Restoring Focus: Putting Veterans First in Community Care

Jan 22, 2025

Statement of

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Communications & Public Affairs

Veterans of Foreign Wars of the United States

Before The

United States House of Representatives

Committee on Veterans' Affairs

With Respect To

"Restoring Focus: Putting Veterans First in Community Care"

Washington, D.C.

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Chairman Bost, Ranking Member Takano, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide the VFW's and my personal remarks on this critical topic.

The VFW believes the Department of Veterans Affairs (VA) community care program and its Community Care Network (CCN) of providers are a vital component of VA health care as it delivers the care and services that VA hospitals and community-based outpatient clinics either cannot or do not provide. Since no institution can be everything for everybody, community care options are force multipliers as they permit VA to continue providing the world-class health care that veterans prefer, deserve, and have earned while also ensuring they have access to the range of health care services they may need throughout their lives.

When used properly, CCN can save lives and improve the health outcomes for countless veterans, but when problems with CCN arise it can drive people away from the care they have earned. We have also called on VA to lean on its third-party administrators to ensure consistent delivery of community care to veterans who are eligible. Unfortunately, VA has not heeded these calls, and we regularly hear from veterans whose potential community care eligibility has been stifled by bureaucrats at the local level. The VFW has been unequivocal since the Phoenix crisis in 2014 that community care must be a part of VA care. It always has been. However, veterans expect consistency. When 23 Veterans Integrated Services Networks interpret the *VA MISSION Act of 2018* in 23 different ways, veterans are overlooked, as the VA Inspector General pointed out earlier this year in Buffalo, New York.

VA's CCN is plagued with too many problems that need thoughtful solutions. Care in the community is necessary for some veterans but, if given the choice, our members routinely tell us they prefer VA direct care. We believe some of that sentiment is driven by negative experiences with the community care process. We must fix those issues because our veterans have earned quality care regardless of who provides it. My story below is just one example of a negative experience that could have been easily avoided.

As a nearly decade-long VA patient, I wholeheartedly agree with the VFW in its view of the necessity of the VA community care program, and it is not because I am a VFW employee or

hold a life membership therein. I have interacted with VA community care on numerous occasions, including a successful surgery that VA was unable to perform. However, I was called here today to illustrate my recent experience obtaining inpatient mental health treatment through VA.

My journey with mental health care began on active duty during my first deployment in 2010. Initially spurred by relational challenges and interest in addressing childhood traumas, my needs intensified after I experienced the devastating 2011 earthquake in Japan and was in a combat zone in 2012 where I endured months of harassment from members of my unit in Afghanistan. For years, I struggled to sleep because I was flooded with recurring nightmares and night sweats. Among other symptoms, I also battled persistent and sometimes explosive anger at home and at work, and went emotionally numb. I did not understand what was happening to me and, quite frankly, no one else genuinely did either.

The Department of Defense (DOD) did not accurately diagnose my symptoms as post-traumatic stress disorder (PTSD), which meant that while I was receiving mental health care the treatments were merely band-aids that helped only to a point. I was not diagnosed with PTSD until after I was discharged from the Navy in 2015 and a local Vet Center therapist suggested I file a VA disability claim. PTSD became and remains my highest service-connected VA disability rating.

My PTSD symptoms continued with little meaningful improvement after my transition to VA health care where, until I moved to Washington, D.C., in 2021, I had been under the care of only VA therapists and psychiatrists. With medication and various forms of therapy, some symptoms improved while others changed and new, seemingly more insidious ones presented themselves. Despite consistent mental health care from multiple providers with the tried-and-true treatment modalities available at VA, I continued to battle crippling emotional numbness and had come to blame myself for being “defective.” I also started silently contending with what I came to learn were passive suicidal ideations, and concluded that my brain and my very being were beyond repair.

During fall 2021, after ten years of trying to find understanding and relief, I was referred to a civilian trauma therapist through VA community care due to capacity constraints in the Washington, D.C., VA hospital’s mental health clinic. My new therapist quickly diagnosed me with complex PTSD (CPTSD), which is the first time I can recall a mental health

professional using that term. Shortly thereafter in early 2022, I called the Veterans Crisis Line and after following up with my therapist, she decided that my chronic CPTSD symptoms met the criteria for a higher level of care including inpatient or residential mental health treatment.

It took me a while to warm up to the idea of live-in mental health care, as I was not sure whether things were truly "bad enough" to put my life and new job on pause for a month or more. However, it soon became clear that my passive suicidal ideations were not abating, and neither was my battle with emotional numbness. Going about regular life with weekly therapy appointments was not enough, and I needed my primary daily focus to be my mental health. I agreed to pursue inpatient treatment in May 2022 and my community care therapist quickly acted.

Based on my trauma history and symptoms as well as her clinical expertise, she recommended a military- and veteran-specific PTSD treatment program in Utah. Specifically, my therapist felt it was critical that I go to a women's program that had military cultural competence, approached treatment holistically, offered specific treatment modalities like Eye Movement Desensitization and Reprocessing (EMDR), addressed a range of traumas including those sustained during childhood and during military service like military sexual trauma, and could be completed in roughly 30 days. Since the Utah facility met those requirements and she had heard positive feedback about its program, my therapist began the nuanced community care referral process with VA.

After months of trial and error submitting my referral, my therapist learned in September 2022 that the Washington, D.C., VA could not authorize a referral to the Utah treatment program due to its physical location in VA Community Care Network Four (CCN 4), which is managed by TriWest Healthcare Alliance. The VA employee assisting with the referral noted that we were in CCN 1, which is managed by Optum Serve, and requested that we choose an alternative facility in the Washington, D.C./Maryland/Virginia area. It is noteworthy that a representative at the Utah facility warned us about this by stating, "… we are not in-network with the East region. We have tried several times but have been told 'we do not need any additional providers at this time.' It is frustrating because we get a lot of calls from the East Coast and we haven't been able to help."

Shortly after my referral to the Utah treatment program was denied, I learned that I also

needed reconstructive hip surgery. Disgusted with the denial and knowing that I could not do both due to employment factors, I chose to have surgery even though it meant I would have to wait even longer to go to mental health treatment.

Following my surgery recovery, and with an emboldened need to go to treatment, I revisited the conversation with my therapist to find a suitable inpatient program. However, this time around I had done an immense amount of research on the many symptoms I was experiencing and their root causes. In doing so, I came to learn that in addition to EMDR and other evidence-based methods, an *uncommon* treatment modality called Internal Family Systems (IFS) therapy was also effective in treating CPTSD. Together with my therapist, we decided to try to get authorization to a treatment program in Arizona that, like the Utah program, was in CCN 4 and offered the highly specialized and tailored CPTSD treatment options and holistic care that my therapist and I agreed were necessary. They also offered IFS, which I quickly realized is difficult to find.

I had reason to believe this time would be different because while speaking with a representative from the Arizona program, it was mentioned that service members and veterans from the East Coast had come there in the past. However, it was noted that I would need to convince my VA doctor that an out-of-network exemption was needed to advocate for a community care referral on my behalf. So, on July 10, 2023, I sent a detailed two-page request to my VA psychiatrist via secure message substantiating my interest in the Arizona program. He acknowledged and submitted the request, but I received no updates for about a week thereafter.

Frustrated with the seeming lack of urgency on VA's part, I physically went to the Washington, D.C., VA hospital and found a mental health professional who agreed to speak with me right away without an appointment. She then introduced me to a social worker who could help me with my referral. Without hesitation, the social worker listened to me, did a thorough review of my symptoms and, to my great surprise and relief, he named the emotional numbing that had plagued me for so many years. He agreed that my CPTSD symptoms required the specialized treatment that the Arizona facility could provide and promised to advocate on my behalf that its program was the right fit for my recovery.

On July 21, 2023, the social worker who promised to try to help me get into the Arizona program informed me that since the facility was in CCN 4, it was outside their community

care consult area. He said they were able to submit consults only for programs in CCN 1 or CCN 2. Furthermore, he said he talked with the same representative from the Arizona facility with whom I had previously spoken, and that he would continue to try to find a way to get a referral authorization.

Unfortunately, I did not hear back from the social worker, and my request for inpatient mental health treatment was overlooked for more than a month. I later learned that he went on emergency medical leave and my file was not given to anyone else until September 2023.

Two VA employees –– another social worker and a community care referral manager –– began to help me find a treatment program in early to mid-September. Unfortunately, so much time had passed since my initial treatment request in July, that I could no longer go as soon as a suitable program was found that also had space available to admit me. I would have to wait until January 2024 for my next available window of opportunity to enter treatment.

Nonetheless, the VA employees continued to help me find inpatient programs, but insisted that they be on the East Coast because going to a program in CCN 4 was not an option. At that point, I was firmly put in a position of having to find CPTSD treatment programs comparable with those in Utah and Arizona, which was the proverbial “needle in a haystack.” The employees asked what my criteria were, and they began presenting me with myriad in-network options.

None of the programs they suggested were directly comparable to those offered in Utah and Arizona. Some programs were too long (e.g., 90 days, while others were not the right structure for my needs (e.g., intensive outpatient programs). Some had poor reputations and my therapist steered me away from them. Still yet, others did not offer the range of treatment modalities I needed, or they were primarily focused on treating mental health conditions I did not have such as eating or substance use disorders. One facility was for patients who were dangers to themselves or others, which was not only inappropriate for me but also would have been more detrimental than therapeutic. Another facility I personally interviewed did not understand why I would want to be in a women-only program. To say I was angry and frustrated was an understatement, and I felt bad because while the VA employees were trying to help, the in-network options they presented always seemed to fall short in some way.

After a few weeks of searching, we finally found an in-network treatment facility in Pennsylvania that met most of my criteria. Although the program was not military-centric and did not use EMDR or IFS treatment modalities, it was 30 days long, women-only, holistic, and employed one treatment method called Dialectical Behavior Therapy that could help me manage my CPTSD symptoms. After much consideration and knowing that it was a significant departure from the Utah and Arizona programs, I agreed to compromise and go to the Pennsylvania program.

I checked into treatment on January 3, 2024, and was extremely fortunate to have been matched with a military-connected trauma therapist who helped me begin to identify the root causes of my CPTSD diagnosis and related symptoms. She also ensured that my follow-on care was with a qualified professional who practices both EMDR and IFS treatment methods. I am currently under the care of that professional, who agreed to join the VA CCN in order to treat me. I consider myself very lucky, but getting the right mental health care should never be a matter of luck.

I cannot adequately express how difficult it was to simply acknowledge to myself, let alone others, that my mental health had deteriorated enough to need intensive treatment. After a decade of not receiving the correct diagnoses and related treatments, I felt defeated, defective, and helpless. I learned that passive suicidal ideations are actually a product of the "fight" portion in one's fight-or-flight response essentially giving out. It is unconscionable that I was allowed to get to that point despite consistent DOD- and VA-provided therapy. Considering military and veteran suicide statistics, I am not alone. Had I not advocated for my needs, and as a result been sent to a treatment program that was unequipped to truly help me, it could have been my last attempt at getting better. I trust that I do not need to spell out what that means.

VA must stop its practice of rationing inpatient and residential mental health treatment based on arbitrary, seemingly thoughtless guidelines. Timely diagnosis and placement based on specific needs are crucial, regardless of location. Failure to do so is short-sighted at best and dangerous at worst. Providing veterans with the correct and appropriate mental health care *the first time* maximizes savings lives.

Chairman Bost and Ranking Member Takano, this concludes my testimony. Again, the VFW thanks you for the opportunity to testify on this critical issue. I am prepared to take any questions you or members of the committee may have.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any federal grants in Fiscal Year 2025, nor has it received any federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.