RESTORING FOCUS: PUTTING VETERANS FIRST IN COMMUNITY CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

WEDNESDAY, JANUARY 22, 2025

Serial No. 119–1

Printed for the use of the Committee on Veterans' Affairs

Available via http://govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

59–611 WASHINGTON : 2025

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C O N T E N T S

WEDNESDAY, JANUARY 22, 2025

RESTORING FOCUS: PUTTING VETERANS FIRST IN COMMUNITY CARE

WEDNESDAY, JANUARY 22, 2025

COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The committee met, pursuant to notice, at 1:02 p.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

Present: Representatives Bost, Bergman, Mace, Miller-Meeks, Murphy, Van Orden, Luttrell, Self, Kiggans, Hamadeh, King-Hinds, Barrett, Takano, Brownley, Pappas, Cherfilus-McCormick, McGarvey, Ramirez, Kennedy, Dexter, Conaway, and Morrison.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. The committee will come to order. Good afternoon, everyone. I want to thank you for being here. Welcome to the House Committee on Veterans' Affairs' first oversight hearing for the 119th Congress.

Now, before we start, I wanted to recognize and thank my colleague and friend Chairwoman Miller-Meeks for her leadership. Chairwoman Miller-Meeks originally proposed this hearing topic to be held in a subcommittee, but ultimately, I decided this is an important enough issue to discuss that requires full committee attention. As chairman, I am deeply committed to our shared mission of improving the delivery of care and services to our Nation's veterans. I look forward to working alongside my colleagues on both sides of the aisle to fulfill this mission.

Last Congress, this committee did meaningful work toward the mission by passing the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act. The committee also performed critical oversight of the Biden administration VA to find where the shortfalls were. Today we turn our focus on VA's Community Care Program, which, as we know today, was enacted in the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. The VA MISSION Act passed in 2018 with overwhelming bipartisan support. It was a promise to veterans, a promise to ensure they would never again face delays and access to the healthcare they have earned. It was a solution born from necessity and on the shoulders of what was the Veterans Access, Choice and Accountability (Choice) Act. It was designed to eliminate barriers to care and expand access for veterans nationwide.

It is not a solution to private—and it is not a solution to privatize VA healthcare. Let me say it again, not to privatize healthcare, the VA healthcare, anyone who suggests otherwise should step outside the Beltway and talk to the veterans who live 3 hours from a VA medical center. Community care is that veteran's lifeline.

Healthcare decisions are deeply personal and they should be made by veterans themselves. They know where and when and they need care to fix their needs. However, under the Biden-Harris administration, the program has been hijacked. Biden-Harris administration has prioritized bureaucratic limitations and control of a community care over veterans' needs. Scheduling practices have been manipulated to distort wait times. Appointments have been canceled or rescheduled without veterans' consent. Internal VA guidance has actively discouraged veterans from seeking care outside the VA system. That is dead wrong and likely, like everywhere—and like every other law that that is enacted, it is not optional and it is not a suggestion, it is the law.

When VA inserts itself as the sole decision-maker and plays politics with veterans' health, people get hurt. These actions have real-life consequences, and we are going to hear some of those consequences today from actual veterans, not bureaucrats.

Make no mistake, community care is VA care. It is not a substitute, but an essential extension of VA's mission to serve veterans where and when they need it without delay. With the Trump administration in place, we have the opportunity to ensure VA adheres to the MISSION Act and returns healthcare decisions to the hands of the only authority that matters, the veteran.

Today we will hear from witnesses who have experienced these barriers firsthand. Their stories will remind us that the decisions made here in Washington have a far-reaching impact on the lives of veterans and their families.

To our veteran—or to our witnesses, first off, thank you for the courage and sharing your experiences. Your experiences matter and we are here to listen.

Now with that, I now recognize Ranking Member Takano for his opening comments.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Well, thank you, Mr. Chairman. Today we will hear perspectives from several veterans who have faced barriers in trying to access timely and high-quality healthcare from the Department of Veterans Affairs.

I want to say to our witnesses that I am truly anguished by the unacceptable delays to you and your veteran loved ones. I am anguished by what they have faced and what you have faced in getting the care that you and they need. Your experiences are deeply troubling and I have many questions about how things went wrong. Unfortunately, I am afraid that today's hearing will not help the committee get sufficient answers to those questions and it will not enable us to hold those responsible accountable. That is because the majority has opted not to invite any witnesses from VA or the two third-party administrators of its Community Care Program.

They also opted not to include witnesses from agencies like VA's Office of Inspector General or the U.S. Government Accountability Office, who could provide us with objective, fact-based information about how and why veterans experience delays in accessing healthcare. This hearing was hastily organized just hours after our committee organizing meeting last Thursday. We have six members who are new to this committee, to Congress, three of whom are physicians and understand better than anyone the importance of proper care coordination and the risks of delayed care.

Mr. Chairman, today's VA community care oversight hearing is the first, the first, that you have convened since becoming chairman more than 2 years ago. More than 40 percent of veterans' care is now being delivered in the community and VA is on track to spend more than $42 billion on private sector care this fiscal year. When I was chair of this committee from 2019 to 2022, the full committee and the Health Subcommittee collectively convened six oversight hearings that examined the timeliness of veterans' access to healthcare and payments to community providers, as well as VA's initial implementation of the MISSION Act.

I am explaining all this because what I am about to say may shock members, veterans, and other stakeholders watching today. Last Thursday, we were informed that this one panel hearing will be the only full committee oversight hearing on community care before we advance major legislation on the subject and that we had to content ourselves with two closed-door committee staff-only meetings with stakeholders.

However, since the committee had not formally organized at the time these meetings occurred, no members of their staff were present. Moreover, because these meetings were held behind closed doors, there is no public record of what was discussed.

The minority is only permitted to invite one witness to a hearing and given that the current transition in Presidential administration presents challenges with inviting government officials to testify, so I asked the majority to invite Optum Serve Federal Health Services, one of the third-party administrators for VA's Community Care Program. Optum is a subsidiary of UnitedHealth Group and has contracted with VA since 2019 to establish networks of community providers and process payments to those providers. UnitedHealthcare also holds a contract with VA to conduct medical disability examinations, the exams veterans receive when they are applying for VA disability benefits.

Today, UnitedHealthcare's VA contracts are worth more than $72 billion. That is billion with a B. Worse, that money is not all spent on providing care to veterans. A considerable amount is going to administrative overhead. Imagine how many new hospitals and clinics VA could build and how many clinical staff that VA could hire with that amount of money. However, UnitedHealthcare declined the invitation declined the invitation to testify, citing the lack of sufficient time to prepare for the hearing. Now, I do not know about you, but I do not have much sympathy for a company that is receiving tens of billions of taxpayer dollars complaining that they need more advance notice to appear at a hearing. The chairman's staff, however, apparently do sympathize because they accepted UnitedHealthcare's excuse.

Now that brings me to Dr. Saindon, who is appearing today as the minority's witness. She serves on the Board of Directors of the Nurses Organization of Veterans Affairs, otherwise known as NOVA. NOVA is a nonprofit professional association whose mission is to educate, communicate, and advocate for VA nurses. NOVA is not a part of VA nor is a union. NOVA managed to do what UnitedHealthcare could not: arrange to get Dr. Saindon to D.C. to testify with less than 2 business days' notice. I want to thank Dr. Saindon for being here today.

Now, I know we will not get answers to all our questions in this single hearing. Veteran stories are an important part of oversight and I thank our witnesses again for their bravery and candor in participating in today's hearing. However, oversight is not complete without accountability, and there are no accountable individuals here today. No accountable individuals are appearing before us today.

I want to be clear that I recognize the importance of community care. However, I also do believe any further expansion of community care must be met with similar investments in VA direct care. The two systems should be complementary, in balance with one another to ensure veterans can access the best, most timely, culturally competent care.

That is what is not happening right now. Community care has expanded at the expense of VA direct care. If we continue down this path, VA will crumble. This is where I draw the hard line. Our veterans cannot afford for us to dismantle VA direct care in favor of shifting more care to the community nor, by all accounts, do they want us to. Rushing to pass this legislation without sufficient oversight and diligent efforts to uncover the root cause of problems is a recipe for disaster.

For example, in 2014, after news of "secret VA waiting lists" broke, Congress acted quickly to create the Veterans Choice Program, a temporary program that allowed veterans to receive community care when they faced long wait times or lengthy travel distances. We went from bill to law in the course of 3 months. As we found out over nearly 4 years, over the 3 or 4 years that followed, the Choice Program actually resulted in longer wait times, confusion about payments, and administrative headaches for veterans and staff at VA.

Then in 2018, Congress passed the MISSION Act, further expanding community care eligibility. Yet here we are today, with veterans and VA staff facing many of those same issues with access, care coordination, and transparency. All the while, VA has been rolling out more policies and contract modifications altering the administration of the Community Care Program. How can we address the effect of these administrative changes if we are not conducting proper oversight?

This committee also needs to conduct more oversight of the quality of care veterans are receiving in the community. As we will hear from many of the witnesses today, simply getting a referral to the community is only the first step. We must also ensure that these referrals are actually leading to veterans receiving high-quality care.

Furthermore, we need to ensure that we are being good stewards of taxpayer dollars, as our majority so often reminds us. Care provided in the community is often—often comes at a higher price tag and can be less efficient and less effective than care that VA can provide directly.

We must also consider the long-term future of VA, which serves not only our veterans, but all Americans, through its role in providing world-class and groundbreaking medical research, its Fourth Mission emergency preparedness mandate, as well as providing residency and fellowship training for more than 70 percent of all U.S. healthcare providers at some point in their careers. As a committee, we must candidly assess the long-term and far-reaching consequences of undermining the VA direct care system in favor of prioritizing private healthcare profits.

With that, I yield back.

The CHAIRMAN. I thank the ranking member for his testimony. Let me tell you that this is the first of many hearings focused on community care. We are in our very first hearing. That gives us a golden opportunity for a lot of them. This hearing is solely focused on the hearing the veterans stories so that we can work on this.

Let me explain this to you. The VA, and I have said it so many times, the VA was created not for the VA, not for the bureaucracy, but providing for the veterans. In this hearing, we decided we want to hear from the veterans.

As my position as chair, let me say this again, it is not the majority's position to privatize the VA, but to make sure the VA delivers to our veterans at the level that they need to have their care given to them when and where they need it, with less bureaucracy and given in a way so that incident after incident after incident does not occur where someone falls through the crack for whatever reason, whether it is in the community or at the VA.

With that, we will turn to our witnesses. Testifying before us today is Paul McKenna. Say that correctly for me there, Sergeant Major.

Mr. MCKENNA. Good afternoon, Chairman Bost.

The CHAIRMAN. I am just introducing. I was just trying to pronounce it correctly.

Mr. MCKENNA. Paul McKenna.

The CHAIRMAN. McKenna, thank you. Now, he is a sergeant major of the Marines, traveled from Representative Murphy's district in North Carolina. We also have William Dooley, a 20-year Army veteran, traveling away from Congressman Self's district in Texas; Ms. Lori Willis Locklear, a former VA employee and mother of a Navy veteran, Logan Willis, traveling from Representative Harris' district in North Carolina; Ms. Brittany "Demond," "Diamond"? Just Dymond, there you go. I always wonder why they put that out whenever it was just pretty well that way. Associated director of Veterans of Foreign Wars (VFW); and Dr. Kelley Saindon, secretary/treasurer of the Nurses Organization of Veterans Affairs.

Will the witnesses please stand and raise their right hand?

[Witnesses sworn.]

The CHAIRMAN. Thank you and let the record reflect—you may say thank you and let the record reflect that the witnesses answered in the affirmative.

I now recognize Sergeant Major McKenna for the 5 minutes to deliver your testimony. Sergeant Major.

STATEMENT OF PAUL MCKENNA

Mr. MCKENNA. Good afternoon, Chairman Bost. For the record, I am retired. Chairman Bost, Ranking Member Takano, and members of the House Committee on Veterans' Affairs, thank you for inviting me to testify for the record of today's hearing on veterans' experiences using the Department of Veterans Affairs' Community Care Network. I am here today as a voice for countless veterans in Eastern North Carolina who continue to struggle to effectively and efficiently utilize the critical part of the VA's healthcare system.

As the committee is aware, the VA MISSION Act became law in 2018 and was intended to improve access to healthcare for veterans. My aim today is to illustrate the gaps and seams within the pillars of this legislation that are present in Eastern North Carolina, with specific attention on access to care, the Community Care Network, and the education and training of the VA workforce that coordinates access to care in the community. My hope is that my testimony will offer the committee some insight to the real challenges that veterans face when using the Community Care Network in Eastern North Carolina.

Additionally, and what may sound anecdotal, is to share with you my experiences with using the services of the VA Community Care Network in two different geographical locations, and the experiences of many veterans I have talked to who must utilize community-based services.

My name is Paul McKenna. I retired in 2021 after 36 years of active duty service in the United States Marine Corps. I have learned many lessons, life lessons, from my nearly four decades of service as a U.S. Marine, and at the very top of that list is that no American can afford to be disinterested in any part of their government: county, city, state or nation.

One of the great lessons the Marine Corps taught me was to never take for granted of being in the presence of other Marines and their greatness. For 36 years I walked amongst giants. I will forever cherish those relationships, especially the relationships of those American heroes that never came home. I truly hope that my actions and words today bring honor to their memory and their sacrifice.

[THE PREPARED STATEMENT OF PAUL MCKENNA APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. McKenna.

Mr. Dooley, you are recognized for 5 minutes.

STATEMENT OF WILLIAM DOOLEY

Mr. DOOLEY. Thank you, Chairman Bost, Ranking Member Takano, for inviting me to testify on my frustrating experience with VA Community Care, specifically Dallas, Texas Veterans Affairs Medical Center. I sit here today as a veteran, father, husband, and cancer patient. I apologize for my appearance, any speech deficiencies that I may have while reading my statement. I finished my

final chemo treatment a week ago and I am still having several single—several side effects.

I will start from the beginning of my cancer journey. In September 2023, I voiced my concerns for symptoms while at a regular scheduled doctor's appointment. In November 2023, I voiced my concerns again by scheduling a doctor's appointment for these same symptoms in Bonham, Texas. I completed a sample submission for the doctor and he ordered a colonoscopy. I was told by the scheduling that they were backlogged and community care would be my best route to get care.

I was referred to Community Care in December 2023. I was matched with the Community Care provider, Jenny Sang, at the time. My Community Care provider informed me that May 20th, 2024, was her first available for the colonoscopy. I was scheduled for a colonoscopy 9 months after I voiced my concerns with my primary physician and 5 months after being referred to Community Care program.

On May 20th, I received the colonoscopy and woke up with the dreaded words: you have cancer and need surgery immediately. Multiple phone calls from myself and my wife to the Veterans Affairs resulted in almost no movement forward. I was told it will be September before I would receive the cancer testing required prior to surgery. I was told I had cancer and the best they could do was get me tested in 4 months. This was not acceptable. Community Care was my best option to survive.

We scheduled my first appointment with University of Texas (UT) Southwestern Oncology. With assistance from UT Southwestern, we were able to get scheduling for all required tests set up the following week, not 4 months. Community Care was no assistance and we used our personal insurance for the doctor visit. We eventually received referral and approval from the required testing and received approval for cancer treatment at UT Southwestern. This was only after reaching out for assistance from Representative Self's office.

Unfortunately, after the testing was conducted, it was revealed that I did not have stage 1 cancer and, due to too many—too much time passing for the original colonoscopy, I was currently stage 3 cancer and my lymph node system had been compromised. At this point I was informed by the oncologist that surgery first was not an option and that a very aggressive chemotherapy and radiation treatment was my best option for survivability. The treatment would consist of eight rounds and two types of chemotherapy and five rounds of concentrated radiation. Followed by successful treatment, I would be evaluated to determine the level of surgery required.

I was informed in August after receiving several bills that the treatment I received was not covered. This was due to the referral for cancer treatment not including chemotherapy or radiation. I was informed that of this unit because the billing was rejected only. Once again, we reached out to Representative Self's office for assistance. I do not believe we would have received this approval without the assistance from his office.

Three major problems I encountered during this process. First, the Community Care Program does not communicate directly with

the provider other than the original scheduling. This leads to confusion for the veteran, Adds possibility of poor case management and the treatment for the veteran. In my case, the Community Care worker could have assisted by contacting me and letting me know if 5 months wait was the only option or if other care providers had availability sooner.

Second, the approval of one of the procedures but not the others that is known to be required together. Cancer treatments for us nondoctors usually comes in three forms and in most times all three are used: surgery, chemotherapy, and radiation. Why is it standard procedure to approve surgery but not the other two? It is very confusing to need three separate referrals for the same treatment plan. It adds to the confusion for billing and for referral management, especially when all three have different expiration dates. At no point did my caseworker have direct contact with the provider to discuss the issue and how to resolve it. Any attempt to call my caseworker and facilitate a three-way call resulted in leaving a message and waiting for a call back. This was due to my caseworker being a remote employee and not being provided a direct phone number to her.

Third is a lack of professionalism and compassion from the VA employees. From the beginning of this journey we have been sighed at, told to wait, told to be—treated with disdain by the employees we encountered. I was treated like I was asking for charity and not treated as a disabled veteran that was trying to receive life-saving treatment. Case management displays some of the worst incompetence I have seen in decades. One of the most—on one of the occasions the response that I received from the VA was intertwined with mistruths and blatant lies about timeline and what happened. This was very concerning.

At no point has anyone taken ownership or conducted an assessment of what could have done differently. The response was deny, deny, and counter accuse. Accountability for poor performance and low proficiency is not a strong point of Veterans Affairs.

All these problems were shown last Friday after my submission of my written testimony. On Friday, I received a phone call from the Veterans Affairs. It was my primary healthcare provider. The message was primary healthcare provider asking if I had been scheduled for treatment for the two referrals for chemotherapy and radiation. I just found finished eight rounds of chemotherapy and five rounds of radiation. They would been scheduled over a 5-month period and paid for by the VA. My primary care provider had no idea if I would even started chemo or radiation, and still does not today. This shows the direct breakdown in any communication between Community Care, my primary doctor, and a Community Care provider.

A lot of these questions and concerns could easily be fixed if someone cared enough to do their job as a case manager. The upper level bureaucracy and lack of accountability for poor performance in the Veterans Affairs has become just as much as a cancer as what courses through my body today. I can work on fixing my personal health, but I am asking you to work on fixing the Veterans Affairs because it is unhealthy and full of cancer.

I appreciate the time and opportunity to share my story. More detailed information with names and dates has been provided in my official written statement. I look forward to any questions you may have at this time.

[THE PREPARED STATEMENT OF WILLIAM DOOLEY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Dooley.

Ms. Willis Locklear, you are recognized for 5 minutes.

STATEMENT OF LORI WILLIS LOCKLEAR

Ms. LOCKLEAR. Hello, Chairman Bost and Ranking Member Takano and the House of Representatives' Committee on Veterans Affairs. My name is Lori Willis Locklear.

First, I want to thank God for getting us here. Thank you for the opportunity to speak on behalf of my son, Logan F. Willis, who served in the United States Navy from August 2017 until December 2018. Logan was our only child and his dad, Raymond F. Willis, was an Army veteran. I was a VA employee for 12 years. Logan spent his summers volunteering at the VA. His father passed away in 2015 from lung cancer. It was very difficult on us both. He graduated from high school in 2014 and the University of North Carolina at Pembroke in 2016.

Logan wanted to further his education, so he enlisted. His first duty station was Sasebo, Japan, aboard the United States Ship (USS) Wasp. It was during that time that Logan's mental health began to decline and he attempted suicide multiple times on the ship and later in San Diego.

Logan received an honorable discharge on December 31, 2018, and returned home. I noticed many changes in Logan's demeanor and behavior. He was not the same person. As a VA employee, I directed Logan to seek help from the VA, but was told, we cannot help you. At this point, he developed a distrust for the VA system. Logan was so distraught with the lack of support he had received at the VA one day I came home and Logan had packed up all his belongings and left. Later, he stated he could no longer live in a place where he felt unsupported. The saddest part for me as a mother is that Logan saw me as the VA. Unfortunately, Logan could not see that I was working as hard as possible to help him. I was the mother of a veteran and an employee, but the mother always came first.

In the fall of 2019, he entered the master's program at Wake Forest University. He was still struggling with depression and anxiety, but he was focused on earning his degree. He was receiving counseling that he paid for himself and his medications. As we all know, 2020 was the year of COVID and everything shut down. His classes were all online. There were times when Logan would not leave his home for weeks. I checked on Logan, visited, encouraged him constantly. He became more isolated. As a VA employee, I saw a veteran who was in trouble and needed help. With no trust in the system, he would rather suffer than seek help. Sadly, we see this so much with too many of our veterans who have served their country.

Logan graduated on May 14, 2022, with a master's degree in divinity. After graduation, he was unable to find a job and had to

move back home. As his mother, I encouraged him to seek the services he was eligible for, but, once again, he was skeptical, but decided to reach out to the local veterans service center for help in June. At the meeting with the veterans service officer, he seemed encouraged.

As a pharmacy technician, I feared that Logan was over medicated. On September 1, 2022, I requested a session for Logan to speak with our pharmacist so he could ask questions about his meds and their side effects. Afterwards, I sent Logan to check in and request a mental health provider. He said later that he had been given an appointment. However, I learned after Logan's death that his appointment was not until 5 months later, for February 2023. Logan's mental health issues needed immediate help and again was not met. He was met with a broken system.

The Community Care Act, to my knowledge, was not offered. Protocol at that time was a veteran request—if a veteran requested a mental health provider, they were to be seen or sent to Community Care within 20 days. Logan died 63 days later. He was never contacted. November came and there was still no action in regards to the services Logan had requested, to my knowledge. Again, he was disappointed in the VA and, as a result, his anxiety and depression increased. As his mother I was still working to help find help for my son.

On November 4th, 2022, my worst nightmare occurred. Logan was found in the bathtub at my home by his stepfather with a plastic bag over his head and a helium tank with a hose beside him. I returned 2 weeks after Logan's burial. I was very unstable and not well, but I knew I had to go back to work and report a suicide. After doing so, I waited for weeks and I was never contacted as an employee or a veteran's family member. It was not until February 23rd, I contacted the director to make sure she was aware. She stated she did not have knowledge of said death.

I continued to work for as long as I could. I missed most of '23 from my job. I was not able to function. I took an early retirement. I had to go home. The next year I contacted everybody and anybody that would honestly would speak to me. No one wanted to talk to me and I was treated like a whistleblower. Today I feel like a whistleblower. That is all I have to say.

[THE PREPARED STATEMENT OF LORI WILLIS LOCKLEAR APPEARS IN THE APPENDIX]

The CHAIRMAN. First off, thank you for your testimony. Thank you for the three of you. We are going to come back. A vote has been called in the House. The committee will stand—and I hate to do this right in the middle of this, but it is what happens here. Okay? This is a very serious subject.

If the members would please go to the floor, we have two votes, and then return as quick as possible. The committee will stand in recess at the subject of the call to chair. We expect to reconvene about 10 minutes after the last vote has been called. Thank you.

[Recess.]

The CHAIRMAN. The committee will come to order. I do want to apologize to our witnesses. It is part of what we do around here. The timing was not—well, anyway.

Ms. Dymond, you are recognized for 5 minutes to provide your testimony.

STATEMENT OF BRITTANY DYMOND MURRAY

Ms. MURRAY. Chairman Bost, Ranking Member Takano, and members of the committee, on behalf of the men and women of the VFW and its auxiliary, thank you for the opportunity to provide our remarks on this critical topic.

The VFW believes the VA Community Care Program and its network of providers are a vital component of VA healthcare. However, it does not always work as Congress intended. My story is just one example of a negative experience that could have been avoided. For 10 years, I exclusively received Department of Defense (DOD) and VA-provided mental healthcare. Not only did DOD not diagnose me with Post-Traumatic Stress Disorder (PTSD), the VA did, but VA providers also failed to identify the complexity of my PTSD diagnosis, resulting in treatments that did not fully help. Despite consistent care, I battled crippling emotional numbness and had come to blame myself for being defective. I also started experiencing passive suicidal ideations.

In late fall 2021, I was referred to a civilian therapist through VA Community Care, and she diagnosed me with complex PTSD, the first time I recall a mental health professional using that term. In May 2022, based on my trauma history, symptoms, and her clinical expertise, she recommended a PTSD inpatient program with very specific treatment criteria. However, D.C. VA staff would not authorize a referral to the program because it was in Utah and its physical location was in Community Care Network 4. We were told to choose a local program instead.

Following a service-connected surgery, I revisited the inpatient treatment discussion with my therapist. This time around, however, I had done extensive personal research which indicated that in addition to a method called Eye Movement Desensitization ad Reprocessing (EMDR), a relatively rare therapy called Internal Family Systems (IFS) was effective in treating complex PTSD. My therapist and I decided to try to get approval for an Arizona program that was also in Community Care Network 4 on the West Coast, but offered both EMDR and IFS.

In July 2023, frustrated with the seeming lack of urgency on VA's part, I physically went to the Washington D.C. VA and spoke with a social worker, who promised to advocate for a referral on my behalf. Again, the referral was denied due to its geographic location, but the social worker promised that he would keep trying. Unfortunately, he went on emergency medical leave and my request for inpatient treatment fell through the cracks for over a month.

In September 2024, VA staff tried helping me find East Coast treatment options. However, so much time had passed since my initial request in July, I would have to wait until January 2024 for my next opportunity to enter treatment. I tried finding Utah and Arizona comparable programs while the VA employees offered in-network options on the East Coast. It felt like trying to find a needle in a haystack and VA's suggestions generally fell short. Some programs were too long while others were only part time. Some had poor reputations while others did not offer the correct treat-

ments or they were primarily focused on mental health conditions I did not have, like eating or substance use disorders. One facility was for patients who were dangerous to themselves or others, which was inappropriate for me, while another was coed and did not understand why I would want to go to a women-only treatment program.

After weeks of searching, we found a comprehensive program—or sorry, a compromise program in Pennsylvania that met some of my criteria, but did not offer the EMDR or IFS treatment modalities that I needed. I agreed to go there and, fortunately, my assigned therapist was able to help me understand my complex PTSD symptoms and she ensured my follow-on care was with a qualified professional, who did provide those needed treatments. I am lucky to have landed with the civilian therapist that I did and for the resources family, friends, coworkers and accommodating employer that I have. Not all veterans can say the same.

However, getting the right mental healthcare should never hinge on luck. I have since learned that suicidal ideations are actually a product of the fight element in one's fight or flight response essentially giving out. Had I not been knowledgeable and advocated for my treatment needs and as a result been sent to a treatment program that could not truly help me, it could have been my last attempt at getting better.

VA must stop its practice of rationing inpatient mental healthcare based on arbitrary, seemingly thoughtless guidelines. Arbitrary location rules should never be the only factor in determining which veterans have access to life-saving care. Providing veterans with the correct mental healthcare the first time means saving lives.

Chairman Bost, 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.

[THE PREPARED STATEMENT OF BRITTANY DYMOND MURRAY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Ms. Dymond.

Dr. Saindon, you are recognized for 5 minutes to provide your testimony.

STATEMENT OF KELLEY SAINDON

Dr. SAINDON. Chairman Bost, Ranking Member Takano, distinguished members of the committee, on behalf of the members of Nurses Organization of Veteran Affairs, or NOVA, thank you for allowing us an opportunity to present our views on the topic, "Restoring Focus: Putting Veterans first in Community Care."

As a VA nurse, I want to begin by expressing my sincere sorrow hearing the stories from these witnesses at this table. It is important that we learn from these cases to improve care in the veteran experience throughout the VA. NOVA understands and supports community care when access to VA is not readily available, the distance is too far, or the VA does not provide the needed care. We recognize and acknowledge that we cannot serve everyone everywhere. Our priority is to ensure veterans receive the highest level

of care within the VA and utilize community care as needed to enhance the healthcare experience.

Since the passage of Choice and MISSION Acts, community care has rapidly expanded. Community care referrals have risen by approximately 20 percent annually and 44 percent of Veterans Health Administration (VHA) healthcare funds are spent on community care. While the MISSION Act expanded community care, it was not meant to replace VA's integrated health care system. The legislation was meant to provide a balance between non-VA care when necessary while bolstering VA direct care.

We are beginning to see shifts in care and staffing that risk diminishing the superior care that VA provides veterans. Provider shortages and budgetary constraints continue to affect VA care and community care. The constriction and closure of community healthcare systems have raised concerns about how and when veterans can be referred to the community. The community healthcare systems are saturated and cannot absorb the continued increased demand for veteran care in the community.

Despite innovation and improvement focused on efficiency for community care coordination, the policy-driven steps remain laborious. Inconsistency in scheduling and authorizations across the system create confusion for veterans and for our community partners. A public-facing site that provides detailed information about community wait times, quality metrics, provider credentials, and provider training is imperative for veterans to make informed decisions about their healthcare.

VA clinicians are more likely to have experience and specialized training in recognizing, diagnosing, and treating conditions often encountered by veterans. They are uniquely trained not only on military culture, but on veteran-specific exposures. The standards for our community providers should be no different.

The oversight of care in the community is inadequate at best. We recommend Congress implement strong action and enforcement of mechanisms to increase quality and oversight of community care. Failure to meet quality expectations should result in removal from the network.

It is vital that VA facilities have more control over services provided in the community. Records must be received promptly so the VA can direct further care, including any necessary diagnostic testing. Without proper coordination between VA and community providers regarding the timely return of medical records, veterans may not receive the necessary information to make informed healthcare decisions.

For example, this vulnerability is especially important with lung cancer screening, lung nodule, follow-up mammograms, and colonoscopies. Stories from our membership include VA Community Care staff requesting records three or four times to the community provider with no response. This leaves the veteran at risk for serious and, in some cases, life-threatening poor outcomes.

We recommend the Community Care Network have prescriptive guidelines for record sharing. Current practice leaves much risk for healthcare decision delays. We encourage Congress to implement business rules that permit payment upon receipt of medical records. Studies have consistently shown that VA care equals or ex-

ceeds the quality care provided by the private sector. Recent star rating reviews demonstrate that VA hospitals score higher than non-VA facilities in both patient satisfaction and quality of care.

My hospital, White River Junction, Vermont, received a five-star overall hospital and five-star quality rating in September 2024. It was the only facility in Vermont and New Hampshire to earn the top rating.

A 2024 VFW survey showed overwhelming support for VA to remain the primary deliverer of care for veterans, with most of them saying they prefer using VA medical facilities for their healthcare needs. The VA must remain the primary provider and coordinator of veterans' healthcare, using community care as a supplement when VA services are unavailable. Authorizations and referrals should follow access and eligibility standards. Requirement for both VA and Community Care should include consistent quality and training standards.

Listening to veterans stories helps us understand their needs. NOVA is committed to working with Congress, community partners, and VA leaders to ensure veterans receive timely access to the highest level of care.

Thank you again for this invitation to testify. I am happy to answer any questions many may have.

[THE PREPARED STATEMENT OF KELLEY SAINDON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you. Before we get started, I would like to thank Representative Harris, who represents Ms. Locklear in Congress. He will be joining us later on, but we need to make sure that in accordance with committee rule number 5(e), unanimous consent that Representative Harris from North Carolina be permitted to participate in today's committee hearing.

Without objection, so ordered.

I recognize myself for 5 minutes of questions. Ms. Locklear, you shared how your son struggled to access mental healthcare. If VA had told Logan about his community care eligibility early on, do you think it would have made a difference?

Ms. LOCKLEAR. Logan died and I got some bank statements, his last bank statements. I have bank statements that shows he spent $800-and-some in like 2 months for his mental healthcare. He called me one day at work frantic, saying, Mom, I am out of my medications. What am I going to do? What am I going to do? I said, Logan, you. I directed him to go to his local pharmacy. I said, no pharmacist is going to withhold your mental health meds from you till you can get a new prescription.

He did so, he came home, he had bought $288 worth of medication that day. I looked at the receipt and I was like, Logan. He said, Mama, that is what they said it was, so I just paid it. I was like—and that is one of the reasons why I brought him into our facility, set him down with their pharmacist, and because they—I—they knew the meds he was on and they said, Lori, these drugs he is on are dangerous.

That is the reason after we had that discussion, I said, check into the—check in. I told him, I said, if I could get you into my facility, I can help manage and take care of your mental health—with your mental health needs and his medications; $288 that he paid for out

of his pocket. My son was going into a hole trying to take care of his mental health.

The CHAIRMAN. He did not know that it was available to him.

Ms. LOCKLEAR. He knew it was available, but, I mean, he had no faith in the VA. Then when I finally talked him into it, there was error after error after error that was done in paperwork. He checked in, he got a 5-month appointment, mental health. If he had came home and told me that they had given him a 5-month appointment, I would have said, you come right back to the VA tomorrow, I am going to go down there with you. I would have questioned them. Why are you giving a mental health—a young man, if you looked at his record, he had tried to attempt suicide multiple times in the military. I do not understand why he did not have an appointment when they allowed him to—an honorable discharge in December. Why would not he give him a mental health appointment right then? Why was not he locked into a facility right then for from the military?

The CHAIRMAN. Mr. McKenna, you testified the VA counselors and parents advocate in your written testimony were unable to provide clear guidance on your care options. How do you think VA needs to fix this?

Mr. MCKENNA. Chairman, if I understand the question correctly, it talks about the dichotomy of the two experiences I have had. First, when my wife and I retired, we moved to northwest Florida, specifically in the Pensacola region. Very similar with respect to services as it is in eastern North Carolina, meaning the main VA hospital center for northwest Florida is located in Biloxi, Mississippi. That is about 2–1/2 hours from our home.

Same situation, when I went to the VA clinic in Jacksonville after relocating a year later in eastern North Carolina, the main VA clinic is in Fayetteville, North Carolina. That is again 2–1/2 hours from my residence in Richlands, North Carolina.

These two VA clinics, both in Pensacola and Jacksonville, North Carolina, are completely different in the fact that, one, the process in Pensacola, Florida, was seamless. The quality of care I received from that VA clinic, from meeting with Dr. Sandoval and his team, to talking to VA counselors in the network, Community Care Network, to actually seeing providers out in the community, that entire process from flash to bang was about 10 to 15 days depending on what that specialty care was.

Conversely, in eastern North Carolina, same specialist care I need, one, I cannot be seen at that VA clinic by either a doctor or a nurse because they do not have that capability or capacity there. Additionally, they are not taking any new patients. They, in turn, set me up with care in the community, to a clinic, a Med First clinic. It is a primary and an urgent care clinic. Only thing on staff there are nurse practitioners. No doctors, no nurses. Good people, but probably from drawing your blood to basic medical care like a flu shot, it is beyond the scope of their capability.

They, in turn, will put a referral in. Now, unfortunately, they have to use a third-party vendor to do this. The third-party vendor puts that referral into the VA, again delaying the process.

I think to answer your question more directly, the friction point in eastern North Carolina lies with the third-party vendor. There

appears to be no oversight either from the VA or from Med. First. When I tried to advocate for my own healthcare by saying, hey, can I get an email or a phone number to talk to this third-party vendor, I was told both by the VA and Med First that they are not authorized to provide me that information to be able to communicate, to understand why this process is taking so long.

Then finally, when you do try to, or at least when I try to, understand what is causing these delays and when you talk to the VA counselors either on the telephone or through MyHealtheVet online, I get responses like that is just the way it is here, or we did not receive the required paperwork from your primary care provider out in town.

Now, to the latter statement, I personally watched that nurse practitioner at Med First in Richlands, North Carolina, fax that form to the VA. Then when I followed up the next day having a fax receipt of that, I was basically told, "I do not know what to tell you."

Again, sir, to answer your question more directly, more oversight on that third-party vendor and then better training and education to the VA workforce that works the Community Care Network.

The CHAIRMAN. Thank you. I am way over time, but Ranking Member, you are recognized.

Mr. TAKANO. Well, with that, Mr. Chairman, I am very glad to hear that you intend to hold more oversight hearings and I hope you do that before we rush a bill to the floor that purports to be a solution. Who is precisely missing this panel is the third-party administrator and anyone from VA.

I want to change my question to Ms. Saindon. You know, I find it curious that my majority counterparts want to see VA function more like a private sector actor. They force VA to abide by standards that no one in the private sector would ever accept. For example, can you imagine that UnitedHealthcare would pay claims without receiving a patient's health record or any proof of medical necessity? Medical necessity. Yet through the third-party administrator, in this case Optum, which is in reality UnitedHealthcare, renders payment on behalf of VA without requiring their providers to transmit veterans' medical records back to VA.

Now, Dr. Saindon, do you think that VA's contracts should require network providers to submit medical records as a condition of payment?

Dr. SAINDON. On behalf of the membership at NOVA, yes, absolutely. We have discussed this ad nauseam. It is a huge threat for good coordination of veteran care. We are aware that the contract, the next generation of the contract, is imminent and we strongly advise Congress to consider modifications to that where payment is issued upon receipt of those medical records. We have countless examples of how healthcare has failed those veterans as a result of not having those medical records readily accessible.

Mr. TAKANO. Thank you for that answer. Again, I would point out that Optum, otherwise known as UnitedHealthcare, is not here. They were given a pass for not being here and they are an accountable party and they are a third-party administrator.

I hold VA accountable also for not having contracts written so that this is part of how you do business. VA is forced to operate

not as a private sector company would not think of operating. Any private healthcare network would make this a condition of reimbursement.

How does not having these records affect VA's ability to properly coordinate veterans' care?

Dr. SAINDON. Countless ways.

Mr. TAKANO. Yes.

Dr. SAINDON. Significantly, it poses a real threat to good coordination of care. A good example of this is a veteran gets referred out to a community network provider as a result of a specialty that they may need and have a follow-up with primary care provider a week later, 2 weeks later, whatnot. The veteran's information yet has still come over to the VA from the community provider. That puts the VA providers in a real problem situation, unable to determine what recommendations, what were the treatment plans, et cetera.

Mr. TAKANO. Yes. I would have loved to have VA and UnitedHealthcare here to explain why this has gone on and why it continues to go on.

There are kinds of care that, Dr. Saindon, that private sector care is simply not equipped to provide. They are just not going to invest the money or the resources or research into it. It is unwilling to provide because there is no profit to be made. No profit. That is why the public backs up our veterans when the private sector is just—there is not the incentives to do it.

For example, VA has invested billions of dollars to provide care for veterans with complex spinal cord injuries, traumatic brain injuries, limb loss and prosthetic needs. What will happen to this very specialized care if we continue down this path of community care expenditures outpacing investments in the VA direct care system?

Dr. SAINDON. Community care for these specialized services that you just mentioned are just simply not available. More so in the rural settings. The care is not comparable. If there is a spar resource in the community for that specific specialized care, it is too finite to take care of our veterans adequately.

Mr. TAKANO. Well, thank you. In your testimony you highlight the anticipated national shortage of primary care physicians that the national healthcare system will face in the coming years. That is not just VA doctors, but the national. Can you elaborate on why this makes it more important than ever to invest in a strong direct care network at VA?

Dr. SAINDON. NOVA is incredibly proud of our educational mission. We train 70 percent of healthcare professionals nationwide. In other words, if you ask a healthcare provider if they have had any type of training or stepped foot in a VA during the course of their training, you will hear a lot of the yeses there. Our goal is to grow our own, maintain those trainees, support training the healthcare infrastructure as it relates to providers. Robust scholarships, incentives, continuing education opportunities is a way that we could incentivize that. NOVA strongly supports considering those options.

Mr. TAKANO. Not having a strong direct care network at VA will definitely impact the training of our future professionals?

Dr. SAINDON. Absolutely. We have already seen it. In fact, there is a gross shortage of educators in the healthcare industry as well as preceptors on the front lines in the field, limiting our ability to take student trainee placements. If we continue to struggle budgetary and/or with veteran care, access to veteran care, we will have to continue to limit our capabilities of taking trainee placements, which will ultimately collapse healthcare.

Mr. TAKANO. Thank you. I yield back.

The CHAIRMAN. Dr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman, and thank you all for coming today. Thank you for the service to your country. These are some real difficult stories to hear from somebody who has taken care of VA patients for 35 years and actually continues to do so.

I find it somewhat ironic the ranking member brings out the stories that we are talking about the failures of the VA over the last, good Lord, I do not know how many years, but especially over the last administration where they continue an electronic medical record (EMR) system that is outdated, incompetent, inefficient, does not communicate. I can say this on the front end and the back end, it does not cost a penny, a penny, for me to click a button and send something, a medical record as a community care provider to the VA. Does not cost a penny. We do it all the time when we communicate with all the other doctors. That is not true. It is not anything has to do with profit. It has to do with the fact that we have a inefficient organization that is becoming more and more inefficient. I am so optimistic that with the next administration we are going to crack it down and actually make it like a private organization would be efficient and for the people who actually should benefit from this, our veterans.

You know, I have said this many times here, I have veterans show up and I have no records in front of me, nothing. Community Care is supposed to take care of them. Community Care exists because the VA does not have the medical expertise or the physicians to take care of them. We have our national institutes that govern our medical schools now, which are absolutely being negligent in how they are creating doctors. This situation is not getting any better. It is going to get much worse.

As specialties occur, I just tried to get on a website here to see what urologists were needed in the VA. They are all over the place. If you want, if a veteran needs urologic care, they are either going to not get it at all or they are going to have to go out into the community. It is just a fact. Specialty care, as I have said this before, costs more than other care.

Anyway, enough of that rant. You know, I am happy. I would love to see UnitedHealthcare come in here. I would love to see that. I look forward to that day because they are killing people out in the regular community and they are by denying care and they are doing the same thing with our veterans. The third party stuff, I am looking so much forward to creating some true efficiency within the VA.

Sergeant Major McKenna, thank you for your service. Welcome to—I love, you know, eastern North Carolina. We got a little snow today, by the way, out of the blue. I want you to tell your experience because you were in Florida and you thought you had an effi-

cient community care system. You have come to North Carolina and it is not. Can you tell me the pros, cons, what you think that is all about?

Mr. MCKENNA. Thank you, Dr. Murphy. Just to pile on your point, if I may, what would further assist the VA is building that electronic bridge with respect to medical records from our servicemembers, whether they do 4 years or 40 years, to be able to have those VA doctors and even the care and the community doctors access ALTA or other VA medical and dental records would again bring us into the 21st century.

Mr. MURPHY. Yes, I have gone on about how broken the system is——

Mr. MCKENNA. Yes, sir.

Mr. MURPHY [continuing]. and continues to be inefficient.

Mr. MCKENNA. Back to your question, sir. You know, my wife and I initially resided in Northwest Florida upon my retirement in 2021. There were several factors that drove us to that geographical location to retire. Number one, my wife Michela, who is a Federal employee, took a job in government service at Naval Air Station Whiting Field in Milton, Florida. Number two, the quality of cardiac care in northwest Florida. Michella received a mechanical heart valve after being diagnosed and treated for endocarditis in 2013. Then finally, the word from my fellow retired Marines that the VA healthcare system was first rate in that location.

Michella's healthcare is covered by Treatment, Resources, and Insurance for Care or Active Duty and Retired Military Personnel (TRICARE) for life. As you all are well aware, that insurance.

Mr. MURPHY. Sergeant Major, I do not mean to interrupt, my time is limited, but if you can talk about the 6 months versus the year.

Mr. MCKENNA. Oh, absolutely, sir. The process, and I think I already alluded to it in an earlier statement that in Pensacola, from seeing a doctor at the VA to getting a referral to be in care in the community, to being actually seen in the community 10 to 15 days. Conversely, eastern North Carolina, seeing a doctor not at the VA out in the community, to getting a referral, and I am talking about for specialty care needs, Traumatic Brain Injury (TBI), mental health, orthopedics, urology, I am waiting personally 9 months still for that referral to be approved. Let me repeat that. I am waiting 9 months for that referral to be approved.

Now, my fellow veterans in eastern North Carolina, this story is not unique. We are talking 6 to 9 months to get any type of specialty care in eastern North Carolina. Despite my best efforts to advocate for my health, you know, contacting the VA advocate, those calls go unreturned, you know.

Mr. MURPHY. I have got to close up with my time. The bottom line is, my understanding it is the bureaucracy is not allowing you to see the doctor in a timely fashion. As Mr. Dooley has shown us, that can have up to lethal consequences. Thank you for your service. Thank you for your testimony.

Mr. MCKENNA. Thank you, Dr. Murphy.

The CHAIRMAN. Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman. Thank you to the panel for being here and sharing your stories. I am, you know,

deeply sorry that the VA did not provide the services and the quality of healthcare that each and every one of you and Ms. Locklear's, in your son's case, that they earned and deserve. I am sorry to hear that.

I have to say I have been on this committee for 12 years, and over that 12-year period, I have heard over and over and over again that a very large percentage of veterans say they prefer receiving their healthcare at the VA over Community Care. They believe that the quality of care within the VA is very good and in some cases superior. What we have to kind of wrestle with here on the committee is the more we invest in Community Care, the less we invest in VA care. I think, you know, we have been wrestling with that and we need to continue to find where that balance really is.

I believe in Community Care. For 12 years on this committee, I have advocated for better equality for healthcare for our women veterans. Women veterans have to receive a large portion of their healthcare outside of the VA. It is clear that to provide those services to our women veterans, we have to have Community Care. That is a true phenomena, you know, beyond one population, meaning women veterans.

You know, I think in many cases also that wait times are largely longer in the community than in the VA. Now, I know, Mr. McKenna, you have talked about the processing and sort of the bureaucracy that goes on, and I think that is certainly part of the problem when we talk about longer wait times in the community. It is also true that in most circumstances, wait times in community care are just—they are just simply longer. It is just a fact. The way I see it, the facts that I see is that—and although every VA is not the same, and Mr. McKenna, you have pointed that out—or was it, I am sorry, Mr. Dooley, were you the one that said you got good healthcare one place and not so good?

Mr. DOOLEY. That was actually Mr. McKenna.

Ms. BROWNLEY. Mr. McKenna. Mr. McKenna has pointed that out, that not every VA is not the same. If you receive healthcare in the VA, I think this is a fair fact to say, that if you receive healthcare in the VA, it is usually quality care. The care is also less expensive. The National Bureau of Economic Research recently came out with a working paper that found that VA also reduces total spending by 21 percent relative to non-VA providers. The care is less expensive in the VA.

If we invest more in the VA, wait times will improve and it is what the veterans want. They want the large propensity, the larger percentage of veterans, they want their healthcare within the VA. That is, I think, that is in essence what we kind of have to wrestle with here. You know, where is the right balance?

I think it is—I do not know whether all of you are advocating for—it sounds to me like you are advocating—I am not sure whether you are advocating for more community care or better community care. I am not sure which one it is. If it is better community care, I am with you all the way. If it is more community care, I am not sure that we have found the right balance. That is kind of where I am.

Ms. Dymond, can you just respond to what I have just said?

Ms. MURRAY. Absolutely, and thank you for the question. I would say absolutely better community care. There are many holes which have been illustrated by, you know, the panel, including myself, and I think there needs to be more meaningful effort put behind how veterans are assisted in accessing that community care. A lot of the pressure is put on the veteran themselves to do the work. We were handed off to—I should speaking for myself, I have been handed off. What I have illustrated here and in other experiences, interactions I have had with Community Care where an overwhelming amount of the pressure is put on me to figure out what care I need and find the correct providers because VA is not doing it on their own. It is really tough, better, absolutely.

Ms. BROWNLEY. Well, my time is out. I will just say, Mr. Chairman, I am happy to work with you to improve the process by which we get veterans' Community Care when we need it. I am not willing to, you know, have a large conversation about just increasing, increasing, increasing, increasing.

The CHAIRMAN. That is not what the conversation is. The conversation is providing the best for our veterans and doing it correctly. Right now the system is broken and we have got to fix it because of things like this. It is a quality. The thing is obviously Veterans Benefits Administration (VBA) getting paperwork right and all of that. We have got to quit arguing on whether it is—whether I am right or you are right or who is Republican, who is Democrat, and start arguing for the veterans. That is what we are trying to do.

I have told—and I will tell you this, we will also bring the other ones that the ranking member has asked for. To say that we did not bring them in because we were trying to do some kind of ridiculous thing about arguing over the community and over VA, I think that what we have to do is make sure the veterans get what they want, when they need it, where they need it, at the level that they need. I agree with you that there are a tremendous amount of people that have a tremendous experience at VA if they can get when they need it and if I am not traveling five hours to get there.

We have got to keep working on it together. We cannot just all of a sudden say, well, you believe this and you believe this, and we have got to start working on it together. We have got to.

Ms. BROWNLEY. I believe we have to work on it together, too, but I think we have to have more hearings around this debate——

The CHAIRMAN. I got it.

Ms. BROWNLEY [continuing]. a lot more issues and——

The CHAIRMAN. When——

Ms. BROWNLEY [continuing]. make sure that we are working off common facts.

The CHAIRMAN. When our staff writes our script, maybe what they should also pay attention to is the fact we are trying to work together and quit trying to make look like it is a partisan act. Just saying, so.

Ms. BROWNLEY. I yield back.

The CHAIRMAN. All right. Mr. Hamadeh.

Mr. HAMADEH. Thank you, Mr. Chairman. As a veteran, I understand the obligations we owe to our fellow veterans. Now, President Trump got it right when he signed the bipartisan MISSION Act,

putting veterans in charge of their healthcare decisions. Yet today we are seeing bureaucratic roadblocks that prevent veterans from accessing timely care, especially with mental health services.

Now, the stories we heard today are deeply troubling. I want to commend President Trump's incoming Veteran Affairs Secretary, Doug Collins, who many here know him very well when he served in Congress, for his commitment to accountability at the VA. We must do more to ensure veterans can choose where they receive care. The VA system should work for the veteran, not the other way around. When a veteran needs help, they should not face a maze of prior authorizations and arbitrary denials.

The data is clear. Expanding community care access does not increase cost, it increases quality. We must codify access standards to guarantee veterans' rights to seek care outside the VA when needed. I want to thank all the witnesses for coming today and for their service and for being sharing your brave stories as well.

Now, Mr. Dooley, my first question is for you. You waited 9 months for critical treatment. If you could redesign the VA's authorization process for veterans seeking urgent care, like cancer treatments, what specific changes would ensure veterans get immediate access to the nearest qualified provider, whether VA or Community Care?

Mr. DOOLEY. I think to start that off, the first thing would be to know how fast they can get it from the VA. That is the first thing to know and inform the veteran of that, of when they could get that treatment. The second would be going into community care, if that is the route that they decide to go, being able to reach out to different care—community care providers and finding what amount of time that they could actually get it done. In my case, if it could be done in the VA in, say, 3 months, that is too long. Let us see what community care can do. Then if community care is 5 months, obviously the servicemember being allowed to know that and then make a choice, but then also going back and seeing what other care providers may be available that could get it done earlier, that would provide me with the earliest treatment I could, and then also the knowledge of knowing which one would provide that so I can make an educated decision.

Mr. HAMADEH. Thank you. Now, would you support eliminating prior authorization requirements entirely for certain urgent medical services, similar to how we handle emergency care?

Mr. DOOLEY. Without knowing the full specifics of that, I cannot say that I would recommend one thing or the other. What I could say is I would like the opportunity to cut through the red tape and allowed to get my screening prior to that. It could have made all the difference. If anything, that would be cutting through the red tape and getting the servicemember to that type of treatment as soon as possible, I would recommend.

Mr. HAMADEH. Thank you. Now, Ms. Locklear, you witnessed firsthand, tragically, how delays in mental health affected your son's trust in the VA system. Now, should not veterans have the immediate right to seek mental healthcare from any qualified provider in their community without jumping through bureaucratic hoops?

Ms. LOCKLEAR. Yes.

Mr. HAMADEH. How would this have impacted your family differently if that were to have been the case?

Ms. LOCKLEAR. Well, Logan did that. I mean, he took it upon himself to get the care that he needed because of his distrust in the VA. Unfortunately for Logan, I think he got a provider that just—she just continued to prescribe him medications and he was so desperate to get better, to honestly get better. I think she was over medicating him.

I found out recently, just a few days ago, I knew he had went into the Emergency Room (ER) and I found out he was in the ER because he had lithium toxicity. She had put him on lithium. When I spoke to my pharmacist about it, they said, Lori, that is a dangerous drug. It is old. I cannot believe It is even being used. He was on it and he had to go to the emergency room because he—it became toxic.

I would like to say something in regards to what you are already saying, if you will let me do that. Sixty days to get community care, okay. When Logan checked in, and by the time it took Community Care to sign off on what he needed was 2 days prior to his death. Well, in those 2 days, he still did not get called, so.

At the time, COVID, when COVID came in, we had staff that left our hospital to went home to work remote. They never came back. They worked from home the entire time. Still working from home. Trump telling these the employees to come back to work, they need to come back to work. I do not know that that did not take part and why it took 60 days for someone to look at my child's chart and say he has already tried to commit suicide a number of times. He's depression. We might need to go ahead and get him taken care of as soon as possible. That did not happen.

Mr. HAMADEH. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. Dr. Conaway.

Mr. CONAWAY. Thank you, Mr. Chairman. Thank you to the witnesses for bringing forward their experiences for the edification of this committee.

We as a Nation should be deeply grateful for the sacrifices that our veterans have made on behalf of all of us and their families have made on behalf of all of us. As a physician and veteran myself and someone who spent the last 25 years trying to figure out how to expand access to quality care in my own state of New Jersey, as I listen to your testimony, I can easily point out the many failures on a bipartisan basis that have occurred in advancing access to quality care for members of our society. It is particularly troubling and concerning when we are seeing these problems among our veterans to whom we owe so much.

There are failures to invest in the technology that will allow us to understand what is going on. If we do not understand data about who is being seen, when they are being seen, what paperwork and information that needs to flow from those experiences so that care can be examined and improved, then we are failing. This is anytime you put more and more bureaucracy in a situation in healthcare, and we see this all over the place, whether it be prior authorizations, which has been mentioned, all of this paperwork flowing back and forth, someone goes to see the physician, they get a referral, they follow up to make sure that referral is taken care

of. You do not need a lot of technology around that. This idea of exploring how we get rid of all this paperwork and all these hurdles is certainly a very valuable exercise.

Understand, as I hope everyone in this room does, that these hurdles have been put in place because of a concern about the spend. Every person who works in healthcare, every person receives a service, there is a dollar behind that. Our concern, right concern, about how much we are spending on a particular line item for veterans healthcare, depending on what our priorities are—and, again, in my view, the Veterans Administration has not been properly funded. It has not—does not have the staff it should. That says, in my view, that we are not paying the kind of attention we need to pay to the veterans who deserve our thanks.

I am concerned, as has been raised here, that we do not have—and we are going to have more, and I take the chairman at his word, that we are going to have additional hearings on this, because we certainly need to see and hear from the Third Party Administrators (TPA)s that are managing this healthcare. We certainly need to hear from the VA about their processes and what they plan to do about these very troubling things we have heard today. We need to hear from the Office of the Inspector General about their review of the situation and what we can do to ensure that the data is made available to us so that we can actually know what is going on and where the failures are.

Every time we have applied data, whether it is in the financial services, sending people to the moon, developing the latest technologies, it is all developing the right plans for healthcare so we get the outcomes we want. It is all a data-driven process. We sit here today with a very disturbing lack of the kind of data we need to decide actually what is going on.

I am very sorry, ma'am, for the tragic loss of your son. You do not need to have children for that—I happen to have a couple kids. I cannot imagine the pain of losing a child, particularly when you did so much to try to protect that child as parents do.

We have heard from the administration that there is a hiring freeze. I have heard from perhaps some or all of you that there is a real concern, and certainly, Ms. Saindon, excuse me, about the staffing shortages there. People need to power the system of care. We understand that. If there is—and it has been years that it has been recognized that we do not have enough staff in the VA, again, because of our lack of investment, on a bipartisan basis, by the way, in the VA.

Can you shed some insight on how this hiring freeze will impact a situation which is already dramatically problematic and which, if it continues, will prevent the kind of improvements that need to be made to ensure that veterans get the care we need? Discuss the hiring freeze in the context of the current staffing shortages that we have and the difficulty that it will bring to making the kind of improvements that clearly need to be made in the provision of care through the VA?

Dr. SAINDON. Thank you. The hiring freeze was shocking yesterday for many of our membership. There is already been conversations as to what we can do to advocate to respond to this. We are grossly concerned about the impact it will have on bringing in new

nurses, bringing in new providers, also the reputation for the VA. These individuals, from what we understand, membership, individuals that had been selected and/or were in the process for recruitment, received automated messages. That is not the way we do business in the VA. We like to have conversations with our candidates and our applicants. Yesterday they got automated messages from the platform we use in VA USAJobs saying that the position was rescinded. We are concerned about our reputation to continue to get the most qualified individuals within the VA system and maintain them.

Inability to continue to staff at our ceiling levels or at our approved levels within budget will impact our ability to provide inpatient care. It will impact our ability to maintain clinical access and will be a continued need to coordinate care in the community, which is a threat, also, because that is a heavy, laborious process that requires more staff from the VA to support the coordination of care in the community.

Mr. CONAWAY. I do not know if anyone wants to answer. That is my time, Mr. Chairman. I do not want to go over it, but if you permit anyone else to answer it, I would certainly appreciate that and I will thank you for the time.

The CHAIRMAN. Thank you. Mr. Self.

Mr. SELF. Thank you, Mr. Chairman. On behalf of the veterans across America, like my constituent Mr. Dooley, thank you so much for making the trip to be here with us and tell us your story.

I am ready to turn the page to a bright future. That last questioning. We are going to right size this stuff and we are going to get it right and I will leave it at that. Thanks to the Trump administration, we are going to be able to offer our veterans a helping hand after 4 years of cold shoulders, failures, and broken promises from the Biden administration VA. It is unforgivable that the hardworking Americans who served our country honorably paid the price because VA employees choose to serve bureaucracy rather than our veterans. There is a new sheriff in town and I assure you that I think the changes are coming.

Mr. Dooley, in this committee in the past, I always make the point about the VA wants to talk about inputs. We started this new program, we spent this new money, we did this. They never want to talk about outputs. I want to thank the four of you for coming to talk about outputs in the VA system because that is what this committee ought to be talking about, outputs. Mr. Dooley, it took you 9 months to receive a colonoscopy. What do you think that did to your body over 9 months? Any ideas?

Mr. DOOLEY. I am not a doctor. However, I do know time matters, especially when it comes to cancer. I know that from stage 1 my possibilities of surviving and remaining a long life with my children drastically goes down when it goes to stage 3. Stage 3—stage 1 to stage 3 is literally the mass got big enough and it got into my lymph node system making it stage 3. In that case it is a lot better possibility that it will move to other parts. Even if I am cancer-free now, the chances of it moving on and coming to another part of my body is actually a lot greater.

To answer it very shortly, my life and my chances for remaining and living a longer life got reduced by those 9 months. Could have taken years off of my life.

Mr. SELF. I understand. What broke through after 9 months? What broke through to your treatment?

Mr. DOOLEY. Me waiting. Unfortunately, I waited 5 months for the appointment and then once I found out I had cancer, they said to wait another 4. To be totally honest, your office is the only reason that I got seen.

Mr. SELF. I want to stop right there, Mr. Chairman, and say our veterans should not have to have their Member of Congress be the first line of defense with the VA. That is my most important point today. The Member of Congress is not the first line of defense to get an appointment. Yet for my constituent, it was. That to me is a crucial point in this hearing.

The system that you encountered, Mr. Dooley, do you think it was designed to help our veterans or to put up obstacles and barriers to actual care?

Mr. DOOLEY. From what I personally experienced, it looked like it was—they made incompetence absolutely vulnerable for the area. I saw a lot of people that did not do their job and there was no way to hold them accountable for it. That was very as simple as I was not even given a name and a number to call back. The number that I would call back would be a hotline, and then I could not even leave a message for that person. My written testimony does not have a lot of names in it and definitely does not have any direct numbers. There is a very good reason for that: because I was not provided any. It is really hard to hold somebody accountable when you do not even know who they are.

Mr. SELF. With that, Mr. Chairman, I think those are excellent points and I yield back. Thank you.

The CHAIRMAN. Dr. Morrison.

Mr. MORRISON. Thank you, Mr. Chair. My sincere gratitude to our witnesses for joining us today. Thank you to you and your families for your service to our Nation.

I am glad to be here with all of you today for our first committee hearing of the year and my first as a Member of Congress. I am honored to serve on this committee because military service runs deep in my family. My husband John and my father-in-law are both combat veterans, both former proud Army Rangers. My dad and my grandfathers all served as well. I firmly believe it is our duty here in Congress to provide our veterans with the resources that they deserve and have earned.

I am a physician by trade. I am one of the 70 percent who received some of my training at a VA. Having had the opportunity to care for these brave men and women, I take seriously our congressional oversight responsibilities on this committee and look forward to working in a bipartisan manner to ensure that VA provides the highest quality of care to our veterans.

Now, I am admittedly new to the committee, but it strikes me that we both need community care and we need better oversight of community care. It also sounds like we need to invest in a new EMR. Honestly, as Dr. Conaway referenced, we are grappling with the same workforce shortages that many sectors of our society are

facing. I am concerned about the hiring freeze that you just discussed.

Dr. Saindon, as you know and referenced, VA clinicians are particularly well equipped to treat conditions that frequently affect veterans, such as PTSD, substance use disorder, and traumatic brain injuries. Are there currently standards in place to ensure that Community Care providers are adequately trained to treat these types of conditions?

Dr. SAINDON. This is another frequent topic of discussion among NOVA membership. To our awareness, there does not exist community indication of competencies, training, or quality, and it is concerning that we entrust those providers in the community with our veterans unaware of those data points.

Mr. MORRISON. Thank you for that answer. I assume then that you are concerned that the lack of training and educational requirements may threaten the standard of care that a beneficiary may receive outside of the VA. Thank you.

Thank you, Mr. Chair. I yield my time.

The CHAIRMAN. Thank you. General Bergman.

Mr. BERGMAN. Thank you, Mr. Chairman, and thank of all of you for being here. This has been a long hearing when you have to, you know, the break for vote, so we just appreciate your patience. In life, you got to be patient. You got to be, but you got to be persistent. You have to persevere, all of those things. Some of us who have been on this committee for a while are, I am not going to say getting a little long in the tooth, but we are definitely getting a little frustrated, okay, over the lack of movement of the bureaucracy.

During the 115th Congress, those of us who here were here, it was when the MISSION Act was crafted. Now, I am going to use a visual example. We put the MISSION Act into play, and since then, anybody here not know what the game Whac-A-Mole is, okay? That is what it has been. From the committee's standpoint, and even I would suggest to you from the veterans' standpoint, you hit one mole and it goes down and another one pops up. It is a moving target. It is such that in our roles and responsibilities here, we owe it to the veterans and we owe it to the doctors and the nurses, all the healthcare providers in the VA system to actually eliminate the Whac-A-Mole nature of this so the care can get right to the patient.

What we have seen is that the mid-level bureaucrats in the VA have prioritized to a great extent the bureaucracy over the veterans themselves. They are focused on, well, let us adjust this process or let us do that or that, without concern that the end game of providing care is not there. We have not talked about it today and then I am going to ask a couple questions here, because there is an assumption if you live in an urban or suburban area, you either get in your car, get in the VA service officer's van, get in an Uber, getting on the transportation, and go to your local veterans, you know, hospital or wherever the clinic is. Well, we got rural and remote in our country, too, and especially add a snowstorm. I got a hunch there is probably nobody in South Carolina today on the road. Now, in Michigan, with a snowstorm, they are still going to go on the road to get there. Okay? We have the whole spectrum here of the urban, suburban, rural, and remote to provide the care.

Mr. McKenna, just a quick reaction here. What is your reaction—was your reaction when you discovered that VA counselors were unfamiliar with the basics of the MISSION Act, and by the way, in polite Marine terms?

Mr. MCKENNA. Thank you, sir. Again, to use your analogy of Whac-A-Mole, I think if you go back to the MISSION Act itself and to prevent knocking things down that you have already hit before with respect to training and education, training and education must happen continuous.

Mr. BERGMAN. I am going to cut you off——

Mr. MCKENNA. Yes, sir.

Mr. BERGMAN [continuing]. because my time, as you know, as a Marine here, we are not going to waste time. You are absolutely right. Do not waste time. We waste enough money. You can recover money, but you cannot waste time once it is gone in veterans care. Do you think, when you mention training, that the VA employees should be required to undergo periodic training and updates to familiarize themselves, in this case with the Community Care Program?

Mr. MCKENNA. Yes, sir. I will give you one small example. If you ask a VA counselor, at least my experience has been, can you give me any elements of the MISSION Act, specifically care in the community, and I am talking numerous people, not just one, are completely clueless to this legislation. If that is not an indictment on the VA and their training and education program, I do not know what is.

Mr. BERGMAN. Yes, and it is an indictment, quite honestly, of the leadership, especially at mid-level. Why is the United States military so successful regardless of service? Our staff Non-Commissioned Officer (NCO) corps, our NCOs and our staff NCOs. It has got nothing to do with the officers. It is the staff NCOs and those mid-level folks within the system is what is going to make it work. That is where I believe we need to focus bipartisan because it is not Democrat or Republican. It is about getting the care and it is about retooling, if you will, the bureaucracy. I did not say eliminating it, retooling it, so it actually functions in a 21st century world with electronic health records and all of that data sharing.

With that, I yield back, Mr. Chairman.

The CHAIRMAN. Mrs. Ramirez.

Ms. RAMIREZ. Thank you, Chairman. I want to start by thanking our witnesses. As you heard from other colleagues here, I know that between the votes and coming back, the schedule was a little difficult, but I want to thank you for being here.

I want to especially thank Ms. Locklear for your testimony. I want you to know that your sharing and the pain that you feel was felt by every member here. I want to thank you for your courage to be here and to speak truth to the experience that you have had and the experience you do not want any other parent to have. I just really want to thank you from the bottom of my heart.

One of the most pressing issues our veterans are facing is that quality healthcare, is that access. It is a concern shared by so many everyday Americans really trying to navigate our system of privatized care. In hearings like today, I think it is important that we reflect on some of the assumptions that we are making. You

know, I assume we are committed to meeting the healthcare needs of every single veteran. I want to assume that caring for every veteran means providing them the full spectrum of services. You see, I assume we want our veterans to have the best, the most comprehensive, the most coordinated, the most timely, and the most accountable healthcare we can offer them. I want that for every veteran. Frankly, I want that for every American. I assume we mean the same thing when we talk about community care, but I am learning that we mean different things. Some of my colleagues just mean private care.

Finally, there is another assumption operating of which I cannot get behind, and that is increasing access to private care that would automatically result in better healthcare outcomes for some veterans, but not the others. The evidence shows that public VA facilities provide higher quality veteran-specific care. If you believe that the private sector can do it better, which I do not, then you may be comfortable with the concerning amount of money being funneled away from the VA into privatized care.

Folks, I am concerned that we are not asking whether that care is really leading to healthier and better outcomes, because choice alone is not the point. We want choice, but we also want quality. That is what we should be after. As we have heard from many of my colleagues, there are instances when our veterans cannot access a VA healthcare center due to distances or due to other barriers. However, the VA healthcare system is set up specifically to address the needs of veterans.

Dr. Saindon, did I pronounce it correctly? Good, good. Pronunciation is important for me. Can you tell me how the VA healthcare providers and clinicians are uniquely prepared to care for our veterans? I specifically want you to tell me what trainings are required for you to take to ensure that you are providing culturally competent care to our veterans.

Dr. SAINDON. Every employee is required to do military competence training. In addition to that, based on the occupation or based on the role of the healthcare provider at the VA, they have a whole slew of different trainings that are specific to meeting the needs of those populations that they serve in that role specific.

Ms. RAMIREZ. Dr. Saindon, let me ask you a follow-up question to that. Are Community Care providers required to take those trainings?

Dr. SAINDON. Not that we are aware of.

Ms. RAMIREZ. Additionally, are there third-party administrators who manage a network of Community Care providers required to ensure that providers in the network complete these trainings?

Dr. SAINDON. Membership has spoke about this several times. It is in our written testimony. We are very concerned that there is no such requirement.

Ms. RAMIREZ. Got it. Thank you, Doctor. Look, Community Care is part of the equation that we need to be discussing today. Yes, we certainly need to do everything in our power to ensure our veterans are receiving care. We need to make sure that that care is high-quality care in a timely manner. Veterans have the best, the most comprehensive, the most coordinated, the most timely, most accountable healthcare, that is what we need to be working toward

in this place. As we discuss this conversation today about community care, as we talk about the impact that our veterans are experiencing every single day, as we talk about their own families, I truly hope that choice and quality are going to go hand-in-hand.

I want to thank our witnesses here today. I want to thank the chairman and the ranking member and the vice ranking member here today as well. I look forward to having a fruitful conversation over the work that we do over the next few months where it is centered on our veterans and their career. Thank you.

With that, I yield back.

The CHAIRMAN. Thank you. Mr. Van Orden.

Mr. VAN ORDEN. Thank you, Mr. Chairman. I appreciate being here. I am very sorry I had to step away. This place pulls you in 50 different directions. I have read all your testimony and I want to thank you for coming out here.

I spent my first day in Congress calling the widow of a veteran, the brother of a veteran, and the sister of a veteran—sister-in-law of a veteran who committed suicide because he did not get a mental health consultation. I printed that letter. It has been sitting on my desk for 2 years. It has got a note on there. It says, this is why I am here.

I have learned a couple things. I chair a subcommittee. Learned a couple things over the last 2 years. This is the first Congress here. I have been in Congress for 2 minutes—or 2 years and 5 minutes. I do not want to hear from the VA right now. Our ranking member said, why is not the VA here? You know why, because they do not tell us anything. I have essentially had 10 of the same damn hearings with these guys because nothing changes. No one is held accountable at the VA. Nobody.

Check this out. They made a $25 million estimate to do the digital GI bill. It is going to be a billion dollars, 25 million to a billion. No one is being held accountable. The Cerner trash, I just got off the phone again with two doctors. I just want to check civilians who are using this. Cerner was sole-sourced a contract to do the electronic medical record, $16 billion. They spent 14, they want to do 18. They are saying they had to delay it to 2026 because it does not work, $14 billion into it. You know how much they say it is going to cost to get it across all the business? Take a guess. I will tell you: $50 billion. No one is being held accountable.

Mr. Dooley, I am terribly sorry. I am going to formally apologize to you from the Federal Government. I am so sorry. Let me ask you something, Mr. Dooley. Has anybody that had anything to do with the travesty that has taken place in your life at the VA been held accountable? Anybody?

Mr. DOOLEY. To answer shortly, no.

Mr. VAN ORDEN. Ms. Locklear, my heart breaks with you. It does, and we talked and I thank you for that. We know what it is like. I know what it is like to lose a child. I do not know where you would be and how you hold up with this grief knowing that it was much more preventable than the loss of our daughter. To your knowledge, has anyone been held—or, excuse me, your son. I apologize. It is our daughter. To your knowledge, has anyone been held accountable at the VA?

Ms. LOCKLEAR. No.

Mr. VAN ORDEN. Nobody. Ms. Murray, to your knowledge, has anyone been held accountable for dragging you around and treating you like a hobo who is begging for help, for injuries and PTSD is an injury? Has anyone been held accountable for treating you like a beggar and kicking you around the country?

Ms. MURRAY. None to my knowledge, sir.

Mr. VAN ORDEN. Okay. Well, I personally am looking forward to our new Secretary Collins getting in here and the people that are responsible for these billions and billions of dollars of waste are held accountable. Every single dollar that is wasted is a dollar that cannot go to making sure you can go to a program in a different region. To making sure, sir, that when the VA cannot possibly help you, that you go immediately to Community Care and that you do not have to have 57 different referrals for the same treatment plan. Ma'am, to make sure that no mother or father or brother or sister ever has to find their child in a bathtub after they have committed suicide because they did not get the mental healthcare that they needed.

I know that the men and women on this committee mean what we say. I just believe that some of my Democrat colleagues are misguided. I get all my healthcare through the VA. I am a 100 percent service-connected disabled veteran. I get all my healthcare through the VA. The people that treat me in La Crosse, Wisconsin, are fantastic. That is from the people that are checking me in to my primary healthcare facility. I am so proud of them. Wautoma, Wisconsin, I am so proud of them. Do we have problems? Yes.

The farther up the chain we get, the farther away from reality we get, and I want to have some of these people that have been sitting in these offices at the VA collecting a paycheck go out and talk to you, ma'am. I want them, sir, to go to a medical appointment with you and your family and let them explain to you and your family why you could not get the healthcare you needed because they are too damn lazy and they are more concerned about protecting a bureaucracy than the veteran. That is what needs to happen. Nothing is changed until it does. That is what we are going to do under the new Secretary's leadership and the leadership of this chairman. That is my promise to you.

I yield back.

The CHAIRMAN. Thank you. Dr. Miller-Meeks.

Ms. MILLER-MEEKS. Thank you so much, Chairman Bost, for this hearing.

It is interesting, my conversation and my thoughts as we have listened to this hearing and listened to both members on this side of the aisle and the other side of the aisle proper questions. My questions are different now than they were when I first came in here.

First, Sergeant Major McKenna, my family, my husband's family is all from Richland, North Carolina, and I know that system well. Ms. Saindon, you mentioned about, you know, everything being automated and how concerned you are. Let me just say that I applied for a job as a physician, I am a nurse and a doctor, applied for a job at the VA in 2014. All of my responses were automated, so I am not sure how that is not how we do things at the VA. As I recall, the President at that time was President Obama, and all

the responses were automated and went through USA.gov. That is one of the issues we have with hiring.

In the 4 years that I have been on this committee, there has not been a lack of funding to the VA. As a matter of fact, funding has increased every year. Even in this hearing room, we had a hearing on mental healthcare and suicide prevention. I, as the chair of the Subcommittee on Health, and through that hearing with the VA present, found out that the VA did not consider residential mental healthcare or substance abuse disorder healthcare to fall under the MISSION Act. Therefore, they did not have to get somebody in, a veteran in within 30 days.

Now, as a nurse and as a doctor and a person who has family members who had PTSD and mental health issues, if you are at a point where you think you need residential care for substance use disorder or mental health, you need mental healthcare now. We put forward a bill that it had to be within 10 days.

The first bill that I passed and had signed by a President in 2021 was Brandon Caserta, who 5 hours after he visited the VA in Iowa City, which is an excellent VA, committed suicide. As a nurse and as a doctor and as a veteran, but most importantly as a mother, Ms. Locklear, we feel that we are responsible for our children's happiness and success. I know the burden that you bear, and it is not your fault. It is the responsibility of this committee and members on both sides of the aisle to make sure that what happened to your son does not happen to any other sons and daughters. That is why you are here today.

Ms. Saindon, does the VA send veterans to get care at Veterans Integrated Services networks (VISN)s far away from where a veteran may reside?

Dr. SAINDON. To my knowledge and membership, yes.

Ms. MILLER-MEEKS. Exactly. I am not sure why it is a problem with a veteran such as Ms. Murray, and I do not know your rank, Ms. Murray, my apologies, a veteran to get care for a specialized condition at a place because it happens to be out of network. That is the type of stuff we hear from private insurers, and both of them have problems. If their veteran is not able to get the care at the closest VA to them, and there is the care that they need recommended to them by a provider, they should be able to get that care. I do not give a hoot if it is on the East Coast or the West Coast, because the VA already sends people to other VISNs two or three VISNs away, hundreds of miles away and months away. When we consider the cost of care within the community, not private care, let me re-emphasize this once again, but care within the community.

Let me also say I am a provider of care. I gave community care. I do not think I had to have training for PTSD as an ophthalmologist to do cataract surgery.

Ms. Saindon, is it well known that men in age 40, if they have blood in their stool, that is considered cancer unless otherwise you are a doctor, nurse practitioner?

Dr. SAINDON. To clarify, I am a DNP, Doctor of Nurse in Practice.

Ms. MILLER-MEEKS. Yes.

Dr. SAINDON. Not a prescriber or provider.

Ms. MILLER-MEEKS. Okay. Then I will not ask you that question. Let me just say it is common knowledge. It is common knowledge, we are trained in medical school that if a male has blood in their stool, especially under age 40, which I think Master Sergeant Dooley was, if my math is correct from your testimony, that it is cancer unless proven otherwise. How is it quality of care for the VA not to order a colonoscopy from a VA provider? That is not quality care. Let me say that quality care is no—if no care is provided, that is not quality, whether it is at the VA or Community Care.

Do you think the cost would have been lower, Master Sergeant Dooley, if when you told your physician what your symptoms were, and I am implying what you were, I am presuming as a physician, if you relayed your symptoms, they would have ordered a colonoscopy and then they would have allowed you to go for care and had your appropriate treatment? Do you think maybe the cost would have been less if it was a stage 1 cancer or stage 2 rather than a stage 3?

Mr. DOOLEY. I would like the chance to live, so I would not have cared what the cost was. To answer your question, yes, I do believe treating stage 1 would have been a lot more cost-effective and efficient than in treating stage 3 and for the rest of my life.

Ms. MILLER-MEEKS. As a provider and someone who knows the healthcare system, I am going to wholeheartedly agree with you. That is why we do screening. That is why we do colonoscopies and recommend them over age 50. Why if someone presented with the symptoms you had, even as an ophthalmologist at the VA, I would refer you for an urgent colonoscopy.

My point is this. Our obligation is to make sure veterans have access to care. If you do not have access to care in a close-by VA and your symptoms warrant, then you should get care within the community. That is our responsibility as an organization. As a committee and as Members of Congress, you should not have to come to see your Member of Congress to get the care you have earned. You have earned the care. We are going to make sure that we hold the VA accountable and the community accountable for getting you the proper care in a timely fashion that you so richly deserve.

Thank you and I yield back.

The CHAIRMAN. Representative King-Hinds, you are recognized for 5 minutes.

Ms. KING-HINDS. Thank you, Chairman Bost, and "Hafa Adai" to all of you. Thank you for being here today. Thank you for your service.

To Ms. Locklear, my deepest condolences. Your story is too common to so many families and parents across America.

I come from the Northern Mariana Islands, about 8,000 miles away from Washington, DC, that is my district. It is a chain of islands that, you know, have a lot of people signing up for the military. We have a lot of veterans and our issue basically is just access to service. We have one local physician contracted part-time by the VA to treat veterans 2 days a week. Referrals to available specialists in the district can be made out prior—with prior authorization from VA office in Honolulu, which is thousands of miles away. VHA also occasionally sends specialty care doctors to include neu-

rologists and podiatrists about three times a year. We do have emergency care, although very limited even to nonveterans.

The point is, you know, access to these services is an issue in the Marianas, and I have always assumed that that issue was limited to our islands. One of the reasons why I ran for Congress was to be able to improve the quality of service. As I am sitting here and I look at all of you and I am hearing about all these different challenges, I am crushed. If we are here on the mainland and we are not able to provide the quality of care here in America, then how are we going to be able to be able to address the challenges of our remote islands?

I do not have any questions. I just wanted to say thank you and you deserve better. I truly believe in my heart that through Chairman Bost's leadership in this committee, that everybody has your best interest at heart. I am certainly here to fight not just for my community, but for you as well. Thank you so much.

I yield my time, Mr. Chairman.

The CHAIRMAN. We are glad we have Mr. Harris with us today. Mr. Harris, you are recognized for 5 minutes.

Mr. HARRIS. Well, thank you, Mr. Chairman, for the invitation to be a part of your committee today and for the consent to allow me to share.

Ms. Locklear, first of all, I want to thank you for having the bravery to come in today and to share your son Logan's story. It is truly an honor to have the privilege of representing a selfless American such as yourself. Your willingness to come and share your testimony, I really pray, is going to help us ensure that what happened to you and to Logan will not happen to future veterans and to their families.

Your son had to wait 5 months between his initial contact for a mental healthcare appointment and the scheduled appointment date. Now, the law says that a wait time should be no longer than 20 days before referral to the Community Care Program.

I guess I want to ask you, are you aware of any efforts the VA has made to improve wait times or improve awareness among veterans of the Community Care Program eligibility?

Ms. LOCKLEAR. Yes, I think so.

Mr. HARRIS. Well, sadly, looking at the VA wait time list last night at the Fayetteville VA Medical center, there is currently a 60-day wait time for new patients to get access to individual mental healthcare. You see, I am concerned about what you went through. I just want you to have an opportunity to really help us understand how this experience has affected you mentally and what this has led to in your own life.

Ms. LOCKLEAR. I had worked for the VA for 12 years. I believed in the VA system. I love the veterans. To have my own veteran that I saw in front of me 4 years suffering through what he was suffering through, I was trying to help him. Could not get him to go. When I finally got him to go, this happened. The week he died, I thought he was actually better that Wednesday before he died. I thought he was doing better. Then that Friday when we found him, I was just crushed.

When I went back to my facility, of course my department knew what had happened. They had rallied around me. They had taken

care of me, they had provided for me. I knew I had the knowledge of a suicide, that it needed to be reported. When I went in to report it, they appeared to be very receptive, wanted to know what had happened. They wanted to know how—like I had known for 12 years. How do we fix this? How did he fall through the cracks?

Then when I told him that he was my son, everything I felt like stopped. I kept waiting for someone to call me and say how—can we talk to you? How can we fix this? What happened? All the while I was trying to work and still trying to figure it out. I did not understand what was going on. I knew my child was gone. I did not know he had—I did not know they had given him a 5-month appointment. I did not know that. I did not know that till March of the next year. I kept asking, you know, I just kept waiting.

Finally, I just called. I just called the director of the facility myself and I asked her about it. She was not—she said, I was not aware of that. From the very beginning, I just felt like it became a cover-up. Nobody would speak to me. I kept asking, you know, when I made her aware of it, she said she would get back to me. She never did.

As the months continued, my work performance continued to fail. I worked in the pharmacy department. I have a lot of—I had a lot of responsibility in my job in regards to handling medications, handling drugs. I spent a lot of time the first year after Logan died, I was not at work. I could not function. I could not think. By half the year, I just—I had exhausted every opportunity, everything that I could use to help me to continue to work my job and stay where I was at till I finally decided I—I realized I could not work there. Every time I came through the back doors, I felt like they were—the VA did not help my child. Therefore, I just—in my head, I felt like the VA had caused my child's death. It made me feel like I contributed because I was part of the VA.

In my head, I had to get away from the VA. I said, I have got to get away from this place. I have been diagnosed with PTSD, anxiety, depression. All I asked was, when my child died, I went in and I just said, can you help me? Can you explain to me? Just explain to me what happened, what happened to him? No one—they just—they acted like they did not see me. Now I feel like I am disabled. I still do not function well.

Mr. HARRIS. Well, let me say this. You said something a moment ago that the whole attitude had been, oftentimes, you heard it, how did he fall through the cracks? How did they fall through the cracks? How did they fall through the cracks? I hope that you sharing your testimony today is going to help assure that that does not happen again.

That, Mr. Chairman, I yield back my time.

The CHAIRMAN. I now recognize Dr. Dexter for 5 minutes. Welcome to Congress.

Ms. DEXTER. Thank you so much, Mr. Chair. I apologize.

The CHAIRMAN. I just want to let you know, this every day.

Ms. DEXTER. I am feeling indoctrinated, so thank you. Very much appreciate the testimony from all of the guests here. Particularly as a physician, as a mother, I want to acknowledge the challenges that our system faces.

Having been a VA physician within the system as well as a physician in the private sector who has taken care of patients from the Veterans Administration system, we have a lot of challenges ahead of us. What Mr. Dooley went through, I have had my own patients go through. That delay in care and the lack of continuity of care from the outside is a frustration as a physician, but it is also a failure of the system. We know that building a more comprehensive system that is accessible to the veterans is better care. Our veterans want to be seen within the VA administration. They want to have the physicians who know them, who understand the challenges of having been a veteran. We provide better quality of care, more comprehensive care, and more timely care in an integrated system when it is appropriately resourced. I believe that that is the challenge that we need to rise up to.

We need to have access for mental health, for addiction, for cancer services. The answer is not going to the private sector. It is building the VA Administration services so that we can build capacity within the system.

I also speak as somebody who was a leader in a capitated system that provides coordinated care. When we were struggling financially, we made margin. We made a successful business by bringing services to within our system, to stop paying the bills outside that we have no control over, to stop the escalating costs that will continue. We understand that we are effectively supporting private practices outside of the VA Administration.

Respectfully, Mr. Chair, and to our community members here who have so bravely and candidly spoken for veterans, I will fight for this system and I believe it is enforcing our need to serve veterans from within and to make sure that we resource it appropriately.

With that, I yield back. Thank you, Mr. Chair.

The CHAIRMAN. Thank you. As the ranking member, does Dr. Conaway want to have a closing?

Mr. CONAWAY. Thank you, Mr. Chairman, for holding this oversight hearing. We understand that there is a lot more information we need to collect as a committee in order to ensure that we as a Nation are doing right by our veterans and making sure that they get the care that they richly deserve.

Thank you to the witnesses for taking your time today and enlightening us with your personal experiences. In particular, thank you to Ms. Locklear for your bravery today. It is not easy to come and to talk about tragedy and to be as forthcoming as you have been. We are grateful for that and we are sorry for your loss.

We look forward to working with you in a bipartisan way. This committee has a bipartisan history. May it always be so. We do better when we work together. We do things that are lasting and more sustainable. We look forward to our future work to bring attention to those things which need fixing and to work to make sure that our government does the job it needs to do by our veterans. Thank you all.

The CHAIRMAN. I want to thank the witnesses for joining us here today. It is clear that the previous administration had problem implementing the Community Care Program. The Community Care

Program and the MISSION Act are law. They are not suggestion, they are law. There is a reason for that.

Let me clarify this, no Republican, and I guarantee you no Republican on this committee, has ever said we want to privatize, ever. Democrats have accused us of wanting to privatize. We do not want to privatize. We do understand that the VA was not created for the bureaucrats at the VA. The VA was created for the veterans. If we have people around this Nation and veterans around the world that need services, the MISSION Act should be able to do that.

Now, unfortunately, I think that sometimes the bureaucrats in the VA, for the fear of privatization, refuse to do the job which we have assigned to them and that is what things have shown up. That is the problems—that is some of the problems we have. There is a lot of problems we have trying to get the services to the veteran at the time when they need it. As quickly and efficiently as we can. There is waste in the VA. There is. We need to make sure that it is the most unwasteful, best medical provider that it can be.

Now, remember, there is a whole lot more than the medical side of VA. All those other things that we deal with in this second largest bureaucracy in the world that this committee is over, we are going to work to try to correct those. This is one issue.

I am also going to say this. This is not the last hearing we are having on this. Others will be brought before us that are those people who are the providers and the connection between the patient and the Community Care provider in which they—and how they contract and how they communicate. It is a communication problem both between the VA and the Community Care. As Representative Van Orden said, we care about the veteran. We have got to figure out how to get that there and not put people in this condition again.

I want to say thank you so much for being here. I want to thank the members for a long meeting. With that, we are looking forward to continuing to work on this.

With that point, I want to ask unanimous consent that all members shall have 5 legislative days to revise and extend their remarks and include extraneous material.

Hearing no objection, so ordered. This hearing is now adjourned.

[Whereupon, at 3:49 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Paul McKenna

Chairman Bost, Ranking Member Takano, and members of the House Committee on Veterans' Affairs – thank you for inviting me to submit this written statement for the record of today's hearing on veterans' experiences using the Department of Veterans Affairs (VA) Community Care Network. I am here today as a voice for countless Veterans in Eastern North Carolina who continue to struggle to effectively and efficiently utilize this critical part of VA's health care system.

As the committee is aware, the VA MISSION Act became law in 2018 and was intended to improve access to health care for Veterans. My aim today is to illustrate the gaps and seams within several pillars of this legislation that are present in Eastern North Carolina, with specific attention on access to care, the Community Care Network, and the education and training of the VA workforce that coordinates access to care in the community. My hope is that my statement will offer the committee some insight to the real challenges that Veterans face with when using the Community Care Network in Eastern North Carolina. Additionally, and what may sound anecdotal, is to share with you my experience with using the services of VA's Community Care Network in two different geographical locations and the experiences of many Veterans I have talked to who must utilize community-based services.

My name is Paul McKenna. I retired in 2021 after 36 years of active-duty service in the United States Marine Corps. I have held numerous Military Occupational Specialties (MOSs) throughout my career, with the last 20 years being spent primarily with the infantry and combat arms MOSs. I have 9 combat deployments in support of Operation Restore Hope (Somalia), Operation Iraqi Freedom (Iraq), Operation Enduring Freedom (Afghanistan) and Operation Enduring Freedom, Joint Task Force, Special Operations Force, (Southern Philippines). I have learned many life lessons from my nearly four decades of service as a US Marine, and at the top of that list is that no American can afford to be disinterested in any part of his government, whether it is county, city, state, or nation. One of the great lessons the Marine Corps taught me was to never take for granted of being the presence of other Marines and their greatness. For 36 years I walked amongst giants, I will forever cherish those relationships, especially the relationships of the American Heroes that never came home. I truly hope that my actions and words today bring honor to their memory and sacrifice.

My wife and I initially resided in Northwest Florida after my retirement, and I was able to receive timely and adequate medical care from the VA in that region. There were several factors that drove us to this part of the country; one, my wife, Michela, who is a federal employee, took a new position within government service at Naval Air Station Whiting Field in Milton, Florida. Two, the quality of cardiac care within the area of Northwest Florida. Michela received a mechanical heart valve after being diagnosed and treated for endocarditis in 2013. And three, the word from fellow retired Marines that the VA health care system was first rate. Michela's medical care is covered by TRICARE for Life, and that insurance involves expensive copays for her continued care.

The primary reason for choosing the VA for my medical needs was for our financial wellness and the fact that I earned it. I am 100 percent permanent and total disabled and I use the VA as my primary medical provider. The VA in Northwest Florida (Pensacola) is a VA Clinic associated with the Biloxi VA Medical Center in Mississippi, which was two hours from our home in Milton, Florida. The care at the VA Pensacola Clinic was first rate and Dr. Sandoval and his team always treated me with the highest degree of professionalism, dignity, and compassion. Because I require a specialist in some areas of health care, and the fact that the Pensacola VA clinic does not have that capability or capacity, I was referred to the Community Care Network, i.e., Mental Health (PTSD), Neurology (TBI), Orthopedics, Podiatry, and Dermatology. The process in Pensacola was seamless. Starting with seeing Dr. Sandoval and his Team to scheduling with the Community Care Network counselors

to be seen out in the community. The entire process took no longer than 10 to 15 days.

In June 2022, I relocated to Richlands, North Carolina and registered with the VA clinic in Jacksonville, North Carolina. Just like Pensacola the Main VA Hospital for this region is in Fayetteville, North Carolina, two and half hours away from my residence in Richlands. After registration at the Jacksonville VA clinic, I was informed that I would have to contact the Community Care Network and seek a provider out in the community. This was due to the lack of capacity of doctors and nurses at the clinic and that they were not taking any new patients. Community Care set me up with MEDFIRST in Richlands, North Carolina.

MEDFIRST is a primary and urgent care clinic that only has nurse practitioners on staff. The MEDFIRST nurse practitioners can draw blood and perform only basic medical care. This clinic (MEDFIRST) does not have the expertise or capacity to treat my medical issues which include mental health, traumatic brain injury (TBI), post-traumatic stress disorder, neurology, orthopedics, podiatry, dermatology, and urology. MEDFIRST must put a referral in the VA system for me to be seen out in the community for medical treatment. That referral goes through a third-party vendor who then submits the referral request to the VA. When I call the VA Community Care line or contact the VA through MyHealtheVet to understand why the process is taking so long, all I hear is "That's just the way it is" or "your primary care provider did not submit the correct form." As to the latter statement, I personally watched my primary care provider at MEDFIRST fax the request and the next day when I called to follow up was still told that the VA did not receive it and when I stated that I have the fax receipt, I was told "sorry don't know what to tell ya."

More generally, the third-party vendor appears to have little to no oversight from either the VA or MEDFIRST. I have been waiting for over nine months for some of these referrals to be processed. I draw this conclusion as I attempted to gain their contact information, phone or email and was informed by MEDFIRST and the VA that they are not authorized to provide the contact information of this third party-vendor to the Veteran. My experience is not unique. I have heard the same concerns and complaints from countless Veterans here in Eastern North Carolina. Since moving to Richlands, NC, I continue to experience delays in care from the VA Care in the Community Network.

Despite my best efforts to advocate for my care, I never receive a clear answer from the VA counselors who answer the phones. When I quiz the VA counselors on the fundamentals of the VA MISSION Act, they are clueless of this legislation. I have contacted my VA patient advocate (Sheldon Edwards) numerous times and left voicemails and have yet to hear back from him or his office. No human being, let alone a Veteran should have to wait six to nine months to receive treatment for any medical issue, especially when the injuries occurred while in service to their country.

I am asking this committee to investigate why there is no capacity to properly treat our Veterans in Eastern North Carolina in a timely and adequate manner and direct the VA to properly educate and train their workforce within the Community Care Network on the VA MISSIOIN Act in Eastern North Carolina.

Thank you again for the opportunity to participate in today's hearing on the VA Community Care Network. It is my hope that Congress and the VA can take some of those things that were working in Northwest Florida like the referral process and the access to care and help replicate those qualities for Veterans across the country so that they can get the care they need in a timely manner no matter where they choose to live after service. I look forward to answering any questions you may have.

Prepared Statement of William Dooley

Thank you, Chairman Bost and Ranking Member Takano, for the opportunity to discuss my frustrating experiences with the VA Community Care program. I am a U.S. Army Veteran who enlisted in 1998, serving 20 years on active duty and received a rating of 100 percent permanent and total from the Veteran Affairs. I served in several units over the years, including the 101st Airborne Division, 2nd Infantry Division and The NCO Academy at Ft. Benning, Georgia. In these short years since my retirement, I pursued my Master's in Public Administration, served my community with an appointment as the Chairman of my local county's VA Committee, and obtained my Juris Doctor from Creighton University. I am currently a Prosecutor within the DFW area and proud father of three amazing children between the ages of 22 to 10. I am in front of you today as a Veteran, Father, Husband and a Cancer Patient fighting for a chance to live.

By providing the timeline of my most recent VA Healthcare interactions and points of discussion, I hope to provide insight and perspective of the current problems Veterans are facing today while seeking care under the VA's Community Care Program. I will highlight network inefficiencies, employee complacency, and incomplete case management with the optimism that it will create opportunities to improve this beneficial program and help correct current ongoing and systemic problems present within the Organization.

BACKGROUND

September 11, 2023, I attended an appointment at the Bonham VA Medical Clinic for a routine health check and to establish my transfer of care from the Omaha, NE VAMC. During this appointment I discussed a rising concern I had regarding a significant medical symptom. The physician rejected my concern and waived off any need to investigate the symptom further. I returned to this physician as the symptoms persisted around November 7th to insist that we investigate the cause and again inquired if a colonoscopy would bebeneficial. At this point the physician decided to order a lab test for me to conduct at home.

On November 20, I received a call from the physician informing me that the test confirmed my reports of blood present in my stool and that I was being referred to GI for consultation. During this conversation my physician told me that there was a backlog to schedule a colonoscopy within the VA Network and he advised it would be faster to go through Community Care. Acknowledging the physician's recommendation and my desire to obtain answers as soon as possible, I agreed to his recommendations to seek the screening under Community Care in hopes the results would ease my concern.

On December 8, 2023, I received the authorization to schedule a colonoscopy with Dr. Jenny Tseng, who was selected by the VA. The only information I was provided with was the physician's name, phone number, and the initial appointment of February 8. During this appointment, I was able to schedule the colonoscopy for May 20th. From the time I presented the concern to my Primary Care Physician at the Bonham VA Clinic with my initial request, to the time I was able to receive the screening was nine (9) months.

On the morning of May 20th, immediately upon waking from anesthesia, my wife and I were informed that during the exam, Dr. Tseng located a large mass. She emphasized to us that it was medically urgent to seek an immediate consultation with a surgeon as soon as possible and strongly advised it needs to occur within the next week. The exam findings noted that the mass within my colon was already over 5 cm in length and occupied two-thirds of the space within the circumference of my colon. Think of a Hot Wheels car stuck to the inside of a cardboard toilet paper roll. Not only did this indicate an obvious concern of advanced cancer growth, but this also put me at a high possibility of experiencing severe risks stemming from a bowel obstruction.

On May 22, assuming two days would give adequate paperwork processing time, my wife called the community care number listed on the Dallas VAMC website that did not work. She had to eventually call the VAMC general number and request to be directly transferred to the Community Care personnel.

On the line with Community Care personnel, she explained the provider's concern for medical urgency. The personnel informed her that they could not locate the documentation, and they were experiencing a backlog. At that point CC personnel advised her that she might be able to receive help from the Patient Advocate and transferred. While communicating with Patient Advocacy, my wife inquired what the next step is for a Community Care referral that finds an urgent medical need. The Patient Advocate was not able to provide any tangible information regarding rules, regulations, or procedures to her. The Patient Advocate only advised her to wait until someone from the VA initiated the call. The Patient Advocate responded dismissively and told my wife that she could put in a complaint, but don't expect anyone to reach out for a week because they don't have to respond to complaints until a certain number of days and with the Memorial Day holiday coming up that would extend the deadline over that week anyways.

Immediately following that interaction with the Patient Advocate we sought options that could produce access to care in accordance to the current medical urgency. We were able to schedule an appointment with a GI surgeon at the UTSW Harold C. Simmons Comprehensive Cancer Center who had an existing contract of service with Community Care and immediately received support and advocacy from their Nurse Navigator starting on May 22. On top of not having the ability to seek authorization for care under the VA Community Care program, I was unable to get ahold of my primary care physician to explore VA Facility options. At one point I physically walked the results indicating the presence of my tumor to the Greenville,

TX CBOC, and requested that a doctor contact me as soon as possible as it is an Urgent Medical concern. I did not hear back from the clinic.

It is my belief that we finally received communication from the VA due to the requests for assistance sent through Congressional inquiries. I was contacted by a VA Nurse Navigator on the afternoon of May 23rd. She explained that the VA has a tumor board, but I would need to have imaging complete prior to being put on their schedule. It was dependent on me, the patient, to schedule with the VA imaging facilities. After another round of inaccurate VA listed numbers and waiting multiple hours, the imaging scheduler informed us that I would not be able to receive complete imaging until September, having to wait an additional 4 months. After informing the UTSW Nurse Navigator of this scenario, she advocated for us and was able to coordinate with the VA staff to have imaging completed under Community Care at a civilian location. Around this time, I spoke with Patient Advocate, Ms. Veronica Lopez, who informed me that the Community Care Referral to be seen at UTSW was authorized for Six (6) months to cover treatment needed for Colorectal Cancer. I was not provided with any documentation that outlined details of this authorization and what it covered.

After my initial appointment with the Colorectal Surgeon on May 30th, we unfortunately learned that the imaging and testing indicated that I had T3N1 Colorectal cancer, more commonly referred to as Stage 3 Cancer. This indicates that the cancer was further advanced than we were hoping for, and the Standard of Care directs for a Neoadjuvant Treatment plan prior to surgical removal. My treatment plan over the duration of 6 months consists of 8 rounds of two different types of chemotherapy, 5 rounds of concentrated radiation, and assessment for surgical removal of remaining cancer upon completion. I started receiving treatment in July 2024, under the belief that it was being covered by the VA Community Care authorization.

On August 15, 2024, my wife contacted UTSW over pending billing statements on my account to inquire why they were not being covered by the VA Community Care authorization that should be on file. She was told by UTSW billing department that the VA rejected the billing. At that time, I reached out to Patient Advocate Veronica Lopez who informed me there was no authorization from the VA to receive chemotherapy or radiation, I would have to ask the UTSW staff to send in a request for services for additional approval. I inquired with Ms. Lopez why personnel at the VA were unable to contact the UTSW staff, she told me that she didn't have the time, and it would be best if I were to do it. My wife coordinated with the UTSW staff to submit the requested documents, on the first submission the VA rejected the form, and we were informed by the UTSW staff that when they also tried to speak to personnel at the VA to inquire what was needed, they could not get a hold of a single VA personnel member on the number they were provided. I once again reached out to Representative Self's office to seek assistance.

On August 23, 2024, Savanna Douglas, RN was able to back date the referrals for Medical Oncology and Radiation Oncology. With the previous interactions of the initial authorization and the unclear details, I requested a copy of these documents. She informed me that it was not standard procedure to provide the Veteran with these documents, but acknowledging my concern pertaining to the miscommunication of previous authorizations, she was able to email me the authorization forms. With these forms my wife was able to coordinate with the UTSW billing personnel to correctly code and submit all appointments.

Discussion of Issues

1. The Community Care program does not communicate directly with the provider after original scheduling.

As the Community Care program sets the original scheduling and only alerts the Veteran of the contact information, there are many opportunities for poor communication and misunderstandings. Specifically addressing my scheduling of the colonoscopy, there was no information provided regarding the wait time and how it compares to the VA facility. Relying on the Veteran to be the main individual to coordinate treatment and authorizations is the main reason there was such a misunderstanding for the billing of my treatments. Multiple times we were unsure of what would be covered for the comprehensive plan and received very little support to navigate it.

I also believe there is a risk to evaluate within the VA use of Community Care. With the lack of transparency between Community Care scheduling combined with little to no follow up by Case Management personnel, there could generate a risk that wait times for procedures are not being accurately assessed and inaccurate in-

formation is being provided to Veterans to make important informed consent decisions regarding their access to care.

2. Community Care Authorizations pertaining to Complicated Diagnosis

I was not provided with any referral numbers or what the scope of treatment authorized encompassed. I was asked to fix a problem on my own with no resources and no information on what had or had not been approved. There was no coordination of care provided; however, the authorization was limited in scope. Is it possible for a severe diagnosis, such as cancer, that have an industry standard of care, to be approached with a duty to accept/approve, should the billing be submitted for a patient with a diagnosis known by the VA, by a provider known to the VA, and for a Veteran that is within a patient category, such as 100 percent P&T, that are already established to receive full spectrum care from the VA Medical Network and any care associated.

3. Lack of Professionalism and Compassion from VA Employees.

The Veteran begins their journey typically with an extremely frustrating phone system. Something as tangible as the phone line infrastructure solely lies on the accountability of the Facility's Director. Many phone lines listed or attached to automated menus simply do not work. It is extremely complicated to get in contact with the necessary personnel for any specific requirement. Often a caller must be transferred multiple times and direct numbers provided by employees are not answered with no consistency of availability to leave messages. The default response from VA employees is to take a message and wait for a call back. Throughout this entire process not one time has someone from the VA system offered to schedule any communication. In their responses to our inquiries, the VA claims to operate Community Care within a case management model but refuses to offer appointment scheduling to discuss their case. This is extremely difficult for Veterans, like me, that are working their own jobs, have obligations of family, and are navigating very difficult treatment plans.

Multiple occasions have we been treated with disdain, sighed at, told to wait and dismissed by employees we encountered. Case Management is extremely inefficient and often incomplete. I did not receive end to end case management or proactive engagement. For complicated medical conditions, such as cancer, follow up by Community Care personnel to ensure treatment plans align with authorizations would help decrease misunderstandings and reduce errors that have great potential to negatively impact the Veteran. In my scenario, it seemed that no one cared until we received assistance from Representative Self's office, and I believe that the result would be very different if we had not asked and received intervention on two occasions. I have experienced great care from some amazing VA employees, but an attitude toward complacency and seemingly no accountability permeates many of my interactions. Often VA employees display an attitude that they would do whatever possible to reduce their workload, burden the Veteran with tasks that the employee is hired to conduct, and possess no regard to the fact their actions affect a Veteran's access to care. This is seen top to bottom by the lack of reporting of community care wait times, broken phone infrastructures across the entire facility and network, difficult scheduling procedures, and non-existent case management.

This was especially highlighted by the responses provided to the inquiries submitted on my behalf. At no point has anyone taken ownership or assessed what could have improved the scenario. I, as the Veteran, was regarded as part of the problem, because I chose community care and not care through the Dallas VA. The response reads that I sought care that was not authorized, when I simply sought care, so I don't die.

Conclusion

Community Care is a great program that has expanded previously prohibited access to care and has the potential to continue to improve this access for many Veterans. I believe that Veteran Affairs has amazing employees that work for them. However, accountability for poor performance, a lack of proficiency, and low procedural transparency has generated a toxic atmosphere, that leaves the Veteran having to jump through bureaucratic hoops, holding large financial obligations for uncovered costs, or being denied access to life-saving and critical care.

Communication between the Health care provider and the Case manager should be ongoing with feedback from both sides for this program to be successful. Especially for complex and complicated medical diagnosis that may require comprehensive treatment plans, case management should go beyond the initial scheduling interaction. Clear policies and procedures should be available and known to Vet-

erans in the program. Wait times for services within the VA Network and the Community Care Network should be constantly evaluated and made transparent.

I appreciate the time and opportunity this Committee has given me to share my story. I hope that it will help provide opportunities to improve access to care for other Veterans. I would like to thank Representative Self and his staff for their advocacy and assistance as my family has navigated this challenging time and to each and every member of this Veteran Affairs Committee for their continued interest in the care of Veterans.

Prepared Statement of Lori Willis Locklear

Hello. I am Lori Willis Locklear. Thank you for your time and effort in this important matter.

I've been a Pharmacy Technician for 30 years until recently when I took an early retirement from the Department of Veteran Health Care System at the Fayetteville VA Health Care Clinic where I was employed for 12 years of my service. Prior to that, I worked for the State of North Carolina for almost 4 years. The first years of my career were spent at a local hospital, Scotland Memorial and then to a private pharmacy in Raeford, NC.

Let me begin by telling you a little bit about me. On August 27, 1988, I married Raymond F. Willis, who was an Army Veteran, and he was so proud to have served his country. On August 16, 1995 at 8:16 am, we had our only child, Logan F. Willis, and it was such a wonderful day for us both. On July 16, 2015 my husband died and I had to learn how to navigate life again as a single woman with a child in college. I have been a woman of great faith in God and in our Nation. I believed in the system but I knew that there were areas that needed to be improved upon. I gave all I had to my job and to all my veterans that I came in contact with daily because I was the wife of a veteran who loved his country and so do I. I was proud to serve our nations veterans but things changed for me when my son, **My Veteran**, died by suicide in my home because of the lack of support that he received from the very place that I had spent years as an employee. Not only was I disappointed in the Fayetteville, NC VA, but there was a part of me that was disappointed in myself because I truly believed in Veterans Affairs. As an employee and mother, I felt that I had failed because I believed the VA would take care of my son and at times it was hard for me to determine if I was speaking from a mother's perspective or that of an employee. I believed that Logan felt that I was only the employee and not his mother for he would share that the VA was not willing to help him but I kept telling him to return to the VA. I tried as much as possible to follow the proper protocol, yet, **MY Veteran** died by suicide in my home, from what I believe was a failure to follow the Community Care Act. I believed that our trust in the system was betrayed, promises were not kept, and **Logan's life** was not valued just like so many other veterans who have sacrificed so much for our country.

The year 2015 was a very difficult time for Logan and I because his father died of lung cancer. We were a very close knit family and Logan idolized his father. After his death, Logan and I received counseling and I struggled for a long time. Logan was in college at the time and he graduated from the University of North Carolina at Pembroke. He enjoyed his time in school and wanted to further his education. So we thought the military was an option for him and he wanted to be a Veteran just like his dad because his dad always spoke so highly of his service. He originally wanted to go to the Air Force, but the Navy talked him into going with them. I personally did not think that it was a good fit but Logan believed that he could do it. At the last moment, I tried to talk him out of it because there was something that did not feel right and I wish I had. Later, Logan told me that joining the Navy was the worst decision of his life.

Logan enlisted in the Navy in 2018 and his first duty station was in Sasebo, Japan where he served as an intelligence officer. Shortly after he was on board, he began to mentally deteriorate; I began receiving emails at 3 am from him stating that he couldn't do this, he could not stay on the ship. I constantly told him that things would get better but as the days went on, he became more insistent that he had to get off the ship. He complained the food was terrible, often there was no silverware, the sailors had to eat with their fingers, his computer was constantly down, so his intelligence reports would not be up to date which resulted in him getting in trouble. He was extremely disturbed about the fact that he had been photographed naked while he was in the shower. I believe he also became claustrophobic in his barracks, he had not experienced it to that extreme on board the ship. After some time, he was transferred to San Diego Medical Center. I hoped and prayed that while he was in San Diego and on land that he would get better. One day, the

doctor called and requested that I fly to San Diego immediately. When I arrived, I was informed that Logan had attempted suicide while being there and that he was being released from the hospital. My stay was horrible because I did not recognize the man who was in front of me. My son had always been kind and humble, a young man with a gentle spirit but this person was angry, disappointed, and this was not my Logan. I also discovered later that he had attempted suicide while aboard the ship. Due to all that Logan was dealing with, the Navy gave him an honorable discharge.

Logan came home on December 31, 2018 but he was so different; it was so heartbreaking to witness the transformation that had occurred with my child. Logan was always a kind, loving person and would do anything to help anyone in need. During his younger years, Logan spent a lot of time at the Fayetteville, NC VA where he volunteered all through his high school years and worked at our local library for three years. He had an associate and a bachelor's degree. Another sad part of this story is that Logan was a support for a lot of individuals who had suicidal thoughts. So many have shared how it was Logan who talked them through their trauma and kept them from following through on their desire to commit suicide. Logan had a beautiful spirit but the man that returned was not the man that left home to serve his country. Logan felt that no one cared for him and that his life was not valued and sadly, this is a common theme among many who have served our country. The VA doesn't exist for the VA, it exists for our Veterans and their families and it should do everything possible to help those who are struggling mentally, physically, and financially. I believe my child would still be here if the VA had lived up to their promises that were made to him. Many promises are made to these young men when they enlist to serve their country. Some of these men are broken so much in training that they are never the same and that was my Logan.

In January 2019, I told Logan to go to the VA, get his VA card and request a mental health provider. He came back and he said he was told that they were unable to help him. It was at that time, that he began to hate the very organization that he loved volunteering at during his high school summers; he lost all trust in the VA. The things he had experienced brought about his anxiety and depression but the way the VA treated him increased his mental illness. He was so angry and regardless of how I tried to defend the VA, the response he got from them led him to believe that the VA was not willing to help veterans. During this time, I felt like the worst mother in the world but I continued to encourage him to seek help but instead of seeing me as a support, Logan began to see me as part of the VA instead of his mother.

In June, 2019, Logan used his GI Bill and was enrolled in Wake Forest University in the Master's of Divinity Program in Winston Salem, NC. We all know what happened in 2020, Covid, and this really took a toll on Logan because he was beginning to feel a little better because he became a part of the college community. I thought things might be looking up. However, when all his classes were virtual, Logan became more and more depressed. He would stay inside for weeks and isolate himself from everyone. I became more and more worried about him. He struggled in school and later I learned that his professors noticed that he was struggling and several reached out to help him. He was able to graduate with their help and I truly believe that is why he lasted as long as he did.

I believe Logan felt trapped; in his mind, the Navy had taken his life and now the VA was taking from him as well. On one occasion he called me because he was running low on his medications and was worried about refills. I assured him that a pharmacy would help with his medication; however, I have receipts where he had to pay for his medications. I also have receipts where he had to pay $300 for the multiple calls he made to his mental health provider. When he was in college, he had to pay for health insurance which was very costly. Needless to say, I was so upset to know the lengths that he went to in order to receive help from an organization that was created to protect those who served to protect us.

On May 14, 2022, Logan graduated from Wake Forest University and we were so proud to see him graduate after all the struggles he had been through. He seemed so happy that day and I prayed that day would be a new beginning for my son but little did I know it was the beginning of the end of my child's life. He tried to find a job and an apartment after graduation but was unable to find either. He was forced to return home so once again, he felt like a failure. I began to see him isolating himself again and I constantly encouraged him to seek additional help so he agreed to meet with our local VSO Office in Raeford. Officer Flagg was the officer who appeared to be helping him. I found out later, after his death that multiple mistakes were made on Logan's paperwork (i.e., wrong address). When I informed Officer Flagg of his death, he completed the paperwork for burial expenses and once again, mistakes were made. I informed his supervisor of the multiple mistakes so

he decided to complete the paperwork himself. This is another example of why Logan didn't trust the VA and by this time, neither did I.

In September 2022, I felt more and more that his mental health provider was over medicating him. I was a pharmacy technician so I would ask our pharmacist about his meds and they would provide information. I asked Logan to visit the VA and let our pharmacist go over his meds with him. Afterwards, I sent him to check in and request to be seen or given a mental health appointment. I was adamant about him being seen or provided an appointment. When he returned home that day, I questioned him, and he said I got an appointment but he didn't say when the appointment was and I never asked; that was my big mistake. I found out after his death, in March 2023, that he was given a mental health appointment for February 2023 which was five months out from when he reached out to the VA in September 2022. I was told after Logan's death that our protocol at that time was, if a veteran asked for a mental health appointment, they were either to be seen or sent to community care within 20 days, my child died 60 days after that and was never called. Once again a promise not kept.

A few days after I buried my only child, I telephoned Washington DC to alert them that my child had died by suicide because he was 40 percent service connected for his disability. Upon returning to work on November 22, 2022, two weeks after my son's death, my service department was aware of Logan's death, but per protocol I knew I had a responsibility as an employee to report a death. Therefore, at the time, I felt the patient advocate's office would be appropriate but truly I was not thinking clearly and as I write this today, two years later it is still hard to think. They seemed very interested and shocked to hear of a suicide from our facility and was eager to get the information; yet, when they realized it was my son, things changed. I came in as an employee, one they knew, but then I became the mother. It was at that time, I felt that a cover up began to take place. Over and over, I tried to uncover the truth and it was during that time that I was treated as a whistleblower. They assured me they would get back with me but I was never contacted. Although I returned on November 22, 2022, it wasn't until February 2023 when I personally contacted Director Fryar about my child's suicide that had occurred in our home. She stated that she was totally unaware and sympathetic to what had occurred and that she would be in touch with me as soon as possible; yet, it was not until April 2023 that someone reached out to me. Based on what information was provide to me, it states that a suicide team was supposed to contact the veterans family as soon as they are made aware of the suicide but I guess that policy does not apply to employees of the VA.

After waiting for weeks just for someone to help me to understand what had happened, the first call I received from the facility's risk manager informed me that I had to come and fill out a tort claim which I did understand what a tort claim entailed. On the tort claim, I claimed negligence because I felt that the VA did not help my child. The VA denied my initial claim because they stated they did give him an appointment. A week after filling the claim, I requested his medical records and discovered that the VA had given him an appointment but it was five months from the day we requested help. Why would the VA wait five months when someone is struggling and needing help? When I asked, I was informed that the computer electronically gave him the appointment. Someone should have looked at the date and changed it. Due to the new knowledge, I filled out another claim with a different description but once again it was denied. When I asked why, they stated they were unable to talk with me. I continued to speak with countless people and I ran into roadblock after roadblock within the VA. At this time, I was mentally and physically deteriorating and I could not focus on my job; thus, I took FMLA to go home and try to heal. I felt that my healing would never come as long as I was working for a system that in my mind contributed to the death of my son. In order to bring some sort of closure and healing, I sought therapy and I am still in counseling today. My therapist helped me realize that I have PTSD and every time I walked through the back door to the VA, I literally began to suffer because I blamed the VA for his death. I worked as best as I could to get to my minimum retirement age and then I left. I felt I had no choice because I could no longer do my job. I was holding up my department and causing a hardship. I simply could no longer function as I had prior to Logan's death. I was never processed out of the system as every other employee had been. When I asked my supervisor, she stated that she had not been informed and frankly she was as surprised as I was. Once again, another promise not kept. Another VA employee shared with me that I should seek disability because of my treatment from the VA after my son's death which brought on all the mental and physical issues that I now have. I have been sicker in the past two years since Logan's death than I have been my entire life. I'm almost 58

years old. I applied for disability in November 2023 and have not heard back from the Office of Personnel Management.

I called a local NC representative in January 2023 for help and he was very instrumental in helping me. I have also shared my story with other state representatives. There is so much emphasis put on the Gold Star families for their sacrifice what about the families when a veteran dies by suicide. Personally, I think the least that could be done is the military or VA should have to lay these young people to rest and not their families who entrusted their well being to them when they enlisted to serve. I also think the sole survivors benefits rules should be revisited, how old exactly is this rule. What family can live off of $35,000 a year to qualify for these benefits? I am my child's sole survivor, his father, an Army veteran, is deceased as well. Haven't I lost enough? So, I got remarried a year before my child died and so it disqualified me for this service? Really, I think it's the least that could be done for me! Not to mention, this entire last 2 years of my life has been debilitating because of everything that the VA did to me by treating me like a "whistleblower" because no one wanted to speak to me. I was finally given a meeting over a year later in January 2024 and all of my questions were not answered to my satisfaction nor was I satisfied with the outcome of my tort claim. I hope my efforts will not only bring closure to me but will also help military families in the years to come and the VA will adhere to the Community Care Act which is the law. My hope is that no other veteran dies because the laws are not being followed. I do not want another mother to find their child in a bathtub with a plastic bag over his head with a helium tank inside. This was a total nightmare that never goes away.

In closing, thank you for the opportunity to share Logan's story, he deserved this; his life mattered. My hope is that by sharing his story, this will bring some healing to my broken heart, help me reclaim my life and my prayer is that one day I will be able to think clearly. Last, I hope that no other VA employee who has a deceased veteran will have to endure the hardships that I had to endure. I feel like I was labeled a whistleblower but if it brings positive change to a broken system then it was worth it. I will always wear the title of mother with pride, Logan, my son, you will always be. I also want to thank my husband, Ray Locklear, who has been my constant support during this horrible ordeal. Once again, thank you and God bless you all.

Prepared Statement of Brittany Dymond Murray

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, DC, 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.

Prepared Statement of Kelley Saindon

Chairman Bost, Ranking Member Takano and Distinguished Members of the Committee, thank you for inviting us to testify today on the U.S. Department of Veterans Affairs (VA) Community Care Program (VCCP).

NOVA is a professional organization for nurses employed by the Department of Veterans' Affairs (VA). The opinions provided here are not that of the VA, but of our members who are nurse managers, frontline and specialty healthcare professionals taking care of Veterans at VA facilities around the country.

As nurses coordinating care and directly involved in referring Veterans into the community, we would like to provide our thoughts on the VCCP program with a focus on Veterans enrolled in the system.

Currently there are 9.1 million Veterans enrolled in VA healthcare. VHA's 2024 *Annual Report* noted that VA delivered more than 130 million health care appointments of which 78.8 million involved direct care and 48.8 million were in the community.[1]

NOVA understands and supports Community Care when access to VA is not readily available, the distance is too far, or the VA does not provide the needed care.

[1] VHA 2024 Annual Report VA Health Care: A Strong Foundation. A Healthy Future.

We recognize and acknowledge that we cannot serve everyone everywhere. Our priority is to ensure Veterans receive the highest level of health care within the VHA and utilize community care as needed to enhance their health care experience.

Since the passage of CHOICE and MISSION Acts, the VCCP has rapidly expanded. Referrals have risen to 15–20 percent annually, and in 2023, 44 percent of VHA health funds were spent on external care. While the MISSION Act expanded community care it was not meant to replace VA's Integrated healthcare system. The legislation was meant to provide a balance between non-VA care when necessary while bolstering VA direct care.

Community care is an integral part of our healthcare delivery system. VHA continues to collaborate and build strong community coalitions. These partnerships are crucial to providing safe care efficiently for veterans. Provider shortages and budgetary constraints continue to affect care in the community. According to the *Association of American Medical Colleges* there is an anticipated national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[2] Constriction and closures of community healthcare systems have raised questions and concerns about how and when Veterans can be referred to the community. Our healthcare communities are saturated, unable to absorb the needs of Veterans. As such, VHA continues to prioritize enhancing partnerships with CCN to deliver care to our Veterans.

Veterans in rural communities are at a higher risk, where the provider shortage is worse, leaving them without access to primary care, mental health, hospital, emergency, and pharmacy services. VHA has worked tirelessly to bring healthcare to the Veterans, technologies have bridged a gap in these rural settings.

Despite much innovation and improvement work focused on expanding efficiency for Community Care coordination, the steps are laborious. Inconsistencies in scheduling and authorizations across the system create confusion for Veterans and our community partners. It is vital that VA facilities have more control over services provided. Records must be received timely so the VA can coordinate additional care, if needed, including scheduling any diagnostic testing that may be requested.

We recommend a public facing site that Veterans can view to make informed decisions as to where they are receiving care. The site should include detailed information on provider wait times, quality metrics, credentials, and training for both VA and VCCP providers.

Training is critical and not required of VCCP providers at this time. Focusing on the veteran should require that all VCCP providers be mandated to complete education and training related to military culture and illnesses seen in veterans.

VHA clinicians are more likely to have experience and specialized training in recognizing, diagnosing, and treating conditions often encountered by Veterans, such as trauma-related injuries, substance abuse, mental health disorders and toxic exposures. VHA providers have logged over three million toxic exposure screenings as of April 2023 with almost 42 percent of those screenings revealing at least one potential exposure.[3] VHA staff are uniquely trained not only on military culture but also on disease and exposures specific to the veteran population.

As a VHA employee, new employee education provides Veteran specific training to ensure competencies are in place before administering care. The standards for our community network should be no different. Our Veterans and caregivers deserve it. As a nurse, in addition to new employee orientation, VA medical centers provide clinical employees an additional clinically focused orientation. At White River Junction (WRJ) the new employee education is three days for all employees, the clinical orientation for nursing staff is a week-long.

Robust training includes clinical reminders, which are nationally generated screening assessment in the electronic health record specific to disease and illness commonly experienced by Veterans. This individualized preventative care and evidence-based practice cannot be found in the community. For example, suicide risk is assessed at each episode of care at a VA medical center. Whether the Veteran is in the eye clinic or the mental health clinic, this is standard. These standards should be no different for community providers treating Veterans.

Care oversight in the community network is minimal at best, we recommend there is strong action to bolster quality and oversight of care. Failure to meet quality expectations should result in removal from the network. Without proper coordination between VHA and community providers with respect to returning medical documentation in a timely manner puts the Veterans at risk of not receiving rel-

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[2] Tim Dall et al., The Complexities of Physician Supply and Demand: Projections from 2018 to 2033 (Washington, DC: Association of American Medical Colleges, June 2020).

[3] "VA PACT Act Performance Dashboard," VA https://www.accesstocare.va.gov/VA__PACTActDashboard.pdf

evant information to make sound and accurate health care decisions. For example, this vulnerability is especially important with lung cancer screening, lung nodule follow-up, mammograms, and colonoscopies. Often the community care staff request records 3 or 4 times with no results sent by the community provider, leaving the Veteran at risk for serious, in some cases, life-threatening poor outcomes.

We recommend the community network have prescriptive guidelines for record sharing. Current practice of faxing leaves much risk for healthcare decision delays. We encourage Congress to reimplement business rules that permits payment to VCCP upon receipt of medical records.

The U.S. Dept. of Veterans Affairs healthcare system in White River Junction (WRJ) is a fully accredited acute medical and surgical care facility offering primary and subspecialty outpatient care, including rehabilitation, and mental health services.

The WRJ Healthcare system serves veterans in Vermont and the four contiguous counties of New Hampshire. Veterans are being redirected to the VA as primary care and certain specialty services in the community are not taking on new patients. The continued increase in community care is a threat to safe and timely access to care for Veterans.

Studies have consistently shown that VHA care equals or exceeds the quality of care provided by the private healthcare sector. Recent star-rating reviews demonstrate that VHA hospitals score higher than non-VA facilities in both patient satisfaction and quality of care.

White River Junction received a 5-star Overall Hospital Quality Star Rating in September 2024. It was the only facility in Vermont and New Hampshire to earn the top rating. The measures used to calculate overall CMS Star Ratings are mortality, safety of care, readmission, patient experience, and timely and effective care. The more stars (out of 5), the better a hospital performed on the available quality measures. Across both VA and non-VA hospitals nationwide, just over 8 percent of facilities rated received a 5-star rating in the 2024 data. These findings are the latest in a series of recent evaluations showing the effectiveness of VA health care compared to non-VA health care, revealing that VA health care is consistently as good as—or better than—non-VA health care and the choice of most Veterans.[4]

A 2024 VFW survey showed "overwhelming support for VA to remain the primary deliverer of care for veterans.", with a majority of the Veterans saying they prefer using VA medical facilities for their health care needs.

The VA must remain the primary provider and coordinator of Veterans healthcare, using community care as a supplement only when VHA services are unavailable. Authorizations and referrals should follow access and eligibility standards. Requirements for both VHA and VCCP should include consistent quality standards and training.

Listening to Veterans' stories helps us understand their needs. NOVA is committed to working with Congress, community partners, and VA leaders to ensure Veterans receive timely access to the highest level of care.

Thank you for the opportunity to provide our perspective on this critically critical issue. We look forward to working with the Committee as we focus on ensuring Veterans continue to receive timely, high quality compassionate care now and into the future.

[4] HCAHPS: Patients' Perspectives of Care Survey CMS

STATEMENTS FOR THE RECORD

Prepared Statement of Alzheimer's Association and Alzheimer's Impact Movement

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the United States House Committee on Veterans' Affairs Hearing on "Restoring Focus: Putting Veterans First in Community Care." The Association and AIM thank the Committee for its continued leadership in ensuring our nation's veterans have the proper health care and resources that are important to those who are living with Alzheimer's and other dementia and their caregivers. We also wanted to thank the Committee for the enactment of The Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act (P.L. 118–210), which included several bipartisan and bicameral proposals to reform and improve the delivery of healthcare, benefits, and services at the Department of Veterans Affairs (VA). This statement highlights the importance of dementia care and support programs at the VA and outlines how our nation's veterans living with dementia are benefiting from such programs.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

Nearly half a million American veterans have Alzheimer's—and as the population ages, that number is expected to grow. In 2022, an estimated 451,000 veterans were living with Alzheimer's, and more than 130,000 new cases were diagnosed. The VA has projected the number of veterans living with Alzheimer's dementia will increase by 8.4 percent through 2033 to more than 488,000.

For veterans, the prevalence of Alzheimer's may grow even faster in future years because they have a higher risk of developing dementia. The significant increase in the number of veterans with Alzheimer's and other dementias will place a heavy burden on the VA health care system. Veterans with dementia are 2.6 times more likely to be hospitalized than other veterans—and hospital stays are, on average, 2.4 times longer. The average number of outpatient psychiatric visits is three times greater among veterans with dementia than veterans without. More than 60 percent of the VA's costs of caring for those with Alzheimer's are for nursing home care.

We are grateful for the VA's participation in the Department of Health and Human Services (HHS) Advisory Council on Alzheimer's Research, Care, and Services, which plays a key role in developing and annually updating the National Plan to Address Alzheimer's Disease, as set forth by the National Alzheimer's Project Act (P.L. 111–375). The National Plan is a roadmap of strategies and actions of how HHS and its partners can accelerate research, expand treatments, improve care, support people living with dementia and their caregivers, and encourage action to reduce risk factors. The most recent update to the Plan was released in December 2024 and includes several highlights on the VA's continued work to better serve our nation's veterans living with dementia. We were excited to see Congress take action in the 118th and enact the bipartisan NAPA Reauthorization Act (P.L. 118–92) and Alzheimer's Accountability and Investment Act (P.L. 118–93) that will extend the National Plan to Address Alzheimer's Disease and ensure researchers at the National Institutes of Health continue to receive the funding necessary to sustain vital Alzheimer's and dementia research. These laws will ensure the nation continues addressing Alzheimer's as a national priority, providing continuity for the community.

The VA's Continued Role in Increasing Enrollment in Clinical Trials

The VA continues to collaborate with federal agencies on a number of the key goals of the National Plan, including Action 1.B.3 to increase enrollment in clinical trials. The VA Office of Research and Development (ORD) and the National Institute on Aging (NIA) have a strong, ongoing collaboration. Among many activities, the VA and NIA have partnered on a program launched in 2020 in which the NIA provided supplemental funds to five Alzheimer's Disease Research Centers (ADRCs) co-localized with VA facilities or research centers to increase the recruitment of veterans into NIA-funded studies. Strategic priorities for the pilot include recruiting veterans, especially from diverse populations, and investigating unique risk factors for this population. Research coordinators at each participating ADRC have worked directly with the VA and NIA staff to identify and address challenges, develop pragmatic solutions, and share best practices and materials to increase veteran outreach and sustain enrollment. The pilot program successfully enrolled 99 veterans into ADRC studies, including 39 individuals from historically underrepresented racial and ethnic groups. The project also registered 172 veterans in AD registries. The results and impact of this pilot program were published in February 2024 and laid the groundwork for future collaborations between the NIA and the VA. Last, tools specific to veteran recruitment have also been included in the NIA's Alzheimer's and Dementia Outreach, Recruitment, and Engagement (ADORE) repository.

The VA's Continued Role in Addressing Alzheimer's Disease in Rural Areas

The VA continues to collaborate with federal agencies on a number of the key goals of the National Plan, including Action 2.A.1 to educate health care providers on Alzheimer's disease. The VA's GeriScholars program offers staff training to integrate geriatrics into primary care practices in three training programs: (1) intensive individual training with didactics, quality improvement coaching, and clinical practicum experiences; (2) limited team-based training, including Rural Interdisciplinary Team Training (RITT); and (3) self-directed learning through webinars, simulation learning, case studies, and enduring educational materials (such as dissemination of pocket cards on dementia, delirium, and depression). VA GeriScholars includes a wide variety of training activities, many of which include or are focused on dementia training. Examples of Fiscal Year 2022 trainings include webinars such as "Treating PTSD in the Context of Cognitive Impairment," "Dementia and the Age-Friendly Health Systems Initiative: Integrating the 4M's of Mobility, Mind, Medications, and What Matters into the Care of Older Veterans", and "Enduring Education"—as well as case studies and virtual geriatrics conferences, such as Healthcare Planning and Management for Older Adults with Dementia and Geriatric Patient with Cognitive Impairment.

We also ask that the Committee continue to support the Veterans Health Administration's 20 Geriatric Research, Education, and Clinical Centers (GRECCs), which are geriatric centers of excellence focused on aging. GRECCs reported in the 2024 National Plan Update that their work included 78 research grants in dementia covering basic science to clinical care and health services research and 25 clinical innovation projects that directly served veterans with dementia and their families. GRECC faculty have developed numerous clinical programs to aid family members and care providers, including e-Consults for Behaviors in Dementia, Health Care Directives for Veterans with Dementia, Reaching Out to Rural Caregivers and Veterans with Dementia Utilizing Clinical Video-Telehealth, and Virtual Dementia Caregiver Support Programs. The GRECC Program produced 56 educational programs for staff and trainees on best practices in dementia care, including the use of simulation technology to demonstrate techniques for communication and facilitating activities of daily living for veterans with dementia. Finally, GRECC authors published 259 manuscripts in peer-reviewed journals in Fiscal Year 2022 on their research and clinical work in dementia. The VA must continue supporting the GRECCs in disseminating findings from this research to integrate scientifically proven dementia interventions into local and rural communities.

Educating Health Care Providers in the Indian Health Service and Tribal Care Systems

The VA also continues to collaborate with the Indian Health Service (IHS) and Centers for Disease Control and Prevention (CDC) on the National Plan Action 2.A.6 to strengthen the ability of primary care teams in Indian country to meet the needs of people with Alzheimer's and related dementias and their caregivers. For example, in 2022, the IHS launched the Indian Health GeriScholars Pilot, developed with the support and collaboration of the VA Office of Rural Health. Modeled after the highly successful VA GeriScholars Program that has built geriatric expertise into the primary care workforce over the past decade, the Indian Health GeriScholars pilot is providing primary care clinicians at IHS, Tribal, and Urban

Indian Organizations (UIO) programs with an individual intensive learning track for professional continuing education, including a week-long intensive training in geriatrics through an approved Geriatrics Board Review course, mentored geriatric improvement project at their local facility, mentorship in geriatric practice, and ongoing education, training, and peer support as an Indian Health GeriScholar.

During the pilot's first two years, 31 providers and pharmacists at 28 sites across 10 IHS areas participated in training and finished projects focused on detecting and diagnosing dementia, medication safety, fall prevention, and other locally relevant topics. Demand increased for the 2024 cohort to include eight physicians, one nurse practitioner, and 14 pharmacists from 21 sites, representing seven IHS areas. The Indian Health GeriScholars are encouraged to participate in the educational offerings available to the VA GeriScholars.

These are only a few examples of ways in which the VA remains involved in working to ensure a high-quality, well-trained dementia care workforce and continue bridging the gap in cognitive services in rural areas. The National Alzheimer's Project Act as a whole has led to great achievements in the treatment and research of Alzheimer's disease, and we are looking forward to seeing more progress in the 119th Congress.

Conclusion

The Alzheimer's Association and AIM appreciate the Committee's steadfast support for veterans and their caregivers and the continued commitment to advancing issues important to the millions of military families affected by Alzheimer's and other dementia. We look forward to working with the Committee and other members of Congress in a bipartisan way to advance policies that will ensure access to high-quality dementia care and support in rural areas, especially as the population of veterans living with dementia continues to grow.

Prepared Statement of Mission Roll Call

MISSION ROLL CALL

January 21, 2025

Statement for the Record

Subject: Community Care and Mission Roll Call Polling Results

Mission Roll Call regularly conducts polling to help inform and advocate on behalf of the veteran community. The poll results on the following pages highlight issues surrounding community care and underscore the need for improvements in delivering care to veterans and their families.

As the results indicate, the Department of Veterans Affairs (VA) can enhance several critical aspects of care delivery. Notably, the VA should strive to deliver care without unnecessary delays and should seek to improve their process of informing veterans of their rights to community care. Our polling shows room for improvement in the VA's scheduling process, which often frustrates veterans due to lengthy wait times for appointments at VA facilities. Additionally, there is broad support among the veteran community to ensure that those with lengthy travel requirements to access VA care are given seamless access to options within their local community.

Mission Roll Call advocates for policies that place the veteran first in the discussion of improving medical care access. Overcoming bureaucratic challenges such as unnecessary delays, long wait times, and restrictive access to community care is essential to delivering the critical care that veterans and their families have earned through their service to our country.

Mission Roll Call

At Mission Roll Call, our approach is apolitical and unbiased, and we are not affiliated with any political party. Our focus is on gathering input from veterans, spouses, family members, and caregivers, so we can take a collective voice directly to lawmakers and interest groups and advocate more effectively on behalf of veterans and their families.

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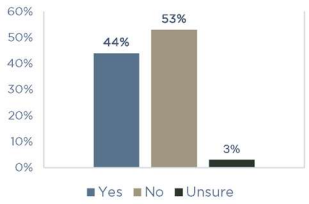
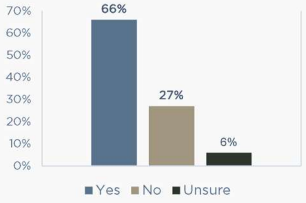
POLLING RESULTS ADDRESSING COMMUNITY CARE

The following are recent and historic poll results Mission Roll Call has conducted that directly or indirectly speak to the issue of the VA and community care. Polling results from December 2024 are based on an online survey of a sample of 2,583 U.S. adults who are Veterans (2,080) or have Veterans (503) as immediate family members. This poll's margin of error is 2%.

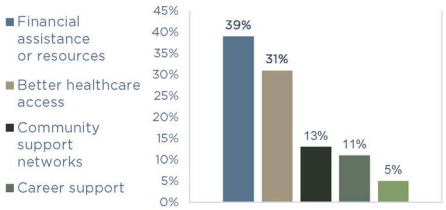
In the past year, have you or the veteran in your family experienced a delay or postponement related to health care services at a VA facility?





Following a delay in receiving care at a VA facility, the VA is required to offer a referral to a health care provider in the community. Did the VA make you (or the veteran in your family) aware of this policy?

As a veteran or military family, what type of support would most benefit your family?



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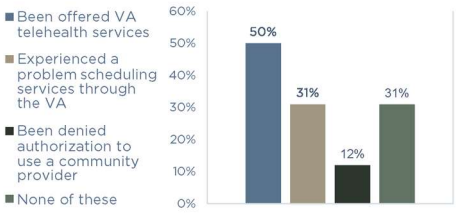
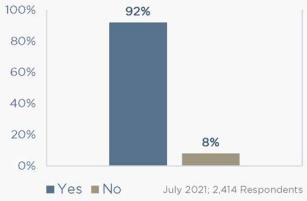
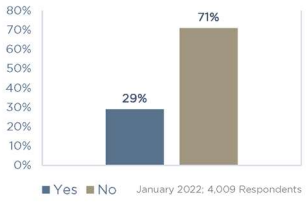
Have you or a loved one... (select all that apply)



The following are older polling results from **2021 through 2022**

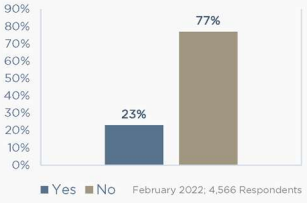
Should the VA be mandated in law to have requirements that make sure veterans can access care within a certain time and distance of their home?





Following a delay in extended services such as inpatient or outpatient mental health care, residential substance use treatment, or other specialty care at a VA facility, has your VA provider referred you for treatment in the community?

Have you experienced a problem scheduling community care services through VA, or getting denied authorization to use the community provider?



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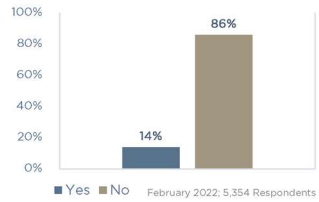
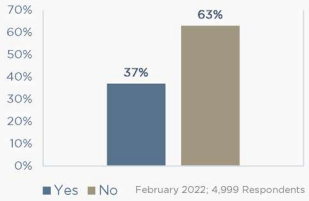
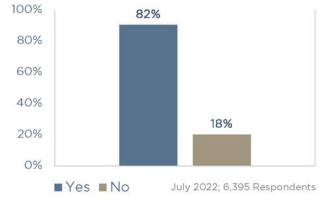


In the past year, has the VA referred you to healthcare providers in the community under best medical interest but your referral was later denied by administrative staff upon review?

In the past year, have you or a veteran you know experienced a delay or postponement of any healthcare at a VA medical center?





VA Secretary Denis McDonough recently testified that the cost of veterans seeking healthcare by private providers outside of the VA system now accounts for 33% of the VA's total healthcare budget. Because of this, the VA has said it may alter the rules for accessing community care, effectively making it harder for veterans to get the care they need in a timely fashion. Should Congress make the current rules permanent before the VA tries to make changes to access standards?

Mission Roll Call believes that Veterans deserve the best care possible and that includes better access to community care. In line with this belief, we strongly support Congress' efforts to strengthen community care access through legislation.

For further information on this subject please email **Mike Desmond** at **mdesmond@missionrollcall.org**

MISSION ROLL CALL

Prepared Statement of American Psychological Association, Association of VA Psychologist Leaders, Association of VA Social Workers, National Association of Veterans Affairs Physicians and Dentists, National Association of Veterans' Research and Educational Foundations, Veterans Affairs PA Association, Veterans Healthcare Policy Institute

Chairman Bost, Ranking Member Takano, and distinguished members of the committee:

On behalf of our organizations, we thank you for inviting us to submit a statement for the record for today's hearing on how the U.S. Department of Veterans Affairs (VA) can improve the care of veterans in the community. Many members of our organizations are veterans or have family members who are veterans. Many of us have had long careers serving veterans, have published papers on veterans' healthcare in peer-reviewed journals, or have previously presented testimony to your committee. In today's statement, we wish to convey our appreciation for your leadership and abiding commitment to ensuring that veterans receive the highest level of health care within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

Problems in VHA scheduling and coordinating community care—a focus of the hearing—are real, and every veteran's experience deserves careful attention and efforts to rectify. There are stories from multiple vantage points, including veterans who received substandard care in the community. For example, we have a report of a Gulf War combat veteran who, after unusual sleep study results, was referred to a community cardiologist. The cardiologist recommended implanting a pacemaker and offered to perform the invasive procedure the next week. The self-referring and possibly profit-motivated aspect raised doubts in the veteran's mind about whether a pacemaker was necessary, and a second opinion from another cardiologist confirmed that it was contraindicated. Consider also the Vietnam veteran who, despite indicating his strong preference to wait for VHA services, faced pressure from a scheduler to accept community care because the facility felt compelled to reduce its' average wait times. Or reflect on the Iraq War veteran in need of posttraumatic stress disorder treatment who did not feel understood by his community care clinician.

It is essential, however, that we not just listen to the individual stories brought to us, but take into account the aggregate data and research that represent the experiences of all our veterans. Information that encompasses the 9.1 million veterans enrolled in the VHA system is the strongest foundation upon which to base policy decisions and craft legislation. That is putting veterans first.

Our organizations support the need for supplemental community care options when access to VHA services is too delayed or too far away. We share the bipartisan goal of ensuring that the Veterans Community Care Program (VCCP) lives up to its promise—still unrealized—of delivering timely, high-quality care without the prospect of undermining VHA care. To help achieve this aim, we delineate significant challenges within the VCCP that merit thoughtful review and offer recommended improvements.

These are:

1. Ensuring VCCP quality standards,
2. Ensuring VHA authorization for care is not bypassed,
3. Addressing the impact of VCCP usage on VHA staffing and exceptional veteran-centric care,
4. Ensuring the defined meaning of "veterans' health care choice" is applied,
5. Providing veterans with crucial information needed to make educated health care decisions,
6. Addressing the VCCP payment model that encourages unnecessary, costly overtreatment,
7. Addressing the deficiencies with health information sharing between the VA and VCCP,
8. Properly including telehealth in VHA access standards,
9. Protecting the VHA's 2nd, 3rd and 4th Missions by ensuring VHA is fully funded and staffed

Ensuring VCCP quality standards

The VA MISSION Act of 2018 established the VCCP with a laudable purpose: ensuring veterans could access high-quality healthcare, whether at VHA facilities or in their communities when VA care was not quickly available or conveniently lo-

cated. The strong focus on quality was unmistakable. In its charter language, the word "quality" appears 50 times, far surpassing mentions of both "choice" and "community"—a point we'll explore further when discussing veterans' choice.

The quality of veterans' healthcare should always be the north star of Congressional policymaking, yet it has failed to set and enforce quality standards for contract providers. Study after study has found that veterans referred for care in the community have a higher likelihood of dying and are more likely to receive lower quality care than those treated at VHA facilities. Another study published earlier this month in *Health Affairs* found that the quality of care metrics of VCCP providers are substantially lower than those of other private sector clinicians, especially in primary care and mental health care. Given this track record of lower quality of healthcare and potential risks to veterans' health, it is imperative that Congress mandate *uniformity on quality and training metrics for VHA and VCCP providers and programs.*

Ensuring VHA authorization for care is not bypassed

With increasing frequency in recent years, legislative proposals have sought to give veterans unfettered access to private healthcare, bypassing VHA referrals, authorization, and oversight entirely. Though they have not yet come to pass, we mention them here because enacting such legislation would fundamentally alter the VHA's core function. Instead of primarily serving as the provider of specialized, high-quality care for the unique health needs of veterans, the VHA would become more of a payer of private sector services. This would essentially **transform the VHA from a comprehensive healthcare system into an insurance company**. Notably, many Congressional proposals even omit traditional insurance company utilization review functions, which would make the care paid for even more risky to veterans.

Addressing the impact of VCCP usage on VHA staffing and exceptional veteran-centric care

A comprehensive report last year by six healthcare experts raised serious concerns that community care utilization was endangering Congress's intent for the VCCP to supplement, not supplant, the VHA. VCCP care has been relentlessly increasing 15–20 percent year after year, and by 2022, its share of VHA health dollars reached 44 percent. The report concludes that even if no additional changes are made as to who is eligible to receive private sector care, the VHA system's future is at risk due to this unsustainable growth. It is incumbent upon the committee to ensure that new legislation doesn't further exacerbate the issues that the report raises. Should Congress further widen eligibility for the VCCP, it will accelerate spending and imperil the basic survival of the VHA system and thus, the continued availability of choice that so many on this committee have deemed essential to veterans.

Expanding VCCP eligibility, including by allowing the bypassing of VHA authorization, will intensify private sector referrals and divert funding from VHA facilities, **forcing staff reductions, curtailment of programs, and closures of inpatient units, emergency rooms, and entire facilities**. It would also prevent needed infrastructure upgrades despite growing demand for services.

If the VHA does not maintain its position as the sole authorizer of care, and receive sufficient funds to fully meet care demand, its indispensable integrated healthcare system specifically designed to serve veterans will be gradually dismantled. This includes coordinated team-based care, comprehensive prevention screenings, wrap-around legal and transportation services, homelessness programs, caregiving, and enrollment in VA registries. It includes veteran-centric care specialization that deftly address veterans' complex military-related conditions. (For example, VHA clinicians are more likely to have experience and specialized training in recognizing, diagnosing and treating problems such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and exposure-related illnesses.)

As we elaborate further below, jeopardizing the VHA will also have a devastating impact on the training of our nation's healthcare workforce and deprive future clinicians of expertise in veterans' complex health conditions. Additionally, research on veterans' health conditions—research that also helps non-veterans—will also be compromised, as will the ability of the VHA to serve as the nation's healthcare safety net during public health emergencies. It also undermines VA's ability to support the military in time of war or terrorist attacks (a critical capacity in maintaining military readiness) or communities in times of natural disasters.

It is true that many veterans deeply appreciate the convenience of receiving authorized care closer to home rather than traveling long distances to VHA facilities. But when they are polled about preserving the VHA system, veterans' priorities are clear. A VFW survey last month of its members found "overwhelming support for

VA to remain the primary deliverer of care for veterans." A prior VFW report of over 10,000 members found that 92 percent explicitly prefer that the VHA to be "fixed not dismantled." As a Veterans Healthcare Policy Institute report noted, and many studies confirm, many veterans who live in rural areas would have no choice of care providers should the VHA be turned into an insurance provider. This is because of a long-standing crisis in rural healthcare that now deprives rural residents of primary care, mental health care, as well as access to hospital, emergency, and pharmacy services.

Ensuring the defined meaning of "veterans' health care choice" is applied

In the years since the passage of the VA MISSION Act of 2018, there has been a pervasive mischaracterization that the bill gave veterans the "choice to obtain their health care where and when they preferred." That was not the case. In the legislative language, a veteran would be offered the option of receiving healthcare outside of the VHA under six clearly defined criteria. Veterans could choose whether to exercise the option of private sector care **only after they first qualified under the eligibility rules and were authorized by VHA**. The Independent Budget's analysis of the MISSION Act affirmed the understanding at that time that eligibility for VCCP care should not occur "solely based on convenience or preference of a veteran." However, the critical phrases "when eligible," "when qualified" or "when authorized" are often dropped when alluding to veterans having the choice of where and when to receive their healthcare.

Should the VHA be eliminated as the authorizer of care under the promise of more choice, there will be fewer, not more, options for veterans. When VHA funds are diverted to the private sector, millions of **veterans who depend on the VHA—especially those with service-connected conditions** who rely exclusively or near exclusively on the VHA for all their health care needs**—will be deprived of the freedom to choose** the VHA when units and programs they depend on vanish. Many have catastrophic war-related ailments, like lost limbs, traumatic brain injuries, or a variety of toxic exposures, which civilian providers are ill-equipped to recognize, much less treat. Granting the option for unrestricted personal choice is not unequivocally advantageous; it comes at the expense of the majority of veterans, many of whom are in extreme need.

Addressing the VCCP payment model that encourages unnecessary costly overtreatment

VCCP overtreatment and the overuse of expensive testing have been identified in recent scientific and governmental studies. One study scrutinized the care of veterans with prostate cancer. This is the most common cancer among veterans, particularly those who served in the Vietnam War, and were exposed to the carcinogenic herbicide Agent Orange which was used as a defoliant. The study, in the medical journal JAMA, tracked 10,000 veterans with newly diagnosed prostate cancer whose biopsies revealed "clinically insignificant" low-risk disease. The JAMA authors explained that the professionally recommended standard of care for these patients is what is called "watchful waiting." Watchful waiting is the accepted standard because recommending aggressive testing and procedures does little good and can cause serious harm to patients whose tumors aren't progressing. Complications of prostate surgery and radiation of include impotence, incontinence, hair loss, bowel problems, and even death. Despite these well-known problems, the JAMA study found that VCCP providers were twice as likely to provide veterans whose prostate cancer was deemed low risk with expensive, unwarranted, and potentially risky surgery or radiation.

Reviewing the use of imaging services in the VCCP for various other medical conditions, a 2021 Congressional Budget Office (CBO) analysis mirrored the findings of the JAMA study. When veterans were referred for imaging services, VCCP contractors used magnetic resonance imaging instead of less costly tests like computed tomography scans and X-rays. The CBO explained, "Some of those practice differences might stem from the cost control and incentive structures of VHA physicians and private sector providers. VHA does not control the amount or type of services veterans receive once they have been referred to outside providers for a particular episode of care."

Excessive use of expensive and/or unnecessary procedures isn't the only way that VCCP providers endanger veterans and extract resources from the VHA's healthcare system. Another is overcharging for services. One form of this is called "upcoding," i.e., assigning an inaccurate billing code to a medical procedure to increase reimbursement. For example, a provider bills for a "Level 4" complex evaluation and management procedure even though the documented medical notes reveal only Level 3 elements were furnished.

The VA's Office of Inspector General (OIG) found that, in FY 2020, "at least 37,900 providers of about 218,000 community care providers billed level 4 and level 5 evaluation and management services significantly more often than all other providers in their specialty—a potential flag for upcoding." A separate 2021 OIG audit found that 76 percent of acupuncture claim treatments and 55 percent of chiropractic claim treatments were not supported by medical documentation. Another well-designed ambulance study found that non-VA hospitals were five times more likely to report high complexity (and more highly reimbursed) evaluation and management services than VHA facilities.

This pattern of overtreatment and fraudulent billing in the VCCP is hardly unexpected. VHA providers, all on salary, work in a mission-driven system that focuses on enhancing patient outcomes. VCCP providers are paid fees for discrete services and work in a system that emphasizes profit maximization. (Our first anecdote above speaks to this trend.)

Also, the rising cost of outsourced dental care has become financially unsustainable. Medical centers are spending anywhere from $25 to $80 million annually on community dental services alone. While some facilities carefully monitor community care referrals, others automatically refer all eligible veterans to outside providers without considering quality and cost. The situation is further complicated by community dentists who routinely propose treatment plans costing tens of thousands of dollars per veteran. The recently enacted Dole Act pilots, in two VISNs, a stringent review process of community dentist treatment plans, but the most cost-effective solution would be to expand the VHA's in-house dental staff. By providing these services directly, the VHA could deliver the same or better quality of care at a fraction of what is currently being spent on community providers.

Providing veterans with crucial information needed to make educated health care decisions

Another issue in dire need of overhauling in the community care program is the lack of available information that veterans need to make informed health care decisions. Future community care legislation must require private sector transparency about comparative VHA-VCCP wait times and quality metrics.

Veterans also deserve easy access to information as to whether providers treating them have the training, education, and competence to address their specific health concerns. Yet, the directory that is available online doesn't include all the providers in the network, and the listings lack any details about providers' qualifications.

Further, third party administrators evaluate their providers and designate those delivering high-quality care as "High Performing Providers" (HPPs). However, this assessment ignores behavioral and mental health providers, despite the prevalence of mental health challenges that many veterans face. The evaluation system should expand to include mental health providers, and veterans should have direct access to HPP designations through the public directory.

Addressing deficiencies with health information sharing between the VHA and VCCP

For years, including last week, the OIG has documented "difficulties caused by community care providers failing to return medical documentation." When all the relevant healthcare information isn't properly shared between VHA and community providers, care becomes fragmented, and veterans are put at risk. VCCP mental health providers routinely submit requests for treatment reauthorization that lack clinical documentation needed to make decisions. To address these serious issues, Congress should **establish sanctions for failures to bi-directionally share information between the VHA and VCCP** in a timely manner.

Properly including telehealth in VHA access standards

When establishing the VA MISSION Act eligibility rules, the VHA made a significant oversight: they did not include the availability of VHA telehealth when calculating distance or wait times for care. We believe this was a shortsighted decision that has had serious negative consequences. By not considering telehealth options, the VHA has unnecessarily limited veterans' access to quality healthcare while wasting taxpayer money. Telehealth is a valid means of providing health care to veterans who prefer that option. In a survey of veterans engaged in mental health care, 80 percent reported that VHA virtual care via video and/or telephone is as helpful or more helpful than in-person services. And yet, because of existing regulations, VHA telemental health (TMH) does not qualify as access, resulting in hundreds of thousands of TMH visits being outsourced yearly to community practitioners that could be expeditiously and beneficially furnished by VHA clinicians. The best action that Congress can take is to stipulate that VHA telehealth care con-

stitutes "access to treatment." If implemented, this correction would save taxpayers a vast sum—up to 1.1 billion dollars yearly according to a VA's September 2022 *"Congressionally Mandated Report: Access to Care Standards."*

Protecting the VHA's 2nd, 3rd and 4th Missions by ensuring VHA is fully funded and staffed

Congressional legislation on community care must attend to the impact on **the VA's vital role in researching veterans' complex health conditions**. For decades, VHA's electronic health records and access to VHA patients have enabled groundbreaking discoveries and treatments through large-scale data analysis of veterans' healthcare conditions. The VA's innovations in diagnostic testing, disease management, rehabilitation, geriatrics, patient safety, and numerous other fields have advanced healthcare for all Americans. The VHA has also proved invaluable and irreplaceable in its ability to study and compare the efficacy of different medications on patients' health This crucial research capability would disappear if veterans' care fragments across the private sector, where no unified system exists to study veterans' health outcomes or implement and evaluate innovative treatments systematically.

Congress should also be wary of expanding access to community care in a way that would **jeopardize the critical role the VHA plays in the training of future healthcare professionals across the nation**. More than 70 percent of all U.S. physicians train at a VHA facility early in their careers. At a time of dire mental health professional shortages, VHA is the largest single educator of psychiatrists and psychologists. Expanding care in the community will have jarring effects far beyond VHA itself by constraining the development of a critically needed workforce.

Likewise, expanding care in the community that downsizes VHAs will **degrade VHA's capacity to support its "Fourth Mission:"**–assisting the nation in times of emergencies and disasters. The VHA has supported this mandated mission with direct patient clinical care, testing, education and training in response to natural disasters, pandemics (like COVID–19), and other crises. VHA also serves as the first fallback to the military health system in times of war. The VHA is uniquely suited to support these missions because of the national distribution of its facilities, the unique training and experience of its staff, and the exceptional integration of its services.

Suggested solutions to improve the provision of community care.

To strengthen use of community care, we propose these essential reforms:

1. The VHA and VCCP must operate under uniform quality standards and training requirements.

2. The VHA and VCCP should publicly disclose wait times, and provider directories must detail healthcare professionals' qualifications and quality metrics.

3. Predictive modeling capabilities to forecast how varying levels of VCCP utilization will impact VHA's operational capacity should be quickly developed.

4. The VHA's internal staffing should be expanded to fully meet demand.

5. The VHA should retain clear authority in determining community care eligibility.

6. It's crucial to reinforce the message that veterans' access to community care depends on first meeting established criteria.

7. Timely VHA telehealth should be recognized as meeting the access to care standard.

8. Timely health record sharing between VHA and community providers should be reinforced through meaningful penalties for non-compliance.

9. Rigorous monitoring must be implemented to identify and sanction community providers who engage in unnecessary testing, optional procedures, or fraudulent billing practices.

We respectfully thank you for the opportunity to provide our perspectives on these essential matters. We look forward to working with the committee to ensure that veterans can receive timely, high-quality compassionate care in the VHA and the community now and in the future.

Prepared Statement of The American Legion

STATEMENT FOR THE RECORD
THE AMERICAN LEGION
MATTHEW CARDENAS
HEALTH POLICY ANALYST
TO THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
ON
"DEPARTMENT OF VETERANS AFFAIRS'
COMMUNITY CARE PROGRAM"
January 22, 2025

Chairman Bost, Ranking Member Takano, and distinguished members of the committee, on behalf of National Commander James A. LaCoursiere Jr. and more than 1.6 million dues-paying members of The American Legion, we thank you for the opportunity to comment on the Department of Veterans' Affairs' Community Care Program. The American Legion is directed by active Legionnaires who dedicate their time and resources to serving veterans and their families. As a resolution-based organization, our positions are guided by almost 106 years of advocacy and resolutions that originate at the grassroots level of our organization. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

The American Legion (TAL) was a leading force behind the passage of the VA Mission Act. On May 7th, 2018, when the VA MISSION Act was working its way through Congress, TAL signed on to a VSO support letter along with nearly all of the other major Veteran Service Organizations (VSOs) in support of the bill, saying in part that "[it] would consolidate VA's community care programs and develop integrated networks of VA and community providers to supplement, not supplant VA healthcare...This carefully crafted compromise represents a balanced approach to ensuring timely access to care while continuing to strengthen the VA healthcare system that millions of veterans choose and rely on."[1]

TAL still stands by the MISSION Act being intended to supplement – but not supplant – the VA direct care system, serving as a relief valve. The VA should remain the center of veteran healthcare with a constant focus on improvement, keeping the veteran as their North Star. In December 2024, in testimony before the House Committee on Veterans' Affairs Subcommittee on Health, VA&R Director Cole Lyle highlighted The American Legion's staunch support of keeping the VHA as the coordinator of care for U.S. veterans. If, however, the VA cannot provide veterans with the care they need, when they need it, community providers are the only realistic solution that is in the best interest of the individual veteran. Important changes in policy to reduce barriers to accessing care, streamline appointment scheduling, support gender-specific care unique to women veterans, and improve reimbursement requirements are critical to providing veterans with the healthcare they have earned.

As part of the Legion's outreach involving satisfaction with VA community care, TAL staffers met with Lillian Moss, a Legionnaire and member of Post 310 in San Diego, CA. Throughout the interview she highlighted several stark inadequacies of referrals and VA operations. In addition to being a survivor of combat and military sexual trauma (MST), Lillian was diagnosed with cancer in December of 2017. Thanks to her VA care, she underwent a double mastectomy in 2020. Her

cancer was removed, however inadequacies with her follow up reconstructive surgery were left unresolved for years. She described waiting on various calls and confirmations for appointments that always seemed to be just around the corner and just out of reach.

Lillian further struggled with financial hardship after her local VA pulled back her community care referral for her psychologist. Devastated at the thought of losing a trusted provider, Lillian was forced to pay out of pocket for her desired mental healthcare. She is now waiting for what she was told would be another quick call to requalify her referral but has been waiting for months with no progress made. These delays are an unacceptable burden to place on veterans seeking mental healthcare. For veterans engaged in specialty care, a continuum of care is critical to the veterans' well-being. We know how challenging transitions can be for members of the veteran community and abrupt changes can be devastating to those receiving care.

One solution is for VHA to improve access to specialty services in house, particularly in urban facilities with large catchment populations. These areas make the most economical sense for providing in-house services, whereas the current community care model might be more reasonable in rural areas. This fits much better with the VA's mission of providing care to veterans in an effective and timely manner than finding ways to delay and deny veterans' access to community care providers.

When veterans qualify for community care and elect to go in that direction, that decision should be between a veteran and their providers. While current access standards are not codified, they are part of VA policy and need to be followed. The Secretary of the VA has discussed making changes to access standards in the past to keep more care in the VA[2]. While no official changes to access standards have been made, there are reports that the VA has been informally restricting access[3]. We have heard this on our site visits as well, both from veterans and VA employees. Efforts to keep a veteran in VHA care should be made before treatment is needed, not at a time when a veteran is simply trying to get better. Sidelining veterans with bureaucratic or unnecessary procedural roadblocks requiring extra reviews, referrals, and conversations does nothing to accomplish VA's mission or improve on it, nor does it help veterans.

The American Legion conducts regular visits to VA facilities each year as part of our System Worth Saving (SWS) program. In these visits, we talk to veterans at VA hospitals, along with staff, to find better ways to work with the VA and Congress to improve veteran outcomes. Access standards have consistently been identified as an area for improvement. One issue that has come up repeatedly from staff in facilities with large rural catchment areas is that community care access standards are not reasonable for rural communities. Often, veterans qualify for care in the community due to time and distance rules, only to end up with private sector appointments that are even further out and further away than what VA can provide.

This goes against the spirit of the MISSION Act, which was to provide veterans with closer and timelier access to care. Congress and the VA should look closely at codifying access standards, but making sure that there is a provision in the standards that makes sure that the time and distance standards are also compared to what is available in the community to ensure that veterans are not going out of the VA care system just to receive care that is further away, a longer wait, or both.

Chairman Bost, Ranking Member Takano, and all the distinguished members of this committee, thank you again on behalf of National Commander James A. LaCoursiere Jr. and every one of our members of The American Legion for this opportunity to amplify the voice of the veteran. It is together with you that we do the great work of making a truly modern VA that provides the top-of-the-line healthcare veterans deserve. We look forward to working together with you to continue this sacred duty.

Prepared Statement of American Association of Nurse Anesthesiology

American Association of
NURSE ANESTHESIOLOGY

Written Statement for the Record by:

Janet Setnor, MSN, CRNA, Col. (Ret), USAFR, NC,
President
American Association of Nurse Anesthesiology

House Veterans Affairs Committee
"Restoring Focus: Putting Veterans First in Community Care"

364 Cannon House Office Building
Washington, DC 20515

January 22, 2025

Background on AANA and CRNAs

Chairman Bost, Ranking Member Takano, and Members of the committee, thank you for the opportunity to offer this statement for the record. The American Association of Nurse Anesthesiology (AANA) is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists, with membership that includes more than 65,000 CRNAs and student nurse anesthetists representing over 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who provide anesthesia, as well as acute, chronic, and interventional pain management services. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. CRNAs are highly trained and skilled anesthesia providers who have full practice authority in the Army, the Navy, and the Air Force, as well as the Indian Health Service. CRNAs are the primary provider of anesthesia on the battlefield, including in forward surgical hospitals.

AANA applauds the Committee's continued oversight of the ways the Department of Veterans Affairs (VA) provides quality care and services for our nation's veterans. This hearing is an important opportunity to address inefficient models of care within the VA health system that can lead to veterans seeking and receiving care in the community. The VA has unnecessarily restrictive practice models for anesthesia that intentionally underutilize CRNAs, driving up costs for taxpayers, increasing wait times for veterans, and creating significant inefficiencies and unnecessary redundancies in the system. This was readily apparent at the Hampton, Virginia VA Medical Center (VAMC), where a lack of physician anesthesiologists meant that CRNAs were not allowed to provide anesthesia despite being trained and educated to do so. This directly led to unnecessary delays in care, diversion to other facilities, and wasted money and resources.[1] We appreciate the leadership of Chairman Bost and Chairwoman Kiggans on investigating the matter at Hampton VAMC. We also applaud the Trump Administration for their leadership on reducing barriers to care for APRNs, including CRNAs, both by temporarily removing supervision requirements for CRNAs, as well as putting out a report that called for allowing all APRNs to work to the top of their training, which we strongly encourage the VA to follow.

Many of the veterans who turn to community care live in rural and underserved areas. According to data from the VA, there are 4.4 million veterans living in rural areas, and a higher percentage of rural veterans are enrolled in the VA health system than those in urban areas.[2] Additionally, veterans in rural areas are more likely to experience difficulty in accessing care, with longer waits and greater distances to care. In these areas, veterans who opt to utilize community care are far more likely to receive anesthesia from a CRNA. CRNAs make up approximately 80% of rural anesthesia providers and are the sole provider of anesthesia in nearly 100% of rural hospitals.[3] Despite the fact that veterans who are sent out into the community for care are more likely to receive anesthesia from a CRNA, the VA health system itself utilizes an unnecessarily

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[1] https://veterans.house.gov/news/documentsingle.aspx?DocumentID=6424
[2] Department of Veterans Affairs. *Rural Veteran Health Care Challenges.* Office of Rural Health. https://www.ruralhealth.va.gov/aboutus/ruralvets.asp
[3] https://www.aana.com/about-us/about-crnas/

restrictive anesthesia model that significantly contributes to veterans being forced to seek care outside of the VA health system in the first place because it is so inefficient.

The continued requirement of physician supervision of CRNAs within the VA is a persistent roadblock to the delivery of healthcare to our veterans. The practice is costly and dangerous, as it means veterans will see their care delayed or cancelled when an anesthesiologist is not available, despite the VA health system having ample CRNAs who are ready and able to provide care. This model of care is also incongruent with the vast majority of state laws, which do not require physician supervision of CRNA services, and runs counter to the preponderance of peer-reviewed evidence on CRNA safety, which shows that CRNAs can practice independently without any safety concerns. In fact, numerous studies have shown that patient health outcomes are identical when anesthesia services are performed by CRNAs versus physician anesthesiologists. CRNAs possess the education and training to provide care to all patients, even those with complex medical conditions.

To better provide the care that our veterans have earned and deserve, the VA health system must remove costly, unnecessary barriers to care. The VA health system could realize considerable cost savings and improved wait times, all without sacrificing healthcare quality, by allowing CRNAs full practice authority at all VA health facilities. This would allow a considerable number of veterans to receive care within the VA health system should they so choose. Otherwise, the VA health system will continue to face fiscal shortfalls in coming years and our veterans will be forced out into community care in ever greater numbers.

The Important Voice of Nurses

The AANA would like to applaud the committee for including Kelley Saindon, DNP, RN, NE-BC, CHPN as a witness at the hearing. The voice of nurses is critical to our healthcare system and to finding solutions that work for patients. Too often, the thoughts and opinions of the nation's more than four million nurses are forgotten in the halls of Congress. For the twenty-third year in a row, nurses remain the most trusted professional in the country.[4] Given the role that nurses play on the front lines of patient care, their consistent role in interacting with patients, and the incredible public trust they have garnered because of that service, it's important that we learn from them, and we thank you for including a nurse at this hearing. We hope the Committee will continue to engage with nurses as we work together toward our common goal of ensuring that all veterans have access to healthcare.

VA Unnecessarily Creating Delays and Inefficiencies

As Chairman Bost mentioned in his opening remarks, the goal of Community Care is to "eliminate barriers to care and expand access for veterans nationwide". This has long been a policy priority for the AANA in both veterans' healthcare and in our broader healthcare system. Too often, outdated and inefficient barriers to care have made accessing healthcare difficult for

[4] Saad, Lydia. (January 13, 2025). *Americans' Ratings of U.S. Professions Stay Historically Low.* https://news.gallup.com/poll/655106/americans-ratings-professions-stay-historically-low.aspx

patients. Community Care plays a significant role in ensuring that veterans have access to timely care.

The VA must get out of its own way when it comes to providing timely access to care. The VA health system continues to utilize incredibly inefficient anesthesia models that increase waits times for veterans, increase costs to taxpayers, and harm veterans' health by delaying or denying care. In too many cases, the VA health system uses 1:1 and 1:2 supervision ratios, wherein a physician anesthesiologist, making close to $400,000 a year, supervises a single CRNA on a single case at a time.[5] This is a comically inefficient use of taxpayer money and healthcare resources. Such supervision models continue to lead to the VA unnecessarily delaying care and forcing veterans to seek care outside of the VA health system, even if that is their preferred provider. These same models of care are rare in the private sector, and veterans who seek community care will almost certainly receive care from a far less restrictive anesthesia model, one that allows CRNAs to work far more independently and efficiently than the VA health system currently does.

We have seen firsthand at the Hampton VAMC the damage that the VA health system's inefficient anesthesia models can cause. The facility previously employed just one physician anesthesiologist and had canceled or delayed care when that physician was unavailable. The VA was therefore paying multiple CRNAs at the Hampton VAMC, who were not being allowed to provide care when the physician anesthesiologist was not present, despite being fully capable of doing so. Not only was this a waste of taxpayer dollars, but an affront to our veterans. The Hampton VAMC, due to this misguided policy, had to divert patients to other facilities and borrow physician anesthesiologists from other Veteran Integrated Services Networks (VISNs), furthering the inefficiency of care already guaranteed by the artificial limits to CRNAs' scope of practice at the VA.

As VISN 6 leadership has admitted, they are forced to contract with outside anesthesia providers, unnecessarily increasing costs for care at a time the VHA is facing budget shortfalls. The VISN 6 leadership also mentioned that they are working with the Department of Defense to recruit active-duty providers in the region. This is ironic as active-duty CRNAs, under the rules of the Defense Health Agency, enjoy full practice authority everywhere, including when they practice within the state of Virginia. The current anesthesia models within the VA health system are untenable for our veterans, and it is the result of a misguided policy employed by both the VA in general and the Hampton VAMC specifically, and represents a broken promise made by the VA nearly a decade ago.

Community Care and CRNAs

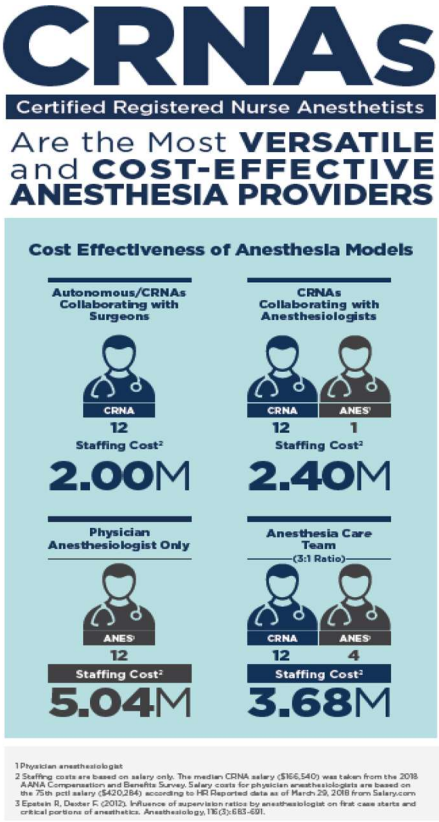
The AANA strongly believes that the VA should move to grant CRNAs full practice authority to increase access to care, so that every veteran who wants to access care within the VA can do so, especially with the increasing number of veterans eligible for care under the PACT Act. For those who cannot access care within the VA system, Community Care represents an option that will help to increase access and improve timeliness of care. Yet, a major disconnect occurs

[5] https://www.va.gov/OHRM/Pay/2021/PhysicianDentist/PayTables_20210103.pdf

between the VA and all other practice environments. While the VA utilizes overly strict supervision models that impede access to care without any corresponding increase in outcomes, the majority of states do not require these supervision models. The VA even quixotically uses these restrictive and inefficient models when they are in conflict with state requirements.

Currently, only seven states have supervision requirements for CRNAs in their Nurse Practice Act, Board of Nursing rules, or their equivalent, and twenty-five states have opted out of Medicare's supervision requirements for CRNA services. The trend of states opting out of supervision requirements for CRNAs has accelerated recently, with eight states opting out just in the last five years. This represents an ongoing, bipartisan trend towards increasing access to care and removing administrative burdens that harm patients.

When we meet veterans where they are to provide care, it is often CRNAs who are providing that anesthesia, particularly in the rural and underserved communities that are most reliant on community care. If CRNA led anesthesia care is good enough for Community Care, and is good enough for the Defense Health Agency and every branch of the military, why isn't it good enough for the VA health system? While there are legitimate concerns that sending more care out into the community created budgetary issues for the VA, the delivery of anesthesia is one area where the private sector has moved to be more efficient. It is time to bring the VA in line with the rest of the country by allowing CRNAs to provide high-quality, timely care. They must be granted full practice authority within the VA if we are to live up to our promise to care for our veterans.



Comparing various methods of anesthesia delivery, an autonomous CRNA collaborating with a surgeon is the most cost-effective model for anesthesia delivery. Current trends in the QZ modifier, which is utilized when a CRNA is billing for anesthesia without supervision, have shown a steady increase in the utilization of this billing modifier, implying an increase in CRNA autonomous practice. The anesthesia care team model, of 1:3 supervision is one of the most expensive anesthesia delivery models possible. Allowing for autonomous practice by CRNAs allows facilities the flexibility to choose a model that meets their needs and helps to keep costs down. Unfortunately, the VA health system is known for significant waste in their anesthesia delivery models, including the utilization of the highest cost 1:1 supervision model, and incurring millions of dollars in costs due to outside anesthesia contracts. Veterans and taxpayers deserve better than VA's inefficient anesthesia delivery models.

Independent Recommendations and Clinical Data

While the VA continues to utilize inefficient models and waste taxpayer dollars while simultaneously harming veterans' access to care, they have made it clear multiple times that they do not see evidence that CRNA independent practice provides outcomes any different than other, more restrictive anesthesia models. On the contrary, the VA has supported CRNA independent practice as equally safe as our anesthesiologists' colleagues, stating in a 2016 rule, "'over 900 CRNAs provide every type of anesthesia care, as well as chronic pain management services, for our Veterans in the VHA. The safety of CRNA services has long been recognized by the VHA and underscored by peer-reviewed scientific studies, including a major study published in Health Affairs which found that '"anesthesia care by CRNAs was equally safe with or without physician supervision.' VA agrees with these comments."[6] Additionally, the VA agreed in their materials published with this rule that "anesthesia care by CRNAs was equally safe with or without physician supervision."[7]

The evidence is overwhelming that CRNA independent practice is just as safe as the anesthesia care provided under supervision or by our physician anesthesiologists colleagues. In a study that the VA commissioned from Temple University, it was found that "studies have found that CRNAs who had an expanded scope of practice did not have worse patient outcomes, complications, or mortality when compared to anesthesiologists."[8] A peer reviewed study published in the Journal of Medicare Care in 2016 looked at anesthesia related complications for CRNA only, anesthesiologist only, and a team-based approach and found there were no differences in complication rates based on delivery model.[9] This corroborates an earlier peer reviewed study published in Health Affairs in 2010 that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs were no different than outcomes in states that maintained supervision.[10] A comprehensive review completed by the Cochrane Library in 2014 further reinforced these finding, when it reviewed the literature on anesthesia staffing and found that there could be no definitive statement can be made about the superiority of anesthesia delivery models.

During his first Presidency, the Trump Administration released a report on "Reforming America's Healthcare System Through Choice and Competition" that included recommendations to "allow all healthcare providers to practice to the top of their licensure, utilizing their full skill sets".[11] President Trump also put in place policy during the Public Health Emergency to

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[6] "Advanced Practice Registered Nurses" (A rule by the Veterans Affairs Department, 2016). https://www.federalregister.gov/documents/2016/12/14/2016-29950/advanced-practice-registered-nurses

[7] Department of Veterans Affairs, op. cit.

[8] Baumle, op. cit.

[9] "Scope of Practice Laws and Anesthesia Complications" (Negrusa, Hogan, Warner, Schroeder, and Pang, 2016). https://journals.lww.com/lww-medicalcare/abstract/2016/10000/scope_of_practice_laws_and_anesthesia.4.aspx

[10] "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians" (Dulisse and Cromwell, 2010). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0966?journalCode=hlthaff

[11] Department of Health and Human Services. (December 3, 2018). *Reforming America's Healthcare System Through Choice and Competition.* https://public3.pagefreezer.com/browse/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html

temporarily waive the supervision requirement for CRNA services. The VA Health system needs to continue in this vein. The situation will become even more dire in the coming years, both within the VA and in Community Care as the Association of American Medical Colleges predicts as shortage of specialty physicians, including anesthesiologists, of between 10,300 and 35,600 by 2034.[12] The combined physician shortage and nursing shortage makes clear that we can no longer rely on outdated anesthesia models that are already untenable, and will become increasingly dangerous with a growing and aging veteran population. It is imperative that all qualified anesthesia providers, including CRNAs and our physician anesthesiologists' colleagues, need to be providing direct patient care-especially to ensure that our veterans have the timely access to care they deserve, either at the VA or through Community Care. Veterans and taxpayers can no longer afford to pay healthcare providers to stand around and provide unnecessary supervision when they could be, and should be, providing actual patient care. Not only is this the right thing to do for veterans, but it aligns with the Department of Government Efficiency's goal of removing administrative burdens and more efficiently using taxpayer funds.

Conclusion

The VA continues to create its own problems with its woefully outdated anesthesia models that hurt veterans and taxpayers equally. The VA needs to make changes now. We applaud the work of your committee and the vision that that Trump administration has laid out to remove barriers to APRNs and to increase competition and choice within the healthcare system. We believe this will benefit veterans at every level and save American taxpayers money. We hope to be helpful partners in your work to provide our veterans with the highest quality care possible.

[12] Heise, Stuart. (June 11, 2021). *AAMC Report Reinforces Mounting Physician Shortage*. https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage