is often centered in men, and now increasingly in women, who do not attend college or do not graduate from college, et cetera. So are we talking about a veteran issue, or are we talking about a demographic issue because you mentioned how it is true whether you are a vet or not? So again, is this peculiar to veterans, or they are just part of that same demographic?

Dr. CANTOR. I think it is a systemwide issue. I think veterans have unique challenges in terms of both receiving treatment and then comorbidities when frequently having mental health issues along with substance use disorder. So they are a very unique population, but in terms of actual capacity and delivery of care, I think it is a systemwide problem.

Senator CASSIDY. It seems like that a veteran would have more options for care because the veteran still has the VA plus a more traditional healthcare system. So is that not a correct analysis?

Dr. CANTOR. I think it is just that mostly that most folks who need care do not actually receive it.

Senator CASSIDY. I am a little frustrated on this, sorry. Are they not receiving it because they do not seek it because they are too much into their addiction and they do not want to get out of their addiction or because they do not have access to the resource even if they want to get out of their addiction?

Dr. CANTOR. For veteran-specific or just people in general?

Senator CASSIDY. Well, let us just stay with veterans.

Dr. CANTOR. I think it is a combination of both, that there is a lack of knowledge in terms of where they can receive care and it is difficult to navigate the actual system and the fact that whether or not there are numerous barriers about care, but I do not want to just oversimplify any one individual person's decision as to whether or not to seek care.

Senator CASSIDY. Yes, but unless we have some sort of—I am not simplifying an individual.

Dr. CANTOR. Yes.

Senator CASSIDY. But unless we have some sort of—kind of—you know, we actually feel like, you know, 40 percent of people just do not want care. They are in their addiction. They would rather be an addict than actually go seek care. I worked in an inner city hospital, and frankly, that is kind of what I found sometimes. But we need to have numbers behind that because we are being asked to apply resources, but unless you have a sense of what the need is and the particulars of it—so anyway, that is—anyway, okay. I yield.

Senator MORAN. Thank you, Doctor.

Senator Manchin.

SENATOR JOE MANCHIN III

Senator MANCHIN. Thank you, Mr. Chairman, and thank all of you. I appreciate very much you all being here.

Dr. Kroviak, according to the U.S. Census, we are the third most rural State in America, West Virginia. We do not have one city or

one town over 50,000 population. So we are a State of towns and about 1,800,000 people.

But with that being said, how do you all determine what a rural veteran is? What is your determination of rural veterans?

Dr. KROVIAK. So in our oversight work, we would look to VHA's definition of rurality. So they have highly rural and rural locations that are based on data. I believe it is with HUD and—I am blanking on the other. But they have a system in place that we follow when we conduct our oversight work.

Senator MANCHIN. Yes, if you could get back to me on that——

Dr. KROVIAK. Absolutely.

VHA Response: The Veterans Health Administration (VHA) relies on standard definitions of rurality developed by the U.S. Department of Agriculture Economic Research Service (USDA-ERS). The USDA-ERS uses a framework for determining rurality called the Rural-Urban Commuting Area Codes, or RUCA codes. The RUCA codes consider population density, urbanization, and daily commuting to classify geographic areas. RUCA is based on U.S. Census data and the 2006–2010 American Community Survey (ACS) and can be applied to either counties or census tracts. The VHA uses RUCA codes to group Veterans into Urban, Rural, and Highly Rural based on their residential address that is mapped to a census tract and its corresponding RUCA value assigned for rurality.

RUCA includes primary classification codes numbered from one to ten, with one being an urban area and ten including the most rural. Generally, a Veteran is considered rural or highly rural if their residence is in a census tract with a RUCA code between two and ten. USDA-ERS is due to update the RUCA data using 2016–2020 ACS data in Fiscal Year 2024.

OIG Response: The VA OIG does not make our own determination of which VHA facilities are considered rural. Rather, we follow VA's definitions. We have provided Senator Manchin's staff a link to VA's website where they explain their methodology. Because the definition of rurality is managed by VA, we have also connected the Senator's staff with the appropriate contacts at VA to provide any additional information that is needed.

Senator MANCHIN [continuing]. Because my whole State should be. I have four different veteran hospitals and some clinics.

Also, I was going to ask you on services. I understand we are having a hard time. Basically, in a very rural area, we have the mobile. We have a mobile VA clinic. Are they able to treat for substance abuse?

Dr. KROVIAK. So there are Mobile Vet Centers that do not provide treatment but can serve to set veterans up with clinical support for detox, withdrawal, more intense services as well as long-term substance abuse treatment.

Senator MANCHIN. I mean, I am saying if they are far away from a center and they need services and they cannot get to the centers on a frequent basis because of transportation, is the mobile service available to them?

Dr. KROVIAK. So I would have to get back to you on whether the mobile services can actually offer intensive—the intensive treatment you are describing.

VHA Response: Readjustment Counseling Service (RCS) maintains a fleet of 84 Mobile Vet Centers (MVCs) to extend focused outreach, direct services, and referral services to communities that do not meet the requirements for a ''brick-and-mortar'' Vet Center. In many cases, these communities are distant from existing services and are considered rural or highly rural. Each MVC includes a confidential counseling space for direct service provision, as well as a state-of-the-art satellite communications package that includes fully encrypted teleconferencing equipment; access to all relevant Veterans Affairs (VA) information technology systems; and connectivity to emergency response systems.

MVCs are placed at parent Vet Centers with close access to rural communities, major military installations, and used as demand developers in areas with unmet needs. MVCs are easily moved to meet the demands across the country, whether it be to support an event or a long-term solution to unmet demand. RCS utilizes MVCs in these communities while often seeking to establish a Vet Center Community Access Points (CAPs). RCS staff work with local partners to establish CAPs by using donated office space for face-to-face appointments to occur in the communities where the need exists. Services are provided anywhere from once a month to several days per week. These partners are often Veterans Service Organizations, community providers, and local governments. Additionally, virtual services are available for all Vet Center clients, and would be available to support those who are unable to attend in person.

OIG Response: The programs and services that can assist rural veterans with accessing intensive substance use disorder treatment are managed by VA. We have therefore connected Senator Manchin's staff with the appropriate contacts at VA to assist in providing additional information on their capabilities.

Senator MANCHIN. One final thing from the clinics, I was at—we have some problems, as you know, in some of the deaths that we had in one of our hospitals. But I was there talking about substance abuse, and I had one of the nurses who was very straightforward, and she says, well, if you all did not call and raise so much Cain with us about because we will not give veterans their drugs they want, because if we do not give it to them they would call and berate that service, that that hospital is poor and give them poor ratings, which brought more scrutiny. Are you familiar with all of this?

Dr. KROVIAK. So I understand the concern they are finding. I am not familiar with the specific statistics.

Senator MANCHIN. Do you know if that has been changed?

Dr. KROVIAK. If the——

Senator MANCHIN. I understand we put a piece of legislation that changed you could not—you cannot complain about the disbursement of drugs because I can tell you a lot of the veterans knew exactly. They knew more than the pharmacists knew about what drugs they wanted and why they wanted them, and they were determined to get those drugs. And if they did not, they would call their representatives, Senators or Congress people, and complain they were getting poor service, and we found it mostly over drug dispensation.

Do you have a—I can see you want to say something.

Dr. KROVIAK. If I could just add, though, it is a fair concern. The pendulum has swung dramatically, and veterans who are on a chronic opioid or any type of chronic pain treatment, to aggressively taper is not an appropriate form of management.

Senator MANCHIN. We are not saying, aggressively. Some of these nurses know better than what anybody else knows.

Dr. KROVIAK. No question.

Senator MANCHIN. They are not able to do their job, but I am hoping that has reversed. Does anybody up there know about what I am talking about? Have you heard? Chelsey, do you want to talk?

Ms. SIMONI. Yes, I have heard about it, and I have experienced it, and it is twofold like you mentioned.

Senator MANCHIN. Tell me which way it is going.

Ms. SIMONI. Well, so it is not always the veteran that is seeking the drugs. You know, I mean, it is an interesting move, but I bring this as one month of pills from the VA that I did not ask for, that the providers thought I needed. And I said to them, if I take all these, I probably will not wake up.

This is one month, and so with all due respect, trazodone to help me sleep, ropinirole and——

Senator MANCHIN. Is that on a daily basis?

Ms. SIMONI. This is on a daily basis.

Senator MANCHIN. Oh, someone take a picture of this.

Ms. SIMONI. But this is—so it is not always the veteran that is asking for these.

Senator MANCHIN. So it is basically being prescribed to them.

Ms. SIMONI. We are not looking at it from a holistic perspective.

Senator MANCHIN. You got to be kidding me. This is——

Ms. SIMONI. Oh, there is two more. There is two more.

Senator MANCHIN. Put them all out there. Yes, please, get this.

Ms. SIMONI. And so if I take these together, there is a good chance I will not wake up. And thankfully, as a healthcare provider, I know I cannot take this with this and that with that. But these are all my pills, and so——

Senator MANCHIN. Have you talked—I mean, knowing that you have the medical expertise, have you talked to the providers why they did this?

Ms. SIMONI. When I said to the provider—I went to the VA two months ago, and I said, my back is getting worse. My spine is collapsing on itself.

Senator MANCHIN. Right, right.

Ms. SIMONI. I am 32 years old.

Go to physical therapy. Here is some more gabapentin. This should help with the numbness.

I said, that does not work. I have been doing this for 10 years. What else can I do?

Oh, you can have a spinal fusion.

So I cannot walk. I said, this is not—that does not work for me. I cannot sleep. I cannot stop tossing and turning, and it is solely based on an injury.

And so if this is not an addiction in the making—and this is recent. This is one month. If this is not an addiction in the making, I do not know what is, and this is why it is critical to see patients in person.

Senator MANCHIN. Well, this is what I was saying, too. I have been told basically—and I have talked to a lot of our servicemembers who have been deployed, and they are able to get anything they want, any concoction they want, just to get through the day.

Ms. SIMONI. Except if they want alternative treatment, respectfully.

Senator MANCHIN. It is the same, isn't it? Mr. Chairman, we have got to do something.

Senator MORAN. Thank you, Senator Manchin.

Senator Sullivan.

SENATOR DAN SULLIVAN

Senator SULLIVAN. Thank you, Mr. Chairman.

And, boy, Ms. Simoni, that is some serious——

Senator MANCHIN. I teed it up for you.

Senator SULLIVAN [continuing]. Drugs you got there. You know, we have had hearings on this. I want to commend Senator Manchin. He has done a lot in this area, on this topic.

Dr. Kroviak, that was not one of the questions I was going to ask, but is there a concern from the IG's Office about these kind of prescriptions that could lead to a dangerous situation?

Dr. KROVIAK. That is catastrophic care coordination like I have never seen, and it is a huge concern when multiple providers are involved. Usually we see the greatest concern between VHA and the community. When that information is not being shared real time, dangerous concoctions can happen like this, and patients might be completely unaware.

Senator SULLIVAN. So are those all from the VA?

Ms. SIMONI. Yes, sir.

Senator MORAN. How many providers? Does that come from more than one, obviously, more than one provider?

Ms. SIMONI. Neurology, mental health, and that is it. Two.

Senator SULLIVAN. From the same VA? Which VA is that?

Ms. SIMONI. New England VA Healthcare System. It is in the New England VA Healthcare System.

Dr. KROVIAK. So there is a misstep in medication reconciliation, and I obviously do not know the specifics of your care, but that sounds like a big gap in medication reconciliation.

Senator SULLIVAN. Yes, you might want to look into that. Right? We do not want anyone from that system or any system, or any of our veterans, dying of a drug overdose that is induced by too many pills. That is outrageous.

Let me turn to the topic at hand, Dr. Kroviak, and—by the way, I want to thank all the witnesses. A lot of you are veterans and are caring for veterans. It is not easy. So all four of you I actually appreciate very much. I read all your backgrounds. Impressive what you have done and your concern, so thank you to all the witnesses here.

Do we have a sense—just going back to some basic issues—on wait times with regard to the VA, and is there a significant difference between urban and rural areas in terms of wait times?

Dr. KROVIAK. So we do look at those in rural versus urban. We do see somewhat of an increase in rural if you look at fiscal year '22. It is not—I think some of the mental health differences for referrals were seven or eight days' difference, and I can get those exact numbers that our office drew from VA data. But it is measurable in terms of when you compare rural to urban, that rural has a longer wait time, especially for specialty care.

Senator SULLIVAN. Okay. You know, I come from a State with more vets per capita than any State in the country, and our very

rural State, Alaska, we do not even have one full-service VA hospital in the State.

And one of the issues that my State has experienced, particularly with regard to rural providers, is the lack of experience in terms of the providers themselves. And so can you speak to that? Are there recruitment efforts that are being made with regard to trying to get more experienced providers in our rural areas? Maybe this is an issue beyond Alaska.

And what can we do about it? Is there pay scales that we can provide? Are there incentives that we can provide to make sure we are getting high quality providers to people in rural Alaska? It should not matter on your ZIP code how good your VA or private care provider is.

Dr. KROVIAK. So I appreciate the question. Unfortunately, in oversight, we have no role in determining VA's hiring or retention and recruiting activities. So that would be better directed to them.

But if I could just say, we do understand the quality concerns that you are describing, particularly again when you go out into the community, that clinical information sharing opportunities are lost or so delayed that I cannot tell you what type of quality of care is happening outside of the VA, and I am very concerned they cannot either. So your concerns about the caliber or the credentialing, the experience of the providers they are hiring, in VA as well as in the community, is definitely warranted.

Senator SULLIVAN. Let me ask one final question, and I will throw it out for all the witnesses. Senator Cassidy, Dr. Cassidy, was talking about this issue of the prevalence of substance abuse in the veteran population, and then beyond just the veteran population, Dr. Cantor, he was a having a discussion with you.

But it also certainly seems like it is a younger generation issue. Is that a trend that you are seeing, any of you, in your experience, that these substance abuse issues are hitting a younger demographic, and if so, why? And if not, then maybe that is not an area of focus. Anyone on that? No one knows whether—go ahead.

Ms. SIMONI. I can speak on behalf of civilian. Every—I work 40 hours a week in the ER, doing three on, four off, and I see roughly, at Mass General Hospital, 10 overdoses a week in just my practice alone in individuals under the age 35.

Senator SULLIVAN. So it is a younger demographic.

Ms. SIMONI. From my practice and personal experience, yes.

Senator SULLIVAN. Anyone—Dr. Cantor, have you seen this as a broad demographic trend, or you do not have the data on it?

Dr. CANTOR. I do not have the data on that.

Senator SULLIVAN. Anyone else? Dr. Kroviak?

Dr. KROVIAK. I do not have the data, but if you are targeting an age group, we are doing work now in that high risk transition period from active duty to civilian, or to veteran, when you will find typically a younger age. And we are doing work now looking specifically at ensuring that those diagnosed during active duty with opioid use disorder, that that information is translated into the VA record. We are seeing there are a lot of gaps in even ensuring that once the diagnosis is made in active duty that veterans are being recorded as having that diagnosis and immediately getting treat-

ment and support for it. So it does softly hit your age target that you were describing.

Senator SULLIVAN. Okay, good. Thank you.

Thank you, Mr. Chairman.

Senator MORAN. Thank you, Senator.

Maybe for Dr. Kroviak or anyone, so are there statistics that—let me preface what I am going to say. So 2014, we saw an inability of the VA within their hospital system to meet the needs of veterans. That is when we saw and learned about the fake waiting lists, the fake appointment lists, and we responded; Congress responded with CHOICE in 2014. So for 10 years, we have been trying to figure out how we can get the Department of Veterans Affairs to provide health care in more locations by using community care.

Community care existed before CHOICE. My view is that CHOICE was implemented by the Department of Veterans Affairs in which it needed more, greater restrictions in our language to make sure that community care was actually provided. We had to encourage the Department to use that option.

So we passed MISSION, giving some pretty specific directions and outlines in which the circumstances—and again, only in the circumstance in which a veteran wants to have community care. And still, we find that the gaps continue.

My interest in this, I mean, is broad across the country—the deaths in the hospital in Arizona, et cetera—but it is also very local for me. I represent a State—a congressional district at the time that is the size of the State of Illinois. There is no VA hospital, and it is hours to drive for almost every veteran to a VA hospital.

And so we have tried legislatively to encourage, force, require when the choice was the veteran's to receive care in the community.

Any inspector general reports that demonstrate any success in those efforts? Are things getting better? Do we still have problems in the utilization of community care?

I have legislation that we are going to, I hope, mark up soon that will require you to make those analyses so that we can determine whether or not the efforts that we have undertaken over a decade are making a difference. Any commentary?

Dr. KROVIAK. Your question is massive; I mean, it really is. I am a bit biased as a former provider in the VA. What CHOICE did not solve, what MISSION has not solved is when you are engaging with the community, reliably getting that clinical information back, so VA and the community provider are on the same page at the same time to manage the veteran's care.

It gets so much worse when there is complexity introduced. So if there is a mental health diagnosis, if there is a cancer that requires multidisciplinary specialties to get involved, the coordination is enormously difficult, and it remains so.

And technology is likely the ultimate solution, but we are not there yet to where the EHRs can interface, to have that real-time connection going.

Every report the Office of Healthcare Inspection writes touches on some form of care coordination gaps, failures, and they are usually highlighted in that community care collaboration setting. So

until there is a way to ensure that a primary care provide in the VA who sends their patient out to the community for that dermatology or cardiology referral, until they can know in real time how that patient is being managed, you have no assessment of the quality.

Senator MORAN. What is the current capability?

Dr. KROVIAK. It depends on the part of the country. You know, there are HIEs, but our understanding is very few community providers participate in the Health Information Exchanges. We are still especially in some rural communities relying on faxes, and those faxes get sent to a space in a facility where already a stressed staff in terms of number have to just scan those records in, and we do not even find there is uniformity in the scanning. So the record might be there for the provider to look at, but they have no idea how to find it, what is the naming convention. It is a dangerous relationship right now.

Senator MORAN. And are there other reasons? Perhaps you are suggesting that a provider within the VA would be reluctant to make the referral because the lack of communication between——

Dr. KROVIAK. I do not want to imply that they would delay care intentionally for their patient, but when we do hear stories where the veteran is choosing to stay, I can, you know, honestly say, I get it, where they are choosing to wait for the VA provider as opposed to being sent into the community. But I do not want to suggest that we have anything that VA providers are scared to send their patients so they do not because that is something we have not looked at.

Senator MORAN. I would tell you that, anecdotally, so many times I have—mostly what I know about what is going on in veterans' lives is the conversations I have with veterans. No offense to RAND or to the Inspector General.

Dr. KROVIAK. None taken.

Senator MORAN. I should read your reports more frequently, but veterans are willing, usually, to have a conversation. And so often it is that, I am seeking community care, but I cannot get the referral from the Department of Veterans Affairs.

So there seems to me to be some bias if it is based upon a concern about medical care, but it is certainly a slow process——

Dr. KROVIAK. Yes.

Senator MORAN [continuing]. By which the VA will make the decision when someone asks, when a veteran asks for community care.

And what I have heard in the time that I have been here in front of this panel is that there is no time to spare. And so a system that is designed to save lives and improve one's well-being, particularly, I suppose, it could be other things than mental health and drug addiction, but certainly in those circumstances we need a system in which a referral is made quickly.

I understand that in many communities across Kansas and the country there are not enough providers in mental health and substance abuse services to make those referrals to. It is a shortage across the board. But I want—it is a goal of mine—to make sure there are no artificial, unnecessary impediments, or no bias against a veteran who chooses or needs care quickly or needs care because

of geography, that the VA is not making those referrals in a timely, medically necessary fashion.

Dr. KROVIAK. Again, that is a huge undertaking, and I really appreciate the concern. Even if you take it out of this one aspect of community care you are looking at, this is a massive system, and it has a lot of policies and practices in place. And getting frontline staff to consistently apply those rules is difficult, especially when you do not have standardization across the board that builds in that accountability.

In my oral testimony, I highlighted incredibly dated handbooks and guidelines for clinical practice. So we cannot fix the interface of EHR today, but things that we can do in the immediate term is update the policies and practices, clinical and administrative, give the front line a chance to practice the rules consistently, and then standardize some type of structure at whatever level, maybe even looking at the VISN, to make sure those rules are being carried out. That is an immediate or a near immediate solution that will at least get you more comfortable that the staff is offering the veteran, based on the wait times, care that they need and the opportunity they have to get care outside the VA.

Senator MORAN. Well, it is another experience, and as an Inspector General you would not, I do not think, find this surprising. So many times, I mean, I bring a case to the Department of Veterans Affairs, and nationally, here in Washington, DC, I am told that this is the policy and if it was not the policy we have now fixed the policy. But that is—well, let me be more precise. It is often the case that that is not what the person in the VISN or in the hospital or in the community outpatient clinic—that is not what they know the policy to be.

So I am often told, here is the policy. Senator Moran, we have got the policy that you want. But that is not close to what——

Dr. KROVIAK. The SOP, the local business rule, might be completely different. So the frontline staff is being honest; here is what I do because I am told to do this. And they are being honest when they are delivering the policy. And when they conflict, who loses? The veteran.

Senator MORAN. Yes. I am not off this topic. I mean, I am off this topic for the moment, but I am not off this topic generally.

Let me highlight how grateful I am to Ms. Simoni for what is a very difficult testimony to provide. I appreciate you sharing your personal and family story.

You indicated in your testimony that the data you shared with the Committee also notes many examples of where care offered by the VA has fallen short for many of your fellow veterans. Would you expand on what you are telling us?

Ms. SIMONI. Of course. You know, you are the Senator of Kansas. So I mean, a perfect example, you know, in terms of community care——

Senator MORAN. You have got something else in your bag?

Ms. SIMONI. No, no. I wish. I usually have a lot of—no. You know, it brings me back to the fact I deal mostly with oncology and veterans with terminal cancers, and you know, SOP goes out the window when time is on the clock. And I mean, I say that in the most humble way possible, but year to date, we have lost—only the

ones that I know of, that I have physically cared for—119 Post-9/11 veterans from cancer.

And so two years ago, we had a veteran who was in the Kansas VA healthcare system. He was on this third diagnosis of terminal cancer, and the VA said to him, there is nothing more we can do. And being he was only 34 years old, with three kids, I did not accept that. I said, let me try. Let me call. Let me do something.

And so we finally got him care down at MD Anderson, and when he requested through his provider who writes the order or the allowance for community care, his provider says, that is not evidence-based. You cannot go there. I am not writing that order.

And we fought for two weeks, and as two weeks goes by, time is running out. Finally, I said, I will pay for it myself because you can always make more money but you cannot save a life once it is gone. And myself and my co-worker, Matt, reached out to your office, and you had him squared away, like squared away instantly. And it saved his life, and he is still alive today, which is incredible because he was given a terminal diagnosis two years ago.

So this is something we face every day. And I mean it in the most humbling way possible; I do not have time. My patients, my veterans, the people I served with, myself, my brother, we do not have time to wait for processes to be implemented or systemic problems to be fixed. These are—time is running out.

Twenty-four hours in a day. Time is running out. Every single 24—every hour that goes, that time matters. And if I have to pay for it myself, I will because you can always make more money but you cannot save a life once it is gone.

Senator MORAN. That was not the answer I was soliciting, but I appreciate the fact that you took extra—greater willingness to go another step to make a difference.

It is also a good reminder. And I make the same mistake. I talk about the MISSION Act in terms of geography, which is a huge component to people for substance abuse and mental health issues and suicide and just general care. But the MISSION Act is also designed to get expertise that may not exist within the VA, perhaps such as oncology, that can also serve a veteran if that is, again, his or her choice.

You know, Ms. Simoni, that I recently introduced the Veterans' HEALTH Act that aims to address some of the issues that we are talking about today. Would you share with me, so I can repeat it when we have a debate and conversation about this legislation, why your organization decided to endorse that legislation?

Ms. SIMONI. Absolutely.

Senator MORAN. Please do. Please tell me why your organization endorsed that legislation.

Ms. SIMONI. Oh, sure. So I have bad hearing.

Senator MORAN. My wife tells me I am a terrible communicator.

Ms. SIMONI. I just—I cannot hear that well. So our organization supported that legislation because, you know, at the end of the day, like I said, it is not about if we vote Democrat, Republican, you know, whether veterans—whatever it may be. This is about the veteran.

And so the HEALTH Act I found very interesting because it allows us to get the veteran care where they are at. And for a lot

of these rare cancer cases—and a lot of these are rare cancers that we deal with. Substance use. Like I mentioned, it is dual diagnoses and polytrauma. It has to be looked at holistically.

And so a lot of my patients end up dying because they do not receive unique veteran-specific care, and I believe that your HEALTH Act can make a big difference in that. I believe that they will be able to receive care at some of the best hospitals in the country, such as MD Anderson, such as Moffitt, such as Dana-Farber, more quickly, more adequately, more holistically, and at the end of the day, that is all that matters to me and our organization.

Senator MORAN. Thank you.

Ms. Mathis, your written testimony included a recommendation to the VA to increase the number of Clinical Resource Hubs to better aid veterans who live in areas that experience bandwidth problems. We have been talking about technology, and we have been talking about telemedicine, telehealth.

My staff and I are proponents of this initiative of the Office of Rural Health and routinely ask the VA if they are requesting adequate funding for Clinical Resource Hubs or could benefit from additional hubs. In addition to serving on this Committee, I am an appropriator as well.

Can you share with us DAV's recommendations on how many additional Clinical Resource Hubs VA could use to serve VA's rural and highly rural veteran population?

Ms. MATHIS. Thank you for that question, Senator. I do not have the data as far as how many they need. That would be a VA data-driven kind of answer.

But I will say that in rural communities, as you know, they do have bandwidth issues. And if a veteran cannot get to the technology that is supposed to help them because they do not have the capacity to do so, then how is technology supposed to be helping that veteran?

So the Clinical Resource Hubs are really beneficial for the rural veteran to be able to get the quality care that VA provides, and so they do have efforts such as the Virtual Living Room where you can go to, say, your local DAV chapter and have a private conversation with your provider using these Clinical Resource Hubs or these Virtual Living Rooms as well.

Senator MORAN. I want to hear what you had to say, but I also thought of another issue.

Ms. MATHIS. Sure.

Senator MORAN. I could not hear either. So related to these topics, ATLAS pods was something that was touted—we have one in Kansas, in Emporia—in which mental health services were to be provided so that a veteran who did not have access to the technology or the broadband width to receive and send signals to a provider could go to a central location within the community. In this case, a Veterans Service Organization worked with a private company to put in the pod. The VA has paused the implementation of that.

Do disabled American veterans know about that program? Anything that you want to share with me or just I will use this as an opportunity to remind myself and the VA that pause has been going now for months.

Ms. MATHIS. I do not know about that program, but I am very interested to hear about it.

Senator MORAN. Okay. Do you think it could have merit?

Ms. MATHIS. I do not—I do not know.

Senator MORAN. Do not know.

Ms. MATHIS. I would have to look at it.

Senator MORAN. Okay. Anyone else?

[No response.]

Senator MORAN. Thank you very much, all, for your testimony. I want to thank you, I do thank you, for being here.

We will continue to make certain that we do everything we can to see that veterans receive high quality care, particularly as it relates in this hearing to mental health and substance abuse disorders, and I am grateful for the care and compassion that each of you has shown for those who served our country.

One reason I was late, incidentally, is today is the 248th anniversary of the Army, and so we were cutting cake. I chair the Army Caucus, and I was responsible for helping cut the cake. But I am glad I made it to hear the testimony that I did and have the conversations with you.

We will keep the record open for a week in case my colleagues and I have questions that you can then reply to the record, and for today, the hearing is adjourned. Thank you.

[Whereupon, at 4:48 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

STATEMENT OF ERICA SCAVELLA, M.D. FACP, FACHE
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BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

"CONNECTIONS TO CARE: IMPROVING SUBSTANCE USE DISORDER CARE FOR VETERANS IN RURAL AMERICA AND BEYOND"

June 14, 2023

Good morning, Chairman Tester, Ranking Member Moran, and distinguished Members of the Committee. Thank you for the opportunity today to discuss VA's substance use disorder (SUD) treatment programs in rural America. Accompanying me today is Dr. Tamara Campbell, Executive Director, Office of Mental Health and Suicide Prevention, and Dr. Bradley Watts, Director, Veterans Rural Health Resource Center.

There has been an upsurge in morbidity and mortality from SUDs over the past 10 years as powerful and hazardous illicit drugs have become more widespread in the United States. From fiscal year (FY) 2018 to FY 2022, the number of Veterans diagnosed with a SUD (which includes alcohol use disorder) and receiving treatment in VHA increased from 522,544 to 550,412.

Due to the complexity of SUD, no single remedy, no clinical or law enforcement intervention alone, nor any single agency, VA or otherwise, will suffice in meeting our nation's challenges with substance use and the associated overdose epidemic. Therefore, VA is working alongside the White House's Office of National Drug Control Policy (ONDCP) and other Federal agencies to implement an evidence-based, comprehensive strategy to address the Nation's challenges with SUD and the threat they pose to the well-being of the American people. VA embraces its role in helping to fulfill the National Drug Control Strategy and is grateful for the support VA has received from Congress in implementing programs to ensure that Veterans receive the highest quality SUD prevention and treatment services they need and deserve. Treatment for rural Veterans with SUD occur in the context of VA's overall efforts to treat Veterans experiencing substance use concerns. Enterprise-wide efforts are focused on ensuring the needs of all Veterans with SUD are met with no wrong door to accessing care and focused attention to ensure application of those efforts to rural Veterans.

To reduce the burden of SUD in the Veteran population, it is important to use broad-based national preventative and treatment strategies. To achieve its goals, VA uses both whole-of-Government and whole-of-Nation approaches. These are exemplified by VA's interagency collaborations. As an illustration, the Department of Defense (DoD) and VA collaborated to produce clinical practice guidelines for the management of SUDs. To meet the needs of Veterans with or at risk of SUD, VA also

collaborates closely with several other Departments and agencies, including the Departments of Health and Human Services, Energy, Justice, and Housing and Urban Development. VA's efforts in coordination with other Federal agencies support the priorities defined by the National Drug Control Strategy. In alignment with the Strategy and the President's Unity Agenda's priority to address the overdose crisis, VA is working to expand access to evidence-based treatment for SUDs and enhancing evidence-based harm reduction efforts aimed at reducing overdose fatalities. VA offers a comprehensive continuum of specialty SUD services for Veterans founded in the evidence. Our VA/DoD Clinical Practice Guidelines,[1] updated in FY 2021, provide the foundation for evidence-based treatment within VA and have positioned VA to respond to emerging drug use trends.

Overview of SUD Treatment at VA

Rates of substance use, types of substances used, and treatment for SUD vary geographically. VA is committed to ensuring Veterans have access to treatment for SUD regardless of where they live. Using the Census Bureau's Rural-Urban Community Area (RUCA) coding system that designates census tracts as urban, rural, highly rural, or unknown, we assigned patients these applicable codes based on their home address. Consequently, of the over 550,000 Veterans currently receiving SUD care from VHA (8.5% of all patients who received care from VHA), we determined that VA treated a total of 124,275 rurally-located Veterans with alcohol use disorder (AUD) and 66,439 rurally-located Veterans with drug use disorders through the second quarter of FY 2023 (Note: a Veteran may be counted in both data points). Of those Veterans with drug use disorders, 18,880 were treated for opioid use disorder (OUD), 20,581 were treated for stimulant use disorder, and 38,465 were treated for cannabis use disorder.

Over the last decade, VHA has worked to mitigate risk factors associated with opioids and stimulants use among Veterans, including by launching a national Opioid Safety Initiative a decade ago and a national Stimulant Safety Initiative last year. In addition, VA provides comprehensive services for the treatment of SUD, including screening and brief intervention for alcohol use disorder; outpatient and intensive outpatient SUD specialty services; pharmacotherapy for OUD, including office-based buprenorphine, extended-release injectable naltrexone and Opioid Treatment Programs that provide methadone; evidence-based treatments for stimulant use disorder; SUD residential treatment programs; and withdrawal management. Peer specialists also are being embedded across the continuum to support Veterans in recovery and treatment for SUD within primary and specialty care settings, pain management clinics, emergency departments, and general mental health clinics. Beyond treatment for SUD, VA provides both primary and secondary prevention specific to OUD in addition to efforts specific to risks associated with substance use in general.

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

As an integrated health care system, VA is uniquely situated to address the needs of Veterans diagnosed with SUD by providing support to address co-occurring medical, mental health and psychosocial needs, including support for employment and housing.

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

Current policy, grounded in the latest evidence, requires facilities provide access to a comprehensive continuum of SUD treatment services ranging from early intervention and harm reduction services through intensive outpatient and, when needed, residential or inpatient treatment for SUD. In addition, current policy requires facilities provide same day outpatient access for Veterans with emergent substance use treatment needs. This care may be provided in person or via telehealth in several settings including general mental health, primary care mental health integration clinics, and SUD specialty clinics. Core characteristics of SUD services include timely same day triage, a no wrong door approach, concurrent treatment for co-occurring needs and Veteran-centered and individualized treatment based on the needs and preferences of the Veteran.

VHA national policy explicitly states that Veterans cannot be denied access to care due to their use of a substance. Further, both national policy and the VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders define expectations that Veterans be retained in care and that programs do not use criteria that would require automatic discharge from treatment due to substance use. Over the last several years, there has been significant emphasis on engagement in care with a focus on meeting Veterans where they are in their recovery. Meeting people where they are is the underlying principle in harm reduction.

In addition, VHA continues to improve service delivery and efficiency by integrating services for mental health disorders, including SUD, into primary care settings. VHA-enrolled Veterans from all service eras have primary care teams (Patient Aligned Care Teams, or PACTs) with co-located mental health staff to identify and address potential mental health and substance use treatment needs. Secondary prevention services include diagnosis and assessment of possible SUD in patients presenting with medical problems that suggest elevated risk of SUD. While most Veterans with SUD are treated in outpatient programs, providers in these outpatient

treatment settings are expected to collaborate with colleagues in inpatient and residential SUD care settings to coordinate Veterans' transitions across these levels of SUD care. Such efforts are necessary for helping ensure continuity of SUD care that is consistent with a chronic disease model of care and responsive to changes in Veterans' clinical status.

Considering the frequent co-occurrence of SUDs with posttraumatic stress disorder (PTSD), VHA also has assigned a SUD specialist to each of its hospital-level PTSD services or teams. The SUD-PTSD specialist is an integral member of the PTSD clinical services team and works to integrate SUD care with all other aspects of PTSD-related care. Among the specialists' responsibilities are identification and treatment of Veterans with co-occurring SUD and PTSD. Specialists also promote preventive services for Veterans with PTSD who are at risk for developing a SUD.

VHA provides two types of 24-hour care to patients with severe or complex SUD. These include inpatient withdrawal management and stabilization in numerous medical and general mental health units, equivalent to Level 4, Medically Managed Intensive Inpatient Treatment as specified by the American Society of Addiction Medicine Patient Placement Criteria (https://www.asam.org/asam-criteria/about-the-asam-criteria), and provision of care in Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) otherwise referred to as Domiciliary SUD beds. VHA offers care in MH RRTPs to Veterans with complex, co-occurring mental health, substance use, medical, and psychosocial needs. Specialty Domiciliary SUD programs provide treatment equivalent to Level 3.7, Medically Monitored Intensive Inpatient Services, as specified by the American Society of Addiction Medicine Patient Placement Criteria. Today, more than 70 Domiciliary SUD programs are in operation with more than 1,700 beds focused specifically on intensive, medically monitored residential SUD treatment. In addition to those MH RRTPs formally designated as Domiciliary SUD programs, additional SUD specialized services are offered through tracks in other MH RRTPs, and most Veterans served (more than 95%) by MH RRTPs are diagnosed with a SUD. Several new Domiciliary SUD programs are under development with the number of programs expected to grow over the next few years.

Programs to end homelessness among Veterans are encouraged to have SUD specialists as a part of their multidisciplinary teams. There are SUD specialists working in the Department of Housing and Urban Development – VA Supportive Housing, Grant and Per Diem and the Health Care for Homeless Veterans programs; however, the use of SUD specialists can vary locally based on site-specific needs. These specialists emphasize early identification of SUDs as a risk for maintaining permanent housing, promote engagement or re-engagement in SUD specialty care programs, provide evidence-based SUD treatment services, and link Veterans to specialty SUD treatment when such Veterans need more intensive SUD treatment services. In 2022, VHA supported the expansion of VA case managers integrated with existing homeless program staff to assist Supported Services for Veteran Families (SSVF) grantees with engaging Veterans experiencing SUD concerns into VA services, including but not limited to SUD specialty care or residential treatment when needed.

VHA's existing infrastructure within the Homeless Program Office provides a foundation by which HPO can quickly direct resources, through grants, to community providers with the intent of rapidly engaging or re-engaging Veterans with SUD services specific to their treatment needs. Because people experiencing unstable housing or homelessness are at high risk of overdose, VHA has been working to place Veterans experiencing homelessness into permanent housing.

Treatment for Alcohol Misuse

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

Treatment for Opioid Use Disorder

With national initiatives like Stepped Care for OUD, Train the Trainer, and the Psychotropic Drug Safety Initiative, VA emphasizes access to evidence-based treatments for SUDs. These initiatives aim to increase access to both evidence-based pharmacotherapies and evidence-based psychotherapies for SUD. According to the National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration, only 22% of the general population with OUD received medication for OUD in 2021. In calendar year 2022, VA more than doubled that rate, with over 47 percent of patients with OUD having received medications for OUD from VA within the last 12 months ending March 31, 2023. Appropriate use of medications approved by the Food and Drug Administration for OUD can lower the risk of illicit opioid use, overdose, suicide, and other mortalities.

Treatment for Stimulant and Cannabis Use Disorders

In 2022, VA provided psychosocial or behavioral therapy for SUD to almost 172,000 Veterans. VA is using national training initiatives to ensure that these treatments are as effective as possible, expanding access to strong, evidence-based cognitive behavioral therapies and contingency management programs. Notably, contingency management is the most effective evidence-based treatment for stimulant use disorder and has shown success in treating cannabis use disorder, two SUDs that are increasingly common in the VHA patient population. More than 6,200 Veterans have

received contingency management treatment since 2011. Over 90% of the nearly 80,000 urine samples that those Veterans submitted tested negative for the target drugs, which are frequently stimulants and occasionally cannabis (THC). For Veterans with AUD, VA offers both evidence-based medications as well as evidence-based psychotherapies, separately or in combination depending on the shared decision-making between Veterans and their treatment providers. VA recognizes that not all Veterans with SUD will embrace abstinence among their recovery goals.

Harm Reduction

SUD, like hypertension or diabetes, is a chronic, relapsing condition; even Veterans who are striving to abstain from substances may not always be consistently successful. Because any exposure to substances can be fatal for individuals with SUD, VA provides Veterans with evidence-based interventions to protect them from harms, like overdose or infectious diseases like human immunodeficiency virus (HIV) and hepatitis, that could otherwise lead to their death. In just the past year, VHA equipped over 70,000 Veterans with naloxone to reverse potentially fatal opioid overdoses. Furthermore, over 1 million naloxone prescriptions have been provided to Veterans since 2014, when we launched our Overdose Education and Naloxone Distribution (OEND) initiative. This initiative has led to more than 3,700 overdose reversals. As part of this effort, VA uses data-driven modeling to identify Veterans at high risk of overdose and conducts clinical case reviews to inform their customized treatment plans. We appreciate Congress' support, which has been critical for the success of VA's overdose prevention efforts by allowing VA to provide naloxone at no cost to Veterans at high risk for overdose.

VA has also aligned its policies and operations with interventions in the National Drug Control Strategy related to harms related to bloodborne infections spread through contaminated injection equipment, particularly HIV infection and chronic hepatitis C virus infection. VA pioneered integrated care for SUD patients with these life-threatening conditions, with cure rates among Veterans with alcohol, substance use, and mental health disorders that are similar to cure rates in those without these conditions.[2]

Education and Training

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

- Initiatives to educate primary care practitioners on the diagnosis and treatment of AUDs.
- Harm reduction approaches to reduce negative consequences of substance use.
- Programs developed for Veterans and Veterans' families.

[2] Belperio PS, Chartier M, Ross DB, Alaigh P, Shulkin D. Curing Hepatitis C Virus Infection: Best Practices From the U.S. Department of Veterans Affairs. Ann Intern Med. 2017 Oct 3;167(7):499-504

- Clinician training and consultation programs to improve their knowledge, skills, and abilities to treat Veterans with SUD.
- SUD training programs for trainees participating in clinical training with VA.

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

SUD Treatment Programs for Rural Veterans

To expand access to SUD treatment for Veterans, including those who reside in rural areas, who may not seek treatment in specialty care settings, VHA continues to invest in a complement of team members to increase access to evidence-based treatment for SUD both within and outside specialty SUD care. One of the essential interprofessional care team providers is the Clinical Pharmacist Practitioner (CPP). The CPP serves as the medication expert delivering comprehensive medication management (CMM) to Veterans using a patient-centered, collaborative approach in conjunction with all members of the health care team.

In delivering CMM care, the CPP focuses on ensuring medications are assessed for appropriateness, effectiveness, and safety given the patient's clinical status, comorbidities, other medications, and patient's ability to adhere to a medication regimen. CPPs improve VHA's ability to accomplish the quintuple aim of better care, reduced health care costs, improved patient experience, provider well-being, and health equity; CPPs have demonstrated positive impacts on access, Veteran engagement, treatment retention, and telehealth care delivery. CPPs provide risk mitigation strategies, perform screening, and deliver brief interventions, referrals, and treatment. The CPP is part of the solution for the unmet need in OUD and AUD treatment, especially for rural Veterans.

Starting in FY 2020, as part of a rural health initiative, VA hired 64 CPPs across 52 rural facilities to support VHA's strategy to provide the best care in a timely manner. These CPPs ensure Veterans have access to a medication expert providing CMM services to 43,262 Veterans over 129,078 patient care encounters with over 68% of the visits delivered using telehealth modalities. To scale best practices and drive innovation, this project delivered system-wide training focused on SUD screening, care, and treatment with a whole health focus to 266 CPPs across the system. As a result of the training, there has been a 52% increase in CPPs delivering overall SUD care, 53% increase in CPPs providing AUD care, and a 97% increase in the number of CPPs providing OUD care since FY 2018. To continue improving SUD access to rural Veterans, VA has provided funding to 24 facilities to hire 30 new CPPs in Primary Care Mental Health Integration and Behavioral Health Integrated Programs teams, which will include a provision of SUD care within their practice, including AUD, OUD, and

stimulant use disorder in the fourth quarter of FY 2023. Priority will be placed on specific populations to decrease SUD disparities.

Veterans living in rural communities often face unique challenges that limit their access to health care. Barriers such as long distances to clinical facilities and a shortage of qualified providers can put rural Veterans and their families at risk. Rural Veterans have a 20% greater risk of suicide than their urban counterparts.[3] At the same time, rural areas have fewer mental health care providers than their urban counterparts.[4] To overcome these challenges and reach rural Veterans with critical health care needs, VA has expanded access through telehealth programs. This includes the development and ongoing expansion of Clinical Resource Hubs (CRH) – a network of VA centers in large, urban settings that are skilled in delivering their services to Veterans in rural areas at medical centers, VA community clinics, and in the home through telehealth technology.

Utilization of Telehealth for SUD Treatment

During the pandemic, VA was able to ensure continued access to SUD treatment to Veterans in rural areas through expanded use of telehealth. This was facilitated by pandemic prescribing flexibilities under Federal law that improved access to OUD pharmacotherapy (e.g., Buprenorphine) through virtual modalities in the absence of a prior in-person medical evaluation.

While the Drug Enforcement Administration (DEA) and the U.S. Department of Health and Human Services (HHS) have extended pandemic prescribing authorities while modernizing national telehealth regulations, not all States have . Variable restrictions in State rules may be barriers to rural Veterans getting SUD treatment through telemedicine, including for some of our most rural and vulnerable Veterans. This is a significant concern, which is why VA has endorsed a legislative proposal in the FY 2024 budget request (Maintaining Consistent Access to Critical Treatments Through Telehealth) to ensure VA providers can furnish clinically appropriate telehealth care to every Veteran they treat, regardless of where the patient is or resides or where the provider is licensed or located.

Despite telehealth challenges, the rates of SUD treatment and risk mitigation efforts are comparable between urban and rurally located Veterans based on the SUD treatment metrics that VA monitors. This includes the percentage of Veterans with OUD who receive life-saving medication for OUD, the percentage of Veterans with OUD and stimulant use disorder who received naloxone, and the percentage of Veterans with an overdose who receive an interdisciplinary team case risk review.

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[3] McCarthy, J.F., Blow, F.C., Ignacio, R.V., Ilgen, M.A., Austin, K.L., & Valenstein, M. (2012). Suicide among patients in the Veterans Affairs health system: Rural–urban differences in rates, risks, and methods. American Journal of Public Health,102(S1), S111-S117. doi: 10.2105/AJPH.2011.300463

[4] Varia, S.G., Ebin, J., & Stout, E.R. (2014). Suicide prevention in rural communities: Perspectives from a Community of Practice. Journal of Rural Mental Health, 38(2), 109

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

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

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

As of May 31, 2023, over 61% of the more than 1,100 positions have been filled or are in the final steps of the hiring process. VA continues to respond to emerging illicit drug threats to ensure the needs of Veterans experiencing substance use concerns are met. During FY 2024, VA plans to establish program management leads for harm reduction at each facility and will work collaboratively to develop policy and national tools to support implementation of targeted harm reduction strategies throughout VHA by addressing critical issues such as stigma and the need for technical assistance for the field to support implementation of emerging treatment approaches.

The VHA Office of Rural Health also continues to invest in research and innovation focused on meeting the needs of rural Veterans experiencing SUD. These projects, often proposed by rural VA medical centers, seek to understand opportunities and develop novel solutions in the rural SUD space. Examples include a telehospitalist-led pilot for inpatient management of AUD, a project developing a telehealth model to improve treatment access for rural Veterans with SUD, collaborative pain care for rural patients with OUD and other SUDs using telehealth technologies, and research to understand drivers of mental health services utilization at remote locations. These are ongoing projects without final results, but each will contribute to the future treatment options for rural residing Veterans experiencing SUD.

Conclusion

We appreciate the Committee's continued support in this shared mission. Nothing is more important to VA than supporting the health and well-being of the Nation's Veterans and their families. VA has employed broad, evidence-based strategies to address the opioid epidemic, including patient and provider education, pain

management and access to non-pharmacological modalities, risk mitigation strategies, and addiction treatment for Veterans with SUD. This critical work saves lives. My colleagues and I are prepared to respond to any questions you may have.

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF JULIE KROVIAK, MD
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FOR THE OFFICE OF HEALTHCARE INSPECTIONS,
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BEFORE THE
U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
CONNECTIONS TO CARE: IMPROVING SUBSTANCE USE DISORDER CARE
FOR VETERANS IN RURAL AMERICA AND BEYOND
JUNE 14, 2023

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

VHA faces significant challenges in meeting the complex needs of individuals with substance use disorders, and rural settings can pose additional obstacles in addressing those patients' needs. With more than three million veterans in rural and highly rural areas enrolled in VHA, the need for innovative and immediate healthcare access solutions for those veterans with substance use disorders is urgent.[1]

The devastating effects of substance use disorders on veterans, their families and caregivers, and communities cannot be overstated. Veterans with substance use disorders often have co-occurring mental health conditions that can place them at higher risk for suicide. Veterans living in highly rural areas are also 65 percent more likely to die from suicide that those residing in urban settings.[2] Given that VHA's top clinical priority is to reduce veteran suicide, timely access to evidence-based substance use disorder treatment programs is imperative to addressing the clinical needs of these high-risk patients.

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[1] VHA Office of Health Equity (OHE), "Access to Care among Rural Veterans" (fact sheet), March 10, 2020.
[2] VHA OHE, "Access to Care among Rural Veterans" (fact sheet), March 10, 2020.

The OIG reports highlighted in this testimony help to identify VHA challenges specific to providing veterans access to community care and coordination for high-risk patients. The risks to patient safety and care when either is deficient are significant and will only grow as VHA increases its reliance on community care providers. Recent OIG-collected data shows that in fiscal year (FY) 2022, more than 237,000 veterans enrolled at rural facilities have been referred for community care, including 7,400 for mental health treatment. The findings and recommendations in the highlighted reports that follow help underscore the need for (1) timely access to appropriate care, (2) oversight of VHA staff adherence to community care referral guidelines, and (3) care coordination and clinical information exchange between VHA and community care providers.

Our reports focus on issues relevant to leaders across the system in all settings—urban and rural. However, because of the inherent challenges of rural healthcare delivery, and the burdens these communities face in providing outreach and treatment to patients with mental health and substance use disorders, VHA and rural facility leaders must pay special attention when conducting risk assessments for these conditions. This statement focuses on a report involving a region of Texas to introduce key VHA requirements related to referrals for residential treatment for substance use. It also details a report that found substantial errors in the management of the care of a veteran undergoing alcohol withdrawal at the Tomah VA Medical Center, one of VA's rural facilities. While the findings from these reports are specific to one facility, they are intended to be reviewed and assessed across the system.

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

In August 2021, the OIG hotline received allegations that staff for the domiciliary substance use disorder treatment program (DOM SUD) at the VA North Texas Health Care System (VA North Texas) placed patients on waitlists for two to three months and failed to offer non-VA community residential care referrals for substance use disorder treatment.[3] The complainant also alleged that VA North Texas staff denied patients' requests for community residential care referrals, whereas patients from the Central Texas Veterans Health Care System in the same region (VISN 17), received community residential care treatment. During the OIG staff's review of the allegations [including examining 15 VA North Texas DOM SUD consults (referrals) and electronic health records for 10 patients], the team identified additional concerns related to compliance with required scheduling procedures and the assignment of mental health treatment coordinators to patients awaiting admission. To understand the context for the resulting report's findings, it is important to consider VHA's program goals and requirements.

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

Background

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

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

According to VHA's requirements, patients referred to MH RRTPs must be screened within seven business days by a team that includes a licensed mental health professional and a medical provider to determine whether admission is appropriate. If accepted, the patient must receive a tentative admission date and a point of contact at the MH RRTP.[4] So VHA can track admission wait times, the patient must be added to the pending bed placement list.[5] Since 2018, VHA has required staff to include information in the patient's electronic health record to improve tracking of program wait times and capacity.[6]

Community Care Program Eligibility Criteria

The MISSION Act mandated changes to VHA's community care program.[7] Those changes led to VHA's Office of Community Care issuing implementation guidance stating that "wait time and drive time access standards are only applicable to primary care, specialty care, and non-institutional extended care services." The guidance further said MH RRTPs "are considered institutional extended care services" and do not follow the same wait-time standards.[8] When MH RRTP care is not available within

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

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

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

[7] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

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

VA facilities for an eligible patient who "elects to receive care in the community," VHA will authorize community residential care. Further, for MH RRTP admission wait times greater than 30 calendar days, facility staff must offer the patient alternative care that addresses the patient's needs and preferences, including a referral to community residential care or another VHA program. Additionally, facility staff should discuss outpatient care options with the patient while the patient awaits MH RRTP admission. It is important to note that the COVID-19 pandemic put additional stresses on VHA and that the Texas facilities were not alone in facing long wait times. In February 2021, VHA estimated that 3,500 patients nationally were pending admission with an average wait time of more than 150 days. At that time, VHA required MH RRTP staff to provide alternatives, including community residential care, if unable to admit patients within 30 days.[9]

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

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

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

Of the 10 North Texas patients' records the OIG reviewed, five had one DOM SUD consult placed and the other five had two consults placed, resulting in a total of 15 consults examined. Of the 15 consults, 13 were referrals to the Bonham DOM SUD and two were referrals to the Dallas DOM SUD. Seven consults were closed when the patients were admitted within 30 days, declined screening, or were not approved for admission. Among the eight remaining consults, two were closed when the patients declined admission and six resulted in patients waiting an average of 79 days before VA North Texas staff offered DOM SUD admission or removed the patient from the pending bed placement list. For

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

seven of the eight consults, staff documented that the "anticipated admission date exceeds 30 days; however, there is no available alternative to consider at this time."

The OIG determined that the VA North Texas chief for Patient Administration Services, who oversees community care, misinterpreted community care guidance and provided inaccurate information to VA North Texas leaders and staff. Specifically, the Office of Community Care's guidance states that community care wait time standards were not applicable to MH RRTP. Facility staff should have instead followed VHA policy requiring a patient with a wait time of greater than 30 days be offered alternative residential treatment or another level of care. Alternative residential treatment could include a referral to a community program, another program in the VISN, or another program in another VISN.[10]

However, the Patient Administration Services chief told the OIG team during the review that MH RRTPs are "excluded from the MISSION Act" and not eligible for community care based on access standards—reflecting an inaccurate understanding of the Act. In contrast, the national director of the MH RRTP reported that although drive time and wait time standards do not apply to DOM SUDs, community care referrals are expected when a patient is determined to require a residential level of care and VHA is unable to provide treatment within the required timeframe.

In September 2020, the MH RRTP national program office released guidance that included instructions for community care referrals. In February 2021, VHA provided guidance that VISN chief mental health officers and facility leaders must ensure that patients who require a residential level of care are offered a VA MH RRTP bed or community residential care. VHA further required that each facility provide the operational status of MH RRTP beds and "information on the availability of community based residential treatment options."[11] VISN 17's response to the February 2021 guidance indicated that the Dallas and Bonham DOM SUDs were not making community residential care referrals.

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

[10] VHA Directive 1162.02.

[11] VHA assistant under Secretary for health for clinical services, "Ensuring Access to Residential Treatment for Veterans with Mental Health and Substance Use Disorders during the Pandemic," memorandum.

Recommendations for Corrective Action

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

The OIG made five recommendations in this report related to VA North Texas deficiencies and associated lack of oversight.[12] The first recommendation was for the VA North Texas director to ensure that staff provide alternative treatment options, including community care when MH RRTP admission wait times exceed 30 days. VA concurred with this recommendation. The second recommendation called on the director to conduct a comprehensive review of the management of community residential care referrals. VA concurred in principle with this recommendation. VA concurred with the remaining three recommendations described below.

There Was Inadequate VISN Oversight

The OIG determined that VISN 17 leaders did not ensure local facilities were adhering to the national MH RRTP policy. According to the MH RRTP directive, each VISN mental health lead is responsible for ensuring that all MH RRTPs in their region collect data sufficient for oversight related to VHA policy implementation.[13] Additionally, the national director of the MH RRTP confirmed the VISN has oversight responsibility to ensure eligible patients have access to a residential level of care, although there are not defined expectations related to community care utilization monitoring. The VISN 17 chief mental health officer provided guidance to VA North Texas leaders on three occasions in 2021 regarding the use of community residential care. However, she reported that the VISN role did not carry the authority to ensure policy adherence or "direct oversight" because "oversight is at the local facility management level." The third report recommendation was for the under secretary for health to make certain that VISN leaders provide adequate oversight to ensure that access to care for MH RRTPs is provided consistent with VHA policy.

Bonham MH RRTP Nonadherence with VHA Scheduling Requirements

During the inspection, the OIG team also identified that the Bonham MH RRTP standard operating procedure was inconsistent with VHA's minimum scheduling effort requirements, as it instructed schedulers to close a consult after three failed scheduling contact attempts with patients rather than the four required. Since 2016, VHA has required healthcare providers to document a request for other

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[12] The OIG considers all five recommendations currently open pending the submission of sufficient documentation that would support that adequate progress has been made on implementing them. The OIG requests updates on the status of all open recommendations every 90 days, which are then reflected on the recommendation dashboard found on the OIG website. VA may, however, submit evidence of implementation sufficient to close a recommendation at any time. For this report, VA's first recommendation status update is due in mid-June.

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

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

National Program Process Needed on Mental Health Treatment Coordinator Assignment

Finally, the OIG found that VA North Texas policy did not include information about the requirement for MH RRTP staff to assign a mental health treatment coordinator for patients awaiting admission to a residential program. Since 2012, VHA has required facility staff to assign a mental health treatment coordinator to patients who are receiving treatment in an outpatient mental health setting, have been admitted to an inpatient mental health setting, or are "waiting to engage in a different level of care," including an MH RRTP bed.[14] However, in an interview, the national director for the MH RRTP acknowledged not having an assignment process for patients waiting for MH RRTP admission. This failure to develop a national-level process likely contributed to the VA North Texas MH RRTP leaders' lack of knowledge that the VA North Texas policy should address the identification and assignment of a mental health treatment coordinator for accepted patients awaiting admission. Not only can this lack of policy awareness contribute to a coordinator not being assigned, it can also diminish the likelihood of patients' engagement in outpatient care while waiting for placement. The fifth report recommendation is related to strengthening coordinator assignment procedures for patients waiting for an MH RRTP bed.

MISMANAGEMENT OF A PATIENT WITH ALCOHOL WITHDRAWAL AT THE TOMAH VA MEDICAL CENTER

In 2021, the OIG issued a report reviewing allegations related to the care at the Tomah VA Medical Center of a patient suffering from alcohol withdrawal who subsequently died at another VA medical center from a presumed anoxic (lack of oxygen) brain injury.[15] The inspection team found that facility physicians' failure to prescribe an adequate medication regimen to address the patient's delirium tremens (withdrawal symptoms) effectively, review the patient's abnormal electrocardiogram prior to haloperidol administration, and transfer the patient earlier likely contributed to the patient's deterioration

[14] VHA Deputy Under Secretary for Health for Operations and Management memorandum, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

[15] VA OIG, *Mismanagement of a Patient at the Tomah VA Medical Center in Wisconsin*, August 21, 2021

and ultimate death. The team substantiated that a non-VA paramedic documented that a supplemental oxygen flow was not active.[16] Tomah VA Medical Center leaders and staff reported they did not know about the failed oxygen delivery. The inspection team also found that the nursing staff did not complete all required alcohol withdrawal assessments; a physician improperly ordered restraints; nurses failed to obtain full vital signs while the patient was in restraints; and nurses did not receive restraint training as expected. Finally, leaders did not conduct an institutional disclosure with the patient's family in a timely manner, as required.

The OIG made 10 recommendations to the facility director related to educating personnel on alcohol withdrawal and cardiac risks, the need for a review to determine the causes of the failed oxygen delivery, identification of root causes and performance deficiencies, workgroup outcomes, alcohol withdrawal assessment protocol adherence, restraint management and training, compliance with admission criteria, emergency detention, and institutional disclosures. The Tomah VA Medical Center has provided documentation on sufficient corrective actions and the recommendations are closed.

Assessing and stabilizing patients who are at risk for life-threatening complications from alcohol withdrawal is critical. Failure to ensure appropriate staff training on such care puts patients at risk for severe consequences, including death. Because hospitals in rural settings often have limited specialty and intensive care services on-site that do not meet the need for higher-level care, clinical interventions related to assessment and stabilization are even more critical while patient transfer arrangements are made.

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

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

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[16] Tomah VAMC Policy MS-03, *Emergency Services*, March 7, 2017, requires staff to respond to medical emergencies by calling "911," as necessary for non-VHA emergency assistance. The emergency medical services personnel who responded to the patient included a lead paramedic, a second paramedic, and an emergency medical technician. The paramedics performed an endotracheal intubation on the patient and the patient was transported to a non-VHA facility by helicopter. The lead paramedic completed the documentation that noted failed oxygen delivery. Three days later, the patient was transferred from the non-VHA hospital to another VA medical center.

In a report on the deficiencies found in the care and administrative processes for a patient who died by suicide, the OIG review team found that administrative errors and confusion in the Phoenix VA healthcare facility's community referral process delayed specialized psychological testing for a veteran. The veteran died by suicide never having received the appropriate testing and resulting targeted treatment.[17]

Another oversight report focused on a patient who ultimately died by suicide after not receiving several authorized community care counseling sessions. This was due to deficiencies in the coordination of the patient's care between the Memphis VA facility's community care staff, providers in the community, and the third-party administrator.[18] In addition, the patient suffered from hyperthyroidism, a condition that can aggravate anxiety. The patient declined a referral to endocrinology at the facility, due to the distance from home, but was never offered a referral to the community.

AN ONGOING FOCUS ON RURAL VETERANS, COMMUNITY CARE COORDINATION, AND MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Considering VA's persistent challenges caring for high-risk and complex patients identified in prior reviews, the OIG continues to initiate proactive projects to highlight threats to patient safety and quality of care as well as detail specific facilities' innovative solutions to these issues. The following work demonstrates the OIG's broad oversight footprint across VA and our continued focus on veterans who require mental health and substance use disorder treatment, with special consideration for those living in rural locations.

In the past two fiscal years, OIG's healthcare inspection teams conducting cyclical reviews visited nine medical centers designated by VA as rural.[19] OIG teams also performed inspections of 12 VISNs that are responsible for the management of 265 rural and highly rural facilities and community based outpatient clinics. During FY 2024, the OIG will be rolling out an updated healthcare facility inspection program that will use a more customized and data-driven approach to better highlight distinct challenges that affect the quality of healthcare delivery, such as those specific to rural settings.

The OIG's cyclical reviews of vet centers have focused on 36 locations, with three in rural and highly rural settings. Vet centers are community-based counseling centers that offer myriad services to eligible veterans, service members, and their families.[20] These centers are critical to VHA's efforts to expand outreach and support more veterans in getting the care they need, particularly mental health care.

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

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

[19] VHA has a total of 16 medical centers, hospitals, or healthcare systems in rural locations.

[20] For more information, visit the vet center website at www.vetcenter.va.gov/.

Moreover, VA's 80 mobile vet centers are meant to be used for outreach and services to underserved populations—often in highly rural areas. The OIG's vet center review teams are including mobile vet centers in their current inspection cycle.

The OIG's newest planned cyclical review will inspect mental health inpatient units of all sizes across the system. Currently in the pilot phase, the planned launch is for FY 2024. In July 2023, a new VISN community care cyclical review is also being undertaken to evaluate the administrative and care coordination processes to veterans receiving care through VHA's Community Care Network (CCN).

A review will also soon be released that assessed care coordination for patients of the VA Eastern Kansas Health Care System who have been receiving care and dually prescribed opioids and benzodiazepines from CCN providers.[21] Veterans are at a higher risk of harm associated with concurrent use of opioid and benzodiazepine medication due to the prevalence and severity of chronic pain that is often accompanied by mental health comorbidities when compared to nonveterans. The OIG team assessed VHA and CCN providers' care coordination, documentation processes, and use of risk-mitigation strategies for patients, as well as VHA's oversight of CCN providers' opioid prescribing practices.

After Congress passed the SUPPORT for Patients and Communities Act in 2018, requiring the expansion of substance use disorder treatment, the Office of Mental Health and Suicide Prevention developed a large-scale national hiring initiative to expand the availability of such treatment to veterans at VA medical centers during FY 2022. This initiative included a requirement to hire 90 percent of the 1,180 approved positions before the end of September 2022. The OIG is currently assessing how well medical centers have met the FY 2022 substance use disorder hiring initiative goal. The review team has already analyzed national hiring data at 139 medical centers to determine if the facilities achieved the initiative goal. The team selected a statistical sample of four medical centers (two of which are located in rural areas) for a deeper review to understand how different VISNs and medical centers managed the initiative and to identify any internal obstacles to facilities' meeting the hiring goal.

Collectively, these OIG reviews and other oversight reports provide veterans and their families, VA staff and leaders, the public, and Congress with a comprehensive understanding of VA health care and mental health services delivered in a variety of settings.

CONCLUSION

Every veteran deserves high-quality, timely, and well-coordinated care. This is particularly critical for veterans in rural areas with limited resources who are at high risk due to their mental health and substance use conditions. The pandemic disrupted healthcare delivery in all practice areas, including addiction treatment, while escalating the demand for interventions. VHA will need to continue to rely on

[21] VHA has been sent a copy of the report and it is under review for their comments.

community providers to deliver care when veterans' needs cannot be met within VA's own facilities. As the reports highlighted in this testimony demonstrate, VHA faces numerous challenges in providing needed substance use and mental health treatments—exacerbated by the limited availability of appropriate treatment services for veterans living in rural and highly rural locations. The OIG will continue to focus on these matters to assist VA in mitigating the risks inherent in providing and coordinating behavioral health care both within VHA and with community partners.

Chairman Tester, Ranking Member Moran, and members of the committee, this concludes my statement. I would be happy to answer any questions you may have.

Geographic Availability of Substance Use Disorder Treatment for Veterans

The Need for Data-Driven Solutions

Jonathan H. Cantor

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Geographic Availability of Substance Use Disorder Treatment for Veterans: The Need for Data-Driven Solutions

Testimony of Jonathan H. Cantor[1]
The RAND Corporation[2]

Before the Committee on Veterans' Affairs
United States Senate

June 14, 2023

Chairman Tester, Ranking Member Moran, and members of the committee, I want to thank you for your invitation to testify today on what is a pressing and urgent public health problem. My name is Dr. Jonathan Cantor. I am a policy researcher at the RAND Corporation. My training is in health policy research, and I have conducted extensive research on the geographic availability and accessibility of substance use disorder (SUD) treatment for veterans, military service members, and the civilian population.[3]

During my almost seven-year career as a RAND researcher, I have sought to develop and improve the quality of metrics to measure and track the geographic availability of SUD treatment—both where treatment is located and whether those in need can actually access this care. I have examined the marketplace of SUD care provided by the U.S. Department of Veterans Affairs (VA) and non-VA providers. In 2018, I was a task lead for a study that calculated novel measures of geographic accessibility of SUD treatment for a national sample of

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[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

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[3] According to Catherine McLaughlin and Leon Wyszewianski, "*Availability* measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. *Accessibility* refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location" (Catherine G. McLaughlin and Leon Wyszewianski, "Access to Care: Remembering Old Lessons," *Health Services Research*, Vol. 37, No. 6, December 2002, p. 1441. Emphasis in original).

U.S. veterans.[4] We found that, while many veterans lived within a 15-minute drive of an SUD treatment facility, most lived around an hour from a VA facility that provided specialized SUD treatment. While these data are useful, our research highlights significant challenges to accurately measuring the geographic availability and accessibility of SUD treatment. These challenges include an inability to access data on the total capacity of a facility, the services the facility offers for veterans particularly, the approximate wait time to the next appointment, and the quality of care received. Today, I will discuss how existing data limit our ability to comprehensively measure geographic availability of SUD treatment for veterans. I will also discuss how existing data inhibit our ability to calculate disparities in access based on where veterans live, as well as their personal attributes, such as sex, race, and ethnicity.

In this testimony, I will first discuss the complexity of SUD treatment for veterans given the frequent existence of co-occurring mental health problems. Second, I will provide a brief overview of the geographic accessibility of SUD treatment for veterans based on our research. Third, I will describe why it is difficult to assess disparities in the geographic accessibility of SUD treatment for veterans. Finally, I will recommend a few ways to improve data collection and reporting on providers to better understand the geographic availability and accessibility of treatment for SUD for veterans and ways it can be measured over time.

SUD Treatment for Veterans Is Complex Because of Co-Occurring Mental Health Problems

In 2020, around 12 percent of veterans 18 years of age or older had an SUD, according to the National Survey on Drug Use and Health.[5] Approximately 1.1 million veterans suffered from *both* an SUD and a mental illness.[6] Most individuals who present with a co-occurring mental health problem and an SUD do not receive treatment for either condition.[7] There are many possible contributors to this treatment gap. For example, addiction counselors lack awareness of mental health conditions and lack training on how to treat co-occurring disorders.[8] Other possible

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[4] Eric R. Pedersen, Kathryn E. Bouskill, Stephanie Brooks Holliday, Jonathan Cantor, Sierra Smucker, Matthew L. Mizel, Lauren Skrabala, Aaron Kofner, and Terri Tanielian, *Improving Substance Use Care: Addressing Barriers to Expanding Integrated Treatment Options for Post-9/11 Veterans*, RAND Corporation, RR-4354-WWP, 2020, www.rand.org/pubs/research_reports/RR4354.html.

[5] Substance Abuse and Mental Health Services Administration, "2020 National Survey on Drug Use and Health: Veteran Adults," presentation slides, July 2022, www.samhsa.gov/data/sites/default/files/reports/rpt37926/2020NSDUHVeteransSlides072222.pdf.

[6] Substance Abuse and Mental Health Services Administration, 2022.

[7] Katherine E. Watkins, Audrey Burnam, Fuan-Yue Kung, and Susan Paddock, "A National Survey of Care for Persons with Co-Occurring Mental and Substance Use Disorders," *Psychiatric Services*, Vol. 52, No. 8, August 2001.

[8] Substance Abuse and Mental Health Services Administration, *Substance Use Disorder Treatment for People with Co-Occurring Disorders*, Treatment Improvement Protocol (TIP) 42, SAMHSA Publication PEP20-02-01-004, March 2020.

reasons for this treatment gap include personnel shortages and workforce burnout.[9] Burnout among mental health staff compromises the quality of the patient-provider relationship and has led many to leave the workforce.[10] In short, veterans may have more-complex requirements than nonveterans when seeking treatment for SUD, and they may seek treatment in the context of a more constrained workforce with limited expertise or capacity to provide them with effective care for their specific needs.

There are a multitude of other reasons why a veteran with an SUD would not receive the necessary care. First, some veterans who use substances do so to self-medicate their posttraumatic stress disorder (PTSD) symptoms.[11] These veterans may be hesitant to seek treatment because of their treatment providers' policies. For example, some behavioral health treatment programs will not accept a patient unless the patient is abstinent from substances for a certain period of time.[12] Second, many veterans fear seeking mental health or SUD treatment because it could negatively affect their career advancement.[13] In qualitative interviews, a sample of veterans told researchers that they find it difficult to balance their recovery, which would benefit from treatment, with vocational goals that may require that they disclose that they are receiving such care.[14] Third, co-occurring disorders often go unidentified. A practitioner may identify an SUD or a mental health disorder but not necessarily both.[15] Finally, the appropriate treatment for an individual with an SUD and a co-occurring mental health disorder is more complex than treating one or the other alone. Many treatment facilities that specialize in either mental health or SUDs are not equipped to address the needs of veterans with co-occurring disorders. There are not enough opportunities for formal training in the treatment of co-occurring

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[9] Claire Snell-Rood, Robin A. Pollini, and Cathleen Willging, "Barriers to Integrated Medication-Assisted Treatment for Rural Patients with Co-Occurring Disorders: The Gap in Managing Addiction," *Psychiatric Services*, Vol. 72, No. 8, August 2021.

[10] Committee to Evaluate the Department of Veterans Affairs Mental Health Services, National Academies of Sciences, Engineering, and Medicine, "Mental Health Workforce and Facilities Infrastructure," in *Evaluation of the Department of Veterans Affairs Mental Health Services*, National Academies Press, 2018.

[11] Howard D. Chilcoat and Naomi Breslau, "Posttraumatic Stress Disorder and Drug Disorders: Testing Causal Pathways," *Archives of General Psychiatry*, Vol. 55, No. 10, October 1998.

[12] Alan Bernhardt, "Rising to the Challenge of Treating OEF/OIF Veterans with Co-Occurring PTSD and Substance Abuse," *Smith College Studies in Social Work*, Vol. 79, No. 3–4, July–December 2009; Karen H. Seal, Greg Cohen, Angela Waldrop, Beth E. Cohen, Shira Maguen, and Li Ren, "Substance Use Disorders in Iraq and Afghanistan Veterans in VA Healthcare, 2001–2010: Implications for Screening, Diagnosis and Treatment," *Drug and Alcohol Dependence*, Vol. 116, No. 1–3, July 1, 2011.

[13] Ann M. Cheney, Christopher J. Koenig, Christopher J. Miller, Kara Zamora, Patricia Wright, Regina Stanley, John Fortney, James F. Burgess, and Jeffrey M. Pyne, "Veteran-Centered Barriers to VA Mental Healthcare Services Use," *BMC Health Services Research*, Vol. 18, No. 591, 2018.

[14] Brian J. Stevenson, Ummul Kathawalla, Camille Smith, and Lisa Mueller, "Career Development in Transitional Work Settings: A Qualitative Investigation Among Veterans and Vocational Counselors," *Journal of Career Development*, October 28, 2022.

[15] Mary Ann Priester, Teri Browne, Aidyn Iachini, Stephanie Clone, Dana DeHart, and Kristen D. Seay, "Treatment Access Barriers and Disparities Among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review," *Journal of Substance Abuse Treatment*, Vol. 61, February 2016.

disorders;[16] thus, there are a limited number of providers able to provide evidence-based care for co-occurring disorders. This could be particularly pronounced in areas of the country with a dearth of behavioral health care providers—called *Mental Health Professional Shortage Areas*.

Fortunately, the Veterans Health Administration (VHA) appears to be addressing this problem. According to the 2018 National Mental Health Services Survey, more than half—around 56 percent—of VA medical centers (VAMCs) had a specialized treatment program for co-occurring disorders.[17] More-recent data indicate that this percentage has been increasing.

Geographic Access to SUD Treatment Is Difficult to Measure with Existing Data Resources

Recent national research found that less than 10 percent of veterans with an SUD in 2020 received any treatment.[18] A key determinant for whether an individual receives SUD treatment is how far they have to travel for care.[19] To date, there have been few studies that have examined distance to SUD treatment (geographic accessibility) as a barrier to care for a national sample of veterans. A study of 266,301 female veterans who received *any* care from VHA in 2009 found that the longer the drive time to a provider, the less likely the veteran received outpatient care in the following two years.[20] Distance also predicts whether veterans obtain step-down aftercare, which is incredibly important for achieving long-term treatment success, after discharge from inpatient SUD treatment. Less than half of patients who received inpatient SUD treatment and lived more than 25 miles from their nearest outpatient mental health care facility received any follow-up care.[21]

Under the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act (MISSION Act) of 2018, VA established an access standard of a 60-minute drive time for specialty care, including SUD treatment.[22] In 2019, the Wounded Warrior Project (WWP) partnered with RAND researchers to understand geographic accessibility of co-occurring mental

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[16] Howard Padwa, Erick G. Guerrero, Joel T. Braslow, and Karissa M. Fenwick, "Barriers to Serving Clients with Co-Occurring Disorders in a Transformed Mental Health System," *Psychiatric Services*, Vol. 66, No. 5, May 2015.

[17] Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey (N-MHSS): 2018: Data on Mental Health Treatment Facilities*, 2019.

[18] Substance Abuse and Mental Health Services Administration, 2022.

[19] Kyle Beardsley, Eric D. Wish, Dawn Bonanno Fitzelle, Kevin O'Grady, and Amelia M. Arria, "Distance Traveled to Outpatient Drug Treatment and Client Retention," *Journal of Substance Abuse Treatment*, Vol. 25, No. 4, December 2003.

[20] Sarah A. Friedman, Susan M. Frayne, Eric Berg, Alison B. Hamilton, Donna L. Washington, Fay Saechao, Natalya C. Maisel, Julia Y. Lin, Katherine J. Hoggatt, and Ciaran S. Phibbs, "Travel Time and Attrition from VHA Care Among Women Veterans: How Far Is Too Far?" *Medical Care*, Vol. 53, No. 4, Supp. 1, April 2015.

[21] Susan K. Schmitt, Ciaran S. Phibbs, and John D. Piette, "The Influence of Distance on Utilization of Outpatient Mental Health Aftercare Following Inpatient Substance Abuse Treatment," *Addictive Behaviors*, Vol. 28, No. 6, August 2003.

[22] U.S. Department of Veterans Affairs, "VA Launches New Health Care Options Under MISSION Act," news release, June 6, 2019.

health and SUD treatment.[23] We used two national databases to assess geographic accessibility of mental health and SUD treatment facilities nationwide. We linked these data with two different sets of data from the WWP, which included information on WWP alumni veterans' zip codes of residence. Our calculations indicated that, on average, WWP alumni lived 12 minutes from a *mental health facility* that had a co-occurring SUD program and 11 minutes from the nearest *SUD treatment facility* that had a co-occurring mental health program. For these veterans, the closest VAMCs or VA-affiliated facilities that provided treatment for co-occurring mental health disorders and SUDs were, on average, 57.0 and 66.3 minutes from where the veterans lived, "for mental health and substance use treatment facilities, respectively."[24] Our results were encouraging: Most WWP alumni veterans were able to access treatment programs for co-occurring mental health conditions and SUDs within the 60-minute drive time standard.

One major limitation of this line of research is that while a facility may be within a 60-minute drive time, it may not be able to accept the veteran as a patient. Our study did not incorporate measures of treatment capacity or wait times. Currently, there is no national database that includes these measures for all VA and non-VA facilities that provide SUD treatment. A second limitation of this work is that a veteran's zip code is a pretty broad indicator of where the veteran lives, and our estimates would be more accurate if we used veterans' specific addresses. Finally, our study was based on a sample of WWP alumni veterans, and whether these findings hold for all veterans is unknown.

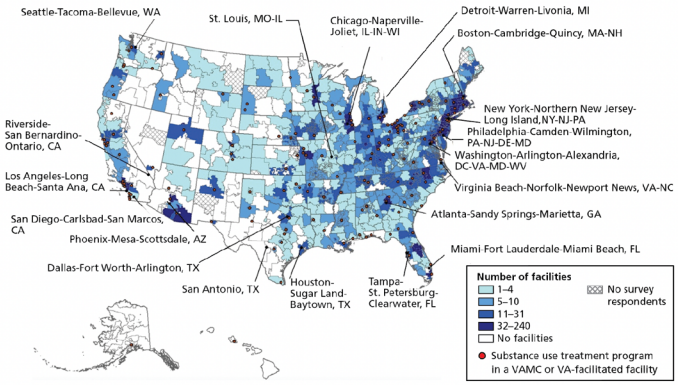
Disparities Are Also Difficult to Measure Using Existing Data Resources

Figures 1 and 2 are heat maps that demonstrate the large variability in geographic accessibility of mental health and SUD treatment facilities with specialized treatment programs for co-occurring disorders and WWP alumni. Areas in white are zip codes that lack one of these facilities within a 60-minute drive time from the veteran's zip code. The maps show that VAMCs and VA-affiliated facilities tend to be located in areas of the country with the largest number of non-VA facilities that serve veterans (as shown by the darker blue shading). In other words, facilities that serve veterans, be they VA or non-VA, cluster together. However, additional analyses by our research team indicated that, if we were to remove the VAMCs and VA-affiliated facilities from the maps, there would be less geographic accessibility for veterans to receive treatment, highlighting the critical role that VA plays in substance use treatment for veterans.

[23] Pedersen et al., 2020.

[24] Pedersen et al., 2020, p. 74.

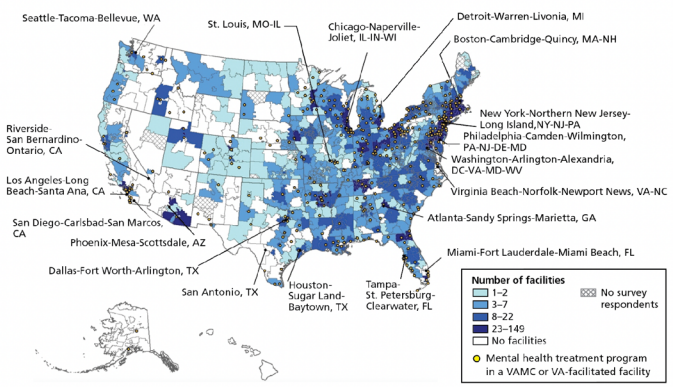
Figure 1. SUD Treatment Facilities with a Specialized Co-Occurring Disorders Program and a Specialized Treatment Program for Veterans



NOTES: Darker blue shading indicates increasing availability of facilities within a 60-minute drive time from the centroid of 2019 WWP Alumni Survey respondents' three-digit zip codes. White areas had no facilities within a 60-minute drive time. Areas with a hatch pattern had no survey respondents residing in them. Core-based statistical areas (CBSAs) with 200,000 or more veteran residents, according to the VetPop data, are labeled on the map, with the lines pointing to the CBSAs' centroids.

SOURCE: Reproduced from Pedersen et al., 2020.

Figure 2. Mental Health Treatment Facilities with a Specialized Co-Occurring Disorders Program and a Specialized Treatment Program for Veterans



NOTES: Darker blue shading indicates increasing availability of facilities within a 60-minute drive time from the centroid of 2019 WWP Alumni Survey respondents' three-digit zip codes. White areas had no facilities within a 60-minute drive time. Areas with a hatch pattern had no survey respondents residing in them. Core-based statistical areas (CBSAs) with 200,000 or more veteran residents, according to the VetPop data, are labeled on the map, with the lines pointing to the CBSAs' centroids.

SOURCE: Reproduced from Pedersen et al., 2020.

Almost one-quarter of U.S. veterans reside in rural communities.[25] There is a concern that it is more difficult for rural veterans to receive care given that they must travel farther than veterans who live in urban areas. Treatment services in rural areas have challenges that include a shortage of specialized providers and a lack of accessible public transportation. In one study of 15 VHA primary care clinics in eight Midwestern states, distance was listed as a significant barrier for rural veterans seeking health care. And the effect of distance can be compounded by other factors, such as a veteran's health status, functional impairment, travel cost, and work or family obligations.[26] In 2019, the U.S. Government Accountability Office examined whether there was a disparity in SUD treatment utilization based on whether the veteran resided in an urban or a rural locality. The study found that veterans in urban and rural localities used VA SUD treatment services at a similar rate.[27] Thus, while there is a concern that there is a geographic disparity in health care access between rural and urban veterans, this disparity does

[25] Office of Rural Health, U.S. Department of Veterans Affairs, "Rural Veterans: Rural Veteran Health Care Challenges," webpage, undated, www.ruralhealth.va.gov/aboutus/ruralvets.asp.

[26] Colin Buzza, Sarah S. Ono, Carolyn Turvey, Stacy Wittrock, Matt Noble, Gautam Reddy, Peter J. Kaboli, and Heather Schacht Reisinger, "Distance Is Relative: Unpacking a Principal Barrier in Rural Healthcare," *Journal of General Internal Medicine*, Vol. 26, No. 2, Supp. 2, November 2011.

[27] U.S. Government Accountability Office, *Veterans Health Care: Services for Substance Use Disorders, and Efforts to Address Access Issues in Rural Areas*, GAO-20-35, December 2019.

not appear to affect utilization rates for SUD treatment. But more work is needed to confirm this result.

The geographic accessibility of SUD care could also vary based on the sociodemographic characteristics of veterans. For example, women veterans, racial or ethnic minority veterans, or older veterans may disproportionately live in areas with fewer SUD facilities. Our study did not focus on these potential disparities. There are extensive data challenges in quantifying these differences. Such analyses would require detailed data on the addresses, or at least zip codes, of veterans, as well as data on their race/ethnicity, age, and gender. Finally, and perhaps most challenging, the data would need to include whether the veterans suffered from SUDs only or SUDs and mental health problems.

Recommendations

Drawing on my research and existing work, I have several recommendations. Each recommendation pertains to the relative dearth of detailed data that we have on providers or patients. For providers, it would be important for VA to consider updating its SUD programs website to include additional details on the specific types of SUD treatment that a particular facility provides.[28] The existing information includes locations, names, addresses, and phone numbers of existing services, but it may be difficult for a veteran to identify the provider that best serves their unique needs. Veterans would benefit from knowing the types of services provided or the specific substances that the facility offers treatment for. Similarly, there is no listing of wait times or capacity for treatment that VA keeps detailed information for.[29] Pieces of this information are included on other portions of the VA website,[30] but it would be useful to have all the data integrated into one location.

VA's SUD programs website refers individuals to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Behavioral Health Treatment Services Locator for treatment outside VA.[31] This locator has historically been based on annual surveys of both mental health and SUD treatment facilities to understand the availability of treatment resources and to help patients identify a provider. (The surveys have since been combined into one.) SAMHSA could consider asking treatment facilities additional specific questions in its annual survey of providers that informs the locator. One approach would be to ask whether specific treatment approaches are available for veterans. Currently, the survey asks about the types of

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[28] U.S. Department of Veterans Affairs, "Locations: Substance Use Disorder (SUD) Program," webpage, last updated November 3, 2021, www.va.gov/directory/guide/SUD.asp.

[29] U.S. Department of Veterans Affairs, "Average Wait Times at Individual Facilities Search," web tool, undated, www.accesstocare.va.gov/PWT/SearchWaitTimes.

[30] U.S. Department of Veterans Affairs, "Find VA Locations," web tool, undated, www.va.gov/find-locations/.

[31] Substance Abuse and Mental Health Services Administration, Behavioral Health Services Locator, web resource, undated, www.samhsa.gov/resource/dbhis/behavioral-health-treatment-services-locator?gclid=CjwKCAjw-IWkBhBTEiwA2exyO_ry7dxpmu35RCm5ybl9kx7RxOgUTWcn7C9od3MGCif0XLOMdIdQ_xoC3-EQAvD_BwE. See also Substance Abuse and Mental Health Services Administration, FindTreatment.gov, homepage, undated, findtreatment.gov.

specialized treatment programs that are present at the responding facility. However, the questionnaire does not ask what treatment approaches are used within those programs. Using 2019 SAMHSA data, we identified 3,782 mental health treatment facilities that contained both a specialized treatment program for veterans and specialized treatment for PTSD and co-occurring disorders. Similarly, we found that there were 5,484 SUD treatment facilities that offered a specialized treatment program for veterans and specialized treatment for trauma and co-occurring disorders.[32] However, SAMHSA's data do not describe what the specialized treatment programs for each of these facilities entail. The most recent iteration of the National Substance Use and Mental Health Services Survey, the survey that the locator is based on, has supplementary questionnaires for substance use VA facilities and mental health VA facilities on specific treatment approaches related to suicide.[33] This could be one model to use for asking more-detailed questions on treatments for co-occurring disorders. Separately, one recent audit study of the Behavioral Health Treatment Services Locator data asked targeted questions about residential treatment programs, including questions concerning the costs of services, average wait times, and travel-based inducements to receive treatment at the facility, such as car transportation.[34] Many of these measures could be collected by SAMHSA in its annual survey or in audits of the responses of specific facilities in a given year. An eventual long-term goal should be to incorporate quality-of-care measures for these facilities.

A separate limitation of the SAMHSA Behavioral Health Treatment Services Locator data is that the information on the treatment services that the facility provides is outdated and not easily understandable by the user.[35] Previous studies have found that contacting these providers and posing as a patient provides a more accurate measure of the payments accepted, treatments provided, and time to the next available appointment. Either SAMHSA or VA should consider conducting regular audit studies among non-VA facilities to get a more accurate understanding of the forms of treatment offered, approximate wait times to the next appointment, and total capacity of the facilities for SUD treatment.

Similarly, we lack information on disparities in geographic access to facilities based on sociodemographic characteristics of patients. Given that there may be differences in treatment approaches based on these characteristics, the audits should include calls to treatment facilities by individuals with different genders, races, and ethnicities.

Finally, it would be important for VA to consider alternative ways to expand treatment availability and accessibility of resources. Since the onset of the coronavirus disease 2019 (COVID-19) pandemic, there has been a rapid rise in the use of telehealth services. Preliminary

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[32] Pedersen et al., 2020.

[33] Substance Abuse and Mental Health Services Administration, "Supplement for Mental Health Veterans Affairs Facilities," supplementary questionnaire for National Substance Use and Mental Health Services Survey, March 31, 2023.

[34] Tamara Beetham, Brendan Saloner, Marema Gaye, Sarah E. Wakeman, Richard G. Frank, and Michael Lawrence Barnett, "Admission Practices and Cost of Care for Opioid Use Disorder at Residential Addiction Treatment Programs in the US," *Health Affairs*, Vol. 40, No. 2, February 2021.

[35] Aneri Pattani, "National Addiction Treatment Locator Has Outdated Data and Other Critical Flaws," KFF Health News, May 9, 2022.

work has shown that telehealth has increased treatment initiation for SUD in at least one VA hospital outpatient alcohol and drug treatment clinic.[36] While telehealth may increase retention for new and continuing opioid use disorder patients, it may do so differently based on characteristics of veterans.[37] Research should continue to be conducted on the effectiveness of telehealth in the population of veterans with SUDs and co-occurring mental health problems to reduce geographic disparities.

Conclusion

Far too many Americans, and especially veterans, fail to receive treatment for SUD each year. I am confident that we can increase the number of veterans who receive treatment and prevent unnecessary drug overdose deaths, but that will require an infusion of funding to improve current data collection systems and ensure that veterans can access the information necessary to make treatment decisions. It will also require research on best practices for identifying high-quality providers that meet the needs of veterans. In my testimony today, I outlined several data limitations and how we might be able to address data gaps to understand the availability of SUD treatment resources for veterans. The lack of real-time measures on the capacity and wait times for both VA and non-VA providers for SUD treatment is a significant barrier that hinders our ability to monitor the availability of SUD treatment for veterans. Thank you for giving me the opportunity to speak on such an important issue, and I look forward to your questions.

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[36] Rebecca E. Sistad, Justin Enggasser, Nicholas A. Livingston, and Deborah Brief, "Comparing Substance Use Treatment Initiation and Retention Between Telehealth Delivered During COVID-19 and In-Person Treatment Pre-COVID-19," *American Journal on Addictions*, Vol. 32, No. 3, May 2023.

[37] Madeline C. Frost, Lan Zhang, H. Myra Kim, and Lewei (Allison) Lin, "Use of and Retention on Video, Telephone, and In-Person Buprenorphine Treatment for Opioid Use Disorder During the COVID-19 Pandemic," *JAMA Network Open*, Vol. 5, No. 10, October 2022.

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STATEMENT OF
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FOR THE SENATE COMMITTEE ON VETERANS' AFFAIRS
JUNE 14, 2023

Chairman Tester, Ranking Member Moran and Members of the Committee:

On behalf of DAV's (Disabled American Veterans) more than 1 million members, thank you for inviting us to provide testimony for the Senate Veterans' Affairs Committee hearing titled, "Connections to Care: Improving Substance Use Disorder Care for Veterans in Rural America and Beyond."

DAV members are wartime service-disabled veterans who were wounded, injured, or made ill during their service. They utilize Department of Veterans Affairs (VA) benefits and Veterans Health Administration (VHA) services at extremely high rates, which many depend on as their sole source of health care. Our members live in locales across the country and beyond, which provides us with an insight into the plight of rural veterans and their unique struggles with access to care.

Today's hearing on rural veterans and access to health care for substance use disorders (SUD) is very important to DAV and our membership. Many of our members have benefited from these specialized programs and services. Our testimony will address VA's existing SUD programs and the unique challenges and barriers to care that exist for rural veterans and women veterans and a few recommendations.

EXISTING VA SUBSTANCE USE DISORDER PROGRAMS

VA offers a range of services to treat veterans with SUD. This includes short-term inpatient medication management for withdrawal, long-term medication management, individual and group behavioral health interventions, and residential rehabilitation treatment programs (RRTP) to manage addiction and develop new life skills simultaneously.

VA's residential rehabilitation units provide a comprehensive and intensive level of care. The Mental Health RRTP mission is to provide state-of-the-art, high-quality residential treatment services for veterans with co-occurring mental health and substance use disorders, medical concerns, and/or psychosocial needs such as homelessness and unemployment. This includes 24/7 nursing coverage and support for medication compliance and administration. In addition, VA's SUD treatment programs

focus on a whole health model of care and provide alternatives to traditional medicine such as meditation, yoga, acupuncture, and tai chi.

VA is currently working on using innovative ways to reach veterans dealing with SUD such as peer specialists and mobile apps. Peer support specialists are often helpful in personalizing a veteran's health care experience, especially if specialists have had similar lived experiences as those they are working with and are in recovery from issues such as SUD, post-traumatic stress disorder (PTSD), eating disorders, or the effects of military sexual trauma (MST). For women veterans, who are more likely to indicate they have poor social networks than male peers, connections to other women veterans may be critical to their recovery and long-term abstinence. VA has stated it plans to use more peer support in mental health settings, including SUD programming, to improve veterans' retention and engagement in evidence-based treatment.

In May 2018, VHA launched the Stepped Care for Opioid Use Disorder – Train the Trainer (SCOUTT) initiative. The SCOUTT program has demonstrated that medication-assisted opioid use disorder treatment can be successfully provided outside of specialty care and that a stepped-care approach to treatment provides opportunities to address the broader spectrum of SUD treatment needs.

The Office of Rural Health (ORH) has approved two notable enterprise-wide initiatives to increase access for rural veterans by leveraging Clinical Pharmacist Practitioner (CPP) providers in SUD care.

At least 15 VA Medical Centers (VAMCs) currently operate Syringe Service Programs, which provide veterans who are IV drug users with clean and safe syringes. When combined with medications that treat opioid dependence (also known as medication-assisted treatment), there is a demonstrated reduction in HIV transmission.

Coaching into Care is a free service for families and friends of veterans where responders briefly assess a caller's concerns and provide appropriate resources and referrals. Through 10 to 30-minute calls, licensed psychologists and social workers offer guidance and help for starting conversations with a veteran who might be dealing with substance use and motivating them to seek treatment if it is needed.

According to VA, in 2022, more than 550,000 unique veterans were seen in VHA with a substance use disorder diagnosis. VA acknowledges fewer than 15% of veterans with a SUD diagnosis in 2022 received treatment. Of those who do receive VHA care, fewer than half receive such care in specialized settings and only about 46% of veterans diagnosed with opioid use disorder and 14% of those with alcohol use disorder received medications recommended under VA and DOD's clinical practice guideline.

VA has one of the country's premier SUD programs, providing high-quality evidence-based therapies and treatments. However, there are many challenges to adequately fund and staff this specialized programming, which is particularly concerning for the 4.7 million rural veterans in the United States, 58% of whom are enrolled in VHA.

It is clear that, due to these challenges and barriers, rural veterans are less likely to receive the standard of care for SUD.

CHALLENGES AND BARRIERS TO RURAL HEALTH CARE

In general, rural veterans have lower average household incomes than other veterans (52% have annual incomes of less than $35,000); 27% do not access the internet at home; they often face long driving distances to access quality health care; and there are fewer health care providers and nurses per capita in rural areas. This coupled with VHA inconsistencies in staffing and a lack of transportation, creates disparity for rural veterans trying to access primary health care and specialty treatment for SUD.

Inconsistent Policy

Consistency in implementing standards across VHA continues to be a challenge due to each facility's interpretation of VA policy as noted in a recent January 2023 Office of Inspector General (OIG) report. The report showed VA staff at a facility in North Texas misinterpreted policy when referring patients to residential care, which included a rural facility.

The U.S. Government Accountability Office (GAO) also noted similar findings as indicated in its Watch Blog from May 16, 2023, "...about one-third of veterans enrolled in the Veterans Health Administration (VHA) live in rural areas. However, in our review of VHA data, we found that rural veterans use intensive mental health care services, such as residential care or intensive case management, less than urban veterans, raising questions about access."

During a recent House Veterans' Affairs Committee hearing on SUD, witnesses stated there is a very short window from the moment a veteran with substance use disorder indicates they are willing to go to inpatient treatment, to successfully get them into care. When asked what would be a reasonable timeline, a witness indicated 72 hours would be the maximum amount of time. We understand the challenges VA faces when getting this cohort into care, but having a veteran wait 30 days for treatment (the current access standard for routine admission) is a far cry from 72 hours. SUD is also associated with an increased risk of suicidal ideation, suicide attempts, and death by suicide, making it imperative that veterans ready to start treatment have expedited access to care.

Transportation Concerns

Rural veterans face issues accessing health care similar to those faced by the general population, including a lack of transportation. In rural communities, distance to a health care facility, time, cost of fuel, and access to transportation are all exacerbated and known barriers to care. Veterans may lack access to public transportation or are no

longer able to drive because of age, health status, or driving restrictions. Some rely on family, friends, or community service organizations.

DAV's Transportation Network

DAV operates a fleet of vehicles around the country to provide free transportation to VA medical facilities for injured and ill veterans. DAV stepped in to help veterans get the care they need at the time when the federal government terminated its program in the 1980s, which helped many of them pay for transportation to and from medical facilities. The vans are driven by volunteers, who are recruited and organized by DAV, and the rides are coordinated by more than 156 DAV Hospital Service Coordinators around the country.

Since the program's inception in 1987, DAV departments and chapters have donated 3,665 vehicles to VA, along with Ford Motor Co., which has donated 256 vehicles at a cost of more than $92 million. Volunteer drivers have logged over 700 million miles. Last year alone, they drove over 9 million miles. While this program is highly successful and beneficial for the veterans we serve, we continue to face administrative challenges with expediting volunteer driver examinations. Specifically, there is a breakdown in the onboarding process for our volunteer drivers nationally. For example, our transportation coordinator in Montana tells us they had 30 applications for volunteer drivers, and by the time VA completed onboarding a year and a half later, they were left with only two applicants. Montana is not unique in this extraordinary delay.

Unfortunately, there is no standard onboarding process for volunteers and local cooperation can vary highly. Some VA facilities do not make volunteer physicals a priority and do not realize delays create a barrier to access for veterans who need our services. DAV proudly serves and will continue to serve rural states to include Montana, Kansas, North Dakota, South Dakota, Ohio and Nebraska among others.

Recommendation:

- Standardize and expedite the volunteer driver onboarding process VHA-wide, as soon as possible.

Telehealth

The ability to offer telehealth services provides options for patients and provides a potential path to address a health issue timely and conveniently but is impacted by barriers in rural communities regarding the availability of equipment and adequate bandwidth. Too many of our rural and tribal veterans are unable to participate in the programs established by VA such as Telehealth, TelePain, and eConsults. A July 2020 OIG report found that these programs are underutilized in highly rural Community-Based Outpatient Clinics (CBOC). While funds exist to expand the capacity of the programs, it may not be feasible due to a lack of broadband access in rural areas.

Recommendations:

Continue to expand telehealth options when and where appropriate to supplement in-person SUD treatment

- **Expand Rural Veteran Tablet Program.** This VA program distributes video-enabled tablets to veterans, allowing them access to their primary and specialty care providers. Research indicates high satisfaction with the program and increasing it would provide greater access to SUD treatment and continuity of care.

- **Increase number of Clinical Resource Hubs (CRHs).** To aid veterans who live in areas that experience bandwidth problems, but are still too rural for easy access to care at a VAMC; paired with telehealth technology, CRHs allow veterans to connect with distant primary care, mental health, and specialty care teams to improve access to health care.

- **Expand and fund Virtual Living Rooms.** In partnership with the Rural Broadband Association, this program leverages locations where there is broadband access in a comfortable, private area such as a library, church, community center, or a local fraternal building.

Staffing for primary care is a major challenge in rural America, but specialty care is even scarcer. Compounded with the often complex needs of a veteran—the medical care and services they need are just not there. Even in terms of using community care, these specialty care providers are often not available. Particularly in areas outside of the continental United States (CONUS).

Veterans outside the Continental United States (CONUS)

The Philippines is the only foreign country in which there is a VA Outpatient Clinic to serve eligible veterans. Recently, we began receiving complaints from our members who indicated VA had completely stopped dispensing Schedule 1 medication. This was not without advance notice to the veterans affected; however, the options faced by this population of veterans were to either travel to Guam, go into the community, stop the medication, or travel to the United States whenever a refill was needed. Further, the community-dispensed medication is not FDA-approved; therefore, the quality of these medications is not regulated or guaranteed. VA's own website under the Foreign Medical Program states, "physicians should only prescribe medications that are legally available within the veteran's country of residence and are accepted by VA and the U.S. Food and Drug Administration (FDA)." Service-disabled veterans deserve access to high-quality care and should not have to travel to great lengths to receive needed medications.

Guam, American Samoa, Puerto Rico, U.S. Virgin Islands, and the Northern Mariana Islands face even greater challenges due to limited or poor infrastructure.

Veterans living in these areas sometimes have to take commercial aircraft, which are frequently not disability friendly, to get to appointments or fill prescriptions. Severe weather events affect these areas differently than rural areas within CONUS. According to VA's website, not one of the outside CONUS sites has a specialty SUD program.

A new Mental Health RRTP is scheduled to open in San Juan, Puerto Rico in 2024 to treat veterans on the island who are in desperate need of these services. Puerto Ricans serve in the Armed Forces at higher numbers per capita, than many states within the union. We hope there will be a concerted effort to treat veterans with SUD and particularly gender-specific programming, to include a separate section for women veterans.

An additional barrier facing veterans residing outside of the United States is the Beneficiary Travel Self-Service System, which was designed to automate the travel reimbursement claims process. A May 2023 OIG report found significant problems with this system. While DAV supports this modernization effort, there continue to be complaints regarding the slow processing of payments, and improper payments made to beneficiaries.

Consider a service-disabled veteran who is wheelchair-bound and lives in Guam. That veteran experiences severe back pain that requires a medical procedure, but due to the lack of specialty care on the island, they are forced to travel to Hawaii, over 3,000 miles away, for their care. The veteran is eligible to take a military plane, but there are none available, so they must take a commercial flight, which the veteran must pay for up-front, and could cost $1,200. The veteran then needs transportation to the VHA facility, as well as a hotel—again, an up-front expense to the veteran. After spending thousands of dollars and flying 16 hours roundtrip for their medical care, the veteran finally returns home and files a claim using VA's travel reimbursement portal if they are technologically informed and/or have access.

They now have to wait weeks and very often, months, to get reimbursed, and not always the full amount that they originally paid out. This scenario is not just true for our veterans living outside of the continental United States, but also occurs in rural America.

Recommendation

- VA should conduct a needs assessment to determine if adding SUD programming for outside CONUS communities is warranted**.** As noted above, there are no SUD programs in any of the outside CONUS territories. In fact, many of these areas do not have VA facilities at all, making it difficult for veterans to access even basic health care.

WOMEN VETERANS AND SUD

Unfortunately, not only rural veterans face challenges with SUD treatment. Women veterans have a different and unique set of roadblocks to these specialized services and care. Like their male counterparts, rural women veterans also deal with health care access disparities due to long distances to medical facilities and lack of transportation. But for women veterans, there is also limited gender-specific programming for SUD services. Currently, there are only two gender-specific residential treatment programs with two pending. While VA has 13 gender-specific programs across nine locations, it is limited in what it can provide to women veterans in locations without more comprehensive residential treatment programs.

VA will provide beneficiary travel to the closest available facility offering the care, but it must work within current authorities, or coordinate other arrangements if the veteran is ineligible for beneficiary travel. Child care or concern over losing custody of children because of care-seeking for significant mental health conditions and/or SUD may be another barrier for women who need more intensive specialized care. Average and median wait times for women's care in domiciliaries were found to be slightly higher for women than men. VA reports that wait times are, on average, 24 days for women compared to 22 days for men. While 72 hours is VA's goal from screening to admission, fewer than 16% of women and 20% of men are admitted within this timeframe.

Some of the additional waiting time for women may be due to VA's lower capacity to address women's needs. VA reports fewer than half of all residential facilities have separate dorm space for women veterans and only 13 programs have gender-specific services for women veterans compared to 27 programs exclusive to men.

SUDs are associated with family instability, decreased worker productivity and declining health, and increased risk for suicidal behavior in veterans, especially in women. Women's bodies also respond differently to substance use and withdrawal, and their reasons for both using substances and stopping or reducing their substance use may be different from those of men. Understanding these differences is important to providing effective care. Additionally, while access to more tailored care is necessary for improving screening and SUD services for women veterans, it is critical that VA ensures safe and private therapeutic settings conducive to their recovery. Women are shown to be more likely than male veterans or non-veteran women to have co-occurring psychiatric and medical impairments, in many instances linked to a history of sexual trauma or domestic violence.

A 2020 study noted that women veterans of Operation Iraqi Freedom/Operation Enduring Freedom in Puerto Rico, utilized VA health care services at higher rates and had greater barriers to care than their U.S. counterparts.

Recommendation:

- Conduct a nationwide analysis of the need and efficacy of women-specific programs that treat and rehabilitate women veterans with drug and alcohol dependency to determine if expanding gender-specific SUD inpatient care is warranted.

In closing, DAV is grateful for VA's whole-health integrated model of care along with top-tier evidence-based treatment and supportive services for veterans struggling with substance use disorders; however, only a small percentage of veterans diagnosed with SUD seek specialized treatment for their condition. This, coupled with the access challenges for rural and women veterans, make it clear that we need to address existing barriers to treat all veterans who need this life-saving specialized care. We appreciate the Committee's consideration of our recommendations to improve and expand these important services throughout this testimony.

We thank the Committee for the opportunity to testify on this important issue and are pleased to answer any questions you may have.

Statement of
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Clinical Nurse Researcher & Executive Director
of the
HunterSeven Foundation

Chairman Tester, Ranking Member Moran, and members of the Senate Veterans Affairs Committee, I appreciate the opportunity to come and speak this evening on substance use in the veteran community.

Today, I speak before the committee as a licensed healthcare provider with advanced medical degrees, including public health and epidemiology specialty certifications. I've spent over fifteen-thousand hours working in emergency medicine, long- and short-term substance use settings, and military veteran-specific mental health clinics. I've published in numerous academic journals and presented at conferences nationwide. However, I speak to the committee today as the sister of a combat-wounded Marine losing his battle with addiction… as the child of an alcoholic and heroin-addicted father. I speak today as a disabled Army veteran dealing with constant, debilitating pain and the uninterrupted emotional burden I face daily. The testimony I share today is, unfortunately, entirely true.

I am the youngest of five. My sister and I share a mother, while my three brothers and I share a father. My three brothers lived with our aunt, as my father was preoccupied with shooting heroin and rotating between a "*halfway house*" and jail. Growing up, I thought drug use was regular for most adults. Everywhere I turned, I'd find a hypodermic needle or a spoon with a rubber band nearby. Sometimes I'd see the ambulance come to our apartment complex, and shortly after, a stretcher with a black body bag would roll by where I was playing. Some nights I'd stay awake crying, wondering if my parent would come home that night and if they did, I'd pray they wouldn't be so intoxicated that they would fall. I was always afraid when they drank because they would get hurt. While most ten-year-old kids enjoy sleepovers with their friends on the weekends, I was busy caring for my parent, confirming they got into bed, and checking on them throughout the night to ensure they were still breathing.

By fourteen, I needed to get a job; I skipped school and had never done my homework. I got into fights and did everything I wasn't supposed to, so I failed my freshman year of high school. At fifteen years old, I lost my oldest brother to an overdose. My mother told me my 24-year-old brother planned to enter substance use treatment the following Monday. He didn't make it. He had shot up the night before with friends of my fathers; he had fallen asleep and began to throw up… instead of calling 9-1-1 and keeping him awake, those he was with had moved his body into the hallway, where he choked on his vomit and died.

Shortly after his death, I was expelled from school. My behavior was self-destructive and lacked structure and discipline. It was difficult to talk about my situation at home with those who didn't understand, especially with those who just thought I was a "bad kid" but never figured to ask why. By sixteen, in 2007, my youngest brother had signed up to serve as an infantryman in the United States Marine Corps; we wrote to each other often while he was in boot camp at Parris Island. He loved it, every single minute of it. I had just graduated high school when my brother told me he would be deployed as one of the first waves into Marjah, Afghanistan, under President Obamas' "Surge," to disrupt Taliban forces. He spent seven months in southern Afghanistan.

While he was deployed, I'd sit at night and watch the evening world news to keep myself in the loop of what was happening in the war. Every time I heard about unnamed Marine casualties, my heart sank. It was almost daily. In total, 68 Marines were killed in action during that seven-month deployment, and 697 Marines were wounded in action[1]. In turn, I enlisted in the United States Army.

[1] Defense Casualty Analysis System (June 9, 2023). U.S. Military Casualties - Operation Enduring Freedom (OEF) Casualty Summary by Month and Service. Retrieved from: https://dcas.dmdc.osd.mil/

In August 2011, he redeployed to Sangin, Afghanistan, for eight months. Thirty Marines had been killed in action, while 582 Marines were wounded in action. One of those wounded Marines was my brother. While he had lost men he considered brothers, and witnessed his closest friends suffer near-death amputations from hidden improvised explosive devices and others who had been physically ripped apart from RPK machine gun rounds, my brother felt lucky. He had sustained outrageous blast injuries from explosions and rocket-propelled grenades. One blast so severe his MRAP vehicle had flipped over, throwing him from the turret, causing him to break four ribs, fracture his skull and sections of his lower back. He came home, but the physical pain was moot compared to the emotional guilt and moral injury he tried so hard to hide.

Over the next year, he struggled with physical pain and depression; the guilt overwhelmed his life. What began as a short-term Vicodin prescription for pain management became a full-blown addiction where he would steal Fentanyl patches from the regiments Navy corpsmen. He had kept his habit under the radar until a random drug test found opiates in his system. Sixteen days later, he was discharged under "*Other than Honorable*" conditions for illicit drug use. He was homeless, jobless, emotionally and physically unstable, and addicted. He was too embarrassed to seek help; he suffered in silence and ended up sleeping on our aunts' couch.

Around the same time, I suffered a severe spinal injury while serving in the Army. I remember the electrifying pain, it wasn't like any pain I had experienced before, but my adrenaline was high, and the mission made the pain seem nonexistent. It wasn't until later that evening that I lost control of my bladder, and pins and needles drove up my leg, causing a debilitating painful paralysis. At 21 years old, I was told my injury led the discs in my lower back to partially paralyze my spinal cord, and I needed surgery. My military career was placed on hold, but that wasn't the case for the rest of my team. In the months leading up to the major surgery I was scheduled for, I was given more than 300 pills of the mild opiate hydrocodone-acetaminophen, better known as "Vicodin." I was told to take them every 6 hours for pain. In case the Vicodin wasn't working, I was given 100 pills of Tramadol, a synthetic opioid that reduces the pain felt through the central nervous system. To lessen the right-sided leg numbness, severe neuropathy, and muscle spasms, I was given 100 pills of Flexeril. My anxiety was front-and-center at all of this, so I was given 30 pills of Lorazepam, an anti-anxiety benzodiazepine, to take "as needed" for anxiety.

Two weeks later, I received a call that one of my closest friends I had known since I was 14, was killed in Dawlat Shah, Afghanistan. I felt helpless, motionless, stuck in time; I couldn't move. The "pain" had gotten worse. The more of these pills I took, the less "pain" I had. And as time went on, everything became easier to deal with; or at least that is what I had thought.

I went through a three-hour surgery and was on the road to recovery. The first few nights were hell. I had severe nightmares; dreams I'd never wish anyone would experience; I'd wake up covered in sweat and unable to move. The pain worsened; I was given 60 pills of oxycodone-acetaminophen (Percocet) and told to stop taking the Vicodin as it may have been an adverse reaction. I couldn't swallow the pills without vomiting, worsening the post-operative pain. I was sent home with an 8oz. bottle of "Oxydose" - liquid oxycodone.

It helped with the pain; eventually, it subsided as I healed. I felt great. Looking back, I cannot remember a time in my life when I felt that relaxed or carefree. I could sleep. My mind stopped overthinking, and my heart stopped racing. I wasn't sad. I wasn't worried about the future; I was enjoying the present. And when I started to feel myself come back to reality, I'd grab the medicine bottle and take another sip. Like most 21-year-olds, I didn't have a way to measure the amount I was taking. Instead, I'd rely on my balance to let me know if I had taken enough. I don't remember much besides laying in my bed thinking, isn't life great.

I loved how I felt in those moments; it was an unmatched feeling. I took medication not for the physical pain but to cover my emotional pain, which worked very well – until it almost killed me. Late one night, I was lying in bed and had drunk too much. I laid back and felt a sudden sickness; I went to get up and felt my legs get weak. Using the side of my bed, I slowly slid to the ground… I don't remember much afterward until I woke up minutes later, covering my floor with vomit. I cried; I knew what happened. The next day I knew I had to get rid of it, which wasn't easy. But what kept me motivated was returning to uniform and being with my team again. There is a reasonable probability that is what kept me alive. To this day, I know I cannot take Percocet – I enjoy it too much.

While dealing with my situation, my brother battled something similar. He was figuring out his next steps, but none knew he was battling addiction. While staying with our aunt, he had been taking prescription opiates… when those ran out, and he couldn't get more, he turned to heroin.

He was alone one night and had shot up heroin that we later discovered had traces of fentanyl. He passed out on the couch, and when our aunt found him, he was covered in vomit and not breathing. She called 9-1-1 and began CPR; his lips were dusky and cold. He was given Narcan, intubated, and rushed to the emergency department, where the medical team worked to save his life. The doctor said it was a miracle he survived because he shouldn't have. They were cautiously optimistic as his brain was oxygen-deprived for some time, and we wouldn't know the severity until he was out of a coma.

He was transferred to the intensive care unit at the Department of Veterans Affairs in Boston, where he would spend the next few weeks hooked up to a breathing machine. Every night after dinner, I would sit with him; I'd play his favorite band, Stone Temple Pilots, while he lay there on life support. I'd wash his face and brush his hair. Weeks later, he was brought out of the coma, his neurological function was intact, but his attitude was almost careless – which surprised me the most. He had told me everything that had happened, from his other-than-honorable discharge to his lack of ability to receive services within the VA Healthcare System, as he had difficulty enrolling in care. He didn't have a backup plan and felt trapped as if he had returned to the bottom where he started. It took more than seven years to enroll him in substance use treatment and nearly ten years to have his military service discharge overturned.

While my brother faced his battles, I received medical clearance to remain in the Army despite having just had a life-changing surgery. My provider had told me that the chances of another injury occurring are inevitable and that I may not be so lucky this time around. Against his medical advice and warning of imminent pain and suffering, I knew it was where I belonged. It was my comfort zone; it was the family I never had. But as predicted, years later, I suffered a re-injury. This time was equally painful, but I could still move and manage. For me, long story short, my career was over. Discharged.

It will always be the most dangerous time in any service member-turned-veterans' life. You are leaving a tight-knit group, leaving a feeling of "*belonging*," and reintegrating into a society that couldn't give a shit about you, your service, your situation, or your struggles. There is no "team" or "tribe" that you can turn to or fall back on; there is no safety net or mirroring experience in a fellow veteran for you to voice your thoughts and feelings with.

I went to bed as a service member and woke up the following day as a civilian. My pain had become increasingly worse. My temper became short, my anger and frustration grew, and my anxiety worsened. I was alone with myself and my thoughts. My grandparents had invited me to stay with them while I figured out my situation; with their help, I enrolled in school in hopes of receiving my undergraduate degree in nursing. Opposite to my time in high school, college became much easier for me. I was structured, disciplined, motivated, and mission-focused, but it felt like I was passing the time. I didn't feel like I was where I belonged.

I woke up one morning during my senior year of college, and it was like a trap door had fallen from underneath me. The best way to describe it is that I felt like I was running full speed on a treadmill. What that something was, I do not know. But I hit the lowest point in my life. I was running on empty. I couldn't stop crying – and I didn't know why. I couldn't eat or keep any food down. Instead, I drank whiskey to keep the anxiety and emotions at bay, leading to an ulcer eating my stomach lining. I hid my sadness from my family and friends. I was alone as if I was on the outside looking in. I had lost any meaningful purpose in my life, and I knew I didn't belong.

You can only run so much before you are on empty. And I was on empty.

I had a commemorative military pistol from the unit, a Sig Sauer P250, .45 ACP, underneath my bed, and I laid down on my bedroom floor looking up at the ceiling with the pistol in my right hand. I pointed the gun toward myself and placed the barrel in my mouth. I can remember the cold feeling and taste of steel. The only reason why I am still here today is two-fold.

I couldn't kill myself in my grandparents' house. I couldn't do that to them or have them wondering why for the rest of their lives. I got in my car and drove; I pulled over and texted, "**I'm not okay**," to the only person I knew would understand. My

nursing professor a 29-year Air Force veteran and flight nurse. She understood. Thirty minutes later I was at the VA Hospitals' mental health urgent care getting the support I needed.

I didn't tell you all my life story for sympathy but to emphasize the importance of understanding the "bigger picture" concerning substance use, pain management, mental health, and recovery in military veterans. As difficult as it is to share at times, it is a lived experience that will provide some context for what I am about to say and hopefully guide your decision-making process regarding how post-9/11 military veterans receive potentially life-saving care.

ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood events (ACE) are a list of eight negative experiences that occurred during one's childhood before age 18. These include living with a person who is mentally ill, depressed, or suicidal, living with an alcoholic, living with a person who used or abused illegal or prescription drugs, living with someone who had been incarcerated, parental divorce or separation, witnessing intimate partner violence, and being physically, emotionally, or sexually abused. Notably, a shift toward an all-volunteer military force has provided insight that children who experience adverse childhood events (ACE) are more than twice as likely to enlist in the Armed Forces[2]. For those who experienced situations similar to my brother and I, enlisting in the military served as an instrumental, live-changing choice to escape a dangerously destructive environment. Like myself, many of those who experienced adverse childhood events… crave regularity, routineness, safety, reliability, and structure—everything the military gives us.

In contrast, comparing those veterans who experienced no adverse childhood events, veterans who had experienced at least one were more than twice as likely to attempt suicide, while those with four or more adverse events during childhood were nearly four times more likely to attempt suicide[3]. Additionally, those who experienced adverse childhood events were upwards of ten times as likely to report substance use and addiction, and for those who had overlapping adverse childhood events and a substance use history, their risk of attempted suicide increased by 60%[4].

PHYSICAL HEALTH

Since 2001, more than three million veterans have served in the Global War on Terror / Post-9/11 era. Notably, various studies across different spectrums have determined that the following service, post-9/11 era veterans have poor physical health and higher levels of disability within specific body systems[5]. Post-9/11 veterans, when compared to non-veterans, experience significant elevations in prevalence with back and neck pain (49.3%), fractures and bone-joint injuries (47.6%), and arthritis (26.2%), leading to a relative risk of roughly *three-and-a-half-times* more likely to experience these issues following military service.

Furthermore, musculoskeletal conditions in veterans have also been associated with poor mental health status. In a study of Iraq War veterans, physical pain was twice as high in Iraq veterans diagnosed with post-traumatic stress (50%) than those without (26%)[6]. Not only can post-traumatic stress and related depression limit any desire for physical activity, but post-traumatic stress and constant elevated "*fight or flight*" can also exacerbate injury through inflammatory pathways[7]. For some, such as myself, when we experience pain, we can be particularly susceptible to experiencing elevated anxiety due to pain but also injurious limitations and feeling "stuck." Utilizing medicinal or prescription opiates to treat chronic pain in post-9/11 military veterans is a dangerous downward slope, as it can be used as a temporary Band-Aid for a much larger problem.

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[2] Bloshnich, J., Dichter, M., Cerulli, C., Batten, S. & Bossarte, R. (2014). Disparities in adverse childhood experiences among individuals with a history of military service. *Journal of the American Medical Association Psychiatry*, 71(9): 1041-1048. https://doi.org/10.1001/jamapsychiatry.2014.724

[3] *Ibid.*

[4] Douglas, K. et al. (2010). Adverse childhood events as risk factors for substance dependence: Partial mediation by mood and anxiety disorders. *Addictive Behaviors*, 35(1): 7-13. https://doi.org/10.1016/j.addbeh.2009.07.004

[5] Cypel, Y. et al. (2023). Physical health of Post-9/11 U.S. Military veterans in the context of Healthy People 2020 targeted topic areas: Results from the Comparative Health Assessment Interview Research Study. *Preventive Medicine Reports*, 32. https://doi.org/10.1016/j.pmedr.2023.102122

[6] Nazarian, D., Kimerling, R. & Frayne, S. (2012). Posttraumatic stress disorder, substance use disorders, and medical comorbidity among returning U.S. veterans. *Journal of Traumatic Stress*, 25(2): 220-225. https://doi.org/10.1002/jts.21690

[7] Banihashemi, L., Wallace, M., Peng, C., Stinley, M., Germain, A. & Herringa, R. (2020). Interactions between childhood maltreatment and combat exposure trauma on stress-related activity within the cingulate cortex: A pilot study. *Military Psychology*, 32(2): 176-185. https://doi.org/10.1080/08995605.2019.1702831

EMOTIONAL HEALTH & SUICIDAL IDEATION

If you ask any veteran if they miss serving in uniform, they will say yes, through good and bad times, even while at war. It is a complex, paradoxical relationship – but it is critical to understand the deeper meaning behind the "why." When my brother came home and told me what had happened while deployed during the height of the war, I figured his response and reaction would be more traumatic. He visually described his teammate that rescued two wounded Marines while running under a hail of gunfire and eventually stepping on a pressure-plate bomb that tore his legs cleanly from the bone. He told me war is destructive and dangerous, and there is no shortage of suffering – he said it was no worse than being at home, but at least in Afghanistan, he had his brothers by his side. Emotional suffering is much less evident and damaging if surrounded by others who understand. Most importantly, it gave each marine a sense of purpose, meaning, and identity more significant than themselves[8].

The first six months to a year are considered the "*transition*" period following separation from military service and reintegration into civilian life. Veteran suicide risk appears particularly elevated during this first year. Historically, during this period, veterans have a suicide rate 2.5 times higher than that of active-duty service members[9]. It can be similar to a culture shock when leaving service and losing the close-knit cohesion and interdependence obtained in service, mixed with modern-day civilian societies' level of isolation and disconnection can perceive the feeling of individual alienation and lack of belonging. Suppose you are one of those veterans who had a forced end to your military career from addiction or other maladaptive behaviors, physical injury, or mental health disorders. In that case, your risk for self-harm, substance use, and suicide increases dramatically, and if compounded with a history of adverse childhood events, your chances of survival are slim, and the worst part is that you are alone.

SUBSTANCE USE & ADDICTION

The most effective way to explain why veterans become addicts at increasingly higher rates is best reflected by the "Rat Park Experiment" conducted by psychologist Bruce K. Alexander[10]. The experiment aimed to explore the role of social and environmental factors in drug addiction. Traditionally, addiction research had predominantly focused on individual drug exposure and chemical dependency. The Rat Park experiment sought to challenge this perspective by examining the influence of social and environmental factors on drug-seeking behavior. In the experiment, researchers created two distinct environments for laboratory rats.

The first environment was a traditional small cage with solitary housing, where rats had access to two water bottles: one containing plain water and the other laced with morphine. The second environment was a larger enclosure called "*Rat Park*," which provided an enriched social and physical environment with a variety of stimuli, such as toys, wheels, and the presence of other rats. Similarly, the rats in Rat Park had access to the same two water bottles. The study results showed that the rats in Rat Park consumed little-to-no morphine-laced water than solitary housing rats. The researchers concluded that the rats in Rat Park, with their enriched environment and social interactions, were less inclined to become addicted to morphine. They hypothesized that the rats in solitary housing were more susceptible to drug addiction due to their lack of social and environmental stimulation, challenging the idea that addiction is solely based on chemical dependency[11]. Healing veteran addiction is possible through community, not through a rural clinic hours away.

While various factors were touched upon, from musculoskeletal injuries to childhood experiences, mental health, suicidal ideation, and transition, everything mentioned in this testimony is critical in understanding how to treat best (and prevent) military veteran addiction. While the Department of Veterans Affairs does a fine job with non-emergent, chronic conditions, the same isn't to be said for veterans dealing with polytrauma and dual diagnoses. Instead of treating these conditions separately, they must be treated simultaneously and from a whole-body, head-to-toe approach.

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[8] Hedges, C. (2003). *War is a force that gives us meaning.* Anchor Books, Random House, Inc. 1st edition. ISBN: 978-1-61039-359-1

[9] Ravindran, C., Morley, S., Stephens, B., Stanley, I. & Reger, M. (2020). Association of suicide risk with transition to civilian life among U.S. military service members. *Journal of American Medical Association,* 3(9): e201621. https://doi.org/10.1001/jamanetworkopen.2020.16261

[10] Alexander, B., Coambs, R. & Hadaway, P. (1978). The effect of housing and gender on morphine self-administration in rats. *Psychopharmacology,* 58(2): 175-179. https://doi.org/10.1007/BF00426903

[11] *Ibid.*

After reviewing services within the Department of Veterans Affairs Healthcare System nationwide for care related to addiction, 365 VA facilities offered new patient substance use programs. Of those, an initial appointment's average wait time is nine days. While some locations had no wait time data, and others didn't offer substance use treatments (i.e., Guam), other locations had upwards of 40 to 99 waiting days for substance use treatment. As mentioned above, mental health and co-morbid post-traumatic stress often overlap with military veterans who suffer from substance use. The most effective way to approach and successfully treat addiction is to look at the big picture holistically. After gathering the wait days for substance use, the process was repeated for a new veteran patient(s) wait days for mental health and post-traumatic stress, respectfully. The average wait for mental health services was 32 days, while post-traumatic stress-specific services were widely unavailable in more than half of the locations treating veteran substance use. I invite the Committee to review this chart included in the appendix.

In Montana, for example: if a veteran lives in Glacier County, the closest VA facility offering substance use treatment is Great Falls which is only 1.5 hours away and has no wait time for new patients. However, it doesn't provide PTSD-specific care and has a 74-day wait list for mental health treatment. The next closest facility is in Kalispell; the wait is only 26 days for substance use and 13 days for mental health, PTSD-specific care isn't available, but the drive is more than 2.5 hours away. This isn't a feasible option for rural area veterans. Many of us who have faced substance use disorders and co-occurring post-traumatic stress, depression, or any type of mental health disorder do not have the time to wait. Most who suffer from dual-diagnosis disorders such as mental health and substance use do not have the means to travel 2.5 hours away for care, nor do many have the transportation resources. Successful treatment for addiction begins with, first, the individual determining they have a problem and, second, their willingness and readiness to seek treatment. Neither of which can wait 26 days.

To positively change and impact military veteran care, **the approach should be less about the Department of Veterans Affairs and more about the veterans themselves**. Meeting the veteran where they are and allowing them to be the Captain of their ship giving them the slightest bit of self-control and self-determination regarding their healthcare. I ask that the committee consider civilian and non-Veterans Affairs options, access, and coverage to substance use and mental health / post-traumatic stress-specific care in the community. Mr. Chairman, and members of the Senate Veterans Affairs Committee, I appreciate your listening to my story and many other military veterans nationwide. That concludes my statement, and I would be pleased to answer any questions you or the Committee members may have.

VA NAME	CITY	STATE	ZIP	SUBSTANCE USE WAIT (DAYS)	MENTAL HEALTH WAIT (DAYS)	PTSD SPECIFIC WAIT (DAYS)
ALASKA VAHCS (JBER)	ANCHORAGE	AK	99504	0	28	NOT OFFERED
BIRMINGHAM EAST VA CLINIC	IRONDALE	AL	35210	0	52	0
TUSCALOOSA VA MEDICAL CENTER	TUSCALOOSA	AL	35404	3	43	18
HUNTSVILLE VA CLINIC	HUNTSVILLE	AL	35805	0	45	NOT OFFERED
CENTRAL ALABAMA VAMC	MONTGOMERY	AL	36109	15	46	0
CENTRAL ALABAMA VAMC	TUSKEEGEE	AL	36083	0	28	0
EUGENE TOWBIN HEALTHCARE CENTER	NORTH LITTLE ROCK	AR	72114	0	38	0
FAYETTEVILLE VAMC	FAYETTEVILLE	AR	72703	0	12	1
FORT SMITH VA CLINIC	FORT SMITH	AR	72903	71	25	NOT OFFERED
CONRAD VAHC CLINIC	GLIBERT	AZ	85297	0	63	0
MESA VA CLINIC	MESA	AZ	85212	8	65	NOT OFFERED
HAYDEN VAMC	PHOENIX	AZ	85012	46	34	NOT OFFERED
TUCSON VAMC	TUCSON	AZ	85723	40	39	0
SOUTH TUCSON VA CLINIC	TUCSON	AZ	85747	0	40	NOT OFFERED
BOB STUMP VAMC	PRESCOTT	AZ	86313	6	25	50
REDDING VA CLINIC	REDDING	CA	96002	0	48	0
CHICO VA CLINIC	CHICO	CA	95923	1	36	NOT OFFERED
YUBA CITY VA CLINIC	YUBA CITY	CA	95991	0	3	NOT OFFERED
MCCLELLAN VA CLINIC	MCCLELLAN PARK	CA	95652	0	31	0
FAIRFIELD VA CLINIC (TRAVIS AFB)	TRAVIS AIR FORCE BASE	CA	94535	0	9	NOT OFFERED
MARE ISLAND VA CLINIC	MARE ISLAND	CA	94592	0	1	NOT OFFERED
SACRAMENTO VAMC	MATHER	CA	95655	1	15	0
MARTINEZ VAMC	MARTINEZ	CA	94553	0	64	0
SAN FRANCISCO VAMC	SAN FRANCISCO	CA	94121	40	33	0
21ST STREET VA CLINIC	OAKLAND	CA	94612	8	43	0
PALO ALTO VAMC	PALO ALTO	CA	94304	0	29	0
FREMONT VA CLINIC	FREMONT	CA	94538	0	48	NOT OFFERED
STOCKTON VA CLINIC	FRENCH CAMP	CA	95231	0	77	NOT OFFERED
ROSEMARY MARINER OUTPATIENT CLINIC	VENTURA	CA	93003	13	39	NOT OFFERED
SEPULVEDA VAMC	SEPULVEDA	CA	91343	78	59	0
WEST LOS ANGELES VAMC	LOS ANGELES	CA	90073	64	116	0
LOS ANGELES VA CLINIC	LOS ANGELES	CA	90012	3	58	0
CABRILLO VA CLINIC	LONG BEACH	CA	90806	0	NOT OFFERED	NOT OFFERED
TIBOR RUBIN VAMC	LONG BEACH	CA	90822	33	24	50
PLACENTIA VA CLINIC	PLACENTIA	CA	92870	0	75	NOT OFFERED
ESCONDIDO VA CLINIC	ESCONDIDO	CA	92025	5	82	NOT OFFERED
JENNIFER MORENO VAMC	SAN DIEGO	CA	92161	12	23	97
MURRIETA VA CLINIC	MURRIETA	CA	92562	0	148	NOT OFFERED
KEARNEY MESA VA CLINIC	SAN DIEGO	CA	92123	7	39	60
RIO VA CLINIC	SAN DIEGO	CA	92108	15	0	123
CHULA VISTA VA CLINIC	CHULA VISTA	CA	91910	6	37	0
SANTA ANA VA CLINIC	SANTA ANA	CA	92705	0	60	NOT OFFERED
JERRY PETTIS VETERANS HOSPITAL	LOMA LINDA	CA	92357	18	0	NOT OFFERED
LOMA LINDA VA CLINIC	LOMA LINDA	CA	92373	18	63	NOT OFFERED
GRAND JUNCTION VAMC	GRAND JUNCTION	CO	81501	0	12	5
SALIDA VA CLINIC	SALIDA	CO	81201	0	0	NOT OFFERED
ALAMOSA VA CLINIC	ALAMOSA	CO	81101	0	0	NOT OFFERED
GOLDEN VA CLINIC	GOLDEN	CO	80401	36	65	0
LINDSTROM VA CLINIC	COLORADO SPRINGS	CO	80907	0	32	0
ROCKY MOUNTAIN REGIONAL VAMC	AURORA	CO	80045	29	61	0
LOVELAND VA CLINIC	LOVELAND	CO	80538	0	0	0
NORTHERN COLORADO VA CLINIC	LOVELAND	CO	80538	6	65	0
JAMES DUNN VA CLINIC	PUEBLO	CO	81008	0	26	NOT OFFERED
WEST HAVEN VAMC	WEST HAVEN	CT	6516	15	39	0
ERRERA VA CLINIC	WEST HAVEN	CT	6516	0	0	NOT OFFERED
NEWINGTON VA CLINIC	NEWINGTON	CT	6111	16	11	NOT OFFERED
WASHINGTON VAMC	WASHINGTON	DC	20422	1	16	16
KENT COUNTY VA CLINIC	DOVER	DE	19901	0	8	NOT OFFERED
SUSSEX COUNTY VA CLINIC	GEORGETOWN	DE	19947	0	19	NOT OFFERED
WILMNGTON VAMC	WILMINGTON	DE	19805	10	7	NOT OFFERED
BRUCE CARTER VAMC	MIAMI	FL	33125	0	25	6
WILLIAM KLING VA OUTPATIENT CLINIC	SUNRISE	FL	33351	0	6	0
WEST PALM BEACH VAMC	WEST PALM BEACH	FL	33410	1	19	0
LEE COUNTY VA CLINIC	CAPE CORAL	FL	33909	34	18	NOT OFFERED

VIERA VA CLINIC	VIERA	**FL**	32940	25	25	16
WEST LAKELAND VA CLINIC	LAKELAND	**FL**	33811	0	0	NOT OFFERED
ORLANDO VAMC	ORLANDO	**FL**	32827	6	11	20
SOUTH HILLSBOROUGH VA CLINIC	RIVERVIEW	**FL**	33579	0	6	NOT OFFERED
LAKE BALDWIN VA CLINIC	ORLANDO	**FL**	32803	0	12	0
46TH STREET SOUTH VA CLINIC	TAMPA	**FL**	33617	0	3	0
JAMES HALEY VAMC	TAMPA	**FL**	33612	0	21	0
C.W. BILL YOUNG VAMC	BAY PINES	**FL**	33744	4	27	10
BROOKSVILLE VA CLINIC	BROOKSVILLE	**FL**	34613	0	22	NOT OFFERED
WESTSIDE PAVILION VA CLINIC	DAYTONA BEACH	**FL**	32114	0	53	0
THE VILLAGES VA CLINIC	THE VILLAGES	**FL**	32162	5	91	0
LEO CHASE JR VA CLINIC	SAINT AUGUSTINE	**FL**	32086	2	45	NOT OFFERED
OCALA VA CLINIC	OCALA	**FL**	34474	5	16	NOT OFFERED
JACKSONVILLE SOUTHPOINT VA CLINIC	JACKSONVILLE	**FL**	32216	58	27	0
GAINESVILLE 1 VA CLINIC	GAINESVILLE	**FL**	32608	27	25	16
LAKE CITY VAMC	LAKE CITY	**FL**	32025	28	29	0
ERNEST THOMAS VA CLINIC	TALLAHASSEE	**FL**	32311	43	93	0
MACON VA CLINIC	MACON	**GA**	31220	17	51	NOT OFFERED
CARL VINSON VAMC	DUBLIN	**GA**	31021	20	6	NOT OFFERED
ROBERT POYDASHEFF VA CLINIC	COLUMBUS	**GA**	31904	0	43	NOT OFFERED
FORT MCPHERSON VA CLINIC	ATLANTA	**GA**	30310	0	70	NOT OFFERED
JOSEPH MAXWELL CLELAND VAMC	DECATUR	**GA**	30033	44	22	NOT OFFERED
HENDERSON MILL VA CLINIC	ATLANTA	**GA**	30345	0	0	1
COBB COUNTY VA CLINIC	MARIETTA	**GA**	30062	0	38	NOT OFFERED
AUGUSTA VA MEDICAL CENTER (UPTOWN)	AUGUSTA	**GA**	30904	11	17	53
OAKWOOD VA CLINIC	FLOWERY BRANCH	**GA**	30542	0	0	0
WAYCROSS VA CLINIC	WAYCROSS	**GA**	31501	20	19	NOT OFFERED
VALDOSTA VA CLINIC	VALDOSTA	**GA**	31601	8	32	NOT OFFERED
SAVANNAH VA CLINIC	SAVANNAH	**GA**	31419	27	43	NOT OFFERED
GUAM VA CLINIC	AGANA HEIGHTS	**GU**	96910	NOT OFFERED	71	NOT OFFERED
MATSUNAGA VAMC	HONOLULU	**HI**	96819	0	12	29
CEDAR RAPIDS VA CLINIC	CEDAR RAPIDS	**IA**	52404	0	92	0
CORALVILLE VA CLINIC	COARLVILLE	**IA**	52241	22	63	68
DAVENPORT VA CLINIC	DAVENPORT	**IA**	52801	12	0	NOT OFFERED
DES MOINES VAMC	DES MOINES	**IA**	50310	40	24	0
DUBUQUE VA CLINIC	DUBUQUE	**IA**	52003	0	77	0
IOWA CITY VAMC	IOWA CITY	**IA**	52246	0	31	NOT OFFERED
LINN COUNTY VA CLINIC	CEDAR RAPIDS	**IA**	52402	0	NOT OFFERED	NOT OFFERED
OTTUMWA VA CLINIC	OTTUMWA	**IA**	52501	0	11	NOT OFFERED
WATERLOO VA CLINIC	WATERLOO	**IA**	50701	1	50	NOT OFFERED
BOISE VAMC	BOISE	**ID**	83702	20	36	0
AUBURN GRESHAM VA CLINIC	CHICAGO	**IL**	60620	0	31	NOT OFFERED
BOB MICHEL VA OUTPATIENT CLINIC	PEORIA	**IL**	61615	0	37	0
JAMES LOVELL FEDERAL HEALTH CENTER	NORTH CHICAGO	**IL**	60064	0	13	29
CHICAGO HEIGHTS VA CLINIC	CHICAGO HEIGHTS	**IL**	60411	0	0	NOT OFFERED
DANVILLE VAMC	DANVILLE	**IL**	61832	8	31	0
EDWARD HINES JR. HOSPITAL	HINES	**IL**	60141	0	11	0
JESSE BROWN VAMC	CHICAGO	**IL**	60612	32	13	3
MARION VAMC	MARION	**IL**	62959	3	8	0
ROCKFORD VA CLINIC	ROCKFORD	**IL**	61107	0	0	NOT OFFERED
STERLING VA CLINIC	STERLING	**IL**	61081	0	64	NOT OFFERED
ADAM BENJAMIN JR VA OUTPATIENT CLINIC	CROWN POINT	**IN**	46307	0	27	NOT OFFERED
BROWNSBURG VA CLINIC	BROWNSBURG	**IN**	46112	0	51	NOT OFFERED
EVANSVILLE VA CLINIC	EVANSVILLE	**IN**	47715	6	29	0
FORT WAYNE VA CLINIC	FORT WAYNE	**IN**	46805	12	52	45
JACKIE WALORSKI VA CLINIC	MISHAWAKA	**IN**	46545	99	51	116
LAFAYETTE VA CLINIC	LAFAYETTE	**IN**	47905	0	97	NOT OFFERED
MARION VAMC	MARION	**IN**	46953	37	38	72
MUNROE COUNTY VA CLINIC	BLOOMINGTON	**IN**	47403	0	11	NOT OFFERED
NEW ALBANY VA CLINIC	NEW ALBANY	**IN**	47150	0	52	0
RICHARD ROUDEBUSH VAMC	INDIANAPOLIS	**IN**	46202	0	8	0
RICHMOND VA CLINIC	RICHMOND	**IN**	47374	0	24	NOT OFFERED
TERRE HAUTE VA CLINIC	TERRE HAUTE	**IN**	47803	0	78	NOT OFFERED
WAKEMAN VA CLINIC	EDINBURGH	**IN**	46124	1	79	NOT OFFERED
COLMERY-ONEIL VAMC	TOPEKA	**KS**	66622	8	25	28
EISENHOWER VAMC	LEAVENWORTH	**KS**	66048	0	13	22
HUTCHINSON VA CLINIC	HUTCHINSON	**KS**	67502	0	22	0
ROBERT DOLE VAMC & REGIONAL OFFICE	WICHITA	**KS**	67218	0	21	56

BEREA VA CLINIC	BEREA	**KY**	40403	0	29	NOT OFFERED
FLORENCE VA CLINIC	FLORENCE	**KY**	41042	0	29	NOT OFFERED
FORT KNOX VA CLINIC	FORT KNOX	**KY**	40121	0	52	0
FRANKLIN SOUSLEY CAMPUS	LEXINGTON	**KY**	40511	19	21	1
GRAYSON COUNTY VA CLINIC	CLARKSON	**KY**	42726	0	0	0
GREENWOOD VA CLINIC	LOUISVILLE	**KY**	40258	0	40	0
NEWBURG VA CLINIC	LOUISVILLE	**KY**	40218	0	48	0
PADUCAH VA CLINIC	PADUCAH	**KY**	42001	12	23	NOT OFFERED
ROBLEY REX VAMC	LOUISVILLE	**KY**	40206	18	26	NOT OFFERED
SOMERSET VA CLINIC	SOMERSET	**KY**	42503	0	0	NOT OFFERED
STONYBROOK VA CLINIC	LOUISVILLE	**KY**	40299	0	38	0
ALEXANDRIA VAMC	PINEVILLE	**LA**	71360	0	26	19
LAFAYETTE CAMPUS B VA CLINIC	LAFAYETTE	**LA**	70506	0	98	NOT OFFERED
BATON ROUGE SOUTH VA CLINIC	BATON ROUGE	**LA**	70810	10	25	0
HAMMOND VA CILNIC	HAMMOND	**LA**	70403	0	37	NOT OFFERED
NEW ORLEANS VAMC	NEW ORLEANS	**LA**	70119	4	46	196
SLIDELL VA CLINIC	SLIDELL	**LA**	70460	0	15	NOT OFFERED
OVERTON BROOKS VAMC	SHREVEPORT	**LA**	71101	24	71	32
BROCKTON VAMC	BROCKTON	**MA**	2301	23	41	96
BEDFORD VAMC	BEDFORD	**MA**	1730	9	16	NOT OFFERED
EDWARD BOLAND VAMC	LEEDS	**MA**	1053	10	25	NOT OFFERED
JAMAICA PLAIN VAMC	BOSTON	**MA**	2130	13	15	36
SPRINGFIELD VA CLINIC	SPRINGFIELD	**MA**	1104	0	18	NOT OFFERED
WORCESTER VA CLINIC	WORCESTER	**MA**	1604	51	62	NOT OFFERED
BALTIMORE VAMC	BALTIMORE	**MD**	21201	1	57	42
CUMBERLAND VA CLINIC	CUMBERLAND	**MD**	21502	0	53	NOT OFFERED
BANGOR VA CLINIC	BANGOR	**ME**	4401	0	108	NOT OFFERED
TOGUS VAMC	AUGUSTA	**ME**	4330	16	109	0
BATTLE CREEK VAMC	BATTLE CREEK	**MI**	49037	44	22	0
GLADSTONE VA CLINIC	GLADSTONE	**MI**	49837	0	30	NOT OFFERED
HANCOCK VA CLINIC	HANCOCK	**MI**	49930	0	14	0
IRONWOOD VA CLINIC	IRONWOOD	**MI**	49938	0	0	0
JOHN DINGELL VAMC	DETROIT	**MI**	48201	7	18	0
LANSING VA CLINIC	LANSING	**MI**	48911	0	22	NOT OFFERED
CHARLES KETTLES VAMC	ANN ARBOR	**MI**	48105	19	57	32
MANISTIQUE VA CLINIC	MANISTIQUE	**MI**	49854	0	26	0
MARQUETTE VA CLINIC	MARQUETTE	**MI**	49855	0	63	0
MENOMINEE VA CLINIC	MENOMINEE	**MI**	49858	0	17	NOT OFFERED
SAGINAW VA CLINIC	SAGINAW	**MI**	48603	21	24	42
WYOMING VA CLINIC	WYOMING	**MI**	49519	7	28	NOT OFFERED
BEMIDJI VA CLINIC	BEMIDJI	**MN**	56601	0	95	NOT OFFERED
FERGUS FALLS VA CLINIC	FERGUS FALLS	**MN**	56537	0	0	NOT OFFERED
MINNEAPOLIS VAMC	MINNEAPOLIS	**MN**	55417	0	29	0
ST CLOUD VAMC	ST CLOUD	**MN**	56303	0	7	NOT OFFERED
BRANSON VA CLINIC	BRANSON	**MO**	65616	0	18	NOT OFFERED
FARMINGTON VA CLINIC	FARMINGTON	**MO**	63640	16	14	NOT OFFERED
GENE TAYLOR VETERANS OUTPATIENT CLINIC	SPRINGFIELD	**MO**	65807	1	4	NOT OFFERED
HARRY TRUMAN VETERANS HOSPITAL	COLUMBIA	**MO**	65201	0	38	0
JOHN PERSHING VAMC	POPLAR BLUFF	**MO**	63901	0	18	0
JOPLIN VA CLINIC	JOPLIN	**MO**	64804	0	20	NOT OFFERED
KANSAS CITY VAMC	KANSAS CITY	**MO**	64128	18	12	NOT OFFERED
WEST PLAINS VA CLINIC	WEST PLAINS	**MO**	65775	28	40	NOT OFFERED
BILOXI VAMC	BILOXI	**MS**	39531	1	73	NOT OFFERED
GV MONTGOMERY VAMC	JACKSON	**MS**	39216	1	17	5
GREENVILLE VA CLINIC	GREENVILLE	**MS**	38701	0	8	NOT OFFERED
HATTIESBURG VA CLINIC	HATTIESBURG	**MS**	39402	0	0	0
KOSCIUSKO VA CLINIC	KOSCIUSKO	**MS**	39090	0	0	NOT OFFERED
NATCHEZ VA CLINIC	NATCHEZ	**MS**	39120	0	0	0
BENJAMIN CHARLES STEELE VA CLINIC	BILLINGS	**MT**	59102	0	60	NOT OFFERED
BUTTE VA CLINIC	BUTTE	**MT**	59701	0	0	NOT OFFERED
DAVID THATCHER VA CLINIC	MISSOULA	**MT**	59808	0	0	NOT OFFERED
FORT HARRISON VAMC	FORT HARRISON	**MT**	59636	0	54	0
GLASGOW VA CLINIC	GLASGOW	**MT**	59230	0	0	NOT OFFERED
GREAT FALLS VA CLINIC	GREAT FALLS	**MT**	59405	0	74	NOT OFFERED
HAMILTON VA CLINIC	HAMILTON	**MT**	59840	0	0	NOT OFFERED
KALISPELL VA CLINIC	KALISPELL	**MT**	59901	26	13	NOT OFFERED

TRAVIS ATKINS VA CLINIC	BOZEMAN	**MT**	59715	0	78	0
CHARLES GEORGE VAMC	ASHEVILLE	**NC**	28805	1	49	0
DURHAM COUNTY VA	DURHAM	**NC**	27705	40	40	16
FAYETTEVILLE VAMC	FAYETTEVILLE	**NC**	28301	61	89	NOT OFFERED
FRANKLIN VA CLINIC	FRANKLIN	**NC**	28734	0	71	NOT OFFERED
GREENVILLE VA CLINIC	GREENVILLE	**NC**	27834	16	117	NOT OFFERED
HICKORY VA CLINIC	HICKORY	**NC**	28602	0	24	NOT OFFERED
JACKSONVILLE 4 VA CLINIC	JACKSONVILLE	**NC**	28546	62	40	0
KERNERSVILLE VA CLINIC	KERNERSVILLE	**NC**	27284	0	17	0
MSGT JERRY CRUMP VA CLINIC	FOREST CITY	**NC**	28043	8	32	NOT OFFERED
MOREHEAD CITY VA CLINIC	MOREHEAD CITY	**NC**	28557	0	147	NOT OFFERED
NORTH CHARLOTTE VA CLINIC	CHARLOTTE	**NC**	28213	0	40	NOT OFFERED
SOUTH CHARLOTTE VA CLINIC	CHARLOTTE	**NC**	28208	0	35	0
W.G. HEFNER SALISBURY VAMC	SALISBURY	**NC**	28144	0	41	0
WAKE COUNTY VA CLINIC	RALEIGH	**NC**	27603	68	73	NOT OFFERED
WILMINGTON VA CLINIC	WILMINGTON	**NC**	28405	0	40	0
FARGO VAMC	FARGO	**ND**	58102	14	44	0
GRAFTON VA CLINIC	GRAFTON	**ND**	58237	0	0	NOT OFFERED
GRAND FORKS VA CLINIC	GRAND FORKS	**ND**	58201	0	75	NOT OFFERED
JAMESTOWN VA CLINIC	JAMESTOWN	**ND**	58401	0	49	NOT OFFERED
GRAND ISLAND VAMC	GRAND ISLAND	**NE**	68803	0	28	NOT OFFERED
LINCOLN VA CLINIC	LINCOLN	**NE**	68510	3	30	0
OMAHA VAMC	OMAHA	**NE**	68105	0	41	37
MANCHESTER VAMC	MANCHESTER	**NH**	3104	4	68	NOT OFFERED
SOMERSWORTH VA CLINIC	SOMERSWORTH	**NH**	3878	0	39	NOT OFFERED
ATLANTIC COUNTY VA CLINIC	NORTHFIELD	**NJ**	8225	18	10	NOT OFFERED
CAPE MAY COUNTY VA CLINIC	RIO GRANDE	**NJ**	8242	0	19	NOT OFFERED
CUMBERLAND COUNTY VA CLINIC	VINELAND	**NJ**	8360	0	18	NOT OFFERED
EAST ORANGE VAMC	EAST ORANGE	**NJ**	7018	9	20	0
HOBBS VA CLINIC	HOBBS	**NM**	88240	0	30	NOT OFFERED
RAYMOND MURPHY VAMC	ALBUQUERQUE	**NM**	87108	8	68	0
IOANNIS LOUGARIS VAMC	RENO	**NV**	89502	31	57	42
NORTH LAS VEGAS VAMC	NORTH LAS VEGAS	**NV**	89086	7	14	0
SOUTHWEST LAS VEGAS VA CLINIC	LAS VEGAS	**NV**	89113	42	18	NOT OFFERED
BATAVIA VAMC	BATAVIA	**NY**	14020	0	0	5
BATH VAMC	BATH	**NY**	14810	0	0	NOT OFFERED
BINGHAMTON VA CLINIC	BINGHAMTON	**NY**	13901	0	33	NOT OFFERED
BROOKLYN VAMC	BROOKLYN	**NY**	11209	0	9	0
BUFFALO VAMC	BUFFALO	**NY**	14215	24	30	NOT OFFERED
CANADAIGUA VAMC	CANADAIGUA	**NY**	14424	0	30	0
CASTLE POINT VAMC	WAPPINGERS FALLS	**NY**	12590	15	2	NOT OFFERED
ELMIRA VA CLINIC	ELMIRA	**NY**	14901	0	0	0
ERIE WEST VA CLINIC	SYRACUSE	**NY**	13204	12	34	21
FDR HOSPITAL	MONTROSE	**NY**	10548	0	24	0
JAMES PETERS VAMC	BRONX	**NY**	10468	10	7	0
MARGARET COCHRAN CORBIN VA CAMPUS	NEW YORK	**NY**	10010	5	16	16
NORTHPORT VAMC	NORTHPORT	**NY**	11768	2	18	NOT OFFERED
ROCHESTER CALKINS VA CLINIC	ROCHESTER	**NY**	14623	0	29	0
SAMUEL STRATTON VAMC	ALBANY	**NY**	12208	0	27	0
SYRACUSE VAMC	SYRACUSE	**NY**	13210	4	NOT OFFERED	NOT OFFERED
WATERTOWN VA CLINIC	WATERTOWN	**NY**	13601	0	31	4
AKRON VA CLINIC	AKRON	**OH**	44319	12	12	NOT OFFERED
ATHENS VA CLINIC	THE PLAINS	**OH**	45780	0	0	NOT OFFERED
CAMBRIDGE VA CLINIC	CAMBRIDGE	**OH**	43725	0	17	NOT OFFERED
CANTON VA CLINIC	CANTON	**OH**	44702	6	18	NOT OFFERED
CARL NUNZIATO VA CLINIC	YOUNGSTOWN	**OH**	44504	0	16	NOT OFFERED
CHILLICOTHE VAMC	CHILLICOTHE	**OH**	45601	0	32	0
CINCINNATI VAMC	CINCINNATI	**OH**	45220	20	8	NOT OFFERED
DAVID WINDER COMMUNITY BASED CLINIC	MANSFIELD	**OH**	44906	0	12	NOT OFFERED
DAYTON VAMC	DAYTON	**OH**	45428	28	21	0
EAST LIVERPOOL VA CLINIC	CALCUTTA	**OH**	43920	0	20	NOT OFFERED
LAKE COUNTY VA CLINIC	WILLOUGHBY	**OH**	44094	0	15	NOT OFFERED
LANCASTER VA CLINIC	LANCASTER	**OH**	43130	0	30	NOT OFFERED
LORAIN VA CLINIC	SHEFFIELD VILLAGE	**OH**	44035	5	12	NOT OFFERED
LOUIS STOKES CLEVELAND VAMC	CLEVELAND	**OH**	44106	7	26	85
MIDDLETOWN VA CLINIC	MIDDLETOWN	**OH**	45005	0	29	NOT OFFERED
NEW PHILADELPHIA VA CLINIC	NEW PHILADELPHIA	**OH**	44663	0	13	NOT OFFERED

PARMA VA CLINIC	PARMA	**OH**	44129	0	36	0
PORTSMOUTH VA CLINIC	NEW BOSTON	**OH**	45662	0	26	NOT OFFERED
RAVENNA VA CLINIC	RAVENNA	**OH**	44266	0	15	NOT OFFERED
SANDUSKY VA CLINIC	SANDUSKY	**OH**	44870	0	22	NOT OFFERED
TOLEDO VA CLINIC	TOLEDO	**OH**	43614	19	31	0
WARREN VA CLINIC	WARREN	**OH**	44485	0	21	0
ERNEST CHILDERS VA OUTPATIENT CLINIC	TULSA	**OK**	74133	13	28	NOT OFFERED
LAWTON VA CLINIC	FORT SILL	**OK**	73503	0	18	NOT OFFERED
MUSKOGEE EAST VA CLINIC	MUSKOGEE	**OK**	74403	3	27	NOT OFFERED
OKLAHOMA CITY VAMC	OKLAHOMA CITY	**OK**	73104	3	16	0
PORTLAND VAMC	PORTLAND	**OR**	97239	19	28	0
ROBERT MAXWELL VA CLINIC	BEND	**OR**	97701	0	79	NOT OFFERED
ABIE ABRAHAM VA CLINIC	BUTLER	**PA**	16001	19	18	NOT OFFERED
ARMSTRONG COUNTY VA CLINIC	KITTANNING	**PA**	16201	0	0	NOT OFFERED
BERKS COUNTY VA CLINIC	WYOMISSING	**PA**	19610	0	65	0
CLARION COUNTY VA CLINIC	MONROE TOWNSHIP	**PA**	16214	0	0	NOT OFFERED
COASTESVILLE VAMC	COATESVILLE	**PA**	19320	0	10	63
MICHAEL CRESCENZ VAMC	PHILADELPHIA	**PA**	19104	24	24	0
CRANBERRY TOWNSHIP VA CLINIC	CRANBERRY TOWNSHIP	**PA**	16066	0	21	NOT OFFERED
CUMBERLAND COUNTY VA CLINIC	MECHANICSBURG	**PA**	17055	0	62	0
DUBOIS VA CLINIC	DUBOIS	**PA**	15801	0	15	0
ERIE VAMC	ERIE	**PA**	16504	0	1	0
HUNTINGDON COUNTY VA CLINIC	MAPLETON DEPOT	**PA**	17052	0	35	NOT OFFERED
INDIANA COUNTY VA CLINIC	INDIANA	**PA**	15701	0	69	0
JAMES VAN ZANDT VAMC	ALTOONA	**PA**	16602	4	18	35
JOHNSTOWN VA CLINIC	JOHNSTOWN	**PA**	15904	0	33	0
LANCASTER COUNTY VA CLINIC	WILLOW STREET	**PA**	17584	0	17	NOT OFFERED
LEBANON VAMC	LEBANON	**PA**	17042	10	34	0
PITTSBURGH VAMC	PITTSBURGH	**PA**	15240	12	32	0
STATE COLLEGE VA CLINIC	STATE COLLEGE	**PA**	16801	0	29	NOT OFFERED
WILKES-BARRE VAMC	WILKES-BARRE	**PA**	18711	17	18	NOT OFFERED
YORK VA CLINIC	YORK	**PA**	17402	0	53	NOT OFFERED
EURIPIDES RUBIO VAMC	PONCE	**PR**		0	38	NOT OFFERED
MAYAGUEZ VA CLINIC	MAYAGUEZ	**PR**		72	49	NOT OFFERED
SAN JUAN VAMC	SAN JUAN	**PR**		70	37	31
PROVIDENCE VAMC	PROVIDENCE	**RI**	2908	0	24	0
GOOSE CREEK VAMC	GOOSE CREEK	**SC**	29445	0	53	NOT OFFERED
DANA CORNELL DARNELL VA CLINIC	GREENVILLE	**SC**	29605	16	26	NOT OFFERED
MYRTLE BEACH VA CLINIC	MYRTLE BEACH	**SC**	29577	10	9	0
RALPH JOHNSON VAMC	CHARLESTON	**SC**	29401	2	21	0
WILLIAM JENNINGS BRYAN DORN VAMC	COLUMBIA	**SC**	29209	11	16	17
FORT MEADE VAMC	FORT MEADE	**SD**	57741	24	17	41
HOT SPRINGS VAMC	HOT SPRINGS	**SD**	57747	0	23	NOT OFFERED
RAPID CITY VA CLINIC	RAPID CITY	**SD**	57701	0	45	8
ROYAL JOHNSON VA HOSPITAL	SIOUX FALLS	**SD**	57105	3	21	NOT OFFERED
ALVIN YORK VAMC	MURFREESBORO	**TN**	37129	15	14	NOT OFFERED
CAMPBELL COUNTY VA CLINIC	LAFOLLETTE	**TN**	37766	0	127	NOT OFFERED
CHATTANOOGA VA CLINIC	CHATTANOOGA	**TN**	37421	29	68	0
CLARKSVILLE VA CLINIC	CLARKSVILLE	**TN**	37043	16	15	NOT OFFERED
JAMES QUILLEN VAMC	MOUNTAIN HOME	**TN**	37684	6	14	0
LTC LUKE WEATHERS JR VAMC	MEMPHIS	**TN**	38104	5	19	26
MORRISTOWN EAST VA CLINIC	MORRISTOWN	**TN**	37813	0	22	NOT OFFERED
NASHVILLE VAMC	NASHVILLE	**TN**	37212	44	15	0
WILLIAM TALLENT VA OUTPATIENT CLINIC	KNOXVILLE	**TN**	37919	0	32	0
ABILENE VA CLINIC	ABILENE	**TX**	79606	0	12	NOT OFFERED
AUDIE MURPHY VAMC	SAN ANTONIO	**TX**	78229	13	28	NOT OFFERED
AUSTIN VA CLINIC	AUSTIN	**TX**	78744	24	32	0
BEAUMONT VA CLINIC	BEAUMONT	**TX**	77707	0	49	NOT OFFERED
DALLAS VAMC	DALLAS	**TX**	75216	3	26	0
DORIS MILLER VAMC	WACO	**TX**	76711	11	23	0
EL PASO SOUTH CENTRAL VA CLINIC	EL PASO	**TX**	79905	1	24	NOT OFFERED
GEORGE OBRIEN JR VAMC	BIG SPRING	**TX**	79720	35	8	NOT OFFERED
HARLINGEN VA CLINIC	HARLINGEN	**TX**	78550	26	58	0
KERRVILLE VAMC	KERRVILLE	**TX**	78028	0	23	0
LUBBOCK VA CLINIC	LUBBOCK	**TX**	79415	10	18	NOT OFFERED
MCALLEN VA CLINIC	MCALLEN	**TX**	78501	0	41	NOT OFFERED
MICHAEL DEBAKEY VAMC	HOUSTON	**TX**	77030	19	66	1

NORTH WEST SAN ANTONIO VA CLINIC	SAN ANTONIO	**TX**	78251	27	35	0
OLIN TEAGUE VETERANS CENTER	TEMPLE	**TX**	76504	24	22	18
THOMAS CREEK VAMC	AMARILLO	**TX**	79106	3	10	NOT OFFERED
TOMBALL VA CLINIC	TOMBALL	**TX**	77375	0	45	NOT OFFERED
WICHITA FALLS VA CLINIC	WICHITA FALLS	**TX**	76306	0	66	NOT OFFERED
WILSON AND YOUNG MEDAL OF HONOR CLINIC	ODESSA	**TX**	79765	0	0	NOT OFFERED
GEORGE WAHLEN VAMC	SALT LAKE CITY	**UT**	84148	30	26	NOT OFFERED
OGDEN VA CLINIC	SOUTH OGDEN	**UT**	84403	0	64	32
FREDERICKSBURG 2 VA CLINIC	FREDERICKSBURG	**VA**	22408	0	66	NOT OFFERED
HAMPTON VAMC	HAMPTON	**VA**	23667	26	20	20
HARRISONBURG VA CLINIC	HARRISONBURG	**VA**	22801	0	40	NOT OFFERED
MASSAPONAX VA CLINIC	FREDERICKSBURG	**VA**	22407	0	85	NOT OFFERED
NORTON VA CLINIC	NORTON	**VA**	24273	0	1	NO
RICHMOND VAMC	RICHMOND	**VA**	23249	41	48	26
SALEM VAMC	SALEM	**VA**	24153	0	41	76
BURLINGTON LAKESIDE VA CLINIC	BURLINGTON	**VT**	5401	0	1	NOT OFFERED
NEWPORT VA CLINIC	NEWPORT	**VT**	5855	20	0	NOT OFFERED
WHITE RIVER JUNCTION VAMC	WHITE RIVER JUNCTION	**VT**	5001	0	27	NOT OFFERED
AMERICAN LAKE VAMC	TACOMA	**WA**	98493	13	12	5
SEATTLE VAMC	SEATTLE	**WA**	98108	4	35	16
VANCOUVER VAMC	VANCOUVER	**WA**	98661	28	40	0
BARABOO VA CLINIC	BARABOO	**WI**	53913	0	0	NOT OFFERED
CLEMENT ZABLOCKI VAMC	MILWAUKEE	**WI**	53295	41	25	51
TOMAH VAMC	TOMAH	**WI**	54660	0	30	NOT OFFERED
WAUSAU VA CLINIC	ROTHSCHILD	**WI**	54474	0	9	NOT OFFERED
WILLIAM MIDDLETON VETERANS HOSPITAL	MADISON	**WI**	53705	8	23	0
BECKLEY VAMC	BECKLEY	**WV**	25801	0	45	0
HERSHEL WOODY WILLIAMS VAMC	HUNTINGTON	**WV**	25704	0	26	0
LOUIS JOHNSON VAMC	CLARKSBURG	**WV**	26301	0	27	0
MARTINSBURG VAMC	MARTINSBURG	**WV**	25405	0	40	0
PETERSBURG VA CLINIC	PETERSBURG	**WV**	26847	0	63	NOT OFFERED
CHEYENNE VAMC	CHEYENNE	**WY**	82001	0	80	0
SHERIDAN VAMC	SHERIDAN	**WY**	82801	0	28	0

Questions for the Record

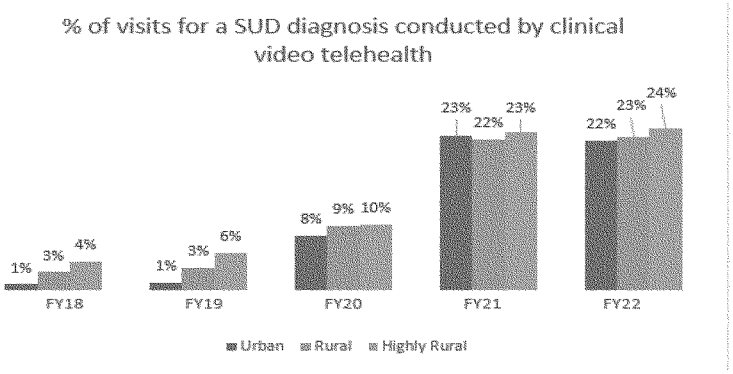
Department of Veterans Affairs (VA) Questions for the Record
From a Hearing Titles
"Connections to Care: Improving Substance Use Disorder Care for Veterans in Rural America and Beyond:
Committee on Veterans' Affairs
United States Senate

June 14, 2023

Questions for the Record from Senator Kyrsten Sinema

Question 1: 1 in 10 veterans in Arizona use substances to cope with trauma, depression, and anxiety. Staffing shortages have implications for the quality and timeliness of care we are able to provide. As staffing shortages, particularly in rural areas, continue, how is VA prioritizing timely care for mental health services in situations where staffing is slim?

VA Response: Of the more than 550,000 Veterans currently receiving substance use disorder (SUD) care from the Veterans Health Administration (VHA), VA treated a total of 124,275 rurally located Veterans with alcohol use disorder (AUD) and 66,439 rurally located Veterans with drug use disorders through the second quarter of fiscal year (FY) 2023. Historically, most SUD care was provided in person. Highly rural and rural patients adopted clinical video health for SUD treatment at higher rates pre-pandemic. In FY19, rates of clinical video telehealth visits for a SUD diagnosis ranged from 1-6% for urban, rural, and highly rural patients. The COVID-19 pandemic led to rapid and sustained increase in use of clinical video telehealth for SUD care in urban, rural and highly rural settings. In both FY21 and FY22, overall use of clinical video telehealth in visits for a SUD diagnosis was between 22-24% regardless of rurality. SUD funding is currently supporting telehealth-delivered SUD services in rural settings through attachment of SUD positions to several clinical resource hubs (CRH) and local VA medical center (VAMC) telehealth initiatives.



Regarding rural hiring efforts, VA relied on locally assessed need for clinicians across the enterprise. Hiring clinicians for telehealth positions (including at CRHs) helps ensure that care is available regardless of geography, either via video-telehealth or phone alone. Of the over 1,100 positions approved as part of SUD expansion, 149 are rural positions, of which 68 are onboard as of June 13, 2023. In addition, SUD funding supported 43 telehealth positions with a focus on serving Veterans who had challenges accessing face-to-face care (including rural populations). Of those 43 positions, 29 are onboard.

VA's Office of Rural Health (ORH) supports national SUD treatment initiatives. In FY 2023, ORH provided more than $5.3 million to support telehealth services for Veterans with SUDs. These telehealth services were provided through 48 VAMCs. ORH is providing more than $6.3 million to enhance access for Veterans experiencing SUD who live in rural areas with Clinical Pharmacist Practitioners (CPP). CPPs increase patient access, improve quality of care and decrease provider burden through the delivery and optimization of comprehensive medication management services for rural Veterans. This program connects Veterans to timely and appropriate care with 64 CPPs at 52 facilities hired to provide SUD care within the CPP Rural Veteran Access (CRVA) Project. VA has completed 129,078 SUD visits by CPPs in rural health projects.

The CRVA Mental Health Rural Expansion Access and Coordinated Health Efforts in SUD Project will extend on past efforts and integrate CPPs into Primary Care Mental Health Integration and Behavioral Health Interdisciplinary Program areas beginning in FY 2024. This project will seek to achieve the quintuple aim of access, quality, patient satisfaction, provider experience and health equity and is dedicated to expanding care to rural Veterans.

<u>Question 2</u>: While a long waitlist undoubtedly discourages veterans from seeking help in our VA facilities, there are many other social and institutional factors that may be preventing veterans from seeking the care they need. What can Congress and VA do to ensure veterans are made aware of the benefits available to them?

VA Response: VA has undertaken its largest outreach initiative in its history in support of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (P.L. 117-168), which was enacted on August 10, 2022. This has included specific outreach to eligible—but not yet enrolled—Veterans through earned, owned and paid media efforts. Our messaging is focused on the expanded eligibility for health care and other benefits among new segments of the Veteran population. Each VAMC continues to stage multiple outreach events this year, including a special effort during July 2023 (more than 130 local events), to reach Veterans in specific zip codes where there is a high presence of these non-enrolled Veterans. VA's paid advertising campaign communicates to Veterans, their families and influencers broadly through TV, radio, social media, search and digital means, and includes special marketing toward Veterans of color, Tribal Veterans, women Veterans, homeless Veterans, LGBTQ+ and Veterans with other-than-honorable discharges. For example, there were events in Tucson and Page, Arizona where staff assisted Veterans applying for benefits, completing toxic exposure screenings and enrolling in VA health care. VA is also reaching out to eligible Veterans individually through a direct marketing campaign (email and mail) during June and July 2023.

To further ensure VA can reach every eligible Veteran, Congress could continue to fully support VA's appropriations request. VA is grateful for the support of Congress and appreciate Congressional staff's involvement with offsite events and the Committee's side-by-side relationship.

Question 3: We know that substance use and mental health disorders are often co-occurring. In situations where treatment may require shared decision-making, how is VA approaching holistic treatment that considers all medical and non-medical factors, and how can the VA improve this approach to minimize relapses?

VA Response: VHA Directive 1160.04, *VHA Programs For Veterans With Substance Use Disorders*, includes requirements pertaining to treating Veterans with co-occurring SUD and mental health disorders, as well as a shared decision-making approach to SUD care. Care is not time-limited, and treatment for co-occurring mental health, medical and psychosocial concerns is provided regardless of the current status of the Veteran's SUD diagnosis or current substance use.[1]

All specialty SUD programs and services are designed to meet the needs of Veterans with a SUD diagnosis, particularly those Veterans with new onset, unstable, severe or complex SUD conditions (e.g., co-occurring mental health and medical conditions). As such, specialized SUD programs must have the capacity to offer harm reduction services, identify co-occurring conditions, provide concurrent treatment and arrange appropriate follow-up care when indicated.

[1] https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=10070.

VHA Directive 1160.04 identifies shared decision-making (SDM) as a formal communication process for consensus building between a VA health care provider and patient when multiple evidence-based treatment alternatives exist to treat the patient's condition or problem. The provider and patient jointly participate in the process to arrive at a clinical decision or treatment plan. SDM requires the following three components: 1) clear, accurate and unbiased medical evidence about reasonable alternatives, including no intervention and the risk and benefits of each; 2) clinician expertise in communicating and tailoring the evidence for individual patients; and 3) patient values, goals, informed preferences and concerns, which may include treatment burden.

In addition, VHA is transforming from a traditional disease-based model to a system focused on empowering and equipping Veterans to take charge of their health and well-being and live their life to the fullest. The Whole Health model of care is a shift from episodic points of clinical care, primarily focused on disease management, to one that is based on a partnership with Veterans across time focused on whole health. This approach expands upon the traditional medical model to include a comprehensive continuum of care, suicide prevention services and other resources to empower and equip Veterans to take charge of their own health and wellbeing in support of their personal goals.

Department of Veterans Affairs
July 2023

Statements for the Record

Statement of Record

Forge VFR

Connections to Care: Improving Substance Use Disorder Care

For Veterans in Rural America and Beyond

It is clear that Substance Use Disorder (SUD) has a direct correlation with Veteran suicide. The 2022 National Veteran Suicide Prevention Annual Report, reporting numbers from 2020, shows that while between 2001 and 2020 the overall trend in Veteran suicide among individuals with a *known* SUD is down, we see the rate per 100,000 increased between 2019 and 2020[1]. This trend is alarming, as it is well understood by those who serve Veterans that the *known* SUD diagnosis is not an accurate representation of SUD among the Veteran population. Alcohol use in the military is engrained in our culture. We use alcohol to celebrate, to mourn, to commemorate and to reward. It would be naïve to suggest that this alcohol use disorder doesn't lead to other substances, including cannabis, opioids and hallucinogens. Furthermore, we need to understand the separation from service for failing drug tests does not always result in a dishonorable discharge or legal involvement. There are Veterans who were separated from service for substance use who are eligible for VA health benefits, and there are separated service members who do not have VA benefits with a SUD. Those who suffer from a SUD continue to do so upon separation from service, even if undiagnosed prior to separation.

Substance Use Disorders among Veterans are often associated with other health conditions. Substance use can be used as a coping mechanism for those suffering from Post Traumatic Stress, those that suffered from Military Sexual Trauma, as well as those suffering from physical pain stemming from service-connected

[1] Office of Mental Health and Suicide Prevention, 2022 National Veteran Suicide Prevention Annual Report, pg 26 § (2022).

injuries. Substance use diagnosis among "recent veteran users" rose from 27.9% in 2001 to 41.9% in 2020. [2] We know this, and even have a term for this, "self-medicating." The issue we face is how to alter this state of self-medication. And the answer to that must be access to care.

Under the MISSION ACT of 2018, current access standards for behavioral health care services, including substance use treatment, require the VA either provide an appointment within 20 days of request for care, and that this appointment be at a facility within 30 minutes of average drive time. Unfortunately, these standards are not equally met in all facilities, resulting in Veterans reporting wait times upwards of 30 days or more to begin needed treatment. Additionally, the MISSION ACT leaves room for Veterans to agree to waiting beyond these limits, without requiring the Veteran be made aware of their rights to care in the community.[3] When given no alternative offer, Veterans will often accept the appointment being offered beyond these standards under the impression that there is no alternative available. Finally, the Veteran has the right to request care in the community when it is agreed that it is in the best medical interest of the Veteran to receive community care, however the process for determining what is in the best medical interest of the Veteran is not specified, leading to different processes implemented in VAs around the country. We have all heard the saying "If you've seen one VA, you've seen one VA." While this colloquial saying helps diffuse contentious discussions, it does nothing to enforce uniformity in regulation among VA locations, leaving Veterans to have aggressively different experiences from VA to VA, and even from provider to provider within the same VA. Without frequent reporting on the usage of the Community Care Network (CCN), we are unable to determine trends in CCN referrals among facilities and the impact these referrals can have on wait times for Veterans, which was one of the primary intentions of the MISSION ACT.

[2] Office of Mental Health and Suicide Prevention, 2022 National Veteran Suicide Prevention Annual Report pg 27 § (2022).
[3] "VA Launches New Health Care Options Under Mission Act," VA News, June 6, 2019, https://news.va.gov/press-room/va-launches-new-health-care-options-under-mission-act/.

Veterans, as a population, are often resistant to reaching out for care, especially for behavioral health care. When Veterans do finally reach out, it is often at a time near crisis, or in crisis. While emergency care is available, and actions such as the COMPACT ACT work to increase access to emergency care, preventative care continues to be a difficult level of care to access. Getting a Veteran into an outpatient or intensive outpatient level of care is more cost effective for the VA and can prevent a SUD from becoming a crisis. The right care, at the right time, at the right place needs to be the standard practice implemented to prevent crisis from occurring. Emergency care is an important tool but should not be the primary focus.

Additionally, the MISSION ACT authorized the "Anywhere to Anywhere" telehealth approach for the VHA. This allows for the VA to utilize any and all internal providers for care via telehealth, regardless of location to the client. The same way that Veterans are a community within the community, regional differences can make care difficult at times. By choosing to utilize providers outside of the Veterans local community in lieu of utilizing the CCN, Veterans are forced into a telehealth treatment with an individual that may not understand their local culture. This ability to cross state lines for care is unique to the VA, and circumvents state laws that restrict the private sector, without the states having control.

Substance Use Disorder remains prevalent among active-duty service members and continues when service members separate. Access to care for behavioral health treatment can prevent an active SUD from becoming a crisis. This rings true in densely populated urban areas as well as rural and highly rural areas. The location in which a Veteran life should not impact the quality of care they have access too. Getting access to culturally competent, local care in a timely manner can prevent Veteran suicide. Ensuring this standard is equally implemented throughout the VHA system needs to remain of the utmost importance.

FORGE VFR

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June 12, 2023

Members of the Senate Veterans Affairs Committee,

Thank you for taking the time to read this personal statement in relation to the hearing discussing substance use disorders in military veterans and at the request of the HunterSeven Foundation. I cannot speak on behalf of the entire veteran community, but I can share my personal, painful, experiences. I wrote this in my "sobriety journal," which is hundreds of pages of moral injury, stories of overdosing in bathrooms, attempts at suicide, and the painful reality we face daily. Written in 2018, I was 32 years old.

I am a Special Missions Unit veteran,
I am a wounded, combat veteran,
I am a father, I am a son,
I am an **addict**.

The first time someone tried to kill me, I felt many emotions. I felt fear. I felt anger. I was worried about my teammates. Then there was confusion. I was not expecting to be *confused*. My confusion was surrounded by motivated hate. The longer you spent downrange, the more determined you became to get home. **Amidst all the confusion and fear, I also felt alive.**

I felt wired because every moment you are being shot at, you are harmoniously, breathtakingly alive in the most barbarically instinctual way imaginable. You are introduced to a high you will **forever** chase. It is your first love; it's also your first **addiction**. Every single day something is blowing up. Every day your brain rips apart a little more. Gunshots tear up your memory, and IED blasts ruin your functioning. They chew holes into spots that used to be filled. That's where your identity used to be. You lose grip on your past, have trouble functioning in the present, and cannot fathom planning a future. Writing a sentence takes twice as long as I struggle to place this pen on the paper. Phone conversations send shards of metal piercing into my eardrum and deep into my brain.

I always thought I was crazy, but I have a ***broken brain***. I died at war. The old me left everything I knew to go to war. I never came home.

The son my parents knew, the brother my siblings knew, and the caring, passionate man my girlfriend knew… he never came home. Since I didn't die, what else would you call it? I liked the old me, but the old me died, covered in the blood of others. He died from the blasts, died staring down the barrel of my gun. The new me is crazy and anxious and can't remember. The new me lost all love; the new me runs, and the new me avoids. The new me remembers enough about the old me to miss him and resent the monster I've become. Those who miss the old me stand before the new me and feel my loss even though I am standing there. Everyone who knew the old me wants him back; they don't like who I've become, and no one wants to be around the new me… especially me.

Every day, I live with that. Over and over, the same smell, the same heat, the language, the women yelling in the streets, there is nothing sweet about it; it's all spoiled misery, and I was their unwelcomed company. For the most part, I was okay with it…

The static covers my brain. All I see is white… where am I? What is happening?

I am in the lead vehicle, dismounting to open the door to a skeleton. Or what is left of him. There are pieces of his skull, his torso fused to his plating; you can't hear anything besides the air zipping by your head, and you cannot see anything else but the misplaced chunks of hair and flesh tossed on the truck interior. You turn back to see the flames and flashes and hope that one accurately placed round will end your misery. Through the flashbacks, binge drinking, drug overdoses, addiction, and contemplating suicide attempts. WHAT IS GOING ON WITH MY BRAIN? Last night, I sat in my cot, and across the room, sitting in the chair, was a young girl covered in blood. Why is that farmer from the Hajj mart dead in my

shower? Their eyes stay with me. They are all black. Their monstrous eyes pierce through my soul. No colors. Just black. I loved owning the night, but with the night came the darkness.

Like most, I felt most comfortable and in control in combat. You wake up and expect to die; you ***commit to death***, and punch your ticket before stepping off the objective for another mission. You ran the scenarios in your head, and once the rush was gone, you became a drunken, drug-abusing, narcissistic human being who could barely make it through the day. I didn't have much of anything going on, on the inside. So, I had to make up for it on the outside. I went from being a top performer on the team, and a respected professional, to becoming a nuisance and a burden who created more work and problems for everyone around me. It is a difficult concept for me to understand.

Simply, I exist from second to second. As I said earlier, there is no meaning to my past, my present is intolerable, and honestly, I don't expect my future to exist. When the sadness and brutal depravity of this world are laid at your feet and you find yourself sinking knee-deep, embedded within it rather than above, what hope do you really have?

All my shattered, spent, halfhearted actions have produced nothing but sadness, disappointment, and misery to those who I love. Do we endure? Do I endure? Do I tolerate this life I am plummeting into? Do we… do I let go of all things? I should remove my attachments. My Resentments. My Possessions. Even my loved ones. Should they do that so I can be free of pain and suffering? But what if I am already completely and utterly emotionally ***detached from this world***, I've invested in nothing. I am not even investing in myself. I should be steps away from freedom, right?

The old me is gone, and she hates the new me… "*Pull the damn trigger, end my life, end my misery… clean the goddamn walls and get on with your life.*"

Deep down, I knew a part of her wanted to end it all, her stress, the drug abuse, end the nightmares. But no, I'm on my own. In the darkness, I own the night. I am **high up again**, much to her dismay. I am walking down into the basement. It's cold, damp, and dark but quiet—bone-chilling silence.

When it's dark, the darkness brings them back, I see them, I see their dark, black beady eyes. I hear their voices, their screams. I feel their blood. I sat there facing the wall, staring at the hole in the concrete. In an instant, I am back on the streets of Baghdad, the same hole from the blast that killed my brain. The darkness, the shadows, the numbing sound of silence, everything is quiet… except their voices. I don't know where I am. I can't tell if the smell is from freshly spilled blood in the heat of the night or leaking rusted pipes. I am holding the shotgun under my chin, the cold sensation of steel sending chills down my spine, familiar chills, chills from death, chills that know when death is near. Safety off, finger on the trigger. This is where I'll die, not in a firefight like Rabbit, not in an ambush like Top, not in the war, but in a dark, cold basement… buttstock on the ground, resting my head on the muzzle, hand gripping the barrel, thumb on the trigger.

…but I didn't pull the trigger.

And then I found myself here. Writing this to you. Writing about my pain. About my… addiction.

The darkness. The dark companion you'll always have, either assimilate or go absolutely bloody insane. I found love for Benzos in the teams; it took the edge off the steroids. Now a sudden, civilian navigating the system, I find myself in front of a VA doc who made it seem as if I was wasting his time. Rushing through a medication list he prints me off: *"In the morning: Adderall, Xanax, Gabapentin, Ropinirole, Pantoprazole, Tramadol for hypersensitivity, anxiety, nerve pain, restless leg, and acid reflux"*, with a blank stare, he continues on, "*in the afternoon, Xanax, Gabapentin, Ropinirole and Soma… you know what they are for,*" and then he finishes with, "*before bed take Trazodone to help you get to sleep, Xanax, Gabapentin and Ropinirole again, Zoloft and Prazosin for your nightmares…*" If I weren't going to kill myself, surely this chemical cocktail would kill me.

In 2018, that is where I was, full-speed, suicidal. Coming home to an empty house, everyone in my life had left, and only at the expense of myself, only I was to blame. I lost the brightness in my life, and I only had the darkness and the chemical cocktail to thank. I was angry and upset at those strangers around me for being disconnected from human life. They reminded me of preschoolers, kicking and screaming, running around with no purpose or motive while assuming

they are the most important know-it-alls. Our American way of life is so disconnected that it is tough for me to find where I can connect into it all. We are a severely detached and divided nation, and for once, I actually missed Afghanistan. I missed the tribal feeling, the one-mission, one-goal those men and those women had. Their connections with one another are truly admirable. It sucks knowing you will never meet the caliber of men you met at war. **Never.**

But I was "home", and my "welcoming" came with a brutal hit to rock bottom. You'll either learn to cope, or you'll kill yourself. So, I decided to immediately cease the V.A. prescribed cocktail all at once. For I knew, the next bottom that I would hit would certainly be death.

This rock bottom came hard and fast, and I was alone. Quitting everything at once is something I'd never recommend to anyone. I laid in pain. Tossing and turning. Crying on the cold floor of an empty apartment. Changing my sweat-soaked clothes and shivering, vomiting, and keeping my Glock 19 nearby.

I don't know what physically pained me most, detoxing or the ***darkness***.

I suffered in pain for fourteen days. I cried for hours, over the guilt and the urge to escape came over me.

On the fifteenth day, I drove from New York to Jacksonville, Florida, to enter a private, inpatient rehabilitation facility for 30 days. If I didn't do this, I was going to die.

I moved to the oceanfront city to find "myself" again, to try and fix my broken brain. This time I wasn't alone. From meetings to working out, running the beach every morning, and learning new skills. I kept busy, but a purposeful busy.

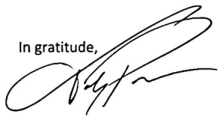
Two years later, and I still hold to that. I am purposefully busy. I live by the values that encompass a stoic, virtuous man. I show up every day. I value myself. I have a renewed sense of purpose. Am I perfect? Hell no. But I continue to invest in myself. I set short-term goals and conquer them; for the first time in a long time, I have ambitions for the future. I own my time. I know that time is precious and limited.

I am sober.

I've found that when you love your flaws and imperfections, are entirely self-reliant, and depend on no one and especially no substance; you will create your own '*brightness.*' If anything I've written connects with you, I challenge you to follow that path. Just fight the urge to do it alone, and don't go cold turkey, but get sober. Find a therapist and a care team that will take you seriously, especially those actively finding ways to heal our TBIs, mental health concerns, and addiction. Exercise, do yoga to help with the pain, meditate, and find others who understand. Reach out to those that have already started that mission. You must be on a mission to heal yourself, your brain, and your soul, all together, holistically. I challenge you to find ways to build a new tribe, have fun, take action, create change, and always move to become a better version of yourself actively. We are leaders. Be heard when you aren't speaking. Be present when you aren't there.

In closing, I ask you to consider opening availability to my brothers and sisters in arms to seek substance use care and treatment where they are and when needed so they do not drive 15 hours to receive a holistic, whole-body approach to care.

In gratitude,



T. Paul Provenzano