

Senator Jon Tester, Chairman  
Senator Maize K. Hirono, Committee Member  
Committee on Veterans' Affairs

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#### Experiences Associated with VA Healthcare

I retired from the United States Air Force after 32-years of honorable service to the State of Hawaii and the United States of America on 30 September 2015. I filed my claim through the State Office of Veterans' Services, E Building, Tripler Hospital and began my medical journey with the Hawaii Veterans' Administration healthcare in 2016. I received medical care from the Veterans' Administration until 2021. I requested use of Community of Care due to anxiety and PTSD issues exacerbated by VA's lack of patient care.

From the onset, I was beleaguered with numerous sets of problems or roadblocks. I was placed into the Women's Healthcare program and assigned to Dr. Li, who became my Primary Care Provider (PCP). After my first visit, I was instructed to bring my healthcare directive and other legal documents to the VA for entry into my medical records. Documents were dropped off at the reception area on the 2<sup>nd</sup> floor. I was instructed to sign VA documents, which requested medical records from my civilian medical provider for inclusion into my VA medical records. Somewhere along the way my documents were misplaced or lost. My records were never found; therefore, I was asked to resubmit a second set of documents. When I went to the 2<sup>nd</sup> floor to submit, I asked that my records be updated while I waited, to ensure it would not be lost again. I received terse responses when I insisted upon waiting for the update.

Prior to VA's website offering appointments and messages to my PCP it was difficult to reach my PCP. I would have to call several times and leave messages before I was able to speak

to someone and make an appointment. One instance is captured in a secure message sent to my PCP on 21 Jan 2020. I received my 1<sup>st</sup> Shingrix shot on 12/28/19. Normally, before you leave the follow-up, in this case my 2<sup>nd</sup> Shingrix shot would be scheduled. However, the schedule was not available on that day. I was instructed to call back and set up an appointment. I called several times and left messages with no return call; therefore, I secure messaged and received a response from a staff member on 01/23/20. The staff member made my appointment for my 2<sup>nd</sup> shot on 01/28/20. I showed up for my appointment and was turned away because the 2<sup>nd</sup> shot must be done 2-6 months after the 1<sup>st</sup> shot. Waste of sick leave and my time!

On one occasion, I was the first appointment of the day and as customary of a military member, I arrived ahead of my appointment. I checked in at 0800hrs for my 0830 appointment. I sat in the Women's Health Center waiting area for my scheduled appointment. The waiting area is outside the clinic reception area and outside the doctor's office. Entrance to both was locked and secured. The staff asked that I leave the area and wait in the hallway because they were going to a staff meeting. I asked if I could stay in the waiting area because the chair supported my injured back. I was told no. All other clinics do not ask patients to leave the waiting room and wait in the hallway. Only the Women's Health Clinic!

I received poor patient care on a Saturday appointment. My appointment was at 0800hrs, yet I was not seen until after 0900hrs. There was no courtesy extended to me and I had to ask why I was waiting so long. I realized why I waited so long after I saw her briskly walking into the clinic. If I was late for an appointment I would have to reschedule, and my record would state "no show". There seemed to be a disparity between patient care/courtesy and staff responsibility.

Each time I saw my PCP and she reviewed my medical prescriptions in the VA system would halt/terminate. The first time it happened I reasoned that it was a fluke, a system error. However, when there is a pattern of my prescriptions terminating each time I see my PCP something is wrong! My last visit with my PCP was in December 2020 via virtual appointment. Again, my prescription dropped from the VA system. After several calls and secure messages via the VA website, I finally got my refills. It was painful and needless! Anxiety sets in every time I had to see my PCP or deal with the VA. Nothing seems to go right at the VA!

My PCP referred me to a therapist because I suffered an assault during my time in the military. I was seen by Dr. Cabinte and was diagnosed as suffering from PTSD. I was allowed only a few sessions with her and was told I could continue but with a male therapist. I asked for a referral because it would be uncomfortable speaking to a man about the events that led to my PTSD. Referral took approximately four months to consummate. It seems to me that mental health is not an important issue for female veterans. I am glad that I was granted Community of Care services.

The concept of healthcare for women veterans is noteworthy, however, I don't feel Hawaii has a viable program that meets those needs. I feel that there is a lack of empathy, compassion, and care for women veterans. I am very happy with my Community of Care provider. I pray that it continues.

Thank you for allowing me the opportunity to share my experiences with the Senate Committee on Veterans' Affairs.