United States Senate
Committee on Veterans' Affairs

Oversight Hearing:
"Protecting Veteran Choice: Examining VA's Community Care Program"

Statement for the Record
Submitted by:
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Thank you, Chairman Moran, Ranking Member Blumenthal, and committee members for this opportunity to provide a statement for the record of today's hearing to examine VA's Community Care Program. Any care that a veteran seeks is important, and I would like to express that the void of long-term mental health support and care has led to a situation where impactful care is out of reach.

My name is Paige Marg, and I am the daughter of a retired soldier and the wife of a medically retired airman, and I am from San Antonio, TX. I met my husband Charles (Charlie) when I was 15 and we have been married for 23 years. I spent the first half of my career as a DoD civilian supporting overseas family resiliency initiatives and have spent the last 12 years working for a non-profit veteran service organization. I have never worn a uniform, but I have made it a priority to find a way to support military families and veterans.

I am here to be a voice for my husband's experience navigating the Community Care Program for mental health support. There is a need for this process to be developed further, particularly for veterans in a mental health crisis state and for whom long-term care is warranted. My husband's story of mental health struggles stemming from his service are unique, but sadly familiar in the veteran community.

Guantanamo Bay, Cuba
Charlie joined the Air Force in January 2000 for what was initially going to be four years and was medically retired in July 2015. In 2012-2013, my husband was deployed from Germany to Guantanamo Bay for eight months, and while deployed he attempted suicide twice and attempted a third time when he came home to Germany. He was hospitalized at Landstuhl Regional Medical Center. Prior to his deployment, Charlie had never attempted suicide throughout the 12 years of his previous military career and did not suffer from depression or anxiety.

In seeking care through Ramstein mental health clinic, a DoD facility in Germany, he and I were told that he could not have PTSD by his doctor because he was not deployed to a combat location. I advocated for him at the clinic that my husband never had mental

health problems prior to this deployment. Suddenly crowded spaces, having to make decisions – even minor ones, small changes in schedules, having people behind him when he was sitting – led to anxiety attacks with physical reactions. He additionally began developing OCD ritualistic habits to try and control what he could when he felt so much was out of his control. Charlie was instead diagnosed with Major Depressive Disorder and anxiety. Charlie lost his SCI clearance due to the attempt and the medication dosage he was prescribed and was no longer allowed to do his job. In 2014 a medical evaluation board process was initiated. Through this period Charlie's mental health continued to decline and his doctors stated that he would need care and medication for the rest of his life more than likely.

Return to the United States

In July 2015, Charlie was medically retired with a 70% mental health rating. We came home to San Antonio, Texas, as both of our parents retired here, and we needed family support.

Charlie enrolled in the VA Heart of Texas Health Care Network with the intention that the VA would be his primary care service. His experience in trying to get connected to mental health services since retiring has been nothing short of frustrating, demoralizing and the lack of care and concern for him as a person and veteran is evident in the responses that we have received from many VA Heart of Texas Health Care Network healthcare professionals over the years.

Charlie reached out and was assigned a VA psychiatrist for continuity of his mental health prescriptions and he requested counseling. Since 2015, Charlie has been passed and shuffled through the VA mental health system and has been referred several times to Community Care for counseling. The VA Heart of Texas Health Care Network has failed him repeatedly – lack of continuity of care, employees who simply blame and cite red tape as an excuse for lack of care, pointing the finger at other VA departments, pushing community-based resources that were either not viable options or had space for additional patients.

Since retirement, he has received no long term and consistent mental health support. As a veteran who was medically retired at a 70% rating for mental health alone, I do not understand why there was not any kind of transition plan made for him to continue to receive care when he left active duty.

Community Care Referral Process

He has requested counseling from his prescriber, a VA psychiatrist who he sees quarterly that only prescribes his medication but does not offer counseling appointments. His VA psychiatrist will put in a counseling referral to VA counseling services. VA counseling services will come back in 7-10 days that they do not have appointments within the 30-day window. From that point the referral is passed to Community Care, and it generally takes another 7-10 days for Charlie to be contacted from the outside agency. When he is

contacted by the Community Care provider, they will set up and appointment, but this is generally 25 days or more out from the date of the call. The referral to Community Care initially grants 6 visits and another 6 can be added on by the Community Care provider. In the 9 times that he has been through this process since 2018, he has never been granted an extension past 12 weeks and has never seen the same provider for more than one course of care. Many times, he has been 'cured' and released from counseling in the 7–9-week time frame. There have been times too that the extension paperwork was not processed through the VA in a timely fashion, and we have paid out of pocket for visits above the initial 6 that were granted.

In February 2023, Charlie was intensely struggling with his mental health and reached out to his VA psychiatrist for help and counseling. He was able to get a quick turnaround appointment, and I attended with him. He was given a 4-page photocopied document that listed many local therapists that took Tricare. She explained that the VA was backed up and was told he would probably be able to get an appointment through one of these providers quicker if he went through Tricare than the VA, and a follow up appointment was made for March 1, 2023. I held on to this paper as a Hail Mary of hope that someone on these pages would be able to help him; however, I was infuriated and frustrated that this was the level of care that he was receiving. While we do pay and have Tricare, getting pointed to another list of resources, to attempt to navigate with another healthcare system, without Tricare knowledgeable of his mental health history, treatment or current state, is not a well-functioning VA should work.

I called many of the numbers, only to be told that these providers were no longer able to take new patients, or the intake process would take time, up to 30-45 days for him to be seen. I explained over and over that this was an emergent situation but was told by the potential provider's office staff that they were not set up for crisis counseling/therapy. I was not able to find him an option that could see him before his March 1, 2023, appointment.

Suicide Attempt – March 2023

On March 1, 2023, my husband sat in his truck in the North West San Antonio VA Clinic parking lot and attempted to overdose. I kept trying to connect with him on his phone, but he would not answer, and I had an uneasy feeling and left work and went to where I could track his phone. I found him in his truck where he had crushed up about 75 propranolol pills in water and had drunk about 2/3 of it. He was drenched in sweat, crying, and not making sense.

I got him inside the VA, let staff know the situation, an ambulance was called, and he spent several days in a local hospital in the ICU and then in a ward, and then transferred to Audie Murphy where he stayed a couple of days.

When he was released and was referred again to the VA Community Care system for counseling and was seen the 12 visits before he was released from care again. From March 2023 – October 2023 his medication was adjusted and increased multiple times.

Suicide Attempt – October 2023
Emergency Room
On October 4, 2023, my husband left home with no communication and turned off his location services. His best friend reached out that he had had a strange call from him, Charlie told him that he loved him and that he would be out of pocket for a while and hung up. I tried to find him, and when I could not, I reached out to the police, and the police connected with our phone carrier to ping his phone.

We found him in the waiting room of VA Audie Murphy hospital's emergency room. He had not checked in but had been sitting in the waiting room for hours at that point. He disclosed to the police that he wanted to hurt himself but did not have a plan. He was crying and kept repeating that he was so tired of being broken and tired of trying to get help and he wanted to be done with everything. The police filled out the Emergency Detention paperwork and he was processed through the ER and admitted to the psychiatric ward in the early morning on October 5, 2023. I heard from a patient coordinator on the 5th and was told that my husband was very withdrawn and not speaking to anyone and that he would more than likely be kept through the weekend.

Post-Discharge Plan
On October 6, 2023, I heard from one of his doctors at Audie Murphy that he would be discharged that day. I questioned if this was the best plan, especially since the day before he was not speaking to anyone.

I asked what the plan was for follow up care because this was his second hospitalization and suicide attempt in seven months, and we needed a plan in place that was better than what was put in place before because it was not effective. I asked if there was a residential/in patient program that he could be referred to. I was questioned by his doctor on what I meant by a residential program, and I explained my request and was told that the VA did not have anything like that.

I pleaded and admittedly cried to the doctor that a different plan was needed for him after discharge because he needed long term care and support. I was told that he had a safe plan and that if he was feeling bad again, he could always return there. I pressed again that he needed a better plan than to come back to an emergency detention hold and was told to follow up with his doctor. He was discharged on October 6, 2023, and I picked him up and took him home.

Follow up visit
His follow up appointment was on October 10, 2023, and was seen by a Nurse Practitioner at the North West San Antonio VA Clinic. I explained the last few years of navigating

fragmented Community Care counseling and that a longer-term solution was needed for him because this was his second suicide attempt in the same calendar year and to keep repeating the same cycle and expect a different result.

The Nurse Practitioner stated that the VA system did not provide long term counseling and the VA "didn't do mental health well", turned her computer screen towards us, and pulled up www.psychologytoday.com and said to use the website to search for therapists that would accept Tricare.

I requested again for a residential treatment program for him and explained that I had connected with Wounded Warrior Project (WWP) Complex Critical Care team and that there were facilities in the community care referral system that he could go to. We were offered a pamphlet for the STAR program, an outpatient option for two weeks that was local and that she would pass the request for the referral to Dr. Gerardi.

Residential Treatment Referral Request

From October 10-18, 2023, we waited on a decision by the VA on the referral for a residential program within the VA Community Care network and the referral was supported by his VA psychiatrist. On October 18, 2023, Charlie's VA psychiatrist called him to let him know that the referral was declined and to see if Tricare, WWP, or another veteran service organization will pay for the care. The despair and rage that I felt that day when we received the call for the VA, further cemented the feelings and their lack of care, compassion and disregard for my husband and his life. I am not sure what else a person has to do to show they are in crisis, are desperate for help and attempt to take their own life twice in less than a year.

At that point we reached out to WWP and WWP paid for his flight to Tucson and secured a bed for him at Sierra Tucson, in Saddlebrook, Arizona. Charlie flew out on October 21, 2023. WWP paid for his care at Sierra Tucson after the VA again denied the request and subsequent extension request.

South Texas Veterans Health Care System's High- Risk List

On October 24, 2023, the VA sent a letter to Charlie to inform him that he was removed from the South Texas Veterans Health Care System's High-Risk List (HRL) for suicide by his Mental Health/Suicide Prevention team. This was 18 days from his Emergency Detention hold at Audie Murphy VA Hospital, 6 days after his doctor told him to go to outside VA resources for support, and 3 days after he arrived at an inpatient residential treatment facility that the VA denied the referral for. The form letter thanked him for the opportunity to serve him and encouraged him to continue to participate in the health care they offer.

They thanked him. For wanting to kill himself. So that they could have the opportunity to serve him.

Sierra Tucson
Charlie received care at Sierra Tucson and came home December 5, 2023. There his medication was completely reset, he finally received treatment for nightmares, received intensive counseling and was diagnosed with PTSD. When he returned home, WWP and Sierra Tucson connected him with an outpatient daily program through Laurel Ridge.

2024
Charlie has sought counseling through Endeavors and is currently going to counseling through the Vet Center in San Antonio. He attempted to utilize the VA Community Care network but was told that all that was available for him was the same 6 session referral that could be extended by the Community Care Provider if warranted.

It is heartbreaking to see your spouse become a shell of a person, to request over and over for help, to take all his medications and maintain medicine compliancy for more than a decade, to not miss appointments and to be discarded from the entity that should be providing treatment and care that he earned through his military service and sacrifice.

I am incredibly thankful for Wounded Warrior Project, that they helped us navigate getting him care and funded my husband's care – but they shouldn't have to. Charlie earned this care with his service, and his struggles are directly connected to his military service. I have tirelessly worked to become his advocate and at times his voice when he was too tired to fight for himself. I always worry that there will be a day that comes that I will not be there to save him, that I didn't do enough for him, that I didn't fight hard enough for him.

The obtuse, heartless interactions with the VA over and over are why veterans do not seek care. It is why veterans suffer in silence. And it is ultimately why veterans kill themselves because the entity that is supposed to help them shows them again and again that they do not matter. How many veterans need to commit suicide for the VA to prioritize long term mental health? How many veterans are getting lost and giving up in the Community Care system that do not have someone to advocate and fight for them?

Thank you to the Committee members for the opportunity to share Charlie's story. I hope that by sharing his struggles in obtaining care through the Community Care Program with you, his story will save another veteran's life.