STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870

MONTGOMERY, ALABAMA 36104

NOTICE

DATE: October 29, 2021

TO: Applicant and Interested Parties

FROM: Emily T. Marsal
Executive Director

SUBJ: Proposed State Health Plan Adjustment submitted by Veterans Recovery Resources PA 2022-001

A Plan Adjustment, designated PA2022-001, has been accepted as complete on October 29, 2021. Persons other than the applicant have thirty (30) days from October 29, 2021, to electronically file statements in opposition to or in support of the application, as well as any other documentation they wish to be considered by the Statewide Health Coordinating Council (SHCC). Pursuant to SHPDA ALA. ADMIN. CODE r. 410-1-3-.09, all such statements and documentation must be filed at shpda.online@shpda.alabama.gov, together with a certification that the filing has been served on the applicant and/or any other persons that have filed notices of support for or opposition to the application.

This Plan Adjustment can be viewed in its entirety at www.shpda.alabama.gov, under Announcements/SHP/Proposed Adjustments & Amendments /PA2022-001 – 410-2-4-.11(5) Substance Abuse – Veterans Recovery Resources.

Interested parties may address the proposed Plan Adjustment at the SHCC meeting, subject to such time limits and notice requirements as may be imposed by the SHCC Chairman. If the SHCC approves the Plan Adjustment in whole or in part, the adjustment, along with the SHCC's favorable recommendation, will be sent to the Governor for consideration and approval/disapproval. A Plan Adjustment shall be deemed disapproved by the Governor if not acted upon within fifteen (15) days.

SHPDA Rule 410-2-5-.04 – Plan Revision Procedures, may be viewed in its entirety on the Agency's website at www.shpda.alabama.gov, under Announcements/SHP/Approved Adjustments & Amendments/410-2-5-.04 Plan Revision Procedures (Effective 03/23/2018).

Detailed information regarding the applicable deadlines for the proposed Plan Adjustment is listed on the following page.

Emily T. Marsal
Executive Director

STATE OF ALABAMA
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

REVIEW SCHEDULE

TO:
1. Plan Adjustment Applicant
2. All Providers of Similar Services in the Proposed County
3. All Providers of Similar Services in Adjacent Counties
4. Interested Persons

NOTICE: An application for Plan Adjustment has been submitted for review under the provisions of Sections 22-21-260(13), Code of Alabama, 1975. A brief description of the proposal and of the Review Schedule is set forth below:

Emily T. Marsal
Executive Director

October 29, 2021
Date

DESCRIPTION OF PROPOSED FACILITY AND/OR SERVICE

1. Plan Adjustment No.: PA2022-001	2. TYPE FACILITY: SUBSTANCE ABUSE	3. COUNTY: Mobile

4. NAME OF APPLICANT:
Veterans Recovery Resources

5. BRIEF DESCRIPTION OF ADJUSTMENT (Change in bed capacity, service, equipment, units proposed, etc.): The applicant proposes recognizing the need for thirty-four (34) additional substance abuse beds in Mobile County, Alabama, Region IV to provide for a clinically managed detoxification and residential treatment program for veterans and first responders. The treatment facility will consist of eight (8) beds for clinically monitored detoxification, sixteen (16) beds for residential treatment, and approximately ten (10) beds for supervised respite care.

REVIEW SCHEDULE

6. REVIEW PERIOD BEGINS (DAY 1):
October 29, 2021

7. DEADLINE FOR PERSONS WISHING TO SUBMIT INFORMATION IN OPPOSITION TO OR SUPPORT OF THE PROPOSED PROJECT (DAY 30):
November 29, 2021

8. PROPOSED DATE OF PUBLIC HEARING:
December 14, 2021

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P.O. Box 198966
Nashville, TN 37219-8966

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PA2022-001
RECEIVED
Oct 28 2021
STATE HEALTH PLANNING AND
DEVELOPMENT AGENCY

October 28, 2021

VIA ELECTRONIC MAIL

Director Emily Marsal
State Health Planning and Development Agency
100 North Union St.
Suite 870
Montgomery, AL 36104

Re: PA2022-001 - Veterans Recovery Resources

Dear Emily,

Please find attached to this e-mail a revised application for PA2022-001.

This revised application contains the following information as requested by your letter dated October 26, 2021.

1) An e-mail address for John Kilpatrick (jfk@vetsrecover.org).

2) Clarification that thirty-four (34) beds are sought.

3) Additional project cost information.

4) A corrected population estimate for Mobile.

5) A projected utilization analysis for the only existing substance abuse residential agency in Mobile.

6) Clarification that only one substance abuse residential agency currently exists in Mobile.

Please do not hesitate to reach out if you have any questions about the project or if there is anything else we can do to help.

Sincerely,

Colin H Luke

Revised Application for State Health Plan Adjustment

Veterans Recovery Resources

Mobile County

Substance Abuse Beds - Veteran and First Responder Focus

Applicant Identification. An application for a Plan Adjustment must be filed in accordance with SHPDA Rule 410-1-3-.09, and accompanied by the administrative fee specified in Rule 410-2-5-.04(c)(5). The application must include the name of the applicant, physical address, telephone number, the contact person and mailing address, telephone number, and e-mail address.

Name of Applicant:

Veterans Recovery Resources

Physical Address:

1156 Springhill Ave.
Mobile, AL 36604

Telephone number:

251-405-3677

Contact Person:
Col. John F. Kilpatrick, MSW, LGSW
1156 Springhill Ave.
Mobile, AL 36604
251-405-3677
jfk@vetsrecover.org

Project Description. Provide a narrative statement explaining the nature of the request, with details of the plan adjustment desired. (If the request is for additional beds, indicate the number and type, i.e., Psychiatric, Rehabilitation, Pediatric, Nursing Home, etc.) The narrative should address availability, accessibility, cost, quality of the health care in question, and state with specificity the proposed language of the adjustment.

Veterans' Recovery Resources ("VRR") submits this application due to the overwhelming unmet need for residential substance abuse beds in Mobile County. This need is especially acute among veterans and first responders—many of whom struggle with PTSD, substance abuse, and other mental health disorders.

VRR proposes to create a clinically managed detoxification and residential treatment program to decrease substance use disorders, co-occurring conditions and veteran suicide in Mobile County (the "Project"). The Project will include 8 beds for clinically monitored detox, 16

beds for residential treatment and approximately 10 beds of supervised respite care for veterans transitioning from homelessness and waiting for residential treatment, for a total of 34 substance abuse beds.

As noted by one of the authors of the numerous letters of support for the Project, there are no detox facilities within a four-hour drive of Mobile. The only residential substance abuse facility in Mobile is often at capacity and has a waiting list, and is not specially equipped to manage the unique needs of combat veterans and first responders who have experienced intense trauma. Studies have shown that veterans are significantly more likely to suffer from substance abuse and other mental health disorders than people who have never served in the armed forces. *See* Flowers Olenick, *U.S. Veterans and Their Unique Issues: Enhancing Health Care Professional Awareness*, Advances in Medical Education and Practice Vol. 6, 635–639 (2015) (Describing the unique health challenges faced by veterans) (Attached as Exhibit A). Additionally, the link between substance abuse and overall mental health cannot be ignored. Veterans are significantly higher at risk of suicide than non-veterans. In 2017, 18% of all deaths by suicide among U.S. adults were Veterans even though only 7% of the adult population are Veterans. *See* Internal VRR Data; *2019 National Veteran Suicide Prevention Annual Report*, US Department of Veterans Affairs (Sept. 2019) (Providing an overview of veteran suicide statistics and ways to combat veteran suicide) (Attached as Exhibit B). According to Director of The University of Alabama's Office of Evaluation, Karl Hamner, more than 279 Alabamian service members died of suicide from 2016 to 2018, while more than 240 died of an overdose. *See* E-Mail from Karl Hamner to Paulette Risher and Kent Davis, April 14, 2011 11:29am (on file with Waller Lansden). Additionally, the fact that these numbers are often underreported indicates that the totals may be even higher. *See id.*

While the state health plan for 2020-2023 does not show a need for additional substance abuse beds, numerous first responders and veterans are in dire need of substance abuse treatment in Mobile and the surrounding areas yet are unable to access these services without leaving the state or driving several hours north. A recent research study led by the University of Alabama revealed that not only have "drug overdoses in Alabama increased by 20% during 2020," but also that many "Alabamians must travel far distances to get access to treatment like detox or in-patient programs. Many people [must even] travel to a new city, county or across state lines to access treatment." *See Addressing the Opioid Crisis: What Does Alabama Need?,* The University of Alabama (Aug. 23, 2021) (Providing an overview of a recent study conducted by the University of Alabama which investigated the opioid crisis in Alabama) (Attached as Exhibit C). Further, the Mobile County 310 Board Authority 2019-2020 Strategic Plan attached hereto as Exhibit D (see pages 8 to 10) specifically recognizes the need "to provide specialized services for persons dealing with trauma, especially with returning veterans" in the Mobile County area as well as the need for "[a]dditional [substance abuse] residential treatment capacity for adults" and for a "medically supervised and non-medical detox program." This adjustment would provide the ability for VRR to step up to meet that significant need upon the conclusion of this adjustment process and the associated CON process with the State Health Planning and Development Agency.

VRR is a community-based, non-profit provider of mental wellness programs developed specifically for veterans, by veterans. VRR is committed to providing mental health services for substance abuse, PTSD and other medical health conditions to veterans and first responders without regard to their ability to pay. Since November 2018, VRR has served over 550 service members, veterans, first responders, families, caregivers and survivors ("SMVF") making it easier for them to get important services that they need, according to their values, in the warm

environment of VRR's existing interdisciplinary outpatient facility. VRR's innovative plan focuses on three crucial integrated aspects of long-term recovery for SMVF: outpatient treatment, detox and residential treatment, and community integration. The Project will help VRR to further this plan to help meet the needs of veterans and first responders, and will provide exceptional residential substance abuse care, just as VRR provides exceptional care in its existing facility. VRR recently received a two-year, $4 million dollar federal grant from the Substance Abuse and Mental Health Services Administration to become Alabama's first Certified Community Behavioral Health Clinic.

The anticipated VRR Project to be submitted through SHPDA's CON application process, if this adjustment application is approved, is estimated to cost between seven and eight million dollars. An anticipated breakdown of those costs is as follows:

Uses	
Existing Mortgage	$369,000.00
Historic Eligible Hard Construction	$4,000,000.00
Site work	$550,000.00
Canopies	$400,000.00
Soft Costs	$877,000.00
FFE	$675,000.00
Estimating Contigency	$400,000.00
Finance Fees & Interest	$285,000.00
Total	$7,556,000.00

Further, the anticipated VRR Project is expected to have first year operating costs of four million dollars.

Services will be provided to patients without regards to their ability to pay as is the case with all VRR programs. In order to provide the necessary substance abuse beds for this proposed Project, VRR respectfully requests the below language be added as an adjustment to the substance abuse section of the State Health Plan as Ala. Admin. Code § 410-2-4-.11(5):

The SHCC finds that there is a significant and unmet need for additional substance abuse beds in Mobile County, a need that is particularly great among veterans and first responders. Future consideration should be given to locating additional substance abuse beds in Mobile County in a facility which can address the substance abuse needs of veterans and first responders. Notwithstanding anything to the contrary in the State Health Plan, recognizing the need for additional substance abuse beds that have been specifically created to meet the needs of veterans and first responders in Mobile County, the SHCC, through the adjustment process, adjusted the planning policy to recognize the need for thirty-four (34) substance abuse beds to be located in Mobile County, with consideration given to facilities which can address the specialized needs of veterans and first responders.

Service Area. Describe the geographical area to be served. (Provide an 8 ½ ″ x 11″ map of the service area. The map should indicate the location of other similar health care facilities in the area.)

As previously mentioned, the Project will primarily serve Mobile County, Alabama, and this Adjustment request is specific to such county.

A map reflecting all current providers of residential substance abuse treatment services is reflected on the map included with this application as Exhibit E.

Also, below is the existing Mobile County residential treatment substance abuse facility from the Alabama Department of Mental Health, Substance Abuse Treatment Services (OSATS), Substance Use Services Directory:

Salvation Army Mobile Executive Director: Angel Steadman 1009 Dauphin Street Mobile, AL 36604 Telephone: (251) 438-1625	ADMH Medicaid & ADMH Block Grant **Services Offered** Level III.01: Transitional Residential Program (Adult/Male) Level III.1: Clinically Managed Low Intensity Residential (Adult/Male) Level III.3: Clinically Managed Medium Intensity Residential (Adult/Male)

Population Projections. Provide population projections for the service area. In the case of beds for a specific age group, such as pediatric beds or nursing home beds, document the existence of the affected population. An example for nursing home beds is the number of persons 65 and older. The applicant must include the source of all information provided.

The latest CBER projections indicate that Mobile is a growing county with a population of 416,420 as of 2020 and a projected population of 431,909 by 2040, an approximately 3.72 percent increase. This data is attached as Exhibit F.

Further, the US Census Bureau stated that more than 28,000 of Mobile's residents were veterans between the years 2015-2019. This data is attached as Exhibit G.

Need for the Adjustment. Address the current need methodology. If the application is to increase beds or services in a planning area, give evidence that those beds or services have not been available and/or accessible to the population of the area.

The current need methodology for substance abuse beds, found in Ala. Admin. Code § 410-2-4-.11(3), is unclear as to whether it provides a calculation for the entire state or for individual localities. Additionally, the need methodology has not been updated in several years. These issues have led to the current situation, where veterans and first responders are unable to access residential substance abuse services in Mobile County despite the rising population of the Gulf Coast region and the increase in mental health issues (such as PTSD) that can contribute to the formation of substance abuse issues. These facts are attested to in the numerous letters of support attached to this application which describe excessively long waitlists for substance abuse services and first-hand accounts of the impact of substance abuse on vulnerable populations. The current methodology's issues can be illustrated by the fact that if all of the state's substance abuse beds were located in Jackson County, the methodology would arguably show no need for substance abuse beds in Mobile County despite the fact that the two counties are in opposite corners of the state. The distribution of these beds within the State can greatly impact the accessibility for such services for individuals requiring substance abuse services in an area where all of the beds are utilized and waitlists exist or where there are no such facilities within a reasonable distance from where the individual and his or her family reside.

Current and Projected Utilization. Provide current and projected utilization of similar facilities or services within the proposed service area.

The Alabama Department of Mental Health, Substance Abuse Division provide a substance abuse availability update periodically and a recent report from the Adult Treatment Services Coordinator/Program Manager is included below which reflects the limited number of substance abuse beds available for the Mobile County, Alabama, service area. Note that as of October 13,

2021, two of the three Salvation Army residential substance abuse treatment programs listed below (all a part of the only facility currently operating in Mobile County), had a 12-person and 88-person waiting list, respectively, to receive access to a bed for residential substance abuse treatment services.

Additionally, with the number of individuals on the waiting list for the only substance abuse residential treatment facility in Mobile (the Salvation Army Dauphin Way Lodge) nearly doubling the number of residential substance abuse beds in Mobile County (100 on the waiting list compared to a max capacity of 57)—combined with the population growth in the area and the increase in mental illness—we project that utilization of the Salvation Army Dauphin Way Lodge will continue to rise as the COVID crisis ends. Further, with no female or veteran or first responder programs currently offered in Mobile County, utilization of such facilities cannot be calculated, as no such facilities exist.

SUBSTANCE ABUSE RESIDENTIAL BEDS - MOBILE COUNTY AVAILABILITY (as of 10/13/2021)

TOTAL NUMBER OF RESIDENTIAL SUBSTANCE ABUSE BEDS IN MOBILE COUNTY (includes withdrawal management): 57 beds

TOTAL MOBILE COUNTY BEDS VACANT: 45 total beds: 45 male 0 female (includes withdrawl management)

TOTAL MOBILE COUNTY INDIVIDUALS ON WAITLISTS: 100 (Includes withdrawal management)

(NOTE: The only substance abuse residential agency in Mobile County at this time—the Salvation Army Dauphin Way Lodge—is not specially equipped to handle the needs of veterans or first responders. There is no Medically Monitored Detox in Mobile or Baldwin Counties).

Facility	Agency	County	Capacity	Enrolled	Availability	Referred Clients	Clients on Waiting List
Dauphin Way Lodge Male Level III.01	**Salvation Army Dauphin Way Lodge**	**Mobile**	**17**	**1**	**16**	**0**	**0**
Dauphin Way Lodge Male Level III.1	**Salvation Army Dauphin Way Lodge**	**Mobile**	**24**	**5**	**19**	**0**	**12**
Dauphin Way Lodge Male Level III.3	**Salvation Army Dauphin Way Lodge**	**Mobile**	**16**	**6**	**10**	**2**	**88**

If additional staffing will be required to support the additional need, indicate the availability of such staffing.

VRR believes that there is readily available staffing for the Project based upon its existing relationships and access to staff for its currently existing veterans facility in Mobile County.

Effect on Existing Facilities or Services. Address the impact this plan adjustment will have on other facilities in the area both in occupancy and manpower.

This adjustment will have no impact on the other facility in the area in terms of occupancy or manpower. As attested to by the numerous authors of letters of support for the Project, and supported by the above Alabama Department of Mental Health, Substance Abuse Division statistics for existing residential substance abuse treatment facilities in Mobile County, the current facilities have extremely long waitlists. Further, it is anticipated that the veterans focus of the proposed facility will provide VRR with the ability to obtain, and have access to resources for, manpower for the Project that is otherwise not available to a typical substance abuse treatment facility without such a specialized focus and will not impact manpower currently available to other facilities within the service area.

Community Reaction. Give evidence of project support demonstrated by local community, civic and other organizations. (Testimony and/or comments regarding plan adjustment provided by community leaders, health care professionals, and other interested citizens.)

See Exhibit H to this application, for the numerous letters of support provided for the Project.

Provide any other information or data available in justification of the plan adjustment request.

The need for the Project and specialized and additional access to such care for veterans has recently been highlighted by numerous reports written after the twentieth anniversary of the September 11, 2001 terrorist attacks, which note the mental health issues faced by veterans of the conflicts in Iraq and Afghanistan. One such report is attached to this application as Exhibit I.

This application has been revised in response to Ms. Marsal's October 26, 2021 request for additional information, attached as Exhibit J.

The undersigned, being first duly sworn, hereby makes oath or affirms that he is the authorized representative for Veterans Recovery Resources, has knowledge of the facts in this request, and to the best of his information, knowledge and belief, such facts are true and correct.

Affiant: ______________________
John Kilpatrick
Executive Director

SUBSCRIBED AND SWORN to before me Oct. 28, 2021.

____
Notary Public
My commission expires:

STATE OF NOTARY PUBLIC ALABAMA
ROBERT HARRIS
My Commission Expires
March 3, 2024

ROBERT HARRIS
MY COMMISSION EXPIRES
MARCH 3, 2024
NOTARY PUBLIC
STATE OF ALABAMA

(SEAL)

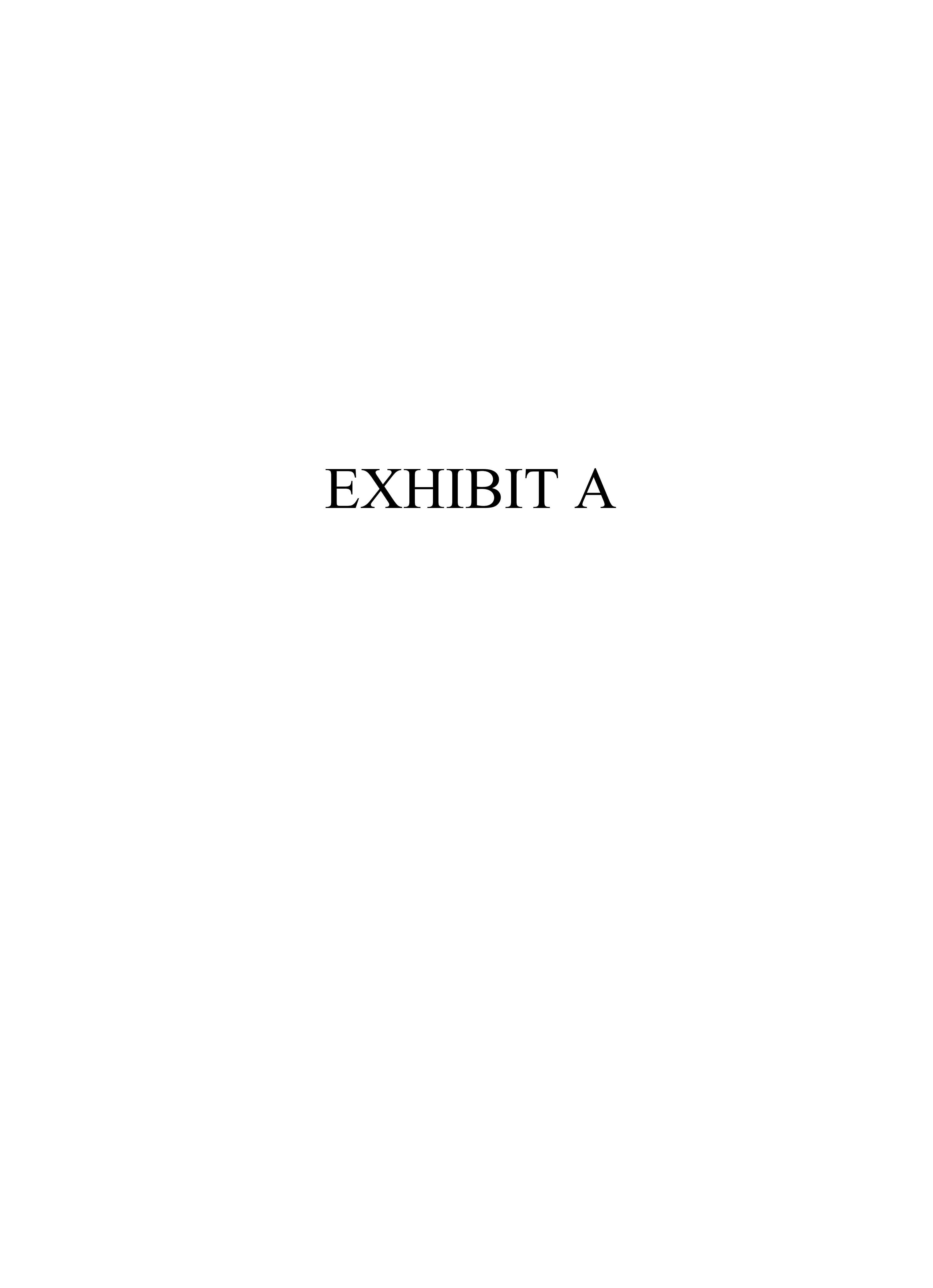

EXHIBIT A

Advances in Medical Education and Practice

Dovepress
open access to scientific and medical research

Open Access Full Text Article

PERSPECTIVES

US veterans and their unique issues: enhancing health care professional awareness

Maria Olenick[1]
Monica Flowers[1]
Valerie J Diaz[1,2]

[1]Nicole Wertheim College of Nursing and Health Science, Florida International University, Miami, FL, USA; [2]Operational Health Support Unit Jacksonville, United States Navy Nurse Corps, Jacksonville, FL, USA

Abstract: United States veterans are a multifaceted population with a distinct culture that includes, but is not limited to, values, customs, ethos, selfless duty, codes of conduct, implicit patterns of communication, and obedience to command. Veterans experience mental health disorders, substance use disorders, post-traumatic stress, and traumatic brain injury at disproportionate rates compared to their civilian counterparts. Eighteen to 22 American veterans commit suicide daily and young veterans aged 18–44 are most at risk. Health care professionals must be aware of patients' military history and be able to recognize suicide-risk factors, regardless of age. Advancement in medical technology has allowed servicemen to survive their injuries but, for many, at the cost of a traumatic limb amputation and associated mental scarring. Health care professionals must be able to address physical safety concerns, as well as, emotional health of veterans. Approximately 49,933 American veterans are homeless and face the same difficulties as non-veterans in addition to service-related matters. Separation from military service and issues related to complex multiple deployments are among specifically identified veteran issues. Successful veteran reintegration into civilian life rests upon providing veterans with training that builds on their military knowledge and skill, employment post-separation from service, homelessness prevention, and mental health programs that promote civilian transition. Preparing health care providers to meet the complex needs of a vast veteran population can be facilitated by implementing veteran content into curricula that includes veteran patient simulations and case studies, and utilizes veteran clinical faculty.

Keywords: veterans, veteran health care, veteran health issues, veteran content

Introduction

United States veterans are multifaceted and may be considered a population, a culture, and a subculture. Military culture includes, but is not limited to, the values, customs, traditions, philosophical principles, ethos, standards of behavior, standards of discipline, teamwork, loyalty, selfless duty, rank, identity, hierarchy, ceremony and etiquette, cohesion, order and procedure, codes of conduct, implicit patterns of communication, and obedience to command (LD Purnell, University of Delaware and Florida International University, personal communication, January, 2015).[1]

The American veteran population is a unique population. Varying military service branches and varying military experiences among the veteran population is unique. Varying wartime eras and health-specific issues associated with those eras are unique among the veteran population. From a comparison of veterans from the Vietnam, Persian Gulf, and Iraq/Afghanistan (Operation Iraqi Freedom [OIF]/Operation Enduring Freedom [OEF]) war eras, Fontana and Rosenheck[2] noted distinct differences. OIF/OEF

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veterans include fewer African-Americans, more Latinos, and more females than other eras. In addition, this group is younger, less likely to be married, less likely to have been incarcerated, and more likely to be gainfully employed.[2] It was also observed that OIF/OEF veterans appear to be more socially integrated, less often diagnosed with substance abuse disorders, and required less Veterans Affairs (VA) disability compensation for post-traumatic stress disorders (PTSDs) when compared to their Persian Gulf and Vietnam veteran counterparts.[2]

US veteran-specific health issues

Mental health or behavioral adjustment disorders

Medical records of veterans reveal "that one in three patients was diagnosed with at least one mental health disorder – 41% were diagnosed with either a mental health or a behavioral adjustment disorder".[3] In compensation or in combination with military-related diseases, many veterans develop substance use disorders (SUDs) and a large number ultimately commit suicide. LeardMann et al[4] found that male veterans diagnosed with "depression, manic-depressive disorder, heavy or binge drinking, and alcohol-related problems" were significantly associated with an increased risk of suicide. Thus, identifying and treating mental health illness has the greatest potential to mitigate suicide risk. Unfortunately, reluctance to seek help or treatment makes diagnosing and treating mental illness difficult in this population.

SUDs

The stressors of military service increase the risk of veterans having problems with alcohol, tobacco, or drugs (or a combination). Johnson et al[5] found that cigarette smoking and alcohol consumption is higher among veterans than non-military personnel. For some veterans, treatment of a co-morbid condition (eg, PTSD, depression, pain, insomnia) may resolve the problem. For others, long-term care is required. Thus, multiple clinical practice guidelines have been developed "and evidence-based screening tools to help clinicians identify veterans with SUDs and improve outcomes".[5]

PTSD

Also known as "shell shock" or "combat fatigue", PTSD results from witnessing or experiencing (directly or indirectly) a traumatic event.[6] The disease is not limited to veterans, however, military personnel experience PTSD almost four fold (8% of non-military men versus 36% of male veterans).[5] PTSD is an amalgam of symptoms, severity, and duration. According to the American Psychiatric Association,[6] diagnosis is based upon four symptom categories: intrusive symptoms (flashbacks), avoidance of reminders (isolation), negative thoughts and feelings ("no one can be trusted"), and arousal and reactivity symptoms (exaggerated startle response). PTSD is often associated with "traumatic brain injury (TBI), military sexual trauma (MST), sleep problems, substance use, pain, and other psychiatric disorders, and requires comprehensive assessment".[5] Treatment is aimed at therapy (psychotherapy, prolonged exposure therapy, family/group therapy, and others), social support, and/or medication such as antidepressants. Screening tools and evidence-based guidelines have been developed to accurately and expeditiously assess and treat veterans.

TBI

TBI is "a traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force".[5] TBI can be classified as mild, moderate, or severe depending on the length of unconsciousness, memory loss/disorientation, and responsiveness of the individual following the event (ie, are they able to follow commands). While mild TBI (or concussion) is the most common, diagnosis is difficult since symptoms include "headaches, dizziness/problems walking, fatigue, irritability, memory problems and problems paying attention".[5,7]

Depression

Among the available data from the National Alliance on Mental Illness (NAMI),[2] depression ranks among the most common mental health disorders. The diagnosis rate for veteran depression is 14% (although NAMI believes depression is under diagnosed). Notably, NAMI[2] found that individuals with PTSD were less likely to commit suicide versus those with depression probably due to the increased awareness and acceptance of PTSD. Despite its devastating effects, major depression is a treatable illness with 80%–90% success rate using medication, psychotherapy, and/or electroconvulsive therapy.[2] Models of care, such as Translating Initiatives for Depression into Effective Solutions, show eight out of ten veterans are effectively treated.[8]

Suicide

With 18 to 22 veterans committing suicide on a daily basis, risk assessment and intervention are paramount.[9] Private and public health care professionals must be aware of patients' military history (since not all veterans seek care in VA clinics)[5] and be able to recognize suicide-risk factors,

regardless of age. Young veterans aged 18–44 years are most at risk of suicide; yet, Kemp and Bossarte[9] found that even older veterans, aged 50 years and older, were still almost twice as likely to commit suicide versus non-veterans (69% and 37%, respectively). Additionally, “11% of veterans who survive a first suicide attempt will reattempt within 9 months, and 6% of those will die”.[5] Kemp and Bossarte[9] found evidence supporting the efficacy of VA health care systems in lowering veterans’ non-fatal suicide attempt rate, thus referral to a VA facility is recommended for appropriate counseling and health services.

Chronic pain

With 82% of OEF and OIF veterans reporting chronic pain, diagnosis and treatment are essential.[5] A comprehensive assessment of pain is crucial, but also identifying associated physiological/biological and psychological factors since “chronic physical pain is often associated with co-morbid conditions, including TBI and PTSD, that may complicate treatment”.[5,7] Treatment should focus on concurrently addressing all conditions, with extreme cautionary use of opioids due to the heightened risk of veterans developing SUDs.

Amputations

Advancement in medical technology and bodily protection allow soldiers to survive injuries at a higher rate than in previous wars. Yet, the scars from a traumatic amputation are deep and many soldiers develop mental health injuries related to the event and “in cases involving multiple limb amputations or disfigurement, body image issues may create multiple social and employment barriers”.[5] According to military casualty statistics, 1,573 veterans have suffered major loss of limb amputations from battle injuries since 2010.[10]

Health care professionals must be able to address the physical safety concerns, as well as, the emotional health of the veteran. Sensory aids, prosthesis, and medical rehabilitation require an interdisciplinary-team approach in healing wounded soldiers.

Rehabilitation care

Many veterans have a hard time reacclimating into society after deployment due to military skills that are not transferrable to civilian life, bodily trauma that rendered that individual handicapped, and/or war-related mental disease. Rehabilitation care is aimed at a balance of vocational, physical, social, and mental therapies to prepare veterans for re-entry into civilian life. Vocational programs help job-seeking veterans develop skills and knowledge required for a particular job. Physical rehabilitation focuses on improving veterans’ quality of life and independence. Social rehabilitation assists veterans to assimilate to non-military life and establish new ways of life post-deployment. Mental rehabilitation teaches veterans with mental health illness the living skills of community functioning and ability to deal with their new environment.

Hazardous exposures

Veterans’ past exposure to chemicals (Agent Orange, contaminated water), radiation (nuclear weapons, X-rays), air pollutants (burn pit smoke, dust), occupational hazards (asbestos, lead), warfare agents (chemical and biological weapons), noise, and vibration increase their risk of health problems even years after the initial assault.[11] For example, long-term health problems have been implicated in association with Agent Orange exposure in Vietnam veterans.[12] For those who served in Iraq and Afghanistan, there is insufficient data to identify long-term health effects of hazardous exposure to pollutants, such as “burn pits” and infectious agents such as rabies, despite the immediate side-effects experienced by most veterans.[5] Obtaining an accurate medical and deployment history is essential in providing accurate diagnosis and appropriate treatment.

Homelessness

It is estimated that approximately 49,933 veterans are homeless (~12% of homeless adult population).[13] Homeless veterans face the same difficulties as non-veterans such as substance use, unemployment, and mental illness; yet plagued with the additional burdens of military-related factors, “such as PTSD, TBI, a history of multiple deployments, and military skills that might not be transferable to the civilian work environment”.[5] National Coalition for Homeless Veterans[13] found that 51% of homeless veterans have disabilities, 50% suffer from a serious mental illness, and 70% have SUDs. National Coalition for Homeless Veterans[13] believes housing and employment opportunities are a top priority for homeless veterans.

Complex deployment and reintegration needs

Veteran issues related to separation from military service and other issues related to complex deployment needs are among specifically identified veteran issues. Veterans’ successful reintegration into civilian life outcomes and interprofessional solutions stem from community involvement, access to resources, and support from peers. Reflection on best practices related particularly to employability

and training builds on knowledge and skills gained in the military (ie, university accelerated programs for veterans where military medics and corpsmen transition through an accelerated program into nursing earning credit for military education and training [such as the Veterans Bachelor of Science in Nursing which is a Health Resources and Services Administration funded program]; Military Police to Criminal Justice, Navigational Experience and Knowledge to Geology and/or Geography, etc), employment post-military separation, reintegration into society, veteran demographics, homelessness prevention and other mental health and SUD programs that facilitate veterans' successful transition into urban civilian and family life. Successful reintegration after military separation is an essential focus for holistic and effective veteran care.

Rationale for integrating veteran-centric content into curricula

The veteran population is growing. In 2014, over 20 million veterans resided in the USA per the US Department of Veteran Affairs, 2015.[14] Veterans are seeking health care services in the Veteran Health Administration as well as civilian treatment facilities. In order to understand and address health care needs of this vast and growing population, incorporating veteran-specific content into curricula is of primary importance. Veteran content specifically illuminates the unique yet complex health issues, mental and behavioral adjustment disorders, veteran wartime era, and civilian reintegration obstacles that, in combination, magnify their physical condition. Transparent presentation of the veteran circumstance can facilitate an interdisciplinary approach to care incorporating nursing, occupational therapy, physical therapy, mental health, pain management, nutrition, psychosocial, and social support services to ensure positive health care outcomes for this population. Several innovative strategies address these unique issues.

Professional curricula

Ideas for strategies to begin integration of veteran content into health care professional curricula include but are not limited to the following:

1. Provide presentations and seminars on veteran content delivered by well-known and distinguished speakers and/or experts on particular veteran content.
2. Embed veteran content into courses (undergraduate and graduate) and identify specific courses to curriculum map where veteran content occurs.
3. Recruit and hire faculty that come from veteran and military backgrounds and experiences.
4. Provide faculty development opportunities to expand and improve their knowledge on veteran issues.
5. Identify veterans in clinical areas and provide clinical experiences for students with veteran patients of different war eras, branches of service, and military experience backgrounds.
6. Provide veteran simulations and case studies as part of undergraduate and graduate curriculum.
7. Provide students the opportunity to develop individualized patient plans and Subjective, Objective, Assessment, Plan (SOAP) notes that reflect needs of veteran patient.

The American Association of Colleges of Nursing[15] offers a "Joining Forces: Enhancing Veterans' Care Tool Kit" (http://www.aacn.nche.edu/downloads/joining-forces-tool-kit/educational-resources) with a variety of educational resources on many veteran issues, references to articles on particular veteran issues, case studies, a veteran assessment tool, curricular examples including slides and syllabi for veteran-specific courses. This site is an excellent resource.

Discussion

Currently, there are approximately 22 million US veterans.[14] Preparing future health care providers to meet the needs of this extraordinary number of veterans is essential. Providing faculty development in the area of veteran-specific health issues and how to integrate veteran content into curricula will contribute to improving veteran outcomes and providing excellent care to those who served this country.

Total enrollees of veterans who utilize the VA health care system (8.9 million in 2013)[16] is less than half the current total veteran population. Furthermore, approximately 61% of all separated OEF/OIF veterans have used VA health care since October, 2001.[17] This means that veterans are largely using civilian medical care facilities further stressing the need for health care providers to be well versed in veteran-specific health issues, war eras, and reintegration issues veterans face; in order to provide excellent veteran care and outcomes.

Conclusion

Promotion and implementation of veteran health issues into curricula, and other veteran content relevant to enhancing veteran care and outcomes, is essential in health care provider education and vital to the holistic care of veterans across the lifespan and across the country. Programs targeted at enhancing veteran-specific knowledge for faculty and

students will serve to improve care for diverse veteran populations.

Acknowledgments

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Disclosure

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14. US Department of Veteran Affairs. *National Center for Veterans Analysis and Statistics*. US Department of Veteran Affairs. Available from: http://www.va.gov/vetdata/docs/QuickFacts/Population_quickfacts.pdf. Accessed August 20, 2015.
15. American Academy of Colleges of Nursing (AACN) [homepage on the Internet]. Joining Forces: Enhancing Veterans' Care Tool Kit – Educational Resources. American Academy of Colleges of Nursing. Available from http://www.aacn.nche.edu/downloads/joining-forces-tool-kit/educational-resources. Accessed August 20, 2015.
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17. US Department of Veteran Affairs [homepage on the Internet]. VA Health Care Utilization by recent veterans. US Department of Veteran Affairs. Available from: http://www.publichealth.va.gov/epidemiology/reports/oefoifond/health-care-utilization/. Accessed August 20, 2015.

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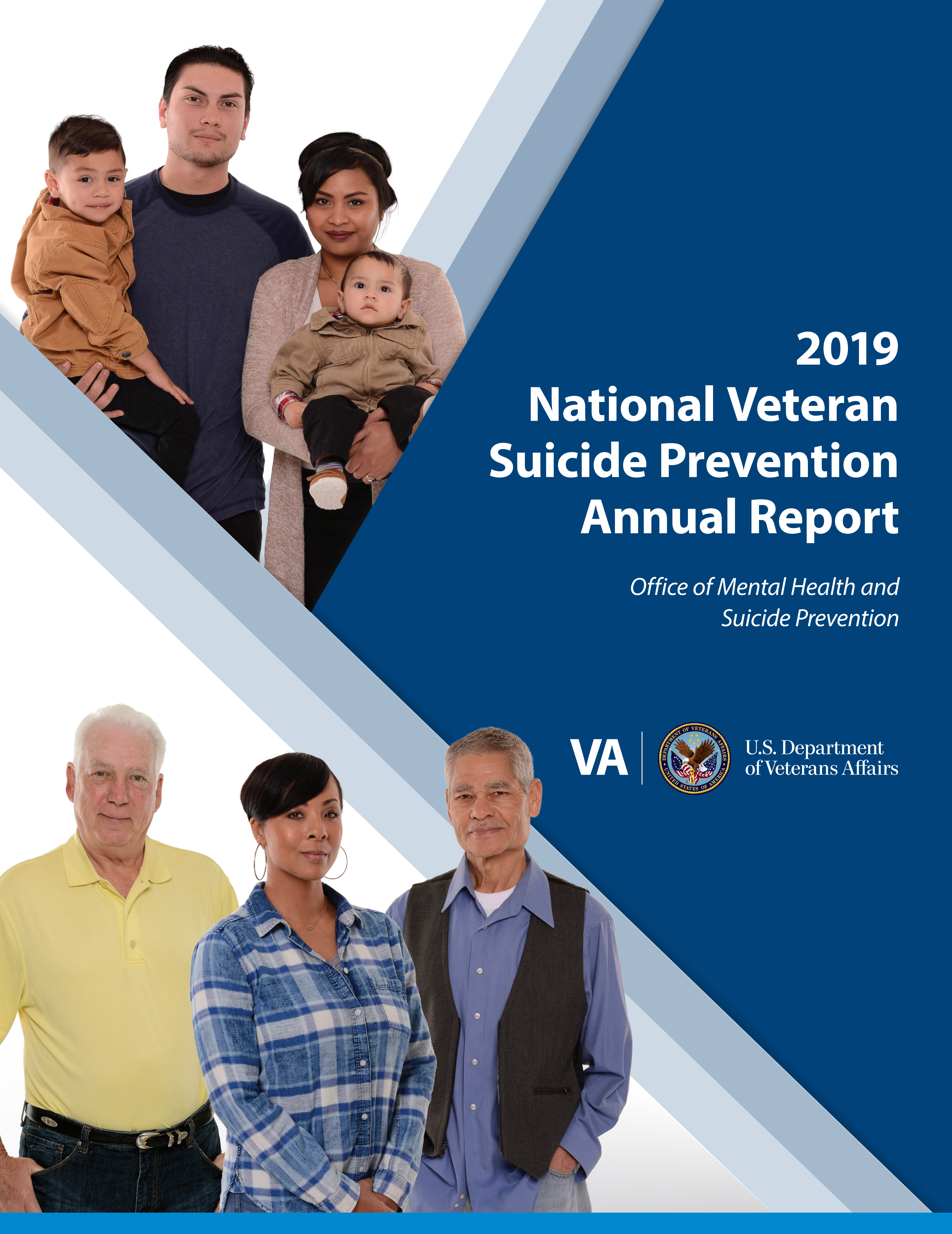
2019
National Veteran
Suicide Prevention
Annual Report
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VA
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of Veterans Affairs

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Executive Summary

45,390 American adults died from suicide in 2017, including 6,139 U.S. Veterans[1]. Our nation is understandably grieving with each suicide, prompting our collective and tireless pursuit of evidence-based clinical interventions and expansion of community prevention strategies to reach each Veteran. VA offers through this report a renewed and determined call to unrelentingly address suicide in our Veteran population and our society, as suicide has no single cause and the tragedy of suicide affects all Americans. Findings in this report reflect the most current national data (available through 2017) from the Centers for Disease Control and Prevention's National Death Index.

Key results include the following:

- The number of Veteran suicides exceeded 6,000 each year from 2008 to 2017.
- Among U.S. adults, the average number of suicides per day rose from 86.6 in 2005 to 124.4 in 2017. These numbers included 15.9 Veteran suicides per day in 2005 and 16.8 in 2017.
- In 2017, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, after adjusting for population differences in age and sex.
- Firearms were the method of suicide in 70.7% of male Veteran suicide deaths and 43.2% of female Veteran suicide deaths in 2017.
- In addition to the aforementioned Veteran suicides, there were 919 suicides among never federally activated former National Guard and Reserve members in 2017, an average 2.5 suicide deaths per day.

Suicide prevention is a national priority and VA is dedicated to this mission. While the data in this report extends only through 2017, since that time VA has continued to work actively in partnership with the White House, Congress, Veterans Health Administration networks, and federal and community partners to address the issue of Veteran suicide. The most recent and notable manifestation of this comprehensive approach to Veteran suicide prevention is the President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS), mandated by an executive order signed by the President in March 2019. A cabinet-level task force has been launched to develop a national roadmap for suicide prevention, which will include proposals and plans addressing integration and collaboration across sectors, a national research strategy, and a cohesive implementation strategy.

Together, we can all make a difference.

[1] See Page 4 regarding Veteran status.

Suicide as a National Problem

One suicide is heartbreaking, notably affecting an estimated 135 surviving individuals for each death by suicide.[2] Our nation grieves with each suicide, necessarily prompting the collective tireless pursuit of evidence-based clinical interventions and community prevention strategies. In this spirit, VA offers in this report a renewed and determined call to addressing the crisis of suicide in our Veteran population and among all Americans.

Veteran Status

It is important to consider Veteran suicide in the context of suicide mortality among all U.S. adults. Also, in reporting on Veteran suicide, we focus on former service members who most closely meet the official definition of Veteran status that is used by VA and other federal agencies (see endnote regarding Title 38).[3] For this report, a Veteran is defined as someone who had been activated for federal military service and was not currently serving at the time of death.

We note that a prior report indicated that there were on average 20 suicide deaths per day in 2014 when combining three groups who died from suicide: Veterans, current service members, and former National Guard or Reserve members who were never federally activated.[4]

This report is specific to Veterans as defined above (Title 38). For this reason, results should not be directly compared with information presented in previous reports.

We include information in a separate section on suicide among former National Guard or Reserve members who were never federally activated. Information regarding individuals who died by suicide during U.S. military service is available from the Department of Defense.[5]

[2] Cerel, J., Brown, M.M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, Cl. (2019) How many people are exposed to suicide? Not six. Suicide and Life Threatening Behavior, 49(2), 529–534.

[3] Section 101(2) of Title 38, United States Code defines "Veteran" for purposes of the title to mean "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." ***https://www.ssa.gov/OP_Home/comp2/D-USC-38.html***. For purpose of this report, Veterans were defined as persons who had been activated for federal military service and were not currently serving at the time of death.

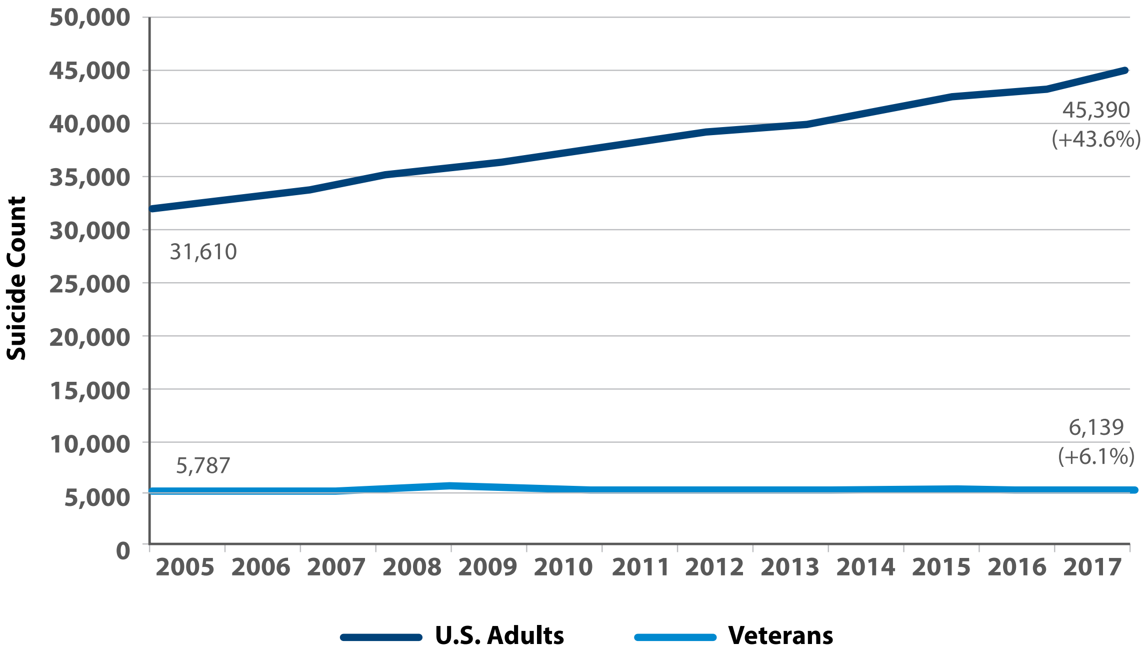
[4] Department of Veterans Affairs, Office of Suicide Prevention. Suicide Among Veterans and Other Americans, 2001–2014. 3 August 2016. ***https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf***

[5] For information on suicide among current service members, official suicide counts are published in the Department of Defense (DoD) Quarterly Suicide Report, available at ***www.dspo.mil/Prevention/Data-Surveillance/Quarterly-Reports***.

Suicide Across the United States

- 45,390 American adults died by suicide in 2017, compared with 31,610 in 2005.[6]
- These deaths included 6,139 Veterans in 2017, compared with 5,787 in 2005.[7]
- In 2017, Veterans accounted for 13.5% of all deaths by suicide among U.S. adults and constituted 7.9% of the U.S. adult population. In 2005, Veterans accounted for 18.3% of all deaths by suicide and represented 11.3% of the U.S. adult population.

Graph 1. Number of Suicides, U.S. Adult and Veteran Populations



Across the nation, the number of suicide deaths has been rising since the turn of the millennium. From 2005 to 2017, there was a 43.6% increase in the number of suicide deaths in the general population and a 6.1% increase in the number of suicide deaths in the Veteran population.

- In 2005, an average of 86.6 American adults, who included Veterans, died by suicide each day. In 2017, an average of 124.4 Americans died by suicide each day.
- In 2005, an average of 15.9 Veterans died by suicide each day. In 2017, an average of 16.8 Veterans died by suicide each day.

[6] The U.S. adult population increased from approximately 215 million to 251 million during this period.

[7] The U.S. Veteran population decreased from approximately 24.2 million to 19.8 million during this period.

Understanding the Cultural Context of Suicide in the United States

There is:

- No all-encompassing explanation for suicide
- No single path to suicide[8]
- No single path away from suicide[9]
- No single medical cause, etiology, or treatment or prevention strategy

Instead, suicide involves dynamic and individual interactions between the following domains:

- International (e.g., war, the global economy)
- National (e.g., economic disparities, media portrayals and accounts, policies pertaining to lethal means access, policies pertaining to health care access)
- Community (e.g., health care access, employment rates, level of community services and connectedness, homelessness rates)
- Family and relationship (e.g., level of social support, intensity of relationship problems)
- Individual (e.g., health and well-being)

Demonstrating the interplay of these dynamic domains, U.S. suicide rates have been found to vary by decade, by economic conditions, by region and state, by demographics, and by occupational categories. Suicide rates among Veteran users of Veterans Health Administration (VHA) services have been found to be affected by economic disparities, homelessness, unemployment, level of military service connected disability status, community connection, and personal health and well-being. The following details highlight VHA Veteran experiences across these domains:

- **Economic Disparities:** Veterans enrolled in VHA care were less likely to be employed and had lower income levels than Veterans not receiving VHA care.[10] Some Veterans report difficulty in transitioning to civilian positions. Their highly developed skills obtained in the military may not translate to higher-level positions in the civilian world. In addition, unemployment and poverty are correlated with homelessness among Veterans.
- **Homelessness:** In January 2017, the U.S. Department of Housing and Urban Development Point-in-Time Count estimated that 40,000 Veterans were homeless and just over 15,300 were living on the street or unsheltered on any given night. Homelessness appears to play a role in suicide for VHA patients. VHA patients with indications of homelessness or who received homelessness-related services had higher rates of suicide than other VHA patients.[11]
- **Service Connection:** VHA patients with military service connected disability status may have lower risk of suicide than other VHA patients.[11]

[8] Turecki, G., Brent, D.A. (2016). Suicide and suicidal behavior. Lancet. 387:1227–39.

[9] Zalsman G, Hawton, K, Wasserman D, van Heeringen K, Arensman E, Sarchiapone M, … Zohar J. (2016). Suicide prevention strategies revisited: 10-year systematic review. Lancet. 3:646–59.

[10] Eibner, C., Krull, H., Brown, K., Cefalu, A., Mulcahy, A. W., Pollard, M., … Farmer, C. M. (2016). Current and projected characteristics and unique health care needs of the patient population served by the Department of Veterans Affairs. RAND Health Quarterly, 5(4), 13. Accessed at: ***https://www.rand.org/pubs/periodicals/health-quarterly/issues/v5/n4/13.html***

[11] McCarthy JF, Bossarte R, Katz IR, Thompson C, Kemp J, Hannemann C, Nielson C, Schoenbaum M. 2015. Predictive Modeling and Concentration of the Risk of Suicide: Implications for Preventive Interventions in the US Department of Veterans Affairs. American Journal of Public Health. 105(9):1935–42.

- **Social Connection:** Isolation has been shown to be a risk factor for suicide.[12] Among VHA patients, suicide rates have been found to be highest among those who were divorced, widowed, or never married and lowest among those who married.[11] Also, among VHA patients, suicide rates were elevated among individuals residing in rural areas.[11] [13]
- **Health and Well-Being:** VHA Veterans who died by suicide were more likely to have sleep disorders, traumatic brain injury, or a pain diagnosis.[11] In addition, mental health diagnoses (including bipolar disorder, personality disorder, substance use disorder, schizophrenia, depression, and anxiety disorders), inpatient mental health care, prior suicide attempts, prior calls to the Veterans Crisis Line, and prior mental health treatment were also associated with greater likelihood of suicide.[11]

In summary, the sociocultural context of suicide provides a complex entwining of factors associated with, but not directly predictive of, suicide. Therefore, meaningful improvement of suicide prevention efforts is possible only through a systematic and unified public health approach addressing international, national, and community-level issues and resources paired with individualized support, care, and personal responsibility.

[12] Steele, I. H., Thrower, N., Noroian, P., & Saleh, F. M, (2017). Understanding suicide across the lifespan: A United States perspective of suicide risk factors, assessment and management. Journal of Forensic Sciences, 63 (1), 162–171. Doi: 10.1111/1556-4029.13519. Accessed at: ***https://onlinelibrary.wiley.com/doi/full/10.1111/1556-4029.13519***

[13] McCarthy JF, Blow FC, Ignacio RV, Ilgen MA, Austin KL, 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:S111–117.

Veteran Suicide in the U.S.

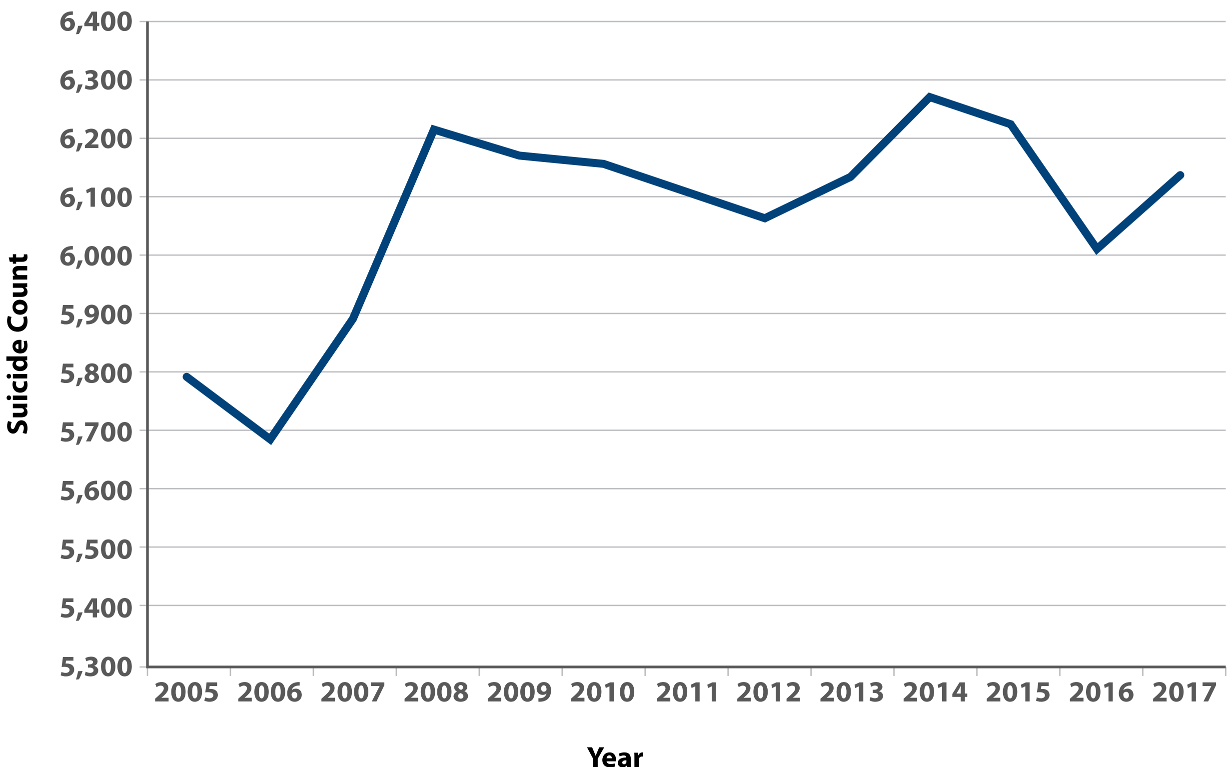
Veterans do not live, work, and serve in isolation from the community, the nation, or the world. The issue of suicide in the U.S. also affects the Veteran population. Below, we convey current Veteran suicide data, looking at both Veterans served by VHA and Veterans not accessing VHA care.

Total Number of Veteran Suicides: 2005–2017[14]

As is true of the United States broadly, the Veteran population has experienced an increase in the number of deaths by suicide.

- The number of Veteran suicide deaths per year increased from 5,787 in 2005 to 6,139 in 2017.
- The annual number of Veteran suicide deaths has exceeded 6,000 since 2008.
- The annual number of Veteran suicide deaths increased by 129 from 2016 to 2017.
- The number of Veteran suicides per year was lowest in 2006, highest in 2014, and the number in 2017 was lower than in five of the prior years.

Graph 2. Annual Number of Veteran Suicides, 2005–2017



[14] The numbers reported in this section are actual counts of each Veteran who died by suicide. Beyond total count, unadjusted rate calculations can be helpful for understanding mortality within each population. Adjusted rates attempt to account for differences between populations, e.g., in age and sex. For further discussion and presentation of suicide rates, see Page 10.

Average Number of Veteran Suicides per Day: 2005–2017[15]

The average number of Veteran suicides per day increased from 2005 to 2017.

- In 2005, an average of 86.6 American adults, who included Veterans, died by suicide each day. In 2017, an average of 124.4 Americans died by suicide each day.
- In 2005, an average of 15.9 Veterans died by suicide each day. In 2017, an average of 16.8 Veterans died by suicide each day.
- The average number of Veteran suicide deaths per day has equaled or exceeded 16.0 since 2007.
- The average of 16.8 Veteran suicide deaths per day in 2017 was higher than the 16.4 average suicide deaths per day in 2016 and equal to or lower than in 2008–2011 and 2013–2015.
- 16.8 Veteran average deaths per day in 2017 is lower than the annual averages in 7 of the last 13 years.

Table 1. Total and Daily Average Numbers of Suicide Deaths, Title 38 Veterans, 2005–2017

Year	Suicide Deaths	Average per Day
2005	5,787	15.9
2006	5,688	15.6
2007	5,893	16.1
2008	6,216	17.0
2009	6,172	16.9
2010	6,158	16.9
2011	6,116	16.8
2012	6,065	16.6
2013	6,132	16.8
2014	6,272	17.2
2015	6,227	17.1
2016	6,010	16.4
2017	6,139	16.8

[15] Previous VA reporting regarding average suicide deaths per day included suicides among Title 38 Veterans, current service members and former never federally activated Guard and Reserve members. In reporting on suicide deaths through 2016, information was provided regarding Title 38 Veterans and, separately, the number of deaths among former never federally activated Guard and Reserve. In this year's report, we focus on the Title 38 Veterans, and in supplemental reporting, we provide not only counts but also rates for the former never federally activated Guard and Reserve. Information regarding suicide among current service members is available from the Department of Defense Suicide Prevention Office.

Age- and Sex-Adjusted Suicide Rate

The Veteran population decreased by 18% from 2005 to 2017. To allow for comparisons between populations and over time, suicide rates have been adjusted to account for population differences by age and sex.[16]

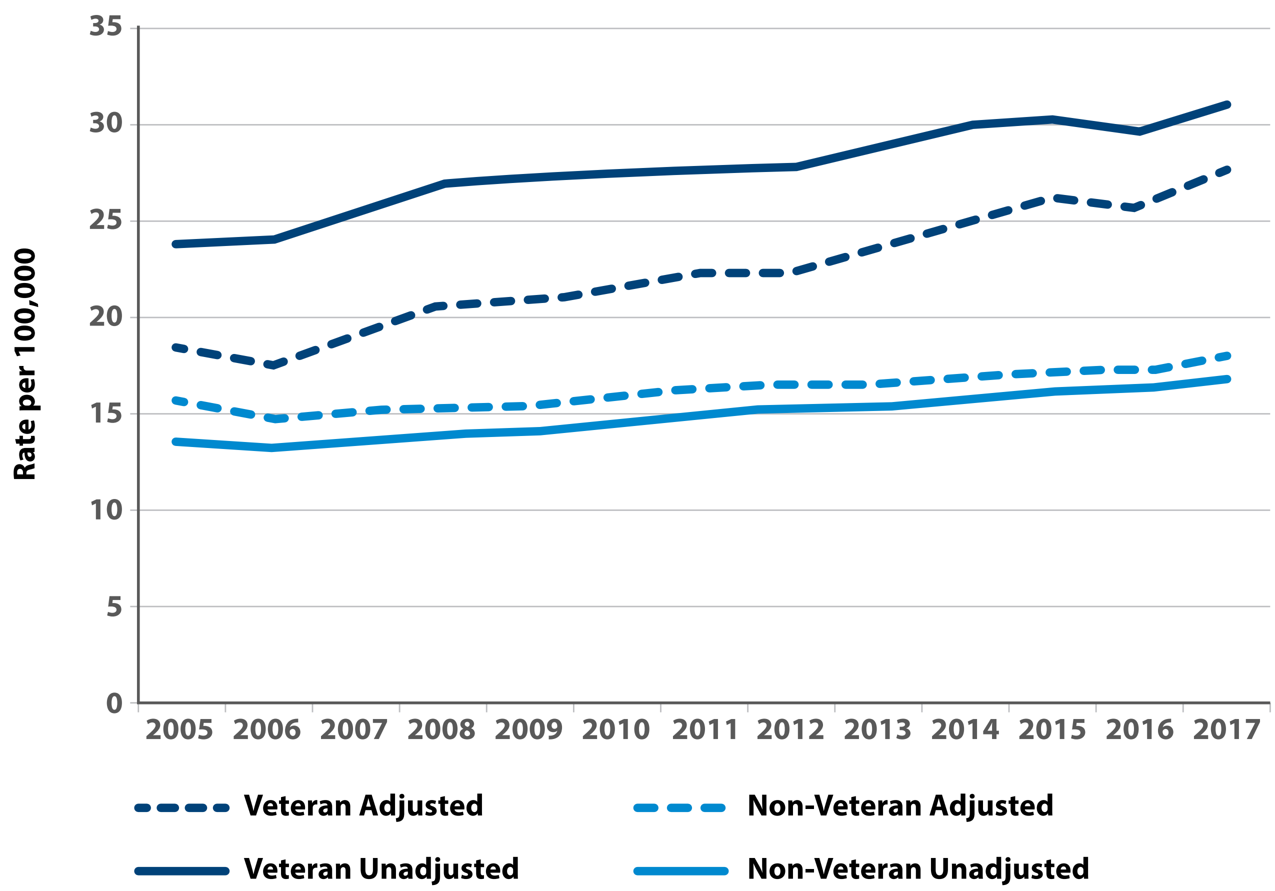
- From 2005 to 2017, the age- and sex-adjusted suicide rate for the overall U.S. population increased from 14.7 suicide deaths per 100,000 to 18.0 per 100,000.
- The suicide rates for both Veterans and non-Veteran adults increased between 2005 and 2017.
- The U.S. population increased by 17.0% from 2005 to 2017.
- The Veteran population decreased by 18.3% from 2005 to 2017.
- The age- and sex-adjusted suicide rate for the Veteran population increased from 18.5 suicide deaths per 100,000 in 2005 to 27.7 per 100,000 in 2017.
- The age- and sex-adjusted rate for the Veteran population increased from 25.7 suicide deaths per 100,000 in 2016 to 27.7 suicide deaths per 100,000 in 2017. The change from 2016 to 2017 is not statistically significant; however, the adjusted suicide rate for Veterans increased significantly from 2005 to 2017.
- In 2017, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, after adjusting for age and sex.

Table 2. Age- and Sex-Adjusted Veteran Suicide Rate per 100,000 Population Members, 2005–2017

Year	Suicide Deaths	Average per Day	Veteran Population	Age-and-Sex-Adjusted Suicide Rate
2005	5,787	15.9	24,240,000	18.5
2006	5,688	15.6	23,731,000	17.6
2007	5,893	16.1	23,291,000	18.8
2008	6,216	17.0	22,996,000	20.6
2009	6,172	16.9	22,603,000	20.8
2010	6,158	16.9	22,411,000	21.4
2011	6,116	16.8	22,061,000	22.3
2012	6,065	16.6	21,765,000	22.4
2013	6,132	16.8	21,415,000	23.6
2014	6,272	17.2	21,029,000	25.0
2015	6,227	17.1	20,560,000	26.3
2016	6,010	16.4	20,170,000	25.7
2017	6,139	16.8	19,803,000	27.7

[16] Unadjusted rates can be helpful for understanding mortality within each population. We note that the Veteran population is older and has a higher a percentage of men in comparison with the non-Veteran population. Thus, we also include age and sex adjusted rates, per the U.S. 2000 Standard Population. Annual rates are per 100,000 population or, for Veterans with recent VHA use, person-years, as risk time could be calculated exactly for the VHA population.

Graph 3. Unadjusted and Age- and Sex-Adjusted Suicide Rates for Veterans and Non-Veteran Adults (2005–2017)

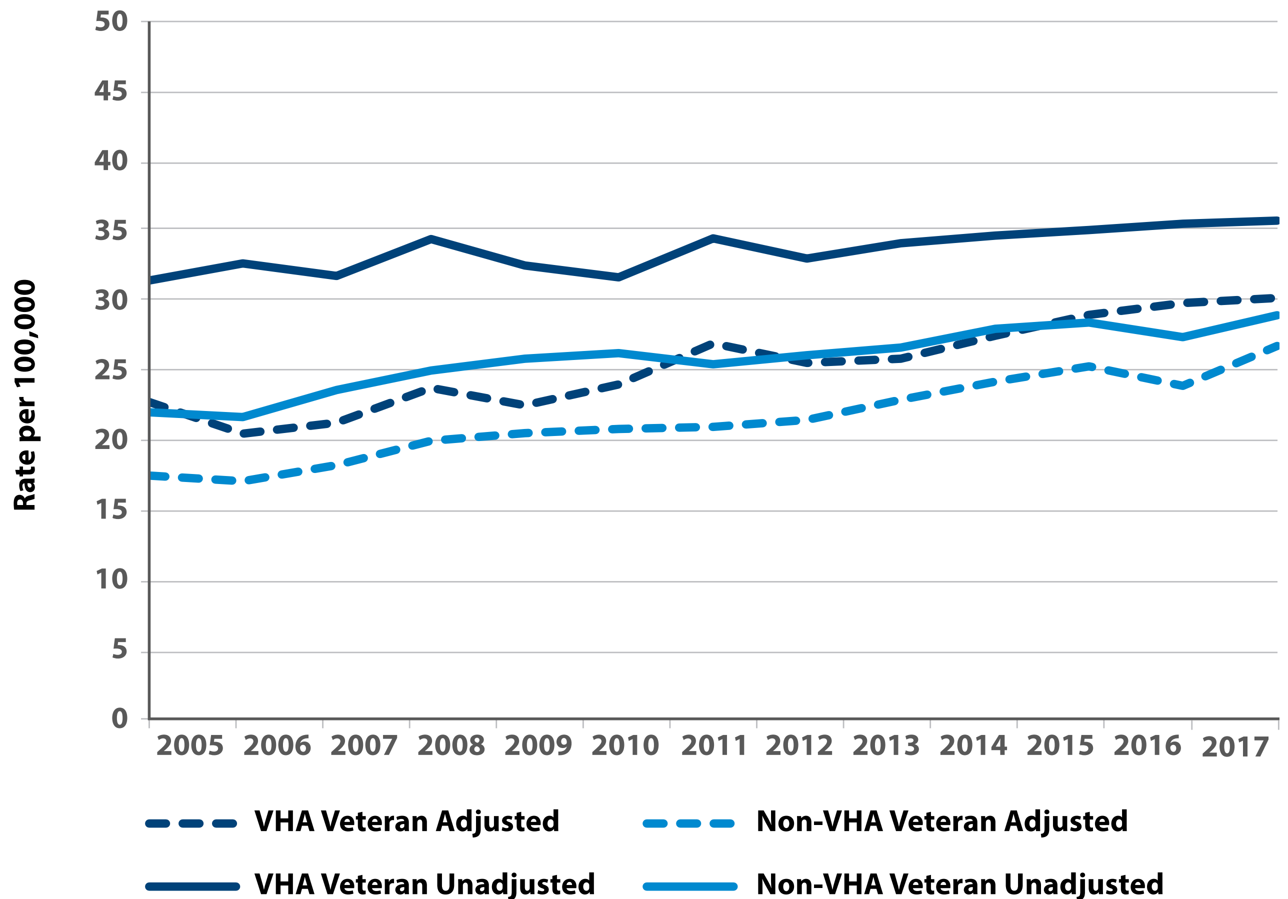


Age- and Sex-Adjusted Suicide Rates for Veterans Who Used VHA Care

This section presents information on suicide deaths and rates among Veterans with recent use of VHA care and those without recent VHA use. Veterans who had recently used VHA care were defined as Veterans who had a VHA health encounter in the calendar year of interest or in the prior calendar year.

- For each year, from 2005 to 2017, Veterans with recent VHA use had higher suicide rates than other Veterans. However, over these years, suicide rates among Veterans with recent VHA use increased at a slower pace than for other Veterans.
- The age- and sex-adjusted suicide rate among Veterans with recent VHA use increased by 1.3% between 2016 and 2017.
- The age- and sex-adjusted suicide rate among Veterans who did not use VHA care increased by 11.8% between 2016 and 2017.

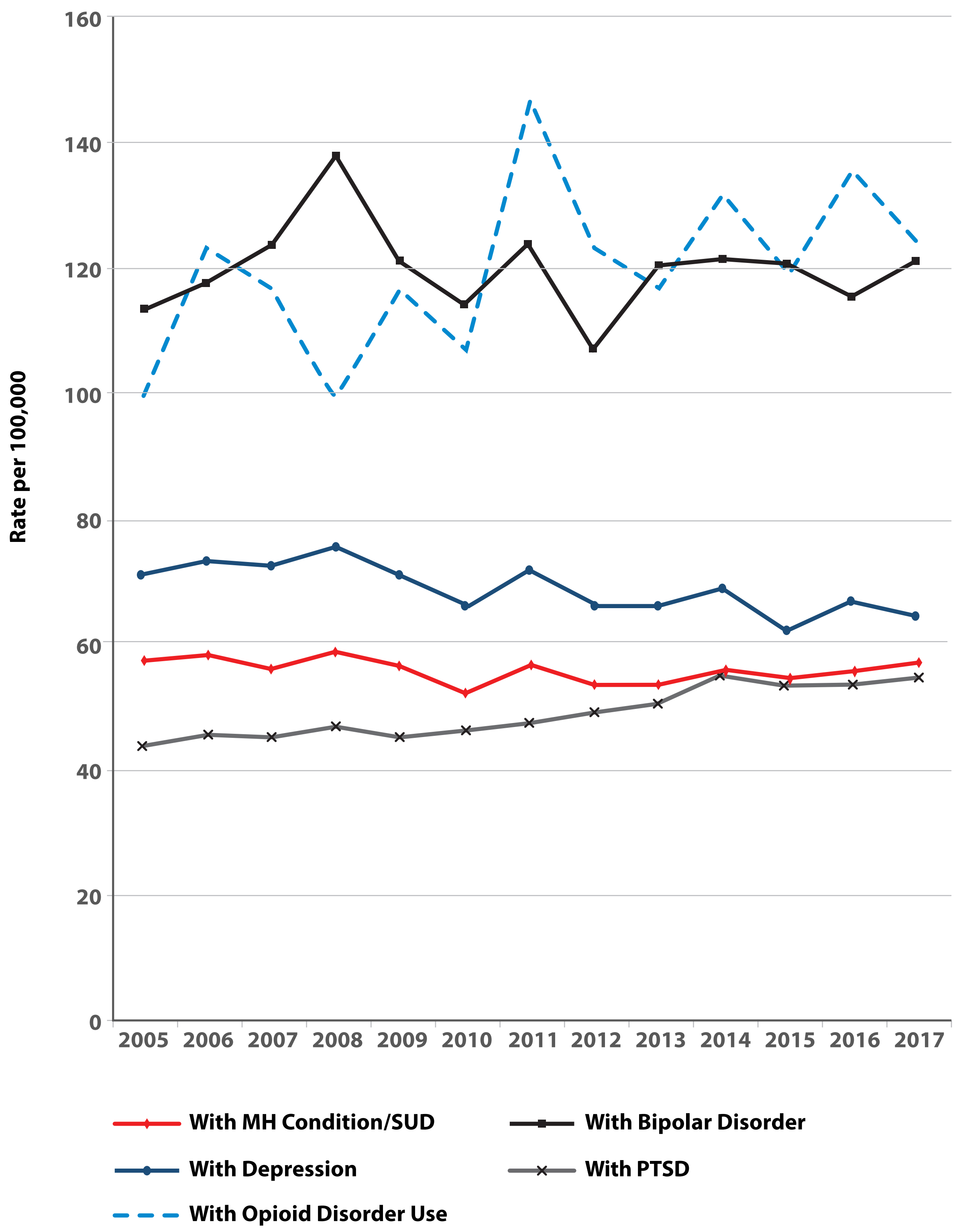
Graph 4: Age- and Sex-Adjusted Suicide Rates, Veterans With and Without Recent VHA Care, 2005–2017



Suicide Rates Among Veteran VHA Patients With Mental Health or Substance Use Disorders

- Among Veterans with recent VHA use who died by suicide in 2017, 58.7% had a diagnosed mental health or substance use disorder in 2016 or 2017.
- In 2017, VHA patients with any mental health or substance use disorder diagnosis had a suicide rate of 56.9 per 100,000, compared with 57.1 per 100,000 in 2005.
- Suicide rates were highest among Veteran VHA patients diagnosed with bipolar disorder and those diagnosed with opioid use disorder.
- For VHA patients diagnosed with depression, the suicide rate decreased from 2005 to 2017, from 70.2 per 100,000 to 63.4 per 100,000.

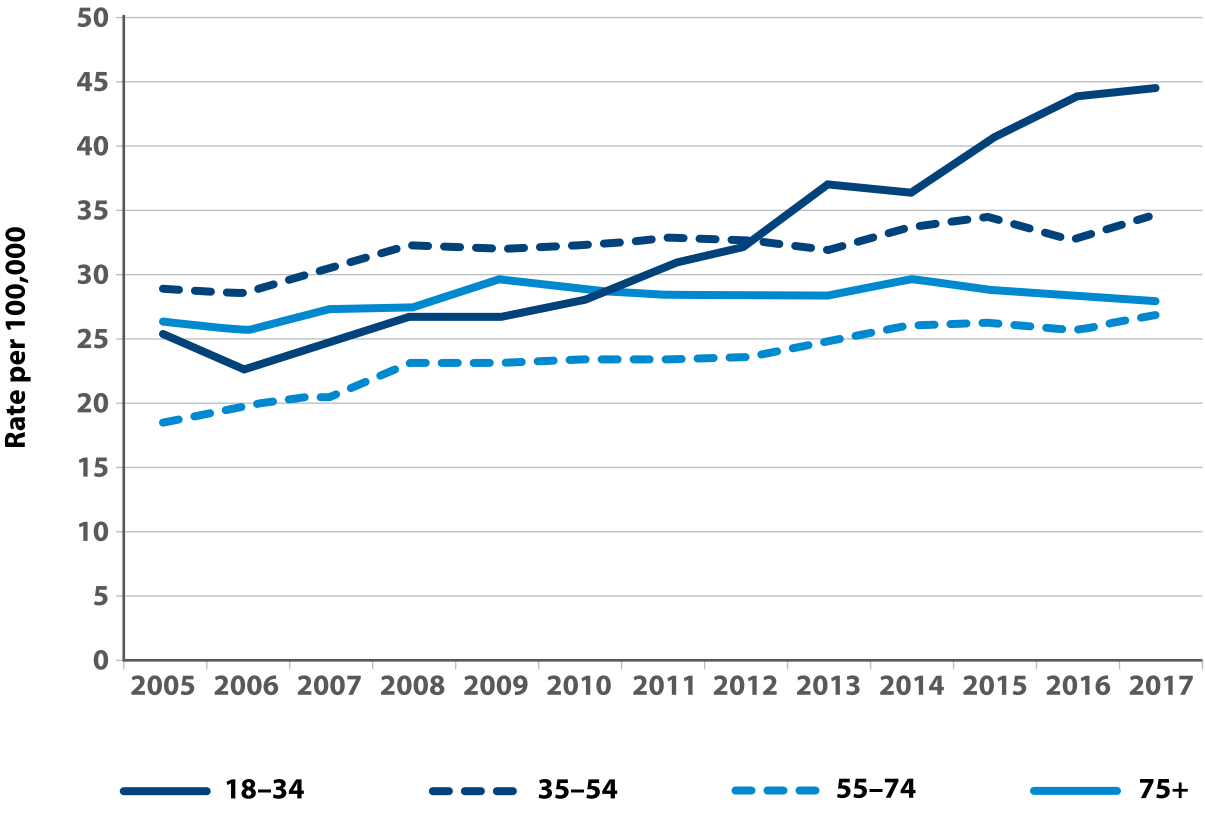
Graph 5. Suicide Rates per 100,000, Among Veteran VHA Patients With Mental Health (MH) or Substance Use Disorder (SUD) Diagnoses, 2005–2017



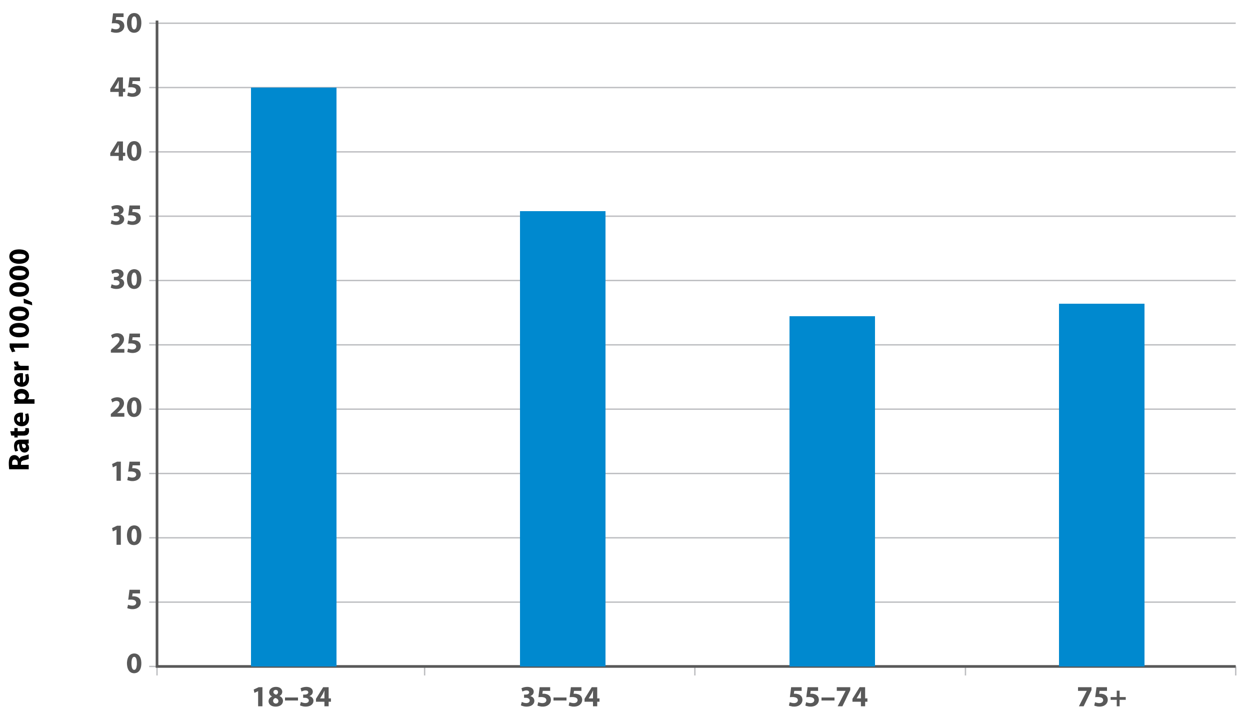
Veteran Suicide Rates by Age Group

- Veterans ages 18–34 had the highest suicide rate in 2017 (44.5 per 100,000).
- The suicide rate for Veterans ages 18–34 increased by 76% from 2005 to 2017.
- Veterans ages 55–74 had the lowest suicide rate per 100,000 in 2017.
- The absolute number of suicides was highest among Veterans 55–74 years old. This group accounted for 38% of all Veteran deaths by suicide in 2017.

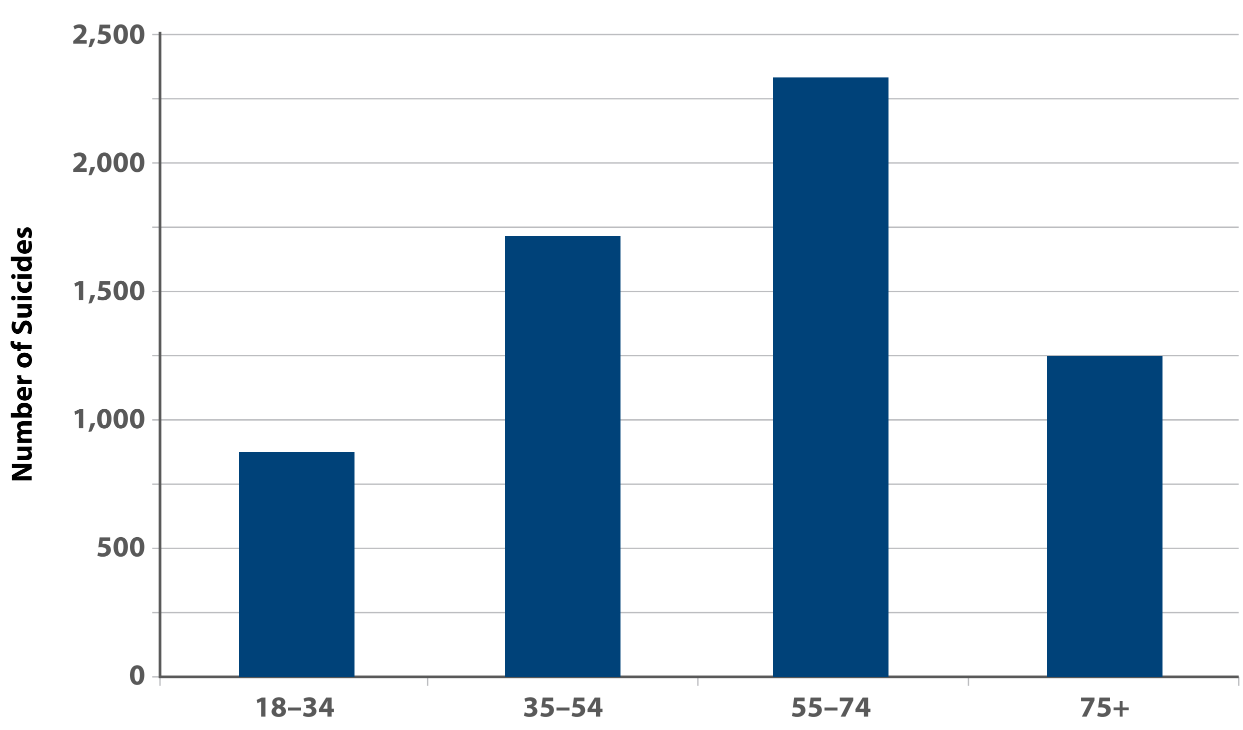
Graph 6. Veteran Suicide Rates per 100,000, by Age Group, 2005–2017



Graph 7. Veteran Suicide Rates per 100,000, by Age Group, 2017



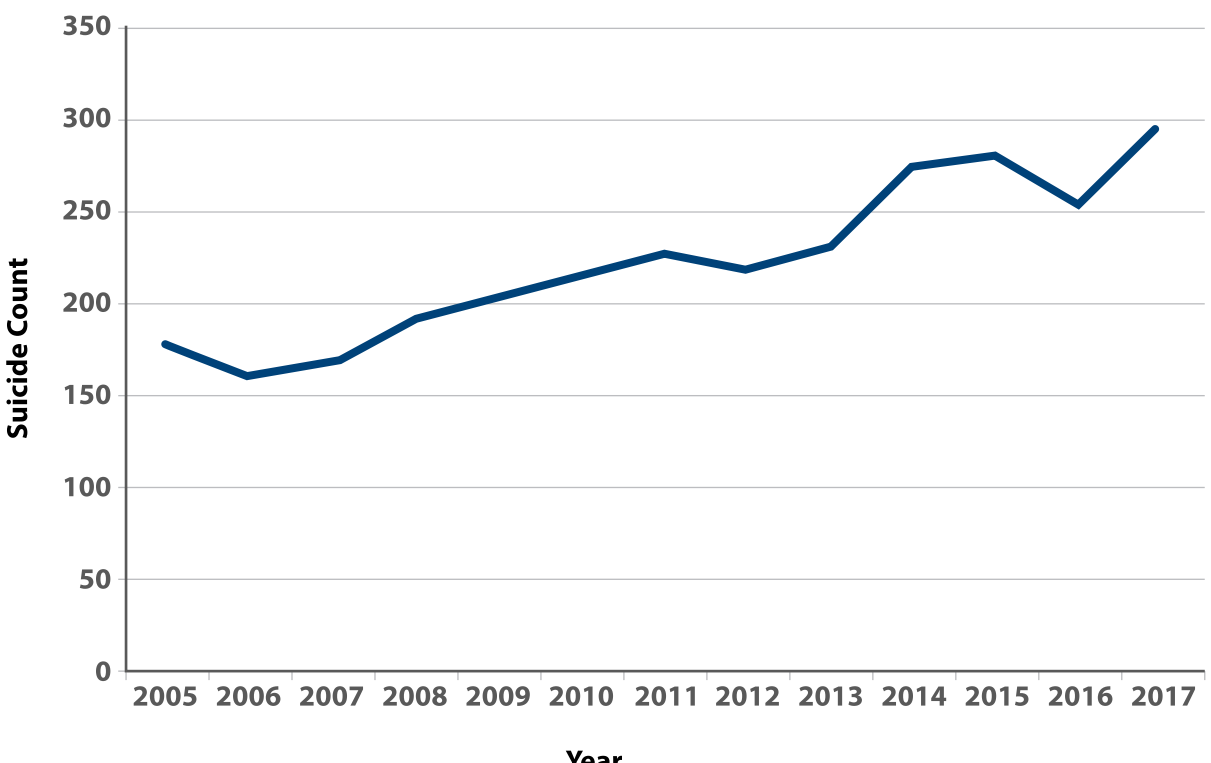
Graph 8. Veteran Suicide Counts by Age Group, 2017



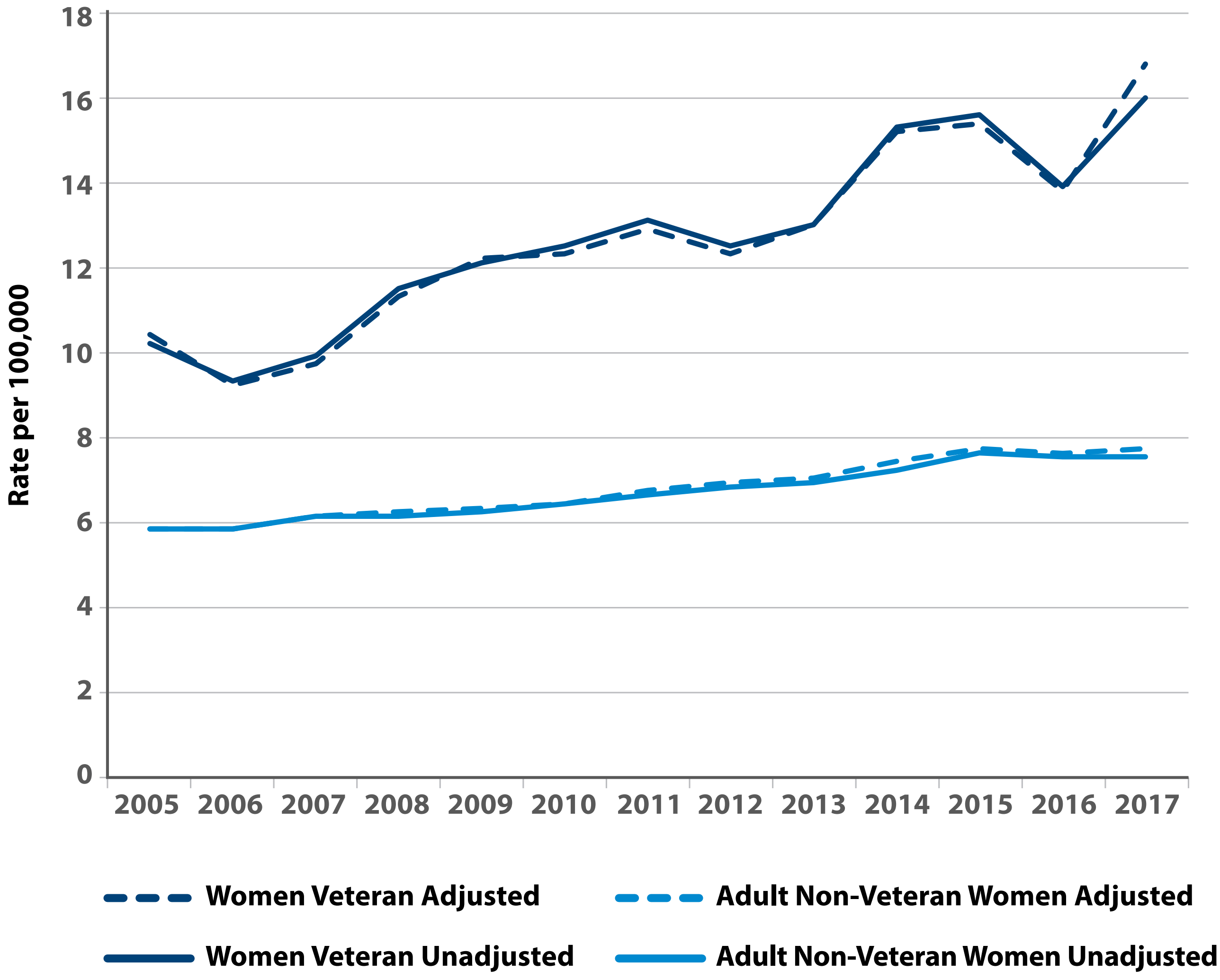
Veteran Suicide Rate by Sex

- Between 2005 and 2017, the women Veteran population increased by 6.5%.
- After adjusting for age, the 2017 rate of suicide among women Veterans was 16.8 per 100,000, compared with 39.1 per 100,000 among male Veterans.
- After adjusting for age, the 2017 rate of suicide among women Veterans was 2.2 times the rate among non-Veteran women.
- After adjusting for age, the 2017 rate of suicide among male Veterans was 1.3 times higher than the rate among non-Veteran males.

Graph 9. Total Count of Suicides Among Women Veterans, 2005–2017



Graph 10. Suicide Rates Among Women Veterans and Non-Veteran Women, 2005–2017



Veteran Suicide Methods

- In 2017, 69.4% of Veteran suicide deaths were due to a self-inflicted firearm injury, while 48.1% of non-Veteran adult suicides resulted from a firearm injury.
- In 2017, 70.7% of male Veteran suicide deaths and 43.2% of female Veteran suicide deaths resulted from a firearm injury.

Table 3. Method of Suicide Among Veteran and Non-Veteran Adults Who Died from Suicide, 2017

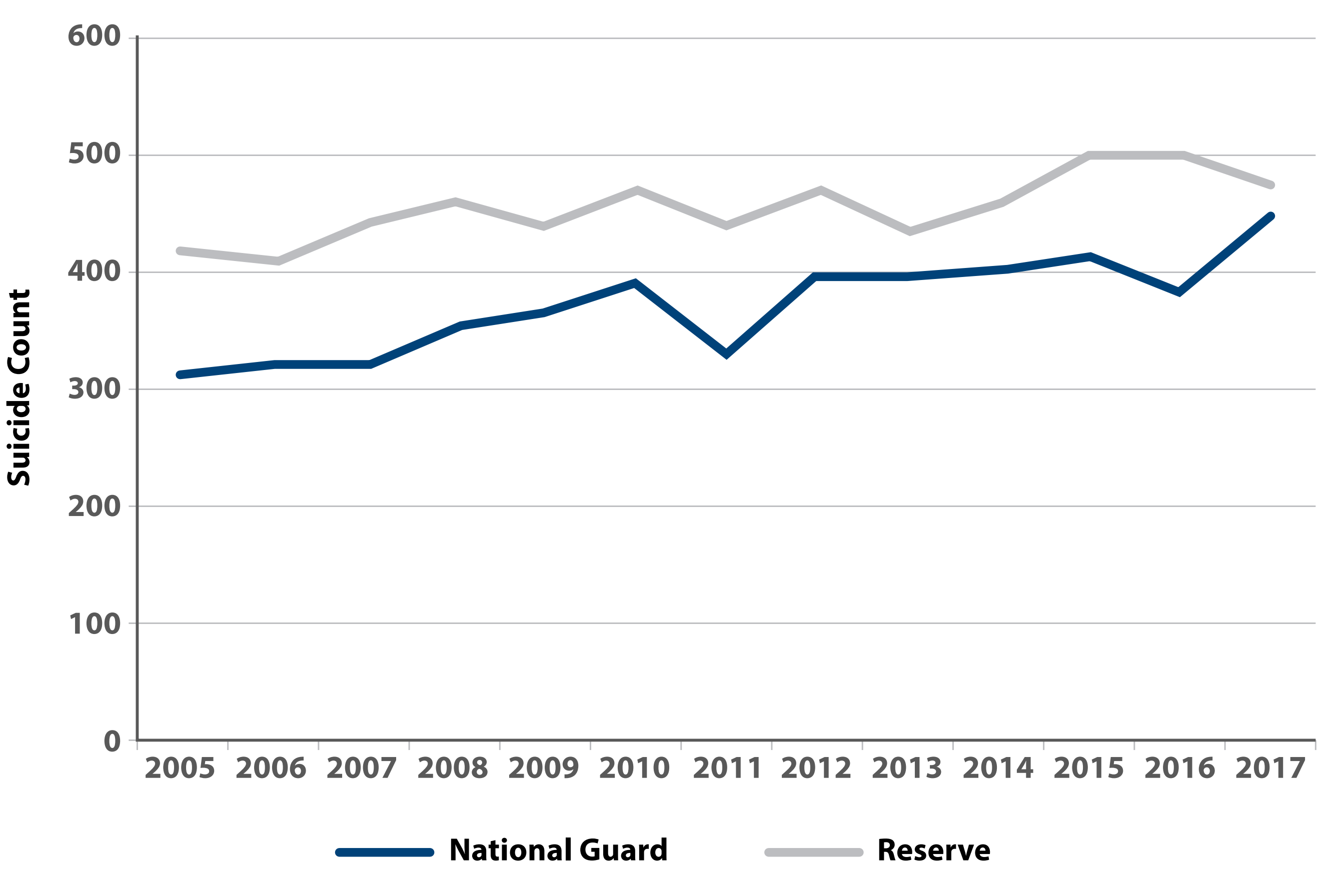
Method	Percentage of Non-Veteran Adult Suicide Deaths	Percentage of Veteran Suicide Deaths	Percentage of Male Non-Veteran Adult Suicide Deaths	Percentage of Male Veteran Suicide Deaths	Percentage of Female Non-Veteran Adult Suicide Deaths	Percentage of Female Veteran Suicide Deaths
Firearm	**48.1%**	**69.4%**	**53.5%**	**70.7%**	**31.3%**	**43.2%**
Poisoning	**14.9%**	**9.9%**	**9.2%**	**8.9%**	**32.3%**	**28.7%**
Suffocation	**28.7%**	**15.8%**	**29.3%**	**15.6%**	**26.6%**	**19.9%**
Other	**8.4%**	**5.0%**	**7.9%**	**4.8%**	**9.8%**	**8.1%**

Never Federally Activated Former Guard and Reserve Members

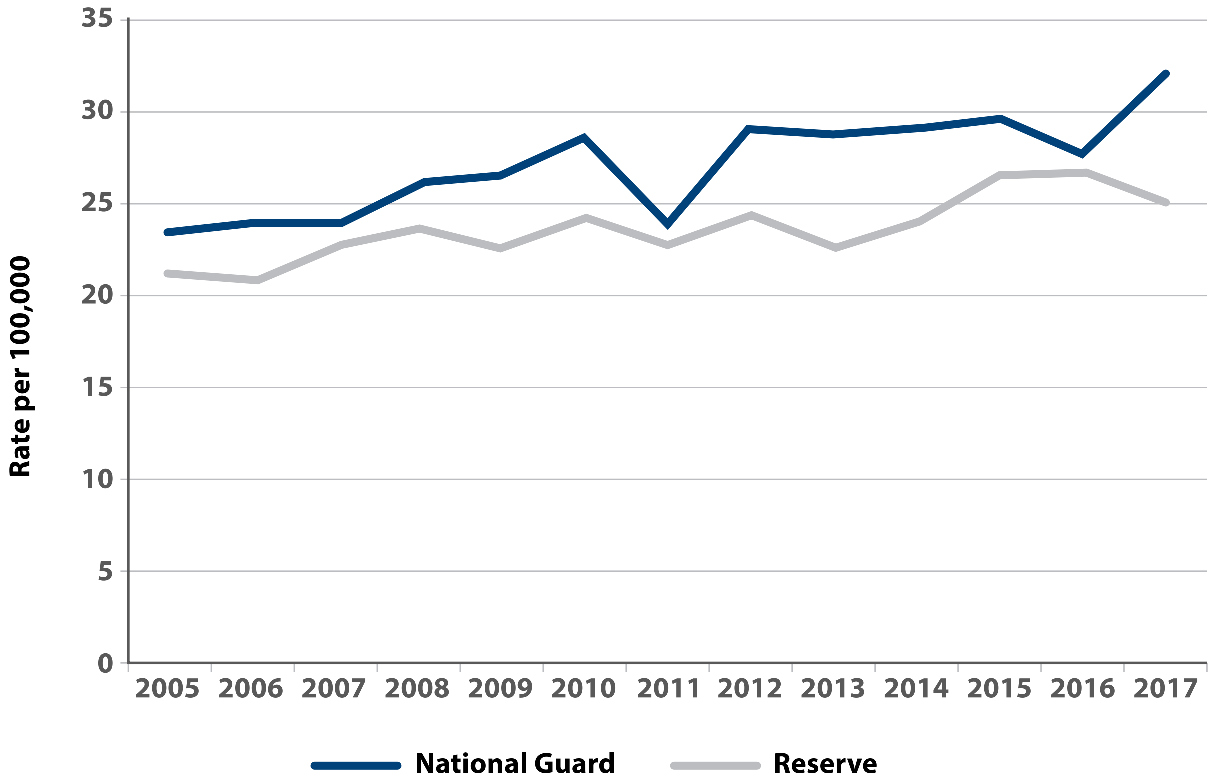
Former National Guard and Reserve members are former service members who may not have Veteran federal legal status due to their type of service. This typically limits their access to VA benefits and services under current laws and regulations. In 2017, there were 919 suicides among never federally activated former National Guard and Reserve members, constituting about 12.4% of the total number of suicides among current and former service members (Graph 11).

- Between 2016 and 2017, the suicide rate among never federally activated former National Guard members increased from 27.7 per 100,000 to 32.2 per 100,000.
- Between 2016 and 2017, the suicide rate among never federally activated former Reserve members decreased from 26.6 per 100,000 to 25.3 per 100,000.
- In 2017, there were 919 suicides among never federally activated former National Guard and Reserve members, an average of 2.5 suicide deaths per day.

Graph 11: Number of Suicides Among Never Federally Activated Former National Guard and Reserve Members (2005–2017)



Graph 12. Suicide Rates Among Never Federally Activated Former National Guard and Reserve Members (2005–2017)



VA in 2017 and 2019: Putting 2017 Data Into Context

Data in this report is derived from 2017 and earlier. It is therefore challenging to directly and immediately evaluate the impact of initiatives and actions in the present. Since 2017, VA has been actively coordinating across VHA Veterans Integrated Service Networks (VISNs), the Veterans Benefits Administration, and the National Cemetery Administration to address Veteran suicide. VA also has worked in partnership with the White House, Congress, the Centers for Disease Control and Prevention, the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, and communities nationwide. Notable developments since 2017 include the following:

Key Initiatives Reaching All Veterans Since 2017

Initiative	Purpose	Key Outcomes
Veterans Crisis Line	Provide 24/7 crisis services for all Veterans by phone, text messaging, or online chat.	• The Veterans Crisis Line is the world's largest provider of crisis call, text, and chat services. • The crisis line improved from answering 70% of incoming calls in 2017 to answering at an average of eight seconds or less 99.96% of calls without rollover in 2019. • The crisis line expanded text and chat access. • The crisis line serves over 650,000 calls per year.
Research and Innovation	Expand awareness and study of innovations that address suicide prevention and mental health concerns in Veteran populations.	• VA has made progress in clinical research developing and testing evidence-based psychotherapy advances; medications; and behavioral, complementary, and alternative approaches to treating PTSD and other mental health conditions affecting Veterans.

Initiative	Purpose	Key Outcomes
Community Partnerships	Expand partnerships with the community to reduce suicide among all Veterans, not just those receiving VHA services.	• VA has expanded its partnerships, with current partners representing hundreds of organizations and corporations at the national and local levels — including Veterans Service Organizations (VSOs), professional sports teams, and major employers. Partners are raising awareness of VA's suicide prevention resources and educating people about how they can support Veterans and service members in their communities. • In March 2018, VA and the Substance Abuse and Mental Health Services Administration launched the Mayor's Challenge partnership to provide cities across the nation with tools and technical assistance for addressing Veteran suicide at the local and community level. The Mayor's Challenge has currently equipped 24 cities with information, resources, and support for creating localized Veteran suicide prevention plans. • The Mayor's Challenge served as a model for the Governor's Challenge, which launched in February 2019 in seven states.
Clinical Partnerships	Expand health care services for Veterans waiting for services or in remote locations with less access to VA locations.	• VA is partnering with community-based mental health providers to expand the network of local treatment resources available to Veterans in need.
Outreach	Expand awareness of and engagement in suicide prevention initiatives within and outside VA.	• More than 400 VA Suicide Prevention Coordinators (SPCs) and their teams, located at every VA Medical Center, connect Veterans with care and educate the community about suicide prevention programs and resources.

Key Initiatives Reaching VHA Veterans Since 2017

Initiative	Purpose	Key Outcomes
Mental Health SAIL Expansion	Provide standardized method for assessing quality of mental health services in VA's SAIL system to provide senior VA leaders with a summary measure regarding VA mental health programs.	• A mental health domain was added to the VHA Strategic Analytics for Improvement and Learning (SAIL) dashboard. • Mental health SAIL includes three composites (population coverage, continuity of care, and experience of care) to "screen" facilities for problems in access or quality, to trigger action planning, and to identify top-performing facilities and best practices. • Facilities with lower than average levels of access and quality in the fourth quarter of FY 2016, as indicated by the SAIL mental health domain, had generally improved by the third quarter of FY 2017, while facilities with excellent access and quality have generally maintained performance over the year. • Of the 48 facilities at more than one-half of a standard deviation (SD) below the mean in FY 2016 Q4, 40 (83%) improved by FY 2017 Q3. Eleven (23%) had large improvement. • Of the 42 facilities at more than one-half of an SD above the mean in FY 2016 Q4, 41 (97%) maintained above-average performance, and 37 (88%) remained more than one-half of an SD above average in FY 2017 Q3.
Primary Care-Mental Health Integration (PCMHI)	Expand primary prevention and early engagement into care by embedding mental health providers in primary care settings and through collaborative care management.	• Expansion of PCMHI focused upon during the MyVA Access Initiative launched in 2016 to improve same day access to service. • Since tracking began in FY 2008, VA has provided over 10 million PCMHI encounters, serving over 2 million patients. In FY 2018 alone, VA provided over 1.2 million clinical encounters for over 400,000 patients. • VA provided more than 1.2 million mental health visits in primary care settings in FY 2017, an increase of 4% from FY 2016 and up 20% from FY 2014. PCMHI same-day access services were only occurring for new Veterans to PCMHI 36.2% of the time (FY 2016 Q4), compared with 53.2% presently (FY 2019 Q3). • The reach of PCMHI services (the percentage of patients in primary care who receive PCMHI services) increased from 7.7% in FY 2016 to 9.0% in FY 2019 (through June 30, 2019).

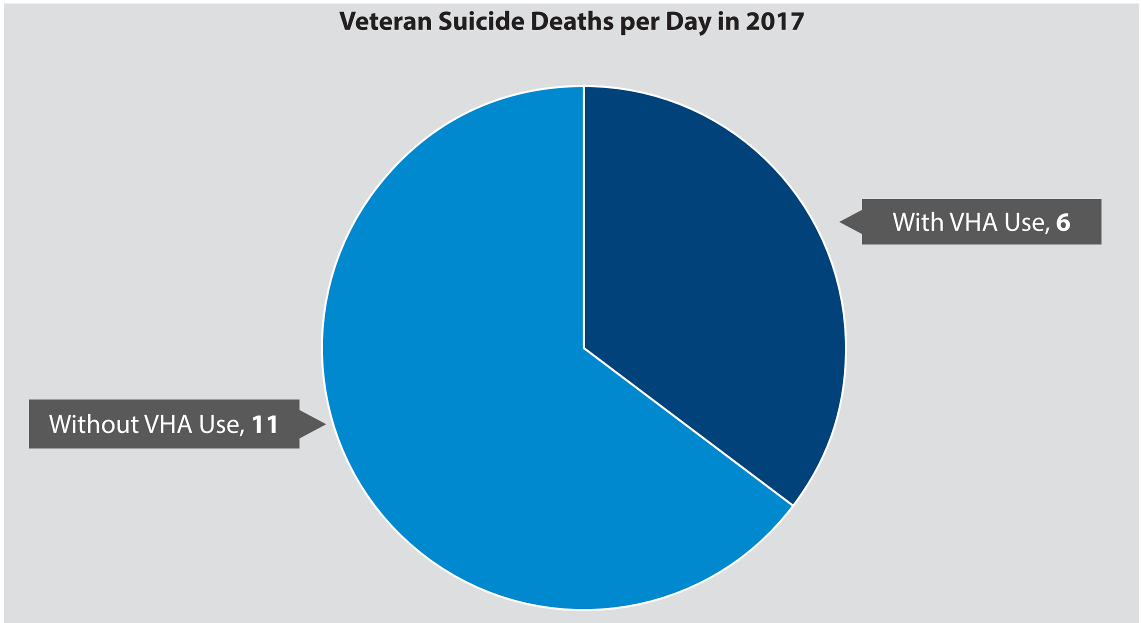
Initiative	Purpose	Key Outcomes
Universal Screening	Provide standardized method for identifying Veterans at high risk for suicide.	• In 2018, VA implemented the largest standardized suicide risk assessment initiative in U.S. health care. • More than 2.8 million Veterans have received standardized risk screening since October 1, 2018, with approximately 3% reporting suicidal ideation.
Expansion of the MyVA Access Initiative	Launched in 2016 with a specific mental health goal of implementation of same day access to services.	• Mental health same-day access service was established across VA in 2017. • In mental health care clinics, the number of same-day scheduled appointments increased from 796,242 in FY 2017 to 824,276 in FY 2018 (an increase from 11.13% to 11.18%). The percentage of new patients with same-day appointments increased from 29.5% (FY 2017) to 33.2% (FY 2018). • In PCMHI, the number of same-day appointments increased from 132,799 in FY 2017 to 179,453 in FY 2018 (representing an increase from 19.1% of all PCMHI appointments to 24.3%).
Mental Health Treatment Coordinator (MHTC)	Assigns an MHTC for each Veteran receiving ongoing VA specialty mental health care to ensure continuity of care and provides the Veteran with a consistent and reliable point of contact, especially during times of care transitions.	• The MHTC serves as a clinical resource for the Veteran and their providers, generally as part of the Veteran's assigned mental health care team. • As of January 30, 2018, 1,347,189 Veterans had an assigned MHTC.
Evidence-Based Treatment Expansion	Expand access to evidence-based treatments for mental health conditions.	• More than 12,700 VA mental health clinicians have been trained in evidence-based treatments, including over 8,500 VA mental health staff members trained in prolonged exposure (PE) and/or cognitive processing therapy, two of the most effective therapies for PTSD. • VA also offers evidence-based medication treatments that may be indicated for a variety of conditions.

Initiative	Purpose	Key Outcomes
Care Related to Military Sexual Trauma	Provide all military sexual trauma-related care free of charge. Veterans may be able to receive this care even if they are not eligible for other VA care. Receipt of free military sexual trauma-related services is separate from the VA disability compensation process; documentation of military sexual trauma (MST) and a service-connected disability are not required for those seeking services.	• In FY 2017, every VHA health care system provided MST-related outpatient care to both women and men. More than 1,325,000 MST-related outpatient mental health visits were provided to Veterans who screened positive for MST — a 9% increase from FY 2016.
Women's Mental Health	Expand access to and quality of mental health services for women Veterans.	• A national network of Women's Mental Health Champions, representing nearly every VA health care system, is now in place to disseminate information, facilitate consultations, and develop local resources in support of gender-sensitive mental health care. • VA has developed numerous clinical training resources for VA providers who treat women Veterans, including a monthly teleconference series, a special teleconference series for prescribers, and web-based advanced clinical training courses that include live demonstrations and role-playing exercises.

Reaching Veterans Not in VHA Care

The majority of Veterans do not use VHA services, and the majority of Veteran suicides occur among Veterans who have not recently received VHA services. VHA has an unparalleled system of recovery-oriented integrated mental health care services, ranging from early preventive services in primary care to intensive residential and inpatient services. One recent study compared over 800,000 Veterans receiving medication treatment for mental health disorders in VHA with over 500,000 comparable individuals in the private sector. The authors found that VHA's performance was superior by greater than 30%.[17] Over 12,700 VHA mental health care providers have received training and supervision in evidence-based psychotherapies.[18] In a comparison of 132 VA hospitals with 402 non-VA hospitals, researchers found that VA performed comparably to or better than non-VA facilities across most nationally recognized quality measures for care, including depression treatment.[19]

As part of the Clay Hunt Suicide Prevention for American Veterans Act (Public Law 114-2), VA mental health and suicide prevention programs were reviewed by independent third-party evaluators.[20] Based on their analyses of the Veterans Outcome Assessment (VOA), these evaluators concluded that engagement in VHA mental services was associated with decreased rates of suicidal ideation and suicide attempts. Twenty-seven percent of Veterans who completed VOA surveys reported that they wished they were dead, 15% reported thoughts of killing themselves, and 8% reported suicidal thoughts or intent in the three months prior to engaging in mental health services. Three months later, Veterans reported decreased suicidal ideation and behaviors. Yet we still are not reaching every Veteran who might benefit from these services.



Note: In 2017, among Veterans who died by suicide, 38% had a VHA encounter in 2016 or 2017 (6.3 suicide deaths per day), while 62% had not (10.5 per day). The chart presents this information as 6 vs. 11 per day to communicate the loss of each Veteran's life.[21]

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[17] Watkins, K.E., Smith, B., Akincigil, A., Sorbero, M. E., Paddock, S., Woodroffe, A., … Pincus, H.A. (2016). The quality of medication treatment for mental disorders in the Department of Veterans Affairs and in private sector plans. Psychiatric Services, 67, 391–396.

[18] Veterans Health Administration (2018). VA Office of Mental Health and Suicide Prevention Guidebook. Washington, DC.

[19] Price, R.A., Sloss, E. M., Cefalu, M., Farmer, C. M., & Hussey, P. S. (2018). Comparing quality of care in Veterans Affairs and non-Veterans Affairs settings. Journal of General Internal Medicine, 33 (10), 1631–1638.

[20] 2018 Annual Report: VA Mental Health Programs and Suicide Prevention Services Independent Evaluation (October 2018). First annual report to Congress written by staff at ERPi, Booz Allen Hamilton and Altarum.

[21] This data includes Title 38 Veterans only. Title 38 Veterans exclude those individuals who were currently in active service at time of death or were former never federally activated Guard or Reserve (see p. 19 for information on this group previously covered in prior reports). It should be noted that this adjustment should be considered when citing these numbers in comparison to previous reports, which were not specific to Title 38 Veterans. These numbers are not comparable.

Call to Continued and Further Action

Much More to Urgently Do for the All-Some-Few

Following the National Academy of Medicine's framework, VA suicide prevention strategies may be understood in terms of three levels of strategic focus. First, *universal* strategies aim to reach *all* Veterans. These include public awareness and education campaigns regarding the availability of suicide prevention resources for Veterans and the promotion of responsible media coverage. Second, *selective* strategies are designed for *some* Veteran subgroups that may be at increased risk for suicidal behaviors. Examples include targeted outreach to women Veterans, to Veterans with substance use challenges, and to Veterans with recent separation from military service. And third, *indicated* strategies are designed for the relatively *few* individual Veterans who are identified as having high risk for suicide. Indicated strategies include referral to the Veterans Crisis Line and clinical review and outreach for those Veterans in the highest tier of predicted statistical risk, as VA has implemented in the REACH VET (Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment) program. Each approach equally and urgently matters.

Current VA Public Health Approaches to Suicide Prevention in Partnership With the Community

VA is actively working to reach not only Veterans receiving VHA health services but also other Veterans in the community. In fiscal year 2019, a key goal for VA was the expansion of the public health approach to save lives by reaching Veterans, their loved ones, their communities, and the greater population. Activities range from reaching all Veterans as a primary prevention strategy before they are at high risk for suicide to immediately addressing the needs of those at highest risk for suicide. The table below outlines these high-priority activities across the continuum of care. We actively welcome partnerships with states, organizations, and individual community members in these approaches as well as new innovations to address these needs across the population of all Veterans.

Table 4. Summary of VA Population Health Approaches

	Universal (All)	Selected (Some)	Indicated (Few)
Individual	1. ASCEND survey 2. RISK ID strategy – PHQ2 + I9 3. Whole health 4. EO 13822 5. Paid media campaign – crisis 6. Separated service member dashboard	1. REACH VET 2. Gun locks 3. Clinical practice guidelines 4. RISK ID strategy – C-SSRS 5. SPED 6. SDVCS nomenclature 7. CPG for SP 8. SPP guide 9. CRISTAL/SPPRITE 10. Independence Fund retreats 11. CBT-Insomnia 12. CBT-Pain 13. $AFE money management 14. Paid media campaign – risk groups 15. IBM – GRIT 16. Objective Zero partnership 17. SPP directive	1. High risk flagging 2. CBT-s telehealth 3. Postvention 4. Suicide data report 5. BHAP/FIT-C 6. Enhanced care delivery – high-risk Veterans 7. Risk ID Strategy – CSRE 8. High-risk flag dashboard 9. Revenue Operations 10. ICD-10/SBOR suicidal behaviors 11. State data sheets 12. Issue brief tracking
Relationship	1. S.A.V.E. training 2. Together We Can literature review series.	1. Caring Letters – SPC 2. Safety planning – SPED 3. Conjoint couples therapy 4. Cohen Veterans Network partnership 5. Warrior Care Network/ Wounded Warrior Project partnership	1. Safety planning – high risk 2. Suicide Risk Management Consultation Program 3. Caregiver toolkit 4. CaringBridge partnership

	Universal (All)	Selected (Some)	Indicated (Few)
Community	1. Veterans Crisis Line 2. Mayor's and Governor's Challenges 3. VISN 23 pilot 4. SP 2.0 initiative 5. SP – public health education 6. SPP guide – outreach 7. Suicide Prevention Coordinators – outreach 8. SP VA Pulse page 9. Zero suicide (Clay Hunt) 10. Together With Veterans 11. PsychArmor S.A.V.E. training 12. CVEBs (VEO)	1. Firearm safety toolkit pilot 2. SP 2.0 initiative 3. SPC hiring initiative 4. From Science to Practice literature review series 5. LGBT health education pilot 6. SP 2.0 dashboard	1. SP CoP VA Pulse page 2. Guidance for action following a suicide on VA campus 3. Rural health survey
Societal	1. National Strategy for Preventing Veteran Suicide, 2018–2028 2. Safe firearm storage campaign	1. Entertainment industry messaging campaign	1. Safe messaging campaign

Join Us in Action

Suicide is a national issue, with rising rates of suicide in the general population. In addition, suicide rates are higher, and are rising faster, among Veterans than among non-Veteran adults. Every death by suicide is a tragedy that affects individuals and communities. Unfortunately, no one strategy in isolation has been shown to be effective in ending suicide. We must come together to address systematically the larger societal issues fueling the increased rates of suicide in our nation, keeping at the forefront of our minds that we prevent suicide through meaningful connection, one person at a time.

The most recent and notable manifestation of this cross-cutting and aggressive approach to Veteran suicide prevention is the recently launched President's Roadmap to Empower Veterans and End the National Tragedy of Suicide (PREVENTS) created by the Executive Order signed by the President in March 2019. A cabinet-level task force has been launched to develop this national roadmap for suicide prevention, which will include proposals and plans addressing cross-sector integration and collaboration, a national research strategy, and a cohesive implementation strategy. The PREVENTS taskforce is being led by an Executive Director with experience in the development and implementation of public health efforts and dedication to eradicating suicide. Efforts supporting the development of a national roadmap are already well underway and on target for delivery in March of 2020.

Acronym Listing

Acronym	Description
BHAP	Behavioral Health Autopsy Program
CBT	Cognitive Behavioral Therapy
CBT-s	Cognitive Behavioral Therapy for suicidality
CPG for SP	Clinical Practice Guidelines for Suicide Prevention
CRISTAL	Capri, REACH VET, Risk Indicators, STORM Tool for Analytic Look-up
CVEB	Community Veteran Engagement Board
EO 13822	Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life
FIT-C	Family Interview (Template) Contact Form
FY	Fiscal year
IBM-GRIT	Not an acronym; a mobile solution for Veteran well-being
MH	Mental Health
MHTC	Mental Health Treatment Coordinator
PCMHI	Primary Care Mental Health Integration
PE	Prolonged Exposure
PTSD	Posttraumatic Stress Disorder
Q	Quarter
REACH VET	Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment
SAIL	Strategic Analytics for Improvement and Learning
S.A.V.E.	Signs, Ask, Validate, and Encourage and Expedite
SBOR	Suicide Behavior and Overdose Report
SD	Standard Deviation

Acronym	Description
SDVCS nomenclature	Self-Directed Violence Classification System
SP	Suicide Prevention
SP CoP	Suicide Prevention Community of Practice
SPC	Suicide Prevention Coordinator
SPED	Safety Planning in the ED
SPP	Suicide Prevention Program
SPPRITE	Suicide Prevention Population Risk Identification and Tracking for Exigencies
VA	Department of Veterans Affairs
VEO	Veteran Experience Office
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization

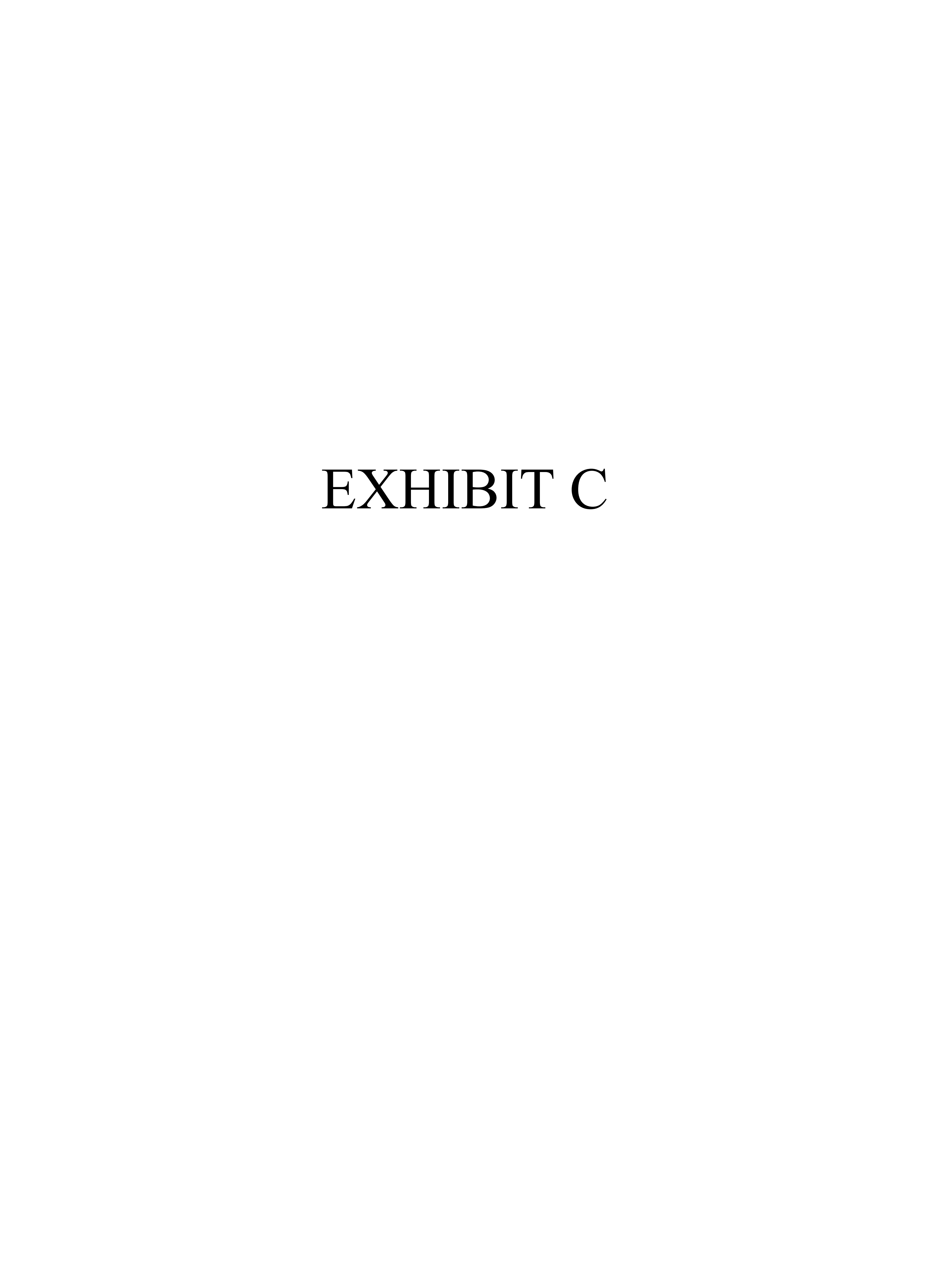


EXHIBIT C

Addressing the Opioid Crisis: What Does Alabama Need?

August 23rd, 2021

TUSCALOOSA, Ala. – Alabamians face many structural barriers to treatment of opioid addiction, such as access and transportation to treatment facilities as well as hostile attitudes among the public and family members to addiction, according to research led by The University of Alabama.

The findings come from statewide surveys and discussions with community leaders and the public. The assessments are the first step to provide a framework to reduce health disparities related to addiction and opioids in Alabama.

The work is part of the Alabama Provider Capacity Project, based at UA, and supported by a $5.1 million grant funded by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. The goal of the project is to decrease health disparities related to addiction and opioids, particularly in Alabama's rural and low-income communities.

The research began during the pandemic as Alabama's opioid crisis worsened. Drug overdoses in Alabama increased by 20% during 2020, according to the Alabama Department of Mental Health.

Researchers found Alabamians must travel far distances to get access to treatment like detox or in-patient programs. Many people travel to a new city, county or across state lines to access treatment. Over 27% of Alabamians struggling with addiction reported transportation as a barrier to seeking treatment. Further, for over 35% of Alabamians seeking treatment, finding a program that fits their schedule is a barrier.

"This is especially a problem in Alabama's rural areas when the same people who lack nearby access to treatment also lack the necessary transportation to get to treatment," said Dr. David Albright (https://socialwork.ua.edu/blog/social-theme-staff/david-l-albright-phd/), project leader and the Hill Crest Foundation Endowed Chair in Mental Health Research in the UA School of Social Work. "By the time someone secures transportation, gets time off work, and finds a treatment center with availability, they've lost interest. We need to be able to help people when they want the help."

The research also suggests a need for more public health education to address knowledge of and stigma surrounding addiction. Attitudes hostile to treatment facilities locating near residential neighborhoods or beliefs about certain treatments being better than others pose as barriers to treatment.

Over 18% of Alabamians who have struggled with addiction described family shame as a barrier to accessing treatment.

"Many people still view addiction as a moral failing rather than a disease," Albright said. "That's simply not true. With the proper resources, this disease is absolutely curable. People with substance use disorder need support, not judgment."

The Alabama Provider Capacity Project is supported through a collaboration between the Alabama Medicaid Agency, the Alabama Department of Mental Health and VitAL, a behavioral health initiative at The University of Alabama School of Social Work.

To complete the research, VitAL enlisted the help of UA's Center for Economic Development, Center for Business and Economic Research, and Institute for Social Science Research.

Visit vitalalabama.com/apcp (https://vitalalabama.com/apcp/) to learn more.

The contents of the research findings do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. government.

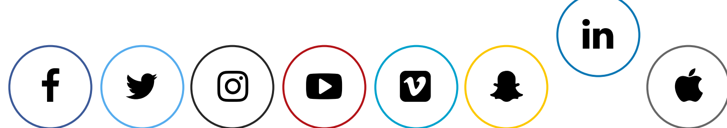
This news release was written by Erin Hackenmueller, research associate with the UA Center for Economic Development.

Health & Medicine (https://news.ua.edu/category/research/health-medicine/), Research (https://news.ua.edu/category/research/), School of Social Work (https://news.ua.edu/category/colleges-schools/school-of-social-work/)

Contact

Adam Jones, UA Strategic Communications, 205-348-4328, adam.jones@ua.edu

The University of Alabama, part of The University of Alabama System, is the state's flagship university. UA shapes a better world through its teaching, research and service. With a global reputation for excellence, UA provides an inclusive, forward-thinking environment and nearly 200 degree programs on a beautiful, student-centered campus. A leader in cutting-edge research, UA advances discovery, creative inquiry and knowledge through more than 30 research centers. As the state's largest higher education institution, UA drives economic growth in Alabama and beyond.



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DID YOU KNOW?

Total statewide economic impact of UA: $2.766 billion, 13,163 jobs, and $136.7 million in income and sales taxes ($42.4 million state sales tax, $41.2 million state income tax, and $53.0 million local sales tax). (UA Economic Impact Report 2017-18)

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EXHIBIT D

AltaPointe Health Systems, Inc.

Strategic Plan

October 1, 2019 – September 30, 2021

Counties Served

Mobile, Baldwin, Clay, Coosa, Randolph, Talladega and Washington counties in Alabama

Brief History

AltaPointe Health Systems, "AltaPointe" (formerly Mobile Mental Health Center) was established in 1957 as the primary provider of services to the mentally ill in Mobile County, Alabama. In the late 1990s, the corporation set about strategically to design a course of development to meet the current and future service needs of its patient base including expansion of service array, diversification of funding streams, and strategic partnerships with other healthcare entities. Today, AltaPointe operates two hospitals, thirty one (31) residential group homes, six foster homes, seven independent living homes, and nineteen (19) outpatient facilities that provide mental health, substance abuse, developmental disabilities, and primary care services to individuals living in South and East-Central Alabama.

AltaPointe is the 310 Authority for planning and service provision to persons with mental illness, developmental disabilities, and substance abuse disorders.

In 2019, HRSA granted AltaPointe status as a public entity Federally Qualified Health Center (FQHC) with two sites: Bayou la Batre (Mobile County) doing business as Accordia Health.

Description of Services/Supports Provided

Mental Illness

Services provided directly by AltaPointe are:

- 24-hour crisis/emergency services
- After-hours mobile crisis response team
- Adult inpatient psychiatric services for Probate Court evaluation, crisis stabilization and treatment
- Adult residential services including intermediate care facilities with partial hospitalization services, medical group homes, group homes with specialized behavioral services, small capacity group homes including one for deaf patients, basic group homes, semi-independent living apartments, Shelter Plus care, permanent housing for the homeless, and other community based residential care designed to assist patients in various phases of recovery from mental illness

- Adult outpatient services for seriously mentally ill adults including psychiatric, nursing, counseling, case management, ACT, and Bridge team services provided through 12 sites in Mobile, Baldwin, Clay, Coosa, Randolph, Talladega and Washington counties
- Integrated services for adults in local federally qualified health center
- On-site behavioral health/substance abuse assessments and brief counseling in local FQ look-alike
- On-campus behavioral health referral and treatment services at local FQ look-alike
- Adult day treatment and rehabilitative day programs
- Supportive housing
- Supported employment
- Jail diversion services for seriously mentally ill adults
- Transitional age residential group homes
- Independent living program for transitional age youth
- Intensive in-home intervention teams for children, adolescents, and adults
- Specialized intensive in-home intervention teams for adolescents with juvenile justice involvement
- Specialized intensive in-home intervention teams for the dually diagnosed and intellectual disabilities/serious emotional disturbance population
- Specialized intensive in-home intervention teams for transitional age youth
- Mental health assessment services provided in local health department and juvenile court
- Outpatient services for seriously emotionally disturbed children and adolescents at seven sites in Mobile, Baldwin and Washington counties
- Child and adolescent day treatment/educational services
- Child and Adolescent afterschool day treatment
- Specialized child and adolescent intensive after school services for the dually diagnosed DD/SED population
- School-based mental health services in 151 sites over 13 school districts
- Child and adolescent inpatient psychiatric services
- Child and adolescent intensive residential services
- 75-desk educational day treatment program for SED children in partnership with Mobile County Public School System, Baldwin County Public School System and other local school systems in the Mobile County region
- In-house full service pharmacy services

Sub-contracted services to the mentally ill

AltaPointe also provides foster home and assisted living home services to adults through sub-contracts with Bayou Oaks, Tajuacha I and II, G&M House, Carrington Place and Carrington Specialty.

Substance Use Disorders

AltaPointe provides treatment for adults with substance use disorders and prevention services for adolescents and transitional age youth on an outreach basis. Specific services include:

- Medication assisted treatment
- Intensive outpatient program including services to the dually diagnosed
- Special Women's intensive outpatient program
- Prevention services in Baldwin County
- Adult outpatient treatment – north region

AltaPointe provides prevention services directly in Baldwin County. A variety of programs are provided aimed at specific target populations and addressing specific risk factors in the community. In addition, the Baldwin County prevention program acts as a bridge builder to improve prevention services for Perry, Wilcox, Marengo, Sumter, Greene, Lowndes, and Washington Counties through the Partnership for Success grant. Prevention services are discussed more fully in the Prevention Plan for AltaPointe.

Developmental Disabilities

Services to persons with developmental disabilities in Mobile County are developed and provided through sub-contracts issued by Region III of the Alabama Department of Mental Health (DMH). DMH contracts directly with and provides oversight of services provided by Volunteers of America, The Learning Tree, AltaPointe, L'Arche, ECI, Inc., as well as several independent contractors providing foster home services. A comprehensive array of services and supports are developed and provided to individuals with intellectual and developmental disabilities and their families who reside in Mobile, Talladega, Clay, Coosa and Randolph Counties. These services are provided through contractual arrangements with the Department of Mental Health Developmental Disabilities Division. Developmental disabilities services and supports may range from information and referral, to case management or hourly services, to maximum supports that provide 24 hour care.

The service array includes:

- Day habilitation
- Residential services
- Skilled nursing
- Behavior therapy
- Physical therapy
- Occupational therapy
- Respite care
- Case management
- Supported employment
- Community experience

Federally Qualified Health Center (FQHC)

AltaPointe owns and operates a Federally Qualified Health Center with a current site in Bayou la Batre, Alabama and a site scheduled to open in Rockford, Alabama in late 2019. The purpose of initiating an FQHC is to develop a care delivery system that shares a joint culture and mission to provide mental health and primary care in an integrated setting. An integrated setting can help minimize stigma and discrimination, while providing opportunities to improve overall health outcomes.

Accordia Health's current service area includes ten Zip Code Tabulation Areas (ZCTAs) along the Southern Alabama Gulf Coast in Mobile County. These ZCTAs include the towns/cities of Bayou La Batre, Coden, Irvington, Grand Bay, Theodore, Saint Elmo, and a portion of Mobile.

Services provided directly by Accordia Health are:

- General Primary Medical Care
- Diagnostic Laboratory
- Diagnostic X-ray
- Screenings
- Voluntary Family Planning
- Coverage for Emergencies During and After Hours
- Immunizations
- Well Child Services
- Gynecological Care
- Obstetrical Care (Prenatal, Intrapartum, and Postpartum): Accordia has collaborative relationships with area hospitals for obstetrical care.
- Preventive Dental through referral arrangements with local dentists
- Patient Education
- Pharmacy through contract with local pharmacy programs
- Mental Health and Substance Abuse
- Case Management
- Health Education
- Outreach
- Assistance coordinating transportation
- Interpretation and Translation services

Population Served

AltaPointe provides or ensures the provision of services to seriously mentally ill adults; seriously emotionally disturbed children and adolescents; developmentally disabled children and adults; and those adults and adolescents with a substance use disorder in the service area.

The metropolitan area including Mobile County is 2,828 square miles. The City of Mobile is the dominant urban area in the county with cities of Saraland, Prichard, Chickasaw, Bayou la Batre and other townships lying north and south of Mobile. The most recent estimated population for the Mobile SMSA is 607,696 with a median age of 35.7. The population is 68% Caucasian, 28% African-American, 1.7% Hispanic and 0.5% other origin. Median household income for the area is $43,876.

Baldwin County, one of the fastest growing counties in Alabama, is a mixed rural, urban and Gulf Coast tourist area of 1,590 square miles bordering Mobile, Clarke, Escambia and Monroe counties of Alabama and the Florida state line. The county seat is in Bay Minette; other municipalities include Daphne, Fairhope, Foley, Spanish Fort and the Gulf Shores/Orange Beach area. The most recent census places the population at 200,111 of which 83% are Caucasian, 9.5% African-American, 4.6% Hispanic and 3% other origin. There is a heavy influx of "snowbirds" or retirees from northern states and Canada who reside in the coastal region during the winter season.

Washington County is located in southwest Alabama and enclosed by the Mississippi state line, Choctaw County, the Tombigbee River and Mobile County. The county is 682,000 acres and about 1,065 square miles. About 88% of the land is situated forest and pine plantations. Urban areas include the towns of Chatom (where a satellite office of AltaPointe is located), McIntosh and Millry. Washington County's population is approximately 17,069. Farming is an important aspect of rural Washington County.

The counties in the north region of Clay, Coosa, Randolph and Talladega are largely rural with a total population of approximately 129,000. The racial makeup in the region is primarily Caucasian and approximately 30% Black or African American. AltaPointe has outpatient offices in Sylacauga, Talladega, Lineville, and Roanoke communities and other residential and day habilitation services throughout three of the four counties.

Mission Statement

AltaPointe Health Systems plans and facilitates a comprehensive behavioral and primary care healthcare system that promotes the wellness of people living with mental illness, substance use disorders and developmental disabilities.

Vision Statement

AltaPointe will be recognized as an industry leader in providing an innovative and comprehensive healthcare system that promotes and advances best clinical practices, education, staff development and satisfaction, strategic partnerships, and advanced technology.

Planning Cycle

As the 310 Authority board for the region served, AltaPointe continuously gathers information to assess needs in the community and plan for services to the mentally ill, the developmentally disabled, and those with substance use disorders. A formal plan for services is developed no less than every two years.

Key Stakeholders and their Roles

Community providers provide information on services currently being performed as well as information on patient demographics, funding sources, development opportunities, barriers to services and patient needs for services.

Patient and family input provides primary source information on services provided and is sought primarily through patient Perception of Care Surveys distributed monthly by AltaPointe's Performance & Improvement department and other providers. The surveys solicit specific suggestions and comments on care and treatment from patients and their family members.

AltaPointe's Regional Consumer Councils consist of patients and/or legal guardians of child or adolescent patients who have volunteered to work with AltaPointe's administration, provide a patient's perspective on the quality of services provided and suggestions for programmatic or operational modifications to better serve patients. The Councils were founded on the premise that patients of AltaPointe should have input into matters concerning patient care. The Councils meet with AltaPointe Performance Improvement staff and provide suggestions for improvement. The Performance Improvement Department takes the ideas and suggestions to the Performance Improvement Committee, consisting of the 310 Leadership team, for consideration, implementation or feedback.

Leadership and management staff of AltaPointe meet monthly with, and play an active role in, the local affiliate of the National Alliance on Mental Illness (NAMI). Topics addressed include patient and family needs for services, access to care, barriers to services and other issues that impact effective service delivery to the mentally ill. All information received is reported to the appropriate member of the leadership staff of AltaPointe immediately following each meeting for problem resolution and exploration of ideas. Over the years, the NAMI membership has provided AltaPointe with valuable information on access to care, crisis intervention services, residential care needs and other service needs of the seriously mentally ill.

The Region III and V offices of the Alabama Department of Mental Health (DMH) serve the local areas for services to the developmentally disabled and are fully responsible for the monitoring and evaluation of services to this population. Through contract with DMH, AltaPointe's north region provides DD case management services to individuals in the region.

Method of Needs Assessment

AltaPointe meets as needed with each of the major providers under contract with the 310 Board for state or local funding, as well as several other agencies and stakeholders in the communities served, to review current service provision and to assist in the assessment of service needs for the area. Those participating in the assessment process include community providers that provide services funded by DMH, patients, family members, the AltaPointe Consumer Councils, the local affiliate of NAMI, the Regional offices for Developmental Disabilities Services for the State of Alabama, as well as other agencies in the community providing services to our patients such as local primary care providers, federally qualified health centers, hospitals, jails, DHR offices, and school systems.

Annually, the AltaPointe Leadership Team reviews its Strategic Plan including the mission and vision statements, budget, clinical and administrative programming and staffing in light of service needs, emerging trends, new treatment alternatives, and program funding for specific community needs.

When a specific service need is noted and funding identified, the Division Director, program manager and other clinical or administrative personnel design a program to meet the need, developing the program description for approval by leadership and third-party funding source, where applicable.

The AltaPointe Consumer Councils, the local affiliate of NAMI, patients and families provide additional sources of information to assist in the assessment of needs for mental illness services. Surveys elicit information on meeting the treatment needs of the patients, patient knowledge of service provision and access to services, involvement in the treatment plan, etc.

Often needs are identified through contact with other agencies in the community that call on AltaPointe to address a particular need. AltaPointe enjoys a respectful working relationship with the various local public school systems, Strickland Youth Center of Mobile, various federally qualified health centers, local and state DHR, and other agencies and healthcare providers in the community where needs and resources are identified and explored.

Because of our proximity to the Gulf of Mexico and its related industries, AltaPointe is often called upon to assist in needed crisis response and disaster relief services. In cooperation with local, state and federal authorities, AltaPointe develops programming to address the mental health needs as identified.

Finally, AltaPointe's certification, accreditation and licensing processes occasionally identify areas of weakness in addressing a particular need in the community.

Information gathered from each of the areas above is reported to the various leadership team members and considered in the annual review of the Strategic Plan.

Prevention Services

Needs for the proposed prevention services (identified in the Strategic Plan for Prevention Services) are identified by compiling and analyzing available information regarding demographic data, youth survey data, and risk and protective factor data for the catchment area. This process solicits input and involvement from key leaders in the community, in addition to service providers.

Other assessment tools/data sources utilized to identify prevention and treatment needs for adolescents include:

- Most recent Census Data for Baldwin, Mobile, and Washington counties
- Alabama Kids Count Data for Baldwin, Mobile, and Washington counties
- Alabama DMH Youth Survey Data for Baldwin, Mobile, and Washington counties
- Alabama DMH Risk & Protective Factors Data for Baldwin, Mobile, and Washington counties
- Alabama DMH Indicators of Prevention Need for Baldwin, Mobile, and Washington counties
- Alabama DMH Epidemiological Profile for Baldwin County
- PRIDE Surveys for Baldwin County for Baldwin County
- Alabama Alcoholic Beverage Control Board Compliance Data for Baldwin County

- Children's Policy Council Needs Assessment for Baldwin County
- Student Incident Reports from Baldwin County Public School data.
- Other data collected from juvenile courts and other youth serving agencies.

AltaPointe provides a comprehensive spectrum of services to persons with developmental disabilities throughout the counties served. Services include residential day habilitation, supported employment, community experience, and other supports. The person centered plan approach is utilized to allow for the choice of services. This approach is the driving force to insure individualized services are provided. Services are provided in conjunction with the Alabama Department of Mental Health and Case Management.

Areas of Greatest Unmet Need

Mental Illness

For a variety of reasons, many persons with serious mental health issues do not receive adequate medical care for their primary care needs. Many of AltaPointe's adult mentally ill patients do not see a primary care physician on a regular basis. Consequently, serious medical issues may be going undiagnosed and untreated.

Medication non-compliance is particularly prevalent among the seriously mentally ill leading to inconsistent treatment compliance and a revolving door of recidivism in inpatient and residential placements.

There is a need for an Extended Observation Unit for individuals in need of intensive observation and assessment in a calming, supportive environment. Such a unit would help achieve the Triple Aim of Healthcare - an enhanced patient experience, improved population health and reduced costs by avoiding unnecessary hospitalizations.

BayPointe Hospital has seen a dramatic increase in average daily census of children. We need to ensure there are sufficient numbers of inpatient and residential care beds for children and adolescents in need of psychiatric care.

There is a need to provide specialized services for persons dealing with trauma, especially with returning veterans.

With very little private psychiatry throughout the service area, there is an increasing demand for outpatient child and adolescent psychiatry services.

Substance Use Disorders

Residential or inpatient treatment for women

Medically supervised and non-medical detox program

Public education regarding available community services available to combat the opioid crisis

Peer specialists

Developmental Disabilities

There is a continued need for sufficient psychiatric services

Residential crisis stabilization and respite services are needed especially with recent and expected future moves of individuals to the community

Summer programming for school-age children is needed to ensure skills are maintained

Transportation is needed to support employment and community integration

Services for people on the Alabama Department of Mental Health waiting list are needed

Prevention

Funding for evidence-based student alcohol and drug surveys for data collection and evaluation purposes

Funding for an evidence-based curriculum targeted for transitional age students

Funding to address underage use of e-cigarettes and marijuana

Funding for recovery support

Needed Expansions

Mental Illness and Primary Care

AltaPointe continues to acknowledge the importance of ensuring its population served receives proper attention to their medical care needs. To this end, AltaPointe has entered the primary care arena, through its primary care arm, Accordia Health. AltaPointe will continue to explore various partnership arrangements with primary care providers up to and including full integration of services and stand-alone primary care services.

With the acquisition of Cheaha Regional Mental Health Center, AltaPointe continues to assess the adequacy of services provided in the north region with special attention to increased psychiatric time, expansion of school-based programming and adequacy of outpatient facilities.

Additional psychiatric time for children and adolescents is needed throughout the service areas.

The south region continues to look for ways to expand its jail diversion program to divert mentally ill adults who do not meet the definition of SMI or those with primary substance use disorders toward treatment services rather than incarceration, when appropriate.

Continue to review treatment needs of the medically fragile including care coordination through local Alabama Coordinated Health Network (ACHN).

Continue to explore need for expanded telehealth in order to make services more accessible, particularly in the more remote areas of the catchment areas served.

Development of specialized services for transitional age youth experiencing a first episode of psychosis to provide early intervention and improve outcomes.

Expand the use of transcranial magnetic stimulation as an intervention for treatment-resistant depression.

Explore telecare and remote support for individuals who desire to live more independently

Explore development of community residential services for individuals who are deaf or hard of hearing.

Substance Use Disorders

Expansions in outpatient services to adolescents including individual, group and family counseling could be utilized.

Additional residential treatment capacity for adults.

There is additional need for psychiatric services for the dually diagnosed to address the needs of those who have non-SMI mental health issues but who need psychotropic medication.

Medication assisted treatment for north region.

Developmental Disabilities

With the recent merger with the Mobile ARC, AltaPointe is assessing needed services and the adequacy of facilities.

Personal care services.

Respite care services.

Additional psychiatric services in the community.

Skilled nursing services

Supported employment

Community integration

Prevention Services

Additional funds for prevention services would allow for expansions in current prevention services and the student drug testing program in Mobile County.

Additional funding for Baldwin County prevention services would be used to help educate parents and youth on the importance of disposing unused prescriptions, decreasing access and availability of alcohol and other drugs, and improved data collection to address drug trends.

FQHC – Accordia Health

Maximize fully integrated service delivery in Bayou la Batre office.

Open newly funded office in Rockford to provide fully integrated primary and behavioral healthcare services.

Current Funding Resources

AltaPointe receives funding from various federal, state and local sources through contracts and grants as well as Medicaid, Medicare, SEIB, PEEHIP, private insurance and private pay.

Future Funding Resources

In addition to the above resources:

AltaPointe is always open to pursuing additional programming and related funding of services offered through the Alabama Department of Mental Health and looks forward to the funding that will be available in 2019-2020 for Therapeutic Mentoring, In Home Services expansion for children, EPSDT and Peer Support.

Although not currently being actively pursued, AltaPointe plans to remain vigilant about changes to the Medicaid funding mechanism since this represents a significant portion of its revenue stream.

A return to the Medicaid Emergency Psychiatric Demonstration project or alternative method of Medicaid reimbursement for the IMD (Institute for Mental Disease) operated by AltaPointe at its EastPointe facility would allow for much-needed Medicaid reimbursement for inpatient services to adults 21-65 years of age.

AltaPointe has had a modest positive response recently to requests for federal and state grant funding in various services to adults. It is anticipated that continued success with grant funding will support many of the additional needed services that have been identified.

AltaPointe will continue to pursue funding to support integrated care models and an Extended Observation Unit.

Goals/Objectives

Goal

Expand child and adult inpatient capacity.

Objectives

a. Fully implement newly acquired certificate of need (CON) for sixteen (16) child and adolescent and eighteen (18) adult inpatient beds at BayPointe Hospital.
b. Increase adult inpatient capacity.
c. Increase children's residential bed capacity at BayPointe Hospital.
d. Continue to educate local officials regarding adequacy of resources for inpatient evaluations.
e. Continuously assess and develop clinical programming to ensure treatment interventions address the intensity of the clinical presentation of patients while ensuring patient and staff safety.
f. Continue to work with marketing staff to facilitate appropriate referrals and discharge follow-up with referral services.
g. Collaborate with the Department of Mental Health, the Alabama Hospital Association, and Medicaid to develop and submit an 1115a Waiver for the purpose of securing inpatient reimbursement for adults ages 22-64 with Medicaid insurance.

Goal

Maintain corporate readiness for changes in healthcare delivery and reimbursement.

Objectives

a. Stay abreast of national and statewide trends in healthcare financing with particular attention to pressures on state, Medicaid and Medicare funding sources.
b. Advocate at local and state level for reimbursement models designed to maximize treatment outcomes and efficient delivery of care.
c. Continue to work closely with the Alabama Coordinated Health Network (ACHN) to provide co-morbid care coordination of services to Medicaid recipients in Regions B and E.

Goal

Work with healthcare community to achieve triple aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

Objectives

a. Explore funding options and best practices for an Extended Observation Unit for patients presenting with primary psychiatric complaints.
b. Maximize fully integrated services in two Accordia Health FQHC sites.
c. Explore ways to capture the patient experience of care in real time so that improvements can be made in real time.
d. Explore opportunities for expansion through mergers and acquisitions with the goal of achieving maximum efficiencies.
e. Pursue available opportunities for behaviorally-led integration of primary care, particularly for the specialty populations served.
f. Work in concert with local federally qualified health centers, FQ look-alike organizations, and independent providers to coordinate care for specialty populations.

Goal

Strengthen partnerships with local law enforcement agencies.

Objectives

a. Promote successful interactions with police departments and persons affected by mental illness through education.
b. Seek funding to support onsite crisis response assistance to law enforcement.

Goal

Expand service capacity in north region of AltaPointe Health.

Objectives

a. Purchase or construct new outpatient offices in Clay and Randolph counties and renovate the existing outpatient office in city of Sylacauga to be more conducive to mental health service provision and accessible to population served.
b. Establish more mobile service provision for patients living in Coosa County.
c. Continue to expand school-based and day treatment services throughout the service area.
d. Explore opportunities to repurpose and put into service the vacant sixteen (16) bed facility on the Sylacauga campus.

Goal

Using enhanced information technology, create updated metrics/tools that allow programs to collect, measure, and report outcomes data to enable strategic decision making and promote continuous improvement.

Objectives

a. Streamline the patient satisfaction survey process to better understand the patient's experience of care, including employee/clinician/provider engagement and the patient's perceived value of services.
b. Identify and incorporate one centralized outcome measurement tool to utilize across all programs to measure the effectiveness of services.
c. Collect data through a software platform to identify, enroll, and manage care planning activities for those with chronic health conditions, including those with severe mental illness.
d. Utilize EMR data to create patient registries to monitor interventions, track progress, and improve health outcomes of patients in specific target groups, including those that face multiple conditions affecting access to healthcare.

Goal

Expand Service delivery options for persons with Developmental Disabilities

Objectives

a. Explore the use of remote monitoring/support services and solutions to help individuals with developmental disabilities gain more independence in living arrangements.
b. Expand the use of telehealth to improve and support primary health care services to individuals receiving residential services.
c. Identify the mechanisms needed to further enhance choice and community integration for persons with developmental disabilities.
d. Develop employment, supplemental training, and long term job site supports for persons with developmental disabilities
e. Explore opportunities to provide skilled nursing to support persons with developmental disabilities in living at home and/or residence of choice.

Plan Monitoring & Evaluation

Mental Illness and Substance Use Disorders

AltaPointe Health Systems, Inc., the primary service provider for services to the mentally ill in the seven-county region, is certified by the Alabama Department of Mental Health, accredited by The Joint Commission and licensed by the Alabama Department of Public Health. These regulatory bodies monitor

the quality of services provided to AltaPointe patients against standards of care promulgated by each certifying body.

Through its Performance Improvement Department, patient and family surveys provide timely monitoring of services provided by AltaPointe. Results of the surveys are forwarded through the various sub-committees of AltaPointe's Performance Improvement program to the Performance Improvement Committee which consists of the top management of the corporation. In addition, AltaPointe employs Patient Needs Specialists whose primary responsibilities are to assist patients and families with problem resolution. As a member of the Performance Improvement department, the Patient Needs Specialist has direct contact with the Director of Performance Improvement allowing a free exchange of suggestions, recommendations and complaints made by our patients.

Annually, AHS' leadership team evaluates the organization's performance during the past year, in terms of resource allocation, service provision and patient satisfaction. This organization-wide review is followed by individual program and departmental reviews and goal-setting, steering the various components of the organization toward congruent goals and objectives. Specific review of programming is conducted to ensure that they meet the current needs of the community.

Our service provision is addressed and programs evaluated for efficacy, comprehensiveness, viability and need. Throughout the year, review of clinical programming and the administrative infrastructure needed to manage the organization is continuous and dynamic to avail AltaPointe of emerging opportunities for advancements in the field of behavioral healthcare and to evaluate its performance in meeting the needs of its patients.

Sub-contractors of services for treatment and prevention services conduct independent satisfaction surveys of recipients of services and conduct pre-and-post-service tests to monitor individual programs' effectiveness with a specific target population.

Patients serving on the Consumer Councils of AltaPointe provide direct input and evaluative services to the organization's leadership on the services they receive. The Director of Performance Improvement works directly with the Consumer Councils to explore and evaluate service provision and access to services.

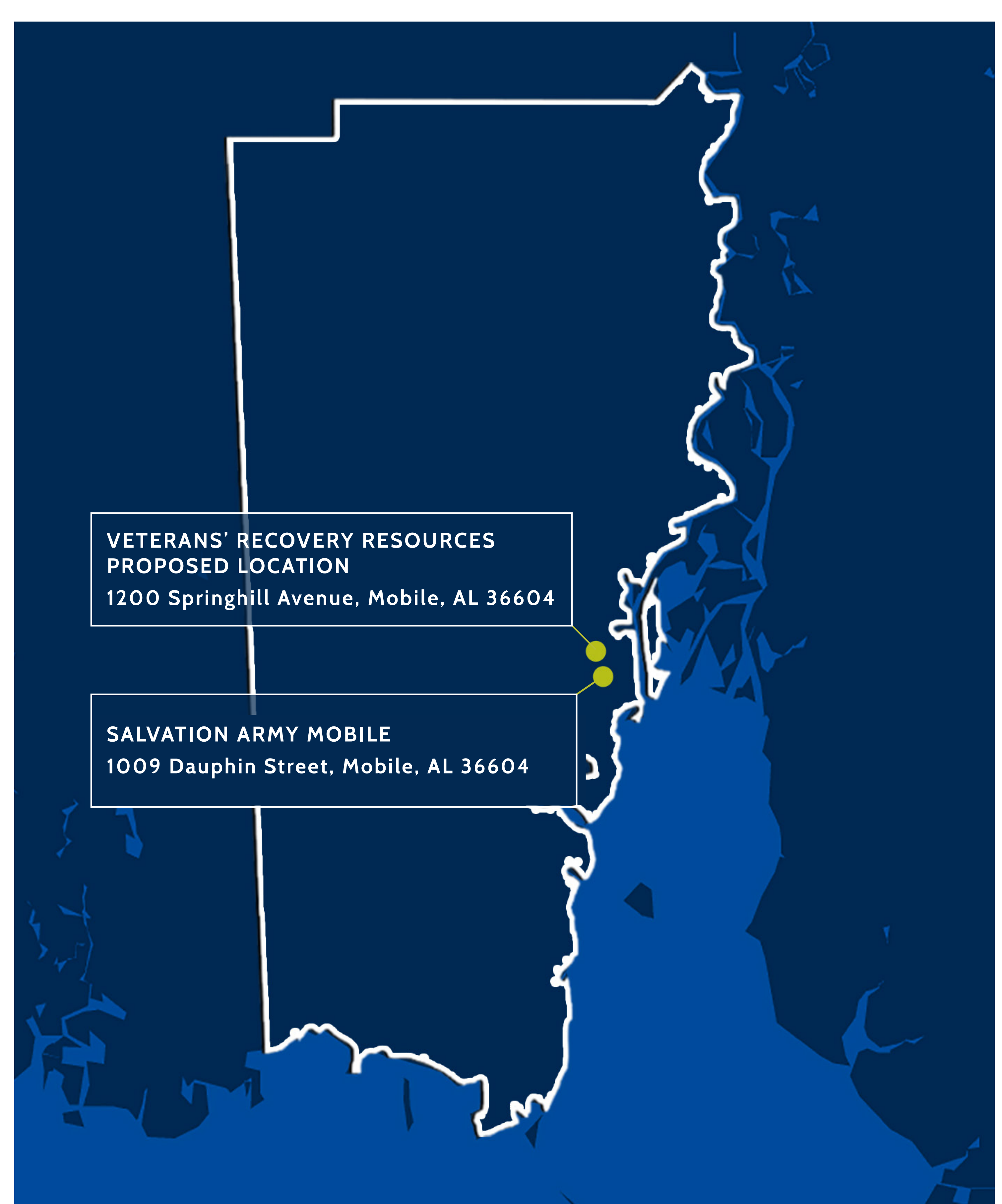
Developmental Disabilities

The Alabama Department of Mental Health Regional offices conduct an annual survey developed by the National Association of State Directors of Developmental Disabilities Service and Human Services Research Institute of individuals receiving services throughout the regions served. The survey seeks direct input from individuals on such matters as provider courtesy, safety and environment, service satisfaction, personal satisfaction, community inclusion, and patient rights. The results are compared with national norms through the National Core Indicator project.

In addition, individual providers of services to the developmentally disabled conduct surveys of patients served to determine patient satisfaction with services/supports and staff.

EXHIBIT E

MOBILE COUNTY RESIDENTIAL ADULT SUBSTANCE ABUSE TREATMENT FACILITIES



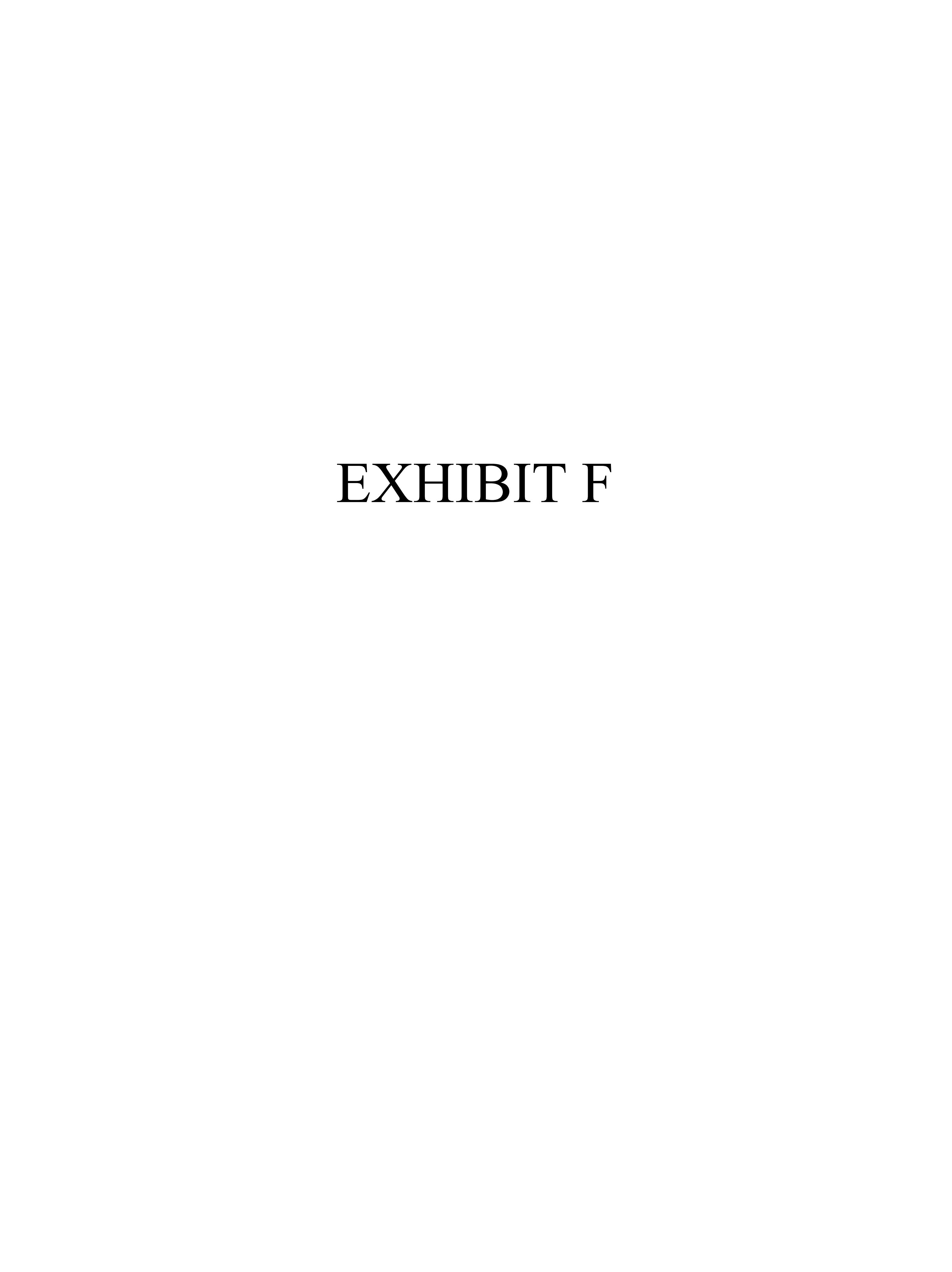


EXHIBIT F

Alabama County Population 2000-2010 and Projections 2020-2040 (Middle Series)

County	Census 2000	Census 2010	2020	2025	2030	2035	2040	*2018 series* Change 2010-2040 Number	Percent
Alabama	*4,447,100*	*4,779,736*	*4,940,253*	*5,030,870*	*5,124,380*	*5,220,527*	*5,319,305*	*539,569*	*11.3*
Autauga	43,671	54,571	56,705	58,464	60,327	62,488	64,771	10,200	18.7
Baldwin	140,415	182,265	222,554	242,345	261,777	281,200	300,899	118,634	65.1
Barbour	29,038	27,457	25,633	24,891	24,288	23,902	23,634	-3,823	-13.9
Bibb	20,826	22,915	22,354	22,174	22,023	21,932	21,885	-1,030	-4.5
Blount	51,024	57,322	58,383	59,154	59,995	61,064	62,095	4,773	8.3
Bullock	11,714	10,914	10,637	10,528	10,414	10,331	10,271	-643	-5.9
Butler	21,399	20,947	19,690	19,233	18,909	18,706	18,558	-2,389	-11.4
Calhoun	112,249	118,572	114,221	113,195	112,529	112,025	111,723	-6,849	-5.8
Chambers	36,583	34,215	33,918	33,709	33,485	33,313	33,147	-1,068	-3.1
Cherokee	23,988	25,989	25,835	25,778	25,709	25,637	25,573	-416	-1.6
Chilton	39,593	43,643	44,308	44,793	45,388	46,119	46,953	3,310	7.6
Choctaw	15,922	13,859	12,475	11,786	11,167	10,639	10,185	-3,674	-26.5
Clarke	27,867	25,833	23,759	22,867	21,995	21,169	20,414	-5,419	-21.0
Clay	14,254	13,932	13,233	12,928	12,639	12,374	12,142	-1,790	-12.8
Cleburne	14,123	14,972	15,104	15,187	15,278	15,374	15,464	492	3.3
Coffee	43,615	49,948	52,318	53,663	55,104	56,661	58,469	8,521	17.1
Colbert	54,984	54,428	54,281	54,026	53,707	53,315	52,890	-1,538	-2.8
Conecuh	14,089	13,228	12,157	11,647	11,195	10,802	10,470	-2,758	-20.8
Coosa	12,202	11,539	10,193	9,717	9,281	8,883	8,523	-3,016	-26.1
Covington	37,631	37,765	37,925	37,994	38,044	38,083	38,096	331	0.9
Crenshaw	13,665	13,906	14,017	14,081	14,150	14,230	14,315	409	2.9
Cullman	77,483	80,406	82,904	83,897	84,776	85,636	86,350	5,944	7.4
Dale	49,129	50,251	48,938	48,411	48,022	47,871	47,780	-2,471	-4.9
Dallas	46,365	43,820	39,219	37,762	36,743	36,054	35,393	-8,427	-19.2
DeKalb	64,452	71,109	71,629	72,394	73,615	75,364	77,344	6,235	8.8
Elmore	65,874	79,303	83,991	86,641	89,231	91,708	93,933	14,630	18.4
Escambia	38,440	38,319	37,284	36,830	36,421	36,110	35,804	-2,515	-6.6
Etowah	103,459	104,430	102,137	101,245	100,612	100,280	100,127	-4,303	-4.1
Fayette	18,495	17,241	16,214	15,698	15,207	14,774	14,380	-2,861	-16.6
Franklin	31,223	31,704	31,633	31,614	31,604	31,614	31,636	-68	-0.2

Alabama County Population 2000-2010 and Projections 2020-2040 (Middle Series)

	Census	Census						*2018 series* Change 2010-2040	
County	2000	2010	2020	2025	2030	2035	2040	Number	Percent
Geneva	25,764	26,790	26,894	27,109	27,361	27,672	28,014	1,224	4.6
Greene	9,974	9,045	7,984	7,601	7,326	7,112	6,907	-2,138	-23.6
Hale	17,185	15,760	14,509	14,047	13,600	13,161	12,805	-2,955	-18.8
Henry	16,310	17,302	17,296	17,443	17,597	17,776	17,969	667	3.9
Houston	88,787	101,547	107,353	110,561	113,789	117,189	120,823	19,276	19.0
Jackson	53,926	53,227	51,736	51,057	50,424	49,836	49,384	-3,843	-7.2
Jefferson	662,047	658,466	662,458	663,999	665,244	666,345	667,433	8,967	1.4
Lamar	15,904	14,564	13,265	12,672	12,086	11,526	11,000	-3,564	-24.5
Lauderdale	87,966	92,709	92,757	92,914	93,309	93,804	94,385	1,676	1.8
Lawrence	34,803	34,339	32,260	31,523	30,914	30,458	30,077	-4,262	-12.4
Lee	115,092	140,247	169,234	180,742	191,587	201,732	211,019	70,772	50.5
Limestone	65,676	82,782	99,775	108,021	116,015	122,976	129,617	46,835	56.6
Lowndes	13,473	11,299	9,667	9,048	8,559	8,242	7,947	-3,352	-29.7
Macon	24,105	21,452	17,617	17,111	16,773	16,492	16,268	-5,184	-24.2
Madison	276,700	334,811	372,447	392,382	412,126	431,697	451,043	116,232	34.7
Marengo	22,539	21,027	19,162	18,647	18,213	17,877	17,605	-3,422	-16.3
Marion	31,214	30,776	29,604	28,956	28,274	27,671	27,122	-3,654	-11.9
Marshall	82,231	93,019	96,219	98,049	100,136	102,494	105,088	12,069	13.0
Mobile	399,843	412,992	416,420	419,698	423,249	427,345	431,909	18,917	4.6
Monroe	24,324	23,068	20,552	19,800	19,163	18,558	17,958	-5,110	-22.2
Montgomery	223,510	229,363	226,832	227,480	228,160	228,882	229,647	284	0.1
Morgan	111,064	119,490	119,865	120,464	121,344	122,557	124,028	4,538	3.8
Perry	11,861	10,591	8,875	8,343	7,925	7,642	7,479	-3,112	-29.4
Pickens	20,949	19,746	20,743	20,535	20,289	19,985	19,668	-78	-0.4
Pike	29,605	32,899	33,231	33,598	34,276	35,029	35,907	3,008	9.1
Randolph	22,380	22,913	22,483	22,370	22,303	22,281	22,301	-612	-2.7
Russell	49,756	52,947	61,932	64,037	66,162	68,385	70,490	17,543	33.1
St. Clair	64,742	83,593	90,634	94,713	100,206	106,219	113,123	29,530	35.3
Shelby	143,293	195,085	224,628	239,859	253,485	265,330	276,373	81,288	41.7
Sumter	14,798	13,763	12,588	12,147	11,727	11,320	10,935	-2,828	-20.5
Talladega	80,321	82,291	79,964	79,164	78,524	78,012	77,644	-4,647	-5.6

Alabama County Population 2000-2010 and Projections 2020-2040 (Middle Series)

								2018 series	
	Census	**Census**						**Change 2010-2040**	
County	**2000**	**2010**	**2020**	**2025**	**2030**	**2035**	**2040**	**Number**	**Percent**
Tallapoosa	41,475	41,616	40,213	39,690	39,214	38,794	38,442	-3,174	-7.6
Tuscaloosa	164,875	194,656	212,769	221,743	230,259	238,579	246,892	52,236	26.8
Walker	70,713	67,023	64,532	64,080	63,759	63,568	63,441	-3,582	-5.3
Washington	18,097	17,581	16,268	15,827	15,436	15,100	14,783	-2,798	-15.9
Wilcox	13,183	11,670	10,450	9,868	9,400	9,025	8,668	-3,002	-25.7
Winston	24,843	24,484	23,388	22,920	22,531	22,198	21,887	-2,597	-10.6

Note: These projections are driven by population change between Census 2000 and Census 2010, taking into account 2017 population estimates. Data on births and deaths for 2000 to 2010 as well as more recent data from the Alabama Department of Public Health are used to derive birth and death rates for the state and each county.

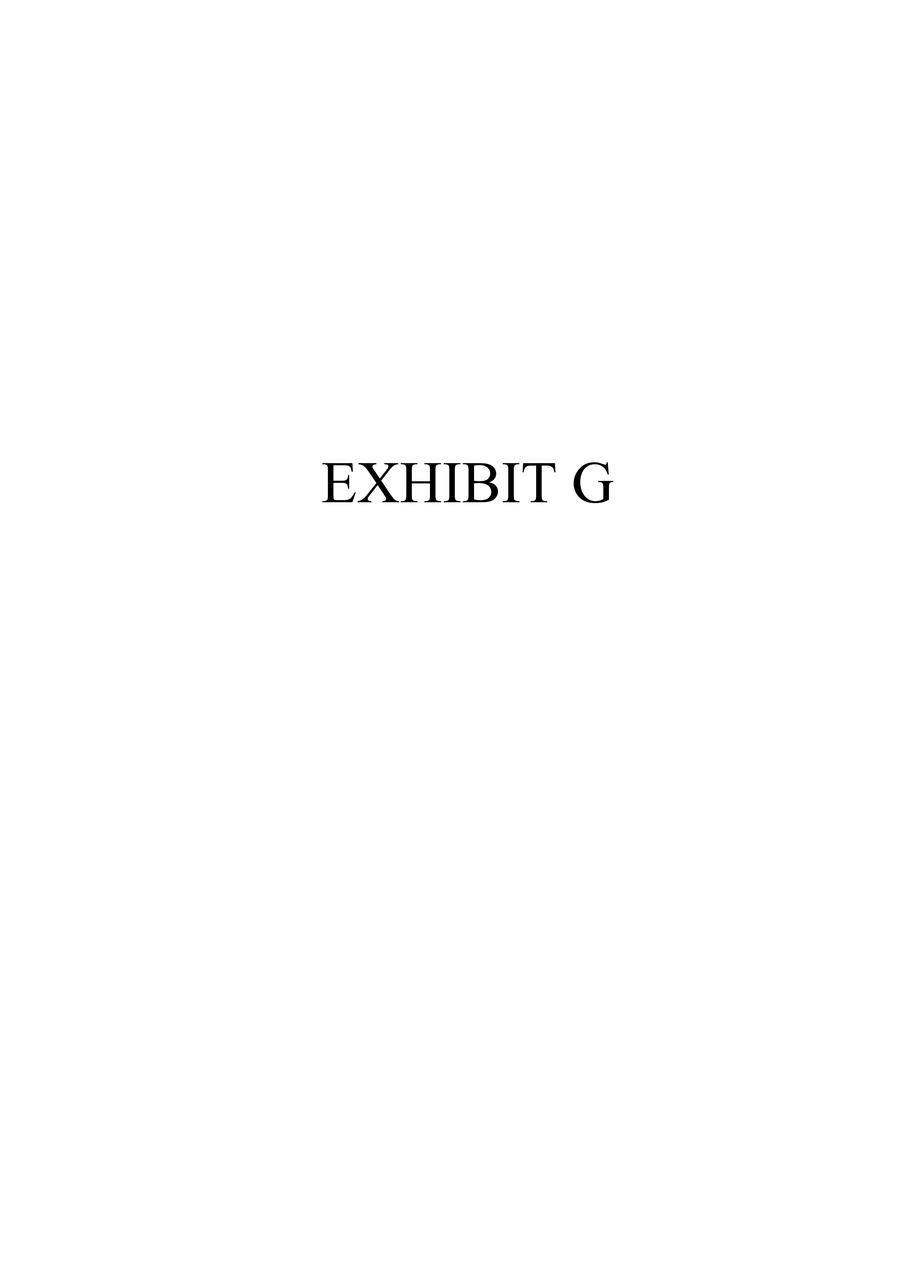


EXHIBIT G

QuickFacts

Mobile County, Alabama

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more***.

Table

All Topics	Mobile County, Alabama
Veterans, 2015-2019	**28,181**
PEOPLE	
Population	
Population estimates, July 1, 2019, (V2019)	413,210
Population estimates base, April 1, 2010, (V2019)	413,139
Population, percent change - April 1, 2010 (estimates base) to July 1, 2019, (V2019)	0.0%
Population, Census, April 1, 2020	414,809
Population, Census, April 1, 2010	412,992
Age and Sex	
Persons under 5 years, percent	6.6%
Persons under 18 years, percent	23.3%
Persons 65 years and over, percent	16.6%
Female persons, percent	52.5%
Race and Hispanic Origin	
White alone, percent	59.0%
Black or African American alone, percent (a)	36.2%
American Indian and Alaska Native alone, percent (a)	0.9%
Asian alone, percent (a)	2.1%
Native Hawaiian and Other Pacific Islander alone, percent (a)	Z
Two or More Races, percent	1.7%
Hispanic or Latino, percent (b)	3.0%
White alone, not Hispanic or Latino, percent	56.5%
Population Characteristics	
Veterans, 2015-2019	**28,181**
Foreign born persons, percent, 2015-2019	3.1%
Housing	
Housing units, July 1, 2019, (V2019)	185,035
Owner-occupied housing unit rate, 2015-2019	64.5%
Median value of owner-occupied housing units, 2015-2019	$130,200
Median selected monthly owner costs -with a mortgage, 2015-2019	$1,177
Median selected monthly owner costs -without a mortgage, 2015-2019	$383
Median gross rent, 2015-2019	$853
Building permits, 2020	934
Families & Living Arrangements	
Households, 2015-2019	156,251
Persons per household, 2015-2019	2.60
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	87.8%
Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	4.6%
Computer and Internet Use	
Households with a computer, percent, 2015-2019	85.0%
Households with a broadband Internet subscription, percent, 2015-2019	74.6%
Education	
High school graduate or higher, percent of persons age 25 years+, 2015-2019	86.5%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019	23.2%
Health	
With a disability, under age 65 years, percent, 2015-2019	9.8%
Persons without health insurance, under age 65 years, percent	12.7%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2015-2019	56.6%
In civilian labor force, female, percent of population age 16 years+, 2015-2019	52.6%
Total accommodation and food services sales, 2012 ($1,000) (c)	617,881
	2,397,151

Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	
Total manufacturers shipments, 2012 ($1,000) (c)	10,562,670
Total retail sales, 2012 ($1,000) (c)	5,102,565
Total retail sales per capita, 2012 (c)	$12,327
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2015-2019	25.0
Income & Poverty	
Median household income (in 2019 dollars), 2015-2019	$47,583
Per capita income in past 12 months (in 2019 dollars), 2015-2019	$25,861
Persons in poverty, percent	17.7%

BUSINESSES

Businesses	
Total employer establishments, 2019	8,755
Total employment, 2019	154,973
Total annual payroll, 2019 ($1,000)	7,035,025
Total employment, percent change, 2018-2019	-0.9%
Total nonemployer establishments, 2018	30,478
All firms, 2012	35,912
Men-owned firms, 2012	17,396
Women-owned firms, 2012	15,511
Minority-owned firms, 2012	13,509
Nonminority-owned firms, 2012	21,087
Veteran-owned firms, 2012	3,705
Nonveteran-owned firms, 2012	30,590

GEOGRAPHY

Geography	
Population per square mile, 2010	335.9
Land area in square miles, 2010	1,229.44
FIPS Code	01097

About datasets used in this table

Value Notes

Estimates are not comparable to other geographic levels due to methodology differences that may exist between different data sources.

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick Info icon to th
row in TABLE view to learn about sampling error.

The vintage year (e.g., V2019) refers to the final year of the series (2010 thru 2019). *Different vintage years of estimates are not comparable.*

Fact Notes

- **(a)** Includes persons reporting only one race
- **(c)** Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data
- **(b)** Hispanics may be of any race, so also are included in applicable race categories

Value Flags

- **-** Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper in open ended distribution.
- **F** Fewer than 25 firms
- **D** Suppressed to avoid disclosure of confidential information
- **N** Data for this geographic area cannot be displayed because the number of sample cases is too small.
- **FN** Footnote on this item in place of data
- **X** Not applicable
- **S** Suppressed; does not meet publication standards
- **NA** Not available
- **Z** Value greater than zero but less than half unit of measure shown

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and P
Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

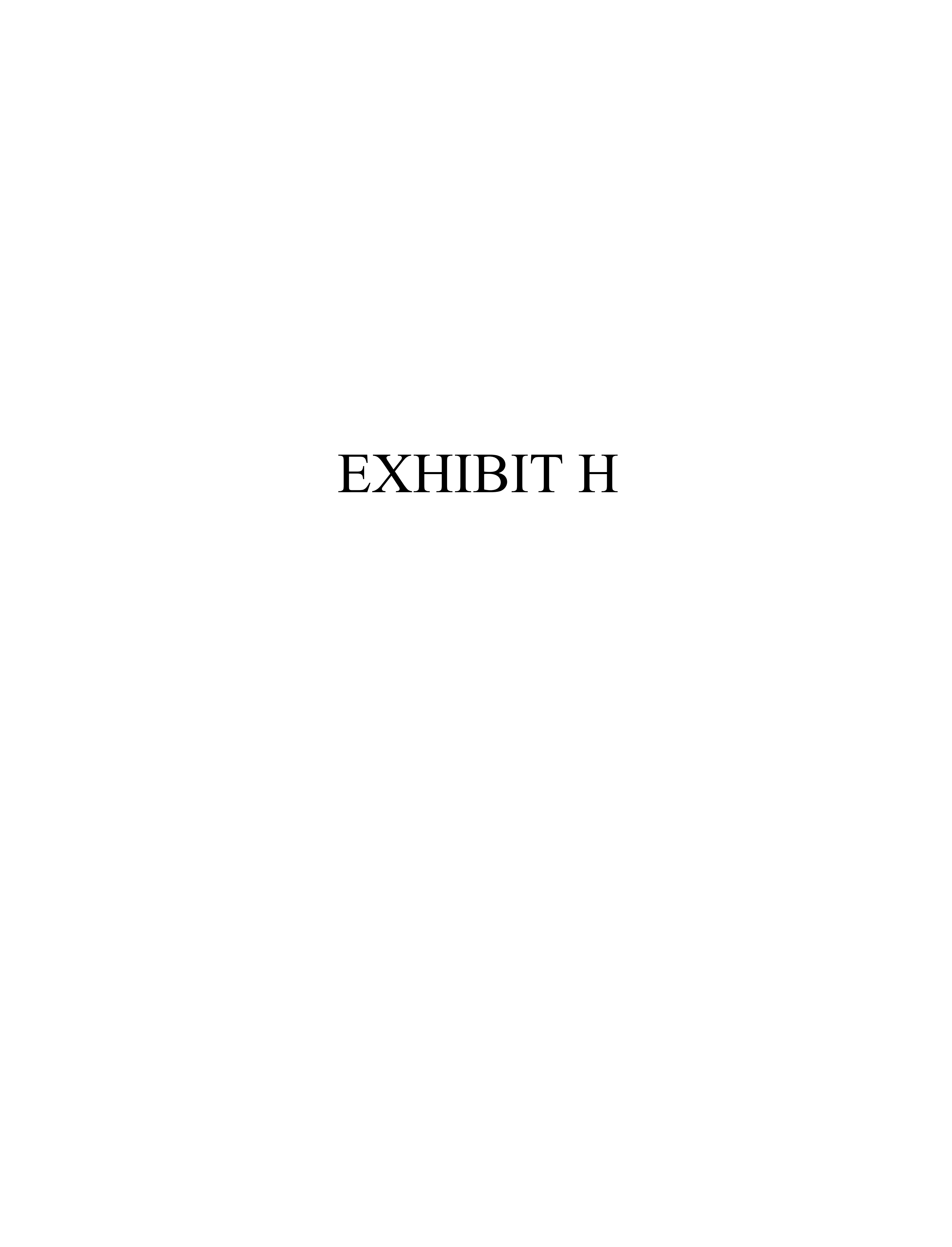


EXHIBIT H

9/11/2021

26358 Cabinet Shop Road
Loxley, Alabama 36551

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment

Dear Ms. Marsal:

I am writing this letter to support Veterans Recovery Resources' ("**VRR's**") application to adjust the state health plan as part of their effort to obtain a certificate of need ("**CON**") to create a Detox and Residential Treatment Facility (the "**Facility**") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile. The Center will increase access to substance abuse, PTSD, and other mental health services for our state's service members, veterans and first responders. It is essential that Alabama continue to expand its capacity to provide these services to our veterans and first responders considering the mental health illness epidemic among our service men and women which has recently been highlighted by the twentieth anniversary of 9/11 and the end of the war in Afghanistan.

VRR is an important and unique health care resource and asset to our community. As a community-based, non-profit provider of mental wellness programs developed specifically for veterans, by veterans, VRR is committed to providing mental health services for substance abuse, PTSD and other medical health conditions to veterans and first responders without regard to their ability to pay. I have spoken with numerous Mobile veterans and first responders, as well as their families, and they have all confirmed that there is a dangerous dearth of mental health resources for veterans and first responders in our community. This is especially true for veterans and first responders who lack the ability to pay for such services. With the exception of VRR, few of the mental health providers possess the necessary military cultural competency necessary to provide the much needed trauma-informed care approach our heroes require.

Additionally, numerous VRR patients have confirmed the excellence of: the primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services VRR presently provides throughout the Mobile community.

As the population continues to grow in the Mobile area, I believe that we must increase and strengthen the services available within the State of Alabama, particularly in south Alabama where there is currently no medically monitored detox facility. This Facility will ensure our service members, veterans, first responders and their families of our area and across the State who require mental health services have timely access to such services when required. If this CON application is approved, VRR will be able to provide timely access to important life-saving mental health services in an appropriate space.

On a personal note, I lost my oldest son to a drug overdose 5 years ago. I had struggled to find resources to help him in his recovery. First, we had to travel out of state for detox, and later we went to a facility in North Alabama for detox. He battled his addiction for 10 years, being in and out of rehabilitation facilities, jail, and sober living. As a result of my son's death and his wishes to help others in addiction, I started the Jace Waters Foundation for Sober Living in Alabama. I work with many groups in the state and see firsthand the need for a local Detox facility.

I fully support VRR's application, and I would appreciate your consideration and approval of VRR's request. I believe one of the most noble attributes of our state is our support for our veterans and first responders. In light of the mental health crisis surrounding the most vulnerable members of these groups, I am confident that VRR's application will be approved.

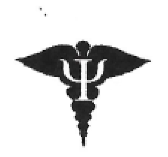
Sincerely,

Julie Waters

Julie Waters, Founder and President

Jace Waters Foundation for Sober Living of Alabama

Comprehensive MedPsych Systems



September 13, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment Application

Dear Ms. Marsal:

As a practicing psychiatrist in the Mobile area for over a decade, I am writing this letter to support Veterans Recovery Resources' ("**VRR's**") application to adjust the state health plan to allow for the creation of new substance abuse beds in Mobile County. I will also support VRR's efforts to obtain a certificate of need ("**CON**") to create a Detox and Residential Treatment Facility (the "**Facility**") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will provide care for our state's service members, veterans and first responders by providing substance abuse, PTSD, and other mental health treatment services in the Mobile County area without regard to their ability to pay. Further, this Facility will fill several Areas of Greatest Unmet Need outlined in the Mobile County 310 Board Authority's 2019-2021 Strategic Plan; namely:

- Specialized services for persons dealing with trauma, especially with returning veterans (page 8).
- Residential or inpatient treatment (page 9)
- Medically supervised detox program (page 9)
- Peer support services (page 9)
- Services for people on the Alabama Department of Mental Health waiting list (page 9)
- Additional residential treatment capacity for adults (page 10)

I sincerely believe that the Facility will enhance the state's ability to provide much needed support to some of the most vulnerable members of our community. It is my understanding that there are currently over 600 persons on the waiting list for substance use treatment in our state. As you are aware, the death toll in Alabama from suicide and opioid overdoses is much higher rates than the national average.

VRR is a non-profit Certified Community Behavioral Health Clinic (CCBHC) developed specifically for veterans, by veterans. As a physician and future collaborator with VRR, I believe I am qualified to affirmatively state that the: primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer

support services VRR presently provides in its CCBHC are all exceptional and have made significant improvements in the lives of countless veterans.

I fully support the state health plan adjustment application and I would appreciate your consideration and approval of VRR's request. I ask that Alabama continue to support of our state's veterans and first responders and respond to the opioid and suicide epidemics that plague our state. Approval of VRR's - application is an important step in that regard.

Sincerely,

Lynda A. Tenhundfeld, M.D.
Board Certified Child, Adolescent and
Adult Psychiatrist
CMPS- Mobile and Fairhope AL

September 13, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment to Allow for Additional Substance Abuse Beds in Mobile County

Dear Ms. Marsal:

I am writing this letter to support Veterans Recovery Resources' ("**VRR's**") application for a state health plan adjustment. My understanding is that VRR must seek this adjustment as part of a process to obtain a certificate of need ("**CON**") to create a Detox and Residential Treatment Facility (the "**Facility**") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will provide substance abuse, PTSD, and other mental health treatment services to service members, veterans and first responders. As a veteran, I can confirm that the countless news stories describing the mental health illness and suicide epidemic which plagues our veterans are not exaggerated. As has been revealed over the past few weeks and months, the scars left on many of our service men and women who have fought and bled for our country in Iraq and Afghanistan may have healed on the outside—but not necessarily on the inside.

As a United States Marine Corps Infantry Officer that fought in Iraq, I know firsthand that PTSD and the substance abuse that often accompanies it is real. I was fortunate to have plenty of resources at my disposal, but very few are in that position.

VRR presently provides incredible: primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services to service members, veterans and first responders (and their families) in Mobile without regard for the patients' abilities to pay. The Facility will expand VRR's ability to provide mental health services to our nation's veterans, which are services that are among the most needed by our veterans and require a level of care not currently available in south Alabama.

We have no detox facility within a four-hour drive of Mobile. The few residential facilities here are often at capacity and really don't know how to address the unique needs of combat veterans and first responders who have experienced intense trauma. This Facility will provide access to life saving substance use and mental health treatment which they currently cannot.

As an Alabama veteran and owner of multiple businesses in the area, I am extraordinarily proud of our state's commitment to the service men and women of our nation. In light of this commitment, I have no doubt that the state health plan adjustment application will be approved.

I fully support the state health plan adjustment application. Your continued support of our state's veterans and first responders is greatly appreciated.

Sincerely,

Nathan L. Cox, USMC

Bradley Sadler, MD | Crystal Threadgill, PhD, MSN, FPMHNP-BC | Valerie Schofield, MSN, PMHNP-BC

Thomas Bennett, PhD | Donovan Dodd, MSN, PMHNP-BC

Nathan Baughn, LICSW, PIP | Miranda Goodwin, LICSW, PIP | Krystal Nicole Smith, CRNP, PMHNP

Lana Jones, LPC | Kimberly J. Wimberly, MSW, LICSW

September 15th, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' CON Application to Adjust the State Health Plan

Dear Ms. Marsal:

As a practicing physician in the Mobile area, I am writing this letter to support Veterans Recovery Resources' ("**VRR's**") application to adjust the state health plan as part of their efforts to obtain a certificate of need ("**CON**") to create a Detox and Residential Treatment Facility (the "**Facility**") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will remove barriers to care for our state's service members, veterans and first response heroes by providing substance abuse, PTSD, and other mental health treatment services in the Mobile County area. VRR is committed to providing mental health services to Alabama's SMVF population without regard to their ability to pay. Further, this Facility will fill several Areas of Greatest Unmet Need outlined in the Mobile County 310 Board Authority's 2019-2021 Strategic Plan; namely:

- Specialized services for persons dealing with trauma, especially with returning veterans (page 8).
- Residential or inpatient treatment (page 9)
- Medically supervised detox program (page 9)
- Peer support services (page 9)
- Services for people on the Alabama Department of Mental Health waiting list (page 9)
- Additional residential treatment capacity for adults (page 10)

As an Alabamian, I am proud of the way my state has supported veterans and first responders and I sincerely believe that the Facility will enhance the state's ability to provide much needed support to some of the most vulnerable members of these groups. Unfortunately, according to the ADMH weekly bed report, there are currently 646 persons on the waiting list for substance use treatment in our state and Alabamians are dying from suicide and opioid overdoses at much higher rates that the rest of our country.

Bradley Sadler, MD | Crystal Threadgill, PhD, MSN, FPMHNP-BC | Valerie Schofield, MSN, PMHNP-BC

Thomas Bennett, PhD | Donovan Dodd, MSN, PMHNP-BC

Nathan Baughn, LICSW, PIP | Miranda Goodwin, LICSW, PIP | Krystal Nicole Smith, CRNP, PMHNP

Lana Jones, LPC | Kimberly J. Wimberly, MSW, LICSW

VRR is a non-profit Certified Community Behavioral Health Clinic (CCBHC) developed specifically for veterans, by veterans. As a physician, I believe I am qualified to affirmatively state that the: primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services VRR presently provides in its CCBHC are all exceptional and have made significant improvements in the lives of countless veterans.

I fully support the state health plan adjustment application and I would appreciate your consideration and approval of VRR's request. As a state, Alabama must continue to support of our great state's veterans and first responders and respond to the opioid and suicide epidemics that plague our state. Approval of VRR's application is an important step in that regard.

Sincerely,

Bradley J. Sadler, MD / Psychiatrist

September 15, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment Application for Additional Substance Abuse Beds

Dear Ms. Marsal:

I am writing this letter to support Veterans Recovery Resources' ("**VRR's**") application to adjust the state health plan to allow for the creation of new substance abuse beds. I will also support VRR's future certificate of need ("**CON**") application to create a Detox and Residential Treatment Facility (the "**Facility**") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will provide substance abuse, PTSD, and other mental health treatment services to service members, veterans and first responders. As a veteran, I can confirm that the countless news stories describing the mental health illness and suicide epidemic which plagues our veterans are not exaggerated. As has been revealed over the past few weeks and months, the scars left on many of our service men and women who have fought and bled for our country in Iraq and Afghanistan may have healed on the outside—but not necessarily on the inside.

VRR presently provides incredible: primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services to service members, veterans and first responders (and their families) in Mobile without regard for the patients' abilities to pay. The Facility will expand VRR's ability to provide mental health services to our nation's veterans, which are services that are among the most needed by our veterans and require a level of care not currently available in south Alabama.

We have no detox facility within a four-hour drive of Mobile. The few residential facilities here are often at capacity and really don't know how to address the unique needs of combat veterans and first responders who have experienced intense trauma. This Facility will provide access to life saving substance use and mental health treatment which they currently cannot.

As the President of the South Alabama Veterans Council, I see the need for a facility and service of this nature daily. In the seven-county area of South Alabama there is an urgent need for this capability to service our over 70,000 veterans alone. I am extraordinarily proud of our state's commitment to the service men and women of our nation. In light of this commitment, I have no doubt that the state health plan adjustment application will be approved.

South Alabama
Veterans Council

an organization for all People, serving all Veterans
A coalition of Veterans, Friends and Organizations working to Benefit and Further the Cause of Veterans

Sincerely,

Louis J. Lartigue Sr.
President

Ms. Emily Marsal
Executive Director
State Health. Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment Application

Dear Ms. Marsal:

I am writing this letter to support Veterans Recovery Resources' ("**VRR's**") application to adjust the state health plan to allow for the creation of new substance abuse beds. This adjustment is necessary for VRR to obtain a certificate of need ("**CON**") to create a Detox and Residential Treatment Facility **(the** "**Facility**") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile. The Center will increase access to substance abuse, PTSD, and other mental health services for our state's service members, veterans and first responders. It is essential that Alabama continue to expand its capacity to provide these services to our veterans and first responders in light of the mental health illness epidemic among our service men and women which has recently been highlighted by the twentieth anniversary of 9/11 and the end of the war in Afghanistan.

VRR is an important and unique health care resource and asset to our community. As a community-based, non-profit provider of mental wellness programs developed specifically for veterans, by veterans, VRR is committed to providing mental health services for substance abuse, PTSD and other medical health conditions to veterans and first responders without regard to their ability to pay. I have spoken with numerous Mobile veterans and first responders, as well as their families, and they have all confirmed that there is a dangerous dearth of mental health resources for veterans and first responders in our community. This is especially true for veterans and first responders who lack the ability to pay for such services. With the exception of VRR, few of the mental health providers possess the necessary military cultural competency necessary to provide the much needed trauma-informed care approach our heroes require

Additionally, numerous VRR patients have confirmed the excellence of: the primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services VRR presently provides throughout the Mobile community. I own and operate residential recovery residences in Baldwin County and our community and veterans are in desperate need of these services, especially in the Coastal Alabama community.

As the population continues to grow in the Mobile area, I believe that we must increase and strengthen the services available within the State of Alabama, particularly in South Alabama where there is currently no medically-monitored detox facility. This Facility will ensure our service members, veterans, first responders and their families of our area and e cross the State who require mental health services have timely access to such services when required. If this application is approved, VRR will be able to provide timely access to important life-saving mental health services in an appropriate space.

I fully support VRR's application and I would appreciate your consideration and approval of VRR's request. I believe one of the most noble attributes of our state is our support for our veterans and first responders. In light of the mental health crisis surrounding the most vulnerable members of these groups, I am confident that VRR's application will be approved.

Sincerely,

Haley Beason, NCAC I, NCPRSS

The Landing Coast-AL Recovery

256.239.6380

Thelanding4women@gmail.com

Lori Ann Renner
108 Bienville Ave, Mobile Al. 36606
251-586-5253

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

September 20, 2021

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment Application

Dear Ms. Marsal:

I am writing this letter in support of Veterans Recovery Resources' ("**VRR's**") application to adjust the state health plan to allow for the creation of new substance abuse beds in Mobile County. This will be a precursor letter to my letter of support for a certificate of need ("**CON**") application to create a Detox and Residential Treatment Facility (the "**Facility**") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will provide substance abuse, PTSD, and other mental health treatment services to service members, veterans and first responders. As a veteran, I can confirm that the countless news stories describing the mental health illness and suicide epidemic which plagues our veterans are not exaggerated. As has been revealed recently, there are scars left on many of our service men and women that may have healed on the outside—but not necessarily on the inside.

VRR provides an incredible continuum of care to include: primary medical care; individual, group and family therapy/ counseling; physical and occupational therapy; and peer support services to service members, veterans and first responders (and their families) in Mobile without regard for the patients' abilities to pay. The Facility will expand VRR's ability to provide exceptional care needed by our veterans that require a level of care not currently available in south Alabama.

We have no detox facility within a four-hour drive of Mobile. The few residential facilities here are often at capacity and often don't know how to address the unique needs of combat veterans and first responders who have experienced intense trauma. This Facility will provide access to much needed services.

As an Alabama veteran, I am extraordinarily proud of our state's commitment to the service men and women of our nation. In light of this commitment, I have no doubt that the CON application will be approved.

I fully support the state health plan adjustment application. Your continued support of our state's veterans and first responders is greatly appreciated.

Sincerely,

Lori Ann Renner, LCSW, RN

REAR ADMIRAL W. KENT DAVIS, USN, (RET.)
COMMISSIONER

STATE OF ALABAMA
DEPARTMENT OF VETERANS AFFAIRS
P.O. BOX 1509
MONTGOMERY, ALABAMA 36102-1509
TELEPHONE (334) 242-5077
FAX (334) 242-5102

September 17, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment Application

Dear Ms. Marsal:

I am writing this letter in strong support of Veterans Recovery Resources' application to adjust the state health plan as part of their efforts to obtain a certificate of need ("CON") to create a Detox and Residential Treatment Facility for Service Members, Veterans, First Responders and their Families in Mobile. The Center will increase access to substance abuse, PTSD, and other mental health services for our state's service members, veterans and first responders. It is essential that Alabama continue to expand its capacity to provide these services to our veterans and first responders in light of the mental health illness epidemic among our service men and women which has recently been highlighted by the twentieth anniversary of 9/11 and the end of the war in Afghanistan.

I currently serve as the Alabama Commissioner of Veterans Affairs, in charge of the Alabama Department of Veterans Affairs (ADVA). ADVA is statutorily chartered to assist the nearly 400,000 veterans residing in Alabama in applying for benefits and services available to them. In order to do this, ADVA must rely on public and private partners in reaching out to Alabama veterans. Veterans Recovery Resources is one of those partners and is uniquely situated to assist with outreach efforts in southwest Alabama. Five million veterans live on the Gulf Coast, with 64,000 in southwest Alabama alone. A formal "Needs Assessment" commissioned by The Community Foundation of South Alabama identified the need for more community-based mental health care, with 1 in 2 veterans reporting a previous mental health diagnosis (e.g., PTSD), recent thoughts of suicide, and/or substance use disorder.

I speak both officially and personally on the critical need for organizations that can assist with mental health services for our veterans. Addressing the mental health of veterans has been an area that ADVA has identified as a priority and we have expanded our staff to help tackle what has become an overwhelming issue for our state. Prior to my current role as Alabama Commissioner of Veterans Affairs, I was once deployed to Afghanistan and I understand the toll the recent events in Afghanistan have taken on some veterans who were assigned to that area during their military career. Thus, my letter of support for this particular application is based on my unique perspective as an official responsible for meeting the needs of Alabama's military veterans as well as a combat veteran myself.

Please feel free to contact me with any questions about this letter of support. Thank you for your earnest consideration of the underlying application by Veterans Recovery Resources.

Sincerely,

W. Kent Davis
Rear Admiral, U.S. Navy (Ret.)
Commissioner

September 13, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Amendment

Dear Ms. Marsal:

As a practicing physician in the Mobile area, I am writing this letter to support Veterans Recovery Resources' ("VRR's") application to amend the state health plan. If the amendment is granted, my understanding is that VRR will seek a certificate of need ("CON") application to create a Detox and Residential Treatment Facility (the "Facility") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will remove barriers to care for our state's service members, veterans and first response heroes by providing substance abuse, PTSD, and other mental health treatment services in the Mobile County area. VRR is committed to providing mental health services to Alabama's SMVF population without regard to their ability to pay. Further, this Facility will fill several Areas of Greatest Unmet Need outlined in the Mobile County 310 Board Authority's 2019-2021 Strategic Plan; namely:

- Specialized services for persons dealing with trauma, especially with returning veterans (page 8).
- Residential or inpatient treatment (page 9)
- Medically supervised detox program (page 9)
- Peer support services (page 9)
- Services for people on the Alabama Department of Mental Health waiting list (page 9)
- Additional residential treatment capacity for adults (page 10)

As an Alabamian, I am proud of the way my state has supported veterans and first responders and I sincerely believe that the Facility will enhance the state's ability to provide much needed support to some of the most vulnerable members of these groups. Unfortunately, according to the ADMH weekly bed report, there are currently 646 persons on the waiting list for substance use treatment in our state and Alabamians are dying from suicide and opioid overdoses at much higher rates than the rest of our country.

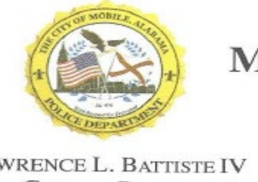
VRR is a non-profit Certified Community Behavioral Health Clinic (CCBHC) developed specifically for veterans, by veterans. As a physician, I believe the: primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services VRR presently provides in its CCBHC are all exceptional and have made significant improvements in the lives of many veterans.

I fully support the application. I appreciate your consideration and sincerely hope for approval of VRR's request. Alabama must continue to support our veterans and first responders, and respond to the opioid and suicide epidemics that plague our State. Approval of VRR's state health plan adjustment application would be an important step in that regard.

Sincerely,

SB Chromiak, MD

S. Blaise Chromiak, MD



MOBILE POLICE DEPARTMENT

LAWRENCE L. BATTISTE IV
CHIEF OF POLICE

2460 GOVERNMENT BLVD.
MOBILE, AL 36606
(251) 208-1701
(251) 208-1705 FAX

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' State Health Plan Adjustment Application

Dear Ms. Marsal:

I am writing this letter to support Veterans Recovery Resources' (VRR) application to adjust the state health plan as part of their efforts to obtain a Certificate of Need (CON) application to create a detox and residential treatment facility for service members, veterans, first responders and their families in the City of Mobile. This treatment center will increase the access to care related to substance abuse, Post-Traumatic Stress Disorder (PTSD), and other mental health services for our city's service members, veterans and first responders. It is essential that VRR continue to expand its capacity in order to provide these services.

VRR is a community-based, non-profit provider of mental wellness programs developed specifically for veterans, by veterans, committed to providing mental health services to these individuals without regard to their ability to pay. As a veteran and active first responder, I am personally familiar with the physical, emotional and mental toll our service takes on an individual. I am also aware that there is a lack of mental health resources specifically for veterans, first responders and their families in our community. This is especially true for those who lack the ability to pay for such services. With the exception of VRR, very few mental health providers in our community possess the necessary military cultural competency necessary to provide the much needed trauma-informed care approach our heroes require.

I believe that we must increase and strengthen the trauma-informed mental health services available to those tasked with serving and protecting our community, as well as the people who love and support them. This facility will ensure our service members, veterans, first responders and their families have timely access to such services. If this application is approved, VRR will be able to provide timely access to important life-saving mental health services in an appropriate space. Therefore, I fully support VRR's application and I would appreciate your consideration and approval of VRR's request.

Sincerely,

Curtis Graves, Commander
Office of Strategic Initiatives
City of Mobile Police Department

Sidney Scarborough
20643B East Blvd.
Silverhill, Al 36576
(850)450-0786

Sept 16, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' Application to Adjust the State Health Plan

Dear Ms. Marsal:

I am writing this letter to support Veterans Recovery Resources' ("VRR's") application to adjust the state health plan as part of their efforts to obtain a certificate of need ("CON") to create a Detox and Residential Treatment Facility (the "Facility") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will provide substance abuse, PTSD, and other mental health treatment services to service members, veterans and first responders. As a veteran, I can confirm that the countless news stories describing the mental health illness and suicide epidemic which plagues our veterans are not exaggerated. As has been revealed over the past few weeks and months, the scars left on many of our service men and women who have fought and bled for our country in Iraq and Afghanistan may have healed on the outside—but not necessarily on the inside.

VRR presently provides incredible: primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services to service members, veterans and first responders (and their families) in Mobile without regard for the patients' abilities to pay. The Facility will expand VRR's ability to provide mental health services to our nation's veterans, which are services that are among the most needed by our veterans and require a level of care not currently available in south Alabama.

We have no detox facility within a four-hour drive of Mobile. The few residential facilities here are often at capacity and really don't know how to address the unique needs of combat veterans and first responders who have experienced intense trauma. This Facility will provide access to life saving substance use and mental health treatment which they currently cannot.

As a practicing Physical Therapist in the State of Alabama, I often witness veterans who arrive in our clinics frustrated with the medical system as they await approvals for continued medical care. The VRR staff in conjunction with a facility such as this, would provide a greater sense of confidence to the veterans and first responders that they can and will be cared for as needed.

Being a 30yr Military veteran, I am extraordinarily proud of Alabama's commitment to the service of the men and women of our nation. In light of this commitment, I have no doubt that the application will be approved. Your continued support of our state's veterans and first responders is greatly appreciated.

Sincerely,

Sidney Scarborough

Sidney M. Scarborough, USAF, Col (Ret)

September 14, 2021

Ms. Emily Marsal
Executive Director
State Health Planning & Development Agency
100 N. Union Street, Suite 870
Montgomery, AL 36104

Re: Support for Veterans Recovery Resources' Application to Adjust the State Health Plan

Dear Ms. Marsal:

As a practicing clinical psychologist and director of a doctoral training program in Clinical and Counseling Psychology in the Mobile area, I am writing this letter to support Veterans Recovery Resources' ("VRR's") application to adjust the state health plan as part of their efforts to obtain certificate of need ("CON") to create a Detox and Residential Treatment Facility (the "Facility") for Service Members, Veterans, First Responders and their Families (SMVF) in Mobile.

The Facility will remove barriers to care for our state's service members, veterans and first response heroes by providing substance abuse, PTSD, and other mental health treatment services in the Mobile County area. VRR is committed to providing mental health services to Alabama's SMVF population without regard to their ability to pay. Further, this Facility will fill several Areas of Greatest Unmet Need outlined in the Mobile County 310 Board Authority's 2019-2021 Strategic Plan; namely:

- Specialized services for persons dealing with trauma, especially with returning veterans (page 8).
- Residential or inpatient treatment (page 9)
- Medically supervised detox program (page 9)
- Peer support services (page 9)
- Services for people on the Alabama Department of Mental Health waiting list (page 9)
- Additional residential treatment capacity for adults (page 10)

As a mental health provider who has a deep appreciation for the profound needs of Alabama's veterans and first responders, I am happy that the state has supported veterans and first responders and I sincerely believe that the Facility will enhance the state's ability to provide much needed support to some of the most vulnerable members of these groups. Unfortunately, according to the ADMH weekly bed report, there are currently 646 persons on the waiting list for substance use treatment in our state and Alabamians are dying from suicide and opioid overdoses at much higher rates that the rest of our country.

DEPARTMENT OF PSYCHOLOGY
UCOM 1000 | 75 South University Blvd. | Mobile, Alabama 36688-0002
TEL: (251) 460-6690 | FAX: (251) 460-6320 | PNSmith@SouthAlabama.edu

VRR is a non-profit Certified Community Behavioral Health Clinic (CCBHC) developed specifically for veterans, by veterans. As a physician, I believe I am qualified to affirmatively state that the: primary medical care; individual, group and family therapy and counseling; physical and occupational therapy; and peer support services VRR presently provides in its CCBHC are all exceptional and have made significant improvements in the lives of countless veterans.

I fully support the application and I would appreciate your consideration and approval of VRR's request. As a state, Alabama must continue to support of our great state's veterans and first responders and respond to the opioid and suicide epidemics that plague our state. Approval of VRR's application is an important step in that regard.

Sincerely,

Phillip N. Smith, Ph.D.
Professor of Psychology
Director of Clinical Training
Clinical & Counseling Psychology Doctoral Training Program
Licensed Psychologist (AL #1746)

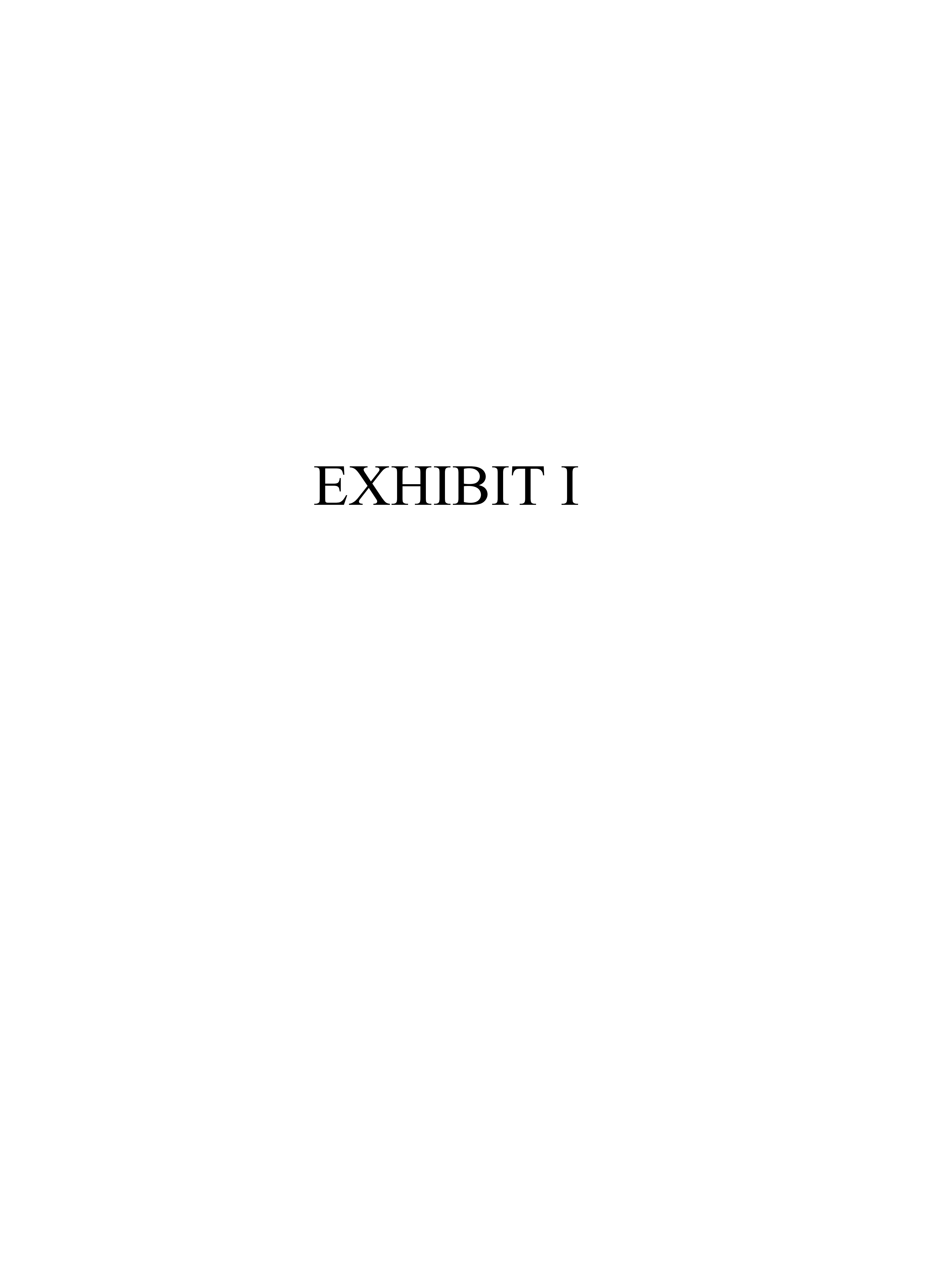


EXHIBIT I

Health

The military after 9/11: How wars impacted veterans' mental health and care

USC experts reflect on the reverberations of 9/11 and the end of the war in Afghanistan, including the impact on veterans and their mental health care.

BY **Ron Mackovich** AND **Emily Gersema** SEPTEMBER 10, 2021

Blackhawk helicopters land in Kandahar, Afghanistan. (Photo/Karla Marshall, U.S. Army Corps of Engineers)

Since America was shaken by terrorist attacks of 9/11, the U.S. military has fought in the longest conflict in the nation's history. That has left multiple generations of veterans suffering from PTSD and other health issues.

In prior wars, PTSD was not well understood, nor were treatments as widely available. USC researchers say they anticipate that the nation's military withdrawal from Afghanistan will not end the trauma, and they are continuing to look for new and better ways to help returning soldiers.

With Afghanistan, "we've never had something happen like this before," Carl Castro of the USC Suzanne Dworak-Peck School of Social Work says of the 20-year war. "There were fathers and sons, mothers and daughters serving in the same war. It's multigenerational.

"It connects back to what many experienced in Vietnam as well. Our nation is not used to losing war, and this is going to be a hard loss to take in many areas, many worlds."

Experts are still trying to help veterans impacted by the 1991 Gulf War and the 2003 invasion of Iraq.

Multiple deployments and veterans' mental health

According to a Pew Research Center survey in spring 2019, 75% of the post-9/11 veterans (about 800,000) were deployed at least once – significantly more than in prior years, when 58% were deployed or in combat. Deployment raises the likelihood that veterans experienced trauma and carry visible and invisible scars, physical and mental.

About 36% of the 1,284 veterans who participated in that survey said they believed they suffered post-traumatic stress; 6 in 10 said they saw someone killed — either someone in their unit or in an ally unit.

Castro directs the social work school's Center for Innovation and Research on Veterans and Military Families, which aims to strengthen the support network for veterans and their families. He anticipates that veterans returning from Afghanistan will suffer a host of confusing emotions.

> Some are going to feel a sense of futility, asking, 'What was this all for?'
>
> Carl Castro

"It ranges from anger, frustration, grief and in some ways happiness that we're out," he said. "Some are going to feel a sense of futility, asking, 'What was this all for?' Winning the battle doesn't always translate to winning the war."

USC researchers want to help. In fact, some have made new tools to draw out the veterans and help them process the trauma that they likely will bear for life.

Reports by the Congressional Budget Office indicate the Veterans Health Administration spends about $8,300 per veteran each year for a five-year treatment plan. The cost is higher for veterans who have a combination of traumatic brain injury and PTSD: $13,800. That adds up to more than $2 billion per year spent on veterans with PTSD.

Veterans' mental health and virtual reality projects

Albert “Skip” Rizzo is a psychiatrist and who directs the medical virtual reality projects at the USC Institute for Creative Technologies at the USC Viterbi School of Engineering. The virtual reality tools he and his team design include games that are tools for clinical assessment, treatment rehabilitation — such as helping seniors improve their range of motion — and resilience.

For veterans, he and his colleagues have developed SimCoach, a virtual reality counselor that can help assess the severity of a veteran’s trauma and depression so that health professionals can determine the best therapy and treatment plan.

Research indicates that the veterans are more honest with a virtual agent than with a human counselor.

> The military now actively promotes the idea that asking for help is sign of strength, not of weakness.
>
> Albert “Skip” Rizzo

Rizzo and his team also developed Bravemind, a virtual reality simulation that enables clinicians and researchers to safely walk a veteran through simulations of traumatizing events that can give health professionals new insight and a chance to provide deeper therapy.

These therapies are in use now in part because cultural and social attitudes in the military have shifted. Service members are now more likely to seek out and accept mental health support.

“The military now actively promotes the idea that asking for help is sign of strength, not of weakness,” Rizzo said. “Thus, as we have seen throughout history, innovations that emerge in military health care, driven by the urgency of war, typically have a lasting influence on civilian health care long after the last shot is fired.”

Virtual reality is only one of the many technologies that engineers and scientists are turning to; they’re also making new devices.

Who’s driving the increased investment in veterans’ mental health?

This surge in innovation is due to increased investment from a key source: the government – including the military itself.

“One of the clinical game-changing outcomes from the conflicts in Iraq and Afghanistan derives from the military’s support for research and development to advance clinical systems that leverage

new technologies," Rizzo said. "These include telerobotic surgical tools, computerized prosthetic limbs with advanced sensors that improve usability and comfort, and the use of virtual reality in treating PTSD. Veterans with brain and body injuries can engage with game-based physical and occupational therapy."

Recently, the Pentagon announced plans to provide mental health support for the military members traumatized by leaving Afghanistan.

The troop withdrawal is an opportunity for the nation's experts to provide help, Castro says.

"Our veterans still need us," Castro says. "Many still need support and services. Just because the war has ended, it doesn't mean it's over. Some veterans will continue to struggle for decades."

Top stories on USC News

Science/Technology

$25 million cumulative gift to transform industrial and systems engineering at USC

USC alumnus Daniel J. Epstein's ongoing support will fund top research expertise in areas such as optimization, machine learning and AI, and harnessing data to solve society's most urgent problems.

Health

USC researchers will use $10 million grant to address concussions in children

Keck School of Medicine scientists will lead imaging data collection and analysis for a study designed to improve interventions for children with mild traumatic brain injury.

Social Impact

Master's student speaks out on funding for historically Black colleges and universities

Gabrielle Chenault came to USC Annenberg to tell impactful stories about underrepresented communities, and she got that chance with a recent op-ed that was published in the Los Angeles Times.

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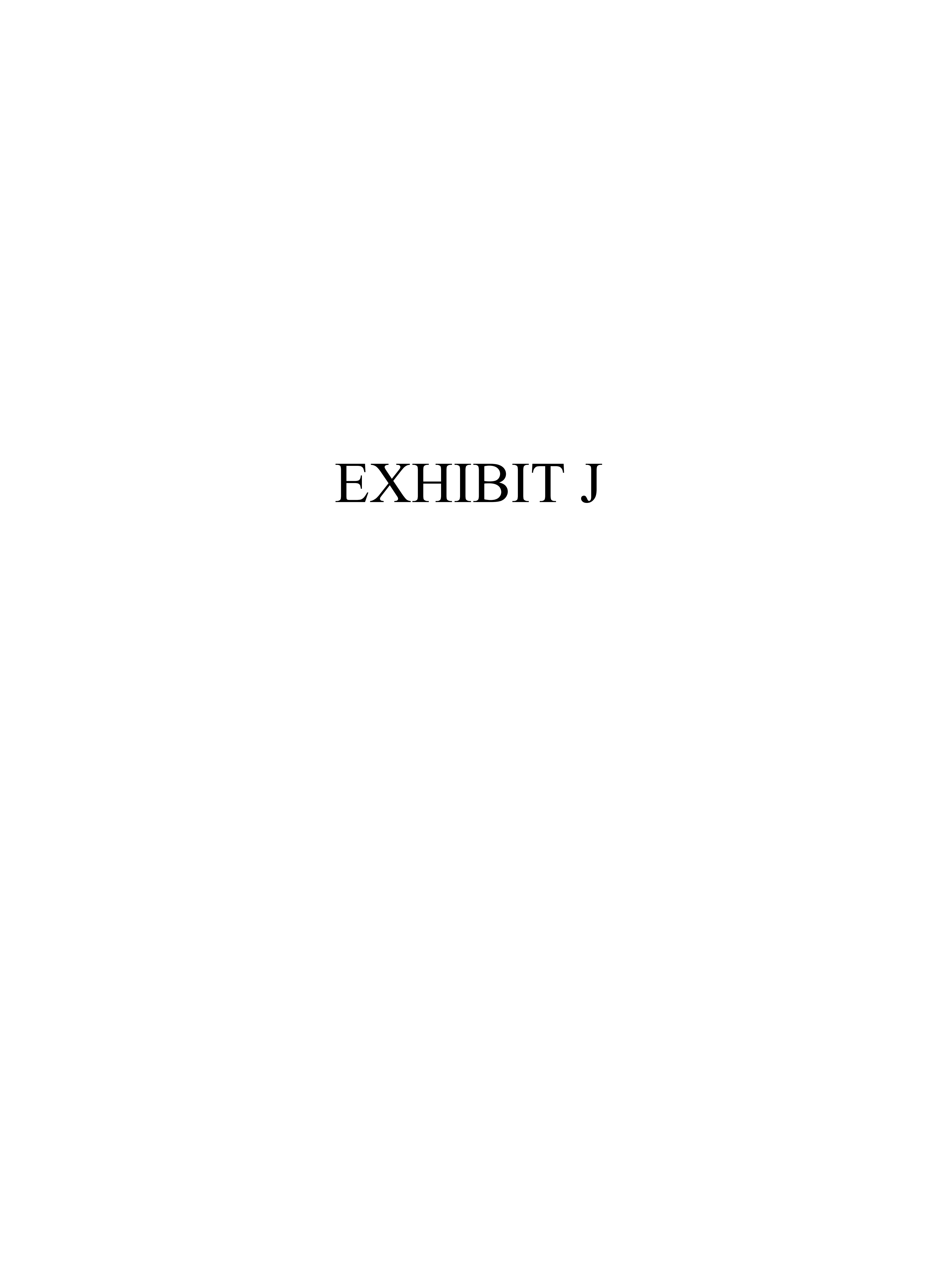
EXHIBIT J

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870

MONTGOMERY, ALABAMA 36104

October 26, 2021

Colonel John F. Kilpatrick, MSW, LGSW
Veterans Recovery Resources
1156 Springhill Avenue
Mobile, Alabama 36604

RE: PA2022-001
Veterans Recovery Resources

Dear Colonel Kilpatrick:

The above referenced Plan Adjustment was received October 14, 2021, proposing the need for thirty-two (32) additional substance abuse beds in Mobile County, Alabama, to provide for a clinically managed detoxification and residential treatment program for veterans and first responders. The treatment facility will consist of eight (8) beds for clinically monitored detoxification, sixteen (16) beds for residential treatment, and approximately ten (10) beds for supervised respite care. Pursuant to ALA. ADMIN. CODE r. 410-2-5-.04(4)(a), it has been determined that this Plan Adjustment does not contain all required information for Statewide Health Coordinating Council (SHCC) review and cannot be accepted as completed.

It is requested that the following additional information be provided on behalf of this filing:

On page 2, *Applicant Identification*: Please provide the email address of the contact person for the Plan Adjustment application.

On page 2, *Project Description*: In this section of the application, it is noted Veterans Recovery Resources proposes to develop a clinically managed detoxification and residential treatment program for veterans and first responders that will consist of eight (8) beds for clinically monitored detoxification, sixteen (16) beds for residential treatment, and approximately ten (10) beds for supervised respite care, resulting in a total of thirty-four (34) beds. However, on page 5 in the proposed language of the adjustment, the applicant reports thirty-two (32) substance abuse beds are needed in Mobile County, Alabama. Please review and correct the discrepancy.

On page 5, *Project Description*: The applicant states if the Plan Adjustment application is approved, the proposed project will cost approximately $8,000,000.00. If available, please provide additional information

MAILING ADDRESS: P.O. BOX 303025, MONTGOMERY, ALABAMA 36130-3025
PHONE: (334) 242-4103 FAX: (334) 242-4113

concerning the estimated costs for construction/renovation, lease expenses, equipment purchases, and first year annual operating costs.

On page 7, *Population Projections*: The applicant incorrectly reports an increase of 4.6% for the total population of Mobile County, Alabama for years 2020 to 2040. Please review and correct the discrepancy.

On page 8, *Current and Projected Utilization*: ALA. ADMIN. CODE r. 410-2-5-.05(f) requires the current and projected utilization of similar facilities or services within the proposed service area to be provided. Please furnish additional information pertaining to the projected utilization for this application.

On page 9, *Current and Projected Utilization*: In this section of the application and in Exhibit E, which contains a map of the service area, the applicant indicates there is only one (1) substance abuse residential agency in Mobile County, Alabama. However, on pages 3, 8, and 11, the applicant reports existing treatment facilities. Please provide clarification to this Agency regarding the specific number of residential substance abuse facilities in the proposed medical service area.

Nothing in this letter should be construed as limiting the authority of the SHCC, following notice and hearing, to grant, deny or modify the adjustment application as ultimately submitted.

Pursuant to ALA. ADMIN. CODE r. 410-1-3-.09, all documents to be filed with this office must be submitted electronically to shpda.online@shpda.alabama.gov in text searchable, PDF format.

Should you have any questions, please contact the Agency at (334) 242-4103.

Sincerely,

Emily T. Marsal
Executive Director

ETM:mst

cc: Colin Luke, Esquire
Kristen Larremore, Esquire