



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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*BEFORE THE*  
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS AND  
SUBCOMMITTEE ON HEALTH  
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS  
*HEARING ON*  
SUPPORTING SURVIVORS: ASSESSING VA'S MILITARY SEXUAL TRAUMA PROGRAMS  
NOVEMBER 17, 2021

Chairwomen Luria and Brownley, Ranking Members Nehls and Bergman, and members of the subcommittees, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the Department of Veterans Affairs' (VA's) policies and procedures related to providing benefits and health care to veterans who have experienced military sexual trauma (MST). The mission of the OIG is to help improve the efficiency and effectiveness of VA's programs and operations through independent audits, inspections, evaluations, reviews, and investigations. In support of that mission, the OIG has made many recommendations to improve the provision of benefits and healthcare services to the survivors of MST.

It is estimated that two of every three sexual assaults suffered during military service, affecting both men and women, go unreported for a variety of reasons to include concerns of confidentiality, retaliation using performance reports, and the perception that the military chain of command will be unresponsive. Unfortunately, these problems have persisted despite efforts to make it easier for service members to report such incidents.<sup>1</sup> As a result, evidence of the trauma can be difficult to subsequently produce or validate. This lack of contemporaneous reporting creates a special challenge for VA when veterans file benefit claims or seek services for posttraumatic stress disorder (PTSD) related to MST.

This testimony will review multiple OIG reports dating back to 2010 detailing the failures in providing disability compensation benefits and healthcare services to veterans who have experienced MST during their service. In a December 2010 report, the OIG determined a lack of specialized training for claims processors contributed to their inconsistent evaluation and processing of MST-related claims filed by women veterans.<sup>2</sup> In an August 2018 report, the OIG identified several processing deficiencies that led to the premature denial of nearly half of denied MST-related claims reviewed due to the lack of

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<sup>1</sup> Department of Defense, Annual Report on Sexual Assault in the Military: Fiscal Year 2021, May 13, 2021.

<sup>2</sup> VA OIG, [Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits](#), December 16, 2010.

specialization, inadequate staff training, inadequate internal controls, and discontinued focus reviews.<sup>3</sup> In an August 2021 report, the OIG determined that the Veterans Benefits Administration's (VBA's) claims processors were still not following the policies and procedures updated in response to the OIG's August 2018 recommendations for processing MST-related claims.<sup>4</sup> In another August 2021 report, the OIG determined that a number of MST coordinators at VA medical facilities were unable to fulfill their roles and responsibilities due to insufficiently protected administrative time, role demands, support staff, and inadequate funding and outreach materials.<sup>5</sup> It is imperative that VA improve its processes and practices that provide compensation and healthcare services to those who have experienced MST during their military service in order to ensure that those seeking care are not retraumatized and their needs are met.

## BACKGROUND

VA uses the term “military sexual trauma” to refer to sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurred while a veteran was serving on active duty or active duty for training.<sup>6</sup> VA defines MST as a “psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.”<sup>7</sup>

MST is an experience, not a diagnosis or a mental health condition. VA reports that its medical record data indicate other frequently associated diagnoses include depression and other mood or substance use disorders, in addition to PTSD.<sup>8</sup> Psychological trauma, such as MST, also increases risk of physical health conditions, such as cardiovascular disease, stroke, and diabetes.<sup>9</sup> In addition to poorer psychological and physical health, female veterans with a history of MST receiving VA health care report more readjustment problems after military discharge, such as difficulties finding employment. MST experiences commonly evoke emotional reactions of anger, guilt, self-blame, and shame. Further,

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<sup>3</sup> VA OIG, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, August 21, 2018.

<sup>4</sup> VA OIG, *Improvements Still Needed in Processing Military Sexual Trauma Claims*, August 5, 2021.

<sup>5</sup> VA OIG, *Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations*, August 5, 2021.

<sup>6</sup> VHA Directive 1115, Military Sexual Trauma (MST) Program, May 8, 2018.

<sup>7</sup> VA, Military Sexual Trauma, November 2020, accessed November 10, 2020, [https://www.mentalhealth.va.gov/docs/mst\\_general\\_factsheet.pdf](https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf)

<sup>8</sup> Military Sexual Trauma, [https://www.mentalhealth.va.gov/docs/mst\\_general\\_factsheet.pdf](https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf).

<sup>9</sup> Harvard Health Publishing, Harvard Medical School, Harvard Women's Health Watch, Past trauma may haunt your future health, accessed February 11, 2021, <https://www.health.harvard.edu/diseases-and-conditions/past-trauma-may-haunt-your-future-health>.

individuals with MST histories may have difficulty trusting others and have problems in interpersonal relationships.<sup>10</sup>

## **VETERANS BENEFITS ADMINISTRATION ACTIONS ON MST-RELATED PTSD CLAIMS**

VBA's process for handling MST claims is complex and involves several levels of employees in its regional offices. Each VA regional office (VARO) has two MST coordinators—one male and one female. They are designated as the local points of contact for veterans with MST-related claims. Upon receipt of an MST-related claim, a veterans service representative (VSR) must send a letter to the veteran to determine whether the veteran reported the claimed traumatic event in service, and if so, determine how it was reported and how to obtain this evidence. If the assault was reported, the veteran is asked to supply the report or provide the name of the military base where the report was filed. If not reported, the VSR reviews other evidence, such as behavioral markers or in-service treatment for mental health symptoms.

VSRs are VARO employees whose duties include determining what evidence is necessary to decide an MST-related claim, undertaking development actions to obtain necessary evidence, and determining when a claim is ready for decision. Once obtained, VSRs must thoroughly review all evidence to confirm the stressor or identify behavior markers for MST. A marker is an indicator of the effect or consequences of the personal trauma on the veteran. If the evidence shows possible PTSD symptoms or a current diagnosis, credible evidence of the stressor, or a single marker for MST, the VSR must request a medical examination. The purpose of this examination is to provide a report that includes a medical diagnosis, if warranted, and an opinion about whether the diagnosis is related to the claimed sexual assault or harassment.

The claim evidence and exam results are then sent to a rating veterans service representative (RVSR), who are also VARO employees, with the authority to make formal decisions on veterans' claims. Before RVSRs can decide a veteran's MST-related claim, they must ensure that all required steps were completed. These steps include executing the procedures for obtaining the veteran's complete military personnel file; thoroughly reviewing all evidence, including the personnel file and service medical records for potential behavioral markers; and requesting a medical examination. Once RVSRs determine that all appropriate procedures have been completed, they evaluate the evidence and make a decision on the veteran's claim. RVSRs may deny an MST-related claim without requiring a medical examination only if there is no credible evidence of a stressor, no evidence of a behavioral marker, or no evidence of symptoms of a mental disorder.

Although VA took some corrective actions based on the OIG's first two reports, the most recent report published in 2021 indicates that additional action is needed to address the OIG's findings and make

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<sup>10</sup> "Military Sexual Trauma: Issues in Caring for Veterans," VA National Center for PTSD, accessed March 29, 2021, [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)

improvements to MST-related claims processing. In 2010, the OIG identified deficiencies in evaluating and processing MST claims and recommended that VBA conduct specialized training and an analysis of the consistency in which MST claims were processed. As a result, VBA implemented special focused quality improvement reviews of MST-related claims and directed VA regional offices to designate MST specialists beginning in 2011. Those measures, while intended to be a positive step, did not resolve ongoing concerns.

### **Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma**

In August 2018, the OIG reported that nearly half of denied MST-related claims were not properly processed following VBA policy and procedures.<sup>11</sup> At the time of the OIG review, VBA reported staff processed approximately 12,000 MST-related claims in fiscal year (FY) 2017 and about 5,500 of those claims (46 percent) were denied. The OIG sampled 169 MST-related claims from a population of 2,851 completed claims that VBA staff denied and completed from April 1, 2017 through September 30, 2017. VBA staff were found to have incorrectly processed 82 of the 169 MST-reviewed claims. Based on these results, the OIG estimated that VBA did not properly process approximately 1,300 of the 2,700 denied MST-related claims (49 percent). This is significant as improperly denied claims are likely to result in undue stress for veterans whose needs remain unmet.

The OIG audit team identified several deficiencies that led to the improper denial of benefits, such as lack of specialization, inadequate MST-related claim-processing training for VBA staff, deficient internal controls, and discontinued special focused reviews. As a result of insufficient implementation of prior corrective action plans, the OIG made six recommendations to the under secretary for benefits:

1. To review all denied MST-related claims since the beginning of FY 2017, determine whether all required procedures were followed, take corrective action based on the results of the review, render a new decision as appropriate, and report the results back to the OIG.
2. To focus processing of MST-related claims to a specialized group of VSRs and RVSRs.
3. To require an additional level of review for all denied MST-related claims and hold the second-level reviewers accountable for accuracy.
4. To resume conducting special focused quality improvement reviews of denied MST-related claims and take corrective action as needed.
5. To update the current training for processing MST-related claims, monitor the effectiveness of the training, and take additional actions as necessary.
6. To update the development checklist for MST-related claims to include specific steps claims processors must take in evaluating such claims in accordance with applicable regulations and

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<sup>11</sup> VA OIG, [Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma](#), August 21, 2018.

require claims processors to certify that they completed all required development action for each MST-related claim.

VBA concurred with all six recommendations and provided acceptable action plans. Through the follow-up process, the OIG agreed to close recommendations 2, 3, 5, and 6. Closing a recommendation means that VBA took its planned action but does not necessarily assess whether the implementation achieved the desired result. The OIG also closed recommendations 1 and 4, but as *unimplemented*, after concerns were again raised about VBA's processing of MST-related claims in the OIG's follow-up review that was published in 2021. Those recommendations were considered and reflected in the follow-up report.

### **Improvements Still Needed in Processing Military Sexual Trauma Related Claims**

Given the importance of this topic and VBA's inability to show sustained improvements, the OIG conducted a follow-up review. In August 2021, the OIG published *Improvements Still Needed in Processing Military Sexual Trauma Claims*, which found VBA did not effectively implement the OIG's August 2018 recommendations, leading to continued deficiencies with MST-related claims processing.<sup>12</sup>

Recommendation implementation was ineffective in part because VBA did not adequately manage the MST-related claims process or provide sufficient oversight to confirm deficiencies identified in the OIG's August 2018 report were corrected. In addition, VBA's governance did not ensure the Compensation Service and the Office of Field Operations communicated effectively to resolve claims-processing deficiencies and was not making certain that managers and claims processors were held accountable for adhering to updated VBA policies and procedures.

The following discusses each of the 2018 recommendations and the follow-up results of the second 2021 audit review.

- **Recommendation 1:** VBA was to review all denied MST-related claims starting October 1, 2016, to determine whether all required procedures were followed, take corrective action, render new decisions as appropriate, and report its actions to the OIG. VBA established a standard operating procedure for reviewing previously denied claims and in September 2019 reported that about 80 percent of the claims reviewed did not require correction. However, based on a statistical sample of claims that VBA reported that did not require correction, the OIG follow-up review team estimated that about 31 percent did indeed have processing deficiencies that resulted in premature denial of benefits.
- **Recommendation 2:** VBA was to require that all MST-related claims were to be handled by a specialized group of trained personnel. VBA issued this mandate which took effect on November 27, 2018. However, the OIG examined claims after VBA implemented the

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<sup>12</sup> VA OIG, [Improvements Still Needed in Processing Military Sexual Trauma Claims](#), August 5, 2021.

recommendations and found noncompliance with this requirement. Based on a statistical sample of 75 claims, the follow-up team estimated about 80 percent denied from October 1 through December 31, 2019, were at least partially processed by VBA employees *not* designated as MST claims processors.

- **Recommendation 3:** All denied MST-related claims were to receive an additional level of review, and VBA was to hold second-level reviewers accountable for accuracy. In response, VBA required that MST claim decisions made by RVSRs undergo a second-level review until the employees demonstrated competency in processing the claims. However, based on a review of a sample of claims processed after that response, the OIG follow-up team estimated that about 73 percent requiring a second-level review did not receive one.
- **Recommendation 4:** VBA was to conduct special focused quality improvement reviews of denied MST-related claims and take corrective action as needed. In November 2019, VBA's special focused review assessed 197 denied claims from May to June 2019 and reported an 85 percent accuracy rate in claims processing. However, the OIG's follow-up review of the claims sampled from this special focused review found errors VBA missed in 13 of 14 claims. Additionally, for 86 percent of the claims that VBA quality assurance staff reported as accurate, the follow-up review team found the quality staff had identified procedural errors but did not report those errors when they conveyed their final results.
- **Recommendation 5:** Training updates were recommended for MST-related claims processors, with monitoring to assess effectiveness. VBA updated the training courses and required all designated claims processors to complete them before processing claims. The follow-up review team examined a statistical sample of claims processed after VBA responded to this recommendation and estimated about 80 percent denied during that period were at least partially processed by staff who had not completed the required training.
- **Recommendation 6:** VBA was to update its MST-related claims development checklists to include evaluative steps that claims processors must take, in accordance with applicable regulations. In October 2018, it developed two checklists and a worksheet to help VBA employees identify MST markers and complete other required processing steps. However, the OIG found claims in which processors failed to complete one or more of the required checklists and the worksheet. The team's review of a sample of claims processed after VBA responded to this recommendation revealed about 51 percent denied from October 1 through December 31, 2019, did not contain the required checklists or worksheet.

### ***VBA Leaders Did Not Establish Adequate Governance of MST Claims Processing***

Although VBA took steps to implement each of the OIG's recommendations from the August 2018 report, VBA did not monitor those steps to make sure they resulted in the accurate processing of MST-related claims. The OIG found this was caused by inadequate governance of the processing of such

claims.<sup>13</sup> Governance is particularly difficult when oversight responsibility is shared among multiple offices for complex processes, as is the case for VBA managers within the Compensation Service, the Office of Field Operations, and the regional offices. Communication among these offices is essential to the successful management of processing MST-related claims.

When VBA attempted to reevaluate the 82 denied claims identified in the OIG's 2018 review, a lack of communication was evident between these three offices that also caused a breakdown in the reevaluation process. For example, the Compensation Service did not share error summaries with the Office of Field Operations. The Office of Field Operations did not follow up with regional offices to ensure errors were corrected. This lack of communication caused VBA claims processors to report no development deficiencies in the prior 82 denied claims they deemed correct.

### ***VBA Staff Continued to Incorrectly Process Denied MST Claims***

Based on a sample of claims processed after VBA was to have implemented prior OIG recommendations, the follow-up review team estimated about 620 of 1,100 denied claims (57 percent) were incorrectly processed from October 1 to December 31, 2019. That rate reflects a decided lack of improvement from the 49 percent error rate noted in the August 2018 report. The OIG concluded that VBA has not effectively and fully addressed or sustained previous corrective actions to OIG recommendations designed to improve MST claims processing.

### **OIG Recommendations from 2021**

The OIG made four recommendations to the acting under secretary for benefits focused on the areas of governance, processes, and communication.<sup>14</sup>

- **Recommendation 1:** Establish and implement a formal procedure to ensure all processing errors on claims identified by the review team are corrected and report the results to the OIG.
- **Recommendation 2:** Develop, implement, and monitor a written plan to address continuing MST claims-processing deficiencies identified by the review team, including reassessing previously decided claims when appropriate, and report the results to the OIG.
- **Recommendation 3:** Strengthen controls to effectively implement and promote compliance with 2018 OIG report recommendations related to MST claims.

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<sup>13</sup> VA Directive 0214, Enterprise Governance Structure Process, May 14, 2019, Governance refers to how VA leaders make decisions, provide strategic direction, and maintain accountability in a transparent and collaborative manner. It enables informed decision-making based on current strategic objectives, VA's accepted risk tolerance, and responsible resource allocation.

<sup>14</sup> VA OIG, [\*Improvements Still Needed in Processing Military Sexual Trauma Claims\*](#), August 5, 2021.

- **Recommendation 4:** Develop, implement, and monitor a written plan that requires Compensation Service and the Office of Field Operations to strengthen communication, oversight, and accountability of MST claims processing.

VBA concurred with the recommendations and provided acceptable action plans. The OIG follow-up process started on November 4, 2021 when we requested an update from VBA on the status of the recommendations. Additionally, the OIG’s website has a recommendation dashboard that provides information on the status of recommendations for ongoing monitoring.<sup>15</sup>

## VETERANS HEALTH ADMINISTRATION MST COORDINATORS

As previously stated, sexual trauma experienced while serving in the military affects both men and women with potentially serious and long-term consequences. The Department of Defense reported “progress reducing sexual assault and increasing help-seeking and reporting between 2006 and 2016.”<sup>16</sup> The Department of Defense reported 6,236 reports of sexual assault in FY 2019, an increase of 3 percent compared to FY 2018.<sup>17</sup>

The VHA Office of Mental Health and Suicide Prevention oversees and provides funding for the national MST Support Team (see appendix A for the organizational chart). The MST Support Team assists with establishing national policy; promoting best practices; monitoring and expanding education and outreach efforts; and communicating directly with Veterans Integrated Service Network (VISN) points of contact (POC), MST coordinators, and VA staff to provide consultation, resources, and training.<sup>18</sup> VISN-level POCs dedicated to addressing MST should be knowledgeable about mental health and informed about MST and treatment of its aftereffects.<sup>19</sup> At the facility level, there is an MST coordinator who “should be a licensed credentialed clinician or otherwise have extensive knowledge of issues arising in the clinical care of MST survivors.”<sup>20</sup> Their responsibilities include: (1) support implementation of national and VISN MST-related care policies, (2) serve as a point of contact for patient and staff on MST issues, (3) establish and monitor MST-related staff training and informational outreach to the facility and community, (4) develop partnerships within the facility to support MST-related care and education, and (5) provide ongoing communication with national, VISN, and facility-

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<sup>15</sup> [VA OIG Dashboard](#).

<sup>16</sup> Department of Defense, *Fiscal Year 2019 Annual Report on Sexual Assault in the Military*, April 30, 2020.

<sup>17</sup> Department of Defense, *Fiscal Year 2019 Annual Report on Sexual Assault in the Military*, April 30, 2020; Department of Defense News Release, “[Department of Defense Releases Annual Report on Sexual Assault in the Military](#),” April 30, 2020. The Department of Defense notes that the increase in reported sexual assaults from October 1, 2018, to September 30, 2019, “cannot be characterized as an increase in the prevalence of the crime of sexual assault within the military, as an active duty prevalence survey was not conducted...”

<sup>18</sup> VHA Directive 1115.

<sup>19</sup> VHA Directive 1115.

<sup>20</sup> VHA Directive 1115.

level leadership and other stakeholders.<sup>21</sup> Funding for facility MST coordinators and programs is incorporated into broader facility healthcare costs and facility leaders determine how to allocate those funds.

Since 2000, VA has mandated that every veteran seen for VA health care be screened for MST experiences.<sup>22</sup> VA provides free treatment for veterans and most former service members with Other Than Honorable discharges with MST-related physical or mental health conditions. Veterans do not need a VA disability compensation rating or documentation of MST experiences to access MST-related care.<sup>23</sup>

Of those receiving VHA care from October 1, 2019, through September 30, 2020, 32.4 percent (141,365) of female veterans and 1.9 percent (77,309) of male veterans reported experiencing sexual trauma while serving in the military. During the same time period, 77 percent of those who screened positive had a VHA MST-related outpatient encounter and over 50 percent of the veterans participated in a mental healthcare encounter. In January 2021, VHA reported that over the prior 10 years, the number of female and male veterans receiving MST-related outpatient mental health care increased by 158 percent and 110 percent, respectively.<sup>24</sup>

Individuals with MST histories may have difficulty trusting others, and given the needs of this growing veteran community, the MST coordinator role is especially critical in establishing and monitoring staff training and promoting a culture of safety to enhance patients' comfort with engaging in screening and treatment. VHA staff who provide MST-related care are required to receive a one-time "training necessary to provide sensitive, appropriate, and high-quality services to MST survivors, and to conduct regular outreach to inform Veterans."<sup>25</sup> All MST coordinators, care providers, registered nurses, and licensed practical or vocational nurses in mental health and primary care services must complete a web-based MST training.<sup>26</sup>

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<sup>21</sup> VHA Directive 1115.

<sup>22</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 VHA Directive 2000-008 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 was typically identified as the initiation of the screening requirement.

<sup>23</sup> For purposes of this testimony, the OIG will use the term *veterans* to refer to individuals seeking MST-related care.

<sup>24</sup> Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Memorandum, Military Sexual Trauma Reports, Fiscal Year (FY) 2020, January 15, 2021.

<sup>25</sup> VHA Directive 1115.

<sup>26</sup> VHA Directive 1115.01, Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers, April 14, 2017, amended May 8, 2020. New mental health and primary care staff are required to complete the MST training within 90 days of employment.

During the OIG's reviews of selected VA medical centers for the FY 2019 Comprehensive Healthcare Inspection Program, the assigned teams evaluated facilities' compliance with selected VHA requirements related to MST, including (1) processes carried out by MST coordinators, (2) provision of care to patients after positive screening, and (3) completion of mandatory staff training. To accomplish this at 43 randomly selected facilities, OIG inspectors reviewed the electronic health records of 1,903 patients who had a positive MST screen from July 1, 2017, through June 30, 2018. They also conducted interviews and reviewed relevant facility documents and training records.

In its annual summary report, the OIG noted overall compliance with several selected VHA requirements regarding MST coordinators and their activities, including informational outreach and tracking of MST-related data. However, the OIG identified deficiencies related to MST coordinators' establishment and monitoring of MST-related training and communication with facility leaders regarding relevant issues, services, and initiatives. Additionally, the OIG found that 199 of 465 primary care and mental health clinical staff across the 43 facilities had not completed required MST training.<sup>27</sup> The OIG made three recommendations to the under secretary of health, working with the VISN directors. Currently one recommendation remains open related to ensuring mental health and primary care staff complete mandatory military sexual trauma training within the required time frame. The VA provided a target completion date of June 2021.

### **Challenges for Military Sexual Trauma Coordinators and Culture of Safety Consideration**

Following a hearing before the Committee's Women Veterans Task Force and its Subcommittee on Oversight and Investigations in February 2020, the OIG conducted a review of select activities and challenges of VHA's MST coordinators.<sup>28</sup> The OIG also reviewed specific aspects of the culture of safety for patients requesting MST-related care.<sup>29</sup>

The OIG conducted a national survey to evaluate the duties and perceived challenges of MST coordinators. The survey was distributed to 158 MST coordinators in August 2020 and completed by 136 of them. The OIG also conducted telephone interviews with 18 MST coordinators at select facilities across VHA to include rural and urban locations, as well as diverse facility sizes with varying complexity levels. Interview questions focused on the adequacy of time allotted to the MST coordinator

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<sup>27</sup> VA OIG, [Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019](#), November 24, 2020.

<sup>28</sup> Subcommittee on Oversight and Investigations and Women Veterans Task Force, Committee on Veterans Affairs, U.S. House of Representatives, Hearing on [Examining How the Department of Veterans Affairs Supports Survivors of Military Sexual Trauma](#), February 5, 2020, accessed February 8, 2021

<sup>29</sup> [Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations](#), August 5, 2021. For the purpose of this OIG report, "culture of safety" refers to a healthcare environment that identifies and honors patient preferences, as available, and promotes a comfortable physical environment.

role, procedures for honoring a veterans' gender preference for their assigned MST treatment provider, and the physical environment where a veteran receives care.

Based on the analysis of the survey results and interview information, the OIG found that a number of factors impeded MST coordinators' ability to fulfill their role and responsibilities. They included insufficiently protected administrative time, role demands, not enough support staff, and inadequate funding and outreach materials.

### ***Challenges to MST Coordinator Responsibilities***

Of the 136 MST coordinators who responded to the OIG survey, 53 reported that they did not have adequate resources to fulfill their coordinator responsibilities to include dedicated time, administrative support assistance, funding, and program materials. The challenges identified in the report relate to the splintering of governance responsibilities, confusion about roles, and lack of clear guidance, which undermine VA's well-intentioned goals and objectives.

Importantly, the OIG also found that MST coordinators who reported more dedicated time than others did not necessarily serve at facilities with higher numbers of patients in MST-related care. For example, an MST coordinator serving in a facility with one of the largest populations of patients receiving MST-related care reported dedicated time of only 0.3 full-time employee equivalent or 30 percent. Accordingly, the OIG recommended that VHA leaders determine meaningful guidance for dedicating coordinators' time that takes into consideration patient needs and MST coordinator role demands.

### ***Culture of Safety Considerations***

VHA requires MST-related services be provided "in a gender-sensitive manner," with accommodations made to honor patient preference for gender-specific treatment providers, and treatment environments sensitive to gender-related concerns.<sup>30</sup>

The 18 interviewed MST coordinators reported that the waiting and treatment areas were not separated solely for MST-related care but were located within clinical areas, such as mental health and primary care. MST coordinators reported that the most commonly received patient complaint was discomfort in having to wait in an area with patients of the opposite gender. Patients who expressed discomfort with the waiting area were reportedly accommodated with an acceptable alternative waiting space, such as an empty office or hallway.

### ***OIG Recommendation in 2021 VHA Report***

The OIG made one recommendation that the acting under secretary for health evaluate the sufficiency of current guidance and operational status regarding MST coordinators' protected administrative time; administrative staff support; and funding for outreach, education, and special project resources—taking into consideration the MST coordinators' responsibilities. He was also called on to take corrective action

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<sup>30</sup> VHA Directive 1115.

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as warranted. VA concurred with the recommendation and provided a target completion date of May 2022. The OIG follow-up process began on November 4, 2021, when we requested an update from VHA on the status of recommendation's implementation.

## **CONCLUSION**

The OIG will continue to provide oversight on these and other processes that have a significant impact on veterans who have suffered trauma during their military service. It is imperative that VA provide disability compensation benefits and healthcare services to all eligible individuals requesting them. These services should be delivered promptly, efficiently, and with sensitivity. Although VBA has expressed a strong commitment to addressing deficiencies identified by the OIG through numerous audit reviews, it has fallen short in effectively implementing the recommendations. VA's failure to fully and consistently sustain improvements that address OIG recommendations can also discourage others from stepping forward to report sexual assault or harassment that occurred during their service or seek subsequent assistance. Accordingly, the OIG remains committed to monitoring the care and services provided to those who have suffered MST.

Chairwomen Luria and Brownley, Ranking Members Nehls and Bergman, and members of the subcommittees, this concludes my statement. I would be happy to answer any questions you may have.

## APPENDIX A: MST GOVERNANCE STRUCTURE WITHIN VHA

