DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of select activities and challenges of Veterans Health Administration (VHA) Military Sexual Trauma (MST) Coordinators and Veterans Integrated Service Network (VISN) Points of Contact (POCs) in response to a request from Congressman Chris Pappas, Chairman of the House Veterans' Affairs' Subcommittee on Oversight and Investigations, and Congresswoman Julia Brownley, Chairwoman of the Women Veterans Task Force. The OIG also reviewed the culture of safety for patients requesting MST-related care.[1] The purpose of the review was to gather pertinent information about the VHA MST Program.

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."[2] However, prevalence data indicated an increase in sexual assaults of women servicemembers from October 1, 2017, through September 30, 2018. The Department of Defense reported 6,236 reports of sexual assault from October 1, 2018, through September 30, 2019, an increase of 3 percent compared to the prior year.[3]

VA defines MST as a "psychological trauma, which in the judgment of a mental health professional employed by the Department [of VA], resulted from a physical assault of a

[1] For the purposes of this OIG report, a culture of safety refers to a healthcare environment that identifies and honors patient preferences, as available, and promotes a comfortable physical environment.

[2] Department of Defense Fiscal Year 2019 Annual Report on Sexual Assault in the Military, accessed February 15, 2021, https://media.defense.gov/2020/Apr/30/2002291660/-1/-1/1/1_DEPARTMENT_OF_DEFENSE_FISCAL_YEAR_2019_ANNUAL_REPORT_ON_SEXUAL_ASSAULT_IN_THE_MILITARY.PDF.

[3] Department of Defense Fiscal Year 2019 Annual Report on Sexual Assault in the Military, accessed February 11, 2021, https://media.defense.gov/2020/Apr/30/2002291660/-1/-1/1/1_DEPARTMENT_OF_DEFENSE_FISCAL_YEAR_2019_ANNUAL_REPORT_ON_SEXUAL_ASSAULT_IN_THE_MILITARY.PDF. New Release, "Department of Defense Releases Annual Report on Sexual Assault in the Military," April 30, 2020, accessed February 11, 2021, https://www.defense.gov/Newsroom/Releases/Release/Article/2170913/department-of-defense-releases-fiscal-year-2019-annual-report-on-sexual-assault/source/GovDelivery/. 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…."

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."[4]

MST is an experience, not a mental health condition or diagnosis. Although posttraumatic stress disorder (PTSD) is commonly associated with MST, other frequently associated diagnoses include depression and other mood disorders and substance use disorders.[5] Psychological trauma, such as MST, also increases risk of physical health conditions such as cardiovascular disease, stroke, and diabetes.[6] 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, individuals with MST histories may have difficulty trusting others and have problems in interpersonal relationships.[7]

Since 2000, VA requires that every veteran seen for VA health care is screened for MST experiences.[8] 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.[9]

Of those receiving VHA care from October 1, 2019, through September 30, 2020, 32.4 percent (141,365) female veterans and 1.9 percent (77,309) male veterans reported experiencing sexual trauma while serving in the military. During the same time period, 77 percent of those who

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[4] VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018. On January 5, 2021, 38 U.S.C. § 1720D, Counseling and Treatment for Sexual Trauma, was amended pursuant to P.L. 116-315, modifying the definition of MST to "…a condition, which in the judgment of a health care professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the former member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination…" Likewise, the definition of sexual harassment under 38 USC § 1720D was modified to mean, "unsolicited verbal or physical contact of a sexual nature which is threatening in character." accessed May 11, 2021, https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1720D&num=0&edition=prelim.

[5] VA, *Military Sexual Trauma,* November 2020, accessed November 10, 2020, https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

[6] 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.

[7] "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.

[8] 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 was typically identified as the initiation of the screening requirement.

[9] For purposes of this report, the OIG will use the term veterans to refer to individuals seeking MST-related care.

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.[10]

The VHA Office of Mental Health and Suicide Prevention oversees the national MST Support Team.[11] MST Support Team leaders reported that funding for facility-level MST programs was incorporated into broader facility healthcare costs and that the allocation of funds was determined by facility leaders. VHA requires that each facility have a designated MST Coordinator who "should be a licensed credentialed clinician or otherwise have extensive knowledge of issues arising in the clinical care of MST survivors." The MST Coordinator "must be given protected time, typically at least" 0.2 full-time equivalent employee dedicated to the MST program responsibilities.[12]

The OIG conducted a national survey to evaluate the duties and perceived challenges of MST Coordinators. The 136 (86 percent) of the 158 MST Coordinators who responded to the survey reported a range of dedicated time for the role, with approximately 80 percent assigned 0.2 full-time employee equivalent or more of protected time. Of the 136 MST Coordinators, 53 (39 percent) reported that they did not have adequate resources to fulfill their MST Coordinator administrative responsibilities. The OIG also interviewed 18 MST Coordinators. Based on the analysis of the survey results and interview information, the OIG found that insufficient protected administrative time, role demands, insufficient support staff, and inadequate funding and outreach materials challenged MST Coordinators' ability to fulfill role responsibilities.

The OIG found that MST Coordinators who reported more dedicated time than other MST Coordinators 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 population of patients receiving MST-related care, reported dedicated time of 0.3 full-time employee equivalent or 30 percent. Given the absence of a logical relationship between the MST Coordinators' dedicated time and the number of patients who are engaged in MST-related care, the OIG recommended that VHA leaders determine meaningful guidance for dedicated time assignment in the context of patient needs and MST Coordinator role demands.

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[10] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Memorandum*, Military Sexual Trauma Reports, Fiscal Year (FY) 2020,* January 15, 2021.

[11] VHA Directive 1115.

[12] VHA Directive 1115. The 0.2 full-time employee equivalent position is equal to eight hours per week or 16 hours per pay period. A 0.2 full-time employee equivalent equates to 20 percent of the employee's work hours being dedicated to that duty.

Of the 18 MST Coordinators interviewed, 14 reported they were the sole MST Coordinator for their facility.[13] Twelve of the 14 MST Coordinators indicated that they did not have enough time to fulfill all the requirements of the MST Coordinator role. VHA requires that the dedicated administrative time for MST Coordinator responsibilities be independent of other duties, including provision of MST-related clinical care.[14] Five of the 18 MST Coordinators specifically noted that clinical and other assigned duties interfered with the time to complete MST-related administrative duties.

Of the 136 MST Coordinators who responded to the survey, 50 (37 percent) reported having administrative assistance and 86 (63 percent) reported not having administrative assistance to support their MST Coordinator responsibilities. Approximately one third (32 percent) of the 53 MST Coordinators who reported inadequate resources noted that the addition of administrative support would be helpful.

VHA requires that MST Coordinators "be provided with additional [full-time equivalent employee]/dedicated administrative time if a facility determines that all MST Clinical Reminder-initiated referrals for MST-related care will be sent to the MST Coordinator."[15] Twelve of the 18 interviewed MST Coordinators reported that their facility used consults for MST-related care referrals and 9 of the 12 MST Coordinators indicated that they managed the referral process.

Of the 53 MST Coordinators who reported inadequate resources, 15 (28 percent) described a lack of funding and program materials for outreach, education, and special projects. As a result of the inadequate funding, MST Coordinators described challenges with providing events and materials including canceling Sexual Assault Awareness Month events, using their own money to fund initiatives, relying on other departments to fund MST-related projects, lacking handouts and signage, and requesting donations for events.

The 18 MST Coordinators interviewed described consideration of culture of safety issues such as patient gender-specific preferences for MST-related care providers, as well as accommodations to foster comfort in the facility's physical environment. Due to the coronavirus (COVID-19) pandemic, the OIG team was unable to conduct planned site visits to evaluate physical

[13] The OIG did not include MST Coordinators who were the only staff assigned to the role but whose site included use of other staff as points of contact or champions for MST-related administrative duties.

[14] VHA Directive 1115.

[15] VHA Directive 1115.

environments and related culture of safety aspects.[16] Twelve MST Coordinators provided photographs that reflected adherence to COVID-19 safety guidelines, such as six-foot separation distance floor markers and increased spacing between chairs.[17]

The OIG found that most MST Coordinators' open text survey entries and interview responses reflected a sincere commitment to the role, thoughtful consideration about challenges to fulfilling the role successfully and completely, and enthusiasm about serving in this capacity. 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 in screening and treatment engagement.

The OIG made one recommendation to the Under Secretary for Health to evaluate the sufficiency of current guidance and operational status regarding protected administrative time, administrative staff support, and funding for outreach, education, and special project resources, with consideration of MST Coordinators' responsibilities, and take action as warranted.

Comments

The Acting Under Secretary for Health concurred with the recommendation and provided an acceptable action plan (see appendix B). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

[16] World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," March 11, 2020, accessed November 10, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. Merriam Webster, Definition of pandemic, accessed November 10, 2020, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. The World Health Organization, Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It, accessed November 10, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[17] Photographs did not include any personally identifying information or personal health information. Although one MST Coordinator was excluded from the interview, the OIG team reviewed the photographs submitted and included for this review. Given the OIG's awareness that many staff were working remotely due to the pandemic, the OIG did not repeat the request for photographs from the seven MST Coordinators who did not provide them.

Contents

Executive Summary i

Abbreviations vii

Introduction 1

Scope and Methodology 10

Survey Development and Distribution 10

Survey Analysis 11

Results 12

1. Challenges to MST Coordinator Responsibilities 12

2. Culture of Safety Considerations 16

Conclusion 17

Recommendation 19

Appendix A: MST Coordinator Surveys Not Submitted by Facility 20

Appendix B: Under Secretary for Health Memorandum 21

OIG Contact and Staff Acknowledgments 24

Report Distribution 25

Abbreviations

MST	military sexual trauma
OIG	Office of Inspector General
POC	point of contact
PTSD	posttraumatic stress disorder
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a review of select activities and challenges of Veterans Health Administration (VHA) Military Sexual Trauma (MST) Coordinators and Veterans Integrated Service Network (VISN) Points of Contact (POCs) in response to a request from Congressman Chris Pappas, Chairman of the House Veterans' Affairs' Subcommittee on Oversight and Investigations, and Congresswoman Julia Brownley, Chairwoman of the Women Veterans Task Force. The OIG also reviewed the culture of safety for patients requesting MST-related care.[1] The purpose of the review was to gather pertinent information about the VHA MST Program.

Background

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."[2] However, prevalence data indicated an increase in sexual assaults of women servicemembers from October 1, 2017, through September 30, 2018. The Department of Defense reported 6,236 reports of sexual assault from October 1, 2018, through September 30, 2019, an increase of 3 percent compared to the prior year.[3] In 2019, the Department of Defense launched "the Prevention Plan of Action – a comprehensive approach to reducing and stopping sexual assault" and additional confidential reporting procedures.[4]

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[1] For the purposes of this OIG report, a culture of safety refers to a healthcare environment that identifies and honors patient preferences, as available, and promotes a comfortable physical environment.

[2] Department of Defense Fiscal Year 2019 Annual Report on Sexual Assault in the Military, accessed February 15, 2021, https://media.defense.gov/2020/Apr/30/2002291660/-1/-1/1/1_DEPARTMENT_OF_DEFENSE_FISCAL_YEAR_2019_ANNUAL_REPORT_ON_SEXUAL_ASSAULT_IN_THE_MILITARY.PDF.

[3] Department of Defense Fiscal Year 2019 Annual Report on Sexual Assault in the Military, accessed February 15, 2021, https://media.defense.gov/2020/Apr/30/2002291660/-1/-1/1/1_DEPARTMENT_OF_DEFENSE_FISCAL_YEAR_2019_ANNUAL_REPORT_ON_SEXUAL_ASSAULT_IN_THE_MILITARY.PDF. New Release, "Department of Defense Releases Annual Report on Sexual Assault in the Military," April 30, 2020, accessed February 11, 2021, https://www.defense.gov/Newsroom/Releases/Release/Article/2170913/department-of-defense-releases-fiscal-year-2019-annual-report-on-sexual-assault/source/GovDelivery/. 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...."

[4] New Release, "Department of Defense Releases Annual Report on Sexual Assault in the Military," April 30, 2020, accessed February 11, 2021, https://www.defense.gov/Newsroom/Releases/Release/Article/2170913/department-of-defense-releases-fiscal-year-2019-annual-report-on-sexual-assault/source/GovDelivery/.

VA defines MST as

> a psychological trauma, which in the judgment of a mental health professional employed by the Department [of VA], 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.[5]

MST is an experience, not a mental health condition or diagnosis. Although posttraumatic stress disorder (PTSD) is commonly associated with MST, other frequently associated diagnoses include depression and other mood disorders and substance use disorders.[6] Psychological trauma, such as MST, also increases risk of physical health conditions such as cardiovascular disease, stroke, and diabetes.[7] 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, individuals with MST histories may have difficulty trusting others and have problems in interpersonal relationships.[8]

VA Response

In 1992, Congress began passing a series of laws that provided outreach and MST counseling and treatment programs for women veterans who experienced sexual trauma while on active duty.[9] In 1994, these services where extended to men who experienced MST.[10] The Veterans Health Program Improvement Act of 2004 permanently extended VA's authority and added MST

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[5] VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018. On January 5, 2021, 38 U.S.C. § 1720D, Counseling and Treatment for Sexual Trauma, was amended pursuant to P.L. 116-315, modifying the definition of MST to, "a condition, which in the judgment of a health care professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the former member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination." Likewise, the definition of sexual harassment under 38 USC § 1720D was modified to mean, "unsolicited verbal or physical contact of a sexual nature which is threatening in character." accessed May 11, 2021, https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1720D&num=0&edition=prelim.

[6] VA, *Military Sexual Trauma,* November 2020, accessed November 10, 2020, https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

[7] 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.

[8] "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.

[9] 38 U.S.C. § 101 note. *Women Veterans Health Programs Act of 1992*, (Public Law 102-585), accessed May 11, 2021, https://www.govinfo.gov/content/pkg/STATUTE-106/pdf/STATUTE-106-Pg4943.pdf.

[10] 38 U.S.C. § 101 note. *Veterans Health Programs Extension Act of 1994*. (Public Law 103-452), accessed May 11, 2021, https://www.congress.gov/103/statute/STATUTE-108/STATUTE-108-Pg4783.pdf.

counseling and related treatment to veterans who experience sexual trauma while serving on active duty or if service was in the National Guard or Reserves (active duty for training)[11] (see figure 1).

Figure 1. Key MST-related legislation and VHA policies.
Source: OIG review of legislation and VHA policies.

[11] 38 U.S.C. § 101 note. *Veterans Health Programs Improvement Act of 2004.* (Public Law 108-422), accessed November 18, 2020, https://www.gpo.gov/fdsys/pkg/PLAW-108publ422/pdf/PLAW-108publ422.pdf.

Since 2000, VA requires that every veteran seen for VA healthcare is screened for MST experiences.[12] VA reports that approximately "1 in 3 women and 1 in 50 men" screen positively for MST.[13] 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.[14]

MST-related outpatient care is available at every VA medical center, "many" community-based outpatient clinics, and counseling is available at Vet Centers.[15] VA also offers more intensive MST-related treatment in residential and inpatient programs, some of which are gender-specific. Veterans can access MST-related care various ways including through primary care, the facility's MST Coordinator, or a Vet Center.[16]

Of those receiving VHA care from October 1, 2019, through September 30, 2020, 32.4 percent (141,365) female veterans and 1.9 percent (77,309) 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.[17]

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."[18] All MST Coordinators, providers, registered nurses, and licensed practical or vocational nurses in mental health and primary care services must complete

[12] 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.

[13] VA, *Military Sexual Trauma,* accessed November 10, 2020, https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf.

[14] For purposes of this report, the OIG will use the term veterans to refer to individuals seeking MST-related care.

[15] VA, *Military sexual trauma (MST)*, accessed February 10, 2021, https://www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/.

[16] VA, *Military sexual trauma (MST)*, accessed February 10, 2021, https://www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/.

[17] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Memorandum*, Military Sexual Trauma Reports, Fiscal Year (FY) 2020,* January 15, 2021.

[18] VHA Directive 1115.

a web-based MST training.[19] As discussed below, in an annual summary report, the OIG identified deficiencies related to staff completion and monitoring of MST-related training during October 1, 2018, through September 30, 2019.[20]

Each Veterans Benefits Administration (VBA) regional office is expected to designate two MST Outreach Coordinators, a male and a female, who are trained to assist veterans who have experienced MST with disability compensation or other types of VBA claim submissions.[21] In fiscal years 2019 and 2020, VBA received 21,678 and 20,285 MST-related mental health disability compensation claims for conditions such as anxiety and depression, respectively.[22] Partly in response to a 2018 OIG report, legislation was passed in December 2020 to require VBA to establish specialized teams to process compensation claims for MST-related mental health conditions and to submit an annual report on MST claims that tracks the "consistency of decisions" across the 14 VBA regional offices.[23]

MST Program Structure

The VHA Office of Mental Health and Suicide Prevention oversees the national MST Support Team[24] (see figure 2 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 VISN POCs, MST Coordinators, and VA staff to provide consultation, resources, and training.[25] MST Support Team leaders told the OIG that since fall 2006, the Office of Mental Health and Suicide Prevention provided funding for the

[19] 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.

[20] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020.

[21] VBA oversees disability compensation, "a tax-free monetary benefit paid to Veterans with disabilities that are the result of a disease or injury incurred or aggravated during active duty military service." VA, VBA, About VBA, accessed March 9, 2021, https://www.benefits.va.gov/BENEFITS/about.asp. Statement of Willie C. Clark, Sr., Deputy Under Secretary for Field Operations, VBA, VA, Before the Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations, U.S. House of Representatives, February 5, 2020, accessed February 15, 2021, https://www.congress.gov/116/meeting/house/110426/witnesses/HHRG-116-VR08-Wstate-ClarkW-20200205.pdf.

[22] A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2019 began on October 1, 2018, and ended on September 30, 2019, and fiscal year 2020 began on October 1, 2019, and ended on September 30, 2020. VA/VHA Employee Health Promotion Disease Prevention Guidebook, VA Finance Terms and Definitions, July 2011, accessed April 13, 2021, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

[23] Press Releases, Pingree's Initiatives to Support Survivors of Military Sexual Trauma, Veterans with Dementia Pass U.S. House, Washington, December 16, 2020, accessed February 15, 2021, https://pingree.house.gov/news/documentsingle.aspx?DocumentID=3569.

[24] VHA Directive 1115.

[25] VHA Directive 1115.

MST Support Team. MST Support Team leaders reported that funding for the facility-level MST Program was incorporated into broader facility healthcare costs and that the allocation of funds was determined by facility leaders.

Each VISN is required to designate a VISN-level MST POC who is "knowledgeable about mental health and informed about MST and treatment of its after effects."[26] The VISN POC is a collateral position with dedicated administrative time to fulfill the responsibilities of the role that includes implementing and monitoring of national- and VISN-level MST policies, and providing support and communication opportunities to MST Coordinators within the VISN.[27]

VHA facility directors are responsible to ensure the appointment of a designated MST Coordinator, which can be a collateral position.[28] VHA requires that each facility have a designated MST Coordinator who "should be a licensed credentialed clinician or otherwise have extensive knowledge of issues arising in the clinical care of MST survivors." The MST Coordinator "must be given protected time, typically at least" 0.2 full-time equivalent employee, as discussed below.[29]

[26] VHA Directive 1115.

[27] VHA Directive 1115.

[28] VHA Directive 1115.

[29] VHA Directive 1115. The 0.2 full-time employee equivalent position is equal to eight hours per week or 16 hours per pay period. A 0.2 full-time employee equivalent equates to 20 percent of the employee's work hours being dedicated to that duty.

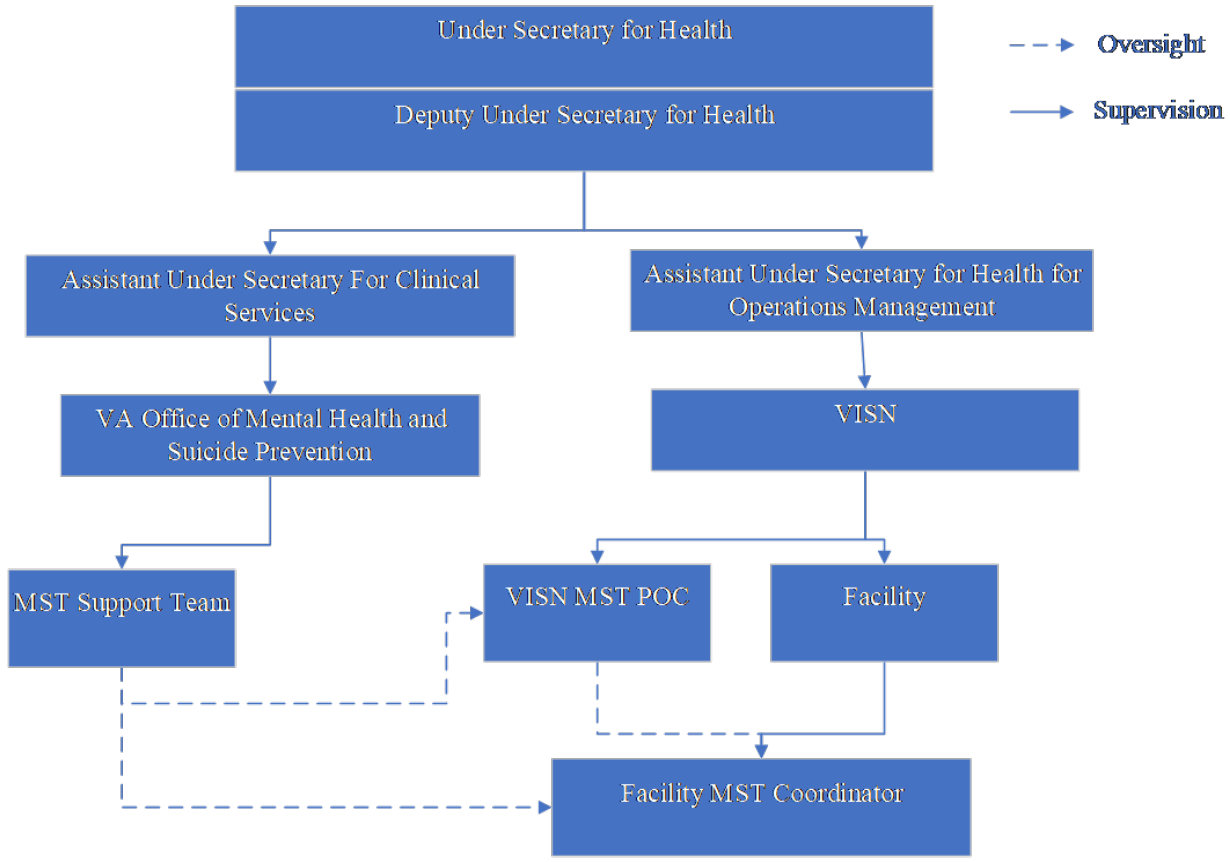

Figure 2. VHA MST Program Organizational Structure.
Source: OIG analysis of VHA Directive 1115 and VHA Organization Chart, July 1, 2020, and OIG interviews with the MST Support Team.

MST Coordinators are responsible to

- support the implementation of national and VISN MST-related care policies,
- serve as the POC for patient and staff MST issues,
- establish and monitor MST-related staff training and informational outreach to the facility and community,
- develop partnerships within the facility to support MST-related care and education, and
- provide ongoing communication with "national, VISN, and facility-level leadership" and other stakeholders.[30]

As discussed above, individuals with MST experiences may feel ashamed, fearful, and mistrustful, and these emotional responses may prevent disclosure. As such, staff sensitivity and

[30] VHA Directive 1115.

specialty training in screening and treatment is critical.[31] In addition to the MST Coordinator's direct support and outreach to patients, the MST Coordinator is critical in establishing and monitoring staff training in screening and treatment to enhance sensitivity and skills to address patients' MST-related care needs. This essential role responsibility contributes to the MST Coordinators' overall goal of promoting a culture of safety to foster patients' trust and comfort in MST-related disclosures and treatment.

MST Support Team

The MST Support Team is comprised of 9.6 full-time equivalent employees.[32] The MST Support Team budgets for fiscal years 2018, 2019, and 2020 were $1,440,502, $1,465,728, and $1,522,473, respectively.[33] The MST Support Team assists with establishing national policy; promoting best practices; conducting national monitoring; expanding education; and providing consultation, training, and resources to MST Coordinators, VISN POCs, and VA staff.[34] The National Deputy Director for MST also stated that it is the MST Support Team's responsibility to assist VA Central Office Congressional requests and stakeholder inquiries.

The MST Support Team sends new MST Coordinators and VISN POCs an orientation email that includes resources for getting started in the role, tips for success, national requirements, and the national MST data dashboard. Additionally, the MST Support Team provides MST Coordinators with

- resources to encourage local outreach and education, such as ribbons for MST awareness month,
- bimonthly training calls,
- an annual conference, and
- linkage to other MST Coordinators in their VISN.

Facility leaders determine how to structure the MST Coordinator role and multiple models have been developed at the facility level to address local MST Program needs, such as assigning select role responsibilities or specific facility locations between more than one MST Coordinator and

[31] "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.

[32] VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017. A full-time equivalent represents the hours worked by an employee in a normal 80-hour pay period. The value ranges from 0.0 to 1.0, with 1.0 representing 80 hours worked in a two-week pay period.

[33] The information provided in this report section is based on interviews with the MST Support Team. The OIG did not independently verify the information. Fiscal year 2018 began on October 1, 2017, and ended on September 30, 2018.

[34] VHA Directive 1115.

assigning MST champions or POCs to serve as on-site representatives, most often in community-based outpatient clinics.

Prior OIG Reports and Congressional Hearing

In a 2018 report, the OIG found that VBA staff did not properly process "nearly half of denied MST-related claims," that may result in the denial of benefits to eligible veterans.[35] As of mid-February 2021, three of the six recommendations remained open. The open recommendations included taking corrective actions following (1) the review of all denied MST-related claims, (2) a focused quality improvement review of denied MST-related, and (3) an update of training for processing MST-related claims and training effectiveness monitoring.

In an annual summary report, the OIG noted compliance with several selected VHA requirements regarding MST Coordinators and their activities including informational outreach and tracking MST-related data. However, the OIG identified deficiencies related to staff completion and monitoring of MST-related trainings and communication with facility leaders regarding MST-related issues, services, and initiatives.[36]

In a February 2020 House Veterans Affairs Committee hearing on VA response to MST, the Deputy Assistant Inspector General of the Office of Healthcare Inspections reported the above-mentioned OIG work that identified deficiencies in claims processing, staff training, and communication with facility leaders. The Deputy Assistant Inspector General of the Office of Healthcare Inspections asserted that the OIG "will continue to monitor all efforts to improve the care and services provided to veterans who have suffered MST."[37]

[35] VA OIG, *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, Report No. 17-05248-241, August 21, 2018. A subsequent VA OIG report, *PTSD Claims Processing Training and Guidance Need Improvement*, Report No. 20-00608-29, December 9, 2020, estimated that VBA improperly processed 16 percent of PTSD claims unrelated to MST.

[36] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020.

[37] Statement of Julie Kroviak, MD, Deputy Assistant Inspector General for Healthcare Inspections, VA OIG, before the 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, https://www.congress.gov/116/meeting/house/110426/witnesses/HHRG-116-VR08-Wstate-KroviakJ-20200205.pdf.

Scope and Methodology

The OIG team conducted a national survey of MST Coordinators and VISN POCs as well as virtual interviews of the MST Support Team and select MST Coordinators.[38] The OIG did not independently review the survey results to assess the validity of the reported data. The OIG team also reviewed relevant VHA policies related to the MST Program, MST Coordinators, VISN POCs, and the provision of MST-related care.

Survey Development and Distribution

The OIG conducted a national survey to evaluate the duties and perceived challenges of MST Coordinators and VISN POCs. Separate surveys were disseminated depending on respondents' roles as either a facility MST Coordinator or a VISN POC.

The MST Coordinator survey requested information regarding time served in the MST Coordinator role and dedicated time assigned to the role. Additional MST Coordinator questions focused on non-clinical duties, availability of administrative assistance, and adequacy of resources to fulfill the role responsibilities. The OIG also inquired about VISN POC meetings with MST Coordinators.

The OIG distributed the survey to 158 MST Coordinators and 18 VISN POCs on August 10, 2020, with a due date of August 21, 2020.[39] The survey was completed by 136 (86 percent) of the 158 MST Coordinators, and 17 of the 18 VISN POCs.[40] (See appendix A for the facilities that did not submit an MST Coordinator survey.) Among those VHA listed as facility MST Coordinators, 18 were also identified as the corresponding VISN POC, and were asked to complete a survey for each role.

[38] The interviews were conducted virtually due to the coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," March 11, 2020, accessed November 10, 2020, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020. Merriam Webster, Definition of pandemic, accessed November 10, 2020, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. The World Health Organization, Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It, accessed November 10, 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

[39] The MST Support Team provided a list of medical center MST Coordinators for 140 sites. Of the 140 sites, 13 sites included more than one MST Coordinator. Five of the 13 sites listed 3 MST Coordinators, and all the listed MST Coordinators each submitted a survey. For the remaining eight sites, two MST Coordinators were listed and both MST Coordinators responded for five sites, one site submitted one survey, and two sites did not submit a survey.

[40] The VISN 20 POC did not respond to the survey.

Survey Analysis

The OIG analyzed survey responses by calculating the frequency of closed-ended responses to questions to determine respondents' perspectives on select aspects of the MST Coordinator and VISN POC roles and duties. The OIG also reviewed survey free-text responses to further understand respondents' perspectives, specifically the explanations from facility MST Coordinators who indicated that they did not have adequate resources to fulfill their responsibilities. The OIG assigned the individual responses to one or more of the identified resource categories that emerged.

MST Coordinator Interviews

The OIG conducted telephone interviews with 18 MST Coordinators at select facilities across VHA to assess the culture of safety for patients receiving MST-related care.[41]

Interview sites were selected to include rural and urban geographic locations and diverse facility sizes and complexity levels.[42] Interview sites represented 18 facilities and 14 VISNs. The average patient population of the sites was 57,506 with a range from 18,905 to 137,653. Three facilities were in rural areas and 15 in urban settings. The VHA-designated complexity levels of the 18 facilities included 10 high, 3 medium, and 5 low.

Interview questions inquired about the adequacy of time allotted to the MST Coordinator role, assessment and procedures for honoring veterans gender preference request of the assigned MST treatment provider, and the physical environment. Due to the pandemic, the OIG team was unable to conduct planned site visits to evaluate the physical environment and related culture of safety aspects. Given this limitation, the interviewed MST Coordinators were asked to provide photographs of signage and waiting areas for MST-related care.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1105, as amended (codified at 5 United States Code (U.S.C.) App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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[41] The OIG excluded one interview from this review due to the MST Coordinator's recent VHA employment and inability to respond to most interview questions.

[42] VHA Office of Productivity, Efficiency, & Staffing, *Facility Complexity Model*, accessed January 22, 2021, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. VHA's Facility Complexity Model is a data driven model that relies on data to identify workload and programs at each facility for the purposes of comparing complexity based on workload and programs at each facility.

Results

Based on the analysis of the survey results and interview information, the OIG found that insufficient protected administrative time, role demands, insufficient support staff, and inadequate funding and outreach materials challenged the MST Coordinators' ability to fulfill role responsibilities. The 18 interviewed MST Coordinators described consideration of culture of safety issues such as patient gender-specific preferences for MST-related care providers, as well as accommodations to foster comfort in the facility's physical environment. Twelve of the 19 MST Coordinators provided photographs that reflected adherence to COVID-19 safety guidelines, such as six-foot separation distance floor markers and increased spacing between chairs.

1. Challenges to MST Coordinator Responsibilities

The 136 MST Coordinators who responded to the survey served in the role for an average of four years, ranging from 8 days to 20 years. Eighty percent of MST Coordinators reported being the sole MST Coordinator for the facility.[43] The OIG found that the majority of MST Coordinators' open text survey entries and interview responses reflected a sincere commitment to the role, thoughtful consideration about challenges to fulfilling the role successfully and completely, and enthusiasm about serving in this capacity.

Of the 136 MST Coordinators, 53 (39 percent) reported that they did not have adequate resources to fulfill their MST Coordinator administrative responsibilities. Figure 3 illustrates the three resources most frequently identified as inadequate by the 53 MST Coordinators.

[43] One of the 136 MST Coordinators did not respond to this survey item and therefore, the OIG calculated these results based on 135 respondents.

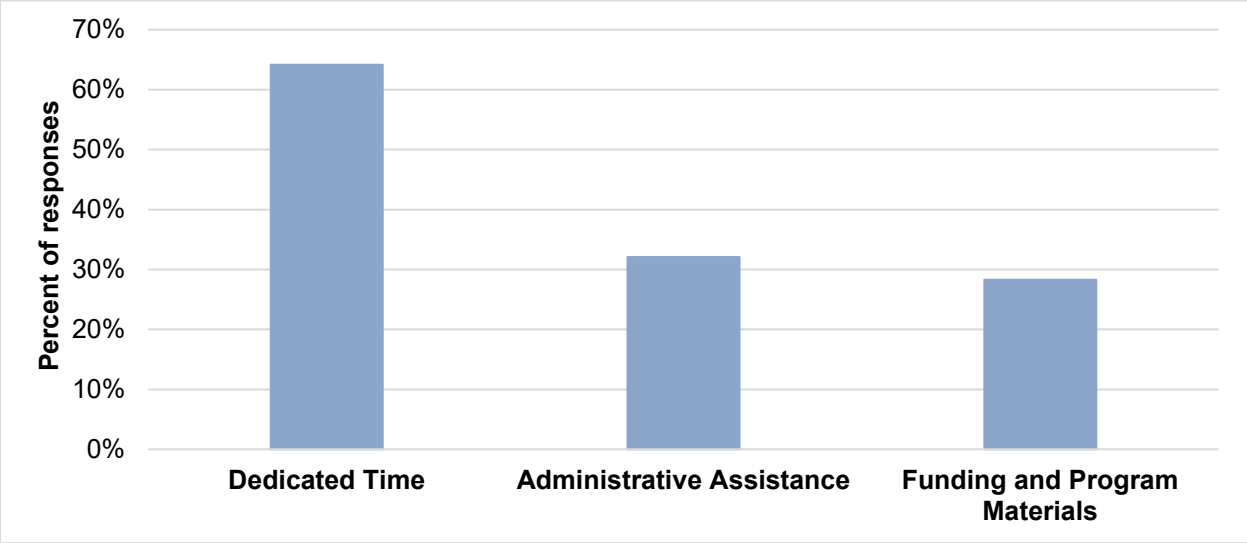

Figure 3. Inadequate resources identified by MST Coordinators.
Source: OIG analysis of the MST Coordinator survey.

Insufficient Protected Administrative Time

MST Coordinators "must be given protected time, typically at least" 0.2 full-time equivalent employee, "specifically dedicated" to perform the administrative responsibilities of the role.[44] Facility leaders are responsible to determine the dedicated time needed by the MST Coordinator to fulfill administrative duties "based on factors, such as facility size and complexity, number of associated [community-based outpatient clinics], the size of the facility's catchment area, and the number of Veterans in the local patient population who have experienced MST."[45] As noted in figure 3, over half (64 percent) of the 53 respondents who reported inadequate resources identified insufficient protected time to fulfill MST Coordinator responsibilities. MST Coordinators specified that additional time would allow them to provide more MST-related services and programs.

The OIG analyzed the relationship between the MST Coordinators' reported dedicated time and the number of patients seen at their corresponding facilities in fiscal year 2020. The OIG found that MST Coordinators who reported more dedicated time 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 30 percent (see figure 4). Given the absence of a logical relationship between the MST Coordinators' dedicated time and the number of patients who are engaged in

[44] VHA Directive 1115. For the purposes of this report, the OIG uses the terms *protected time* and *dedicated time* interchangeably.
[45] VHA Directive 1115.

MST-related care, the OIG recommended that VHA leaders determine meaningful guidance for dedicated time assignment in the context of patient needs and MST Coordinator role demands.

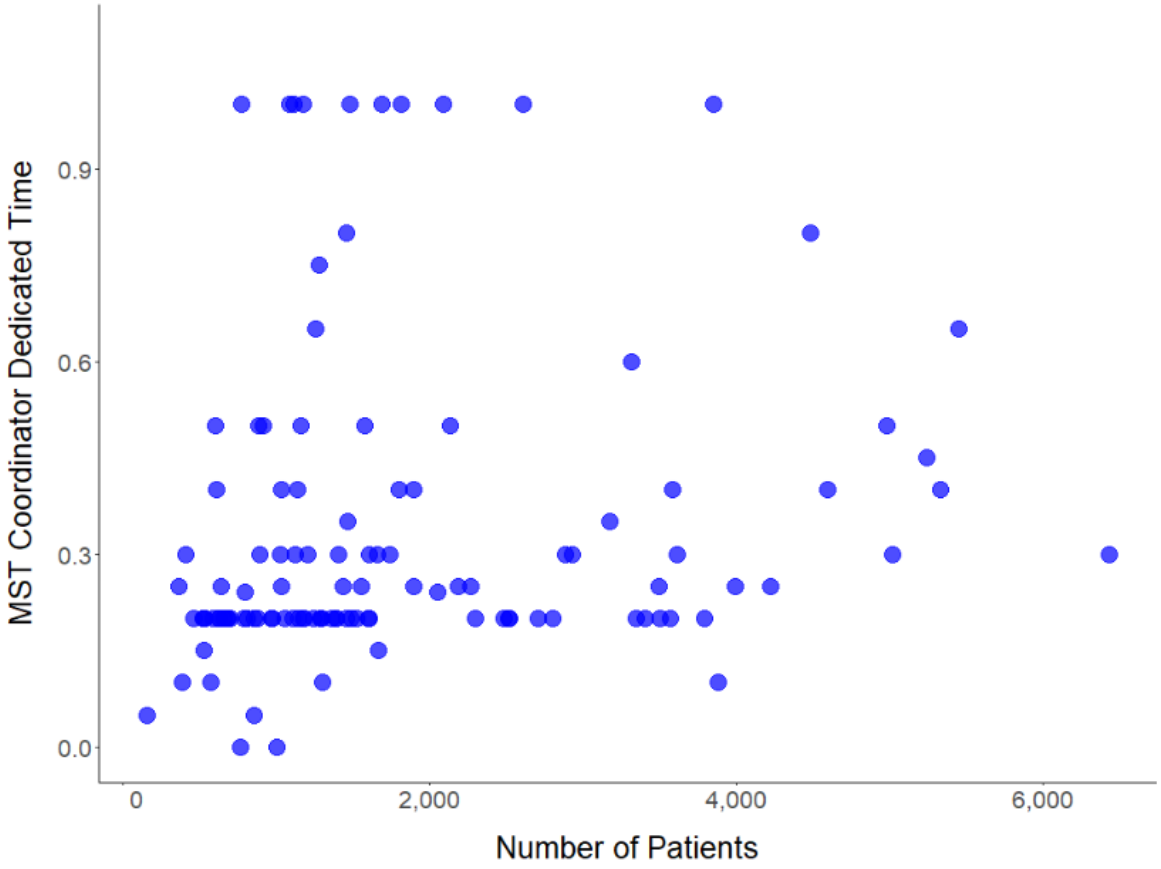

Figure 4. Dedicated time for MST Coordinator role and number of patients at corresponding VHA facilities. Source: OIG analysis of MST Coordinator survey data and VHA Support Service Center data.

Of the 18 interviewed MST Coordinators, 14 reported they were the sole MST Coordinator for their facility.[46] Twelve of the 14 MST Coordinators indicated that they did not have enough time to fulfill all the requirements of the MST Coordinator role. However, MST Coordinators also noted that being the single point of contact was likely less confusing for staff and patients to readily identify them as the facility resource for MST-related information.

VHA requires that the dedicated administrative time for MST Coordinator responsibilities be independent of other duties, including provision of MST-related clinical care.[47] Five of the 18 MST Coordinators specifically noted that clinical and other assigned duties interfered with

[46] The OIG did not include MST Coordinators who were the only staff assigned to the role but whose site included use of other staff as points of contact or champions for MST-related administrative duties.

[47] VHA Directive 1115.

the time to complete MST-related administrative duties. Interviewed MST Coordinators told the OIG that they provided direct patient care in general mental health, Women's Health, and PTSD clinics.[48] MST Coordinators also reported additional collateral duties, such as Intimate Partner Violence Assistance Program Coordinator, Women's Health Champion, and Tele-Mental Health Champion.

Role Demands and Insufficient Support Staff

In the survey, MST Coordinators identified the administrative duties they performed in the MST Coordinator role (see table 1).

Table 1. MST Coordinator Reported Administrative Duties

Administrative Duty	Percentage of MST Coordinators Who Reported Performing Duty
Provision of Education to Staff	96
Provision of Education to Patients	93
Care Coordination	93
Outreach to Patients and Veterans	90
Outreach to Staff	89
Scheduling Care Appointments	45

Source: OIG analysis of MST Coordinator survey responses.

Of the 136 MST Coordinators who responded to the survey, 50 (37 percent) reported having administrative assistance and 86 (63 percent) reported not having administrative assistance to support their MST Coordinator responsibilities. Approximately one third (32 percent) of the 53 MST Coordinators who reported inadequate resources noted that the addition of administrative support would be helpful.

VHA requires that MST Coordinators "be provided with additional [full-time equivalent employee]/dedicated administrative time if a facility determines that all MST Clinical Reminder-initiated referrals for MST-related care will be sent to the MST Coordinator."[49] Although not directly asked in the survey, three MST Coordinators added the comment that MST-related care referral management duties were a factor in inadequate time for the role.

Further, 12 of the 18 interviewed MST Coordinators reported that their site used consults for MST-related care referrals and 9 of the 12 MST Coordinators indicated that they managed the referral process. One of those nine MST Coordinators who managed the referral process was

[48] The 18 MST Coordinators interviewed included nine psychologists, eight social workers, and one mental health professional counselor.

[49] VHA Directive 1115.

assigned 100 percent dedicated time to the role while the others had dedicated time that ranged from 20 percent to 50 percent.[50] On the survey, two of the nine MST Coordinators reported inadequate resources to fulfill responsibilities, but in the OIG interview, seven of the nine acknowledged insufficient time to complete the duties of the role. Given that the 20 percent dedicated time is a guideline and not a requirement, the OIG was unable to determine whether these MST Coordinators were provided with additional dedicated time to manage the referral process, as required by VHA.[51]

Inadequate Funding and Outreach Materials

Of the 53 MST Coordinators, 15 (28 percent) described a lack of funding and program materials for outreach, education, and special projects. As a result of the inadequate funding, MST Coordinators described challenges with providing events and materials including canceling Sexual Assault Awareness Month events, using their own money to fund initiatives, relying on other departments to fund MST-related projects, lacking handouts and signage, and requesting donations for events.

2. 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.[52] The 18 interviewed MST Coordinators reported established procedures to assess patients' preferences for gender of treatment provider, such as a screening question or phone call to the MST Coordinator. Once the patient's gender request for treatment provider was known, a scheduling referral or formal consult was submitted to the schedulers.

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.

[50] Four of the nine MST Coordinators had at least 20 percent dedicated administrative time, with one having 25 percent, two 30 percent, and one 50 percent.

[51] VHA Directive 1115.

[52] VHA Directive 1115.

COVID-19 Pandemic Accommodations

As noted above, due to the pandemic, the OIG team was unable to conduct planned site visits to evaluate the physical environment and related culture of safety aspects. Given this limitation, the interviewed MST Coordinators were asked to provide photographs of signage and waiting areas for MST-related care.

The OIG reviewed the photographs of MST treatment waiting areas for general cleanliness and comfort and modifications in response to the COVID-19 pandemic. Twelve MST Coordinators provided photographs.[53] All photographs of waiting areas presented generally clean and comfortable environments that included MST-related care signage. The waiting areas also included modifications for adherence to COVID-19 safety guidelines, including six-foot separation distance floor markers, increased spacing between chairs, and signage on chairs to indicate the chair acted as a spacer and was not for sitting.

Conclusion

The OIG conducted this review to gather pertinent information about the VHA MST Program in response to a request from Congressman Chris Pappas, Chairman of the House Veterans' Affairs' Subcommittee on Oversight and Investigations and Congresswoman Julia Brownley, Chairwoman of the Women Veterans Task Force. To evaluate the duties and challenges of MST Coordinators and the culture of safety for patients receiving MST-related care, the OIG conducted a national survey that was completed by 136 (86 percent) of VHA MST Coordinators and telephone interviews with 18 MST Coordinators.

VA reports that over the past decade the number of female and male veterans receiving MST-related outpatient mental health care increased by over 158 percent and 110 percent, respectively.[54] Individuals with MST histories are at increased risk of mental and physical health conditions and may present with complex treatment needs. Further, as is common for victims of sexual trauma, those with MST histories may have feelings of mistrust and shame that prevent or delay disclosure and treatment engagement.

VHA requires MST Coordinators "be given protected time, typically at least" 0.2 full-time equivalent employee, "specifically dedicated" to the administrative responsibilities of the role.[55]

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[53] Photographs did not include any personally identifying information or personal health information. Although one MST Coordinator was excluded from the interview, the OIG team reviewed the photographs submitted and included for this review. Given the OIG's awareness that many staff were working remotely due to the pandemic, the OIG did not repeat the request for photographs from the seven MST Coordinators who did not provide them.

[54] VA, *Military Sexual Trauma,* accessed November 10, 2020, https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer Memorandum*, Military Sexual Trauma Reports, Fiscal Year (FY) 2020,* January 15, 2021.

[55] VHA Directive 1115.

Facility leaders are responsible to determine the dedicated time needed by the MST Coordinator to fulfill administrative duties "based on factors, such as facility size and complexity, number of associated [community-based outpatient clinics], the size of the facility's catchment area, and the number of Veterans in the local patient population who have experienced MST."[56]

MST Coordinators reported a range of dedicated time for the role with approximately 80 percent assigned the 0.2 full-time employee equivalent or more of protected time as recommended by VHA. The OIG found that of the 136 MST Coordinators who responded to the survey, 53 (39 percent) reported that they did not have adequate resources to fulfill their MST Coordinator administrative responsibilities. Over half (64 percent) of the 53 respondents reported insufficient protected time to fulfill MST Coordinator responsibilities and specified that additional time would allow them to provide more MST-related services and programs.

The OIG found that MST Coordinators who reported more dedicated time than other MST Coordinators did not necessarily serve at facilities with higher numbers of patients in MST-related care. For example, the MST Coordinator serving in a facility with one of the largest populations of patients receiving MST-related care, reported dedicated time of 30 percent. Given the absence of a logical relationship between the MST Coordinators' dedicated time and the number of patients who are engaged in MST-related care, the OIG recommended that VHA leaders determine meaningful guidance for dedicated time assignment in the context of patient needs and MST Coordinator role demands.

Of the 136 MST Coordinators who responded to the survey, 50 (37 percent) reported having administrative assistance and 86 (63 percent) reported not having administrative assistance to support their MST Coordinator responsibilities. Approximately a third (32 percent) of the 53 MST Coordinators who reported inadequate resources noted that the addition of administrative support would be helpful.

VHA requires that MST Coordinators "be provided with additional [full-time equivalent employee]/dedicated administrative time if a facility determines that all MST Clinical Reminder-initiated referrals for MST-related care will be sent to the MST Coordinator."[57] Although not directly asked in the survey, three MST Coordinators added the comment that MST-related care referral management duties was a factor in inadequate time for the role.

Of the 53 MST Coordinators, 15 (28 percent) described a lack of funding and program materials for outreach, education, and special projects. MST Coordinators described challenges with providing events and materials as a result of the inadequate funding.

The 18 interviewed MST Coordinators were aware of the need for and reported efforts to promote a culture of safety. MST Coordinators described established processes to assist patients

[56] VHA Directive 1115.

[57] VHA Directive 1115.

in requesting and receiving gender-preferred providers. MST Coordinators considered the gender-sensitive issues with regard to waiting and treatment areas and reportedly implemented accommodations to support patient comfort.

Due to the pandemic, the OIG team was unable to conduct planned site visits to evaluate the physical environment and related culture of safety aspects. Twelve MST Coordinators provided photographs that reflected adherence to COVID-19 safety guidelines, such as six-foot separation distance floor markers and increased spacing between chairs.

The OIG found that most MST Coordinators' open text survey entries and interview responses reflected a sincere commitment to the role, thoughtful consideration about challenges to fulfilling the role successfully and completely, and enthusiasm about serving in this capacity. 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 in screening and treatment engagement.

Recommendation

The Under Secretary for Health evaluates the sufficiency of current guidance and operational status regarding protected administrative time, administrative staff support, and funding for outreach, education, and special project resources, with consideration of the Military Sexual Trauma Coordinators' responsibilities, and takes action as warranted.

Appendix A: MST Coordinator Surveys Not Submitted by Facility

Table A. 1. List of Facilities That Did Not Submit Responses

VISN	Facility
1	VA Central Western Massachusetts Healthcare System White River Junction VA Medical Center, Vermont
2	VA Hudson Valley Health Care System, New York
4	James E. Van Zandt VA Medical Center, Altoona, Pennsylvania
5	Martinsburg VA Medical Center, West Virginia
7	Columbia VA Health Care System, South Carolina
10	VA Ann Arbor Healthcare System, Michigan Battle Creek VA Medical Center, Michigan
15	John J. Pershing VA Medical Center, Poplar Bluff, Missouri
16	G.V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi*
17	El Paso VA Health Care System, Texas VA Texas Valley Coastal Bend Health Care System
19	VA Salt Lake City Health Care System, Utah
21	VA Palo Alto Health Care System, California* VA Southern Nevada Healthcare System
23	VA Black Hills Health Care System, South Dakota VA Central Iowa Health Care System Fargo VA Health Care System, North Dakota Minneapolis VA Health Care System, Minnesota

Source: OIG analysis of MST Coordinator survey data.
Note: 19 facilities and 22 MST Coordinators did not respond to the OIG survey.
**VHA listed more than one MST Coordinator for this facility.*

Appendix B: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: June 25, 2021

From: Acting Under Secretary for Health (10)

Subj: Healthcare Review—Challenges for Military Sexual Trauma Coordinators and Culture of Safety Considerations

To: Assistant Inspector General for of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report on the Military Sexual Trauma Program. The Veterans Health Administration (VHA) concurs with the one recommendation and provides an action plan in the attachment.
2. VHA appreciates OIG's attention to evaluating the sufficiency of time and support allocated to the VHA Military Sexual Trauma (MST) Coordinator position. VHA's MST Coordinators play an important role in ensuring that VHA has sensitive, appropriate treatment services available, that MST survivors have streamlined access to these services, that all VHA staff have the information they need to provide effective assistance to survivors, and that ultimately, VHA is meeting the needs of survivors. VHA was particularly gratified to read OIG's observations about MST Coordinators' sincere commitment to the role, thoughtfulness about meeting its responsibilities, and enthusiasm about serving in it.
3. Ensuring MST Coordinators have adequate protected time to accomplish the responsibilities of the role has been a longstanding concern and focus for VHA. As noted in this report, VHA Directive 1115, MST Program, states that when the MST Coordinator position is assigned as a collateral duty, the MST Coordinator must be given dedicated administrative time, typically at least 0.2 Full-Time Equivalent (FTE), specifically allocated to the responsibilities of the role. VHA Directive 1115 notes that additional FTE/dedicated administrative time should be allocated based on factors such as health care system size and complexity, number of associated community based outpatient clinics, the size of the system's catchment area, and the number of Veterans in the local patient population who have experienced MST. It also states that the MST Coordinator must be provided with additional FTE/dedicated administrative time if a system determines that all MST Clinical Reminder-initiated referrals for MST-related care will be sent to the MST Coordinator for initial administrative processing.
4. This approach, wherein systems are given a fair amount of flexibility in the time allocated to the MST Coordinator role (above and beyond the 0.2 FTE minimum), has been driven by a recognition that systems differ in their needs and current status with regard to MST-related policy implementation. For example, systems vary greatly in size, complexity, and the scope of their local MST survivor patient population. Also, some systems have well-established, well-elaborated, and efficiently functioning programs, while others have more areas for growth.
5. To assist systems in identifying an amount of MST Coordinator protected time sufficient to meet local needs and ensure compliance with national MST-related policy, VHA's national MST Support Team has developed a number of tools. For example, an educational Position Guidance document outlines core responsibilities that must be fulfilled as part of the role as well as additional supplemental activities that represent best practices and optimal implementation. National discussion calls were held with MST Coordinators and Veterans Integrated Services Network (VISN)-level Points of Contact when the document was first released in 2016 and the document is emailed to every new MST Coordinator as part of a "Getting Started" assistance email when he/she enters the position. It is also posted on the MST Support Team's intranet website. The MST Support Team also has developed a Facility Self-Rating Tool that allows systems to evaluate themselves point by point against the major provisions in Directive

1115. Concrete standards of practice and tips for meeting each policy requirement are included. Information from these tools and others supports systems in determining the amount of dedicated time that is appropriate for their MST Coordinator. The MST Support Team also provides consultation to MST Coordinators on advocating to local leadership for any additional dedicated time they might need to successfully fulfill the requirements of the role and regularly promotes discussion of these issues as part of its annual conference and other meetings.

6. Most recently, in June, 2020, an operational memorandum was disseminated to VISN leadership, facility MST Coordinators, and VISN MST Points of Contact which requested that all facilities and VISN take action to ensure that facility MST Coordinators have sufficient protected time to accomplish the responsibilities of the role. The memorandum clarified that the 0.2 FTE described in existing policy documents is the minimum time that may be appropriate but will be insufficient in many cases. This baseline amount of FTE may, in some cases, be sufficient at smaller, less complex facilities with smaller MST survivor populations, particularly if the MST Coordinator has no involvement in initial administrative processing of referrals for MST-related care but is unlikely to be sufficient at other facilities. In response to the memorandum, facilities were requested to conduct a local review to assess whether their MST Coordinator has sufficient dedicated time to meet the needs of their facility and to ensure compliance with national MST policy.
7. The June 2020 operational memorandum was released just prior to the OIG's initiation of the review described in this report, and findings described here may not reflect changes made in response to the local reviews conducted. Regardless, VHA concurs with OIG that the issue of MST Coordinator protected time and support is one that warrants continued attention. Indeed, in anticipation of revising VHA Directive 1115 next year as part of its natural recertification cycle, VHA had already begun exploring whether there were more effective means of determining and establishing an appropriate and uniform baseline level of protected time for all MST Coordinators while still allowing for some local tailoring and flexibility as needed.
8. As such, and given OIG's findings, VHA agrees there is significant value to evaluating the sufficiency of current guidance and operational status regarding MST Coordinator protected administrative time, administrative staff support, and funding for outreach, education, and special project resources. As noted, historically one key barrier to issuing more prescriptive guidance and policy in this area has been the tremendous variability in system needs. In particular, evaluating what is an appropriate and uniform baseline level of protected time for all MST Coordinators will be complex, but VHA anticipates a plan to conduct this evaluation can be developed by the target completion date.
9. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office.

(Original signed by:)

Richard A. Stone, M.D.
Acting Under Secretary for Health

Office of the Under Secretary for Health Response

Recommendation

The Under Secretary for Health evaluates the sufficiency of current guidance and operational status regarding protected administrative time, administrative staff support, and funding for outreach, education, and special project resources, with consideration of the Military Sexual Trauma Coordinators' responsibilities, and takes action as warranted.

Concur.

Target date for completion: May 2022

Under Secretary for Health Comments

The Veterans Health Administration Clinical Services program office will evaluate the sufficiency of current guidance and operational status regarding protected administrative time, administrative staff support, and funding for outreach, education, and special project resources, with consideration of the Military Sexual Trauma Coordinators' responsibilities, and will take action as warranted.

OIG Contact and Staff Acknowledgments

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