5218 Rollins Avenue
Jacksonville, FL 32207

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Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, N.W., Ste. 300
Washington, DC 20036

To Whom it May Concern,

I contend the conclusion arrived by the Departments of Veterans Affairs report regarding the Allegation #1 that I made as a whistleblower as indicated on the subject report. The investigation did not clearly set out the facts of the case when concluding that Veterans are obtaining "necessary mental health services" by the Jacksonville Substance Abuse Treatment Team (SATT) Clinic, North Florida/South Georgia Veterans Health System, and that Veterans have not been "negatively impacted in any way" by the agency. First, the current process of assignment and treatment of Veterans does create an excessive caseload size for a qualified and licensed social worker who is required to engage in substance abuse treatment standards established by VHA policy and professional standards of practice. Secondly, the electronic health records clearly show that the great majority of Veterans served by the SATT clinic disengage from the program due to ineffective case management and/or are prematurely discharged without a well-articulated clinical judgment to prevent a drastic relapse of addiction and overall worsening of wellbeing. In the next paragraphs, I describe the expectations of case management for a substance abuse treatment program as outlined by VHA guidelines and policy, which are clearly aligned with the professional standards of practice. In doing so, I'm also describing how ineffective case management, carried out by the SATT clinic, have caused severe poor health outcomes in a population of Veterans in dire need of effective treatment. Moreover, I outline in the next paragraphs, with support of VHA guidelines and policy, how the lack of effective social work case management has caused unnecessary hospitalizations, the prevalence of chronic addiction, emergency health situations, and high risk of suicidality.

My caseload grew drastically as I was following professional standards of practice that does not allow for a premature discharge of Veterans from the program. "Access to necessary mental health services" mean that Veterans are provided effective services within an adequate time frame to prevent the health impacts and negative outcomes that I witnessed while working in the SATT clinic. Let me be clear, a Veteran diagnosed with substance abuse and a comorbid serious mental health disorder (i.e., PTSD, Bipolar disorder, personality disorder, etc.) requires a comprehensive case management and treatment plan that usually lasts an average of 6 months because of the clear expectations laid out by VHA policy and the professional standards of social work case management.

The provision of professional social work case management cannot be performed by psychologists, addiction therapists, and not even a psychiatrist. VHA policy is aligned with the professional standards of the social work profession in the establishment of advanced social work case management. Although some of the knowledge and activities might overlap with the provision of case management by other

professions such as nurses and addiction therapists, social work case management requires an advanced level of training, education, and yearly continuing education standards that allow for continued licensing requirements. When a psychologist and an addiction therapist are authorized to provide this level of case management intervention without the required professional advanced knowledge and yearly training for case management, Veterans are negated the "necessary mental health services" in the SATT clinic. Without the above premises, a SATT clinic that does not have an adequate amount of licensed master level social workers will lead to service deliveries in which Veterans have poor outcomes that lead to unnecessary hospitalizations, the prevalence of chronic addiction, emergency health situations, and high risk of suicidality.

Title 38 U.S.C. 1706, Management of Health Care, is the Federal statute that mandates the VA "to the extent feasible, design, establish and manage health care programs in such a manner as to promote cost-effective delivery of health care services in the most clinically appropriate setting." As such, a substance abuse treatment clinic for Veterans with comorbid serious mental health disorders need professional and advanced social work case management services to provide the most clinically appropriate setting. In implementing the statue, the VHA, as outlined in VHA Directive 1110.04(1), requires substance abuse treatment facilities to have "the qualitative determination of case management level based on a Case Manager's clinical judgement" while following the tiers of case management model as outlined in the same directive. As an example, a Veteran struggling with both severe alcohol use disorder and bipolar disorder, and experiencing financial difficulties, would require intensive social work case management that requires weekly meetings and extensive collaboration with medical staff and Transition Case Management (TCM) services. When such Veterans are prematurely discharged from the SATT clinic by a case manager, they come back with worsening addiction, and high risk of suicidality. If case managers are contacting these Veterans once a month, without articulating a clinical judgement based on policy and practice standards, the patients are not having access to the "necessary mental health services." This risky situation is normalized in the SATT clinic because the need for intensive/stabilization social work case management is not accounted for when establishing the allotted bookable clinic hours in establishing an appropriate caseload. When I was employed at the clinic as a SATT social work case manager, the SATT supervisor directed me not to schedule weekly appointments with the population of Veterans with the highest risk of negative health outcomes. It was explained to me that "we don't have enough case managers to see Veterans on a weekly basis." By doing so, the SATT supervisor was bypassing the authority of the VHA Directives. The agency investigation failed to review the standard and guidelines used by VHA policy (VHA Directive 1110.04), which is required to be followed by the case managers to make the clinical decision regarding the frequency of case management interventions. Instead, the investigation relied on the local guideline created by the Jacksonville SATT clinic, and concluded in the report that the Outpatient Program Traditional (OPT) "requires active participation at least weekly and at least monthly case management." With such a vague guideline, the case managers in the SATT clinic have opted to engage in monthly case management only, unless Veterans are enrolled in the Intensive Outpatient Program (IOP).

The investigation clearly revealed that only Veterans enrolled in the Intensive Outpatient Program (IOP), were expected to have weekly meetings as needed. Although IOP might be one of the main components for delivery of services for substance abuse treatment, VHA policy and professional standards don't allow it to be used as a bench mark for frequency of delivery of case management

services as well as for discharge criteria from comprehensive substance abuse treatment. For example, many Veterans with substance abuse disorder with comorbid military sexual trauma are not ready to engage in a group setting so the case manager must provide therapeutic services as part of an individual treatment plan while collaborating with other necessary programs within the VA. Moreover, graduation of IOP does not equate readiness to change addictive behavior unless clinically established

I decided to continue with a hard-to-manage and increasing caseload because the SATT leadership assured me that support staff for scheduling was in the process of being hired as well as the possibility of hiring a new case manager/social worker. I was hoping that freeing up 25 percent of the time, in my estimation, in scheduling activities would allow me to keep up with increasing workload and caseload while waiting to transfer cases to a new hired case manager. In the past few months leading to my resignation, the leadership made it clear that there are no plans to hire a scheduler or case manager to support what the clinic supervisor recognized as a very high workload. The wrongly mandated indefinite caseload, increased by an assignment of 3 to 4 new Veterans per week, did not allow me to meet the professional, clinical, and ethical standards of delivering effective and efficient social work case management services and clinical care required by both the complexity of cases at the Jacksonville SATT clinic and VHA case management process standards as outlined in VHA Directive 1110.04. The ineffective case management practice of not meeting with the great majority of Veterans who meet criteria for weekly intensive intervention and discharging them from the program prematurely, without an appropriate clinical justification, in order to avoid an unmanageable caseload per case manager, is causing multiple hospitalizations for emergency detox services, worsening of symptoms, increase in suicidality, poor retention of patients, and poor patient engagement in treatment.

The report mentioned that the "Outpatient Program Traditional (OPT) is an 8–12-week program designed to meet the needs of Veterans who have typically completed a higher level of addictions care…" The report indicates that the above information comes from the Jacksonville Substance Abuse Team Clinic, Scope of Practice. July 25, 2019. The investigation is not expected to use a local guideline created by a specific specialty clinic to override general VHA policy. This is irresponsible at best. As far as I know, based on my extensive research of policies and professional practice guidelines, the SATT clinic projected time frame of 3 to 4 months is not supported by any policy or professional guideline. I suspect the VA investigation was not able to find any support for this localized guideline either. The time frame to justify continuation of services in any substance abuse treatment facility is a "clinical judgement" decision as stated by policy and ethically justified through the professional articulation of progress notes in the electronic health records. "The duration of treatment [for this population of patients] is clinically determined based on patient symptoms and functioning…"- VHA Handbook 1160.04 (b)(2). It is not determined by mental health productivity targets as purported in the report.

Rather than applying the mandated case management tiers or levels of care, the SATT clinic is using a model of case management not compatible with VHA policies. Instead of setting a minimum requirement to meet with veterans once a month, unless they are enrolled in IOP, this needs to happen based on required case management level as per VHA Directive 1110.04 (8)(c). In other words, the SATT clinic is placing all Veterans who are not currently enrolled in IOP in the same basket of monthly follow-ups (scheduled clinical appointments) without regard to clinical need. It is important for leadership to understand and to make sure the SATT clinic follows the below model presented by the policy (VHA Directive 1110.04) in order to appreciate the need for establishing a manageable caseload size per case

manager notwithstanding the VHA work productivity policy under VHA Directive 1161. The following is the applicable excerpt from the policy:

> VHA CM Programs further stratify Veterans receiving complex care coordination into "tiers" or "levels" per the type of CM interventions and corresponding "frequency of contact" (e.g., weekly, monthly, and quarterly) by the Case Manager. The qualitative determination of CM level is based on a Case Manager's or LC's clinical judgement and is applied in conjunction with their respective program's administrative requirements…The CM tiers or levels include:
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> (a) Intensive CM. Intensive CM requires at least weekly Veteran contact and family or caregiver contact, as appropriate, whenever there is transition of care or major change in the Veteran's clinical, psychological, functional status, such as: new diagnosis, newly identified cognitive and/or behavioral change, notable change in lifestyle, and/or major access to care concerns. It entails maximum assistance with system navigation and biopsychosocial support from a Case Manager to regain stability.
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> (b) Stabilization CM. Stabilization CM requires at least two times per month Veteran contact and family or caregiver contact, as appropriate, to support the Veteran's ability to gain stability following their transition of care or major change in clinical, psychosocial, functional status. It entails moderate assistance with system navigation and biopsychosocial support from a Case Manager to maintain stability and progress.
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> (c) Progressive or Maintenance CM. Progressive or Maintenance CM requires, at least monthly Veteran contact and family or caregiver contact, as appropriate, to ensure a support system and plan of care is in place. The Veteran is clinically stable, but still needs ongoing intervention for psychosocial or other clinical issues to ensure continuous coordination of care and access to services.

The vast majority of Veterans referred to the Jacksonville SATT clinic requires intensive or stabilization case management (weekly or semi-monthly follow-up appointments). With an average of 3 to 4 new patients or established patients with new problems assigned to each case manager per week, the agency cannot expect a case manager to move through complex cases in an expeditious way to avoid a drastic increase in caseload size and without breaking away from professional, ethical, and clinical standards of both the social work field and case management services as they are outlined in the corresponding VHA handbooks and directives. According to VHA Handbook 1160.04 (3)(b), "the clinical complexity of Veterans who are treated for SUD [Substance Use Disorder] in VA clinics often may have significant complicating features, including: (1) psychosocial deficits including homelessness, unemployment, and lack of social support for recovery; (2) comorbid anxiety disorders, such as Post-Traumatic Stress Disorder (PTSD), panic disorder, and general anxiety disorder; (3) depressive disorders, including major depressive disorder and dysthymia; (4) psychoses, including schizophrenia and bipolar disorder; and (5) Other general medical disorders." One or more of these psychosocial features are present in almost all the patients referred to the Jacksonville SATT clinic; therefore, the treatment coordinated by the case managers should last up to 6 months. Otherwise, the same Veterans are

bounced around different case managers as the SATT clinic electronic health records show. The agency investigation and the SATT clinic irresponsibly assumes that delivery of care for cases with such clinical complexity, as defined above by the VHA handbook, can be easily managed by a system that uses productivity measures with well defined blocks of hours spent with the Veterans.

According to the report, "the 32 bookable hours include 4.5 hours per week for new Veterans appointments (90 minutes each)." The report failed to account, and it seems the SATT clinic purposely failed to report, that at least 1 to 2 daily new appointments entail management of Veterans in crisis. An effective crisis management intervention in the SATT clinic can typically last around 3 hours (180 minutes) due to inherent lack of staff and time resources inherent to the VHA. A typical Veteran presenting in crisis to the SATT clinic is experiencing relationship distress, homelessness or high risk of becoming homeless, lack of social support, and medical disorders. However, the lack of an effective social work case management model in the SATT clinic has led to failure of case managers in operating in logical and orderly process that addresses the Veteran's distress, impairment, and instability when in crisis. Instead, the psychologist and addiction therapists spend the allotted 90 minutes exacerbating the crisis with well-intentioned but haphazard responding. The SATT clinic responds to a crisis with a response that is not active and directive enough while taking problem ownership away from the Veteran. Instead, case managers are expected to arrange ambulance services and coordinate with nursing staff and the psychiatrist for the admission to emergency inpatient treatment when it's not warranted by clinical judgement. In my case, I knew I had to work hard to intentionally meet the Veteran where he or she was at, assess level of risk, mobilize Veteran resources, and move strategically to stabilize the crisis and improve functioning. This is what I mean when I refer to applying social work professional standards of practice in case management. The investigation failed to ask how the SATT clinic handles crisis intervention and how it fits in the productivity model of assigning time-limited bookable hours. The current productivity standards based on bookable hours cannot address effective crisis intervention and leads to unnecessary hospitalization and emergency interventions that cost taxpayer's money. In my experience, Veterans in crisis sent to a higher level of care without proper intervention, leave the inpatient facility they were referred to against medical advice (AMA) and/or disengage from treatment and comeback to the SATT clinic in a worsening psychosocial condition; again, a total waste of taxpayer's money.

According to the agency report, 18 hours per week for case management appointments (30 minutes each or 60 minutes based on clinical judgement) are included in the 32 bookable hours per week. This analysis is very problematic because it assumes the great majority of Veterans only required a frequency of monthly case management appointments; a very risky assumption as I previously explained. The investigation failed to verify the level of case management required by most Veterans receiving services in the SATT clinic at any given time. With the 18-hour-per-week case management model described by the report, hardly any Veteran would be receiving intensive case management. It's an irresponsible cookie cutter approach that leaves many Veterans without the necessary mental health services and high risk of negative health outcomes. In my personal estimation, I was probably the only case manager providing intensive case management services to Veterans, and I was not able to do it effectively due to the caseload size. As per VHA Directive 1110.04, "intensive CM requires at least weekly Veteran contact and family or caregiver contact, as appropriate, whenever there is transition of care or major change in the Veteran's clinical, psychological, functional status, such as: new diagnosis, newly identified cognitive and/or behavioral change, notable change in lifestyle, and/or major access to care concerns. It entails maximum assistance with system navigation and biopsychosocial support from a Case Manager to regain stability." The vast majority of new Veterans admitted to the SATT clinic require intensive case management based on the above criteria outlined by VHA policy. If SATT case managers are not able to

articulate their clinical judgement in the electronic health records for not providing intensive case management, they are denying vital mental health care to Veterans and allowing for worsening of symptoms. I became a "holding pond" for Veterans who did not get required intensive case management by other case managers. I resigned because I was not able to provide intensive case management to Veterans that required weekly appointments. In my experience, Veterans with the psychosocial problems requiring intensive case management, as described above, needed this level of care for few weeks to few months, based on clinical judgement, before assigning them to stabilization case management with semi-monthly appointments.

The math used in the report that concludes that a case manager is able to book 32 appointments (60 minutes each) is flawed because it assumes that the 32 Veterans don't need weekly appointments. With an average of 4 new Veterans assigned to a case manager per week, equal to 16 Veterans per month, it would only take 2 months for a new hired case manager to have a caseload of 32 Veterans in need of intensive case management as new Veterans are showing up on a daily basis. Typically, a Veteran that requires intensive case management needs a 60-minute appointment. That means you can only see 32 of them without new Veterans added to the case load to account for mandatory breaks, and administrative time. As Veterans are moved to stabilization case management (semi-monthly frequency of appointments), a realistic scenario would be the following: a case manager assigned 14 Veterans needing intensive case management (weekly appointments) and 16 stabilization Veterans (semi-monthly appointments) and another 16 Veterans needing monthly case management (30-minute appointments each). The total case load would be 46 Veterans:

Progressive (monthly visits) CM - 2 bookable hours for 4 appointments per week (30-min each; 4 veterans x 4 = 16 Veterans)

Stabilization (semi-monthly) CM - 16 bookable hours for 16 appointments per week (60 min appt. each)

Intensive (weekly) CM - 14 bookable hours for 14 appointments per week (60 min appt. each)

In the above scenario, the case manager is completing 32 appointments per week with a caseload of 46 Veterans. In order to complete a higher number of appointments while receiving 3 to 4 new Veterans per week, the case manager would have to discharge a considerable number of Veterans on a monthly basis and stop providing intensive case management. The Case Manager (AT1) with the highest number of completed appointments on the completed appointments chart shown in the agency report is clearly not seeing too many Veterans on a weekly basis, not engaged in intensive or stabilization case management, and not forming the therapeutic relationship necessary to keep Veterans from returning in worsening conditions to the SATT Clinic. The electronic health records show that the great majority of Veterans are bouncing around the different case managers without meaningful progress. The chart of completed appointments used in the report clearly depicts this scenario. A high number of completed appointments per month, while accepting 3 to 4 new patients per week, reflect the vast majority of Veterans under a case manager were receiving follow-up care once a month even though there was a high likelihood that they needed intensive weekly case management appointments. The chart reflects that the SATT clinic adhered to the formula of booking weekly appointments for the 10 to 15 Veterans enrolled in IOP and booking monthly appointments to the rest of Veterans without clinical justification for doing it.

That's the reason a caseload of more than 50 Veterans is not recommended. A more realistic scenario would have a case manager seeing less than 50 Veterans with no new appointments available until a

veteran successfully graduate from the program. In order to book 128 hours of appointments per month, as indicated by the SATT clinic in the agency report, and while receiving 3 to 4 new Veterans per week, the case manager needs to discharge Veterans in a monthly basis without regard to the level of case management and clinical intervention needed by the Veteran. No consideration is given to each specific need of the Veteran under the work productivity-only model; the SATT clinics place them in a virtual "conveyer belt" without regards to level of case management and clinical care needed. The investigation failed to describe how their mathematical model will allow for providing needed case management and clinical care for 3 to 6 months to one single Veteran. It also assumes that Veterans would graduate successfully in one month with required psychosocial stability without regards to continued symptomatology.

As I experienced in the SATT clinic, most Veterans did not successfully transition to peer specialist and/or community-based programs. Most Veterans "disappear" and don't return phone calls from the case managers or answer the letter sent to them. Case managers keep the caseload size low by placing Veterans into IOP (group counseling) and only following up with them individually once per month after graduation. When a therapeutic relationship is not properly established, Veterans don't return phone calls and eventually come back in crisis and worsening symptoms. The cycle only stops when the necessary therapeutic relationship is developed, through effective social work case management; otherwise, the chronic condition prevails, emergency services are required, and the patient develops high risk of suicidality. Thus, I became the holding pond for Veterans previously managed by one of the Addiction Therapists. Again, most of the times the case management goal of transitioning Veterans successfully to lower level of care is not met. Many Veterans come back to the Jacksonville SATT Clinic, after outreach efforts fail, with worsening symptoms that lead to multiple hospitalizations and increase suicidality. This situation has emerged because the SATT clinic is failing to collaborate with Lead Coordinators (LCs) in other programs for effective discharge planning. The great majority of Veterans previously served by the SATT clinic comeback for substance abuse treatment in psychosocial crisis, as they are not being followed by Lead Coordinators assigned based on "the Veterans' predominant need and their location in the system" (VHA Directive 1110.04(3)(f)(2)).

When the SATT clinic discharges Veterans, case managers rely on consults and referrals with long waits while the Veteran is left without care coordination and attempting to still navigate the other complicating features that led to the substance abuse. In many cases, these same Veterans relapse after graduation from the program because no point person was assigned to address and coordinate the predominant need for which substance abuse was the main symptom. The situation becomes more serious for unstable Veterans who disengage from SUD treatment, due to ineffective case management. Again, these Veterans disengage from the VHA system when they are not assigned a point person (LC) who they can reach and who can help them re-engage in mental health services. Not having Lead Coordinators, as mandated by VHA policies, directly cause unnecessary increase workload, case complexity and poor patients' outcomes.

Without practicing the mandated and required case management standards, SATT case managers are having a hard time re-engaging with each individual Veteran; "Case Managers will establish rapport and build and maintain therapeutic relationships with Veterans to foster trust and engage them in care and empower and equip them in self-care and self-management with the goal of improving positive health and wellness outcomes (VHA Directive 1110.04)." These outcomes are below standards in the SATT clinic considering many Veterans receiving services are frequent clients experiencing multiple emergency hospitalizations, worsening of symptoms, increase in suicidality and lack of engagement in overall healthcare delivery. The SATT clinic can only improve this situation for many of the Veterans in

the caseload panel by developing good therapeutic relationships, providing appropriate therapeutic interventions, developing a solid treatment plan, and using sound clinical judgment to graduate Veterans from the program; this is not happening. "The major goal of the CM process is to increase Veteran autonomy and decrease the long-term dependence on the Case Manager" by following case management standards of practice (VHA Directive 1110.04(7)(b). The SATT clinic is not meeting this goal because productivity targets, as reflected on the report, are prioritized over effective social work case management and clinical care.

Because Veterans are not receiving effective social work case management services and clinical care in the SATT clinic, they are being denied a vital intervention; therefore, leading to drastic psychosocial and medical consequences. Case management is considered a complex level intervention by VHA policy – VHA Directive 1110.04(3)(c). The case manager is mandated by VHA policy with "responsibility for diagnosing, evaluating, and treating the patient's substance abuse disorder" while managing its interaction with (1) psychosocial deficits including homelessness, unemployment, and lack of social support for recovery; (2) comorbid anxiety disorders, such as Post-Traumatic Stress Disorder (PTSD), panic disorder, and general anxiety disorder; (3) depressive disorders, including major depressive disorder and dysthymia; (4) psychoses, including schizophrenia and bipolar disorder; and (5) Other general medical disorders." (VHA Directive 1230). For this reason, effective case management cannot be delivered by a psychologist, nurse, or addiction therapist in the SATT clinic; it is to be delivered by qualified and licensed social workers.

In light of the above analysis, I believe Allegation 1 can be easily substantiated. Clinical providers have excessive caseload sizes when they are seeing more than 50 Veterans, and the case managers are prematurely discharging Veterans to keep the caseload to a manageable size. Veterans have been negatively impacted by the lack of effective social work case management. The investigation report did not provide an analysis of the quality of care received by Veterans as the investigators seemingly disregarded or were not aware of the corresponding VHA guidelines and policy. It seems the investigation relied on the guidelines written by the SATT clinic without verifying it against VHA policy and guidelines. Because Veterans are not receiving the appropriate level of case management, they are being denied access to needed care.

Lastly, the report claims that I only had a caseload of 34 Veterans when I departed the clinic. The SATT clinic indicated that I erroneously reported having a caseload of 92 Veterans. The report concludes "we learned only 34 of the 92 Veterans listed on the whistleblower's caseload list remained active participants in a SATT clinic program." The problem is that the report did not disclose how the 58 Veterans were discharged or whether they engaged follow-up clinical treatment in the North Florida/South Georgia Health Care System. Before I left the SATT clinic, I learned the list was given to the Peer-Support specialist assigned to the Clinic to make a one-time cold phone call. I learned that many of the Veterans on the list, who answered the phone call, were directed to call me, rather than to schedule a case management appointment on the spot; it seems these Veterans were taken from the list pending their efforts to contact me to re-schedule an appointment for case management. I resigned because I was not able to deliver the required intensive and stabilization case management services to those 58 Veterans. I was not able to provide intensive or stabilization case management to these Veterans because they needed weekly and semi-monthly appointments, and I was directed to place them on monthly intervention rather than the needed intensive weekly case management. About 2 months before my resignation, I declined to take new appointments as I was actively engaged with 40 Veterans. By September of 2020, I was completely burned out attending to IOP groups, weekly therapy groups, scheduling activities, biopsychosocial assessment appointments for new Veterans, and frequent

crisis interventions. I was trying my best to engage in a new plan to keep my caseload around 40 Veterans. So, I was playing phone tag with many of the Veterans who were not actively participating on the program. The following is part of my presentation of the issue via e-mail, to the SATT leadership:

> I will see new patients, walk-ins, or post-hospitalization patients when scheduled in my clinic open/available slots. I will see them for brief assessment updates and suicide risk assessments as well as referral to emergency services. I will not add them to my case load unless it goes below 40 patients. At this time, I'm reconciling my list of 92 patients as I'm still getting established patients reaching out to me due to outreach efforts from Peer Support.
> Unfortunately, it is clear that the leadership is not willing to allow me to keep a manageable case load of 40 patients and to stop discharging the time-consuming responsibility of scheduling activities. I'm appalled because the VHA Directive 1230 makes the point clear and the leadership refuses to carry out the mandate that is explicitly expressed in it.

Let me be clear, scheduling activities entail calling about 10 to 15 Veterans per day, leaving voice mails, scheduling their appointments, and/or answering return phone calls to negotiate date and time of appointment. A large portion of my work day was spent on scheduling activities.

It is clear the 54 Veterans on the list were disenrolled from the SATT clinic because they were not "active participants" as the report suggests. Based on my review of their medical charts, my completion of their biopsychosocial assessments, and my clinical judgement, all these Veterans needed at least stabilization (semi-monthly follow-up) case management. Many of them were clearly candidates for intensive (weekly contacts) case management. I hope these 54 Veterans are doing ok, but I'm afraid they either have gone back in crisis to the SATT clinic; have been hospitalized for emergency services; have increased their alcohol/drug use; have become homeless; have been isolating with suicidal ideations; or have disengaged for needed medical services because of the increased addiction. Let me be clear, these situations are not based on my clinical interpretation of possible outcomes; they were the reality I saw when I was working with Veterans who have been engaged in prior case management services in the SATT clinic. A review of the electronic health record reveals this reality. All you need to do is look for any "Assessment" note from the SATT clinic under the names on the list. If poor outcomes are not avoided due to lack of engagement in sound therapeutic relationship with the Veteran, the work productivity problems outlined in the report are a moot issue.

[redacted]