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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.