



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS  
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 the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Department of Veterans Affairs' (VA) programs and initiatives to better serve women veterans. In 2021, the OIG's Office of Healthcare Inspections created the Women's Health Program to increase oversight of VA's efforts to meet the healthcare needs of this expanding population. The OIG recognizes the commitment and focus VA has shown in expanding the availability of gender-specific resources and creating a safe and welcoming environment.

As the number of women veterans continues to increase, VA must work to improve access to women's primary care providers and gender-specific care within their facilities and in the community. More women veterans are accessing VA at a younger age, underscoring the need for maternity and gynecologic care to be readily available. Gender-specific cancer screenings—such as for breast and cervical cancer—must be easily accessible and followed up on diligently. Cardiovascular disease is the number one killer of women, and women veterans are at an increased risk for heart disease, reminding stakeholders it is critically important that VA providers are equipped to diagnose and manage these and other widespread, chronic health conditions.<sup>1</sup>

Women veterans often experience other health conditions, including mental health concerns, at higher rates than their male veteran counterparts. Expanding screening for military sexual trauma (MST) and mental health conditions could help ensure women veterans are aware of the available care and benefits to which they are entitled. VA must also ensure its Intimate Partner Violence Assistance Program is providing the necessary support and assistance veterans require. While the OIG recognizes the efforts of

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<sup>1</sup> The Facts about Women and Heart Disease, <https://www.goredforwomen.org/en/about-heart-disease-in-women/facts>, accessed April 1, 2024; Women Veterans and Heart Health, <https://www.goredforwomen.org/en/about-heart-disease-in-women/facts/women-veterans-and-heart-health>, accessed April 1, 2024.

the Veterans Health Administration (VHA) to build up its women veterans' services, our work has identified deficient programs that are not adequately supporting the needs of women veterans.

This statement will discuss recent OIG reports on VHA women's health providers, mammography program, and reproductive health services to highlight several areas of needed improvement affecting the delivery and environment of care for gender-specific health care. It will also present the substantial work of OIG teams reviewing the delivery of care and benefits to survivors of sexual violence, including military sexual trauma, and intimate partner violence, populations that include a disproportionate number of women veterans.

## **BACKGROUND**

The Veterans Health Care Act of 1992 authorized VA to provide gender-specific services (such as Pap tests, menopause management, mammography, breast examinations, and reproductive health), broadened the context of posttraumatic stress disorder (PTSD) to include care for sexual trauma experienced in the military, and mandated VHA to assign to each region a women veterans' coordinator responsible for enhancing services.<sup>2</sup> Over the past two decades, VHA has built on that authorization by introducing multiple initiatives to improve the access and quality of health care for women veterans. In 2008, VHA's Women Veterans Health Strategic Health Care Group began redesigning the delivery of care.<sup>3</sup> This initiative shaped existing policies, which require all women veterans are offered assignment to a primary care provider and care team who have experience or received training in the care of women veterans. These specialized teams should have a reduced panel size to allow for longer and more frequent visits, as well as enhanced staffing that accommodates chaperone and care coordination needs.<sup>4</sup>

While military sexual trauma affects both women and men, VA reports that approximately "1 in 3 women and 1 in 50 men" indicate they have experienced MST. Between 2011 and 2021, the number of women veterans receiving MST-related outpatient mental health care increased by 158 percent.<sup>5</sup> MST is an experience, not a mental health condition or diagnosis. Although PTSD is commonly associated with MST, other frequently associated diagnoses include depression and other mood disorders and substance use disorders.<sup>6</sup> Psychological trauma, such as MST, also increases risk of physical health conditions

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<sup>2</sup> VHA Directive 1330.01(7), Health Care Services for Women Veterans, May 14, 2023.

<sup>3</sup> National Center for Veterans Analysis and Statistics, America's Women Veterans: Military Service History and VA Benefit Utilization Statistics, November 23, 2011.

<sup>4</sup> VHA Directive 1330.01(7), Health Care Services for Women Veterans, May 14, 2023.

<sup>5</sup> VA, "Military Sexual Trauma," accessed March 11, 2024, [https://www.mentalhealth.va.gov/docs/mst\\_general\\_factsheet.pdf](https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf).

<sup>6</sup> Ibid.

such as cardiovascular disease, stroke, and diabetes.<sup>7</sup> In addition to poorer psychological and physical health, women veterans with a history of MST who receive VA health care report more readjustment problems after military discharge, such as difficulties finding employment.<sup>8</sup> Since 2000, VA requires that every veteran seen for VA health care is screened for MST.<sup>9</sup> Veterans do not need a VA disability rating or documentation of MST experiences to access MST-related care—it is made available at every VA medical center and many community-based outpatient clinics, and counseling is available at vet centers. VA also offers more intensive MST-related treatment in residential and inpatient programs, some of which are gender-specific.

The number of women veterans accessing VHA care has tripled since 2001, growing from about 160,000 to over 600,000 today.<sup>10</sup> Women make up 30 percent of all new VHA patients, despite making up over 10 percent of the overall veteran population.<sup>11</sup> This trend underscores the importance of VA improving the experience and resources available to women veterans.

## **VHA CAN IMPROVE THE DELIVERY AND ENVIRONMENT OF GENDER-SPECIFIC HEALTH CARE**

As VHA has worked to expand the services available to women veterans, the OIG has focused on providing oversight that assesses whether these expanded services are adequately resourced and delivered in a safe environment and in accordance with VA policy. The OIG reports summarized in this section showcase deficiencies in access to care, women’s health program management, and adherence to policy that create barriers to the provision of high-quality gender-specific care at VA.

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<sup>7</sup> Harvard Medical School, Harvard Women’s Health Watch, Past Trauma May Haunt Your Future Health, accessed March 11, 2024, <https://www.health.harvard.edu/diseases-and-conditions/past-trauma-may-haunt-your-future-health>.

<sup>8</sup> “Military Sexual Trauma: Issues in Caring for Veterans,” VA National Center for PTSD, accessed March 11, 2024, [https://www.ptsd.va.gov/professional/treat/type/sexual\\_trauma\\_military.asp#two](https://www.ptsd.va.gov/professional/treat/type/sexual_trauma_military.asp#two).

<sup>9</sup> VHA Directive 2000-008, *Sexual Trauma Counseling Section of the Veterans Millennium Health Care Act*, Public Law 106-117 (RCN 10-0905), February 29, 2000. This directive was rescinded and ultimately replaced by VHA Directive 1115 that mandates screening for experiences of MST for all veterans seen in VA medical facilities. The National Deputy Director for the MST Team told the OIG that although this policy did not specifically mandate screening, it was issued in the context of the mandate to implement the screening software and the need to screen all veterans for MST and that the year 2000 is typically identified as the initiation of the screening requirement.

<sup>10</sup> The Women’s Health Evaluation Initiative, VHA Sourcebook. The Women’s Health Evaluation Initiative consists of women’s health investigators including VA Health Services Research and Development, Center for Innovation to Implementation, and the Health Economics Resource Center at the VA Palo Alto Health Care System.

<sup>11</sup> About Us - Women Veterans Health Care (va.gov), accessed April 1, 2024, <https://www.womenshealth.va.gov/WOMENSHEALTH/about-us.asp>; Veteran Population - National Center for Veterans Analysis and Statistics (va.gov), accessed April 1, 2024, [https://www.va.gov/vetdata/Veteran\\_Population.asp](https://www.va.gov/vetdata/Veteran_Population.asp).

## **A Case Example of Deficiencies in a Women Veterans Health Program**

An OIG team conducted a healthcare inspection of alleged deficiencies in the Women Veterans Health Program (WVHP) at the VA North Texas Health Care System in Dallas, Texas.<sup>12</sup> This report provides a wide-ranging examination of the problems that can potentially exist at any VHA facility when the women's health program is not appropriately managed or resourced. WVHP policy identifies primary care requirements for all women veterans, including gender-specific care, like basic gynecological care as well as breast and cervical cancer screenings. VHA's current goal is that 85 percent of women veterans be assigned to a designated women's health primary care provider. The OIG determined that the facility had an insufficient number of these designated primary care providers trained to provide gender-specific comprehensive care for women veterans. The shortage of women's health primary care providers in the geographic area made it difficult for VHA to recruit staff. Additionally, WVHP staff reported to the OIG that women's health primary care providers' patient panel sizes had not been reduced as required by VHA and the amount of time allotted for appointments was not sufficient for unique gender-specific care needs.

In addition to shortcomings in healthcare delivery, the OIG determined that the facility had long-standing deficiencies in the availability of equipment, supplies, and space to provide gender-specific health care. One of the roles of the WVHP manager is to ensure that construction and renovation projects comply with VHA policy to meet the privacy and dignity needs of women veterans. The OIG found that the WVHP manager was not fully engaged with this process and did not routinely participate in weekly environment of care rounds as required by VHA policy. The WVHP manager's lack of engagement contributed to a failure to identify resources needed for the provision of women veterans' health care, including the renovation of existing space to ensure women veteran restroom access within the clinical area.

Additionally, the facility had an extended vacancy for a gynecologist, which the facility mitigated by using an advanced practice registered nurse and community care providers. After hiring a gynecologist, the advanced practice registered nurse and the gynecologist shared a licensed vocational nurse from another clinical area to serve as the required examination chaperone. This impeded the ability for both providers to conduct examinations simultaneously, and staff said the advanced practice registered nurse also performed ancillary administrative duties, further reducing her availability for appointments.

While community care provided a vital resource during staff vacancies, the facility did not have a standard operating procedure for tracking and reporting community care results back to the requesting VHA provider. The OIG reviewed the electronic health records of 31 women veterans with abnormal

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<sup>12</sup> VA OIG, [\*Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System, Dallas, Texas\*](#), January 23, 2020.

gynecological test results and determined that medical records were not received for seven of the 11 veterans referred through community care.

The OIG made 18 recommendations, now closed based on VHA documentation, for corrective action focused on staffing for gender-specific care provided by designated women veterans health providers, extended appointment times for these healthcare exams, comprehensive healthcare resources for women, WVHP manager routine attendance in environment of care rounds, support staff to provide gynecology services, and ensuring VHA providers receive records from community care referrals.

### **National Review of VHA Reproductive Health Services**

To understand the availability of reproductive health services across VHA and to further examine the staffing and resource challenges of gender-specific care, the OIG released a national review of VHA's reproductive health services for veterans in the fall of 2023.<sup>13</sup> The review's purpose was to capture a snapshot of the availability of reproductive health across VHA, given the rapid demographic change and the expansion of reproductive health services covered in VA's medical benefits package. Approximately half of the 600,000 women veterans who use VHA for health care are of childbearing age, highlighting the need for VHA to ensure ample capacity of these essential services.<sup>14</sup>

The OIG team selected 26 VHA facilities, which included all Veterans Integrated Service Networks (VISNs), with a range of facility complexities, a mix of rural and urban geographical service areas, and varying levels of state restrictions to abortion services. The team interviewed leaders at the selected VHA facilities to identify concerns and offer candid perspectives. Although informative, the findings cannot be statistically generalized across VHA because quantitative data were not analyzed on patients, facilities, or procedures performed within VHA, and the sampling method was not random. The OIG found that the selected facilities were generally able to provide reproductive health services. For the most part, the challenges reported were not unique to the provision of reproductive health and were consistent with recognized broader challenges for health care, including travel distances to obtain specialty care; limited resources and provider availability in the community; and challenges with VHA staffing and recruitment.

To mitigate these problems, facilities used community care resources to provide reproductive health services. However, some facility leaders identified a lack of access to community care resources for a range of reproductive health services. While the staffing and access challenges identified are not unique

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<sup>13</sup> VA OIG, [Review of Veterans Health Administration Reproductive Health Services](#), September 28, 2023.

<sup>14</sup> VHA Women's Health Services, Women's Health Evaluation Initiative, Sourcebook: Women Veterans in the Veterans Health Administration, Volume 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution, February 2018. A VHA analysis of veteran population trends from 2018 found that the number of women veterans under age 35 had tripled over the course of sixteen years.

to reproductive health care, the expanding population of women veterans of childbearing age underscores the need for VHA to focus additional resources in this area.

### **Misconduct by a Gynecologist and Facility Leaders' Failure to Adequately Respond**

VHA has instituted policies to create a welcoming and safe environment for women veterans seeking care. However, the OIG has found that at times these policies, as well as the education and training provided to staff, have not yielded a culture that treats women veterans with dignity.

The OIG conducted a healthcare inspection after receiving complaints alleging a gynecologist's conduct and language were inappropriate while engaging with women veterans and a nurse chaperone failed to provide support to these patients at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi.<sup>15</sup> The inspection team substantiated that the gynecologist's conduct toward five women veteran patients was unprofessional, unethical, and insensitive, and this undermined the culture of privacy, dignity, and safety promised to all patients. Specifically, in the written complaints regarding the gynecologist's misconduct, patients said he was disrespectful; made rude, vulgar, and offensive comments and jokes during examinations and appointments; cut patients off or would not let them speak; and spoke negatively of other facility providers' care. The patients said they felt defeated, numb, anxious, sad, angry, traumatized, powerless, violated, afraid, and alone.

The OIG found VHA had not incorporated key strategies, such as trauma-informed care and sensitive examination policies, into training, policy, and practice, to advance health care for women veteran patients.<sup>16</sup> The team concluded that patients, particularly those with a history of trauma such as MST, or a mental health condition such as depression, anxiety, or PTSD, would benefit from care delivered by health providers who use trauma-informed care principles.

The team also substantiated that the nurse chaperone did not provide support to or advocate for the five patients when the gynecologist engaged in misconduct. The nurse chaperone did not view the conduct as inappropriate and defended the gynecologist's behavior by describing a patient as too sensitive.

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<sup>15</sup> VA OIG, [\*Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi\*](#), February 10, 2021. The OIG also reported on the Montana VA Health Care System's chief of staff, a gynecologist, who practiced without privileges when providing pregnancy care for a patient during her second and third trimesters and did not refer the patient to a community facility equipped to evaluate and manage her obstetric care, placing her and the fetus at risk. The OIG determined facility leaders' oversight did not identify other quality of care concerns, and the facility director twice failed to initiate state licensing board reporting. All 10 recommendations related to ensuring alignment with VHA and facility policies, including those related to privileging, and maternity and pregnancy care; as well as reviewing care deficiencies to identify follow-up needs, processes for ongoing professional practice evaluations, timely completion of administrative actions, and state licensing board reporting remain open. VA OIG, [\*Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena\*](#), February 6, 2024.

<sup>16</sup> Trauma-informed care emphasizes physical, psychological, and emotional safety; honoring patient voice, agency, control, and choice; and minimizing risk of re-traumatization. A sensitive exam is the "evaluation, palpation, physical therapy for, placement of instruments in, or exposure of a patient's genitalia, rectum or breasts." American College Health Association (ACHA) Guidelines, Best Practices for Sensitive Exams, October 2019.

Although VHA policies require the use of chaperones for all sensitive examinations, the policies fall short in outlining the chaperone’s responsibilities, duties, training, or competencies. The lack of specific training regarding the role and expectations of a chaperone may have contributed to the chaperone’s unawareness and insensitivity to the patients’ distress and subsequent deficiencies in support or intervention.

VHA, the VISN, and the facility concurred with the OIG’s six recommendations related to education, tracking patient complaints, reviewing the gynecologist’s conduct and care provided, and reviewing the role and training of providers and chaperones for sensitive exams. Five of the six recommendations have been closed as implemented. However, more than three years from the date the report was published, recommendation 2 remains open pending the release of a chaperone directive in development at VHA.

### **OIG Oversight of VHA’s Mammography Program**

Since the Veterans’ Health Care Amendments of 1983 passed, VHA has provided mammography services to veterans.<sup>17</sup> A mammography program is a distinct subspecialty of the department of radiology functioning within a VA medical facility. According to VHA policy, mammography conducted within VA must meet the requirements of the Mammography Quality Standards Act.<sup>18</sup> Breast cancer is the most diagnosed cancer among women in the United States. Screening and early detection and timely communication with patients may result in improved health and better survival rates.<sup>19</sup>

### ***Delayed Communication of Mammography Results to Patients at the Washington DC VA Medical Center***

In 2021, the OIG performed an inspection focused on allegations that patients were not receiving mammography results as required at the Washington DC VA Medical Center.<sup>20</sup> The inspection was requested by members of the House Committee on Oversight and Reform’s Subcommittee on Government Operations after receiving information that the facility was not in compliance with the VHA policy on communicating exam results and letters to patients.

VHA requires a “lay summary letter” (a written report summary that uses language clearly understood by a layperson) be conveyed to patients from the facility’s Mammography Program within 30 days of a procedure. In addition to lay summary letters, VHA requires that the ordering providers communicate normal mammography results to patients within 14 calendar days and abnormal results within seven

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<sup>17</sup> VHA Directive 1105.03, Mammography Program Procedures and Standards, May 21, 2018.

<sup>18</sup> VHA Directive 1105.03. The Mammography Quality Standards Act sought to ensure all “women have access to quality mammography for the detection of breast cancer in its earliest, most treatable stages.”

<sup>19</sup> “Breast Cancer Facts & Figures,” American Cancer Society, accessed April 26, 2023, <https://www.cancer.org/research/cancer-facts-statistics/breast-cancer-facts-figures.html>.

<sup>20</sup> VA OIG, *Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center*, February 25, 2021.

calendar days of receiving the results. Communication of test results to patients must be documented in the electronic health record.

Following the facility's own internal review, the inspection team completed an independent review of the patients who received mammography exams during the identified time period and found additional mammography exams not identified by the facility's initial review due to errors in diagnostic coding. Facility staff had not consistently entered the appropriate primary diagnostic code for a mammography exam in the electronic health records as required; these exams were later determined to not be abnormal. During its review, the facility identified two patients with clinically significant mammography exams (breast cancer). In an independent review, the OIG identified two additional patients with breast cancer. The OIG determined that all four patients received timely notification of their abnormal results from the ordering provider, while they may not have received the lay summary letters within the required 30-day period. However, the review of other patients revealed that ordering providers did not consistently document patient notification of abnormal mammography results within seven days as required.

The OIG found that the facility mammography program's clerical and administrative functions were not defined in a standard operating procedure manual, and there was inadequate oversight and quality controls for ensuring the lay summary letters were mailed, one avenue for communicating patient test results. Facility leaders also needed to develop a formalized training program for mammography technology staff to make certain that patients are monitored and tracked when experienced facility staff leave employment. Seven recommendations, all closed, were made to ensure the ordering providers notified patients of mammography exam results, a comprehensive standard operating procedure manual for the mammography program was developed and implemented, and a formal mammography technology staff training program was established.

### ***More Progress and Awareness Is Needed to Support the Women's Oncology System of Excellence***

The Making Advances in Mammography and Medical Options for Veterans Act of 2022 required the OIG to report on mammography services and breast cancer care provided to veterans.<sup>21</sup> In meeting this requirement, an OIG team evaluated mammography services delivered through the outpatient settings of randomly selected VA facilities and community providers. The team also assessed the performance of the VA Women's Oncology System of Excellence (WOSE) and breast cancer patients' accessibility to a comprehensive care team, as required by the legislation.

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<sup>21</sup> Making Advances in Mammography and Medical Options for Veterans Act of 2022, Pub. L. No. 117-135, 136 Stat. 1244 (2022) § 106. Currently, this publication is in draft and, consistent with OIG practices, has been reviewed by the Department. This allows VA offices to comment on OIG findings and recommendations, as well as to provide responsive action plans to implement the recommendations. OIG staff are integrating the feedback into the final report before publication. While it is not the OIG's routine practice to testify regarding not-yet-published reports, due to the timing of this hearing and VA having reviewed the draft, the pertinent oversight findings will be generally discussed today.



The OIG evaluation did not identify concerns related to

- patient access to and adequacy of staffing to perform mammograms,
- use of three-dimensional mammography,
- availability and quality of mammogram reports,
- incorporation of mammogram reports into electronic health records,
- timely communication of mammogram results to ordering providers and patients, and
- access to a comprehensive breast cancer care team.

However, the evaluation revealed issues related to WOSE and local cancer registry databases.<sup>22</sup> Most VA facility leaders and staff were unaware of WOSE, and more than two years after its launch, VHA leaders acknowledged there was less progress than they projected. VA facility staff were not entering oncology data into local cancer registry databases in a timely manner.

## **VA MUST IMPROVE THE DELIVERY OF CARE AND BENEFITS TO SURVIVORS OF SEXUAL VIOLENCE AS WELL AS INTIMATE PARTNER VIOLENCE**

Although anyone can experience sexual violence, women make up the overwhelming majority of those targeted.<sup>23</sup> Research estimates that nearly one in two women and one in four men in the United States experience some form of unwanted sexual contact in their lifetime, and approximately one in four women and one in 26 men have experienced completed or attempted rape.<sup>24</sup> Research also suggests that individuals who experience sexual violence are “at risk of a wide range of physical, mental, reproductive, and other health consequences over their lifetime” when compared with those who have

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<sup>22</sup> In October 2020, VA introduced the Women’s Oncology System of Excellence to provide “oncology patients with cutting edge care and access to potentially lifesaving clinical trials.” “VA Creates National Women Veterans Oncology System of Excellence in Fight against Breast Cancer,” October 20, 2020, accessed February 22, 2023, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5549>.

<sup>23</sup> The term “sexual violence” encompasses a range of unwanted sexual contact, characterized by the use of force, manipulation, or coercion, to commit acts of a sexual nature without consent or against a person’s will. Forms of sexual violence include rape, sexual assault, unwanted sexual touching, sexual exploitation, and sexual harassment.

<sup>24</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, “National Intimate Partner and Sexual Violence Survey, 2016/2017 Report on Sexual Violence,” accessed September 18, 2023, <https://www.cdc.gov/violenceprevention/pdf/nisvs/nisvsReportonSexualViolence.pdf>.

not.<sup>25</sup> Even those statistics may be understated as sexual violence is often not reported.<sup>26</sup> Survivors may be reluctant to report sexual violence to law enforcement, seek medical care, or disclose it to family or friends. Commonly cited reasons include fear of not being believed, shame, embarrassment, fear of retaliation, pressure from others, and distrust of law enforcement.<sup>27</sup>

In addition to advancing the services available to women veterans, VA has taken actions to better assist veterans who have experienced MST or intimate partner violence (IPV).<sup>28</sup> Recognizing that sexual assault and IPV often go unreported and that veterans are more likely to disclose having experienced MST or IPV if asked directly, VHA actively screens veterans about these experiences.<sup>29</sup>

The OIG has focused on the importance of appropriate screening and support for victims of sexual violence and IPV, as well as the need for MST benefits claims to be processed accurately and timely by the Veterans Benefits Administration (VBA). Similar to work on women veterans' health care, recent oversight reports have identified the need for additional resources, training, and adherence to existing policy to better support and serve the needs of survivors.

### **An OIG Study on the Use of Health Care and Benefits by Veterans Who Reported Sexual Assault During Military Service**

Last month, the OIG released the results of the first population-based, longitudinal review of VA healthcare and benefits utilization by veterans who reported sexual assault to the Department of Defense (DoD) Sexual Assault Prevention and Response Office (SAPRO) during military service or who later disclosed having experienced MST to a VHA healthcare provider.<sup>30</sup> The OIG assessed the population of

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<sup>25</sup> Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report," accessed February 24, 2022, [https://www.cdc.gov/ViolencePrevention/pdf/NISVS\\_Report2010-a.pdf](https://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf); Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "National Intimate Partner and Sexual Violence Survey, 2016/2017 Report on Sexual Violence," accessed September 18, 2023, <https://www.cdc.gov/violenceprevention/pdf/nisvs/nisvsReportonSexualViolence.pdf>.

<sup>26</sup> US Department of Justice, "Criminal Victimization, 2020," accessed February 24, 2022, <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cv20.pdf>.

<sup>27</sup> National Sexual Violence Resource Center, "About Sexual Assault," accessed February 24, 2022, <https://www.nsvrc.org/>; Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report," accessed February 24, 2022, [https://www.cdc.gov/ViolencePrevention/pdf/NISVS\\_Report2010-a.pdf](https://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf).

<sup>28</sup> VHA defines IPV as violent behavior by a current or former intimate partner that includes physical and sexual violence, psychologically aggressive or coercive acts, and stalking. VHA Directive 1198, *Intimate Partner Violence Assistance Program*, January 24, 2019.

<sup>29</sup> VHA Directive 2000-008, *Sexual Trauma Counseling Section of the Veterans Millennium Health Care Act*; Pub. L. No. 106-117 (RCN-10-0905), February 29, 2000, rescinded March 25, 2005.

<sup>30</sup> VA OIG, [Transition to VA Health Care and Utilization of Benefits for Veterans Who Reported Sexual Assault During Military Service](#), March 14, 2024.

approximately 1.2 million veterans who were discharged from active military service from October 1, 2015, through September 30, 2020.

The data revealed that the 5,101 veterans who reported sexual assault to SAPRO during the review period were more likely to be female, younger, and of a lower pay grade at the time of discharge when compared with those who did not report to SAPRO. The younger age at discharge may explain, in part, the lower pay grades.

The OIG observed that veterans who reported sexual assault to SAPRO were more likely than veterans who did not report to SAPRO to

- apply (and apply sooner) for VA health care;
- use VA health care more frequently, especially mental health care;
- be diagnosed with mental health disorders (rates of PTSD and major depressive disorder were approximately twice as high);
- use vet center counseling services;
- apply (and apply sooner) for education benefits; and
- receive service-connected disability compensation, have a higher service-connected disability rating, and have a mental health disorder component contributing to their service-connected disability rating.

Still, approximately half of the veterans who reported sexual assault to SAPRO did not use VA health care and a third had not received a service-connected disability rating. Future studies may help to examine potential differences between the veterans who reported to SAPRO and accessed or applied for VA health care and benefits and those who did not. The results may help target outreach efforts to those who reported to SAPRO and did not engage with VA. Targeted VA outreach may help these veterans by raising awareness and an understanding of available VA healthcare and benefits resources to address their medical and psychological needs and support their transition into civilian life.

The OIG presented interim results of this review to VBA and DoD. During the presentation, the OIG raised concerns regarding the low rate of veterans who reported sexual assault to SAPRO receiving service-connected disability ratings. Subsequently, a memorandum of agreement was signed by SAPRO and VBA, effective on November 22, 2022. The agreement established a mechanism by which SAPRO provides data from closed unrestricted sexual assault reports to VBA as corroborating evidence to assist with MST-related claims.<sup>31</sup>

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<sup>31</sup> DoD/VBA, “Memorandum of Agreement Between the Department of Defense (DoD) Sexual Assault Prevention and Response Office (SAPRO) and the Department of Veterans Benefits Administration (VBA) for Providing Data to Support Military Sexual Trauma Claims,” VBA-2022-03, November 2022.

The OIG is confident that its review provides valuable information to assist in VA's ongoing efforts to meet the healthcare needs of veterans who experienced sexual assault and MST and support their successful transition from military service to civilian life.

### **Improvements Are Still Needed in Processing MST Claims**

In addition to ensuring that the transition to civilian life is successful and VA conducts outreach about health care services, VA has an obligation to provide veterans who are claiming benefits for MST every opportunity to support their claims. This is especially important given how many incidents are not reported, and how difficult it can be to subsequently produce or validate evidence of the trauma.

In response to this challenge, VBA has established special procedures to help veterans support their claims of PTSD related to MST when they do not have the evidence or documentation usually required to receive benefits. In an August 2018 report, the OIG found that about 49 percent of the MST claims denied between April 1 and September 30, 2017, were not properly processed under VBA procedures.<sup>32</sup> The claims processors had not completed all required actions to obtain and review evidence before making a decision. These premature denials could have resulted in veterans not receiving the benefits they deserved. The OIG made six recommendations intended to help VBA review and correct all prematurely denied MST claims since October 1, 2016, and to better process these claims in the future.

In 2021, an OIG team conducted a follow-up review to determine whether VBA effectively implemented these recommendations and improved how it processed MST claims.<sup>33</sup> The review team found that VBA claims processors did not always follow the policies and procedures for processing MST claims that were updated in response to the OIG's previous report recommendations. This noncompliance occurred because VBA leaders did not effectively implement the recommendations and did not ensure adequate governance over MST claims processing. Overall, the review team estimated that denied MST claims were still not being processed correctly from October 1 to December 31, 2019, and did not find an improvement from the 49 percent error rate noted in the August 2018 report. The OIG concluded that VBA was not properly carrying out recommended changes to assist veterans, and as a result, survivors of MST remain at risk of not receiving the VA benefits to which they are entitled and experiencing additional distress when claims are improperly handled or denied.

Three of the four report recommendations have been closed; however, the OIG team continues to review claims now handled by the MST operations center that VBA set up in response to recommendation 2, which remains open, and will continue to monitor progress until sufficient improvement has been documented to warrant its closure.

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<sup>32</sup> VA OIG, [Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma](#), August 21, 2018.

<sup>33</sup> VA OIG, [Improvements Still Needed in Processing Military Sexual Trauma Claims](#), August 5, 2021.

## **MST and IPV Coordinators Face Barriers in Complying with Program Requirements**

To gather and share pertinent information about VHA's MST and IPV programs, the OIG conducted two separate but similar reviews of medical facilities' compliance with select activities for MST coordinators and requirements for the Intimate Partner Violence Assistance Program (IPVAP), as well as perceived challenges and barriers to compliance.<sup>34</sup>

A review team conducted a national survey to evaluate the duties and perceived challenges of MST and IPV coordinators. An analysis of the survey results and interview information found that failures to more fully protect administrative time, competing role demands, insufficient support staff, and inadequate funding and outreach materials challenged MST coordinators' ability to fulfill their responsibilities. Additionally, over half the facilities did not have the required local IPVAP protocol, which may contribute to leaders' and staff's confusion and lack of knowledge about IPVAP roles, responsibilities, processes, and procedures.

The OIG found that MST and IPVAP coordinators who reported more dedicated time than other coordinators did not necessarily serve at facilities with higher numbers of patients in MST- or IPV-related care. Accordingly, the recommendations called on VHA leaders to determine meaningful guidance for dedicated time assignment calibrated to patient needs as well as MST and IPV coordinators' overall demands.

Most MST and IPVAP coordinators' open text survey and interview responses reflected a sincere commitment to their work, thoughtful consideration of the challenges to successfully and completely fulfilling their roles, and enthusiasm for serving in their capacity. Given the needs of this growing veteran community, the MST and IPVAP coordinator roles are especially critical in establishing and monitoring staff training and promoting a culture of safety to enhance patients' comfort in engaging in screening and treatment.

The OIG recommendation regarding the MST report is now closed. It called on VHA to evaluate for MST coordinators the sufficiency of current guidance and operational status of protecting administrative time; the adequacy of administrative staff support; and funding for outreach, education, and special project resources, with consideration of MST coordinators' responsibilities.

For the IPVAP report, the team made seven recommendations to the under secretary for health related to developing protocols and guidance at medical centers regarding IPVAP coordinators' dedicated time and access to administrative staff support, establishing standardized IPV staff training, developing IPV screening requirements, and evaluating guidance related to the roles and oversight functions of the VISN IPVAP champions and lead coordinators. All recommendations are currently open.

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<sup>34</sup> VA OIG, [Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations](#), August 5, 2021; [Intimate Partner Violence Assistance Program Implementation Status and Barriers to Compliance](#), September 28, 2022.

## **VHA Must Ensure Better Training, Guidance, and Resources Are Available to Manage Emergent Care for Patients Presenting with Acute Sexual Assault**

In December 2023, the OIG evaluated VHA management of the emergent care needs of acute sexual assault survivors.<sup>35</sup> Sexual assault can have medical, psychological, and legal consequences, requiring a coordinated and compassionate response from medical providers and law enforcement officers when survivors seek care. Veterans seeking related care may need two types of healthcare services: (1) an evaluation and treatment of medical and mental health needs and (2) a sexual assault forensic examination. While emergent care for acute sexual assault is a low-frequency event in comparison with other emergency care responses in VA facilities, it is crucial for VHA to handle the survivors' needs properly and sensitively.

The OIG found that because staff did not frequently see patients needing acute sexual assault care, their lack of experience contributed to challenges for VHA facilities such as the following:

- Maintaining staff's procedural knowledge and training
- Garnering adequate facility resources and staying knowledgeable of available community supports
- Providing detailed, facility-specific policy or other guidance

These challenges, along with variability in resource capacity and jurisdictional requirements, highlight the importance of clear, accessible facility-specific policy or other guidance. VHA national program office leaders noted the importance of having enterprise-wide policy to ensure staff are aware of practice guidelines to support both recommended medical treatment and forensic examination protocols that is supplemented by facility procedures tailored to distinct local needs.

The OIG made eight recommendations to the under secretary for health to help improve facility compliance with and local implementation of VHA policy by providing frontline staff with relevant, accessible procedures; local community resources; and jurisdictional requirements to support clinical care and the VA police response to patients with acute sexual assault needs. All recommendations are currently open, and VA's progress will be monitored through the OIG's routine tracking process.

## **CONCLUSION**

The OIG appreciates the opportunity to participate in this hearing, increasing the visibility of its work to women veterans and other stakeholders. We will continue to examine the provision of women's health care and benefits to help ensure that as the population and percentage of women veterans grows, so too does the quality and accessibility of VA's services. The OIG's Women's Health Program is currently conducting a national review to assess maternity care coordinators' workload and fulfillment of duties,

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<sup>35</sup> VA OIG, [\*Greater Compliance with Policies Needed Related to the Management of Emergent Care for Patients Presenting with Acute Sexual Assault\*](#), December 12, 2023.

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with a follow-on review that plans to include the experience of veterans who have received maternity care coordinated by VHA. Staff at VHA have shown a commitment and enthusiasm for providing all the required needs of gender-specific care. However, the reports cited in this statement highlight that there is more work to be done before women veterans are fully supported by the health care and benefits available at VA. Similarly, the OIG audit staff continue to monitor the processing of MST claims for VA benefits that have disproportionately affected women veterans. The OIG is committed to being a voice for survivors and providing the information to VA needed to improve its efforts to better serve women veterans. Chairman Tester, Ranking Member Moran, and members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.