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BEFORE THE

US SENATE COMMITTEE ON VETERANS' AFFAIRS

HEARING ON

CARING FOR ALL WHO HAVE BORNE THE BATTLE: ENSURING EQUITY FOR WOMEN VETERANS AT VA

April 10, 2024

Chairman Tester, Ranking Member Moran, and Committee Members, thank you for your on-going efforts to provide quality care to all veterans and your current efforts to provide quality and equal care for women veterans specifically. I am honored for the opportunity to present my perspective on how we can ensure equitable access to care for women veterans. My testimony is based on my personal experiences using the VA health care system for over 20 years, and on my experiences serving women veterans in multiple professional roles. I'll present three problematic areas, discuss sources of the problems, and suggest solutions.

I am a mental health therapist in private practice where I am contracted with Montana Veterans Association Care in the Community network. I specialize in treating trauma in the Veteran, military, and first responder populations. I am the Mentor Coordinator of the 8th Judicial District of Montana Veterans Treatment Court (VTC). I am also a combat veteran and 23-year member of the Montana Air National Guard where I volunteer as the Women's Initiative Team lead, and as the alternate Sexual Assault Response Coordinator.

The first topic I'd like to discuss is that of the Military Sexual Trauma (MST) reporting and claims process. While MST affects both women and men, I will focus on women in my testimony. The current process does not follow trauma-informed care guidelines. The nature of MST differs from other forms of trauma in that it often includes an aspect of moral injury and institutional betrayal. As military members, we enlist knowing that we will likely experience trauma, but we assume it will be war/conflict trauma. Often an MST perpetrator is also a military member, and therefore, someone that the victim assumed to be on the same team and trustworthy. The idea that our trauma might be caused by one of our own is never considered on enlistment day. Even if the perpetrator is held accountable and the system works as advertised, the victim will never truly feel safe in the military environment again. This creates complex trauma in veterans, which means the reporting and claims processes cannot be the same as the process for a back injury or tinnitus. Although there's been substantial improvement to the reporting procedures for active military personnel, the process remains arduous, retraumatizing, and flawed. Therefore, many victims never report an MST until they are out of the service, and

some will never report. We must create a separate and distinct system for MST disability claims that adheres to trauma informed processes.

For example, I currently have a Marine client who, years after her violent sexual assault, is working on her trauma using Eye Movement Desensitization and Reprocessing (EMDR) therapy. Initially, she presented to therapy with symptoms of severe Post Traumatic Stress Disorder (PTSD). She'd been out of the military for six years, had a disability rating for her physical injuries, and a small rating for depression. After six months of counseling, she finally revealed that she'd been violently sexually assaulted by her supervisor while on active duty. It took another year of counseling and EMDR to treat some smaller mental health issues before she was willing to address the MST specifically. After six months of work on the MST, she agreed to reattempt her MST disability rating. She'd previously attempted to report her trauma symptoms, but froze during the examination with an unknown male examiner and was unable to talk. Her MST claim was denied. She agreed to try again because she is an exhausted mother, working full time, and she rarely sleeps because she spends her nights repeatedly checking that her doors and windows are locked and her children are safe. Obtaining a higher disability rating would allow her to cut back at work, get some rest, and focus on her mental health treatment. She also agreed, because I was willing to help her with the process. We went to the VSO together, and when the VSO asked her how she was doing, she responded, "Fine" and froze. This is exactly the response she'd described regarding her first rating attempt. However, I was present to help her through it. After filing her supplemental claim, we prepared for the examination. To help with this process, the client told her story over the course of multiple sessions, it was recorded, and I transcribed her account after session. She doesn't have her exam date yet, but she will take the transcription with her to the exam, which we hope will keep the examiner from asking triggering questions. Overall, she is absolutely terrified of the exam, but is doing it for her mental health and the well-being of her children. In preparation for this hearing, I asked her if she had any ideas on how the VA could improve the process and she said, *"The whole process basically retraumatizes people. It would have helped if I didn't have to talk to so many people about it. I had to talk to some guy who made me feel like crap, didn't seem remotely interested in what I was saying, and just kept asking me if I was thinking of dying. If I would have said yes, he would have committed me, but because I said 'no' he wrote that I was 'sometimes sad and depressed'. Even this time, I've seen you for years, but I'm still going to have to go see some stranger who's going to meet me once, and somehow make a determination on me. If they could streamline the process, so people who are already in care didn't have to re-tell and basically beg some stranger to believe them; that would be great. I'm just really tired of constantly living in fear that I have to relive these moments, and hope I'm believed."*

The client's suggestion is reasonable and valid. If a veteran is already seeing a mental health professional, that professional with an existing therapeutic relationship, should be able to make a MST determination and mental health diagnosis for the VA. I understand that most mental health therapists are not doctors (MD, PhD), but they know the client and can produce a more reliable determination than an examiner who sees a veteran once and simply completes a checklist based on DSM criteria. This would also free-up the back-logged examiners to focus on other claims. Additionally, the utmost priority should be placed on the correct processing of MST disability

claims. The mental health consequences resulting from an incorrect denial are catastrophic for victims. Finally, veterans with MST claims should be assigned an advocate with specialized training to guide them through the process.

Another women Veteran recently started her claims process for several assaults that happened while she was at the Air Force Academy. These occurred many years ago, but she is finally recognizing her PTSD and is ready to make her MST disability claim. She attempted to get a referral for a Care in the Community provider, but was told that she needed to see the VA counselor first. She attended her first appointment, could barely speak through her tears, and was met with skepticism. She approached me as a mentor and described her session, while very distraught. She stated, *"This was the first time that I'd ever tried to tell anyone."* Her description didn't sound like she had a trauma informed therapist, so I asked her to request the provider's clinical documentation of the session. After reading the note, she stated, *"I was absolutely upset, angry, hurt, and felt totally invalidated. It just reinforced what I had been feeling (during the counseling session) - that he truly wasn't listening to me at all, and why should I even try opening up to a counselor when they are just going to blame me anyway."* The VA therapist wrote several sentences that victim-blamed the veteran, and didn't display a thorough understanding of common MST reactions in victims. I informed her that she is entitled to a therapist of her choosing, but it is difficult to find one. So, we worked the system backwards. I begged a counseling colleague who is trauma informed and accepts VA insurance to take her on as a client. The therapist had a full case load and was doing me a favor, but agreed. Then we notified Care in the Community of the therapist and the first appointment date. This client is still in the claims process and hasn't received a determination, but her case demonstrates how painful and difficult it is to come forward with a MST claim.

The second topic I'd like to discuss is access to women's health care through the VA. A recent Veteran experience will provide the best illustration. *"I started experiencing pain in my armpit beginning in spring of 2022. I requested a mammogram from my PCP, but he declined my request because I had a mammogram in the fall of 2021. By June of 2022, my pain was severe. I called my PCP again, but he was busy so I talked to his nurse who said she'd pass the message to the doctor, and recommended going to the ER. By August, the pain was bad enough that I did go to the ER, but they would not do an emergency mammogram and sent me home. The next day, I was finally able to convince my PCP to order a mammogram. I waited two more weeks with no call, so I called Care in the Community and asked for the referral status, and I told them I was afraid I had cancer. The person on the other line said that he had a whole stack of requests on his desk and that I'd need to wait like everyone else. I waited until 1 November, and finally had a mammogram. I wasn't contacted for two more weeks. At that point, I was contacted and scheduled for an ultrasound at the end of November. After that, I was scheduled for a biopsy on 8 December. At this point, I met with my PCP again, who showed zero empathy and said, 'Worst case scenario is that you have cancer.' Also, during this appointment, I requested an annual gynecological exam. He argued that it wasn't necessary due to my age, but he finally conceded and gave the referral. The next day, the nurse called and told me that the doctor had rescinded the order because he didn't think it was necessary. I ended up scheduling my annual gynecological exam using my Tricare on the civilian side. At that appointment, the civilian provider examined my breasts and showed great concern. On 21 December my PCP*

finally called and told me that I had cancer; after I told him that I was on the highway driving my grandchildren from Texas to Montana for Christmas. I later got a call from a female provider who helped me set-up oncology treatment in Texas instead of Montana, because I was taking my grandkids back after Christmas. I think if I'd had a female provider; they would have taken my complaints seriously. It took from April to August to get a referral for a mammogram. Then it took another 3-4 months to receive a diagnosis. I will see a GYN on my own now since it was not offered to me by the VA. I also did not think it was wise to give me my diagnosis when I was driving long distance with my grandchildren in the back seat. We never did that in the Air Force; we'd wait until there was support and never on a Friday, without being prepared to provide that support. I saw an oncologist on 10 January in Texas and she told me that I should have had the biopsy immediately following the abnormal mammogram, and that I shouldn't have waited a month for an ultrasound."

This example is one story, but multiple aspects sound like so many others. In this veteran's case, she has Tricare as an additional insurance option. This veteran also had an in-depth understanding of the VA health system, because she worked as a VA employee for years. Many veterans only have the VA as a health care option and have no additional knowledge of how to navigate the maze. One of those veterans said, *"I have a gynecologist who is based somewhere else in Montana. That's a whole other story – I don't feel listened to which makes me avoid going, but apparently, she's the only person in town for that sort of stuff with the VA. They tell me she's my only option and I have to drive to Helena to see her if I need anything in-person. In a nutshell, it just feels like they don't really care. But it's all I've got; so I feel like I can't really complain."*

Mammograms, annual gynecological care, reproductive care, and gender-specific preventative screenings should be more accessible and offer access to multiple providers. They should not be dependent on a PCP's gatekeeping. One solution is that women veterans should be able to obtain care from the women's health provider of their choosing without a referral or authorization. They would schedule the appointment with the radiology or gynecological department, and state that they have VA insurance. The process should look similar to the process veterans use to go to the civilian ER or a same day walk-in clinic.

The third issue I'd like to address is the disability claims process. This issue affects all veterans, but it disproportionately affects women veterans. As women veterans, we are still fighting the stigma that women don't go to combat, or that the only way to be injured (mentally or physically) is by going to combat; making a PTSD disability rating more difficult for women to validate during the claims process. Women's PTSD is more likely to be misdiagnosed as depression or a personality disorder than men's PTSD. I'll use a personal example to illustrate the continued stigma. Each time I have an appointment at my local VA facility, the door greeter asks me if I am there to pick up my husband or if I am looking for my husband. Despite three combat deployments as a Weapons Loader on fighter aircraft and as a C-130 Navigator, it is still assumed that I am a spouse. He is a volunteer with good intentions, and I applaud him for staying active in the veteran community, but it emphasizes the bias that still exists, and inevitably seeps into the claims review process. Women veterans are also less likely to serve a 20-year career due to retention issues and in-service disparities that should be the subject of a separate hearing. Therefore, they are more likely to separate after their first or second

enlistment, which leaves them without Tricare benefits and with VA/TriWest as their only insurance option. A current client's situation illustrates this well.

This client served an honorable six years. Her decision to separate was difficult and largely due to the ostracism, discrimination, and harassment she experienced while serving in a male dominated career field. She'd been engaged in counseling for several years with PTSD and Major Depression diagnoses and several in-patient mental health stays. She was separated in July 2023 as an E-4 without much savings, and was basing her expectation of the separation process on what she learned in TAPS. There was an assumption that her VA insurance would kick-in immediately, and within 6 months, she would have her disability rating. The reality is much different. We had a three-month gap in mental health services after she lost her Tricare coverage and was waiting for the VA referral/authorization process to work. Despite not having an authorization, I told her to contact me if she had a crisis, knowing that the VA authorization would not be back-dated to financially cover those services. In November of 2023, her disability claim was blanket-denied, and she was instructed to initiate a supplemental claim, which she did in December 2023. The VA contracted company told her the claim was denied due to the veteran cancelling her exams. However, the veteran was not aware of the exams and did not cancel them. She still does not have the required exams, and recently stated, *"I am so fucking scared, because I can't get a straight answer about my compensation date. Is it July of 2023 or December of 2023? The VSO told me that my compensation date should stay July, but the lady at the VA told me that it is now December. I don't understand how I can do everything I was supposed to do and they can just keep dangling this over my head. I am basically in a panic attack because I don't know who to believe or trust or what to do."*

Based on my experiences in my counseling practice and with Veterans Treatment Court, the compensation process is so complicated that those who need the help most can't figure out the system and give up. Often MST, other sensitive injuries, and discrimination keep women veterans from speaking up and asking for help. Many of my most severe cases don't have adequate disability ratings; because the process is complicated, frustrating, retraumatizing, and demoralizing. It takes a lot of time, effort, and resiliency to make it through the claims process successfully. VSOs are helpful, but it is difficult to get an appointment, and they are so swamped that they don't have the time it takes to walk a veteran through the nuanced process.

Currently, Tricare provides 30 days of coverage after a member separates. One solution that would help ease the pain of the separation and disability claims process is to extend this coverage for 90 days. This would help bridge the insurance gap, allow the veteran time to get established with a PCP, and allow time for the referral/authorizations to work. If the system is going to be delayed, with no way for the veteran to expedite it, we need to ensure the veteran has adequate coverage while waiting.

There are several procedural issues that contribute to the three topics I presented above. The VA authorization process is broken. First, a veteran must make an appointment with their PCP at the VA to receive a referral. This is approximately a 2 week wait. The primary care provider writes the referral. 30-45 days after the PCP requests the referral, the community care mental health social worker will attempt to find a contracted provider with availability. Once the VA social worker finds an available provider, they fax the referral to the civilian provider. The

civilian provider will contact the veteran for an appointment, complete the scheduled appointment letter, and fax the letter back to the VA. Roughly, a week later, the provider receives the final authorization letter from the VA and can see the Veteran for an intake appointment. This process is entirely too long and cumbersome; especially for a veteran in crisis and for overwhelmed providers. Once again, TriWest and Tricare (military member only, not dependents) are the only insurance companies that require any type of referral/authorization for mental health care.

In addition to the lengthy process, TriWest refuses to back-date authorizations. This is a very dangerous policy. I routinely have veteran clients who haven't been actively engaged in counseling for a period of time; but they have a crisis, a trauma anniversary, or become triggered somehow and contact me for an appointment. These veterans are in crisis and time is of the essence. It is essential that a provider be able to schedule a veteran immediately, but usually these situations mean that a provider will not be compensated for 1-3 sessions while the authorization process is working. My most recent example is a veteran who was in long-term inpatient care for substance abuse and was unexpectedly discharged. When he called for an appointment, his authorization had expired. It was important to see the veteran the same day given his circumstances and a high risk of suicide. I immediately contacted the Care in the Community mental health social worker and asked for a rushed authorization back-dated to the client's inpatient discharge date. The reauthorization still took 30 days, and TriWest refused to back-date it despite the unique circumstance. If you ask the VA, they will tell you that any provider can get an emergency authorization at any time, "just call us and we will get it done," which may be true; but it is not realistic. At a minimum, this would take an hour on the phone, and there is no direct number for providers to call. Mental health providers are typically small offices without administrative staff. If a day goes smoothly, we will have 10 minutes of free time between clients. We absolutely do not have the time to call the VA 1-800 number when a client contacts us in crisis. At most, I can use my 10 minutes to call the client in crisis to schedule them. The only direct contact providers have are to the Care in the Community social workers, and they can't influence the authorization process.

The VA needs a provider-only extension where we can get assistance in a timely manner, and coordinate with the veteran's care team efficiently. Currently, a provider has to navigate the same phone tree that the veteran navigates. The VA also should add a secure messaging option on their app for providers. Again, I will remind the committee that VA/TriWest is the only insurance where a provider needs to do any of this administrative/case management work.

Another problematic aspect of the referral/authorization process is finding a trauma-informed/military informed therapist that accepts TriWest and has availability. First, providers finish graduate school with a basic understanding of trauma. Becoming a trauma-informed therapist requires additional expensive and time-consuming training. Most therapists with this level of training and experience do not need to accept insurance; let alone one of the lowest paying insurances with the most paperwork and case management requirements. These providers can fill their practice with cash-paying clients. In Montana, TriWest's reimbursement rate is slightly higher than Medicaid/Medicare, $40-$60/hour less than private insurances, and

requires the most uncompensated work outside of session. It is not a competitive source of income, and many providers are refusing to accept it anymore. This puts veterans in a very difficult position. When a veteran is ready to engage in mental health treatment or unpleasant women's health screenings, it is demoralizing to realize that either you have no agency in choosing your provider, there are no local contracted providers, or that the local providers are full and cannot accept new referrals. The lack of quality providers stops many veterans from getting the care they need.

The following items should be required of future VA insurance contracts, which will help attract more qualified providers and give more choice to veterans.

1. Must back-date authorizations (up to 45 days).
2. Must reimburse providers at a competitive rate.
3. Eliminate the referral/authorization process. Allow veterans to work directly with Care in the Community to find a therapist with openings. Then allow the veteran to schedule and work directly with their therapist.
4. Authorize a CPT code for administrative and case management work. This will allow providers to be more involved in helping veterans file disability claims for MST, mental health, women's health, and other sensitive injuries.

One final issue contributing to the above problems is high provider turn around. Veterans have a joke that we don't even bother learning our PCM's name, because we will never see them again. This is difficult for all veterans, but I believe it disproportionately affects women veterans. MST, suicidality, and gynecological health concerns are very personal topics. If a provider wants to know the truth, they must have a trusting relationship with the veteran. At every PCP appointment we are screened for a history of MST and suicidal ideation, intent, and plan. The screening is conducted with good intention, but very few veterans feel comfortable answering these questions honestly when they don't know or trust the person asking them. The process is not trauma-informed and is ineffective.

In summary, I've offered solutions to the immediate concerns, but the core solution begins with recruiting and retention. The root cause of many issues specific to women veterans is their continued minority status. The long-term goal of the committee should be to increase retention rates among women currently serving. The research doesn't dictate an exact number, but in general, 30% is the accepted percentage of a population needed to reach critical mass. Once critical mass is achieved, the minority group ceases to feel like a minority and is less likely to experience inequity. How do we do that? We must continue to support women's initiatives such as ending the sexual assault epidemic; establishing parental leave policies; mandating lactation rooms; increasing access to after-hours childcare; updating anthropometric standards, and mandating access to gender-specific body armor, maternity uniforms, and flight suits. Many of these topics have been addressed and changes achieved, but without allocated funding, it is difficult to implement the changes at ground-level. I encourage the committee to continue fighting for woman military members and veterans while insisting that the required funding be attached to any enacted change. If we can do a better job of retaining women in the military, we

will eventually reach that 30% number in the veteran population, and ultimately hold hearings that address all veterans equally.

Mr. Chairman, I appreciate the continued focus on the very important women veteran population. My dissertation, "I just want to do my job: the experience of female fighter pilots in the United States Air Force" offers a more in-depth description of the women military and veteran experience. This concludes my testimony, and I am happy to answer any questions you may have. I am also happy to obtain further information or additional statements from any of the anonymous veterans who bravely provided their stories.

All contents of this testimony are based on my personal opinion and does not reflect the official position or stance of the DOD or the Unites States services.