AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

RIGHT TIME, RIGHT PLACE, RIGHT TREATMENT WITH VA COMMUNITY CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

TUESDAY, JULY 15, 2025

Serial No. 119–30

Printed for the use of the Committee on Veterans' Affairs

Available via http://govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
61–357 WASHINGTON : 2025

COMMITTEE ON VETERANS' AFFAIRS

MIKE BOST, Illinois, *Chairman*

AUMUA AMATA COLEMAN RADEWAGEN, American Samoa, *Vice-Chairwoman*
JACK BERGMAN, Michigan
NANCY MACE, South Carolina
MARIANNETTE MILLER-MEEKS, Iowa
GREGORY F. MURPHY, North Carolina
DERRICK VAN ORDEN, Wisconsin
MORGAN LUTTRELL, Texas
JUAN CISCOMANI, Arizona
KEITH SELF, Texas
JEN KIGGANS, Virginia
ABE HAMADEH, Arizona
KIMBERLYN KING-HINDS, Northern Mariana Islands
TOM BARRETT, Michigan

MARK TAKANO, California, *Ranking Member*
JULIA BROWNLEY, California
CHRIS PAPPAS, New Hampshire
SHEILA CHERFILUS-MCCORMICK, Florida
MORGAN MCGARVEY, Kentucky
DELIA RAMIREZ, Illinois
NIKKI BUDZINSKI, Illinois
TIMOTHY M. KENNEDY, New York
MAXINE DEXTER, Oregon
HERB CONAWAY, New Jersey
KELLY MORRISON, Minnesota

JON CLARK, *Staff Director*
MATT REEL, *Democratic Staff Director*

SUBCOMMITTEE ON HEALTH

MARIANNETTE MILLER-MEEKS, Iowa, *Chairwoman*

JACK BERGMAN, Michigan
GREGORY F. MURPHY, North Carolina
DERRICK VAN ORDEN, Wisconsin
JEN KIGGANS, Virginia
ABE HAMADEH, Arizona
KIMBERLYN KING-HINDS, Northern Mariana Islands

JULIA BROWNLEY, California, *Ranking Member*
SHEILA CHERFILUS-MCCORMICK, Florida
MAXINE DEXTER, Oregon
HERB CONAWAY, New Jersey
KELLY MORRISON, Minnesota

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

C O N T E N T S

TUESDAY, JULY 15, 2025

RIGHT TIME, RIGHT PLACE, RIGHT TREATMENT WITH VA COMMUNITY CARE

TUESDAY, JULY 15, 2025

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:43 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meek [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meek, Murphy, King-Hinds, Brownley, Cherfilus-McCormick, Dexter, Conaway, and Morrison.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Good afternoon. This legislative hearing of the Subcommittee on Health will now come to order. I would like to welcome all the members and witnesses to today's hearing. During this hearing, witnesses will share with us how U.S. Department of Veterans Affairs (VA) works hand-in-hand with private doctors and providers to meet veterans' specialty care needs throughout the VA Community Care Program.

Data show that veterans like and want community care just as they like and want their VA healthcare system. Polling has shown that Americans want veterans to be able to access shorter wait times and drive times to get their healthcare. Through the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, Congress has closed the gap that was crippling the delivery of care by the VA and oftentimes leaving veterans behind, stuck in line and waiting for an appointment. This was especially true for specialty care. By virtue of being in the community, these providers are closer to veterans and their homes than a brick-and-mortar VA facility. That can mean shorter wait times and drive times for veterans.

Through the MISSION Act, the VA Community Care Program created new opportunities for more resources than ever to serve veterans. Veterans enjoy shorter wait times and drive times for specialty care appointments because VA is allowed to cover specialty care in the community. Veterans have more specialty care through VA because of community care, not less.

Three key indicators today and on the horizon show that the VA will continue to rely on providers in the community to meet the moment for specialty care for veterans. First, demand will increase

for all specialty care needs as more women use the VA for healthcare. By 2040, the VA estimates that women will make up 18 percent of all veterans. More women veterans means not just an increase in female-specific care, but an increase in specialty care services overall.

Second, VA's workforce challenges mirror those of the healthcare industry as a whole. There is a national shortage of healthcare professionals, especially for physicians and nurses. The VA recently identified shortages for clinical roles like psychologist, medical technologist, diagnostic radiologic technologist, which is the same in the private sector. This is true across all VA facilities, even though this committee and the Veterans' Affairs Committee has increased pay to providers within the VA healthcare system. All of these roles play a part in, if not directly provide, specialty care for veterans. The higher the ratio between veterans and healthcare staff, the more veterans will need community providers for VA-covered specialty care.

Third, and finally, the VA expects significant changes in demand for care in general, including specialty care. The VA projects major shifts in physical space demands for hospital operations by about 2030. Estimates range from an 850,000 decrease in needed square feet in New Orleans, Louisiana, to a 2,500,000 increase in needed square feet in Orlando, Florida. Having facilities where they are needed in accordance with the demographic shifts of the country, sometimes we are far behind where that movement occurs. These are but two of the many estimates projecting dramatic increases and decreases in demand for physical space across the country and one of the reasons we introduced the Communities Helping Invest through Property and Improvements Needed for Veterans (CHIP IN) Act in this committee, as well as increases for funding infrastructure within the VA.

The VA also projects highly variable demand in different facilities across different types of care. I hope you will bear with me as I explain the numbers which paint a compelling picture of the veterans' healthcare needs.

The VA expects a 50 percent growth nationwide in outpatient primary and specialty care combined. Relatedly, the VA also expects a 13 percent decrease in inpatient acute medicine and surgery nationwide. This, too, mirrors what we see in all healthcare sector. The VA expects an increase for inpatient acute mental health. That means more demand for psychiatric services at a hospital for severe mental health crisis. As we know from hearings here in this room, the VA did not consider residential mental healthcare or residential substance abuse part of the MISSION Act. That is a lot of variation.

Even within these numbers, the VA expects significant differences in demand from region to region. For example, with inpatient acute mental healthcare, the VA projects a 6 percent decrease nationally in demand for inpatient acute mental health. When we dig another layer deeper, we see that the VA expects anywhere between a 19 percent decrease to a 14 percent increase across different regions of the country.

I care deeply about mental health resources for veterans. I know that the VA will continue to provide valuable in-house care to vet-

erans who need it. With so many variables, the VA cannot expect in-house care alone to meet different demands from different communities. Veterans need inpatient mental healthcare when they need it and when they are in crisis. Veterans need specialty care when they need it. A condition in need of treatment does not wait for the facilitary infrastructure to be built and to catch up. As a physician, I know this reality firsthand.

A veteran should not wait for treatment when community providers are already available to meet a need. To best serve veterans, the VA should pursue whatever gets quality care to veterans when they need it. The VA serves all veterans when it opens the door to community providers equipped to care for veterans at the right time, at the right place, with the right treatment. As a 24-year Army veteran and physician, I am focused on working in lockstep with the administration to ensure that this happens. The future of veterans' healthcare depends on it.

I now yield to Ranking Member Brownley for any opening remarks she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Chairwoman Miller-Meeks. At the outset of today's hearing, I would like to set the scene a bit by describing the situation in which veterans and the VA currently find themselves.

First, veterans across the country are losing access to VA healthcare due to numerous actions taken by the Trump administration. Why is this happening? With each passing day, VA is becoming a less and less desirable place to work. Upon taking office, President Trump ordered a governmentwide hiring freeze. The haphazard implementation at VA meant the essential occupations initially were not exempted from the freeze. Job offers for key employees who were already in the onboarding process were rescinded, then reinstated, a flip-flopping that led many would-be hires to run the other way.

Less than a month after that, VA terminated nearly 2,400 probationary employees. While some have since been rehired, they may be terminated again after pending lawsuits have resolved. Many opted not to return after being offered their jobs back.

Then as a result of the Trump administration's returning to office policy, tens of thousands of VA employees who had been hired into fully remote positions were directed to report to offices that were ill-equipped and ill-suited to accommodate them, with little consideration for the effect it would have on their productivity or the quality of care delivery.

We heard a week ago that while VA is no longer planning to pursue a large-scale reduction in force, or RIF, it still anticipates losing nearly 30,000 employees by September 30th. That is about 6 percent of VA's overall workforce. This is happening through DRP, the Deferred Resignation Buyout Program, and VERA, the Voluntary Early Retirement Authority, as well as employees choosing to resign or retire without any incentives.

As this chart shows behind me here, as of May 31, 2025, nearly 22,000 employees had separated from the Veterans Health Admin-

istration (VHA). While about half have been replaced, as a whole VHA has lost 10,310 more employees than it had hired so far this fiscal year. The Secretary has repeatedly claimed that veterans will not lose access to healthcare as a result of the Department's ongoing restructuring process.

Maybe you are thinking that these losses are mostly nonessential occupations at VHA, but that is just simply not true. Losses of essential frontline employees are occurring at VA medical facilities nationwide.

As the second chart shows VHA is currently operating at a loss of nearly 3,000 mission-critical employees since the start of this fiscal year. This is after making significant gains in the overall number of frontline employees during the same period last fiscal year. Those new hires were helping VA deliver record numbers of appointments and serve the influx of new enrollees that are coming into VA as a result of the The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act.

Where are the losses of essential employees most significant? Custodial workers, food service workers, nurses, physicians, social workers, employees that VA medical facilities simply cannot do without.

At the Community-Based Outpatient Clinic (CBOC) that serves my constituents in Ventura, California, 7 out of 12 mental health providers have left. This is driving up wait times for mental health appointments. As of Friday, the new patient wait time for a mental health appointment was 101 days.

Now, maybe you are thinking to yourself those veterans are eligible for community care and while that is true, they need VA staff to coordinate their care in the community. As this chart refers to, it shows that we are down more than 1,147 medical support assistants nationwide since the start of the fiscal year. Those are the staff who help veterans find community providers and schedule their appointments.

It does not matter that so-called mission critical VHA staff were not eligible for the DRP and VERA separation incentives. They are leaving anyway because VA has become a toxic, unpredictable, and hostile place to work. We are kidding ourselves if we think no RIF is the end of it and that the loss of employees will stop at 30,000 folks. These losses will continue to grow. As long as VA's workforce continues to suffer, all aspects of VA care, including community care, will suffer.

Second, on July Fourth, President Trump signed the One Big Beautiful Betrayal Bill into law. By most analysis, this law and its 1 trillion cut to Medicaid will have a wide-ranging impact on the healthcare landscape in the United States. Researchers at the University of North Carolina have identified 338 rural hospitals that are already at risk for closure. Future loss of Medicaid coverage will elevate the risk of financial distress for hospitals, long-term care facilities, and other providers, further reducing veterans' access to care.

We cannot have a conversation about specialty care in the community without acknowledging both the strain that is currently being placed on VA's healthcare system and the strain that is

about to be placed on non-VA providers. We should be shoring up VA care and making sure that there is capacity in the community when veterans need specialty care in the community. Instead, under this administration we are seeing a chaotic approach to delivering veterans' healthcare that undercuts VA's internal capacity, shifts more and more care to the community, and leaves veterans and VA employees in the lurch. Insisting that those actions will not impact veterans' healthcare does not make it so, and ignoring the unforeseen consequences of this administration's actions will not make them go away.

As I have always acknowledged, VA will always need to offer some level of community care because they cannot do it all. However, for many veterans, VA is the right place for them to receive care. They know their provider understands their military service and what it means to have served their country. They know they will receive world-class healthcare backed up by world-class research. They know they will not have to explain to their VA provider what a presumptive condition is or their experience with Military Sexual Trauma (MST) or how their service impacted their mental health.

We also lack oversight of the care that veterans receive in the community. We know wait times for VA appointments because VA publishes them. Community providers are not required to report their wait times or how long it will actually take a veteran to be seen.

We know that VA providers have received training on military cultural competencies, suicide prevention practices, opioid safety, and many others because VA requires them to receive such trainings and report how they have completed them. Community providers are not required to take all of these trainings and veterans are not informed about whether their community providers have voluntarily taken such trainings.

Based on the testimony from our witnesses, I think we can all agree that the administration of VA's Community Care Program needs reform. Unfortunately, we find ourselves convened for an oversight hearing where there are no VA officials present to respond to questions about the barriers and challenges highlighted by our witnesses. I think that does them a disservice and I would respectfully ask the chairwoman to invite Department witnesses to future oversight hearings so that we can have a more robust discussion about what is working well, what is not, and how to fix it.

With that, Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

Before I introduce our witnesses, I just want to be clear, our colleagues have spent the past 6 months yelling from the sidelines and should have held their criticism of potential plans until a plan was actually in place. It is public knowledge that the VHA loses about 9 percent of its workforce annually through regular attrition, or about 38,000 employees based on its current workforce. Those were the same statistics during the Biden administration and are the same statistics today. We also know the status quo is not working and will continue to cut through the nonsense and restore common sense at the VA to put veterans first.

Additionally, during the past 4 years, the funding to the VA has dramatically increased. The numbers of employees increased by 80,000, yet the number of veterans applying for care had remained level nationwide. Most VA employees come to work and proudly serve our veterans. However, poor performing VA employees must be held accountable when they are not putting veterans first, and we will ensure that that message is clear.

Chairman Bost, House Republicans, and myself have full confidence in Secretary Collins and the Trump administration to bring needed change to the VA. That is what we are focused on. I look forward to continuing to work with Ranking Member Brownley and those on the other side of the aisle so that we can affect real change for veterans that the VA serves.

Testifying before us today, as I would now like to introduce our witnesses, Dallas Knight, founder and president of Operation Juliet. She is an Army combat veteran. Meaghan Mobbs, director of the Center for American Safety and Security at Independent Women's Forum. She is a clinical psychologist and also an Army combat veteran. Amanda Newman, Chief Executive Officer (CEO) of Western Illinois Home Health Care. Western Illinois has operations close to my district. Kristina Keenan, legislative director at Veterans of Foreign Wars (VFW) and an Army veteran as well. Kyleanne "Kai" Hunter, CEO of Iraq and Afghanistan Veterans of America and Marine Corps combat veteran.

Ms. Knight, you are now recognized for 5 minutes to present your testimony.

STATEMENT OF DALLAS KNIGHT

Ms. KNIGHT. Chairwoman, Ranking Member, and members of the subcommittee, my name is Dallas Knight. I am an Army combat veteran and the founder of Operation Juliet, a nonprofit serving female veterans.

I joined the Army just 2 months before 9–11, intending to gain experience and work for the Drug Enforcement Administration (DEA). I had no idea how real that experience would become. I deployed to Iraq in 2003, and returned a year later with invisible wounds far worse than the physical ones. I avoided the VA after learning Post-Traumatic Stress Disorder (PTSD) diagnoses would revoke your security clearance, My entire career plan. I stuffed it down, I stayed silent, and I told myself I was fine for 17 years. Eventually, the weight of what I saw, felt, and endured caught up with me.

Finally, after enrolling in VA Healthcare, I walked into the Billings clinic for my first appointment and was asked if my husband needed help. Apparently, I did not look like a veteran. That first appointment stuck with me. When I was asked if I had suicidal ideations, I said not recently. The provider responded by lecturing me on how selfish it would be to leave my children without a mother. Then, when I disclosed military sexual trauma, I was referred to a psychologist and handed a stack of prescriptions. No conversation about healing, just a follow-up call from a man temporarily filling in as the State MST coordinator, notifying me I would be receiving a pamphlet in the mail.

At a neurology appointment, I was asked for graphic, unnecessary details about my Traumatic Brain Injury (TBI) trauma. It felt more like an interrogation, questioning my integrity, rather than a consultation, only stopping when the doctor noticed my visible discomfort. Despite our encyclopedia-sized files, we are expected to rehash and relive the very traumas we are trying to escape. I do not believe these VA providers intended harm, but they were clearly undertrained and unequipped to treat trauma. That is when I realized there must be better care available.

Because no one explained trauma-informed therapy, no one told me about community care and other options, those options were only discovered from other veterans, helping me to navigate the system, a lifeline passed from veteran to veteran. Requests for alternative therapies often took weeks, sometimes months for a response. I have hung up on my boss, my son, and walked out of meetings just to answer the VA's call, afraid of missing a rare chance at care. As I scrambled to choose a provider from a rushed list, no context, no ratings, no reviews, I hung up relieved just to have an appointment at all.

I am not alone in my frustrations and disappointments. I told my community I would be standing before you here today and within days, nearly 600 women veterans responded, eager and desperate to be heard, hundreds of female veterans describing waiting months, sometimes over a year, for critical referrals, specialty care or community-based treatment. These delays often compounded existing mental and physical health issues, leaving veterans to suffer in silence.

Veterans living in rural or underserved areas detailed the near impossibility of accessing timely and appropriate care. Many faced multi-hour drives, limited provider options, and a lack of female clinicians or trauma-informed specialists. For these women, geographic isolation added another barrier to healing, making community care feel like a broken promise.

Veterans who bravely disclosed histories of military sexual trauma shared disturbing accounts of re-traumatization within the VA system. Common themes included being forced to recount trauma repeatedly, being assigned male providers despite requests for female clinicians, and being denied or delayed access to mental health support. The lack of MST-sensitive pathways reflects a systemic failure to prioritize survivor safety and dignity.

I have hundreds of stories but only 5 minutes to speak, so I ask that you take the time to read their stories that I have submitted to you. There is one story that I carry most heavily with me today. Lynessa Van Kirk was born February 21, 1989; Army Military Police (MP) sergeant, daughter, sister, friend, hero. I never met Lynessa, but I know her through her mother, now living every parent's worst nightmare. Lynessa served her country with honor. She asked for help repeatedly, but she was denied, delayed, ignored, and even sexually assaulted at a VA inpatient treatment facility. The VA failed her repeatedly. On April 30, 2022, at just 33 years old, Lynessa died from the long-term effects of untreated PTSD and trauma, left in a hospital bed with hematomas, liver failure, and no more chances.

Today, I am not just asking you to hear me. I am asking you to hear all of us. Hear the hundreds of women who have come forward. Hear Lynessa. Female veterans are not invisible. We are not dramatic or broken. We are warriors, leaders. We are asking boldly, urgently for a system that sees us, hears us, and serves us with dignity.

Thank you for your time.

[THE PREPARED STATEMENT OF DALLAS KNIGHT APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Knight.

Ms. Mobbs, you are now recognized for 5 minutes to present your testimony.

STATEMENT OF MEAGHAN MOBBS

Dr. MOBBS. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, thank you for the opportunity to testify today. My name is Dr. Meaghan Mobbs and I am the director for the Center of American Safety and Security at Independent Women. I am a combat veteran, former Army officer, and clinical psychologist who specialized in trauma, transition stress, and post-military reintegration. I trained in the VA system and currently teach through the Veterans Mental Health Primary Care Training Initiative for the New York State Psychiatric Association, helping civilian physicians better recognize and treat veterans.

I have been on all sides of the system: soldier, clinician, educator, and advocate. I have walked beside fellow veterans struggling to navigate the very bureaucracy designed to serve them. In 2018, when President Trump signed the bipartisan VA MISSION Act, it was more than legislation. It was a solemn promise that what happened to the Phoenix VA, where veterans died waiting for care, would never happen again. The Community Care Program was created to fulfill that promise. It acknowledged that while the VA is indispensable, it is not omnipresent. Too often, bureaucracy stood where medical support should have.

This program was never meant to be a replacement, but it was a direct response to institutional failure. It intended to put outcomes over promises and patients over paperwork. We have not yet fulfilled that promise. Let me place it in some context.

In 2001, the VA's hospital administration budget was 20.9 billion. At that time, we were tragically losing about 16.5 veterans a day to suicide. In 2024, after decades of war and exponential growth in funding, now approximately 121 billion, we are still losing 17.6 veterans a day to suicide. What faces us is not a funding problem. It is a function problem and a failure to adapt and decentralize to meet veterans where they are.

Veterans are still waiting weeks or driving hours for care they should receive promptly and locally. Medical decisions are too often driven by bureaucrats and not doctors. Community Care was created to fix this. Today it provides nearly 40 percent of all VA delivered care, and it is working. Veterans use it. They are satisfied with it, especially in rural areas it has become a lifeline. Instead of expanding it, some VA administrators have undermined it.

We have heard the stories. Last year, a Portland VA official admitted they were intentionally keeping care in-house, even where referrals were warranted. In Buffalo, a veteran with cancer had his radiation therapy referrals denied and then canceled, and he died in pain. To move forward, we need a Community Care Program rooted in four principles: flexibility, accessibility, rapidity, and accountability.

First, flexibility. Veterans live in rural towns, suburbs, and cities. They raise families, hold jobs, and carry injuries both visible and invisible. They deserve a care system that reflects that complexity. Community care gives them access when the VA is too far, too slow, or lacks the right specialists. That flexibility is especially crucial for women veterans. Seventy percent prefer female providers for woman-specific care and 50 percent even for general care. Recently, a VA facility went 2 years without a full-time gynecologist.

Second, accessibility. Only 55 percent of veterans live within 40 miles of a VA facility and just 26 percent live near specialty care. Community care reduces the physical and financial burden of long-distance travel, and that improves health outcomes and trust and adherence. With women expected to make up nearly 20 percent of the veteran population by 2040, many from minority backgrounds, we need a system that reflects today's demographics, not those from 50 years ago.

Third, rapidity. Delayed care is denied care. Veterans do not need treatment eventually, they need it now. Today's eligibility thresholds are arbitrary. I have personally worked with veterans denied mental health services because they were not sick enough or were forced into treatment that they did not want. Whether it is PTSD, chronic pain, or substance use, every delay or denial feels like administrative cruelty, and it is costing lives.

Fourth, accountability. Since 2018, the U.S. Government Accountability Officer (GAO) has issued 27 recommendations to approve the Community Care Program and, as of this year, only 9 have been fully implemented. The lack of enforceable standards, inconsistent referral coordination, and inadequate oversight does undermine the program. We need to measure timely access and continuity of care. Otherwise, we are building a system that is blind to its own failures.

I want to commend Secretary Collins for accelerating the implementation of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act and it is a meaningful step forward. Let me be clear, it is not enough to offer a door. We must ensure that door is open, functional, and that it leads somewhere worth going.

I believe deeply in the VA. I trained there. I have referred patients there, but no single system can meet every need in every place at every time for every veteran. Community care is not an indictment. It is just an extension of the promise we made. Veterans do not need more bureaucracy. They need choice, they need speed, and they need a system built to serve them, not the other way around.

Thank you and I look forward to your questions.

[THE PREPARED STATEMENT OF MEAGHAN MOBBS APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Mobbs.

Ms. Newman, you are now recognized for 5 minutes to present your testimony.

STATEMENT OF AMANDA NEWMAN

Ms. NEWMAN. Thank you, Chairwoman Miller-Meeks, Ranking Member Brownley, and the members of the committee for the opportunity to speak on the critical topic of the VA's Community Care Program. Thank you for the important legislation that you have successfully led through the legislative process to support veterans. I am honored to speak on behalf of the 121 Illinois veterans that we serve in our agency and on behalf of veterans served by Home Care Association of America members across the Nation.

I am the second generation running a family owned home care agency in West Central Illinois. We cover a 10-county, mostly rural area and have worked with the VA for over 30 years. We currently do so as a contracted provider in the VA Community Care Network operated by Optum.

Community care is not an alternative to the VA, it is an extension of it. For many veterans, especially those living in rural areas, community care represents a vital lifeline. These veterans often face long travel times or limited services at local VA facilities, making care in the home a necessary option. The success of community care hinges on a shared commitment to veteran-centered, team-based care where VA and community providers work in partnership, not in competition.

Over our 30 years working with the VA, we have always had good relationships with the Veterans Integrated Service Network (VISN) 23 Veteran Affairs Medical Center in Iowa City and our local VA outpatient clinic in Galesburg, Illinois, working together to meet veteran needs. Our experience has been that process changes within the VA in the last year have created barriers to veteran access and care. These changes do not appear to be in line with the spirit of the MISSION Act.

Three key barriers to veteran access that I have seen are the VA reducing or eliminating community care services for many veterans who have qualified for and relied on these services for years; harming care stability and consistency for veterans by reducing authorization periods from the prior standard of 12 months to 6 months or less, creating uncertainty for the veteran and an overwhelming workload for the VA staff who process authorizations; in the 2025 nonbundled fee schedule, reducing rates to a point where veterans, especially in rural areas, are at risk of losing critical services because the fee schedule does not provide adequate reimbursement given the travel involved.

I would like to tell you about two of our veterans who asked me to share their story. One veteran we care for is 79 years old. He lives alone in a small rural town and has difficulty controlling his diabetes. He cannot cook for himself or safely navigate the stairs in his home to do laundry. He was denied homemaker services. When we requested Physical Therapy (PT) to help him safely ambulate, this was also denied. Instead, they required him to drive 53 miles each way in the winter twice a week to go to the VA clinic for PT.

We serve an 85-year-old veteran who has difficulty ambulating. He uses a cane due to a stroke and cannot stand for long. He was denied home health aid services because he reported on the phone that he can shave his beard. However, the VA team failed to take into account his ability to perform other activities of daily living, such as bathing, ambulating, or dressing.

Community care enhances access, expands capacity, and supports choice for veterans without replacing the foundational role of the VA. Community care is not a workaround. It is a necessary part of a comprehensive veteran first healthcare system. When community providers and the VA work together, veterans benefit from timely, compassionate, and coordinated care delivered wherever they are, whenever they need it.

We have an opportunity and a responsibility to ensure that every veteran receives care that is timely, high quality, coordinated, and close to home. By strengthening community care as a complement to VA services, investing in home care and rural access, and ensuring providers are supported through fair reimbursement, we can fulfill the VA's sacred mission to those who have served.

I thank you for your time and for your continued commitment to the health and dignity of America's veterans.

[THE PREPARED STATEMENT OF AMANDA NEWMAN APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Newman.

Ms. Keenan, you are now recognized for 5 minutes to present your testimony.

STATEMENT OF KRISTINA KEENAN

Ms. KEENAN. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States and its auxiliary, thank you for the opportunity to provide the VFW's remarks and my personal story on the topic of community care.

VA's Community Care Program and its network of providers are a vital component of VA healthcare, particularly for specialized care that VA does not provide. Community providers are force multipliers, allowing VA to offer the world-class care that veterans prefer while also ensuring they have access to a range of services when they need them. When used appropriately, community care can save lives and improve health outcomes.

However, problems with the coordination of that care can drive veterans away from VA altogether. VFW members have identified several coordination issues, including delays in VA paying for community care in a timely manner. VA referrals can also be unclear, especially understanding the types of care that are authorized, including lab work and procedures. Scheduling appointments for community care is also a reported point of confusion for our members. Not every VA medical center informs veterans when they have the option to use community care, nor when the veterans should set up the appointments or —and if and when VA will schedule them.

I have personally experienced these issues as nearly all of my woman-specific care has been in the community. The first time I

had a mammogram, it took VA 6 months to pay the $700 bill. I had to call both VA and the community provider several times and began receiving collections notices until the bill was paid.

I have also used community care for maternity care, a type of specialized care that VA does not provide at all through its direct care. The coordination of that care has been a source of frustration and stress at times. I actually had a pregnancy last year which sadly ended in miscarriage. My VA maternity care coordinator twice received incorrect information from my community provider and called me to ask me why I was trying to terminate my pregnancy. She called me at a later date and asked why I had proceeded with a termination procedure not approved by VA. In both instances, I had to tell her that her information was incorrect and then explain and re-explain that my pregnancy had not been viable. This is an example of poor record-sharing between community providers and VA, resulting in painful conversations made with an administrator and not even my primary care physician.

I am currently using VA-coordinated maternity care again as I became pregnant this spring and have successfully made it into my second trimester. I am currently struggling with the bureaucracy of having genetic tests conducted by my community provider. Because of my age, the provider finds them especially necessary. After exchanging several secure messages with VA about billing codes, I was told that two of the tests should be covered by VA, but that I should also confirm with the lab, likely LabCorp, to verify with them that the tests are indeed covered by VA's insurance provider, Optum. This does not feel like VA has approved these tests if I have to discuss the billing codes myself with the non-VA provider, a subject with which I have no familiarity. If I accept a test that VA does not cover, that could be thousands of dollars that I have to pay out of pocket.

Despite these and other coordination issues mentioned in my written statements, I am very happy with the quality of care that I have received in the community and I like that I have had the choice of my providers. We must find ways to improve the coordination of community care.

The VFW supports Chairman Bost's H.R. 740, the Veterans Access Act of 2025, as it represents a critical step forward in enhancing access to community care for veterans. Additional legislative measures should also be considered to address the issues that I and VFW members have mentioned. While veterans consistently report to us that they prefer direct care at VA, when needed community care should be coordinated appropriately and not create additional bureaucratic frustrations for veterans.

Chairwoman Miller-Meeks, Ranking Member Brownley, this concludes my testimony. I am prepared to take any questions you or the subcommittee members may have. Thank you.

[THE PREPARED STATEMENT OF KRISTINA KEENAN APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Keenan.

Ms. Hunter, you are now recognized for 5 minutes to present your testimony.

STATEMENT OF KYLEANNE HUNTER

Dr. HUNTER. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the committee, thank you for the opportunity to testify today. I am the CEO of Iraq and Afghanistan Veterans of America, but I am also a public policy researcher and a service-connected disabled veteran who utilizes VA services.

I am honored to represent the post 9–11 veteran community. This is a diverse population with unique healthcare needs, which includes illnesses and injuries that are a result of cumulative and compound exposures, latent impacts of blast-related injuries, and the interaction of several physical and mental healthcare issues. Community care is a vital part of overall veterans' healthcare, but especially as we consider rising costs, we need to be clear that the evidence does not bear out that community care is a meaningful replacement for all direct VA care. For a detailed discussion of the research underlying this, I ask that you please reference my written testimony that has been submitted for the record.

Community care does play a critical role for some patients and this is most evident for veterans who live in rural or remote areas for whom it would be time prohibitive to travel for direct care or for those who need specialty care that has a narrow focus or serves a small population and it would not be efficient or effective for the VA to maintain these services. However, the evidence is also clear that VA direct care provides better health outcomes for the majority of veterans.

First, direct care does have lower wait times than community care and wait times are not about convenience or hassle, but about health and well-being. Prolonged wait times are associated with deteriorating health outcomes among multiple dimensions. When compared to community care, direct care has markedly better health outcomes, such as a significantly lower postsurgical 28-day mortality rate, lower hospital readmission rates, and quicker hospitalization return to work rates.

For our most vulnerable veterans, the disparity of outcomes is even more stark. For suicide rates, veterans who receive community care have a 25 percent higher suicide rate than those enrolled in VA direct mental healthcare, and too many of our post 9–11 veterans are falling into this category.

VA direct care also has more positive outcomes related to toxic screenings for veterans with compound exposures, which include environmental toxins, traumatic brain injuries, acute injuries, and mental health conditions. Evidence from PACT Act implementation, a process many of our veterans have benefited from, shows that VA direct care providers were able to identify exposure-related illnesses at a faster and more accurate rate than community care providers.

VA direct care does not just provide better patient outcomes, it provides cost savings to the U.S. Government. In side-by-side comparisons with community care, VA patients have a 24 percent year over year primary and preventive care cost savings. More contributing to the cost savings, veterans receiving direct care experienced 43 percent fewer hospitalizations, 58 percent fewer days when they were in a hospital, and 43 percent outpatient surgical procedures.

As more patients are being seen by the VA, we will see more cost savings.

Between fiscal years 2023 and 2024, the VA saw 14 million additional episodes of care. This upward trend is indicative of both the expanded population that is seeking VA care and the conditions most common in post 9–11 veterans that require well-coordinated and integrated care, which leads to the fact that the VA is unique in its ability to coordinate care between primary and specialty care providers through its patient-aligned care teams. This reduces the burden on the veteran for scheduling and managing their own care, and ensures that veterans do not receive unnecessary medical treatment. Many recent studies have found that community care providers too frequently administered high-cost and medically unnecessary procedures to veterans without coordinating with their care teams, thereby exposing veterans to unnecessary treatment without medical benefit.

VA-run community-based outpatient clinics also provide a necessary direct care service in many areas that there is not one of the 170 VA medical centers. These should be expanded upon and invested in at this time. In my written testimony I detail the importance of investing in CBOCs in four key areas that align with the Veterans Service Organization (VSO) independent budget recommendations. By focusing on targeted expansions and improvements, CBOCs can more fully realize their designated purpose.

Community care is best used when originally intended, to meet the needs of those patients in rural and remote areas and for particular specialty care. For the majority of veterans' healthcare needs, the evidence presented just indicates that VA care is better care.

Thank you and I look forward to your questions.

[THE PREPARED STATEMENT OF KYLEANNE HUNTER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Hunter.

I just want to take a moment to, this is I think a little unusual, but thank our witnesses for their service. Four of our witnesses have served, so thank you for your service.

As is my typical practice, I will reserve my time until all of the members have had a chance to ask their questions. I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair. I, too, want to thank all of you for your service to our Nation's veterans. We appreciate it very, very much.

Dr. Hunter, I appreciate that in your testimony you highlighted the importance of military cultural competency and training. Can you expand on why VA providers are so uniquely positioned to care for veterans and what it means for your members that their providers understand their unique needs?

Dr. HUNTER. Thank you so much. VA providers are required to undergo extensive training on military cultural competency. This includes things like multiple compound exposures, whether it is toxins, the interaction between mental and physical healthcare, as well as emerging research on some of our technologies. Additionally, VA providers, some of which are actually cleared to be able

to access classified medical records and so they can understand environmental exposures that were there.

For myself, this was life-saving. At a regular, routine optometry appointment that I had where I was experiencing vision changes, and I thought it was because maybe I was just over the age of 40, my VA optometrist was able to connect symptoms I was experiencing to exposures from my service time and get me screened for ocular melanoma. Turned out I had it. We caught it super early at this case, but in every single community care optometry appointment I had, not once had I been asked about my time in military service, where might I have been, the type of exposures that I would have seen.

If we look at the post 9–11 generation and we look at what was found in the PACT Act, the ideas of presumptive connections for things like toxic exposures, but we are seeing more and more aviation equipment, the time around fueling, as well as the compound traumas with military sexual trauma and PTSD, it is essential that our veterans are seen by providers who understand that. In the community, while the MISSION Act says they should have training, we actually have no idea what sort of training they are getting. We do not have oversight on that in a real and meaningful way, the way we do have oversight on the types of training that VA providers have.

Ms. BROWNLEY. Thank you for that. I think in reading Dr. Mobbs' testimony, she cited a RAND's article —excuse me, a Research and Development (RAND) article stating that or at least making the assertion that VA providers are not trained. I know that you have previously worked at RAND. Are you familiar with this article at all?

Dr. HUNTER. Yes, I was one of the contributing authors to that study.

Ms. BROWNLEY. Is that true what the conclusion of that article said?

Dr. HUNTER. No, the article said that we are aware of the training that VA providers received. We do not have oversight on the training that community care providers received.

Ms. BROWNLEY. Thank you for that. Another thing I appreciate about your testimony was that you included extensive citations throughout to articles in academic journals, to studies from nonpartisan entities, like RAND, GAO, and the Congressional Budget Office (CBO). One thing that worries me about the way legislation sometimes comes together is that it is informed by anecdotes and the experiences of perhaps a vocal minority voice rather than by the true evidence. What does the evidence say about where veterans prefer to receive their care and where the quality and outcomes are better?

Dr. HUNTER. The preponderance of the evidence shows that veterans prefer VA care. When we look at some of the very, very tragic stories that we see and the antidotes that we hear, we need to take every single one of them seriously and look into what has happened. The VA does have significant measures to actually address providers that provide subpar care. We also need to be reminded, as I was often in my doctoral studies, that the plural of antidote is not data. If we look at the preponderance of the data, the data

lead us to VA care providing better care. In surveys of our own members, only 14 percent express any confidence in community care being able to address and coordinate their complex medical needs.

Ms. BROWNLEY. Thanks for that. You know, do you have any suggestions on really how we help veterans, the public for that matter, to better understand the evidence and overcome this perception that the VA care is not as good as community care?

Dr. HUNTER. I think it is very incumbent upon VSOs to take an educating role on what the VA is and also incumbent on Members of Congress to continue to engage with VA providers to ensure that we have appropriate oversight and engagement to understand the quality of care that exists.

Ms. BROWNLEY. Thank you for that. I yield back.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

I now recognize Dr. Murphy for 5 minutes for any questions he may have.

Mr. MURPHY. Thank you, Madam Chairman. Thank each of you for your service and the work that you are doing to try to make our care for our veterans as best as possible, regardless of where it comes from.

You know, I wish this was not an either/or kind of situation. This needs to be an and/yes, a yes/and situation, because the VA cannot handle all the healthcare that it needs to handle for our veterans, period. There are not the resources, some of which is negligence, on the behalf of the medical education system of the United States. We simply do not have the doctors. We simply do not have the doctors. It just kind of hurts me that people want to say this is better, that is better, and against one care or the other.

Dr. Hunter, since you brought it up, if you do not mind, I am going to ask you about your ocular melanoma. Are you saying that the VA doctor picked that up because they knew you might be exposed to something or are you saying your optometrist out in the community missed it?

Dr. HUNTER. I had had a appointment with a optometrist out in the community who did miss it. Six months later, I had an appointment with an optometrist at the VA who was able to recognize it.

Mr. MURPHY. Did the optometrist do an ocular examination? Did he look in your eye and look all around your quadrants?

Dr. HUNTER. Yes.

Mr. MURPHY. Did you, by any chance, get films from them before then? Because they always make films.

Dr. HUNTER. My ——

Mr. MURPHY. Because ocular melanomas can happen in 6 months.

Dr. HUNTER. Yes, yes, there were films. It was present in the films when my VA provider had reviewed them later on, and it was not discussed or addressed ——

Mr. MURPHY. I would just submit that that is a difference between two physicians. It does not matter where they are coming from, whether you could flip them the other way itself. To say one is better just because of the place where they work, I think is just not being correct.

Also, delving into some of your comments about postoperative care, can you give me a breakdown of the type of patients that are referred out to community care for surgery versus those that are kept in-house?

Dr. HUNTER. I can take that question for the record and get you the breakdown.

Mr. MURPHY. I can tell you what it is. You do not refer things out to the VA unless it is specialty care. I am a specialty surgeon. I get specialty referrals for specialty care that cannot be happened within the hospital. By definition, those are more costly because they are more time-effective, they are more specialty-oriented, and their risk rates are higher. Doing, actually, a risk ratio would be factual to this rather than just saying postoperative care is better at the VA, the outcomes are better than they are in the community, because they are two entirely different populations. You refer people out who need specialty care, who, by definition, have greater needs than they do.

I just do not like the tenor that we are putting, they were battling against, you know, saying that community care doctors, of which I am one, are better or are worse. I do not think that is fair. That is not fair to our veterans. Then what are you saying to them? Anybody who gets referred out, well, we are saying we are sending you out for inferior care? That is not fair. I do not think that is fair.

Ms. Knight, let me ask you this. You know, and there are questions about, which has bothered me since I have been on this committee, about our electronic medical record, which I think is just derelict in the VA through how many administrations that we have been going through. I still cannot. I had a patient last week who was a VA and I said, did you bring your records? He said, no, they said you would have them. Of course, they never sent them, and I cannot get access to them. Can you explain to me how just the community care has helped you to access more or less —excuse me, giving you more or less access to VA-covered healthcare?

Ms. KNIGHT. I have more options. I live in Montana, so the biggest city in Montana at 150,000 people, so it is quite small, actually. There are not a lot of providers, let alone specialty providers, from within the VA. I see a chiropractor and an acupuncturist to help with my chronic migraines, of which neither are available within the VA. As I have shared in my testimony, I have had pretty horrid stories and experiences within the VA and good experiences within the community.

My chiropractor, who is a male, actually took the time to review what information was passed to him from the VA with my referral and asked me on my preference on whether or not I wanted a man or a woman physician, which was the first time I have ever been asked as a proactive manner on my preference, given my military sexual trauma.

Mr. MURPHY. There are good experiences or bad experiences, really, probably within both systems?

Ms. KNIGHT. Absolutely. I would ask to just have more control and choice over where I want to go. As I also mentioned in my testimony, most times the gatekeeper within the VA calls and says, here is your list of providers. Where do you want to go? I feel like

I am on this ticking time bomb and of making a decision while, you know, momentarily taking a time out of my workplace, because it is usually Monday through Friday, 9 to 5. In that effort, my typical question is, well, what is closest to me as a convenience for me? Not necessarily are they man? Are they woman? Do they have good reviews? Can I do research on them? I would ask to better understand what my options are, so that I can make a more informed and educated decision for myself.

Mr. MURPHY. Thank you. You know, Dr. Mobbs, it hurt my heart to hear that somebody in administration would withhold care because they would not have the compassion, much less the medical competence, to send somebody out to the community and withhold care. I hope that person, I do not want to say disciplined, I hope they got shown the door because what an absolute disservice it would be to whoever veteran, sadly enough, if they die in pain because they did not get their radiation. That is horrible. That is a horrible story.

Ms. Keenan, in your opinion, if you will, where does community care fit in?

Am I already over? I am sorry, I have been yakking too much. I apologize. I will yield back.

Ms. MILLER-MEEKS. Thank you, Dr. Murphy.

The chair now recognizes Dr. Morrison for 5 minutes for any questions she may have.

Ms. MORRISON. Thank you very much, Madam Chair. I want to thank the witnesses for your testimony and thank you for your service to our Nation and thank you for sharing your very personal stories today. That is not easy to do and I know we are all to going grateful, so thank you for that.

Today's hearing really touches on struggles and frustrations that are all too familiar to me as a physician. One of the reasons that compelled me to serve in Congress was my firsthand experience with how difficult navigating the healthcare system in our country can be at times. Patients and physicians have no shortage of exceedingly valid frustrations with navigating healthcare in the United States. A Gallup poll actually earlier this year found that one in four Americans ranked improving healthcare access and affordability as their highest priority. Over half of Americans ranked healthcare among their top three priorities for government leaders. There is no question that Americans are looking to their elected leaders to act on the issue of healthcare.

The testimony from today's witnesses highlights the reality that like the majority of their fellow Americans, far too many veterans are facing barriers that prevent them from accessing the healthcare we made a commitment to provide. They are asking Congress to make meaningful progress toward improving their quality of care and making sure we are delivering on the promises we made to those who have served our country.

Today's hearing title includes "Right Time, Right Place," and "Right Treatment," and I could not agree more that pursuing improvements to healthcare at the VA does require considering time, place, and treatment. We should absolutely be evaluating whether veterans are receiving the care they need in a timely manner. We should absolutely be focusing on fostering and preserving the spe-

cialized care that research continuously demonstrates is critical to veteran health outcomes. We should absolutely be committed to reviewing cutting-edge scientific evidence and research to bring novel treatments to veterans without delay.

However, if we attempt to pursue all of those goals without considering the present circumstances of the VA or preserving a commitment to evidence-based treatments and rigorous standards, then we cannot in good faith claim to be delivering on what veterans have asked of us. Losing an estimated 30,000 staff in less than 12 months will move veterans seeking direct VA care and coordinated community care away from the "right time." Devastating Medicaid cuts from the so-called One Big Beautiful Bill that President Trump signed into law threaten rural hospitals and access to community care, costing veterans the potential "right places" across areas that need it them most. I worry that if we are not vigilant, the pace at which community care funds are growing will strain VA research and direct care that is indispensable to getting to the "right treatment."

Dr. Hunter, with that in mind, in your testimony you emphasize the importance of following the data. What does the data tell us about how to improve access to timely quality care at the VA?

Dr. HUNTER. Thank you so much for that. We share your concern and commitment for having the right care at the right time.

The biggest thing that the data are telling us is the importance of investing in the patient-centered care teams that exist. Far too often these care teams are cut out of the loop. They are often sometimes the first employees to get cut or deemed nonessential. What we know is that they are the most essential.

The other aspect that is incredibly important, as the data said, is to hold community care to some of the same rigorous standards and information sharing, so that the patient-aligned care team can effectively create an entire course of treatment. In our conversations with medical directors at the VA, what we are finding too often is that community care providers are not required to provide back the full course of treatment that they are engaging in with the patients, which makes it more difficult and adds time to having to understand what the patient is going through, and often leads to patients having to relive horrible stories and events time and time and again because there is not that coordination.

Keeping that patient-aligned care team coordination as the center, investing in it, and strengthening the resources for that team is what is absolutely essential to get the right care to our veterans at the right time.

Ms. MORRISON. Thank you, Dr. Hunter. I agree. VA direct care is vital to meeting unique veteran health needs. There is no question that there are circumstances in which community care is appropriate and essential. This committee cannot claim a serious commitment to either while advancing legislation and cosigning leadership decisions that undermine VA's stability and capacity to deliver on its core missions.

Thank you, Madam Chair. With that, I yield back.

Ms. MILLER-MEEKS. Thank you. The chair now recognizes Representative King-Hinds for 5 minutes.

Ms. KING-HINDS. First of all, thank you to all of you for appearing before us today. Thank you for your service. I just have to say, man, go women power, because just phenomenal women appearing before this committee.

I come from the Northern Marianas, where access to service is very limited. We do not have a CBOC. I think people are going to get sick of me saying that because I am going to say it over and over again until we actually do get access to care, which is why, you know, looking at community care programs is very important to me because of that reason.

Now, one of the things that I am hearing from all of you is that things could be better with regards to the way we deliver those programs. There are gaps.

Dr. Mobbs, is it "Mobs"? You spoke of, in your written testimony that you submitted, you talked about a comprehensive metrics system that needs to be put in place. Can you just kind of dive into that a little bit? Because I am looking for opportunities to improve —to ensure that some of these challenges and gaps that we are talking about and hearing about today are actually addressed in the legislation and that we can improve the system.

Dr. MOBBS. Thank you very much for that question. I think this is critically important. I am certainly a advocate for the —not the either/or, but the and. We have to have both a strong VA and strong community care.

As part of that, the GAO has provided extensive recommendations regarding the opportunity to improve oversight and accountability around community care. In particular, some of the things that have been mentioned here do need to be improved upon. The ability to track scheduling performance, for example; metrics aligned with those timeframes are imperative; meaningful accountability around those metrics. Then, for example, the VA's referral coordination initiative, which was meant to streamline specialty care, has suffered from somewhat inconsistent implementation, unclear guidance about its use, and inadequate performance metrics.

I would simply say that the work has been done around assessing VA Community Care opportunities for improvement. I would just say that we should be looking very extensively at the recommendations provided by GAO in order to enhance them.

Ms. KING-HINDS. Thank you for that.

This is a question to you, Dr. Hunter, because I do agree. I am an attorney by practice, and, you know, when you appear in front of a jury, you have to submit data evidence. Right? Sometimes the anecdote does win. Too often, as a matter of fact, in the community that I come from, these stories are what I hear every single time I meet with constituents. For as long as I have sat in this committee, in this last 7 months, these are the stories that we hear.

You know, you spoke of some of the gaps to include accessibility to recordkeeping and being able to have a more seamless process whereby there is a little bit more accountability with regards to the program itself. Can you give us suggestions as to how we can improve the current situation?

Dr. HUNTER. Thank you so much for that. Because, you know, again, we understand that this is not a either/or. That is not how this should be characterized. It is a yes/and. We really need to im-

prove the coordination side of community care, so it is held to some of the same standards that VA care is.

If we are thinking about the coordination piece, there are a few things that can be done. One is there needs to be some more deliberate looking into some of the VA modernization and the enterprise systems that are being rolled out. This work is sort of early on, preliminary. We are really excited to work with the committee to better understand and ensure that the electronic healthcare record system is being rolled out in an appropriate manner that allows for better coordination.

Because right now, what we are seeing far too often is that the VA, where there are very well-coordinated records kept, is not able to communicate well with community providers, and things are falling through the cracks. We are not getting full care plans. We are not able to ensure that veterans are receiving the same standard and quality of care. First, making sure that process is going well, as well as ensuring oversight and enforcement of the quality standards and training that are required of our community care providers.

You know, the MISSION Act said that needed to happen, but according to multiple independent medical associations, there is not yet a published transparent standard for what community care needs to meet or what sort of records need to be provided back to the VA care teams to ensure the comprehensive continuity of care. In those two areas, I think there is a lot of room to be done, and I think this committee is primed to be able to engage in that sort of oversight.

Ms. KING-HINDS. Thank you. I am out of time. I yield my time. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative King-Hinds.

The chair now recognizes Dr. Conaway for 5 minutes for any questions he may have.

Mr. CONAWAY. Thank you, Madam Chair. Thank you, ladies, for your service and your commitment to veterans and their healthcare. I want to make a few comments and observations.

Since both sitting on this committee and what I have heard today, I hope there is consensus on this committee and across the House, across the government, that we need to have a strong VA healthcare system and that we need community providers because we know the VA does not exist everywhere, particularly in rural areas. We know this partnership needs to exist.

One of the problems, as a physician, practicing physician for 30 years myself, worked on an Air Force base in New Jersey taking care of veterans and in the community and private practice, what my experience tells me and what I have read about and what the research shows and what we all know with the problems with our information system is that there is not coordination across those systems. Once you move outside of a system, even within hospitals in my own little State of New Jersey, getting records to move from hospital to hospital, if they are not on the same platform, is a very difficult thing to achieve. You will have, and particularly —and so you are going to have patients, if they move to different locales,

having to repeat their stories. It is terrible when it involves things like trauma.

When you are in a teaching institution, a resident might see you, might be a medical student, then a resident, then the attending. This is part of the teaching process in teaching institutions. Unfortunately, we will hear stories about people being re-traumatized as this information is collected. That iterative process in teaching institutions is part of driving great outcomes.

I would also say that, you know, we have to rely on data, as you mentioned, and the data has been consistent over many years and repeated that VA care for veterans provides great outcomes. Veterans want the care there. If you think a moment about the different exposures, the experience in the military, where they have been, the experience of people taking care of numbers of veterans over the years that is unlikely to be replicated in most communities, it does not surprise me that outcomes are better in the VA system.

Our problem is that it is hard —well, maybe I should speak for myself, but I think I am speaking for a lot of others, too. When we understand that the administration is cutting tens of thousands of people out of a system that is already stressed, it is hard to imagine that you can achieve the kind of outcome standards that you could achieve if those people were not out of the system.

Now, reform, looking at how things are done, making sure training is correct, maybe having a special access for women who are having particular problems, whether it be reproductive healthcare or sexual trauma in the service, those things are important to put in a system. I think you are more likely to get that in the VA than very often you are in the community, by the way away, because of the sensitivities in the VA system for this, I suspect. As I look at the numbers we have about the people who have been —who are leaving the service now, as I look at the numbers, two-thirds of them are clinical staff: physicians, nurses, support staff.

If we were to decide to bring in or try to recruit more women to deal with sexual trauma in the service, I cannot imagine how that would not be decried as a Diversity, Equity, and Inclusion (DEI) program within the government. You cannot even recognize women who have served, you know, honorably overseas because it is, you know, recognizing women, never mind people of color.

I want to ask this question of you, Ms. Newman, because you work in a rural area and we know now that there are a number of studies that are coming out showing that these Medicaid cuts are going to be particularly devastating in rural areas where Medicaid might make up 40 to 50 percent of their revenue. We heard 338 hospitals at risk. You live and others on this panel live and get care in rural areas. Describe how the loss of hospitals in the community is going to impact access to care, the access that we know veterans need.

Ms. NEWMAN. Thank you for the question. Yes, I do live in a rural area. In my particular area, we already have lost access to hospitals. We are an independent home care agency. These cuts are not going to, in particular, impact our agency, but our —people in our area, they are already used to traveling to receive care.

Mr. CONAWAY. Just reclaiming my time because I am running out of time. Thank you for that. I think it is obvious that if hospitals close, there is going to be an access to care problem.

I asked Secretary Collins at a hearing just like this one about whether or not cuts to Medicare and food assistance is going to impact veterans. He says, I do not foresee that happening now. Well, now it has happened. We know as a result of that big, ugly bill that we are going to see, really, quite devastating dislocation across the land, and particularly in rural areas and also impacting veterans. That is a shame, given the commitment this country needs to keep to our veteran community.

Thank you, Madam Chair. I yield back.

Ms. MILLER-MEEKS. Thank you, Dr. Conaway.

The chair now recognizes Representative Cherfilus-McCormick for 5 minutes for any questions she may have.

Ms. CHERFILUS-MCCORMICK. Thank you so much, Chairwoman, and thank you so much for your testimony. It is truly an honor to be here listening to your testimony.

I do have a background in home health, also. I am second generation and I kind of miss being in there and finding solutions to these problems. I do believe also that community care is imperative to serving our veterans. However, we do need to have bipartisan legislation that can help us fill in those gaps. I was very delighted when I heard what Dr. Hunter was talking about. The need for standardization as far as to make sure that we have accessibility, but also communicating what is going on with the community care doctors, specifically getting on-time or real-time information for our patients, which even in the private side and community care, we are still trying to get up to date.

I wanted to talk to Dr. Hunter a little bit more about that. What recommendations would you put in place so we can actually bridge that gap, specifically when it comes to community care and our veterans' offices?

Dr. HUNTER. Thank you so much for that question. As we said, we know community care is vital, but we know there needs to be better direct communication so that patients are receiving that same quality, integrated, coordinated VA care that leads to better outcomes.

If we look at recommendations that can improve this, one is having the same types of care standards that are required for community care providers as for VA healthcare providers. This is seen very clearly in the mental health area, where when a patient is seen internally to VA direct care, VA direct care mental health providers are required to set a evidence-based course of care for that patient that hits very significant benchmarks that are there.

When they are referred out to the community, they were referred out for a time-based episodes of care. 6 months, 12 months, and then it is reevaluated. Right now there is not a requirement to actually share back with the patient care team what the decided course of care is. In fact, all that is required is a yes, this patient showed up for an appointment and it is either improving or not improving.

First and foremost, to strengthen this is to set the same standards for evidence-based care for VA care and community care and

require that transparency, so that all providers within the VA system know what the course of treatment is across all sorts of specialty care that are provided. This is one very specific example for mental healthcare, but we see this happen in other forms of care as well.

Ms. CHERFILUS-MCCORMICK. Now, you touched upon the problems that we are having with electronic medical records. My other subcommittee is Technology and Modernization. I really hope that we can have a joint hearing so we can be discussing this together. I know we already have strains in even getting the VA's system up to task and up to snuff. I know it will be challenging for us to do that with community care. Do you have any recommendations that you can give us when it comes to electronic medical records?

Dr. HUNTER. I think we do need to take a very close look at the current implementation of electronic health records within the VA. We know it is plagued with problems from the get-go. This is an area that I am new in this seat. I have been a CEO here for a month, but it is one of the things that I have really wanted to dive into to be able to provide those better recommendations to you all as to how we can effectively modernize the VA and create better synergies and more seamless communication between VA and community care, and would love to work with your office to do just that.

Ms. CHERFILUS-MCCORMICK. Thank you. I want to pivot a little bit over back to our home health issues that are happening. When I was the CEO of a healthcare company, what we did, we also had rural areas, Clewiston, Belle Glade, and we were servicing there. We had huge issues when it came to recruiting healthcare professionals to get out there. Also, we did have a good number of Medicaid recipients.

Now, do you have any Medicaid recipients who are actually with your organization?

Ms. NEWMAN. We have very little in our particular organization. We are a standalone home care agency.

Ms. CHERFILUS-MCCORMICK. Right now we are looking at $1 trillion in cuts when it comes to Medicaid. I have deep concerns about the compound effects with the cuts that we have in the VA combined with the $1 trillion in Medicaid cuts and how we are going to keep organizations like yourself, who play such an imperative role in making sure that our veterans can actually retire at home with dignity, with their family, but still get their services. Could you touch on some of those effects for your organization's other home healthcare agencies that will be servicing our Medicaid patients and our veterans?

Ms. NEWMAN. Sure. Of course, as I stated, our particular payer mix, we have very little of the Medicaid and so for us, personally, it will not have a large impact. What we do is, as with any other agency, is we try to meet everybody's needs. In our particular area, we are not hearing feedback.

Ms. CHERFILUS-MCCORMICK. Well, I have a few more seconds and I just wanted to ask you this one question. One of the things I am hearing from home care agencies is that they have real concerns about the people who are going to be kicked off of Medicaid. They cannot abandon those patients. How do you transition that

person who is homebound, cannot get up, cannot take care of themselves, how do you rip their insurance, and how do you leave them there?

Have you guys thought about that transition process? Are we just going to abandon these patients to leave them to themselves?

Ms. NEWMAN. Well, if I can circle it back to the VA, we are actually actively seeing that now with our veterans, where on the VA services, where they have lost homemaker services, home health aide services due to internal cuts within the VA. We are seeing that they have lost access to care. I think it is already happening within the VA, but this started a year ago based off of decisions within the VA.

Ms. CHERFILUS-MCCORMICK. So the compound ——

Ms. MILLER-MEEKS. Thank you very much. Your time has expired.

Ms. CHERFILUS-MCCORMICK. Thank you.

Ms. MILLER-MEEKS. The chair now recognizes Dr. Dexter for 5 minutes for any questions she may have.

Ms. DEXTER. Thank you, Madam Chair, and thank you all again for your service and for being here today. Really, really appreciate it.

One thing that struck me listening to all of you, that I continue to struggle with being new here in Congress and coming here as a physician, is what feels like a binary choice between community care and in-VA care. I know nobody here is advocating necessarily for one versus the other, but I think that is how it feels in this committee at times. One quote that one of you shared was community care is not an alternative to the VA. It is an extension of it. That should be what it is, but it is not what it ends up being because this is a fixed pie that when we take money out of the VA direct care services and get it out to the community, it is a loss from being able to buildup the VA care to the quality that we know.

Dr. Hunter, you spoke to, when we get it to our veterans, it is better quality care and they are more satisfied. The problem is, as Ms. Keenan and so many people have talked to, it is getting them that care and having them available or be able to get availability.

One thing that I would like us to try to center, it is truly a bipartisan endeavor, I believe, is to get our veterans at the center of what we are trying to do and make sure that their needs and their access and quality are what drives our decisions rather than protecting community care, protecting the VA system in district care.

Ms. Hunter and several of you have talked about the data, and I wonder what kind of data would be most compelling for you as a veteran? I will start with you, Dr. Hunter. What would be the most compelling data for you as an advocate for veterans, especially our women veterans who are underserved in so many ways? I do not want to be disproportionately focused on that. What would you want to see? What would help you make decisions about advocating for community care versus in the VA system care, direct care?

Dr. HUNTER. Thank you so much for that question. When we look about where the compelling data is, I will put my researcher hat on, I look at outcomes. Right? Outcomes matter and we know that

patient-centered outcomes are better when with VA care because of the coordination, which does not mean that community care cannot get there, but the coordination needs to get there.

One thing you noted that I really want to touch on is some of the concerns that are coming from the fixed budget. What we are seeing more and more is mandatory spending being directed toward mandatory spending for community care, which necessitates making cuts at the VA. We are hearing from several VA providers that that results in not being able to fill positions, not being able to actually hire the people they need to hire, which creates an unfortunate cycle of demonization of the VA because we have lower morale, lower staff, which leads to longer wait times and sometimes worse outcomes. Again, centering the patient in the outcomes is absolutely essential there.

I think as we are looking at this and we are talking about choice in all of this, and choice is essential, but we need to ensure that we do not remove the ability of veterans to choose VA and to choose a provider at the VA as a one-stop shop for their care.

Ms. DEXTER. No, I appreciate that. I think what I certainly am interested in working across the aisle and with this subcommittee on is centering how do we get the data that we need to make the decisions that really do deliver the quality, access, and service to our veterans that they deserve? It may be that it is wound care in the community is the most effective way, especially in rural areas. Let us have the data so that we understand how long it takes to get for a wound care appointment and how far you have to drive, and then let the patients have a choice.

I do think making clear at the VA that patients or veterans have a choice is important. I heard several of you speak to that, that we should not be trying to deter people from getting care at the VA, but we should not shield them from a choice, but making that choice tangible. I hope that everyone on this committee consider that. I look forward to working with you all on how we get policy amendments, however it looks, so that we can get the right outcomes for our veterans.

Because again, I do not want to be shielding Optum and TRICARE and trying to get them dollars. I want to get those dollars to the VA and to our veterans.

Okay, thank you. With that, I yield back.

Ms. MILLER-MEEKS. Thank you very much, Dr. Dexter.

The chair now recognizes herself for 5 minutes.

Ms. Hunter, you mentioned several times about the challenges of information and training and whether VA-specific providers had specific types of training that did not happen in community care. Is not that a failing of the VA?

Dr. HUNTER. If we think about the training, it could be a failing of the VA.

Ms. MILLER-MEEKS. Yes.

Dr. HUNTER. Could be a failing.

Ms. MILLER-MEEKS. I have got 5 minutes.

Dr. HUNTER. Yes. It could be a VA. We just ——

Ms. MILLER-MEEKS. I just want a simple yes and no question. It is a failing of the VA, agree, disagree?

Dr. HUNTER. We do not have the data, so we cannot say where the failure is.

Ms. MILLER-MEEKS. Okay. Is not the VA responsible for that? The VA can set the standards for community care.

Dr. HUNTER. They can.

Ms. MILLER-MEEKS. Ms. Mobbs, can the VA set the standards for community care?

Dr. MOBBS. They absolutely can. That is correct.

Ms. MILLER-MEEKS. You mentioned the training. You also mentioned the Red Report. I think perhaps you might have some comments you wanted to make on testimony, so I am going to give you an opportunity to clarify that.

Dr. MOBBS. Thank you, Chairwoman. First off, I never said that they do not receive training. That that is an inaccurate characterization of what I said.

I think it is really important if we are talking about specifically data here, and I am going to go where I am an expert in, which is mental health. In the VA system, for example, we prioritized two performance metrics-based, data-driven therapies for post-traumatic stress disorder: prolonged exposure, combat processing therapy. Unfortunately, because that was a trauma-centered therapy, the majority of veterans left after 2.4 sessions, therefore wanting a different type of therapy that they were not allowed to receive in the VA because they were given a PTSD diagnosis and qualification. Unfortunately, other evidence-based cares like interpersonal therapy, community care providers are trained in, were unable to see those veterans and they dropped out and then we could not follow them.

All that to say just because there is training in the VA does not always mean it is the right training. To the chairwoman's point, you can absolutely receive care in the community set by the VA to ensure that they are evidence-based therapies to provide for veterans.

Ms. MILLER-MEEKS. I admit that as a community care provider, as an ophthalmologist, I am given a specific type of treatment for a specific disorder I am supposed to address. There were questions that may have been asked of other type of conditions that I did not need training from the VA for.

Ms. Knight, I am going to ask you to comment because you mentioned receiving care at the VA and care in the community, and you have heard how this specific training better equips VA physicians to handle either PTSD or the variety of issues. I did not hear that in your testimony. Can you comment upon whether you thought that this training uniquely qualified VA physicians, and did you receive better treatment at the VA versus in community care?

Ms. KNIGHT. My answer would be no, Chairwoman. No, I had three different accounts of VA providers, one of whom was a veteran herself. All three, again, I felt more like I was interrogated at times, questioned and validated on my combat service and what I had endured, and drilled.

I would also add that so many of our community providers out there deal with other patients who are similar in trauma exposure, such as our police and firefighters. There are an array of providers,

both in the VA and outside of the VA that are more than qualified to meet the standards. I just feel very strongly that, again, one, they need to ask the questions, but that can be resolved by the patient, by understanding and being educated on who the providers are, whether that is ratings or reviews or anything of that nature. Right now, we are not given that choice. We are not giving that option. We are told where to go. It is more or less being in the military.

If I may, if we are going to talk technology, I would love to see the transition of documentation from U.S. Department of Defense (DOD) to VA fixed first.

Ms. MILLER-MEEKS. Kudos. As an Army veteran, I will say kudos to that. We have been asking for that.

Ms. Newman, have you noticed any decrease in community care referrals for home care services?

Ms. NEWMAN. Yes. In 2024, we noticed a marked decrease, both within our agency and members across the Nation.

Ms. MILLER-MEEKS. Have you heard what the reason for the decrease in referrals would be?

Ms. NEWMAN. In our particular VISN, there was an extra layer of oversight and bureaucracy where their intent was to find reasons to reduce the amount of care authorized.

Ms. MILLER-MEEKS. I can tell you from my exposure, my talks with veterans, it was felt that they were encouraged not to send patients into the community. As a community care provider, it can be extraordinarily challenging dealing with the VA, even when someone is 60 miles away from a center that could give them care.

I think veterans do appreciate and like the care that they receive at the VA. There is a reason why the MISSION Act and Community Care exist. The reason was because people were dying waiting for care at the VA.

Ms. Hunter, do you know how much the budget for the VA has increased in the past 4 years?

Dr. HUNTER. Yes, I have that data right here.

Ms. MILLER-MEEKS. Is it flat?

Dr. HUNTER. No, the budget has continued to increase.

Ms. MILLER-MEEKS. The budget has continued to increase. We know community care is comprised in about 40 percent of care now within the VA, but we also know they do it at about 25 percent of the cost to the regular VA. I am just going to say that, you know, implicating that community care is a downward spiral for the VA and taking money away from the direct care system, I am going to say that does not bear out by the facts when you look at the budget and you look where the spending goes.

I also want to say that we keep talking about this as a fixed budget. If you have providers going to community care, they are not going to get direct care because the budget is the same and there is never any increase in funding. That is patently incorrect. I mean, there has been more appropriation dollars from Congress. This spring, Congress voted billions more into VA, VHA medical services, $75 billion to be exact. I think some of the arguments are poorly founded, although they sound very dramatic.

With that, I yield back my time, as I, too, am over time.

Thank everyone for their participation in today's hearing, for the discussions we have heard on the important topic. I am going to yield to Ms. Brownley if she has any closing comments.

Ms. BROWNLEY. I do have some closing comments. I wanted to just respond, Madam Chair, to what you just said about an increase in the VA budget. I agree, there has been an increase in that budget. There has also been an increase in the community care budget. The issue is the community care budget is increasing at a more rapid pace than the VA. I want to put that sort of fact out there.

The way I want to kind of conclude today's comments is to respond to Dr. Murphy, and I think Dr. Dexter actually did a very good job of responding to some of the things that he was saying. He talked about he was tired of talking about an either/or scenario. He said we need to get to, I believe what he said was "yes" and "and". I agree with him, "yes" and "and."

I think what Dr. Dexter was saying, you know, we should not, you know, we should not have a binary choice, an either/or choice, but the community care should be an extension of the VA care, which in my mind is the yes/and scenario. The point I am trying to make, and I think Dr. Dexter made the point with regards to, you know, one pot of resources can only go so far, and we have got to make those choices.

The other issue I want to make here is, the chart is behind me, is this data that I have here is VA data. It is not anybody else's data. It comes directly from the VA. What it says is that from 2022 to 2023, there was a net gain of employees of a little bit more than 18,000 employees. The next bar chart is from 2023 to 2024, the net gain for employees was almost 14,000 people. Excuse me. The last bar chart here is 2024 to 2025. This shows that there is a net loss of a little over 10,000 employees. What I see here is a trajectory going in a direction that is not going to be good relative to what quality care looks like at the VA.

I just believe that as the workforce at the VA continues to decline, I think as the data shows, and, again, this is VA data, it will absolutely begin to limit the choice a veteran should have, whether they want to get their care at the VA or whether they want to get their care in the community. We will get to a point, I am not saying we are going to get there today or tomorrow, but we could get there to a point where a veteran will only have one choice, and that will be to go to the community for their care.

I think it is very clear, and the data is very clear about this, that veterans want to receive their care at the VA. Now, if you are a female veteran, you have got to go out to the community for —if you are pregnant and you have got to go out to the community to get your care, and you should have your choice of providers when you go to the community care. Generally, veterans want to get their care at the VA because they believe they have more quality time with the doctor, they believe that they understand the veteran better, et cetera. This is just the point that I am trying to make, that we do not want to go down this road.

Secondarily, what is a concern with regards to community care is the impact of a $1 trillion cut to Medicaid. I mentioned in my opening comments, the University of North Carolina has identified

338 rural hospitals at risk for closure. One of the main reasons why we started the MISSION Act and moved toward community care was for rural areas. If these community hospitals are going to have to shut down because of lack of resources, there is not going to be a choice. The only choice then will be the VA. Then, yet, you know, people are resigning, people are retiring, people are leaving because it is just not a healthy place to work and they are not going to be able to provide the resources.

This is what I am just —the point that I am trying to get across. The point, I think, we are trying to avoid a deterioration of the VA, and we do not want to deteriorate community care either. We have got, as I said so many times in these hearings, we have got to find the right balance here.

I worry about this chart. I think the chairwoman said at the beginning, this is just normal attrition what is going on at the VA. This is not normal attrition.

With that, I will yield back. Thank you, Madam Chair.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley. Again, 9 percent of the workforce of VHA is lost annually through attrition. These are the VA's figures, about 38,000 employees based on its current workforce. That is the VA numbers. Those are facts.

For me, this is not an either/or. This should be that veterans have choice over where they receive care. I am a veteran. Neither my husband nor I desire to receive care at the VA hospital. We prefer to receive care in our community either through private health insurance or through Medicare. Would it save us money if we went to the VA hospital? Possibly. We would not have copays or deductibles, but we choose to receive our care in the community. We are asking for the same choice for all veterans and the veterans on this panel.

There is a consensus in my mind that we want both community care and, and VA care. Why both? We are trying to serve veterans and serve veterans first and foremost. There would not be a need for community care had the VA been able to serve veterans, not keep them on waiting lists, not have veterans die, not have the big Public Relations (PR) nightmare of veterans waiting for care and dying waiting for care, a suicide rate that remains at 17 percent and has not gone down. A VA who here in this room in testimony admitted that they did not think that residential mental healthcare, the most critical of care, or residential substance use disorder care fell under the MISSION Act. If you were in a mental health crisis from the VA, it was okay if you waited 30 days or 60 days or 90 days or, by God, a year, or you can go to a VISN two VISNs away, 300 miles away.

That is why we are having this conversation. If the VA was not actively trying to prevent people from going to community care, from my standpoint, it is not adversarial. Let us have the consensus that VA care is community care. That our goal is and always on this committee and in Congress is to serve our veterans.

With that, I would like to thank everyone for their participation in today's hearing, for the discussions we have had on a critically important topic. The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous

consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Hearing no objections, so ordered.

I thank the members and the witnesses for their attendance and their participation today. This hearing is now adjourned.

[Whereupon, at 4:19 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Dallas Knight

INTRODUCTION

My name is Dallas Knight, and I am a U.S. Army combat veteran and the founder of Operation Juliet, a nonprofit organization dedicated to serving female veterans. I served in Iraq in 2003 as a young soldier, returning home with the silent scars of war—scars I didn't feel safe addressing for over 17 years. When I finally sought help through the Department of Veterans Affairs (VA), I encountered judgment, delay, and a system that felt ill-equipped to see or serve me. I quickly realized my experience was not an outlier, but a pattern.

I am here today to speak directly to the title of this hearing: how VA Community Care can become a reliable, timely, and trauma-informed pathway for the women who served.

In preparation for this hearing, I invited female veterans across the country to share their stories with me. Within days, 575 women responded. These were not mere complaints. These were detailed, emotional, and often heartbreaking accounts of neglect, misdiagnosis, invalidation, and persistent barriers to care. Their voices demand to be heard. I have summarized their stories here today, alongside my own, and the tragic account of a woman named Lynessa Van Kirk, whose death underscores the high cost of inaction. (See Appendix A: Analysis of Social Media Responses and Appendix B: Social Media Comments by Female Veterans)

ABOUT OPERATION JULIET

Operation Juliet was founded in 2024 to fill the urgent gap in services tailored to female veterans. Our mission is to empower women who have served by providing safe, supportive spaces for healing, community, and personal growth.

Our programming includes:

- **(not so) Average Jane Retreat** – A five-day, women-only healing experience for female combat veterans, integrating evidence-based and holistic modalities such as equine therapy, art, song writing, resonance repatterning, and trauma-informed care.
- **OUTPOSTS** – Monthly female veteran workshops aimed at fostering connection and reducing isolation through holistic modality education and exposure.
- **Mental Health Scholarship Fund (Launching Fall 2025)** – Designed to help female veterans access healing modalities not supported or difficult to access through the VA.
- **Research Partnership** – In collaboration with Rocky Vista University, we are measuring the efficacy of holistic healing modalities in improving PTSD, MST-related trauma, depression, and anxiety among female combat veterans.

In addition to these programs, Operation Juliet partners with other veteran service providers to support women navigating the complexity of VA referrals, authorizations, and access to community care. These interactions have revealed widespread systemic breakdowns in communication, coordination, and patient education.

Operation Juliet has already served over 50 women through our events and inaugural retreat. Feedback has been overwhelmingly positive, with many participants reporting more healing in five days than they experienced in years of VA-based treatment.

POLLED DATA FROM FEMALE VETERANS

Through a social media video that invited women veterans to share their VA experiences, I collected over 638 unique comments, with 575 women engaging overall. The full thematic breakdown and supporting quotes are included in the appendices for further review. (See Appendix A for quantitative and thematic analysis; see Appendix B for select unedited comment excerpts.) Their stories illustrate a pattern of systemic shortcomings in the VA's ability to provide the right care, at the right time, in the right place.

1. Issues with VA Specialty & Women's Health

- Dismissive treatment related to menopause, endometriosis, hormonal imbalance, and hysterectomies.
- Inadequate access to OB/GYN care and mammograms.

  Quote: *"I was told I was too young for menopause, despite having a hysterectomy."*

2. Barriers to Community Care Access

- Multi-month wait times for massage therapy, acupuncture, and trauma care.
- Lack of education around patient rights to community care.

  Quote: *"The referral process was so long I gave up. They act like community care is a favor."*

3. Retraumatization and Mental Health Crisis

- 82% of MST-related respondents were offered no trauma-informed options.
- 47% reported delays of more than 90 days to access alternative therapies.
- 22% described referrals being denied, lost, or mishandled.

  Quote: *"I now have a worse version of PTSD because of how the VA treated me."*

Additional comments included:

- *"My chronic pain is not in my head. The injuries are real."*
- *"I never see the same provider twice. They don't know my name, let alone my story."*
- *"Please address my overall issues instead of sending me to five specialists."*

THE STORY OF LYNESSA VAN KIRK

Lynessa Van Kirk was born on February 21, 1989. She served as an Army Military Police Officer and attained the rank of Sergeant. I never met her in life, but I know her story through her mother, Corinne.

Lynessa served with honor. She asked for help. But the help never came in time.

Repeatedly denied care, misdiagnosed, and left navigating a system that neither saw her urgency nor understood her pain, Lynessa's health deteriorated. In 2022, at just 33 years old, she died

from hematomas and liver failure—long-term, compounding consequences of trauma and systemic neglect. Her mother buried her daughter while still pleading for answers.

The tragedy of Lynessa's passing makes this clear: delayed or disjointed care in the VA system is not just inefficient—it is fatal.

CALL TO ACTION

The VA must act. Not incrementally. Not eventually. But boldly, and now.

Female veterans need women-centered care designed for their physiological, mental, and emotional realities. They need access to trauma-informed providers—not just prescriptions. They need referrals that are fast, clear, and informed by real patient preference. They need a system that doesn't retraumatize them, ignore them, or dismiss them.

We recommend the following immediate reforms:

- Establish a trauma-informed VA community care provider network
- Mandate clear patient preference options in provider referrals (gender, modality, setting)
- Provide proactive education on community care as a standard option—not just a last resort
- Require follow-up from MST Coordinators within 5 days of disclosure
- Create streamlined digital tracking for referrals and provider availability

And most of all, they need to know they are seen. They are heard. And their service matters.

These reforms are not only based on my lived experience and those I serve through Operation Juliet, but also directly reflect the widespread concerns voiced by hundreds of female veterans who bravely shared their stories with me. Their perspectives are documented in the appended analysis and excerpts. (Appendix A and Appendix B)

I am here today for every woman who never got the chance to speak. I am here for Lynessa. And I am here to make sure that what happened to her never happens again.

Thank you for your time, and your attention to this urgent matter.

Respectfully submitted,
Dallas R. Knight
Founder & President, Operation Juliet

APPENDIX A: Analysis of Social Media Responses from Female Veterans Regarding VA Healthcare Experiences

Overview In preparation for testimony before the House Committee on Veterans' Affairs, Subcommittee on Health, 638 public comments were collected from female veterans on a social media platform in response to a video inviting them to share their VA healthcare experiences. These comments were analyzed for recurring themes to better understand systemic challenges and lived experiences within the VA system.

Total Comments Analyzed: 638
Comments Containing Relevant Content: 446 (70%)
Comments Unclassified/Other: 192 (30%)

Identified Themes and Frequency

1. **Provider Issues – 231 Comments**
   Female veterans repeatedly cited issues with providers, including misdiagnoses, lack of trauma-informed care, dismissiveness, or gender insensitivity. Common concerns include:
   - Being treated by male providers despite requests for female clinicians.
   - Feeling unheard or brushed off by providers.
   - Providers unfamiliar with military-specific trauma or female health needs.
2. **Mental Health Access – 140 Comments**
   Many veterans discussed significant mental health struggles and difficulty accessing qualified care:
   - Inadequate mental health screenings.
   - Lack of continuity with therapists.
   - Medication prescribed without exploration of trauma-informed care.
3. **Women's Health – 70 Comments**
   Veterans highlighted a lack of comprehensive women's health services:
   - Inadequate OB/GYN access.
   - Dismissal of menopause or hormone-related issues.
   - Lack of reproductive care education.
4. **Medication Issues – 69 Comments**
   Numerous reports included:
   - Overprescription of medications.
   - Adverse effects of prescribed drugs.
   - Medications offered in lieu of treatment or therapy.

5. **Military Sexual Trauma (MST) – 50 Comments**
   Many women bravely disclosed experiences of MST and shared the shortcomings in the VA's response:
   - Lack of dedicated MST care pathways.
   - Male providers conducting exams despite requests for female providers due to MST.
   - Retraumatization during the claims or care process.
6. **Community Care Access – 50 Comments**
   Many reported delays and lack of guidance on the Community Care program:
   - Weeks or months to receive a referral.
   - Confusing or inconsistent instructions.
   - Feeling like access to community care was a privilege instead of a right.
7. **Delayed or Denied Care – 44 Comments**
   Veterans expressed frustration with lost referrals, excessive wait times, and outright denial of treatment.
8. **Navigational Barriers – 35 Comments**
   Issues highlighted included:
   - Inaccessible systems (call centers, websites).
   - Inconsistent communication.
   - Veterans needing to manage their own referrals and care.
9. **Dismissal and Invalidation – 21 Comments**
   Themes of being disbelieved, dismissed, or accused of exaggerating symptoms emerged frequently.
10. **Retraumatization – 2 Comments**
    A few women explicitly described being retraumatized by the VA system or its representatives.

Compound Struggles

- **Comments with One Theme:** 253
- **Comments with Two Themes:** 139
- **Comments with Three or More Themes:** 54

This reveals the intersectionality of issues affecting many female veterans: provider bias, administrative delays, and psychological harm often occur simultaneously.

Conclusion This analysis confirms systemic barriers to effective, timely, and trauma-informed care for female veterans. The overwhelming response highlights that these are not isolated

incidents, but a pattern of unmet needs that demand structural reform. These comments provide direct, unfiltered insight from the population most affected and underscore the urgency of reforming VA care to better serve the women who have served.

Respectfully submitted,
Dallas Knight
Founder & President, Operation Juliet

Username	Like_Count	Created_At	Comment
follow_the_navy_vet	1	7/3/2025 17:55	MST!!!!!!
tabethabailey630	1	7/3/2025 18:15	â□¤ï¸□â□¤ï¸□â□¤ï¸□love this ma'am. Female Army Vet here..
cryo_cruiser	5	7/3/2025 18:45	Good luck! We need hormonal coverage for woman over the age of 40. Itâ€™s crazy viagra is covered but hormone replacement therapy isnâ€™t!
neal3700	0	7/3/2025 18:50	wish you had more than 5 minutes
ishouldhaveknown68	3	7/3/2025 19:00	stop making women suffer and fight for hysterectomies to give us a better quality of life
igy6_usnavy	0	7/3/2025 19:02	Talk about the disruptive behavior flag that they are abusing
mrs__maria__	1	7/3/2025 19:22	Not military, but hoping my comment helps with the algorithm. ðŸ™□ Thank you for doing this & for your service.
mermaidhair72	152	7/3/2025 19:24	More female providers, especially in mental health.
gmfutrell	13	7/3/2025 19:34	I donâ€™t even use the VA due to all the issues
fredh049	2	7/3/2025 19:36	GOOD LUCK MAY GOD HAVE YOUR SIX
veyore50	4	7/3/2025 19:43	Stop discounting woman in menopause and offer us real solutions!! US Navy Vet
taunaraye	16	7/3/2025 19:52	Iâ€™m not a veteran. But just women getting a doctor to take their concerns seriously is a nationwide problem. Add that to the problems of dealing with the VA and I can only imagine the wall you hit when trying to get any health issues dealt with. I pray youâ€™re able to get your point across.
yourfriendkp	1	7/3/2025 19:54	@ðŸŒ¹TeliahSwinTâ□¤ï¸□â€□ðŸ”¥
all_the_good_1s_r_gone	6	7/3/2025 19:58	The gaslighting, if you have a working uterus you are never sick just tired or stressed. If your in menopause your just old and stressed.
justanobody1472	4	7/3/2025 20:09	Inability to obtain hormone replacement and or ANY assistance with menopause.
lovinlifeat43	134	7/3/2025 20:29	The biggest challenge and frustration that I have had within the VA system is perimenopause and menopausal medication and lack of medication

brandiejeter	0	7/3/2025 20:49	I'm a female veteran that's wheelchair/SCI bound and I seem to be the only damn one. ðŸ˜†
drmel21	74	7/3/2025 20:50	MORE options to holistic care over allopathic care. chiropractor and/or otseopathic care and fascia physical therapies, red light therapies, nutritional deficiency and cellular function trained PTs,NPs and physicians.
trishilish87	1	7/3/2025 21:04	They just give you drugs and no actual solutions to your problems. I have PTSD, anxiety, depression, gi issues, and back problems. They gave me 12 pills a day and 6 at night but Iâ€™ve received no help to fix the problem.
theshomrim.k9	47	7/3/2025 21:06	As a female combat veteran, my pain symptoms and injuries are CONSISTENTLY ignored. I have a TBI, had brain bleeds, epilepsy, spine injuries, etc and I'm told to take Tylenol and a lidocaine patch.
jessmbnel	21	7/3/2025 21:28	stop brushing us aside! my bladder was fused to the inside of my uterus from a botched csection I had in service and they will not fix my csection scar I get special comp for if it's that bad
christiparvino	1	7/3/2025 21:29	consistent mental health providers! had 4 in one year and said screw it. reliving it with 1 provider was enough!
maegs_life	6	7/3/2025 21:30	Female vet and I work in a Vet Center. Thankfully, my care has always been pretty fantastic. The ONLY issue I ran into is being able to access care at other VAs when Iâ€™m traveling, but itâ€™s not a women only problem.
iamthelively1	56	7/3/2025 21:31	My issue is lack of continuity of care within Mental Health.ðŸ¥º
jrayherself50	1	7/3/2025 21:40	My pcp said he would only take me because I didnâ€™t need yearlies anymore. He also said I didnâ€™t need a mammogram until I was 50 when Iâ€™ve had 3 abnormal ones since I was 34. Iâ€™m 41 nowâ€¦
caboynton1	8	7/3/2025 21:42	When I was at the VAMC for myself I got into it with the desk staff when trying to check in for an appointment. Literally 5x telling that lady I was checking myself in and that I am the veteran (had my kids with me and no man with me). ðŸ¤¬

tracinicolek	37	7/3/2025 21:45	No help with peri and menopause, I was told it happens at my age and only one doctor at the clinic.
jmgrella	4	7/3/2025 21:52	I was separated for multiple spine injuries. The VA told me for 7 years that nothing was wrong with me and I was just depressed. Finally got approved for community care and had multiple emergent spine surgeries scheduled within a month of being seen.
evalani.1970	1	7/3/2025 21:55	Would love to spread the wordsâ€¦
np92153	1	7/3/2025 22:02	ðŸ’ž Iâ€™m a Marine Vet. I use the VA for mental health care and fortunately have had a good experience in being able to get medication, BUT get a therapist is an issue. Iâ€™d like to talk to someone, but there are so many hoops to go through. Also Iâ€™ve had issues getting a gyn appointment. That may be on me, but they make things more difficult than they should be. Last thing, that probably isnt just a female issue, they changed my last name without contacting me. I hadnâ€™t been that last name for three year prior to getting out of the Corps. It wasnâ€™t hard to change it back, but I hadnâ€™t to do it in person and thatâ€™s what made it take longer. My DD214 wasnâ€™t even that last name they changed it to.
gr8whitestephashark	0	7/3/2025 22:05	MENTAL HEALTH. I can't express this enough
jeannette_primtentions	1	7/3/2025 22:07	conversation disorder!! and archaic diagnosis that is still given to women instead of listening to us and helping us with injury
autumnalstar	0	7/3/2025 22:09	SA by VA physician at VA hospital, and finding out afterwards that person had been reported many times.
melissac255	0	7/3/2025 22:16	Hearing loss and tinnitus issues I continue to have an uphill battle to get approved for this issue just because of my MOS. An MOS doesnâ€™t tell all the other duties we are assigned.
izzy_survives	0	7/3/2025 22:24	belittling really bad health issues
teylorkirkpatrick	0	7/3/2025 22:27	Lack of health care for females, being constantly dismissed.
tuckykid	0	7/3/2025 22:31	The fight to get to the source of reproductive issues. Literally told me to take naproxen and these things happen and I wound up having cancer

tuckykid	0	7/3/2025 22:32	Stop treating symptoms and find the source
treasuresbytiffani22	3	7/3/2025 22:39	The system is soooo broken. Logging our medical concerns in our records doesnâ€™t happen correctly. Months upon months to see a specialist. Community care isnâ€™t any better. Months upon months to get mental health treatment after your referral expires. Constantly jumping through hoops for nothing. Disabled Veteran from WA state.
jen.boys	0	7/3/2025 22:40	Menopause treatment. I got a new pcp who looked me in the eye and said â€œIâ€™ve only treated men for the last 25 yearsâ€□ are you kidding me?!?
wynonnawhite	26	7/3/2025 22:45	Education of doctors so they stop saying "Oh, it's your anxiety," or "It's your weight," etc., and to listen to us and our symptoms.
katohyahs	0	7/3/2025 22:47	Not being given a rating for back pain because Iâ€™m hyper mobile and had kids. I used to be a combat medic for an infantry line unit and had to sometimes carry more than the men. My back is ded
nautilus2009	0	7/3/2025 22:50	Not having an actual doctorâ€¦I have a primary care practitionerâ€¦not a female issueâ€¦
melissabosco0	0	7/3/2025 22:54	Thank god for u.
mzritz	7	7/3/2025 22:54	We need providers who have military experience !
melissabosco0	0	7/3/2025 22:56	I know of a situation a female veteran would require 2 units of blood after menses. Instead of an ablation they gave her eligiard to induce menaphase!!!!
melissabosco0	0	7/3/2025 22:57	It lately seems easier to become trans vs female seasons hormonal support
beautifulkhaos29	85	7/3/2025 22:59	my pain is real not imaginary
a_jerman1115	0	7/3/2025 22:59	Doctors constantly changing, Guiana pig for medications and the overall battle of finding someone who truly cares about your health and problems
armyair4cebrat	0	7/3/2025 23:01	This is really great!! Thank you for doing this.
pittrio2022	0	7/3/2025 23:02	Primary doc been waiting to see canceled 2 times now. Yet I am not supposed to be mad. Better treatment t

puddlepirate89	0	7/3/2025 23:04	Lack of community care, lack of health care and the absolute horrible and atrocious thing they call obgyns. Im a CG veteran and a 2 yr Commander with the American Legion 25th District of IL thank you for being our voice
nicknakgrits	0	7/3/2025 23:07	Was told at 29 my mamo was "normal" & the knot was "probably nothing" at the VA. I had to fight to be taken seriously & get a biopsy...it was actually breast cancer! Not genetic & no history! We seriously don't know what all the long term effects are & how females are effected by the environments we're in.
karenjustice4	0	7/3/2025 23:20	Lack of newer medications like Nurtec for migraines, lack of breast cancer screening & in general talking to a human. I live in a rural area 2 hrs from VA hospital & community care I cud use. I can't drive 2 hrs each way have alot medically going on.
wtfzookie	94	7/3/2025 23:23	No mental health groups for PTSD from MST, going to meetings with non-MST veterans lack respect for us and tell us how we are stealing disability resources because we are not wartime veterans, them not realizing everyday dealing with that many men was battlefield.
stopmeangirlsnow	0	7/3/2025 23:24	It took 5 years and a referral to a non VA dr to have anyone listen to me about my endometriosis issues (didnâ€™t know it was that at the time). That was AFTER a Dr removed my gall bladder and didnâ€™t know what the sticky stuff was that moved it and attached it to the omentium.
ehe42_	0	7/3/2025 23:24	Im in daily pain but because my confirmed service connected hip issues allow full mobility it doesn't matter. eat an ibuprofen. so it doesn't matter?!
t_rae14	0	7/3/2025 23:25	I havenâ€™t been out long enough to know about VA healthcare but I love this! And I want to build my female vet community! Letâ€™s all be friends!
stopmeangirlsnow	0	7/3/2025 23:25	Thank you for representing us!

lifewithlexxxx	5	7/3/2025 23:26	Being ignored by males! Had a ton of symptoms- they were ignored. Saw a female doc she said â€œnobody has ordered a brain MRI?!â€ no, nobody had. She ordered one THAT DAY, got a call 2 hours later, it was a pituitary tumor
kelleytyree02	0	7/3/2025 23:30	My Biggest... NC Native, US Navy... Have Never Been Able to Find a Veteran Rep in My Area for One let Alone Willing to Help....
thefyrefam	0	7/3/2025 23:30	Being told to lose weight but get a "diet and exercise" even though I have been. I get they check thyroid levels but what about hormone levels or offering weightloss medication if exercise and diet are tracked for a certain time.
jessicaalcantar24	0	7/3/2025 23:31	Chronic pain & PMDD
n.i.c.013	7	7/3/2025 23:32	My VA has an MRI machine but not mammogram. I have brought this up at town halls but nothing as changed. If we matter, show it.
themissmaryhelen	6	7/3/2025 23:33	It took 10 years to finally get help for my chronic pain. I still feel like a lot of my issues and symptoms are undiagnosed and just brushed off as being related to my pain now too.
purplecummins78	0	7/3/2025 23:33	unfortunately only 5 min is not enough. one exame is basic female care- mammogram for a suspected tumore! my clinic in colorado doesn't have the equipment, so was referred to community care. community care took so long i paid out of pocket to get a mammogram and biopsy.
heatherzannino0	1	7/3/2025 23:33	The biggest problem is they took the call centers from the hospitals and put them at a VISN levelâ€¦so you have someone from another state answering your callâ€¦canâ€™t make your appt and a nurse they are paying $100,000 to take a note that a toddler can take because itâ€™s a templateâ€¦then itâ€™s sent to your team in the hospital for another nurse to have to triage which delays care and is fraud waste and abuse!!! Which Collins loves to hear aboutâ€¦if you want to talk about it DM me and I will speak to you on the phone

docmendi	0	7/3/2025 23:35	To be given larger resources, my VAMC only has a singular room for gynecologyâ€¦ And to get my birth control prescription filled I canâ€™t go down to the pharmacy because they donâ€™t keep it. I have to wait 2-3 weeks for it to be shipped. Yet, male veterans can go to the pharmacy and instantly pick up their Viagra prescription.ðŸ™„
glowstixactual	0	7/3/2025 23:36	Being constantly hit on and touched by male veterans in the waiting rooms
reneebeth	0	7/3/2025 23:37	ðŸ¯
ashhoneycomb	59	7/3/2025 23:38	ED is treated like it's a huge concern but I have to jump through HOOPS ON FIRE to get any help with my ADHD concerns.
ashhoneycomb	7	7/3/2025 23:39	as a woman veteran, my pain is believed to be psychological over my husbands (also vet) pain, which is believed to be physical first.
firehouse_soap	0	7/3/2025 23:40	actually listen and test/xray. there are actual medical problems that aren't because of weight or being moody. took 12 years to get an xray of back. another 14 for thyroid to get checked. but still at 0% and told I'm faking
ashhoneycomb	0	7/3/2025 23:41	I cannot get access to a female psych to talk to because of lack of availability. My male PCP keeps telling me I may have to pay out of pocket is I'm 'that picky' (about MST mind you)
joys_smile	0	7/3/2025 23:42	The director wonâ€™t call me back, I am 2k waiting on travel back pay. Social Worker Supervisor. Gaslite me and told me that I was never assigned a social worker. Disability is causing homelessness. In Cali and Nevada we are barely making it.
joys_smile	0	7/3/2025 23:43	Breast tissue is reproductive tissue.
jennyprettyman	0	7/3/2025 23:44	The VA needs to pay providers competitive salaries
bobwilkerson57	0	7/3/2025 23:44	congratulations unfortunately my late wive was an Army Medic but cancer took her 4 years ago
joys_smile	0	7/3/2025 23:45	Stop diagnosing women real pain and mental health diagnosis. Reno VA Hospital needs to have the director investigate for lack of care. Social workers are taking 90 days to return phone calls and the director doesnâ€™t care.

nurse_ratchet4	8	7/3/2025 23:46	More female providers, providers actually looking at your active duty records to validate our conditions (yeah because I love having these issues) and told we donâ€™t have them because they donâ€™t see it in our VA record. Also, menopause and perimenopause care. Also, more mammogram techs. Tired of being referred out to get a finding but they canâ€™t see the images.
sarah.sisson16	0	7/3/2025 23:49	They told me it was PCOS (without any symptoms) it was a âœ¨brain tumorâœ¨
rebeccabaker215	0	7/3/2025 23:54	Neurology! Lost my neurologist bc she wanted to retire and now Iâ€™m being rejected through community care bc that hospital isnâ€™t seeing new patients. I suffer from TBI, epilepsy, essential head tremors and was in the middle of tests to find out if I have MS. Sudden dip into depression bc of this ðŸ˜
stetsongirl10	0	7/3/2025 23:55	I have to pay out of pocket for pain management because the VA in Oklahoma doesnâ€™t give AFâ€¦ itâ€™s despicable.
kkalbach	0	7/3/2025 23:55	So many bad stories to share, I donâ€™t even know where to start! Between the female issues, being pushed aside and swept under the rug consistently or the gaslighting of your healthcare by both male and female providers. The lack of mental health providers. Not being taken seriously
littlepheonixgrace2.0	0	7/3/2025 23:56	fertility is huge cause it's impacted with what we been exposed to
aprildenny0	0	7/3/2025 23:57	Lack of sexual assault acknowledgment
hulltech_ret98	0	7/4/2025 0:00	Ditto all the comments on mental health/mst/ continuity of care. Ripping a veteran away that has come to trust a community care provider is plain wrong. There should be zero time limit on mental health careâ€¦1 yr or 5 yrs what ever it takes.
mickensyl	0	7/4/2025 0:08	We need better access to HRT and GLP1's
acorp1	0	7/4/2025 0:09	MST should be a service connection. Also Ft McClellan WACs exposed to PFAS chemicals should automatically be serviced connection
therisenphoenixx	4	7/4/2025 0:09	Mental health. Providers lying in medical records. Being told things are in my head when they arenâ€™t.

stormdrag0n2	2	7/4/2025 0:11	Mental health care has no continuity and as a Female Combat veteran I need therapy that understands
hightshoehijinx	0	7/4/2025 0:11	COMMUNITY CARE MENTAL HEALTH.
06dogmom	0	7/4/2025 0:13	Always blaming my weight on things even when I am a good healthy weight for my heightâ€¦Iâ€™m 5â€™10â€ and big chested and Iâ€™m fairly strong I should never be 150 lbs. I would be sick.
kikideliveryservice89	6	7/4/2025 0:14	Being told birth control was the first and only method for my fibroid/cyst treatment. I went for a second opinion and it was endometriosis. I had a partial hysterectomy. No gaslighting just solutions.
code.sign.bubbles	0	7/4/2025 0:14	Both my husband and I are both vets. He says he has pain he gets PT, Xray, and an MRI. I say I have pain, I get pain meds and a â€œwe will retouch on it next appointment if it's still occurringâ€
igmutankaluta	0	7/4/2025 0:14	I have heard this a few times... that women need advocates that will look at the women's military records, discipline, medical, items ignored or looked over in their history as a collective over time in history that could uproot hidden trends of malice focused on gender.
sahntahkelas	0	7/4/2025 0:16	being told females are "not real veterans" by v.a. men get pain meds we are told we don't feel pain
shareecope	0	7/4/2025 0:18	I Asked how best to manage my perimenopause symptoms to be told by my PCM â€œyou just have to deal with it.â€
kellyguccione	9	7/4/2025 0:18	Iâ€™m a Female Marine Corps veteran. We need more providers, and female providers at that, to listen and understand and not brush our problems under the table. A pill doesnâ€™t solve our problems.
shareecope	0	7/4/2025 0:19	Lack of female PCMs and the womenâ€™s clinics are gone for my region.
shareecope	0	7/4/2025 0:19	In order to get specialty womenâ€™s reproductive health care, pap has to be current to get referral to GYN.
shareecope	0	7/4/2025 0:21	PCM spent 20 of my 30 min appt lecturing me not to eat carbs to lose weight because weight caused all my issues.

shareecope	0	7/4/2025 0:23	Needing an optometry appt, but canâ€™t get scheduled until December and Community Care has yet to put in referral/call.
declassified911	0	7/4/2025 0:24	I want the option to continue being seen by the OBGYN I used during my pregnancy as my regular Gynocologist. We grew a relationship, but since Iâ€™m no longer pregnant and my PCP can do exams, I canâ€™t get a Community Care referral. I want to CHOOSE who sees me during extremely vulnerable exams.
thelittlest_oneeight	5	7/4/2025 0:24	Chronic back pain pushed off MANY MANY times.. ignored to the point that I couldn't get dressed on my own, hardly walk, and hardly slept. I was written off as a chronic pain patient and was told that there was no solution... debilitating pains at 26yrs old... After having a major break down that made me want to no longer exist, I took matters into my own hands and sought out multiple other routes for recovery. Paid THOUSANDS out of pocket. Finally got help and have been recovering. My source is also in the VA network but I cant seem to get them approved for coverage. I also had limited visits with VA care for PT and Chiro. Only saving grace was the disability rating, and even then, the evaluator told me not to exaggerate because it would look bad on my file. I refuse to give up my life to pain.
ladykahlanrahl	0	7/4/2025 0:25	Friend was a marine in Iraq. Involved in an IED explosion, lost brothers. VA said her back wasn't service connected (it was, she was medically retired). VA refused to cover her reconstructive back surgery. Her BF at the time of denial was AF vet, non combat. His kidney stone surgery was 100% covered over 10 years after he got out. Its horrible what we go through as females when we have medical issues that are service related.
ninaengland	0	7/4/2025 0:26	Pregnancy during service should not be used as an excuse to dismiss joint problems! Pregnancy during and after service would not have been so hard on my body if it was not already beat down from service.
ebolana77	0	7/4/2025 0:26	Providing OB care for veterans of childbearing age, including coverage for the cost of maternal care.

ktg557	0	7/4/2025 0:27	I canâ€™t even get rated, Iâ€™ve had multiple â€œassessmentsâ€ and get denials especially for ptsd because I pre-existing trauma from my childhood
maikr1985	0	7/4/2025 0:27	I got out in 2010, I was raped while in and treated like I wasnâ€™t. There are hospital records and jag was involved. I got out on a family care plan and my commander (female) looked at me and said you werenâ€™t raped signed off and sent me on my way. Then messed up my paperwork so I canâ€™t collect any benefits.
nezwell	0	7/4/2025 0:28	This explains everything ðŸ™ðŸ™ðŸ™
corkeycora	0	7/4/2025 0:29	Iâ€™ve felt like my pain for the past 12 years was all in my head! I feel like only female doctors put in a full effort to help me.
philly_1206	0	7/4/2025 0:29	took almost a year to get seen again by mental health. had a great therapist out in town but denied bc I was seen by her for too long. then nothing provided by the VA. my insomnia is out of hand, given same drugs expecting new results.
devinhope0	0	7/4/2025 0:30	Make womanâ€™s health important.
jennaslye	29	7/4/2025 0:31	women in perimenopause and menopause have to go through the whole MOVE program before we become eligible for any weightloss medication. I did the whole thing and was able to get on medication. Finally found one that helped me lose the weight I gained with menopause (I had a hysterectomy at 33 and am now 49 but don't "look it"). We also need more options for things to bring us together like the men have...outside of baby showers, tea parties (which always seem to be during working hours for some reason? MANY of us work full time jobs) and hunting or fishing (which would be fun, but are dominated by male vets and are geared toward them more).
hazelruthtx	0	7/4/2025 0:32	Female veteran checking in! I run a 501c3 nonprofit doing music therapy at no cost to veterans
callmeecourtney	5	7/4/2025 0:33	Wow wow wow! Iâ€™ve been so blessed with my VA here in El Paso TX. Iâ€™m so happy that you get to do this for female veterans who are having difficulty with the VA.

dammitdevoni	0	7/4/2025 0:33	I have brain cancer, I can't seem to get my medicine because it's inappropriate care according to the email I received. I'm stage 2 and a single mother. ty
raeforseth	0	7/4/2025 0:33	having a new provider ever year and having to go thru all the history AGAIN! or saying this is my issue and hearing uuum hum as the response. you can get a sex change but cant get any help with weight loss other then the Move class
thelittlest_oneeight	6	7/4/2025 0:34	additonal experience: gynecology, able to get birth control.. but had an expired IUD inserted. Had to go back 2 weeks later to replace it. As of now, I cant seek confident or timely care for issues relating to my IUD due to lack of availability in schedules. Not enough providers in the greater Seattle area to support. addional experience: went to Urgent Care Clinic and ended up paying out of pocket for care because both VA and Clinic kept blaming eachother for a discrepancy. Medical visit was written off as "hormonal" and "stress induced" and that it would just go away. The issue did not infact, just go away - ive just been forced to deal and cope. We need quicker access to better counseling opportunities.
jennyjestes	0	7/4/2025 0:37	Poor mental health care, I was suicidal and it took 9 months of me begging for help before I got service and when I tried to up my disability rating, I was denied and I have a frontal lobe TBI from service. I have to beg for service, medication, and I can never get providers to return a message alone a phone call. I have PTSD from my service, Depression and anxiety and so many issues that are ignored constantly. The mental health in the VA is the biggest joke and fully understand why so many veterans kill themselves.
tdub436	0	7/4/2025 0:39	Being told what happened didnâ€™t bc I didnâ€™t report it
jessica_estes1	0	7/4/2025 0:40	At the Boise VA we have an amazing womenâ€™s clinic but itâ€™s very understaffed. I think all VAâ€™s should have a womenâ€™s clinic because they are awesome, but they soooo busy! We need more doctors

saraigvasquez84	0	7/4/2025 0:47	In Cheyenne, dealing with fertility issues, always being sent to care in the communityâ€¦ all the way in central Colorado, nothing local and getting approval for these things always takes me a minimum of 3 months, this has been ongoing for 2.5 years
mightymouse127	7	7/4/2025 0:48	Consistency of care, I personally went through 4 doctors in a year with no notification. We also need quicker turnaround on community care referrals. Thankfully unlike some majority of my doctors over the years haven't minimized my pain more like we're shocked I can do anything at all.
ohiogirl805	1	7/4/2025 0:50	More services for MST survivors.
jenny_davila_holloway	0	7/4/2025 0:52	I was psych evaluated by a neurologist who didn't believe my pain. Funny, a civilian dr diagnosed me after the proper tests.
haileydietzz	0	7/4/2025 0:52	MST support
user4517390142271	0	7/4/2025 0:53	My PCP is a PA that has never heard of my chronic (& sometimes terminal) illness and doesnâ€™t know how to help me when I go to her for care. I feel like I should have access to a provider that can help me manage my illness.
renlarson99	0	7/4/2025 0:53	Just listen to meâ€¦. My pain exists. Just cuz Iâ€™m female doesnâ€™t mean I just bitch and moan. I have reasons to say â€œmy throat hurtsâ€¦ oh maybe you have strepâ€ should not take 4 SEPARATE visits
grayeyedirish	172	7/4/2025 0:54	I don't need more meds... I need the root caused fixed... please stop pouring more pills in my hands and help me fix the root cause
amandatavie	0	7/4/2025 0:54	I canâ€™t get VA benefits even though I went to Iraq during combat
cannonmae	0	7/4/2025 0:55	Iâ€™m ignored every time I go to the VA. They denied removing my bc for a year. And never listen to me when I talk about my physical pain as well as mental health issues
chasity05rmyk	0	7/4/2025 0:56	ability to get holistic pain relief such as infrared light therapy and hyberbolic oxygen therapy for arthritis and fibromyalgia
beyoutifulheart	0	7/4/2025 0:56	pcp fat shaming, wouldn't address any of my problems and said they all would go away if I lost weight. even with the symptoms of a UTI. "well maybe you should eat healthier"

erikasbarker	0	7/4/2025 1:02	I had kidney stones was given and prescribed toradol at the VA ER.. went to pick it up the prescription at the VA pharmacy literally down the hall and was told VA doesnâ€™t cover toradol. ER doctor then called in Ibuprofen â€¦ for KIDNEY STONES ðŸ™,. They gave my husband Oxy for a UTI at the same exact VA hospital. I was honestly so scared that I had some female issue that the VA ER doc wouldnâ€™t know how to treat that I was considering going to a local hospital but didnâ€™t want to deal with a huge medical bill due to billing issues. Females shouldnâ€™t have to worry about quality of care just because we are females.
jevindae	0	7/4/2025 1:02	I wish my adhd was taken seriously. Iâ€™m treated like a drug addict because I use cannabis to cope with my mental health and the VA refuses to prescribe my life changing stimulant medications
fullcircleranchest1995	0	7/4/2025 1:03	PTSD/anxiety from sexual assault that was never documented in medical records and the fight we have to go through to get the disability for the trama. they still make it ridiculously hard.
o.d_navyvet84	0	7/4/2025 1:03	Lack of available doctors for women's health issues. My local VA hospital has 1 GYN and it's a 6 month or longer wait for an appointment, even if it's a semi-urgent issue.
bookings.at.tiffanys	0	7/4/2025 1:06	That I am not in as much pain as I am. Telling me I don't have what I have already been diagnosed with based on my symptoms/tests/images/etc. Waiting for MONTHS for mental health care. Finding out I had a partially prolapsed bladder after YEARS of explaining my pain and pressure, feeling like my insides were going to fall out (both AD and w/VA).
bonesdarwin	0	7/4/2025 1:06	Being a female provider only patient. I either get appointments more than 6 months away or they aren't taking new patients. (MST survivor with PTSD)

swordandvoice	0	7/4/2025 1:09	They have been lying in my records for years. Saying I refuse treatment, saying I have no symptoms, altering my deployment dates, saying things are genetic when they arenâ€™t, refusing treatment, the patient advocate told me my doctor is allowed to discriminate against me, they also told me there are vets with diabetes who get treated first (Iâ€™m pre diabetic), in the doctors note section (not sure what itâ€™s called) but itâ€™s a part we canâ€™t see and they like to put personality disorder in there on a lot of veterans so they donâ€™t treat them, I was the director for a non profit that partnered with the local VA and the VA recreational employee said some in appropriate things and I reported him then retaliated against, my medical issues are getting worse especially my heart and lungs which was proven to be from the burn pits it was proven in 2012 but they refused treatment
sondra11.11	0	7/4/2025 1:10	They do not listen to us or take our pain seriously. They gave me medication that I was allergic to and it caused internal bleeding and didnâ€™t help with my pain made it all worse. I promise I now have a worse version of PTSD from the VA health care system. Waited 10 years for another MRI because they didnâ€™t take my severe spine injury seriously, vertebra starting to fracture and fall apart all to be prescribed medication that caused me more injuries that will last a lifetime. And not once I have I been prescribed anything more than an anti inflammatory and/or anti depressants.
aubreycain1	0	7/4/2025 1:10	Being taken seriously for my back pain and to fix the issue, not treating the symptoms
jenn_socal_life	0	7/4/2025 1:12	Being called Mr whenever theyâ€™re calling me into the Dr office. Not enough female specific spaces. Menopause pre and post care.
rayb0h	0	7/4/2025 1:12	Believe my pain, believe my mental health story thatâ€™s connected to my service, stop just giving me pills and throwing me out the door. ðŸ™„

mom_wife_retiredusn	0	7/4/2025 1:12	Got an eating disorder from trying to maintain weight standards after having my second child while active duty. The VA told me that I should lose weight, went to their weight loss course, I was the only female. Asked if they had weight loss services for a perimenopausal, eating disorder background, or hormonal imbalance (because the VA took me off my meds for hashimotos, via a tel appointment). Told me nope, eat less & move more! ðŸ¤¦ðŸ¼â€□â™€ï¸□ðŸ¤¦ðŸ¼â€□â™€ï¸□ðŸ¤¦ðŸ¼â€□â™€ï¸□Really?!? Like I haven't heard that multiple times a year for 18 years!
bubbles_the_rockfish	7	7/4/2025 1:16	More information on how the female body differs from males and change standard procedures to reflect those differences. Most of the care is still geared to men, and our differences in our physiology are ignored.
whatwillbewilbe	0	7/4/2025 1:17	Male vets get testosterone and ED care with ease, while it took me about 10 years to get hormone replacement therapy and have to be persistent to get testing for correct dosage.
swhit310	0	7/4/2025 1:17	Infertility care is a nightmare to get approved. The entire process took us almost 2 years to finally get IVF approved due to her service connected infertility
camoney25	0	7/4/2025 1:20	Stop undercutting our PAINâ€¦itâ€™s real. Yes, I suffer from severe back and hip pain, I donâ€™t need a PELVIC doctor.
camoney25	0	7/4/2025 1:21	Continuity in mental health providers, Iâ€™m sick of seeing different docs everytime I go.
aimarmyveteran	0	7/4/2025 1:23	Military sexual assault
huntresstreasures	0	7/4/2025 1:27	Health issues caused by MST/PTSD! The PMC I saw told me it doesnâ€™t happen anymore and that she felt it was a trendy thing. HELP me! Educate them!
carlydean13	0	7/4/2025 1:28	REPRODUCTIVE CARE PROVIDERS! MN VA only has 1 gynecologist on staffâ€¦

carlydean13	0	7/4/2025 1:29	Care needs to be accessible. I deal with way too many fucking billing issues. The VA needs to give out an insurance card or something
freezin1	0	7/4/2025 1:34	VA nurse and vet. Pharmacist told me â€œYou donâ€™t look like a vetâ€ also people looking for my husband not me. Ridiculous
diaryof_des_	0	7/4/2025 1:36	AD but why when I go to the doctor about my pain from migraines and instead Iâ€™m being pushed towards birth control ???
mirandi_24	0	7/4/2025 1:37	There is one gynecologist for the VA North Texas system and trying to go the community care route has put me with three doctors that donâ€™t practice the care I needed and I still havenâ€™t been seen. Itâ€™s been 10 months.
lizzie17864	0	7/4/2025 1:40	My records say I was hostile and agitated but failed to mention they didnâ€™t see me until 2 hours after my appointment time. I canâ€™t imagine why I was agitated.
sublimebeautybar.lulu	1	7/4/2025 1:40	let us go back to the woman's clinic. my pcp doesn't keep up with my woman testing unless I stay on her. never had that issue at the woman's clinic, thank you
lizahbeths	0	7/4/2025 1:41	Lack of OBGYN care and high risk care. MST support groups run during work hours. Our service/pain is less than. Pp pelvic floor issues are ignored.
sarcastic.ceramics	4	7/4/2025 1:44	Our voices are not heard!!! I have to jump thru hoops to get the same level of care that my husband gets
medicalways	0	7/4/2025 1:44	We have zero womenâ€™s health care at our VA here in Ohio. Everything has to out in community care and takes weeks to get seen if we can get in, then I end up fighting with the insurance from the hospitals for months after because they didnâ€™t bill it correctly since I am a veteran and so is my husband.
roberta_adams21	0	7/4/2025 1:45	@caracolleen36 :)
thebirthcoach	0	7/4/2025 1:46	Perimenopause/ menopause should not have any problems to get testosterone as part of HRT

amoscrew	4	7/4/2025 1:50	My chronic pain is not in my head. The injuries I sustained during my time in service are real/documented and arenâ€™t getting better. Stop denying me!
mommamel313	0	7/4/2025 1:50	I stopped using the VA due to being unseen and undiagnosed many times- including what turned out to be a brain tumor! As a former family Army officer, the total lack of good doctors who actually seem to give a damn is unacceptable. Good luck and give â€¯em hell! âœŒðŸ’šðŸ‡ºðŸ‡¸
michelle.bythewood	0	7/4/2025 1:51	I was misdiagnosed for over 2 yrs because of the waits/approvals even with community care. My health declined I was in so much pain, I was so uncomfortable and physically sick and frail. Then lost my job not long after I finally had surgery rough recovery, then with so many appts I had missed so much work with the chronic pain took its toll on my mental health as a single mother of 3.
grumpy_tech_called_qb	0	7/4/2025 1:51	Medical providers seem to think itâ€™s okay to tell us weâ€™re fat. Not nurses - doctors. And itâ€™s irrelevant that weâ€™re hurting, donâ€™t want drugs, are exercising, etc. And we see them eating Ho-Hos.
rachelspice1	0	7/4/2025 1:52	The pain management group is horrific! I was told â€œmost women your age have age related painâ€. Completely disregarding a serious neck and back injury sustained on duty. Meanwhile male vets get instant treatment for chronic pain because they are believed
amoscrew	0	7/4/2025 1:52	Making me relive my trauma to get a rating is bullshit when itâ€™s all documented in my medical records by my VA therapist.
aesereht.b	0	7/4/2025 1:54	We also need women's clinics in all VA clinics/hospitals.
aesereht.b	0	7/4/2025 1:54	The VA needs more female providers so they can stop sending MST survivors to make doctors.
etbarnes	0	7/4/2025 1:57	My clinic doesnâ€™t even have a gyno. I have to see my PCP. And the one gyno I saw just threw more medicine at me and didnâ€™t even check for the problems.

yjjonesy	0	7/4/2025 1:58	Stop putting women in cookie cutter mental health treatments when research has not been done on us! We need more research for women in general but also specifically veterans. Also, it took a YEAR for me to get a referral for a transvaginal ultrasound due to pain possible endometriosis!!! She would not give me a referral to a OBGYN either.
jay449712	0	7/4/2025 1:59	Not everything is because of weight or being pregnant.
fragile_like_a_tornado	0	7/4/2025 2:02	Sent to comm care for MHâ€¦dr kept cnx appt and had to stop meds if been on for 10 years, cold turkeyâ€¦.by myself!
samanthahinchey	0	7/4/2025 2:02	first year out of basic and AIT I caught a 1-ton tent rolling off the back of the army U-Haul. the VA has since claimed that because I was able to walk her way. I must have been fine. 8 years later I'm still dealing with the decompressed spine, three fractured vertebrae in my neck, my back and my hips and waiting for approval for surgeries. all that the VA is saying I don't need to have because I'm still walking
hvnswell_kie8120	0	7/4/2025 2:02	I DO NOT want to have my pelvic exam in a dirty patient room with no privacy! please stop batching the sample requiring me to, 're-do' the test, causing me pain and bleeding for a qeek!
kellyann372	0	7/4/2025 2:03	@Brina
mereditthh42	0	7/4/2025 2:03	I couldnâ€™t get a vaginal ultrasound to check on my IUD because they donâ€™t have the capabilities and the appointment to find that out took 8 months
taylorbaumann22	0	7/4/2025 2:04	The womenâ€™s clinic at the Minneapolis VA has been wonderful with the exception that sometimes I canâ€™t get appointments right away for menstrual cycle concerns or women specific concerns happening in the moment but my care at the womenâ€™s clinic has been by far better then my husbandâ€™s medical care in the same building.
cocoluqjl8h	0	7/4/2025 2:04	Having your concerns taken seriously. I had to submit a congressional inquiry to get them to finally listen. It shouldnâ€™t have to be that way.

chunkynnala	0	7/4/2025 2:14	Not enough services for women in rural areas and long appointments times
chunkynnala	0	7/4/2025 2:15	More female primary clinics at all va and cboc clinics
wildcatigy6	0	7/4/2025 2:17	My pain is ignored
tinabear1975	0	7/4/2025 2:18	I was denied compensation for my SA..even though I had statements from people I was stationed with ..and diagnosed with PTSD..during my CMP exam
amandahayes191	0	7/4/2025 2:20	stop treating us like we're fragile. understand we have kids. stop with the bandaids and fix the problem. 10 braces, a cpap machine, and a hormone imbalance.... no i can't sleep. you sleep like that.
shaunaberntsen439	0	7/4/2025 2:23	never being listened to. our pain is always dismissed. so frustrating.
adairwhitehurst	0	7/4/2025 2:24	Thank you sis for doing this! Iâ€™m one of the lucky few that my primary hears me and gets me to where I need to go.
ambermariewrites	0	7/4/2025 2:27	My ADHD and anxiety is a real problem. Cognitive behavior therapy will not get rid of it. And I need consistent help.
owlchop	0	7/4/2025 2:28	Healthy, 2 kids - deployed (burn pits) - came back, had a hysterectomy 6 months later.
Import1	0	7/4/2025 2:30	from Montana im having to travel for surgery that day! I don't trust or feel safe with my care with changing of the provider happening alot it makes me shutdown.
mundaymornings	0	7/4/2025 2:33	Not being asked where the veteran isâ€¦ ðŸ™ƒ
kimberk7051	0	7/4/2025 2:41	ðŸ™ŒðŸ’ª
seyahmountain	0	7/4/2025 2:43	I wish that I didn't have to be out sourced to community care for 80% of my health care. get more female programs and doctors in the VA
lilred2569	0	7/4/2025 2:47	that my issues/ concerns arnt a problem. blood work was normal so "im ok"

flippinncrazy	4	7/4/2025 2:50	Had to go outside the VA for menopause care. VA ran tests, said â€˜nope, not menopauseâ€™. Couldnâ€™t take the menopause symptoms anymore, paid out of pocket, absolutely was in menopause. VA does provide the medication, but I donâ€™t see them for my womenâ€™s health anymore, I pay out of pocket. (Not to mention worst gynecologist exam Iâ€™ve ever had was from the VA â€˜womanâ€™s health clinicâ€™ that they only had once a month with rotating doctorsâ€¦no continuity of care.)
jk_nyx_tokki	0	7/4/2025 2:53	Trigger Warning:âš ï¸□My friend un-alived herself in a VA parking lot due to not getting the care she needed due to SA. We do NOT have enough support.
evernight83	0	7/4/2025 2:56	I am incredibly sick and tired of the PHARMACISTS having the right to say no to prescriptions my doctor finds necessary; as well as why they have access to my records when they arenâ€™t my direct provider! I donâ€™t want a lot of meds, but some are necessary to a point I have to pay to see medical providers outside the VA and get the prescriptions filled OUTSIDE the VA! Iâ€™m not asking for a lot, just stop the madness of giving unneeded meds and start giving the needed ones!
mommawestx3	0	7/4/2025 2:57	I was assigned a doctor who was also administrator, her hours were only mornings 2 days a week. So I couldn't get in with her and pay for medical myself and get things done.
wanderjen	32	7/4/2025 3:00	Dedicated Women's Health spaces for our care to feel safe. Lots of us experienced MST so going to appts can bring up issues. Help us feel safe at VA!
hollybricker24	0	7/4/2025 3:00	Getting bloodwork to check my hormones instead they say Iâ€™m depressed and prescribe antidepressants when in smdepth bloodwork could identify
mamabearcorby	0	7/4/2025 3:00	They refuse to actually test anything! I have had to beg to get tested to try and figure out whats wrong and just receive eye rolls, told to lose weight (but the move program wouldnt help me), and stop saying my issues are anxiety!ðŸ¥º

dawnkurzatkowski	0	7/4/2025 3:00	we are the veteran, and our issues/problems are real, and we've been dealing with them.they don't go away.
pinkfox360	0	7/4/2025 3:01	I need my appoints addressed in a timely manner. It once took me 2 years just to get an appointment for my back that I have a rating for, the doctor they sent me to just gave a prescription to ibuprofen. What! I have to bulging disk!
_11janedoe11	0	7/4/2025 3:04	Im tired of meds and referrals. But I also learned to use my local PMC for the best care. I use the same insurance for both.
rarag1982	0	7/4/2025 3:05	Lack of female providers, pain is different than men, long wait times for help. No help with menapause
kellya.hernandez	0	7/4/2025 3:06	I need bilateral knee replacement, I can barely get around and care for myself at 39 years old, but my pain is brushed off and treated like itâ€™s not real. My husband goes in and they treat his pain without question. Iâ€™m 100% disabled Combat Vet and because Iâ€™m female Iâ€™m not treated the same as my male counterparts.
ninjaboo56	4	7/4/2025 3:08	Not all clinics or hospitals have mammogram machines or womenâ€™s clinics or programs.
mrs.baconmt	2	7/4/2025 3:08	Diastasis recti and hernias. Was told by a surgeon that never saw me I just had diastasis recti and no hernia. I had 3 hernias. Will continue to get more until I pay out of pocket for my diastasis recti repair.
lenaprice1234	0	7/4/2025 3:09	ptsd treatment for women
framboise_42	0	7/4/2025 3:11	PCOS? that muscular pain in you left hip is of course due to an ovarian cyst. My off-base GYN was baffled by the male PA's idiocy
framboise_42	0	7/4/2025 3:13	pregnant? ok, your severe back and hip pain which makes it so you can't walk or sleep will be addressed after you give birth because the unborn child matters more than you as the service member

nimphadoradeatheater	0	7/4/2025 3:13	How about the fact that I messed my back up in basic training and had to go home but I canâ€™t claim to be a veteran because I didnâ€™t graduate basic training. And I canâ€™t get the care I need cuz I canâ€™t afford it. I have crushed bulging and herniated discs
n.chante1	0	7/4/2025 3:15	They focus solely on boobs and crotch as women's care. Women Veterans need drs who understand how medications will be affect us differently from the men- there aren't enough women seen by my doctors for thrm to be experienced in how women's bodies are different from men's - beyond boobs and reproduction.
framboise_42	0	7/4/2025 3:15	15 years to have SVT dx'd...they kept telling me it was anxiety. When the cardiologist saw the heart rate monitor jump to the 300s without prompting, his face was terrified
pinkladyjenna	0	7/4/2025 3:16	Why are female vets cut off from pain meds when our male counterparts are not?
buttacream06	1	7/4/2025 3:17	Not enough support for perimenopause/ menopause issues or finding root cause of autoimmune conditions.
the.superior.northpeach	0	7/4/2025 3:19	no one calls me back when i need help and they keep pushing pap smears when I say no.
lala71165	0	7/4/2025 3:22	I am actually having pretty good care at the VA in Cape Coral Florida. I am going out in the community to deal with my mental health. I just didnâ€™t want to take a pills everyday
aimeebrown1402	0	7/4/2025 3:25	Chronic pain and no rating because itâ€™s in my head.
yarncore	0	7/4/2025 3:26	misdiagnoses, generally having symptoms written off, being told to eat better, sleep more, etc as the solution rather than taking my concerns seriously. prescribing medication that exacerbates other conditions (anti depressants contributing to heightened symptoms of anxiety)
amandagarrettwall	0	7/4/2025 3:29	Continuity of care for Mental Health
flyonthewall29	4	7/4/2025 3:32	After 2 Iraq deployments, my menstrual cycle went crazy and started causing other issues. VA denied all womenâ€™s health claims and refuses to acknowledge

amiecraig	0	7/4/2025 3:32	complications due to pregnancy and childbirth. my epidural was done incorrectly and has caused back pain with debilitating spasms monthly. I was pushed aside and threatened with UCMJ for "disobeying an order" because I wanted to go home after childbirth and didn't want to stay for 5days because of high blood pressure. they didn't give me a chance to push and looked at me as a way to teaching tool and not a person. I felt I had no voice
dree333universally	0	7/4/2025 3:34	We are strong, and we have a societal responsibility to hold that strength, so we don't always know know how to talk about our pain.
karliemastrogee	0	7/4/2025 3:37	The fact that I have told numerous providers for years about the pain in my spine with documentation about the damage for them to tell me itâ€™s not service related when I literally fell off a cargo net and consistently was required to carry toolboxes that weighed over half my body weight.
memphislady	0	7/4/2025 3:37	I'm sick of being fat shamed by VA doctors when it was the VA that put me on steroids for years which aided my weight gain.
mrs.amelia_bedilia	0	7/4/2025 3:41	Sexual assault should not be brushed under the rug!
savanahadams3	1	7/4/2025 3:41	Safe place for female veterans from men coming into the womenâ€™s clinic. Improvement of after care and treatment for DV and the physical effects afterwards from the damage caused by the physical abuse. My face was shattered and now my face is lopsided and I canâ€™t get it fixed but a man who wants to be a woman can get drugs to transition and get a boob job
samfu3	0	7/4/2025 3:42	There is so much to unpack, that finding a starting place is hard. From dismissal of symptoms to the zoo we have to navigate. Combat veterans have it worse in a lot of aspects.
marnie0567	0	7/4/2025 3:44	The length of time to get a mammogram. 7 months supposedly first available
bigmamajil_	0	7/4/2025 3:44	I hurt! Physically, mentally and emotionally. Iâ€™m not making it up and I donâ€™t want pills.. I want to be heard and acknowledged!

genxtism	0	7/4/2025 3:45	Talk about how much harder it is for a female vet to get rated for PTSD than a male. My husband had a 15 min video call and got diagnosed. I've been applying since 2015 and can't get seen by a doc.
kimcheedealer	3	7/4/2025 3:46	When I came back from deployment with crippling migraines VA brushed it off and didnâ€™t take it serious. They tried to tell me Iâ€™m depressed from adjusting back into society. Long story short, my civilian primary care found out that my hormones were out of wack and I have thyroid issues. I had to advocate for myself to get an IUD and educate VA doctors on current research. Why am I doing their jobs? I have a list of things why I have an issue with VAâ€¦ I had to argue with them why I wasnâ€™t a MALE. It was their error and they wanted me to send my birth certificate to provide it. I asked what male goes to the OBGYNâ€¦ then it was fixedâ€¦
ret2023	1	7/4/2025 3:52	Combat nurse, 3 tours, lost civilians and friends. Took vet center to be taken seriously about PTSD. 5 years to get taken seriously at VA for PTSD
jaylope79	0	7/4/2025 3:52	Child care in the VA or a nursery for an hour or 2 in order to attend appointments. I had to bring my 9 month old to my orthopedic appointment and I couldnâ€™t even fit the stroller in the room it was so awkward so I had to hold her while trying to do my exam for my back which included bending over and laying down.
adayinthelifeofjamie	0	7/4/2025 3:54	I just retired (army) 3 months ago and so far only had 1 Va appt to establish care. My next one to finish that appt is at the end of the month- with blood work so no real update on my end. Im in the Ft Campbell area for VA care
thereal_supergirl	0	7/4/2025 3:56	I shouldnâ€™t need a consult from my primary care to see Womenâ€™s Health (GYN). I should just be able to schedule an appt with them. Men donâ€™t need a consult for sexual dysfunction concerns. So why donâ€™t we have more access to womenâ€™s health providers??
1tjpeach1	0	7/4/2025 3:56	Community Care mental health providers - having the ability to have a consistent SINGLE source to talk to.

elizabethj319	5	7/4/2025 3:57	Getting ignored because â€œyou didnâ€™t deployâ€ like my efforts at home were as good if better than those who deployed before me
barrackbunny_	0	7/4/2025 3:58	Lack of support for ptsd for us that have gone through mst! I donâ€™t need meds I need a knowledgeable person to speak to or a group of women who can share and help each other.
warriorforwomen	0	7/4/2025 3:59	We need HRT care
auntieairmi	0	7/4/2025 4:00	I need them to listen, no it's not my weight, no more pills, please give back extended hours.
seychiita10	0	7/4/2025 4:04	Iâ€™m a 24 year old (i look younger) and I get treated that Iâ€™m not â€œold enoughâ€ to get treated for the disabilities that I have and want to constantly right me off like my pain is â€œnormalâ€.
jadeslayervibes	0	7/4/2025 4:10	HORMONAL CARE & TREATMENT
helenkotek	0	7/4/2025 4:12	Doctors with better understanding of womenâ€™s G.I./gut issues. They just prescribe omeprazole and say itâ€™ll fix everything. Would love more holistic approaches to healthcare also.
e.e.brantley.1	0	7/4/2025 4:16	Care for women, I'm not a male, please stop treating my symptoms as such. Ivf, iui, should be for us not males with fertility issues, no perimopause, menopause care.
samanthalovette2011	26	7/4/2025 4:17	(1) Not being addressed as the person who served. My husband never served but gets addressed as the veteran when he goes to the VA with me. (2) The attitude when calling to check on status of things. Then it takes 2 weeks to track down the doctor to get answers. I get that the portal can be quicker, but I like to ask follow up questions on the spot. (3) Iâ€™d rather treat my issues without a bunch of pills. The VA doesnâ€™t approach any natural routes just pushing pills. (4) The doctors treat you as a number rushing through appointments and donâ€™t explain things. Iâ€™m left to play Dr. Google then they tell you youâ€™re wrong but canâ€™t follow up on how.

spanishblueeyes	0	7/4/2025 4:19	Access the care, need more female providers, empathetic and patient centered training for male providers as our symptoms or pain is real and to not make us feel like itâ€™s all in our heads or something else.
sarge.t	0	7/4/2025 4:21	Losing your reproductive organs due to exposure to fuel and being deployed in the Middle East is service connected.
sarah_allen20	0	7/4/2025 4:23	Found a mass, and was told that it was just a sore ligament. Took 6 months to find out that it was an incarcerated femoral hernia. Was told that I needed to see mental health, and was given a heart monitor. Had to advocate for myself, use the help of a patient care advocate, and finally was sent to see a surgeon.
aes11377	0	7/4/2025 4:27	This is amazing!!! ðŸ’—
sstrandlund	0	7/4/2025 4:28	Never actually being taken seriously or care for. Constantly pushed to the side
bochord5	0	7/4/2025 4:28	more female doctors I'm tired of male doctors taking one look at my boobs and go oh those are the problems ðŸ˜’
doc_b449	0	7/4/2025 4:29	Doctors please listen and stop shoving medications down our throats
alyssawith2as	0	7/4/2025 4:31	Take me with you
gnarlynarwhals	0	7/4/2025 4:35	I just started my va process. felt hopeful since all they guys i know are helping me get the ball rolling, love them for that, but now idk if im going to be treated like they were and get the same results. ðŸ˜” im so tired of having to work 2x as hard to get the same results the men around me do. being in acft mx that was my life. please ðŸ˜
jacquelineroberts70	0	7/4/2025 4:41	On while I was active duty missed signs of an ectopic pregnancy, had to have emergency surgery to remove fallopian tube. Get sharp pains in the area every month right before my cycle and the VA told me that because there is no outer scar from the surgery that I can't have pains

pintsizedfullstrength	0	7/4/2025 4:56	Womenâ€™s specific clinics. Before I was assigned to the womenâ€™s clinic, any time I had an issue with anything between my shoulders and my hips (breasts, uterus, etc) I could see my PCP visibly shudder. I brought up concerns about breast issues and it was brushed off. A year later I was diagnosed with stage 0 breast cancer.
melissalakay	0	7/4/2025 4:57	Itâ€™s been since February that Iâ€™ve been dealing with not being able to hear out of my ears I finally get seen in August at the ENT this is ridiculous
angelinaevelynquiles	0	7/4/2025 5:09	my old female VA primary ignored 2 medical conditions for years that both required surgery to fix. not everything is anxiety. anxiety can make conditions worse but it's not the sole problem
kimberlysraydulan	0	7/4/2025 5:15	When I was hospitalized there were no female socks, gowns, all braces are to big for females. Everything is only in male sizes!
rhondaheartsfreedom	0	7/4/2025 5:26	@rhinda89
rhondaheartsfreedom	0	7/4/2025 5:26	@gaylarodgers
emergencyboot	0	7/4/2025 5:34	How i have a low V.A. rating but can barely walk sometimes. Most of my claims have been "not service related."
rhondaheartsfreedom	1	7/4/2025 5:43	Thank you for speaking for us!!
chucklz8	1	7/4/2025 5:45	Can we get some doctors at the VA that didnâ€™t graduate last in their class? That actually care about their jobs?
victorybelle81	0	7/4/2025 5:51	Can therapists who are for post-911 veterans please realize women were there too & our issues matter too. Especially female therapists who seem to only realize or feel male service members matter more & that female service members went through things too!
okiedawn	0	7/4/2025 5:56	More. Fucking. Female. Providers. Providers that wonâ€™t tell me that my chronic pain from my combat deployment isnâ€™t their problem to address or solve.

victorybelle81	0	7/4/2025 5:57	A huge thing. VAâ€™s realizing women do serve. We serve in combat, combat zones, hazardous jobs, high stress jobs. Some still act as though women who serve only serve in jobs where they are not in harms way, no hazards, no combat, no war zones. It seems crazy but training to realize that isnâ€™t the case. In 2025 how are they unaware? Iâ€™ve been to 5 diff VAâ€™s. Same outcome.
manda_marie_17	0	7/4/2025 6:04	Weight loss is the biggest issue and more gyno female doctors!
blue_sage_cottage	10	7/4/2025 6:08	IBS and Endometriosis are two distinctly different diagnoses.
roselillian_	2	7/4/2025 6:08	The difficulty women face in healthcare is not because women are inherently harder to treat, itâ€™s because the system was built without them in mind. Improving care for women means updating research, addressing bias, increasing access, and listening to patientsâ€™ voices more deeply and consistently.
yoterryo	0	7/4/2025 6:11	Mental health, post menopause and MST are real for female veterans and often we seek help only after caring for our families. Take our health as seriously as you do Erectile dysfunction, and educate and adopt more forward thinking female providers
katethegreat1984	0	7/4/2025 6:14	The pharmacy call to get started on birth control feels like a riot act. Do you want me to get pregnant?
rox.shep	0	7/4/2025 6:16	I was diagnosed breast cancer. needed assistance and tried to turn to VA. to only be told I need an intake appt which is a month out. and no guarantee to be given assistance. ðŸ˜µâ€□ðŸ’« my appt is currently pushed out another month. no outreach or assistance as if now.
dawnguerrero123	0	7/4/2025 6:20	we need massage therapy to be covered...I've done physical therapy, gone through acupuncture and chiropractors ...I do not want to take muscle relaxers or any meds... massage is the only thing that will relax my muscles to where the pain goes away for a while
unicorn120387	1	7/4/2025 6:28	please address my overall issues instead of sending me doctor to doctor for each symptom. there is something bigger causing this but none of the doctors communicate or look at the bigger picture.

miss_cat406	0	7/4/2025 6:31	Healthcare sucks providers. Youâ€™re always changing. They never know your background. It feels like a waste of time.
donna.vf22	0	7/4/2025 6:37	Be able to self refer to womenâ€™s health instead of needing to get a referral from my primary care doctor first
maryammahfeli	0	7/4/2025 6:38	we need more appointments available i had to wait 8 m9nth to see nutritionistØŒ we need cure for our issues not painkillerØŒ we need help with mental issues not bunch of medications
soycynthiii	0	7/4/2025 6:47	Safer therapists!! I used to feel so safe with my therapist, then pulled my notes and realized he was judging me HARD especially torwards my MST and anything related. I havenâ€™t had the courage to speak to anyone since.
allshapezyoga	0	7/4/2025 6:52	Move program is not designed with women hormones. More alternative methods are needed.
allshapezyoga	8	7/4/2025 6:54	Not being proactive on mammograms or Pap smears when they are needed. Being told that post hysterectomy no more checks are needed no help for pelvic floor pain and therapy
cecyxena	0	7/4/2025 7:03	We need more female veteran therapists
sara_only_account	0	7/4/2025 7:08	I'm an older female. in less than 10 years, I may not able to drive the 1.5 or 4 hours one way to the VA clinics, and the few female providers in my town said they will never take me because of defaulted VA payments .
naygrant08	0	7/4/2025 7:18	I have only been retired for three days and haven't experienced anything myself yet, but I have heard a lot of horrible stories. I am still navigating my way around. Good luck, and thank you.
spec4packmule	0	7/4/2025 7:21	Being called a pain med addict but not getting any help with pain. Pain is not the problem being in pain every day for 20 yrs is the problem. Sexual assault victims. Civilians treat us like crap at the VA. CIVILIANS WORKING AT THE VA DO NOT CARE CAUSE THEY CANT GET FIRED! HIRE ONLY VETS.
leticiarios342	0	7/4/2025 7:23	More MST women therapist

jennshonuff	0	7/4/2025 7:32	I have to take my husband with me in order for my PCP to take my symptoms (that I'm downplaying) seriously. Also being told that my POTS was just anxiety, or that I couldn't possibly have hEDS. I went to specialists on my own dime in order to get these diagnoses.
ohhdemonicaaa	0	7/4/2025 7:40	Iâ€™ve fired two male pcpâ€™s, both were very dismissive and one was also really disrespectful, Iâ€™ve dealt with chronic pain for over 4 years now with no real answers, told test results are normal when theyâ€™re marked out of range and have had to seek multiple kinds of care outside the va, out of pocket. Iâ€™d be not alive if I didnâ€™t get EMDR and ketamine therapies on my own that the va denied me to get. Iâ€™ve been patronized by MH providers, sent to a dietician 3 times for being â€œoverweightâ€ at 170lbs, did 3 circuits of CBT, failed 6 different antidepressant trials, told I didnâ€™t have PCOS when the US imaging stated â€œMULT BIL OV CYSTSâ€. Iâ€™m mf tired and canâ€™t believe I still go, I donâ€™t have other care since I donâ€™t work (100% SC P&T) ðŸ«©
sunflower0322	0	7/4/2025 8:06	Having OB docs instead of referring out to other docs that are crap
koalama79	0	7/4/2025 8:28	We as women need the resources to have the correct specialists for female health. I have stopped VA healthcare due to my PCP was also my gyno and they scheduled my pap as a telehealth appointment.
ddddeeeesssssss	0	7/4/2025 8:31	Lack of leadership understanding ptsd from mst
docqueen420	0	7/4/2025 9:43	Olivia in Martinsburg malpractice the uterus out of my body
brandywhiddon76	1	7/4/2025 9:48	Mental health- inconsistent providers. No one wants to open Pandoraâ€™s box several times a year and deal with the spiral of pulling those memories up.
serendipitousbehavior	0	7/4/2025 9:48	I need community care more available, I live in a rural area, but because its exactly an hour away, I have to drive to the VA for everything, ruining my options for work, cuz I have so many Dr's appointments. and travel pay got so cut im broke from traveling so much.

probably_doing_it_wrong	0	7/4/2025 9:52	ED is considered a horrible disability but FSD isnâ€™t even acknowledged
joythomas02	0	7/4/2025 9:55	1 how they treat you after surgery.Csection and they never give me vitamins and tryed to help heal the scars.2if you are a little overweight,they dont want to treat any problems you have,and just push blood sugar pills.when you have reactions like hair loss they do nothing.
randomuser93822	0	7/4/2025 10:11	Lack of help for autoimmune issues or chronic diseases women deal with. Asked to see an ENT for MCAS testing. ENT didnâ€™t know what MCAS was. Anxiety is a SYMPTOM not a full diagnosis for everything. I stopped going for help due to lack of it. I just deal with it.
denisemar00	0	7/4/2025 10:22	The disregard for female veterans in general. As if we are non existent, as if our issues donâ€™t matter at all. Invisibility
jena_w	0	7/4/2025 10:23	Female Vet from Oklahoma - we have 1 oncologist that covers 2 VAâ€™s (all of eastern Oklahoma) and all types of cancer. I asked for a specialist and was denied. 1 oncologist can not treat all cancers. They need to open up community care for cancer and female medical issues - the VA clinics and hospitals just donâ€™t have the experience to treat these yet.
nyliyaahh	0	7/4/2025 10:26	My therapist belittled me, told me that my problems and symptoms were nothing compared to her other clients, ONLY talked about her other clients and so much more. Very inappropriate. Iâ€™ve had great therapist up until the VA. In addition, men harassing me every time I go to a damn appointment at that facility.
koreanhope7	0	7/4/2025 10:53	My frustration is pain management. They say that they are non opiod route which is fine. I had arthroscopy hip surgery that cost $95,000. I have an option to get PRP injection (using your own blood and pulling platelets) but they will not cover it ($500) and has better success. I would rather get PRP injections for superficial tear than getting a steriod injection.
jenuse	0	7/4/2025 11:05	HORMONE THERAPY HELP!! No More meds, more female providers and more womenâ€™s clinics.

sailor_jenny	0	7/4/2025 11:30	no help for female s3xual disorder (caused by MST and hysterectomy) ðŸ˜• hurts my relationship with my husband
kc_ak99508	0	7/4/2025 11:33	Dedicated women's health clinics, I'm fortunate because the VA im at does have one but it is very small. we need a focus on training female providers and focus on issues like perimenopause and MST women's mental health that is often ignored
holisticveteranswellness	2	7/4/2025 11:34	Lack of holistic, smart, integrative approaches to the perimenopause and menopause community.
lexindoggos	0	7/4/2025 11:51	The VA continuously misdiagnoses female veterans with anxiety instead of ADD/ADHD. Why? Because they base their diagnosis from research of symptoms in male patients.
ambermc811	0	7/4/2025 11:53	As a female veteran of a certian age, there are no perimenopause/menopause specialists. Just couldnâ€™t get answers. Had to go outside and pay out of pocket to get help.
joleneferreira420	0	7/4/2025 11:54	Pain is real not in my head. When I stand up for myself its not me being rude its calling advocating
kristin_thecounselor	0	7/4/2025 11:56	10 years ago, the VA told me I couldnâ€™t get my tubes tied without â€œmy husbandâ€™s consentâ€□â€¦ Now, Iâ€™m 40 and getting a hysterectomy, through a female provider at the VA. More female providers!!!
mamastrickland65	0	7/4/2025 11:56	I have
bookishanie	0	7/4/2025 11:59	I get no female reproductive health.
paulmcdthenp	0	7/4/2025 12:00	I am a veteran and a C&P examiner. I can help with some amazing nexus letters backed with medical literature.
m144206	0	7/4/2025 12:07	My care was actually great but physically Iâ€™m actually pretty healthy. My qualm is that after the cuts, my mental health care was delayed. I know thatâ€™s not gender based, but please donâ€™t let them forget that we need more job fillings in the VA!
country_gal_48	0	7/4/2025 12:17	Mental health physicians that understand the female psyche and understand how they process PTSD and other mental health issues differently!

ladymarine_1977	12	7/4/2025 12:22	Ya, I need someone to ask why men can get ED pills and testosterone, but I canâ€™t get any type of hormone replacement therapy at all. But also, there is a significant issue when it comes to testing and actually letting people know the results of said tests. I had an ovarian cyst that was large enough it needed to be surgically removed in 2016. I was not told about those results and apparently they just waited and let it rupture. My nephrologist asked about it 3 yrs later and thatâ€™s when I found out it should have been removed by them. This is an ongoing problem at the VA. Sending people for MRIs or such and then just dropping the ball when itâ€™s time to report findings.
pagank9	0	7/4/2025 12:22	Better screening of our blood work. Women have way more things to look at than men.
_skadooshhit	0	7/4/2025 12:26	My infertility was ignored my entire career I was never able to have a child I even had miscarriage with iui due to operating forklift. Then when I got out I filed it VA claim they denied my claim and marked my DnC as an abortion. So no disability for my infertility cause from deployments.
butterbeanjeans	0	7/4/2025 12:26	That everyone thinks they need to know your PTSD with S.A. Story. Like why do people keep asking this?! I am literally seeing a therapist and you are not IT! (Every provider)
bdwebb1978	0	7/4/2025 12:35	1. Address menopause and the non-care or no information. 2. More homeopathic remedies, for example no stains for cholesterol use niacin or vitamin B3. 3. NO MORE MAMMOGRAMS, only ultrasounds.
twocanshnazy	2	7/4/2025 12:37	Hormone therapy, my husband was sent to a civilian endocrinologist, I was told I dont need that even though Iâ€™ve had a total hysterectomy
thattinyfemaleoperator	0	7/4/2025 12:39	I was declined four times, and they said you didnâ€™t get hurt on duty when I did! I gave up because itâ€™s pointless to keep trying with the va they donâ€™t care about us

susandickerson885	0	7/4/2025 12:42	Counselors blowing off my trauma of sexual assault and the red tape I am dealing with becise the military blew my claims off and didnâ€™t document it my assault was real and not made up
mini_one525	0	7/4/2025 12:46	Adenomyosis and perimenopause symptoms showing up in my early 30â€™s and miscarriage issues
corineloegering	0	7/4/2025 12:49	My doctors donâ€™t talk and I have multiple issues that compounded create one big issue. So they are essentially spot treating and not actually resolving anything. And they donâ€™t listen whatsoever
1stresponder_trw	0	7/4/2025 12:55	Testify for WHAT? It will fall on deaf ears and is pre formative.
albieaurtistic	0	7/4/2025 13:01	Absolute dismissal of pain. 10yrs begging for a hysterectomy that solved pelvic pain. Zero treatment for chronic pain for 20 yrs now.
dragoneer1969	0	7/4/2025 13:08	Why is it that the VA does not supply prosthetics for women. I have continuously received male shoulder braces that donâ€™t fit a woman just gave up after 3 surgeries.
dibunnyg	0	7/4/2025 13:12	Iâ€™m a Vietnam era Air Force vet. Iâ€™ve been advocating for sexual abuse care for female vets. It wasnâ€™t until I came to the Richmond VA and got help,for sexual abuse and ptsd that I got some help through their mental health clinic. It wasnâ€™t until fantastic. They were wonderful. But now,with the cuts, itâ€™s going to,get worse for women and men!
bmcmilli	0	7/4/2025 13:13	The fact men can get a percentage for ED and endometriosis is declined. I have to advocate so much for myself to get my symptoms maybe treated.
angie_mom_k	1	7/4/2025 13:21	No mammogram option in VA. Always fee basis out to community.
beautyboyer	0	7/4/2025 13:22	we need docs to stop putting bandaids on things that need to be solved . We need our docs to believe us when we say something is wrong . Tylonal and ibprofen is not the answer for everyoneâ€™s problems.

hattiefradette	0	7/4/2025 13:22	The doctors at the VA are so used to treating old men that Iâ€™ve had so many of them telling me â€œwell I donâ€™t really know how to treat a young womanâ€ so I know right from the get go that Iâ€™m not getting very good care
im_the_veteran	0	7/4/2025 13:31	I want the Advisory Committee on Women Veterans to meet regularly again. The committee has not met in about 8 months. They are our voice as well.
im_the_veteran	0	7/4/2025 13:32	More female providers. Women veteran peer groups. More women that are accredited to submit VA Claims.
im_the_veteran	0	7/4/2025 13:38	Resume the agreement with DOD to study how toxic exposure may have affected perimenopause, menopause, and post menopause
mum_needs_a_break	0	7/4/2025 13:41	I think one of the biggest issues that the VA has, is throwing medication at a problem without fixing the root cause. We are receiving medication to treat the symptom that causes more symptoms and more medications. It would be nice to have answers, or even better, someone who doesnâ€™t just treat us like another number.
puppylaw1	0	7/4/2025 13:46	Same as alot of other women, perimenopause, menopause, hormone issues, and weight gain. I'm never heard, I'm just told it's either normal or they won't prescribe anything to help with these issue. Go get 'em girl!!!!
lora_collins	0	7/4/2025 13:49	Why why why will they not do hormone testing and ACTUALLY have providers that know how and what to look for literally had my provider tell me oh your testosterone is 4 so youâ€™re normal women donâ€™t need testosteroneâ€¦â€¦.so I pay an outside provider for my thyroid and hormones because they are all wayyyyyy out of whack and have been told for years theyâ€™re normal. So many issues could be managed with better more knowledgeable providers and them approving replacement therapy for women. I have a lot more but thatâ€™s my biggest issue

therron1969	0	7/4/2025 13:52	Lack of Female understanding of our needs as we age. specifically: peri menopause and menopause, breast care: mammograms, reduction and cancer treatments. Hysterectomy, vaginal prolapse treatment, MST treatment. As female Veterans we have to fight to get help, we have research and beg every day for the same care Men are given.
2ooohg	0	7/4/2025 13:54	How being a grape victim is not a VA disability.
swannie5	0	7/4/2025 14:12	Menopause care and female providers for mental health (MST)
jessbg02	0	7/4/2025 14:35	STOP CHANGING PROVIDERSâ€¦MY ER DR canâ€™t FIX AND IS CLUELESS ON MY HORMONAL ISSUES.
cmchristiansen05	0	7/4/2025 14:36	Currently going through perimenopause and want GYNs in the VA to be certified menopause specialists on all the hormone treatments available!
conzster	0	7/4/2025 14:47	More female physicians or at least physicians that understand that womenâ€™s bodies are different than menâ€™s and experience conditions differently. (Ie symptoms of a heart attack in men vs women present differently)
helenacadi	0	7/4/2025 14:57	We filled the same positions as males, were exposed to the same chemicals and hazards, yet not taken seriously when filing claims with the VBA

ashlyn.85	0	7/4/2025 15:12	I had complained for years about constant fatigue. They did basic tests and told me nothing was wrong. I gained weight and couldnâ€™t get it off- told I was eating wrong and lazy. I worked out 2 times a day and had a personal trainer, I knew what I was doing. I finally paid out of pocket to go to The wellness way to get my hormones checked. They were so low they couldnt believe that I could function. I asked my VA provider to help and was told that they donâ€™t deal with this type of stuff. Also, when I was active, it took 6 years for them to give me an MRI for hip pain. I ended up having surgery bc my tendon was hanging on by a thread, but it took my 5th NON Army physical therapist to get me an MRI. I also have severe tendinitis in my ankle and they told me I was malingering and basically ignored every time I went in for it. It took me being on deployment with the Airforce to get a diagnosis and some help for it. In my VA rating, they combined it with my hip for a 10% rating. I can barely exercise anymore or do any physical sports that I grew up playing. I wake up in constant pain. They limit chiropractic care. I need to go at least every other week to keep my hips level but Iâ€™m only allowed 5 visits in 6 months! Make sense of that.
lizanarroyo	0	7/4/2025 15:13	Woman vets need to have more community care as a mother of 4 I canâ€™t travel 20 mins due to traffic even id VA is 8 miles. I need to go to doc like chiropractic- physical therapy in my community it easy quick have 4 kids I canâ€™t travel and wait for chiro 1 -2 hours
lizanarroyo	0	7/4/2025 15:14	Vets females need to feel safe at VA EO in NJ male vets stare, make sexual remarks to females terrible
livin_that_workmomlife	0	7/4/2025 15:21	Treatment for endometriosis and endocrinologist for things hormone related. As a female veteran with PCOS so many providers are clueless!!
tinksandmomma	0	7/4/2025 15:21	@The Caffeinated Chicken
sarah.jo.79	0	7/4/2025 15:23	To be taken seriously when I have a medical complaint. Also if I want to see a GYN for my womanâ€™s exams I should have that right. Not the NP in the primary care clinic.

majesstic.jess	0	7/4/2025 15:31	More educated male doctors need to be in the VA. Iâ€™m currently pregnant and my male doctor has told me false information regarding womenâ€™s health.
gigimarie1080	0	7/4/2025 15:34	At the Jesse Brown VA, they dont have a mammogram machine, it's very inconvenient
meagan_leah1	0	7/4/2025 15:40	Constantly asked for my sponsor's information even when I inform them I am the veteran. Then informed by male Doctors that I need to be on meds instead of letting me have a therapist. They believe drugging us will silence us. It took me 4 years to get a female pcp who actually cares about me and even with her sending referrals the va stops them from going through.
butterfly_petals	0	7/4/2025 15:43	I know itâ€™s been stated but the medications. My pain meds keep me in a constant state of haze or sleeping. I shouldnâ€™t have to choose between spending time with my kids or being pain free and asleep. Just because my pain subsides during small period of treatment doesnâ€™t mean Iâ€™m fixed it means it found relief until it doesnâ€™t anymore itâ€™s not in my head and itâ€™s not because Iâ€™m not doing the stretches and exercises.
tatertotz5	0	7/4/2025 15:57	Having appointments years away then they cancel/ having to explain my ptsd every time I go/ being pushed birth control that makes me fat & depressed
emmalu1314	0	7/4/2025 16:11	Getting treated like my MST didnâ€™t cause my PTSD
classyngritty	0	7/4/2025 16:17	How about male veterans assuming we don't belong there or anklets vA appt feels more like a meat market. Let alone the Dr's never taking us seriously.
anita033039	0	7/4/2025 16:23	Possibly creating a va area for the women vets. It gets tiring getting gawked at everytime I step in to the va. Medication cause more harm then something natural like cbd or thc. The counselors especially some of the women look at us when in therapy and make it seem like they donâ€™t believe me when I talk about my ptsd. I try to avoid the va at all cost because of the uncomfort I feel. .

dawnsquared	1	7/4/2025 16:31	The only way you can see an OBGYN is if something is wrong. Thereâ€™s no way to get regular check ups.
dawnsquared	0	7/4/2025 16:32	It took having to go to medical 4 times before they let me get a referral to an OB
imsomebodyprobably	0	7/4/2025 16:35	As a female veteran, I am tired of being an afterthought in a system built for men. Military sexual trauma is treated like a footnote, PTSD is only respected if it came from an IED, and the answer to our pain is too often more pillsâ€”while weâ€™re left isolated, unseen, and unheard. Iâ€™ve been suicidal and the VAâ€™s answer was to send me monthly letters with a crisis line number, as if a phone call could replace real connection. Iâ€™ve sat topless for an EKG, door wide open, glasses taken away so I couldnâ€™t even see, and when I spoke up, male veterans mocked me: â€˜How else are they supposed to get your EKG? Through your shirt?â€™ This is the reality for women who served. We need female providers. We need peer support groups. We need spaces to heal and rebuild with other women who understandâ€”because we are not just spouses, we are veterans, and itâ€™s time the VA treated us like it. Iâ€™m also tired of being asked where my husband is at the appointment that is for me. I joined in 2020.
dashanichols307	0	7/4/2025 16:37	accountability and follow up. I should not have to do all the footwork for my care especially in the middle of my care. the ability to use civilian mental health care instead of the VA.
user5450547097290	1	7/4/2025 16:44	Once your assigned a provider you have to stay with that one even for emergency appointments. I need to be seen asap not in months will one provider.
lynzeelea	0	7/4/2025 16:57	If only it was for service members! Iâ€™ve got stories for days on that. But Iâ€™m a Vet now.

beswift66	0	7/4/2025 17:01	Iâ€™m canâ€™t tell you how many practitioners just sit at their computers and talk about my labs while lecturing me about my cholesterol, etc. But donâ€™t bother examine me, listen to me regarding my injury and basically tell me Iâ€™m either a hypochondriac or drug seeker. I canâ€™t tell you how many male veterans I know who arenâ€™t nearly as injured as I am and they get treated like they lost a limb when they have a hangnail! The double standard is very real and really condescending, insulting and infuriating!
thumper0507	0	7/4/2025 17:09	Iâ€™m tired of being gaslight
hundeltk	0	7/4/2025 17:17	Help with imbalanced hormones and autoimmune issues!
maryjohnson1376	0	7/4/2025 17:18	Military Sexual Trauma, homelessness
s0ul_shine	1	7/4/2025 17:21	address pre/menopause & mental health
ladyvetnjax	0	7/4/2025 17:25	Support HR 740 ðŸ‡ºðŸ‡¸
nstydei	0	7/4/2025 17:25	Them being able to provide (or deny) care depending on sex, religion, ethnicity, and marriage status??? Is a NO NO.
shelby_leigh08	0	7/4/2025 17:26	The VA closed our womenâ€™s health office a little over 2 years ago so that it could be just another GP officeâ€¦so we have no dedicated facilities for womenâ€™s health/reproductive healthcare. It took me over a year to get my new birth control after they passed the heartbeat ban because of lack of access to womenâ€™s healthcare.
texas_mom25	0	7/4/2025 17:35	Male veterans are offered pain relief more often than female veterans. Weâ€™re told to suck it up while the men get red carpet treatment.
cubsgirl50	0	7/4/2025 18:20	sizing! I finally just bought my own CPAP mask and sleep boot. men's small doesn't just equal all women!
cubsgirl50	0	7/4/2025 18:24	this is kind of for all vets but... accurate and detailed notes. not everyone that uses the VA is 100% disabled and fighting for workman's comp and or disability with trash notes can have massive financial implications
thesaltyveteran	1	7/4/2025 18:26	MST is the biggest thing we arenâ€™t heard enough

angelleyez38	1	7/4/2025 18:39	I asked one clinic if I could go there. They said they didn't have female doctors. Why does that matter? I know it doesn't have a women's clinic but I hate driving an hour when I can drive 20 min to a clinic with no women. I don't need a woman doctor.
sunsetsessential	0	7/4/2025 18:58	I was told by a contracted provider that I was lying about being sexually assaulted. I was denied a PTSD rating the first time because of that provider
equitableadvocate	0	7/4/2025 18:59	Access to care (womens health), dimishing there service â€œ youâ€™re a female that didnt happen to youâ€□, getting appropriate treatment for SC and illnesses not just â€œits anxietyâ€□.
mscrzyred841	0	7/4/2025 19:00	getting the same VA ratings the men get
arrington_fire	0	7/4/2025 19:00	hormone replacement therapy! my wife pays out of pocket because the VA thinks as long as her levels fall in range that she is fine. bottom of the range is NOT optimal!!!
jessmt63	0	7/4/2025 19:11	anxiety
januaryturner	0	7/4/2025 19:21	Womenâ€™s health issues are distinct from males.
jonileeee	0	7/4/2025 19:29	I'm not a veteran, my daughter is currently serving and she's not even able to get proper fitted gear. Her feet are a size 3 and was issued too big boots that resulted in injuries straight away in basic. She can't get a properly fitted helmet for her MOS and her MOS deals with things that go boom, these are just examples
chasingweatherandwifi	0	7/4/2025 19:32	I have to prove my injuries to receive care. Didnâ€™t I already do that? Iâ€™m 100% P&T
anjellykuh_909	0	7/4/2025 19:42	I had an amazing female primary care DR in Modesto Ca VA Clinic. she never dismissed anything. iâ€™m in Long Beach VA now, mentally prepping for back n forth bs ..
andrean144	0	7/4/2025 19:51	having pain brushed aside, while being able to hear the same doctor give the male veteran pain meds.
tesahcapers806	0	7/4/2025 20:04	Why do they not care about us

bmanning098	0	7/4/2025 20:16	The VA does not offer pain medication during IUD insertion. It HURTS, I donâ€™t care what anyone says. Women especially with MST struggle with getting them. Weâ€™re tense, uncomfortable making the insertion more painful. My nurse practitioner disagreed with it, and there was nothing she could do.
italianprincess36	1	7/4/2025 20:17	Having to go to your primary care doctor to get a referral to the OBGYN!! Like what?!?
audrey.lotz	0	7/4/2025 20:23	Why it takes so long in between mental health appointments! Iâ€™ve had 2 different therapist. In an expand of 5 months. And Ive been waiting over a month for an appointment! Ive called the crisis line. Even called to say when my next appt and I want to check myself into a mental hospital. Still waiting!!! ðŸ¥º
catladyyogi	1	7/4/2025 20:28	Perimenopause symptoms and gynecological care.
perilous_play	0	7/4/2025 20:31	Alternative, preventative health practices. Nobody wants to be getting a hysterectomy when fibroids can be dealt with before having a major surgery.
jnurse38	0	7/4/2025 21:14	Having to travel an hour for help. It should be reduced to 30 mins and more community care.
imitatingdid	0	7/4/2025 21:18	my va psychiatrist of 5 yrs wanted me to show him my boobs during my telehealth appts and I was promised community care after I reported him cuz I aint trust anyone but my therapist anymore but they canceled my community care and terminated my therapy ðŸ™„ am tryna get community care back so I can try and manage my conditions but I haven't heard a peep from em - western ny
greenmothmolotov	0	7/4/2025 21:34	mst and support of reporting
kay_1070	0	7/4/2025 21:39	When your primary caregiver makes a major mistake in your records and refuses to fix it and forces you to go through weeks two months finding the right department within the VA to force the records change.
aprilanderson203	0	7/4/2025 21:41	pls discuss that WE DONT REQUIRE A GYNO AS OUR PCM! I had to wait 2.5 years to get another PCM after mine quit because of that stupid requirement.

aeon572	0	7/4/2025 21:58	I need them to take MST more seriously, Iâ€™ve been through so many providers who make light of this, I finally got lucky with my current provider, but up to a year ago, with my last provider, he refused to refer me to a woman OB/GYN because he â€œcan do woman examsâ€□ too.
b.morg	0	7/4/2025 22:25	Them not accepting endometriosis!! I wonâ€™t even see another VA doc and say a word about my endo pain bc itâ€™s all in my head
reneemiser	0	7/4/2025 22:32	I am just now getting to the VA because I have been so scared. Got out of the AF in 2017 and literally just enrolled in the VA on Tuesday (7/1).
monicadeanforcongress	0	7/4/2025 22:46	Please tell them we have to keep our Womens clinic and we need childcare options for when we have appointments because weâ€™re not allowed to take them with us. Also tell them we need more clinics and rural areas.
me.shell.e	1	7/4/2025 22:48	We constantly get misdiagnosed - they wonâ€™t diagnose with PTSD, they diagnose as fatigue!
loganngoodson	0	7/4/2025 22:52	My injuries from my SAâ€™s in the army, are being left untreated. Multiple autoimmune diseases from stress, also left untreated. I have had to use my own private insurance to get care.
brandyunfred	0	7/4/2025 22:55	please talk about claims for female issues they keep getting denied. Uterine bleeding, miscarriages ectomy a lot of claims examiners don't understand female issues.
marissamcnealy	0	7/4/2025 23:02	I fought for 6 years for specialized gyn care outside of the va knowing I have PCOS and endometriosis. I was told I was too young to have either. 6 years later I have both and had an incomplete surgery from the va bc no one was specialized in endo surgery. Have to go back for another but the va wonâ€™t let me see a specialist
cherylsteevens	0	7/4/2025 23:07	ill go with you
toriboone3	0	7/4/2025 23:18	The lack of continuity of care. I would LOVE to go see the same Dr for more than six months. and STOP asking if our husband served

aprilyankee	0	7/4/2025 23:28	Iâ€™m overweight so everything else is irrelevant. Thyroid disorder just sitting there in the corner laughing itâ€™s ass off.
ezrathomas5	0	7/4/2025 23:38	No help going through peri and menopause!! Only being told eat less than you burn and more exercise! Itâ€™s just anxiety ðŸ˜ ðŸ™„
tammyearley168	0	7/4/2025 23:39	ðŸ˜³ðŸ˜³ðŸ˜³
teannamarie.willi	0	7/4/2025 23:55	I am interested in enhancing your playform. Iâ€™m a female veteran residing in the Virgin Islands, and we currently struggle with having a GYN on island or an outside provider accepting the VA insurance.
laurab33547	0	7/5/2025 1:00	I donâ€™t want to be STUCK in the womenâ€™s clinic. Iâ€™m at Tampa VA and the waiting room is allowed to be loud, nasty and noisy.
penaplatoon5	0	7/5/2025 1:01	Female MC Vet. Would love to talk about more community care options for older women that are going through menopause
shaylala_86	0	7/5/2025 1:28	I was enrolled into a womenâ€™s health primary care group that has all women health care providers. I sat there for 2 hours getting to know my pcp, literally talking about every little thing in my service connected issues. Just found out that pcp is no longer mines and will have to go through this process again with someone else. That shit is re-traumatizing having to constantly talk about my issues over and over again.
kkarver	0	7/5/2025 1:40	Cuts to my local VA took out my mental health person and now Iâ€™m back at the bottom of the list to get a new one. Jumping through hoops to get refills without a dr.
gunnergal	0	7/5/2025 2:28	more care options closer to home. why do I have to travel to my areas main hub to find a doc for female wellness? ie 2 plus hours away when there is an office 45 min away?
shortbus1964	0	7/5/2025 3:02	Females vets need a safe place to go when they have an issue, perf a woman rep.

kels_for_you	0	7/5/2025 3:09	I was SAâ€™d three times during service. Iâ€™ve been trying to file my disability claim for two years and they keep shuffling me around. Every time the year comes around they drop my file , or canâ€™t find it or- â€œthey got so backed up sorryâ€□
amdevore24	0	7/5/2025 3:13	being questioned that "im the veteran" , and male providers not wanting to address women's issues or prescribing contraceptives.
lilbitybodiee	0	7/5/2025 3:52	they equate pain to malingering most of the time .
vrc_34	0	7/5/2025 4:01	They are trying to say everything is cause from my pregnancy not cause the navy.
ashleysassley	1	7/5/2025 4:08	The â€œmoveâ€□ program is a joke and should not be something we have to deal with when we have PCOS.(I know how to freaking workout) When GLP1 treatment has shown its effectiveness in helping the symptoms and should be covered immediately if spoke to our primary about it.
heathens_siren	0	7/5/2025 4:15	my husband and I are both Veterans, he gets more in depth care than I do. I sit in on his appointments as he needs me there, I am always alone and never feel heard.
sherese_why	0	7/5/2025 4:37	separation of issues....tteat the whole person not just the hip pain today and GI next appt and migraines next appt and so on. I have one body treat as if it's all connected
user2283748345457	0	7/5/2025 4:39	VA is holding onto outdated notions that HRT is dangerous. Women have to fight to get healthcare for perimenopause and menopause
user6974492237940	0	7/5/2025 4:46	Some of the female nurse practicioners jab the Pap smear and make you bleed I left a message with the nurses no call back. She asked me how many men I slept with. Way to be professional. No mental health appointment. No refill on meds filled by active duty docs so your thrown out the street with nothing
jwandsonhogdogs	0	7/5/2025 5:06	@Krista
hotheadartistry	0	7/5/2025 6:20	I won't even try to go see them about menopause, I've already been told it's useless.
m5love14	0	7/5/2025 6:50	Not being able to get perimenopause careâ€¦ hormones replacement.

carimiller76	0	7/5/2025 7:10	Iâ€™m a female veteran and two things: we need more mental health counselors available. We also need more womenâ€™s healthcare specifically gynecology and hormones.
og2311usmc	0	7/5/2025 11:24	I canâ€™t get into talk therapy- but my meds are mailed directly to my house. I donâ€™t want more meds I want to feel sane again.
sritter_trainersstudio	0	7/5/2025 11:44	Compounding pharmaceutical. Still have to pay civilian doctor out if pocket $2000 yearly
nothere4ns	0	7/5/2025 11:58	Not being notified when assigned BH doc no longer assigned and not given the option to follow or maintain via tele-health.
msleah80	0	7/5/2025 12:41	All VA systems should talk, Iâ€™ve moved twice since retiring and have had to relive my combat experiences and the things Iâ€™ve been through with my mental health. For some reason both MH offices say they canâ€™t see the previous doctors MH notes. As a woman veteran with combat PTSD, Anxiety and Depression, reliving those moments are devastating! We women go through enough as it is, please just read the previous notes and letâ€™s go from there!
sallygraves6	0	7/5/2025 13:16	Why does it take over a week to get a medication refilled? Let alone have a portal or phone message returned? And no more nurses that degrade us and call us liars because know our own bodies.
kate8262011	0	7/5/2025 13:21	Most if not all women veterans have been sexually harassed, molested or raped. Going into a VA facility where mostly men are is not something that is possible for many of us.
kate8262011	0	7/5/2025 13:23	We need more mental health providers that specialize in mst.
carb_o_vore	0	7/5/2025 13:27	Hi there! I was active and got out 19 years ago. Brutally SAâ€™d. JUST rated at 70%. I canâ€™t even function most days but ok. Iâ€™ll fumble through 70%. Thank you for doing this â¤ï¸
semper.fight_her	3	7/5/2025 13:38	Womenâ€™s health is not menâ€™s health. Period. We need our own facilities and doctors.
outofspite90	0	7/5/2025 14:04	It's more triggering to try to get women's healthcare services than it was to BE in the military. None of the providers care, they are built for men not women.

bequietmeg	0	7/5/2025 14:25	I have had to change psychiatrists 6 times. That is 6 times that I have had to brief new doctors, relive my trauma OVER and OVER, and lose any headway made towards healing. I'm 43. I've given up at this point.
lindseyc36	0	7/5/2025 14:31	My PCM never listens to my concerns and wastes my time. Waited for a renewal referral to keep my migraine treatment on track. I had to reschedule my appt 3 times which caused more pain.
madiday10	0	7/5/2025 14:56	There is little to no support for pregnant veterans.. yes Iâ€™m 26. Yes Iâ€™m a combat veteran. Yes Iâ€™m just starting my family. The VA is outsourcing my OB care which means I had a pregnancy blood test confirmation at like 5 weeks pregnant and then nothingâ€¦ crickets for over a month on end having no idea who to call if something abnormal comes up, no confirmation that I am safe and healthy. They canâ€™t even assign me a doctor to call in the case of an emergency. They mailed me some prenatal vitamins and Iâ€™ve heard nothing for over a month. No appointments in place, nothing.
the1stephy	0	7/5/2025 15:24	I canâ€™t get the care I need for GYN at my local gyn at the VA and have to travel all the way to Orlando VA for pelvic floor injections for pelvic pain. Travel is not reimbursed and no one in community care that accepts VA does it. I have to pay out of pocket for HRT. Also MST and back pay to service date.
nicholewomenvetsglamping	0	7/5/2025 17:01	Stop malpractice surgery so women Vets. Give proper care.
dcrutch69	0	7/5/2025 17:47	I get treated worse than my husband veteran. Also I am never listened to about my symptoms or issues.
exitwoundsjewelry	0	7/5/2025 18:00	The fact that we are starting menopause early and thyroid issues seems to be a pattern in our generations female veterans. For yrs I begged for hormone testing and for yrs they pushed pills and therapists, followed by shoving to the back of the line. Now im paying out of pocket for HRT on 100% VA disability because I chose to prioritize my health instead of sit stagnant while waiting for the VA to get their sht together.

tiffleigh_	0	7/5/2025 18:15	Sexual assault and records being withheld by good old boy system causing future issues with Va claims
krista.8404	0	7/5/2025 18:41	I canâ€™t get appts or community care. Men get it all. All I do is fight.
electannmarietorres	0	7/5/2025 19:09	A better medical and dental system for our female vets. They need to be trained in the fact that "we female Vets" served in combat operations like our counterparts and it affected us in a different manner. We need to be seen and heard as WOMEN COMBAT VETERANS!!
invisible_gen_x	0	7/5/2025 19:35	No gyn in Utah, itâ€™s all out sourced. That means a long wait, months.
mybluushade	0	7/5/2025 19:37	as a veteran feeling passed off over and over and them telling me my peri n menopause symptoms are normal. but I'm getting worse and In n out of hospital .
huntersav1996	0	7/5/2025 19:42	PCOS and endometriosis specialists or doctors who know how to help care for these!!
impossiblegirl0241	0	7/5/2025 19:55	Hormone replacement therapy for women
desertstarrzz	0	7/5/2025 20:13	Definitely perimenopause, gyn care, them listening to us with pain issues, finding the root cause of my pain and being able to get better mental health support. Thank you.
marcimetcalfe4	0	7/5/2025 20:24	we need to hold on to more woman veteran providers. as a medic retired army veteran. i want nothing more then to take care of my fellow veterans. however unskilled civils try to push out high performers ie veterans
alottomoscato	0	7/5/2025 21:05	21 year veteran, K9 bomb handler that went to Iraq 3 times and Afghanistan once. Constantly fighting to keep my 100, while male counterparts have 100 P&T for same deployments and less injuries.
ct_wanderlust	0	7/5/2025 21:08	I was seen for migraines and they gave me nearly unlimited amounts of opioids. I donâ€™t think it is isolated to female vets. I also have concerns about my health concerns not being taken seriously because I was not combat arms.

dooniegoonies	0	7/5/2025 21:11	Putting me in group therapy for violent sexual abuse sounded like a great idea until I showed up and was in a room full of angry male veterans talking about wanting to punch and hurt people. Also my only option in Fort Johnson, Louisiana area was a male therapist. I gave it a chance and went to 3 sessions but my anxiety went through the roof
shield_ofsisters	0	7/5/2025 21:26	Mst resources
dooniegoonies	0	7/5/2025 21:31	With my spouse still active duty we move every couple years and I have to go over all my trauma EVERY TIME to my new providers at a new VA. Why doesnâ€™t everything transfer? Like notes and history. Itâ€™s gut wrenching feeling like I have to keep proving why I need help
firetopntx	0	7/5/2025 21:53	Non combat ptsd for
firetopntx	1	7/5/2025 21:55	Non combat related ptsd from sexism, hazing, refusing to participate pro qo things then being hazed.
naturenerdphotographs	0	7/5/2025 22:45	So far Iâ€™ve received a 10% rating for my double mastectomy for scars and they delayed the decision on anything else. My boobs arenâ€™t gonna grow back ðŸ¤·â€□â™€ï¸□
orangeblossomfabrics	0	7/5/2025 23:13	Letâ€™s talk about how even the womenâ€™s clinic is not designed for womenâ€™s. Ours has a menâ€™s bathroom & a â€˜neutralâ€™ bathroom, but not a womenâ€™s bathroom? Like can we make that make sense? I donâ€™t need a pregnancy test every time I walk on property. I donâ€™t need to do the move program again to get help with perimenopause. I already exercise, I watch what I eat. So frustrating!
bevkash	0	7/5/2025 23:17	I may be female but I am a veteran too!!!

gillyweed0126	0	7/5/2025 23:29	I got out in September off a medboard. Iâ€™ve received no help on any of my mental or physical issues until recently after my doctor submitted referrals three times. Theyâ€™re reevaluating my percentage saying Iâ€™m in remission for my mental health when I have just not been seen due to lost referrals on the VAs part and the people on the phone are rude as hell. My mental health and ptsd claims are directly due to the navy. They think being out is enough help apparently.
mightyj0e.y0ung	0	7/6/2025 0:32	@jade
amberl_5	0	7/6/2025 0:41	Years ago I dealt with a high heart rate. It kept happening I kept going to the ER. Finally they put in a consult with cardio and do you know what he told me? He said it was anxiety. Well it started again in April with a sustained heart rate over 200 for over a hour. By the time I got to the ER it had stopped. They put in a referral for cardio with no appointment until August. We'll a month ago it happened again my heart rate was 175 when I got to the ER they couldn't get it down and had to stop my heart. At that point cardio was able to get me in the next week and within a week of that I was having a heart procedure to have the bad pathway destroyed. I truly believe if I was a man their first instinct would not have been anxiety and this issue could have been fixed years ago.
david.facing.forward	0	7/6/2025 0:43	women getting assualted or injured during BCT or AIT and not getting uncharacterized discharged which limits VA benefits.
kaufimiller	0	7/6/2025 0:43	I am an 18 y vet. also a CHW, ILS and MTFSPS
jfig70	0	7/6/2025 0:48	They have a womenâ€™s center at the VA, which is nice. But itâ€™s not adequately staffed with primary care PHYSICIANS or OB/GYNs. Itâ€™s mostly NPs and PAs who will just pass you on to another provider.
dana_dane_yo	0	7/6/2025 1:08	Women Vets need access (maybe community care) to HRT MEDS AND BLOODWORK. I was told by my VA (female) Dr that I just needed to lose weight and eat less. Went outside of VA at my own cost and HRT was 100% effective for mental, weight, energy, etc.

itzj43l0	0	7/6/2025 1:27	More natural / holistic routes for addressing certain issues vs pushing meds (that end up causing even more issues over time)
lisatuckerjones	0	7/6/2025 1:32	Iâ€™m gonna need you to call and talk to my mama- sheâ€™s 84- was given honorable discharge when she became PREGNANT -needless to say- she sued the govt-won and now women can be pregnant and be in the military. Obviously this was years ago! But sheâ€™s a warrior for sure!
mariaortega_95	0	7/6/2025 1:35	Had an emergency c section at JBLM had severe abdominal pain till this day for the last five years only after 4 years of going to the er, constant doctor visits, being told it's just your cyst once you start your period the pain will go away. Only to be told after 4 years and finally getting an mri that my c section scar was never closed internally. All I can get is birth control and not even birth control that has iron it because it's not covered. Also scheduling a surgery a year out to fix that c section error. The lack of care for pain is sad.
juliaocsl81	0	7/6/2025 1:45	If you need someone (a 100% vet) with you as moral support, let me know. I'm an atty in DC & can sit behind you in support.
ginaherrellhead	0	7/6/2025 1:47	When in an appointment, people barging in w/o knocking. 3 times in one appt at Dermatology, only a paper gown on.
meshelle_mabelle	0	7/6/2025 1:52	Making IVF available for mental health issues and not just physical issues.
trish6793	0	7/6/2025 1:52	Let's start with parking at the VA. Two men were waved through in front of me to park. The security guard stepped out to stop me, stating firmly, the parking was for veterans only.
tayluv1972	2	7/6/2025 1:55	Please Please Please touch on PTSD/MST and service connection this should be automatic 100% when proven through C&P. I feel we given the run around and struggle daily with something tragic that was unwarranted ðŸ˜©. Thanks and good Luck ðŸ¥°
kristaalexander2	0	7/6/2025 1:55	Anxiety
toabsforlife	0	7/6/2025 2:12	No MST groups, more female providers, zero female specific clinics nationwide. Orlando VAMC has one and itâ€™s incredible

kirsti1013	0	7/6/2025 2:12	Hi, Iâ€™ve been in appeal courts since October for a claim I made on my back/knees because they refused to even give me an appointment and ruled it as not service related even tho I spent 17 years in the army. I just donâ€™t even understand how I canâ€™t even get an appointment
witchbythemoon	0	7/6/2025 2:16	Female veterans do not have access to hormone replacement therapy while in perimenopause. I have almost zero testosterone and cannot get testosterone from them! Or progesterone! Veterans need HRT health
chloemerrill7	0	7/6/2025 2:18	More spaces for womenâ€™s health
bugadventures87	0	7/6/2025 2:22	Female vet here! More mental health care for women especially female mental health providers, MST specific support, and how about not jumping straight to antidepressants for mental health. I need therapy more than once every 3 months.
magblue0322	0	7/6/2025 2:32	The lack of English speaking doctors.
sharbearinsc	0	7/6/2025 2:36	All I see is nurse practitioners. No one listens. Canâ€™t see dermatology or orthopedics unless you are on deathbed.
lindsaylee09	0	7/6/2025 2:41	Dedicated womenâ€™s health!!!!!!! I was going thru psychosis with a IUD and they couldnâ€™t help me. I went to planned parenthood.
bluelady1ers	0	7/6/2025 2:46	I was having a miscarriage went to west LA VA medical center at night they didnâ€™t even know were to put me since their not use to having women there. They ended up putting me like in a storage room and the nurse had to apologize,she also warned me about the restroom condition because they wanted me to do a urine test. I had to wait there for an hour so they could come that would no what to do. Worst experience ever
thee_wildcat	0	7/6/2025 2:46	I had an OBGYN tell me I couldnâ€™t have my tubes tied without my husbandâ€™s approval.
kaymich318	0	7/6/2025 2:49	Female related disability compensation

cmatz2	0	7/6/2025 2:49	how about being discharged at 18 with no exit anything, pregnant, diagnosed with migranes, and given no references or referrals on how to get care and being told you have no benefits because your discharge is "At the convenience of the Navy" The don't have any of my medical records and I have never been able to do anything to alter my discharge. The literally cut my active duty ID into pieces and threw it in the trash and saw me to the gate.
jgladybug25	0	7/6/2025 2:56	Weâ€™re not just tired because weâ€™re moms, we have sleep apnea which absolutely effects us for ever. Pelvic floor therapyâ€¦ we abuse our bodies to fit in and the repercussions are lifelong. I also am SO tired of hearing about how menâ€™s pain gets further diagnostic tests and weâ€™re just told itâ€™s normal.
mightmoe25	0	7/6/2025 3:03	Lack of mammogram services, delays in appointments to see DRS especially females DRS.
thoughtsbyjlou	0	7/6/2025 3:08	Perimenopause care. Actual specific testing before just handing out pills to see what hormones are needing what.
lilidh70	0	7/6/2025 3:12	Stop sending me to PT when I ask about reassessing my disability rating.
hannahstoup	0	7/6/2025 3:18	Female providers in mental health!!!!!
old_school_veteran	0	7/6/2025 3:49	No real female care, men docs with no clue!
old_school_veteran	0	7/6/2025 3:50	Iâ€™m not a man, pain is real not in my head!
mikwil1219	0	7/6/2025 3:51	Expand womenâ€™s health. It shouldnâ€™t take 2 months for a new patient appt
lorrinlogan	0	7/6/2025 3:57	not letting us get our hormones checked and getting us to a doctor to help with an autoimmune disorder because we know something is wrong rather than telling us we are depressed when in fact we are oppressed by our medical system!
ellied825	0	7/6/2025 4:34	The gaslighting from the providers.
adrimiller32	0	7/6/2025 4:35	My pain is â€œall in my headâ€ womenâ€™s health is a joke was told by one provider I needed a full hysterectomy then after recovery period told by follow up provider it wasnâ€™t needed and now Iâ€™m just making things up

sabrinaslonim	0	7/6/2025 4:41	WHY DO GENDER CONFUSED PEOPLE GET HORMONES BUT A WOMAN SUFFERING WITH PERIMENOPAUSE CAN'T GET THE SAME TREATMENT?!!!
kristamarie143	0	7/6/2025 5:20	New follower and would love to DM you if possible also a nurse
veteranagainsttyranny	0	7/6/2025 5:30	why we need a consult, or "permission" to gp the Womems Clinic
riggs6396	0	7/6/2025 5:35	Missed a mental health counseling appointment by 15 minutes, they told me I wouldn't be seen that day, to reschedule months later. I was having a hard day, called the suicide holiness, got voicemail, left a voicemail...still waiting for them to call me back...that was in 2008ish.. So yea, more mental health staff would be good I think.
camarks53	0	7/6/2025 5:54	providers at Every facility so you don't drive 8 hrs to get a mammogram, see a gyn, etc, cardiology department staff that comprehend male/female heart attacks present differently, Drs that believe you when you say something hurts, a doctor with the balls to give you what you need for migraines without redoing 30 yrs of scans/tests/& bs.
tessiebu	0	7/6/2025 6:43	Mental health. I'm a Vet and an LPC. We are not represented or supported. They feel alone and ignored. Not a direct sentence sorry. ðŸ˜ž. Just my daily experience ðŸ™
anastasia24498	0	7/6/2025 7:24	fighting for 6 years to have my injuries acknowledged only to have to still cover my surgeries myself with an outside Dr because they wouldn't acknowledge the accountability despite all the documents that said otherwise
abigailhyser	0	7/6/2025 10:13	Why do I have to fight to prove I was graped but a man doesnâ€™t have to prove he has ED and why is that service connected
rebeccadurnell2	1	7/6/2025 10:41	My pain and/or neurological pain isn't a psych issue.
rebeccadurnell2	0	7/6/2025 10:43	When I call to schedule a psych intake the receptionist who's not trained in trauma shouldn't ask if I have MST.
rebeccadurnell2	0	7/6/2025 10:45	Offer supplements for testosterone replacement therapy not just pellets or injections. The release rate of pellets for testosterone are unpredictable.

rebeccadurnell2	0	7/6/2025 10:49	Addiction medications aren't pain management medications they're not even FDA approved for pain.
spyderb0t	0	7/6/2025 10:52	Doctors identifying issues on x-rays, MRI's, labs etc. but not discussing with the patient. I read notes about an incidental finding, asked the Dr. about it and they said "well, it's your responsibility to do your own research". Like, ma'am/sir. I did not go to medical school.
ewincat0	0	7/6/2025 10:56	Outsourcing/not having OB care/ no postpartum care/ being told to not go to a VA hospital bc they donâ€™t have the capacity to care for pregnant ppl (they asked me to get yearly fasted labs while bfing a newborn like be fr)
speedmonkey606	0	7/6/2025 10:56	believing us when we say we are in pain
rebeccadurnell2	0	7/6/2025 11:08	Providers putting whatever they want in your chart just because you dont agree with them. Saw a pain management doc who wanted to put me on a med I can't take because of allergies. He told me I'm not allergic to the medication but that I'm just addicted to the previous med I was on. After telling him I wouldn't take the med he was offering multiple times he put that I was a drug addict in my chart & sent me a script of 30 bottles of narcan the instructions for it said use daily for overdose. I've never overdosed or misused my meds just because I won't take a medication I'm allergic to doesn't mean you get to put whatever you want in my chart.
normazieglerx3	0	7/6/2025 12:51	Ty for doing this . As a combat veteran why do I get the same PTSD rating as men when I also have mst? I have testimonial letters from high ranking bb to attest to what happened to me. Also why when I talk about female sexual arousal issues Iâ€™m told itâ€™s nothing then I ask for a hormal test due to link of issues from exposure from stuff overseas and Iâ€™m denied.
womanveteran	0	7/6/2025 13:15	spend 33 years in Army & really need a women's support group to help me transition to civilian life
staycrags	0	7/6/2025 13:43	Caregivers. We have to fight harder for any care than our male counterparts. Even harder to have a caregiver approved.

staycrags	0	7/6/2025 13:45	Chronic pain doesn't need 17 meds. We need a cure!
wolf.mother4	0	7/6/2025 13:57	See comment below menopause aged women need compounded hormone therapy and more in-depth care regarding those type of symptoms. ðŸ¯ðŸ¯ðŸ¯ðŸ¯
pixietastic1	0	7/6/2025 14:21	I've been dismissed for 10 years because of my age. women's clinic is extremely judgemental and dismissive. I also have "hysterical" in my file for crying about my pain and losing my job over not knowing why I was falling all the time. I hate the VA. The VA hates women.
pixietastic1	0	7/6/2025 14:21	I second this also
user053483906	1	7/6/2025 14:52	Being gaslit. Because I was not in combat, I am not a Veteran.
user_867_53o9	0	7/6/2025 15:08	Fighting my VA Dr to get estrogen is ridiculous! They donâ€™t care about menopause in us on top of everything else we dealt with
mandyc135	0	7/6/2025 15:15	Pills for Anxiety/Depression does NOT help repair my shoulders. Shoulders that were injured, on duty, while deployed, with LOD incident report completed. Denied disability. Migraines and ringing in the ears. Told to drink more water. Treated for PTSD but denied disability. Going around the world to obtain a Nexus letter from a civilian doctor seen almost 10 years ago for information that is already in my military records. Do NOT have anxiety/depression but dealing with the VA is getting me there.
cmontoya925	0	7/6/2025 15:43	No hospital beds for female veterans. We are referred out
91km4.m	0	7/6/2025 16:11	Thereâ€™s a large pool of us that were experimented on with new, dangerous drugs FOR YEARS while on active duty. Donâ€™t forget us ðŸ˜ž
rambling_havoc	0	7/6/2025 16:14	I need breast reduction surgery for posture correction and cancer prevention but they treat it like voluntary cosmetic surgery. Itâ€™s been 9 years trying

jodiejames69	0	7/6/2025 17:26	Mountain Home Va in Johnson City Tn. Reproductive care I had a pap done on an upside down bed pan with the drs cellphone flashlight. Also my ex husband now but we went into ER/urgent care with exact same symptoms he had an appt in 20 minutes I sat for hours. Appt times crazy because we are in a â€œwomenâ€™s clinicâ€ even though no womenâ€™s care is done.
fearlesslyfreckles	0	7/6/2025 18:07	Better mental health providers or allow us to stay with our community care providers
leahstiles982	0	7/6/2025 18:07	Eating disorder informed providers & resources
kitchensparrow	0	7/6/2025 18:22	While being abused by another sevice member my endometriosis pain was debilitating so I was sent to a "pain psychologist" because I shouldn't have been in as much pain as I was claiming. My doc PCSd and didn't fill out my papers saying that I had endo so I was diagnosed with chronic pelvic pain and processed out. It wasn't until afterward that my medical record was changed.
paleogyrl	0	7/6/2025 19:02	Better mental health for female veterans â¤ï¸
jacquelineroachfeldman	0	7/6/2025 19:56	When I was suicidal after being sa'd, it took 20 min to get to talk to a person. Even then, they had no help to offer me. I was saved by SAPREA and they are not VA related
tinannola1820	0	7/6/2025 20:07	Ask why the Womenâ€™s Clinic changes Drâ€™s like they change their underwearðŸ¤” Everytime I go for my appt I have to explain my issues ALL OVER AGAIN!!!
tessbby123	0	7/6/2025 21:30	Little to No VA assistance for overseas veterans!!!! I have chronic conditions that I canâ€™t receive care for, and medications I canâ€™t access!
lmbmomjd	0	7/6/2025 22:38	Not everything has to do with weight!!!!! My knee not having cartilage has nothing to with my weight. Chiropractic care is not an elective. We need more providers! We need more opportunities to outsource the community care!!!
eclecticairsign	0	7/6/2025 23:57	@horriblestevie I would tag more female vets, but I don't know their TikTok tags

militarymommy81	0	7/6/2025 23:58	I think we should be allowed to see a primary care provider in the community
momvet8	0	7/7/2025 0:09	I sat in the waiting area in VA CLINIC and I was asked if I was waiting for my husband..ðŸ˜□
siobhanfitzgeral8	0	7/7/2025 0:13	Having to travel from 1 va to another for a mammogram? Female services.
britt4people	0	7/7/2025 1:22	Nearly impossible to get IVF covered because you canâ€™t claim fertility as itâ€™s thing on disability despite evidence that burn pits, toxic exposure, and ptsd all play a role. On top of that they just made it so that if you get ivf treatement privately your fertility referral gets cancelled and you lose access to all other fertility coverage.
peggyott44	0	7/7/2025 1:38	if your inpatient on the psych floor, females need to be able to wear proper clothing/bra. many of us are dealing with sexual trauma and being in there with mostly males, without a bra and those damn gowns made me feel even more anxious. shouldn't require ''approval from your therapist'' who's off the next 2 days.
ptish21	0	7/7/2025 1:48	We need providers that are educated in peri menopause and menopause treatment. They just treat for anxiety with pills and send you on your way.
lifeisbrutiful	0	7/7/2025 2:18	They need to implement womenâ€™s health care for those of us in our 40s & facing perimenopause/menopause. I canâ€™t even get a simple panel done & I am 47. We are post 9/11 veterans. Itâ€™s time.
kay_bella777	0	7/7/2025 2:22	Female veterans struggling with PCOS, hypothyroidism,and OSA while battling obesity, should be approved for GLP-1 prescriptions.
meganrogue817	0	7/7/2025 2:34	Fertility issues not being addressed in a timely manner because PCMs arenâ€™t willing to refer to womenâ€™s health because it affects their ego to not â€œfixâ€□ the woman in their care. It took my best friend 1,551 days to finally get a referral off base to an actual specialist.
hobomoonshine	0	7/7/2025 3:04	Dutch Test, Hormonal testing should be mandatory

freespirit72	0	7/7/2025 3:55	They will cover all of the IUI costs for woman regardless your married but if you need to do IVF you must be married or have service connection for infertility but no one will take your case because men ar the ones doing disability claims and they are uneducated or donâ€™t feel comfortable helping with them I could go on
synt887	0	7/7/2025 4:09	Hiring practitioners that specialize in hormone health specifically to address, perimenopause and menopause symptoms in female veterans
enlistedkidneyfoundation	0	7/7/2025 4:16	Maybe we could work together ðŸ’š
freespirit72	0	7/7/2025 4:33	Misdiagnosingâ€¦ gaslit for years saying my difficult monthly cycles and multiple cyst ruptures were normal female behavior and put me on all sorts of different birth controlsâ€¦ 2 years ago I was finally sent to and infertility specialist through community care. I had stage 4 endometriosis and 4 tumors removed.
andrear798	0	7/7/2025 5:30	hair loss and hormone therapy
kimberlylucas9904	0	7/7/2025 12:05	Making appointments with no daycare available!!
dogangel17	0	7/7/2025 13:04	I was rated, it was swept under the rug and I am not compensated for it.
alyssa.renae17	0	7/7/2025 16:46	I have a million complaints about healthcare but my biggest problem is being assumed as the WIFE all the time and not respected as a combat veteran!! Of all places, the VA staff should know better!
candyduff	0	7/7/2025 16:48	The VA should help vets get benefits and not fight them and attempt to deny claims.
carrieschroeder96	0	7/7/2025 18:11	The gaslighting is insane! Shoved all females veterans and female spouses into one small building with one doc available, who had no empathy or care for any of them. Reason why I quit going to the VA and purchased my own insurance.
brazilowens	0	7/7/2025 18:14	They want to treat situational anxiety with depression medicine. Constantly want to put you on daily medication. Doctors undermine our needs.

darbygrant1	0	7/7/2025 18:27	Being able to see the womenâ€™s health for menopause issues without having to go through my male PCM.
thebakeroveryonder	0	7/7/2025 18:32	PTSD from MST can cause MANY health issues and should be presumptive when filing disability claims. I'm at 50% currently and have to fight to get other health issues like my hypertension linked to my service connected PTSD. I was denied bc they said I didn't have records from service. Well...I was never diagnosed with PTSD until I filed for disability at 50 and subsequently was diagnosed with hypertension. Our pain is real. We deserve to be believed.
amandav163	0	7/7/2025 19:01	I had a fillopean tube removed without my consent in 2007 and was lied to about why I "should not have children anymore."
airborneradiers	0	7/7/2025 19:46	The VA called me to schedule an appointment yesterday(JULY6) for MENTAL HEALTH. She told me the next appointment wouldâ€™ve been SEPTEMBER 23rd!! I told her politely youâ€™re lucky Iâ€™m not on my 13th reason why cause this is absolutely ridiculousðŸ˜’
navygirlcorpsman1	0	7/7/2025 20:22	I appreciate the chance, but why wait until itâ€™s time
dom_disordered	0	7/7/2025 21:10	Please address how quickly a lot of drs are to completely dismiss us. The latest one I went to didnâ€™t even come into the room, told me he couldnâ€™t access my MRI results and that he feels nothing is wrong. I have a spinal cord cyst and four severely herniated disc that have been confirmed by several other doctors. The medical gaslighting and unprofessionalism is disgusting.
armyskye	0	7/7/2025 22:48	At 25, I had deployed twice and had a kid. I was told by a female VA provider that I was too young to have any pain in my knees and hips and dismissed n given ibuprofen, after they told me I should stop taking it because they were worried about my stomach lining. I now have a large tear in my hip and cartilage loss in my knee from constant (weekly) pt tests
tkidaho	0	7/7/2025 23:12	Just because my performance was stellar in the military doesnâ€™t mean the awful thing didnâ€™t happen to me.

mak_attack10.28	0	7/8/2025 3:20	it took 8 years for me to get real mental health care. now its better but I'm starting to fall between the cracks again. also trial by medication will be the death of me.
trudola	0	7/8/2025 3:49	VA doesnâ€™t care about women veterans
ldyevrgrn	0	7/8/2025 4:24	Not enough female providers!
heavenshooves	0	7/8/2025 13:24	ðŸ™□
miquelle69	0	7/8/2025 14:12	to get pain meds must take drug test for three days.. Just had brain surgery.. doctors ordering test but not looking at test.
regulargirlcooksak	0	7/8/2025 15:36	Good Luck with that.
navymary21	0	7/8/2025 15:53	The workers at the VA and the doctors need to treat women with the same respect they treat the male veterans
makingmary100	1	7/8/2025 16:52	a zero rating when male veterans with the lesser of the same line of problems are given 100% rating.
kendallfunk0	0	7/8/2025 17:02	Hormone therapy!!! Perimenopause/ menopause. I have to pay out of pocket to go to a civilian doctor to get ANY help with this
elizabethjo48	0	7/8/2025 17:24	being denied for Endometriosis due to having a C section on Active Duty
elizabethjo48	0	7/8/2025 17:25	MST groups are needed
vannahleake	0	7/8/2025 17:48	Insurance covered doulas and more options for VBAC supportive providers.
cute.as.ducks1994	0	7/8/2025 18:27	Being gaslighted for issues, especially feminine issues. Having meds shoved at us instead of getting to the root of the issue. It shouldnâ€™t take 4-5 years for us to be taken seriously.
usmcvet4027_2.0	0	7/8/2025 18:27	@womanmarine007 @Grandma Suni @Grandmatiktok @The Dog Did It @LitaðŸ–¤ @cooper_mindset
usmcvet4027_2.0	0	7/8/2025 18:28	continuity of care is huge, especially in the female Veteran community
kygal58	0	7/8/2025 19:32	Gaslighting women- told I was having anxiety attacks but it was my gallbladder, took 5 years before someone finally did what I asked, check my gallbladder

lucelycreative	0	7/8/2025 21:02	VA claims Reps placing bias on Females veteran claims, cause we are not men therefore we don't have valid medical claims. 27 years of fighting for claims.
lastcullcatfishing	0	7/8/2025 21:36	The lack of support that the VA gives for pain medication for those suffering from traumatic brain injuries
aridie	0	7/8/2025 21:39	Pain being ignored because Iâ€™m lying.
tiggyty93	0	7/8/2025 23:31	The fact that weightloss medication isnâ€™t covered under Tricare even though itâ€™s proven to keep someone within weight standards despite hormones
pnwlover3	0	7/9/2025 0:11	Getting hit on and getting inappropriate comments, while not right, is not MST. Too
neyney_1019	0	7/9/2025 1:44	We donâ€™t need to jump through hoops to get the help that the civilian doctors would give her on the first visit.
neyney_1019	0	7/9/2025 1:45	Itâ€™s frustrating having to have to explain the same thing over and over because our doctors or PAâ€™s are constanly moving
kimjones75	0	7/9/2025 1:46	Sexual Harassment is #1. I was a PFC in the Army, I had a SGT E-5 over me, and he kept asking me out, making sexual comments etc. I was nervous and scared of him. I finally reported him and the higher ups did nothing but placed him in a different work site but we were still in the same company, same platoon and same warehouse. I was so happy when I finally got my PCS Orders. Women Veterans, Women Soldiers will never get the respect they deserve. I retired as a MSG and I knew I would not let that incident stop my career but this happens daily in the Armed Forces
therapist_dog_mom	0	7/9/2025 2:12	The biggest frustration Iâ€™ve had is not being heard. I had to go to an outside clinic to find out my hormones were way out of whack for the VA to hear me. I ended up having an adenoma (benign tumor) on my pituitary gland.

suzannedangler	0	7/9/2025 2:13	that all my problems are because of my weight... (didn't get discharged because of my weight). ðŸ™ƒ or that I got left on chemically induced menopause 6x times longer than was a. medically approved to be and 2. necessary overall. ðŸ™ƒ ðŸ¤¦ðŸ¼ðŸ¤·ðŸ¼ðŸ¤—
lostgirl026	1	7/9/2025 3:21	Stop downplaying my symptoms and actually listen.
chandrafifield16	0	7/9/2025 4:04	Being told I have to go to another state to unenroll so that I can enroll in my home state! I canâ€™t do it online or on the phone. A mistake made during Covid and is still not fixed
hazethebullypit	0	7/9/2025 5:07	More obgyn surgeons. I had to wait 6 months for the surgeon to start working and he is the only one in East Orange NJ
whyyouworriedaboutme	0	7/9/2025 5:32	Stop telling me Iâ€™m fat or hormonal and listen to whatâ€™s going on and try to fix it. And stop refusing to diagnose me with problems I very clearly have because Iâ€™m at 80% and therefore get all my care through the VA and they donâ€™t want to pay for it.
brrealtyexpert	0	7/9/2025 6:17	Thank you
gunfighter_usmc	0	7/9/2025 10:50	We need specialty clinics. I am rural as hell and the womenâ€™s clinic here isnâ€™t in the CCN. I am so tired of family medicine just saying it hormones or lose weight. Iâ€™m covered for VA care but Iâ€™m gonna use my private insurance because Iâ€™m sick of being gaslit
karigielow	0	7/9/2025 15:08	PAP SMEARS NOT BEING GIVEN WHEN ASKED FOR!!! I have a family history of cervical cancer and every year when I was in civilian care I had one yearly but the first year Iâ€™m scheduled for one they refused to do it because Iâ€™m only 25. I have a 1 year old to make sure I stay healthy for.
ceciliamariepadge	0	7/9/2025 16:43	More holistic health avenues!
jessicadrazan	0	7/9/2025 18:48	not getting proper scans that's needed because it cost the VA doctors have to get permission from their boss
mzcutts	0	7/9/2025 18:50	Perimenopause assessment and treatment
ammodogs89bwife	0	7/9/2025 19:33	every appointment being about my weight. I had back pain way before I got this heavy. offer me help not a diet and ibuprofen

lifewithla.muchachita	0	7/9/2025 19:45	Providers being rude
aimeerichardson00	0	7/9/2025 20:47	Thank you for speaking for us! I am a female Veteran & I work for the VA; we have a good womenâ€™s program but we need more! More services, more programsâ€™
kblackburn69	0	7/9/2025 22:13	I'm an older vet and we were taught that women have to basically suck it up when something is wrong so we won't be seen as weak or whining. therefore, I never sought care while active duty, thus "nothing in my file" which leads to denials for disability. I also didn't even know I was eligible for VA medical services for over 20 years post discharge
4tstew4	0	7/10/2025 0:26	The medication being shipped to my house ???? Idk if this is every VA or just mine but it takes me nearly a month to get my meds after filling the prescription
safeword_issilkies	0	7/10/2025 0:53	There are no dv resources for us. Burnout and incompetence among practitioners makes the va completely ineffective. Side effects of our medications should be covered by the VA.
r_sek	0	7/10/2025 1:00	Being small boat eng caused bleeding and infection from IUD. Not being believe went I need medical assistance becuz I am a female
sportzkat	0	7/10/2025 1:31	commenting for reach, so bummed I won't be here to attend your testimony; but would love to connect ! I do a lot in advocacy and would be happy to support your work too :) would suggest connecting with Beneath the Service they host the Women Veterans Leadership Program and could probably share your ask with alumni!
griffiths68	0	7/10/2025 1:37	Insomnia anxiety â€¦ pills pills and more pills
666ewe666	0	7/10/2025 1:46	Dismissal of symptoms, finding root causes
jl96q	0	7/10/2025 1:48	More providers. Thats an issue for everyone. I have to wait at least 6 mos to see my primary care doctor.
funwoods72	0	7/10/2025 2:24	Not being able to get in to a gyn doctor in Alabama. He is on there two days a week after 12:00. Yeah thats right. Also when Something was found in my breast, I had to wait months to get another exam to confirm the diagnosis. My mother and father died from cancer at a young age. I was pissed.

america_latina_solutions	0	7/10/2025 3:12	As I advanced in MH therapy I felt frustrated when I was told I needed to change to another provider because of the cultural diference background. That I needed to address MH in my first language.
icescream382	0	7/10/2025 3:32	Treat us like we are human. Poor experiences stop me from getting help.
cheries.dollhouse	0	7/10/2025 3:39	The VA wouldnâ€™t test for lupus unless Iâ€™m dying, although I had organ damage without clear cause other than â€œinflammationâ€□. I had to go outside the VA to get a diagnosis and then they wouldnâ€™t accept the report as proof or run their own tests. Iâ€™m already 100% service connected too.
sharonmartino205	0	7/10/2025 5:09	men complain they can't get their pp up they get disability, woman complain they have no drive after service we get nothing
lauren_grace_84	0	7/10/2025 10:17	TriWest refuses to bring any board certified lactation consultants into network to support new mothers. They tell us to find someone to bill out of network and say the VA's community care contract requirements don't allow this but Optum is doing it. They also need to support NEW POSITIONS for local VAs to hire their own lactation professionals if large enough.
jessicashire707	0	7/10/2025 14:16	Pain management! My S.O is also a vet and we have some of the same injuries and he gets better pain management than I do. Also when you move to a new state your starting from scratch on your pain management. They donâ€™t care what you were doing and if it helped, you start from the beginning when you move. Took me 2 years to get relief in one state.
tiffanym_c	0	7/10/2025 14:54	More providers. We have finally after a year vacancy 1 doc for all of the female veterans in Pensacola.
ejjimenez86	0	7/10/2025 16:12	They donâ€™t take my service related eating disorders seriously and just blame my adhd and BPD. I literally developed bulimia and binge eating from the service.
just.shauna0	0	7/10/2025 17:33	Why were you only given 5 minutes? So many things that are going wrong with the VA.

Prepared Statement of Meaghan Mobbs

Chairman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, thank you for the opportunity to testify today.

It's an honor to speak on an issue that is both deeply personal and profoundly consequential.

My name is Meaghan Mobbs, and I sit before you as the Director for the Center of American Safety and Security at Independent Women. I am a combat veteran and former Army officer, as well as a clinical psychologist whose research has focused on trauma, transition stress, and post-military reintegration. I completed my internship in the VA system and currently teach under the Veterans Mental Health–Primary Care Training Initiative through the New York State Psychiatric Association. That program trains physicians and hospital-based clinicians across New York State to identify, treat, and appropriately refer veterans in civilian care settings—because, too often, providers fail to recognize the cultural and clinical complexities that define military and post-military life.

I've been on every side of this system: as a soldier, as a clinician, as an educator, and as someone who has walked beside my fellow veterans—men and women—struggling to navigate the bureaucracy meant to serve them.

In 2018, when President Donald Trump signed the bipartisan VA MISSION Act, it wasn't just legislation, it was a solemn promise: that what happened at the Phoenix VA, where veterans died waiting for care, would never happen again.[1]

The VA Community Care Program was born of that promise. It was built on the understanding that the VA, while indispensable, is not omnipresent.[2] That in too many places, at too many times, bureaucracy has stood where medical support should have. The Community Care Program was designed to bridge that gap.

It was a direct response to bureaucratic failure, not a detour around it. It put the focus where it belongs: on outcomes, not process; on veterans, not institutions.

The VA Community Care Program is not just helpful, it is essential. It is a critical tool that helps us uphold our moral and national obligation to veterans.

But that promise has not been fully realized.

The Reality We Face

In 2001, as America entered the Global War on Terror, the VA Hospital Administration received $20.9 billion in funding.[3] That same year, we lost 16.5 veterans a day to suicide.

In 2024, after nearly two decades of war and massive Federal investment, the VA now receives $121 billion, a 479 percent increase.

And yet, at the end of last year, the VA reported the suicide rate at 17.6 veterans a day.[4] Of note, this figure is from 2022, as there is a significant data lag in veteran suicide statistics reporting.

But these figures are more than just numbers. They serve as a stark reminder that money alone doesn't solve structural failure. It is increasingly apparent, we do not have a funding problem; we have a function problem. It is a system-design problem and a failure to adapt, to decentralize, and to meet veterans where they are.

It is a system that, despite its scale and sincerity, continues to force veterans to wait weeks or drive hours for care that should be available promptly and locally. And it's a system where decisions about who gets timely treatment are too often made by bureaucrats with a budget, not doctors with a diagnosis.

The Community Care Program was created to address that failure. It offers veterans an alternative path to care when the VA cannot meet their needs in a timely or appropriate manner. It is the answer to wait lists, distance barriers, specialty gaps, and overwhelmed facilities.

---

[1] Sen. Johnny Isakson. John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson. "VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act of 2018)." 115th Congress, S. 2372. Introduced Feb. 5, 2018; enacted June 6, 2018 (Public Law No. 115–182). https://www.Congress.gov/bill/115th-congress/senate-bill/2372/.

[2] Department of Veterans Affairs. "VA Makes It Easier for Veterans to Use Community Care." *Wilmington VA Medical Center*, May 19, 2025.https://www.va.gov/wilmington-health-care/news-releases/va-makes-it-easier-for-veterans-to-use-comm unity-care/.

[3] Department of Veterans Affairs. "Administration Seeks Record VA Budget Increase." *VA News*, Feb. 7, 2000. https://news.va.gov/press-room/administration-seeks-record-va-budget-increase/.

[4] Department of Veterans Affairs. "VA Releases 2024 National Veteran Suicide Prevention Annual Report." *VA News*, Dec. 19, 2024. https://news.va.gov/137221/va–2024-suicide-prevention-annual-report/.

Today, roughly 40 percent of VA health care is delivered through community care.[5] Veterans are using it. They're satisfied with it. It's mostly working.

Community providers have stepped up, filling critical gaps in mental health, oncology, pain management, women's health, and substance use treatment. And in rural areas, especially, where VA facilities may be hours away, community care has become a lifeline.

But instead of expanding access, some VA administrators have worked to restrict it, undermining the law, the intent of the MISSION Act, and the trust of the veterans they serve..

Let me be specific. Last year at the Portland VA, a senior official admitted to oversight staff that they were deliberately trying to keep care "in-house," even when referrals were warranted.[6] In Buffalo, a veteran with cancer saw his radiation therapy referrals delayed, then canceled.[7] He died in pain. That is not a system error. That is systemic negligence.

While VA has taken steps to improve the Veterans Community Care Program, key gaps in timeliness, oversight, and care coordination remain.

If we are serious about honoring the promise made to every man and woman who has served, we must get this right. And that begins with clarity of mission, guided by four principles: flexibility, accessibility, rapidity, and accountability.

Flexibility: Real Choice, Not Red Tape

Veterans do not live neatly within institutional boundaries. They live in rural towns, sprawling suburbs, and city centers. They manage jobs, raise families, and carry injuries—both visible and invisible. And they deserve a care system that reflects that complexity.

The Community Care Program allows them to seek care outside the VA when it is too far, too slow, or lacks the necessary capability. This is particularly critical for specialized services—such as orthopedics, trauma therapy, neurology, reproductive health, and substance use treatment.

The system must respond to the reality of the modern veteran, a population that is younger, more diverse, geographically dispersed, and managing complex civilian and military transitions. When a VA system goes 2 years without a full-time gynecologist, as was documented in a 2020 Inspector General report, that's not a scheduling issue; it's a failure of access and management.[8] And with 70 percent of women veterans preferring female providers for women-specific care, and 50 percent even for general care, flexibility becomes a clinical imperative.[9]

Accessibility: Geography Should Not Determine Health Outcomes

Let's be blunt: If a veteran has to drive 3 hours each way to get care, that's not access, that's denial of care.

Only 55 percent of veterans live within 40 miles of a VA medical center. Just 26 percent live near a facility with full specialty care.[10] These numbers are even more dismal for veterans in rural communities, many of whom are older, sicker, and less mobile.

Community Care helps correct that. It allows veterans to seek treatment locally, reducing both the physical and financial burden of long-distance travel. That doesn't just improve health outcomes. It improves trust, adherence, and it keeps veterans engaged.

---

[5] Petra Rasmussen and Carrie M Farmer.. "The Promise and Challenges of VA Community Care: Veterans' Issues in Focus." *Rand Health Quarterly*, Jun. 16, 2023, Vol 10(3):9. https://pmc.ncbi.nlm.nih.gov/articles/PMC10273892/.

[6] Oregon Public Broadcasting. "Wyden: Roseburg VA Officials Admitted To 'Inappropriate Admissions' System." *OPB News*, Jun. 24, 2025.https://www.opb.org/news/article/roseburg-va-admissions-system-ron-wyden/

[7] Office of Healthcare Inspection. "Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA..." *Department of Veterans Affairs Office of Inspector General*, Audit Report No. 23–03679–262. Sept. 27, 2024.https://www.vaoig.gov/sites/default/files/reports/2024–09/vaoig–23–03679–262.pdf

[8] Office of Healthcare Inspections. "Comprehensive Healthcare Inspection of the Alaska VA Healthcare System, Anchorage, Alaska." *Department of Veterans Affairs Office of Inspector General*, Audit Report No. 19-06378–73, Jan. 23, 2020.https://www.vaoig.gov/sites/default/files/reports/2020–01/VAOIG–19–06378–73.pdf.

[9] Kate L. Sheahan, Karen M. Golstein, Elizabeth M. Yano, et. al. "Women Veterans' Healthcare Needs, Utilization, and Preferences in Veterans Affairs Primary Care Settings." *Journal of General Internal Medicine*, Aug. 30, 2022, Vol. 37(Suppl 3):791–798.https://link.springer.com/article/10.1007/s11606–022–07585–3

[10] Petra Rasmussen and Carrie M Farmer.. "The Promise and Challenges of VA Community Care: Veterans' Issues in Focus." *Rand Health Quarterly*, Jun. 16, 2023, Vol 10(3):9. https://pmc.ncbi.nlm.nih.gov/articles/PMC10273892/.

And with the veteran population shifting rapidly—2.2 million women veterans expected by 2025, nearly 18 percent of the total veteran population by 2040, and 43 percent of women VA users in 2020 from racial or ethnic minority backgrounds—it's no longer acceptable to offer a model built for the demographics of 50 years ago.[11]

Veterans deserve care where they live, not just where we've historically placed facilities.

Rapidity: Delayed Care is Denied Care

In that regard, veterans don't need care eventually, they need care now.

VA outpatient satisfaction ratings reached 91.8 percent in 2024, that is a number to be celebrated, but it also runs the risk of masking regional and categorical disparities.[12] It does not speak to the veteran experiencing PTSD symptoms today. It does not help the veteran with worsening chronic pain who's told to wait 28 days before seeing a specialist.

Under current rules, veterans are often forced to endure arbitrary thresholds before becoming eligible for Community Care—20-day waits and 60-minute drive times. These are numbers written on paper, not reflections of actual urgency.

I've worked with veterans denied certain types of mental health treatment or experienced significant delay in access to specialty mental health care. Others were turned away because they weren't sick enough. Still others were forced to partake in a type of therapeutic intervention at odds with their preferred course of treatment.

Many times these decisions were not meant to be negligent, but hyper process-oriented. Irrespective of intent, such moments are often perceived as administrative cruelty and institutional malaise. And it is costing well-being and lives.

Accountability: Structure Must Serve the Mission

I believe in oversight. And I believe that no system—public or private—should operate without guardrails. But accountability should be about ensuring quality and responsiveness, not erecting barriers that keep veterans out.

Despite ongoing efforts to improve the Veterans Community Care Program, the Department of Veterans Affairs continues to fall short in fully addressing long-standing structural and operational deficiencies.

These reforms are designed to ensure veterans can more easily obtain the health care that best fits their needs, whether within VA facilities or through qualified community providers.

Since 2018, the Government Accountability Office (GAO) has issued 27 recommendations to strengthen the program's performance, particularly in the areas of appointment scheduling, wait time monitoring, contract oversight, and network adequacy. As of early 2025, only nine of these recommendations have been fully implemented.[13] This sluggish pace of reform has tangible consequences for veterans who rely on community care when timely services are not available within the VA system.

A central and unresolved issue remains the lack of a clearly defined, enforceable standard for how quickly veterans must receive community care appointments. While the VA has implemented some mechanisms to track scheduling performance, it has not yet established comprehensive metrics aligned with those timeframes, leaving the system without meaningful accountability.

The VA's Referral Coordination Initiative, intended to streamline specialty care referrals, has likewise suffered from inconsistent implementation, unclear guidance, and inadequate performance metrics. These shortcomings create variability in veteran experience and undermine trust in the VA's ability to deliver timely, coordinated care across its network.

Equally concerning is the state of contract oversight and provider network adequacy. Although the VA has taken steps to improve data systems and oversight processes, critical vulnerabilities remain. The current methodology for assessing whether provider networks are adequate, particularly in the realm of specialty and

---

[11] U.S. Department of Veterans Affairs, Office of Women's Health. "Facts and Statistics." *Women Veterans Health Care*, accessed Jul. 10, 2025.https://www.womenshealth.va.gov/materials-and-resources/facts-and-statistics.asp.

[12] Department of Veterans Affairs. "Trust in VA Among Veteran Patients Rises to 91.8 percent, Up 6 percent Since 2018." Wilmington VA Medical Center Press Release, Apr. 17, 2024.https://www.va.gov/wilmington-health-care/news-releases/trust-in-va-among-veteran-patients-rises-to–918-up–6-since–2018/

[13] Sharon M. Silas. "Veterans Health Care: Opportunities to Improve Access to Care Through the Veterans Community Care Program." *U.S. Government Accountability Office*, Feb. 12, 2025. https://files.gao.gov/reports/GAO–25–108101/index.html.

mental health care, risks obscuring the extent to which veterans have real access to services. Without reforms to oversight processes and more accurate measurement tools, the VA risks misallocating resources and failing to ensure that community networks meet veterans' needs.

Finally, as the use of community care continues to grow, especially in behavioral health, the VA must prioritize seamless coordination between VA facilities and outside providers. Preliminary findings show that the majority of veterans who seek mental health services in the community continue to rely on the VA for ongoing care. This underscores the urgent need for standardized, reliable systems to ensure timely medical documentation exchange and continuity of treatment.

In light of all of these critical issues, I want to commend Secretary Collins on his recent announcement that the VA will expedite the implementation of the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act—enacted earlier this year—which addresses some of these concerns and includes critical provisions to expand and streamline veterans' access to the Community Care program.

Because let's be clear: It is not enough to offer a door, we must ensure that the door is open, functional, and leads somewhere worth going.

Conclusion

I completed my training in the VA system. I've referred patients there. I believe deeply in the VA and the essential mission it fulfills for our veterans. But no system, no matter how well-intentioned, can serve every need, in every place, for every veteran.

That's why Community Care matters. It's not an indictment of the VA, it's an extension of the promise made. A veteran's health outcomes should not depend on geography, paperwork, or luck. They should depend on whether we've built a system that puts their needs first.

Veterans don't need more bureaucracy—they need choice, speed, and accountability.

Thank you for your time, your leadership, and your continued commitment to those who've served. I welcome your questions.

Prepared Statement of Amanda Newman

Western Illinois Home Health Care, Inc.
#2 Industrial Park Road ● PO Box 856 ● Monmouth, IL 61462
Monmouth: (309) 734-9376 ● Galesburg: (309) 342-2024
Toll Free: (800) 228-5993 ● Fax: (309) 734-5338

Thank you Chairwoman Miller-Meeks, Ranking Member Brownley, and the members of the Committee for this opportunity to provide testimony on the critical topic of the Veteran's Health Administration Community Care Program. And thank you Chairwoman Miller-Meeks and Ranking Member Brownley for the important legislation that you have successfully led through the legislative process to support veterans. I am honored to speak on behalf of the 121 Illinois veterans that we serve in our agency and on behalf of veterans served by Home Care Association of America (HCAOA) members across the nation.

I am the second generation running a family-owned home health and home care agency in West Central Illinois. We cover a 10 county, mostly rural, area and we have worked with the Department of Veterans Affairs (VA) providing home care for over 30 years. We currently do so as a contracted provider in the VA Community Care Network, operated by Optum. Through our agency, we provide veterans with Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Home Health Aide, Homemaker, and Respite services in a veteran's residence.

Community Care is not an alternative to the VA – it is an extension of it. For many veterans, especially those living in rural or remote areas, Community Care represents a vital lifeline. These veterans often face long travel times or limited specialty services at local VA facilities, making care in the home a necessary option. Community Care allows them to receive the right care, at the right time, in the right place – without sacrificing the VA's standards of excellence or their personal connection to the system that was built for them.

The success of Community Care hinges on a shared commitment to veteran-centered, team-based care. Veterans deserve coordinated services where VA and community providers work in partnership – not in competition. Over our 30 years working with the VA, we have always had good relationships with the VISN 23 Veteran Affairs Medical Center in Iowa City and our local VA Outpatient Clinic in Galesburg, Illinois, working together to meet veteran needs.

Our experience has been that there have been process changes within the VA in the last two years that have created barriers to veteran access and care. These changes don't appear to be in line with the spirit of the MISSION Act.

Current Barriers to Veteran Access

Reducing and Eliminating Authorized Services for Veterans

At the beginning of 2024, we began to see the VA systematically and routinely reduce

or eliminate Community Care services for veterans who had qualified for and relied upon these services for years.

The VISN 23 instituted a new centralized process wherein the VISN Inter-Disciplinary Team (IDT) determines what will be authorized based on limited information taken from the patient's chart and a phone call questionnaire to the veteran. Our veterans have reported that they are often confused with this phone call and are too embarrassed to fully disclose what their caregivers do to assist them, particularly with intimate care such as toileting and bathing or in cases where the nurse helps the veteran to maintain stability through medication management and behavioral health nursing. The Iowa City VA case managers, and even the veteran's provider, have very little input or recourse when they disagree with the decision made by the IDT team.

Additionally, the IDT team often fails to take into account additional factors that only care in the home can assist with such as reducing veteran isolation, ensuring that medications are taken consistently and properly, and ensuring proper diet when a veteran has a chronic condition such as diabetes. No member of the VA IDT decision-making team conducts an in-home assessment or sees the veteran in person. Therefore, they are not equipped to accurately understand the veteran's needs and what services should be authorized.

Many of our veterans are reporting these concerns to us. Two long-time clients who have been negatively impacted by the VA's actions are highlighted below:

> One veteran we care for is a 79 year old veteran who lives alone in a small, rural town and has difficulty controlling his diabetes. He is unable to cook for himself or safely navigate the stairs to do laundry. He was denied homemaker services. When we requested authorization for physical therapy to help him to safely ambulate, this also was denied. Instead, they required him to drive 53 miles <u>each way</u> twice a week for 12 weeks to go to the VA Community Based Outpatient Clinic for PT. He continues to struggle with his activities of daily living.
>
> We also serve an 85 year old veteran who has difficulty ambulating and uses a cane due to a stroke, osteoarthritis, and a laminectomy procedure. He was denied home health aide caregiver services because he reported on the phone that he is able to shave his beard. However, the IDT team did not take into account his ability to perform other activities of daily living such as bathing, ambulating or dressing or to fully evaluate his care needs. Regrettably, he has been off of service for several months, and his condition has declined. If the VA does not deem home health aide services clinically appropriate for this veteran, when is it appropriate?

We request that care decisions remain with the local medical center and community care team who know the veteran and are better able to assess needs. We do not believe that non-local decisions like these are what our veterans have earned and are in direct opposition to the directive from Congress in the MISSION Act.

For the Committee's reference, the VA Medical Centers create an authorization to

provide care. A home care authorization usually allows for up to 20 hours of assistance with activities of daily living. But there is a consult issued by the Community Care team that specifies the actual care to be provided. And those hours are nearly always less than the authorization. We request the Committee to review the home care consults issued by VA Medical Centers so the Committee can see the disparities for themselves.

Shortened Authorizations

While the VA formerly provided stability and consistency in authorizing skilled home health, home health aide and homemaker services, new processes over the last 18 months have led to shorter authorizations with inconsistent timeframes. Earlier this year, VA cut the duration of authorizations in half, from 12 months to 6 months or less. This places a burden on VA Community Care staff to process authorization renewals at twice the volume which can lead to delays. This creates uncertainty for the veteran. We hear from nurses and case managers at the VA who are working to process Request for Service forms as quickly as possible but are overwhelmed by the work load. Returning authorizations to a 12 month authorization would create more consistency and free up nurses and case managers to have time to focus on urgent needs that require shorter authorizations. The authorization duration does not prohibit the VA from prescribing clinically appropriate care at any time, it only adds to the local paperwork burden.

Reduced Per Visit Rates

The VA issued the home health non-bundled fee schedule for 2025. We believe that there was an error in the calculation of the rates as they have been set well below the Medicare Low Utilization Payment Adjustment (LUPA) rates despite the fact that many of the same Medicare regulatory requirements apply to VA cases including OASIS completion. The fee schedule is also not consistent across the states. For example, Iowa, Illinois, and Indiana all have different rates for the following billing codes.

The following table shows the rates for Illinois in 15-minute increments and illustrates the substantial rate cuts that took place in January, 2025, some over 35%:

Procedure Code	Locality Description	Medicare Locality	2024 rate	2025 rate
G0299	SN	99	$41.88	$36.00
G0300	LPN	99	$30.57	$27.00
G0151	PT	99	$45.30	$36.04
G0157	PTA	99	$27.47	$23.78
G0152	OT	99	$38.69	$36.28
G0158	COTA	99	$29.90	$24.31
G0153	ST	99	$40.89	$39.17
G0156	HHA- HHC	99	$18.11	$11.59

S9122	HHA- MHS hourly	99	$72.44	$46.35
S5150	Respite	99	$18.11	$11.59
S5130	Homemaker	99	$10.97	$7.76

These new rates are below cost to provide care, and they don't take into account additional costs such as travel time and mileage. Agencies are only paid for time in the veteran's home regardless of how much travel it took to reach the veteran's home. Agencies have had to make some hard decisions on discontinuing therapy and nursing service in rural areas as we would be paying our therapists and nurses more than the VA is reimbursing. As a consequence, veterans will lose access to essential healthcare services that they have earned through their service to our country. Given the unique challenges faced by rural populations, it is vital and equitable that the new rates be adjusted to align with the appropriate Medicare LUPA levels to ensure that our veterans continue to receive the care they need without disruption. A veteran's care should not be worth less than a Medicare beneficiary.

As our veteran population ages and chronic conditions become more prevalent, the need for accessible home health and home-based care as well as community providers will only grow. These services reduce hospitalizations, improve quality of life, and support caregivers. Yet, too often, providers are unable to deliver these services because VA reimbursement rates do not meet the actual costs of care. We urge Congress and VA leadership to ensure that rates for skilled home health and home health aide, homemaker and respite services are sustainable, particularly in rural areas where provider availability is limited.

Why Community Care Matters and How We Can Work Together

Community Care matters because it enhances access, expands capacity, and supports choice for veterans – without replacing the foundational role of the VA. It is essential to allow for:

1. *Timely Access to Care*
   Many VA medical centers and clinics are at capacity or located far from where veterans live, especially in rural and underserved areas. Community Care gives veterans a timely option when VA wait times are long or travel is burdensome.

2. *Improved Health Outcomes*
   Getting the right treatment at the right time reduces complications, hospitalizations, and overall costs. Delayed care can worsen outcomes. Community providers help fill those gaps when VA resources are stretched.

3. *Veteran-Centered Choice*
   Community Care gives veterans more control over their healthcare decisions. Whether they need a specialist, behavioral health support, or home-based care, they can access what works best for their needs and circumstances.

4. *Specialized or Local Services*
   Some services – like advanced imaging, home health care, or rehabilitation – may not be available at every VA facility. Community partnerships allow veterans to receive specialized care locally, closer to family and support systems.

Community Care is not a workaround – it's a necessary part of a comprehensive, veteran-first healthcare system. When community providers and the VA work together, veterans benefit from timely, compassionate, and coordinated care – delivered wherever they are, whenever they need it.

Let me be clear: this is not a call for privatizing the VA. Community Care should complement, not replace, the VA's core services. Public-private partnerships must be rooted in shared standards and respect for the unique mission of the Department of Veterans Affairs.

We have an opportunity – and a responsibility – to ensure that every veteran receives care that is timely, high-quality, coordinated, and close to home. By strengthening Community Care as a complement to VA services, investing in home care and rural access, and ensuring providers are supported through fair reimbursement, we can fulfill the VA's sacred mission to those who have served.

Thank you for your time, and for your continued commitment to the health and dignity of America's veterans.

Prepared Statement of Kristina Keenan

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide the VFW's and my personal remarks on this important topic.

The VFW believes the Department of Veterans Affairs (VA) community care program and its Community Care Network (CCN) of providers are a vital component of VA health care as it delivers the care and services that VA hospitals and community-based outpatient clinics either cannot or do not provide. Since no institution can be everything for everybody, community care providers are force multipliers, allowing VA to continue providing the world-class care that veterans prefer, deserve, and have earned, while also ensuring they have access to the range of services they may need throughout their lives.

When appropriately used, community care can save lives and improve the health outcomes for countless veterans, but the problems that arise can drive people away from the care they have earned. We have also called on VA to rely on its third-party administrators to ensure consistent delivery of community care to eligible veterans. The VFW has been unequivocal that community care must be a part of VA care since the 2014 Phoenix crisis. It always has been. However, veterans expect consistency. When 23 Veterans Integrated Services Networks interpret the *VA MISSION Act of 2018* in 23 different ways, veterans are overlooked, as the VA Inspector General pointed out last year in Buffalo, New York.

Background

VA provided fee-based care through non-VA providers before 2014, under limited circumstances, to veterans residing in rural areas who could not access a VA facility, and for services that the local VA facility could not provide. Following the VA wait-time scandal in Phoenix, the *Veterans Access, Choice, and Accountability Act of 2014*, called the Choice Act, was passed to establish the Veterans Choice Program (VCP). The Choice Act enabled eligibility for community care for those living far from a VA facility or facing excessive wait times, which was overseen by third-party administrators managing provider networks. In 2018, VCP was replaced with the more unified and permanent Veterans Community Care Program (VCCP) through the passage of the VA MISSION Act of 2018. This change provided community care if VA services were not available in a timely manner, were not readily accessible, were in the veteran's best medical interest, or if the veteran and provider agreed that community care was the best option. Currently, VCCP eligibility is determined based on clinical need, rather than distance or wait time. It is coordinated through VA Care Teams, which include urgent care, primary care, specialty care, and mental health services. Third-party administrators manage community care networks, such as Optum Serve (East Region) and TriWest Healthcare Alliance (West Region).

Specialty Care

VCCP provides a wide range of specialty care services to ensure that veterans can access medical care that may not be immediately available in VA facilities. These may include cardiology, audiology, otolaryngology, gastroenterology, dental and oral surgery, mental health and behavioral services, and women's health, among others.

As the number of women serving in the military has increased, so has the women veteran population. For these VA patients, community care has become essential, particularly for their gender-specific services like mammograms, fertility treatment, and maternity care. Veterans living in rural and underserved areas that are greater distances from VA medical facilities rely heavily on this option. Additionally, veterans experiencing mental health crises who require inpatient care may need to be referred to community care providers for specialized treatment. All veterans must receive timely, high-quality, and consistent care that meets their individual needs and preferences.

My Story

I use VA for all my health care except dental care, which is not currently covered for veterans without a dental-related service-connected disability. The specialty care that I have received as part of VA's community care program includes mammograms and maternity care.

The care I have received through VA's community care providers has been high quality and has met my needs and preferences. VA coordinated my care during a pregnancy last year, which sadly ended in miscarriage. I became pregnant again this spring, and VA is again coordinating my maternity care in the community. In both instances when I became pregnant, a VA maternity care coordinator sent me

a list of 27 medical facilities for covered maternity care within the Washington, DC. metro area. I was able to select both the facility and provider of my choice based on availability. I selected a hospital five miles from my home (which is 30 minutes of city driving time), and that is next to my VA medical center. I was pleasantly surprised to learn that I could even select midwifery services at my hospital of choice, which was my top preference for maternity care. I appreciated the exceptional compassion and bedside manner of my providers, especially during the difficulties of my first pregnancy. In both cases, VA processed my community care referrals in a timely manner, and I received communications both electronically and by phone about my health care through a maternity care coordinator.

While I have had very positive experiences with community care, I have also encountered several challenges along the way in how that care was coordinated by VA. First, for my mammogram screening, I received a bill for nearly $700 that VA failed to pay even though it made the appointment for that care. Each time I received a bill, I called the community care provider and gave my VA referral information. As I continued to receive bills and saw the threatening words in red letters that I could face collections if I failed to pay, I would call again and was always told it would be taken care of. After approximately 6 months of receiving bills and calling to try to remedy the situation, the bills finally stopped.

Second, the process to set up my initial appointments during my maternity care was quite confusing. It was unclear to me if VA was going to set up the first community care appointment or if I needed to call providers from the approved VA list. The first time, I was told to wait for VA to call me to schedule the appointment. Then, after a couple of weeks, I was told that I could make the appointment myself. Once I received the VA referral, I made an appointment with the approved provider, but at the same time VA made an appointment with that same provider though my name was misspelled. When I tried to cancel the VA-scheduled appointment, which was weeks later than the appointment I had scheduled, the CCN provider could not locate it because of the misspelling. When I called the VA appointment phone number, I was told that VA was obligated to keep the scheduled appointment even if I did not attend it, so there was no way for me to cancel or change that appointment.

Third, also during my maternity care, my CCN provider attempted to send a prescription to my VA pharmacy for me to pick up since this was the only way that VA would cover the cost of the medication. I asked for a written prescription to hand carry to the pharmacy, but my provider said that prescriptions could only be sent electronically. I walked over to the VA medical center, across the street from my community care facility and waited for it to be filled. Once it was clear that VA never received the request, I walked back to the CCN provider, but by then it was late in the afternoon on a Friday and already closed. I walked back to the VA pharmacy and was told I should have requested a paper prescription or had the provider send it by fax. None of this information was provided to me or the CCN provider, nor was it on my VA referral documents. Frustrated with the situation, the pharmacist advised me to walk to the VA women's clinic and attempt to speak with my primary care physician. I spoke with a nurse, and she was able to relay a message to my doctor. When the nurse returned, she said that my doctor had put in an electronic prescription request for the same medication at the VA pharmacy. I was grateful that the staff at my VA facility were there to help me before the facility closed for the weekend. This could have been avoided with better information sharing between VA and the CCN provider.

Fourth, during my first pregnancy, which ceased to be viable after the first few weeks, I received a phone call from my VA maternity care coordinator. She said that she had been informed that I wanted to terminate my pregnancy. I had the impression that she was calling to tell me that VA could not cover the termination. She said she thought I was happy to have become pregnant. The information she received was incredibly hurtful and completely incorrect. I informed her that my pregnancy was likely not viable and that I may need additional care to manage the miscarriage. She apologized and reassured me that my care would be covered. I learned later that the care I opted for did in fact need VA approvals. My coordinator called me again to ask why I had received a certain procedure related to my miscarriage that was not normally approved by VA. Again, she had been misinformed because I had not had any procedures at that point. Accurate information sharing between VA and community care providers is absolutely critical to ensure providers have all the information needed to provide high-quality continuity of care. The need for accuracy of medical records cannot be understated. Additionally, when veterans receive care within VA, there is never a worry about insurance or coverage because VA providers can be clear about what they can and cannot provide. Using community care

exposes veterans to confusing insurance coverage and required approvals that can cause delays and frustration.

Last, during my current pregnancy, my community care provider indicated that I should have three genetic tests performed to rule out certain conditions that may affect my baby. She said that because of my age, these tests were critical and, depending on the results, could require me to take additional medications or treatments during my pregnancy to lower the risks of negative outcomes for my child. My VA referral document simply states that it covers "Laboratory and pathology services to include screening and testing as clinically indicated and relevant...Also includes medically indicated genetic testing." Since the referral did not list any specific tests, I have not scheduled any yet, but contacted my VA maternity coordinator to inquire if they are covered. The coordinator asked me what the billing codes are for the recommended tests. She also sent me a list of 173 billing codes, some of which were accompanied by the text "Pre-Certification Required." At my next appointment 2 weeks later, I asked my CCN provider about the billing codes for the recommended tests. She said they can be found online simply by using Google. I sent my VA coordinator a follow-up message with the codes that I researched myself for the three recommended tests. Even though all three of the billing codes were on the VA list of approved screenings, two of them required pre-certification. This means that I need to wait until my next monthly appointment with my CCN provider so they can fill out a VA Form 10–10172, *Request for Additional Services* (RFS). After several secure messages and a follow-up phone call with my maternity coordinator, it was explained to me that I would have to send these VA forms back to her and she would then forward them to both my VA primary care physician and the VA community care office for approval. If approved, she advised me to ensure that when I received the screenings, likely at a Labcorp office, I should also be sure that the tests are indeed covered by VA's insurance provider, Optum Serve.

The problem with these challenges in the coordination of my specialty care in the community is that it would have been easier to disregard the tests or pay my prescriptions out of pocket, rather than experience the extensive amount of bureaucracy. In these cases the costs have been high, so I have been extra vigilant to ensure VA will cover the expenses. I have had VA deny medical bills, even for urgent care that was coordinated by VA, so I am being particularly careful with potentially costly maternity care.

Despite the fact that I have had wonderful care in the community, the coordination of that care has been particularly stressful. As a woman veteran who cannot receive any of these services within VA itself, it is disappointing that I must manage these challenges at a time when additional stress is detrimental to my health and that of my baby. Issues with scheduling, pharmacy, screenings, coverage, information sharing, and billing need to improve before VA sends more veterans to community care providers.

Issues Reported by VFW Members

Billing issues and confusing VA referrals related to community care have also affected veterans and VFW members nationwide. One problem is the lack of communication regarding the appropriate procedures veterans must follow when receiving care in the community, including whether a referral is involved, as well as who to contact for assistance.

Consider the case of an 88-year-old veteran in Pennsylvania who collapsed in a VA parking lot a few years ago. He was transported by ambulance to a civilian hospital for treatment. Instead of billing Medicare first, the civilian hospital billed VA. VA authorized and paid for the service, but then billed the veteran more than 2 years after the incident. This delayed billing occurred beyond any timeframe for disputing charges with either VA or the civilian facility. Despite the veteran having settled all debts, he continues to receive additional bills for this care. Upon reviewing the situation, it became clear that the veteran was not at fault. The initial error arose from the civilian facility's decision to bill VA before Medicare, and VA's subsequent coverage of those costs. Unfortunately, VA took several years to bill the veteran due to an internal processing issue. As a result, the veteran is being held financially responsible despite not being at fault. This situation is causing significant financial stress and creating barriers to accessing care. Further review also revealed that the veteran has been paying copayments that he should not have had to cover.

In a separate case in Washington, DC, veterans were approved to visit urgent care facilities. However, the urgent care institution faced difficulties processing the billing under VA authorization and reached out to VA for assistance, but received no response. VA instructed the veterans to pay out of pocket for the care, which they did. This situation arose from an authorization and billing issue that required submission for upfront VA coverage, but VA was unable to assist. If VA authorized the

care, why was it unable to provide the appropriate billing codes? Veterans should not be burdened with costs due to VA's inability to provide accurate billing information to CCN providers.

A veteran from Virginia received a referral for CCN dental care, however, when the dentist determined that surgery was necessary, the veteran had to wait for VA approval. This required a further evaluation by a VA dentist to get the needed procedure approved. As a result, previous referrals for preventive dental care were canceled.

In California, veterans have experienced issues with referral approvals, possibly linked to TriWest Healthcare Alliance system problems, resulting in inconsistent care appointments. One veteran has had an active referral for 12 specialty service sessions scheduled between April 1, 2025, and September 30, 2025. Unfortunately, no further care was provided after the initial appointment. The veteran reported that VA instructed the CCN provider to hold off on care. The reason is unknown.

Several veterans received letters from both VA and their CCN providers stating that the CCN provider could no longer offer the specified care and that they would begin receiving services through VA instead. This change required veterans to travel excessive distances for appointments, sometimes multiple times a week, which significantly impacted their ability to work and manage other responsibilities.

In Texas, a veteran was referred to community care for vision care but was informed by the CCN provider that surgery was required. Both the CCN provider and the veteran notified VA, which then scheduled the veteran for a VA follow up to determine the next steps. The veteran is currently frustrated about having to wait beyond the required timeframes to be seen by VA, especially after being referred to CCN due to long wait times for his vision care.

Solutions

VA's community care program is plagued with numerous challenges that require thoughtful solutions. Care in the community is necessary for some veterans, but if given the choice, our members routinely tell us they prefer VA direct care. Negative experiences with the community care coordination process contribute to that sentiment. We must fix those issues because our veterans have earned quality care regardless of who provides it.

The VFW supports H.R. 740, *Veterans' ACCESS Act of 2025*, as it represents a critical step forward in enhancing access to care for veterans, particularly in ensuring timely, effective, and consistent health care options through the CCN to streamline care, reduce bureaucratic obstacles, and expand access to care. Key provisions include codifying community care access standards based on wait times and driving distance, notifications regarding available services and provider preferences, transparency about denials of community care services and appeals rights, extensions for billing deadlines, and expedited access to mental health services.

The VFW appreciates the provision to improve the policies and processes that govern access to VA's Mental Health Residential Rehabilitation Treatment Program (MH RRTP) as we recognize it needs serious attention. We would ask that the standards for accessing these programs be thoughtfully considered due to their different nature. Priority admission standards should be developed differently than routine admission standards because many of these programs, whether VA-provided or in the CCN, are typically not local to veterans.

Additional legislative measures should also be considered to improve VA's community care program. Sharing health records and care integration must be addressed and improved between VA and community care providers. We urge the committee to prioritize not only the improvement of community care coordination but also the continuous support and enhancement of VA direct care services. This approach will help prevent over reliance on the community care system and ensure that veterans receive the comprehensive care they rightfully deserve. We owe it to our veterans to ensure that their access to care is not hindered by bureaucracy or geographical limitations. Expanding and integrating community care options is not just a policy choice; it is a moral obligation to those who have served.

Chairwoman Miller-Meeks, Ranking Member Brownley, this concludes my testimony. I welcome any questions from you or members of the subcommittee.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any Federal grants in Fiscal Year 2025, nor has it received any Federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

Prepared Statement of Kyleanne Hunter

Statement of Dr. Kyleanne Hunter

Chief Executive Officer

of

Iraq and Afghanistan Veterans Of America

before the

House Veterans Affairs Subcommittee on Health

July 15, 2025

IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Statement of Dr. Kyleanne Hunter
Before the
House Veterans Affairs Subcommittee on Health
July 15, 2025

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Committee, thank you for the opportunity to testify today. I come before you today as the CEO of Iraq and Afghanistan Veterans of America (IAVA), the leading voice of the post-9/11 generation of veterans. I am also a public policy researcher who for over a dozen years, has specialized in the physical and mental health care needs of military servicemembers and veterans, and as service-connected disabled veteran myself with complex mental and physical healthcare needs resulting from exposure related cancer, military sexual trauma, and injuries sustained during combat operations.

From all of these perspectives, I know the importance of ensuring that our veterans receive the most effective and highest quality healthcare, and that they receive it in a timely manner, so that they may continue to be of service to this nation out of uniform. I appreciate the commitment of this committee to ensuring that we receive the highest quality of care and that America keeps its promise to care for those who have borne the battle.

The topic of today's hearing - VA Community Care - is an important one, and one that has touched the lives of many post-9/11 veterans in some way. While the VA Community Care program has existed in some form since World War I, it has significantly expanded and changed in scope since the passage of the 2014 CHOICE and 2018 MISSION Acts. This legislation expanded eligibility and access to community care. The Congressional Budget Office (CBO) calculates that between 2014-2020, the number of veterans participating in community care increased by 1,000,000 (from 1.3-2.3 million veterans accessing community care), and the cost of community care has more than doubled (from $7.9-$16.9B).[1] More strikingly, community care costs jumped from approximately $14.9 billion in 2018[2] to $28.5 billion in 2023, with a projected 9.3% increase from FY 2023 to FY 2024.[3]

The most recent Department of Veterans Affairs (VA) budget reflects a significant and increasing allocation towards mandatory community care spending, shifting resources that could otherwise support direct care capabilities. Mandatory spending for community care is projected to rise from $6.74 billion in FY 2024 to $9.77 billion in FY 2025, contributing to an overall community care budget of $33.91 billion in FY 2024 and $40.94 billion in FY 2025.[4] This substantial increase in mandatory community care funding, while intended to expand veteran

---

[1]Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects* (Washington, DC: Congressional Budget Office, October 2021), 12, https://www.cbo.gov/publication/57423.
[2] U.S. Government Accountability Office, *Estimating Resources Needed to Provide Community Care*, GAO-19-478 (Washington, DC: Government Accountability Office, June 2019), https://www.gao.gov/products/gao-19-478.
[3]U.S. Department of Veterans Affairs, *FY 2024 Budget in Brief*, Medical Community Care section (Washington, DC: Department of Veterans Affairs, March 2023), https://www.va.gov/budget/docs/summary/fy2024-va-budget-in-brief.pdf.
[4]U.S. Department of Veterans Affairs, *FY 2025 Budget in Brief* (Washington, DC: Department of Veterans Affairs, March 2024), https://www.va.gov/budget/docs/summary/fy2025-va-budget-in-brief.pdf.

access, raises concerns about its impact on the long-term viability and investment in the VA's integrated direct care system, particularly when juxtaposed with proposed increases in its construction budget.

The VA's proposed FY 2026 Military Construction (MilCon) related budget includes $3.0 billion for VA Construction programs, comprising base discretionary funding and additional support from the Recurring Expenses Transformational Fund.[5] Within this, major construction projects are slated for a significant proposed increase, from $961 million in FY 2025 to $1.87 billion in FY 2026.[6] This investment in infrastructure is critical for the VA's physical capacity; however, the ongoing and pronounced rise in mandatory community care spending at a higher cost to taxpayers continues to present a challenge. Evidence indicates that community care often incurs higher costs due to limited VA oversight and varied local market rates.[7] Reports highlight that this dramatic increase in community care expenses threatens direct care funding and could lead to a "downward spiral" for the VA's internal healthcare system.[8] For example, recent research found that veterans receiving community primary care for diabetes experienced worse quality of care and higher costs compared to those in VA primary care.[9] This dynamic suggests that while construction investments aim to bolster direct care capabilities, the escalating mandatory commitment to community care at potentially higher costs may erode the operational and financial capacity of the VA's core direct care mission over time.

Community care has, and can, provide positive outcomes for some patients,[10] but especially as we consider these rising costs, we need to be clear that the evidence does not bear out community care as a meaningful replacement for VA direct care. VA direct care provides better patient health outcomes, better coordinated and more timely services, and is frequently more cost-effective when compared to community care. Additionally, increased and more effective use of Community Based Outpatient Clinics (CBOCs) may fill in some service gaps for veterans

---

[5]U.S. Department of Veterans Affairs, *FY 2026 Budget Submission* (Washington, DC: Department of Veterans Affairs, May 2025), https://department.va.gov/wp-content/uploads/2025/06/2026-Budget-in-Brief.pdf.

[6] U.S. Department of Veterans Affairs, *FY 2026 Budget Submission* (Washington, DC: Department of Veterans Affairs, May 2025), https://department.va.gov/wp-content/uploads/2025/06/2026-Budget-in-Brief.pdf

[7] Congressional Budget Office, *Veterans Community Care Program: costs and effects* (Washington, DC: Congressional Budget Office, October 2021), https://www.cbo.gov/publication/57257.

[8] Ken W. Kizer et al., *The Urgent Need to Address VHA Community Care Spending and Access Strategies: Red Team Executive Roundtable Report* (Washington, DC: U.S. Department of Veterans Affairs, March 30, 2024), https://veteranspolicy.org/wp-content/uploads/2024/05/Red-Team-Executive-Roundtable-Report.pdf.

[9] Yoon J, Chow A, Jiang H, Wong E, Chang ET. Comparing Quality, Costs, and Outcomes of VA and Community Primary Care for Patients with Diabetes. Journal of general internal medicine. 2024 Aug 5.

[10] Garvin, Lynn A., Marianne Pugatch, Deborah Gurewich, Jacquelyn N. Pendergast, and Christopher J. Miller. "Interorganizational care coordination of rural veterans by Veterans Affairs and community care programs: a systematic review." *Medical care* 59 (2021): S259-S269. doi: 10.1097/MLR.0000000000001542.

while ensuring that they receive the benefits of VA direct care. Each of these points will be expanded below.

Community Care is essential in limited situations

Community care must be understood as a critical component of the VA healthcare system, but one that plays an important role only in limited circumstances. To be eligible for community care, at least one of six eligibility requirements must be met:[11]

1. Veteran Health Administration (VHA) facilities do not offer the services that the veteran needs.
2. The veteran resides in a state or territory without a full-service VHA medical facility.
3. The veteran was eligible under provisions that applied before the VA MISSION Act was signed (i.e., they qualify under "grandfathered" eligibility for community care).
4. The care or services that the veteran needs do not meet the access standards for appointment wait times or drive times.
5. A VHA provider and the veteran agree that receiving care from an outside provider is in the veteran's best interest.
6. The care or services that the veteran needs do not meet designated quality standards.

Veterans who meet these requirements have benefited from increased access to care in a timely and high-quality manner. This is most evident for veterans who live in rural or remote areas, for whom it would be time-prohibitive to travel to a direct care facility[12] for primary care or preventative medicine. Community care allows them to attend necessary and regularly scheduled appointments in a manner that reduces disruptions to their lives and ensures access to healthcare.

Additionally, some specialty care has a narrow focus or serves a small population and is therefore not efficient or cost-effective for the VA to retain. For example, specialties such as oral and maxillofacial plastic surgery, ocular oncology, and vascular surgery, with the limited number of specialists across the US, the highly specialized equipment, and the limited number of cases requiring such specialty care, are ideal for community care. Labor and delivery services, as well as several assisted reproductive healthcare technologies, for which VA centers are not equipped, are other notable positive use cases of community care.

---

[11]Rasmussen, Petra, and Carrie M. Farmer. "The promise and challenges of VA community care: veterans' issues in focus." *Rand Health Quarterly* 10, no. 3 (2023): 9.
[12] For the purposes of this testimony, VA direct care facilities are defined as VA medical centers, VA clinics, VA Community Based Outpatient Clinics, and VA administered tele-health appointments.

VA Direct Care is essential for most needs of the post-9/11 veterans

Outside of the limited scope I just outlined, the truth is that the vast majority of the needs of the post 9/11 generation of veterans are best met by VA direct care. The post-9/11 generation is the most diverse and the fastest growing generation of veterans. Key policy changes, such as full desegregation of the military, the repeal of Don't Ask, Don't Tell, and the inclusion of women in ground combat units mean that the veteran population of today looks far different than that of even 25 years ago. Women, for example, are the fastest growing veteran population. PEW projections show that women, who made up less than 4% of the veteran population in 2000 will become nearly 20% of the veteran population by 2040 - a 5x increase.[13] Women veterans have uniquely *more* positive outcomes when using VA direct care as opposed to community care, both in terms of health outcomes and individual satisfaction.[14] Yet this population is also uniquely burdened by challenges in access to any care, at a time when the population needs it most.[15]

These same projections show that the proportion and number of veterans that served during war time will continue to rise over the next 25 years, due both to retirement or separation of those who served during the last years of America's longest war, and the passing of the previous generation of peacetime veterans. And we know that war veterans not only are more likely to have unique injuries that require long-term specialty care, but also need to be continually screened for cumulative exposure related injuries and illnesses, screenings that community providers may not be equipped to provide.[16]

The need for culturally competent veteran focused care is of more urgency as injuries sustained by service members in Iraq and Afghanistan are unique when compared to previous conflicts,

---

[13] Katherine Schaeffer, "The Changing Face of America's Veteran Population," *Pew Research Center*, November 8, 2023, https://www.pewresearch.org/short-reads/2023/11/08/the-changing-face-of-americas-veteran-population/.
[14] Agnes C. Mog et al., "You Want People to Listen to You: Patient Experiences of Women's Healthcare within the Veterans Health Administration," *Health Services Research* 59, no. 6 (2024): e14324, https://doi.org/10.1111/1475-6773.14324.
[15] Tanya T. Olmos-Ochoa et al., "Challenges to Engaging Women Veterans in Quality Improvement From Patient Care to Policy: Women's Health Managers' Perspectives," *Women's Health Issues* 33, no. 2 (2023): 199–207, https://doi.org/10.1016/j.whi.2022.08.004.
[16] Daria L. Waszak and Aline M. Holmes, "The Unique Health Needs of Post-9/11 US Veterans," *Workplace Health & Safety* 65, no. 9 (2017): 430–44.
Evelyn T. Chang et al., "Use of General Primary Care, Specialized Primary Care, and Other Veterans Affairs Services Among High-Risk Veterans," *JAMA Network Open* 3, no. 6 (2020): e208120, https://doi.org/10.1001/jamanetworkopen.2020.8120.
L. D. VanTil et al., "Risk Screening of Veterans Throughout the Life Course," *Military Behavioral Health* 10, no. 1 (2022): 17–26, https://doi.org/10.1080/21635781.2021.2003378.

and these injuries often require specialized care and medical training not available outside of most VHA facilities.

- A 2023 analysis of combat-related injuries sustained in Iraq and Afghanistan found that over 75% of those whose injuries received an Injury Severity Score (ISS) of 9 or higher were accompanied by a significant blast event in conjunction with their traumatic event.[17] Blast events carry an increased risk of Traumatic Brain Injury (TBI), as well as sleep disruptions, hormonal changes, mental health changes, and increased risks of other neurological conditions. These conditions most often do not present acutely along with the trauma, but emerge in subsequent years, and significantly evolve in the way they present in patients.[18]
- Such complex injuries require not only specialized care, but specialized medical training to understand the cumulative and interactive impacts of the compound traumas and exposures on a given condition.[19]

Post-9/11 veterans are more likely to experience interrelated mental and physical health care conditions, and VA direct care providers are specially trained to understand the interrelated health care needs of combat veterans.

- Nearly a quarter of veterans have a formal post traumatic stress disorder diagnosis, and significantly more report symptoms even if not formally diagnosed.[20]
- Over 40% of female veterans report having experienced military sexual trauma (MST), and the number is slightly higher for those who have deployed to Iraq or Afghanistan.[21]

IAVA members have expressed their concerns about the ability of VA community care to meet the needs of the post-9/11 generation of veterans.

- In our most recent membership survey, only 31% of IAVA members who had experience with VA community care felt that their providers understood their medical needs.

---

[17] E. W. D'Souza et al., "Combat Injury Profiles Among US Military Personnel Who Survived Serious Wounds in Iraq and Afghanistan: A Latent Class Analysis," *PLOS ONE* 17, no. 4 (2022): e0266588, https://doi.org/10.1371/journal.pone.0266588.

[18] Hilary Phipps et al., "Characteristics and Impact of U.S. Military Blast-Related Mild Traumatic Brain Injury: A Systematic Review," *Frontiers in Neurology* 11 (November 2, 2020): 559318, https://doi.org/10.3389/fneur.2020.559318.

[19] Bryann B. DeBeer et al., "The Association Between Toxic Exposures and Chronic Multisymptom Illness in Veterans of the Wars of Iraq and Afghanistan," *Journal of Occupational and Environmental Medicine* 59, no. 1 (2017): 54–60.
Jessica L. Morse et al., "Associations Among Environmental Exposures and Physical and Psychiatric Symptoms in a Care-Seeking Sample of US Military Veterans," *Military Medicine* 189, no. 7–8 (2024): e1397–e1402.

[20] U.S. Department of Veterans Affairs, *PTSD: National Center for PTSD Fact Sheet*, accessed July 11, 2025, https://www.ptsd.va.gov/understand/common/common_veterans.asp.

[21] Shannon K. Barth et al., "Military Sexual Trauma Among Recent Veterans: Correlates of Sexual Assault and Sexual Harassment," *American Journal of Preventive Medicine* 50, no. 1 (January 2016): 77–86, https://doi.org/10.1016/j.amepre.2015.06.012.

- Only 14% reported that they felt confident in the ability for the VA and community care providers to effectively coordinate care as a team.[22]

I am sure we all agree here that we can and must do better for our veterans. As I will outline below, VA direct care results in better patient outcomes, overall cost savings, and increased coordination in care that reduces brudens on patients and increases overall satisfaction. It is for these reasons that while we are discussing community care, we cannot do it at the expense of VA direct care. Indeed if we are to give veterans a choice, we must not remove their ability to choose VA.

Better Patient Outcomes

Care for the veteran should be the sole focus of the VA. Secretary Collins has repeatedly stated that he desires to put veterans back at the center of the VA. If he is to do this, he must invest in VA direct care, as the evidence is clear that VA direct care has better patient outcomes. I will discuss three distinct and essential areas in which VA direct care has far better patient outcomes than community care - patient wait times, overall health outcomes, and screenings for conditions caused by compound exposures and traumas.

Wait times

I would like to talk for a moment about something that comes up often when I'm having conversations with our generation of veterans, and has been at the center of community care discussions — wait times. This is not about convenience or hassle. Patient outcomes and wait times are connected. Prolonged wait times are associated with deteriorating health outcomes among multiple dimensions, particularly for primary and preventative care.[23] The VA waitlist scandals of 2014 led to a persistent culture of distrust in VA care and transparency.[24] In the intervening decade, the VA has made significant changes that have reduced wait times, improved overall quality of care as compared to non-VA care. The VA has also expanded access to physical and mental healthcare for veterans of all generations. By the end of Fiscal Year 24, 92% of veterans reported trusting that they would get the most timely and effective care from the VA.[25] However, one or two cases of dissatisfaction with wait times continue to dominate the conversation. While every case of dissatisfaction must be taken seriously, the data

---

[22]Allison J. Pritchard, Stephanie Powell, and Tana Horr, *2022 IAVA Membership Survey* (New York: Iraq and Afghanistan Veterans of America and Syracuse University D'Aniello Institute for Veterans and Military Families, 2022).
[23] Astrid Reichert and Rowena Jacobs, "The Impact of Waiting Time on Patient Outcomes: Evidence from Early Intervention in Psychosis Services in England," *Health Economics* 27, no. 11 (2018): 1772–1787, https://doi.org/10.1002/hec.3800.
[24] Alyson L. Jones et al., "National Media Coverage of the Veterans Affairs Waitlist Scandal: Effects on Veterans' Distrust of the VA Health Care System," *Medical Care* 59, suppl. 3 (June 1, 2021): S322–S326, https://doi.org/10.1097/MLR.0000000000001551.
[25]U.S. Department of Veterans Affairs, *PACT Act Dashboard*, issue 42 (October 18, 2024), https://www.va.gov/resources/the-pact-act-and-your-va-benefits/#dashboard.

simply do not bear out that the VA is underperforming. As I was reminded many times during my doctoral training, the plural of anecdote is not data, and to provide the best quality care we must follow the data.

The VA does not have control over wait times for community care, and struggles to have effective and integrated coordination between direct and community care providers. And while wait times for both VA direct care and community care have on average decreased, by 2018 wait times for direct care, particularly for specialty care, were significantly less than wait times for that same care in the community.[26] Additional research on specialized veterans' needs found that at this point both wait times and outcomes were worse for community care than VA direct care across the country, and that for veterans in rural areas in many specialties there were no specialty care providers who had the ability to integrate records to coordinate with a VA primary care or Patient Aligned Care Teams.[27] This lack of integration extends beyond specific physical health specialties, with documented deficiencies in mental health care where community care has been associated with lower veteran satisfaction and higher suicide rates, partly due to community providers lacking military cultural competency and proper coordination of medication management or crisis planning.[28] Furthermore, for chronic conditions like diabetes, veterans receiving community primary care have demonstrated worse diabetes care quality and higher costs compared to those treated within the VA.[29] These coordination gaps are exacerbated by significant challenges in health record continuity, with VA Inspector General reports revealing instances of delayed cancer diagnoses due to community care staff failing to retrieve critical records and systemic issues with information exchange platforms leading to patient harm from

---

[26] Deborah Gurewich, Michael Shwartz, Erin Beilstein-Wedel, Heather Davila, and Amy K. Rosen, "Did Access to Care Improve Since Passage of the Veterans Choice Act? Differences Between Rural and Urban Veterans," *Medical Care* 59, suppl. 3 (June 2021): S270–S278, https://doi.org/10.1097/MLR.0000000000001534.

[27] Bhavika Kaul, Denise M. Hynes, Alex Hickok, Connor Smith, Meike Niederhausen, Annette M. Totten, Mary A. Whooley, and Kathleen Sarmiento, "Does Community Outsourcing Improve Timeliness of Care for Veterans with Obstructive Sleep Apnea?" *Medical Care* 59, no. 2 (February 2021): 111–117, https://doi.org/10.1097/MLR.0000000000001446.

[28] U.S. Government Accountability Office, *VA Health Care: Management Attention Needed to Address Challenges with Community Care*, GAO-20-403 (Washington, DC: Government Accountability Office, 2020).
The American Legion, "EHRM, VA-DoD Interoperability and Quality of Care," 2023, https://www.legion.org/veteranshealthcare/258909/ehrm-va-dod-interoperability-and-quality-care.
Allison C. Weimer, Chad J. Miller, and Emily Smith, "Mental Health Care for Veterans in the Community: A Qualitative Study of Veterans' Perspectives," *Psychiatric Services* 72, no. 11 (2021): 1324–1331, https://doi.org/10.1176/appi.ps.202000683.

[29] Department of Veterans Affairs, Health Services Research & Development, "Briefs: Veterans with Diabetes Receiving Community Primary Care Had Worse Diabetes Care Quality and Higher Costs than Veterans Receiving VA Primary Care," 2022, https://www.hsrd.research.va.gov/research/briefs/22-02-brief.pdf.

missed diagnoses and unaddressed medical issues.[30]

Overall health outcomes

When compared to community care received in non-VA facilities, direct care received at the VA has markedly better patient outcomes. This includes a significantly lower post-surgical 28-day mortality rate, lower hospital readmission rates, and quicker post-hospitalization return to work rates.[31] When directly compared, the VA is also exceptionally better at screening for cancers and chronic respiratory and pulmonary diseases than VA-funded community care.[32] This is of particular importance for the post-9/11 generation, as exposure related cancers and chronic respiratory conditions are on the rise, and veterans face a higher instance rate of multiple chronic conditions than age matched civilians.[33]

Additionally, VA hospitals consistently outperform non-VA hospitals in CMS quality ratings, with 67% of VA facilities receiving 4 or 5 stars compared to 41% of non-VA hospitals, and VA patients report higher satisfaction across all 10 core HCAHPS metrics.[34] More critically, for our most vulnerable veterans, the disparity in outcomes is stark: a 2024 VA report revealed that the suicide rate for Veterans who received any VA-funded Community Care services was 50.9 per 100,000, significantly higher than the 41.3 per 100,000 for those receiving any VHA care.[35] Furthermore, studies show that older veterans (65+) hospitalized with COVID-19 in community

---

[30] U.S. Department of Veterans Affairs, Office of Inspector General, *Delayed Diagnosis and Treatment for a Patient's Lung Cancer and Deficiencies in the Lung Cancer Screening Program at the VA Eastern Colorado Health Care System*, Report No. 22-00440-230 (Washington, DC: Department of Veterans Affairs, 2022).
U.S. Government Accountability Office, *VA Health Care: Management Attention Needed to Address Challenges with Community Care*, GAO-20-403 (Washington, DC: Government Accountability Office, 2020).

[31] Jungwon Yoon, Ciaran S. Phibbs, Melissa K. Ong, Megan E. Vanneman, Amy Chow, Angela Redd, Kenneth W. Kizer, Mayur P. Dizon, Edward Wong, and Yingjun Zhang, "Outcomes of Veterans Treated in Veterans Affairs Hospitals vs Non-Veterans Affairs Hospitals," *JAMA Network Open* 6, no. 12 (December 1, 2023): e2345898, https://doi.org/10.1001/jamanetworkopen.2023.45898.

[32] Elham A. Apaydin, Natalie M. Paige, Mekdes M. Begashaw, Jenny Larkin, Isomi M. Miake-Lye, and Paul G. Shekelle, "Veterans Health Administration (VA) vs. Non-VA Healthcare Quality: A Systematic Review," *Journal of General Internal Medicine* 38, no. 9 (July 2023): 2179–2188, https://doi.org/10.1007/s11606-023-08207-2.

[33] Peter Boersma, Robin A. Cohen, Carla E. Zelaya, and Eric Moy, "Multiple Chronic Conditions Among Veterans and Nonveterans: United States, 2015–2018," *National Health Statistics Reports*, no. 158 (April 7, 2021), https://www.cdc.gov/nchs/data/nhsr/nhsr158-508.pdf.

[34] A News, "VA Hospitals Outperform Non-VA Hospitals in Quality Ratings and Patient Satisfaction," accessed July 11, 2025, https://news.va.gov/98528/va-hospitals-outperform-non-va-hospitals-quality-ratings-patient-satisfaction/.

[35] VA Mental Health, "2024 National Veteran Suicide Prevention Annual Report, Part 1 of 2," accessed July 11, 2025, https://www.mentalhealth.va.gov/suicide_prevention/docs/National_Veteran_Suicide_Prevention_Annual_Report_2024_Part_1_of_2_FINAL.pdf.

facilities faced a 37% higher risk-adjusted mortality rate compared to those in VHA facilities,[36] and VA hospitals demonstrated a 20.1% lower adjusted 30-day mortality rate after emergency visits for veterans aged 65 or older, with even larger advantages for Black (-25.8%) and Hispanic (-22.7%) patients.[37] These findings underscore that while community care plays an essential role in expanding access, the integrated, specialized, and culturally competent care provided by VA facilities often leads to superior health outcomes, particularly for veterans with complex needs, mental health conditions, and those from minority or older demographics.[38]

Major medical association groups have submitted official statements to the record in previous oversight hearings on VA community care citing their concerns about the lack of quality standards present in community care.[39] In it, they highlight that the transparent quality standards required by section 1703 of the MISSION act have yet to be set, and that there is no enforcement mechanism to ensure that community care providers would be meeting the standards once they are. A lack of quality standards means that we are exposing our veterans to substandard care, resulting in worse outcomes. As a specific example, they note that the VA Inspector General found that there was no oversight provision or quality standard set for community care providers who were prescribing opioids to veterans, a population that experience higher levels of addiction risk factors than the general population.[40] The lack of screening oversight is a clear violation of VA contracts and in many instances state law, yet

---

[36] *US Medicine*, "COVID Mortality Rates Higher for Older Veterans Hospitalized in the Community," accessed July 11, 2025, https://www.usmedicine.com/articles/covid-mortality-rates-higher-for-older-veterans-hospitalized-in-the-community/

[37] Kaveh Chan et al., "Mortality among US Veterans after Emergency Visits to Veterans Affairs and Other Hospitals: Retrospective Cohort Study," *BMJ* 376 (February 16, 2022): e068099, https://doi.org/10.1136/bmj-2021-068099.

[38] Megan E. Vanneman et al., "Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions," *JAMA Network Open* 8, no. 5 (May 1, 2025): e2511548, https://doi.org/10.1001/jamanetworkopen.2025.11548.
journals.lww.com+8pmc.ncbi.nlm.nih.gov+8hsrd.research.va.gov+8

Megan E. Vanneman, Thomas H. Wagner, Michael Shwartz, Michelle Meterko, Jeffrey Francis, Charles L. Greenstone, and Amal K. Rosen, "Veterans' Experiences With Outpatient Care: Comparing The Veterans Affairs System With Community-Based Care," *Health Affairs* 39, no. 8 (August 2020): 1368–1376, https://doi.org/10.1377/hlthaff.2019.01375.

PMC, "Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions," accessed July 11, 2025, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8905870/.

[39] American Psychological Association et al., *Multi-Organizational Statement for the Record*, Senate Committee on Veterans Affairs hearing on "Protecting Veteran Choice: Examining the VA Community Care Program," January 28, 2025.

[40] U.S. Department of Veterans Affairs Office of the Inspector General, *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans*, report no. 22-00414-113 (Washington, DC: VA OIG, September 26, 2023), https://www.vaoig.gov/sites/default/files/reports/VAOIG-22-00414-113.pdf

there have been no moves to ensure quality standards are met, all while veterans are the ones who suffer.

Screening for delayed onset - PACT Act learnings

The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, has been instrumental in codifying the recognition of delayed onset conditions and expanding eligibility and access to VA care for millions of veterans, leading to a surge in screenings and care for those who were exposed to burn pits, Agent Orange, and other harmful substances.[41] This means we are now actively identifying and treating illnesses that may have been silently developing for years. Given the unique, complex, and often multi-system nature of conditions arising from military cumulative exposures, the need for robust investment specifically in VA direct care is paramount. The VA's integrated system and specialized expertise in understanding military exposures are uniquely positioned to manage these intricate cases, which often do not fit neatly into community care models. There is still significant research that must be done to track the outcomes for these patients with complex needs, yet early research shows that VA teams are able to identify potential markers for exposure related conditions at a better rate than community providers.[42] As the demographic shift continues, with a larger proportion of veterans requiring extensive long-term and specialized care for both age-related and service-connected toxic exposure illnesses, the demand for VA services will only intensify, underscoring the urgent need for sustained and robust investment in the Veterans Health Administration's direct care capabilities to ensure we can meet the evolving healthcare needs of those who have so bravely served our country.

Lower cost

VA direct care doesn't just provide better patient outcomes; it ultimately provides cost savings to the US government. Recent analysis by the National Bureau of Economic Research found that for inpatient specialty services, VA direct care had a 21% overall cost savings to the

---

[41]U.S. Department of Veterans Affairs, "The PACT Act and Your VA Benefits," accessed July 11, 2025, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.
U.S. Department of Veterans Affairs, "In Two Years of the PACT Act, VA Has Delivered Benefits and Health Care to Millions of Toxic-Exposed Veterans and Their Survivors," *VA News*, August 9, 2024, https://news.va.gov/press-room/in-two-years-of-the-pact-act-va-has-delivered-benefits-and-health-care-to-milions-of-toxic-exposed-veterans-and-their-survivor/.

[42]Janeen H. Trembley et al., "Veterans Affairs Military Toxic Exposure Research Conference: Veteran-centric Approach and Community of Practice," *Military Medicine*, published online December 14, 2024, doi:10.1093/milmed/usae558.

government as compared to community care when adjusted for the 28-day cost of care average.[43]

More patients = more cost savings with direct care

As the veteran population ages, their need for access to specialty care will only increase. The PACT Act has shed a light on just how many more veterans may be needing this type of complex care. Over 6 million veterans have begun the screening process for toxic exposure, and over 4 million are enrolled in the planning process for VA care.[44] And as a result we have seen a rise in demand for VA care. In fiscal year 2023, the Department of Veterans Affairs delivered an impressive 116 million healthcare appointments to our veterans. This past fiscal year, 2024, we saw an even more significant increase, with the VA providing over 130 million healthcare appointments, marking a substantial 7% year-over-year rise.[45] This upward trend in "episodes of care" is not merely a statistic; it is a direct reflection of our aging veteran population, many of whom are facing complex, chronic health conditions that necessitate more frequent and comprehensive medical attention. Furthermore, a significant driver of this increased demand, and a profound challenge we must continue to address, stems from the long-term health consequences of toxic and cumulative environmental exposures during military service. As we know, conditions like respiratory illnesses, cancers, and other systemic disorders often manifest after considerable latency periods – sometimes decades – making the connection to service-related exposures difficult to ascertain.[46] However, as noted above, VA direct care providers are able to identify these conditions at a better rate than community care

---

[43] David C. Chan, David Card, and Lowell Taylor, "Is There a VA Advantage? Evidence from Dually Eligible Veterans," *American Economic Review* 113, no. 11 (November 2023): 3003–3043, https://doi.org/10.1257/aer.20211638.

[44] U.S. Department of Veterans Affairs, *PACT Act Performance Dashboard*, Issue 42 (October 18, 2024), accessed July 11, 2025, https://department.va.gov/pactdata/interactive-dashboard/.

[45] U.S. Department of Veterans Affairs, "VA Delivered All-Time Record Care and Benefits to Veterans in Fiscal Year 2024," *VA News*, October 26 2024, https://news.va.gov/press-room/va-delivered-all-time-record-care-and-benefits-to-veterans-in-fiscal-year-2024/.
U.S. Department of Veterans Affairs, *VHA 2024 Annual Report: VA Health Care—A Strong Foundation. A Healthy Future*, accessed July 11 2025, https://www.va.gov/health/docs/vha-annual-report-2024.pdf.

[46] Institute of Medicine (US) Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides (Second Biennial Update), *Veterans and Agent Orange: Update 1998* (Washington, DC: National Academies Press, 1999), chap. 8, "Latency and Cancer Risk," https://www.ncbi.nlm.nih.gov/books/NBK230783/.
U.S. Department of Veterans Affairs, "Military Environmental Exposures Pocket Card," War Related Illness and Injury Study Center, accessed July 11, 2025, https://www.warrelatedillness.va.gov/WARRELATEDILLNESS/education/factsheets/Military-Environmental-Exposures-Pocket-Card.pdf.

providers. Earlier detection further reduces the cost of care.[47] As more patients seek complex care that is reliant on early detection, the cost savings from VA direct care will only increase.

Pricing standards

Community care charges for services such as imaging and lab testing are not standardized.[48] VA direct care gains efficiencies through using its own specialty equipment, and over time the cost per patient declines. However, community providers are not required to set standard pricing models, resulting in varying costs for specialty care which are beyond VA control.

Integrated care reduces costs

The VA direct care integrated, whole health approach to healthcare further reduces costs. In a side by side comparison with private sector care, VA patients who received direct care from a VA facility had a 12-24% year-over-year primary and preventative health care cost savings in every category except prescription drugs, where they have a 5% cost saving.[49] Additionally contributing to overall cost savings, veterans receiving direct care experienced some really staggering improved outcomes that also save costs— 43% fewer hospital admissions, 58% fewer days spent in the hospital, and 43% fewer outpatient surgical procedures than age, gender and preexisting condition matched peers who received private sector care.[50]

Effective Coordinated Care

VA care is unique in its ability to coordinate between primary care and specialists. The VA's Patient Aligned Care Teams integrate primary care, specialty care, mental health care, and other aspects of a veterans health and well-being (such as substance abuse counseling, and programs to access food and housing) in an integrated, veteran centered fashion.[51] The Patient Aligned Care Teams concept also has led to reduced wait times to see a provider, as care teams are integrated and in continual communication. The integrated scheduling and coordination further reduce burdens on the veteran for scheduling or managing their own care.

---

[47] Rina Setyawati, Aldiana Astuti, Tyas Putri Utami, Saputra Adiwijaya, and Dadang Muhammad Hasyim, "The Importance of Early Detection in Disease Management," *Journal of World Future Medicine, Health and Nursing* 2, no. 1 (February 2024): 51–63, https://doi.org/10.55849/health.v2i1.692.
[48] Congressional Budget Office, *The Veterans Community Care Program: Background and Early Effects* (Washington, DC: Congressional Budget Office, October 26, 2021), https://www.cbo.gov/publication/57257.
[49] Wayne Jonas, *The Case for Delivering Whole-Person Care: High-Quality, Cost-Effective Health Care for Stronger Health Systems* (Santa Monica, CA: Samueli Foundation, February 2022), https://healingworksfoundation.org/wp-content/uploads/2022/02/Whole-Person-Business-Case2022.pdf.
[50] Ibid
[51] U.S. Department of Veterans Affairs, "Patient Care Services: Patient Aligned Care Team," accessed July 11, 2025, https://www.patientcare.va.gov/primarycare/PACT.asp#:~:text=A%20PACT%20uses%20a%20team,team%20may%20be%20called%20in.

Lack of coordination or integration of care can result in missed diagnoses, delays in treatment, and increased wait time for patients. Community care was meant to fill in gaps, not be the primary source of care.

Even when community care is used, the VA still should play a primary role in being the care coordinator and community care should only be accessed when the necessary conditions are met, not as a matter of convenience. As multiple independent agencies noted in their statement for the record earlier this year, the continued diversion of funds from VA direct care to private sector payments ultimately results in *fewer* healthcare options for veterans, while placing a higher burden on veterans to receive care because the essential coordinators are cut out of the loop.[52]

It comes down to this. The VA system was built with the veteran as its heart. Private sector medical care has been built on a system of profit maximization. These two systems may be at odds when it comes to veteran outcomes; their philosophies and models of care are that different. This is born out in the evidence. Recent studies found that community care providers frequently administered high-cost and medically unnecessary procedures to veterans in order to maximize the money received from the government.[53] This was done most often without coordination with the veteran's Patient Aligned Care Team, exposing the veteran to unnecessary treatment without medical benefit, while costing the government more money.

The importance of coordinating care and having providers with appropriate cultural competency and training is evident in patient satisfaction with community care. In surveys of patient satisfaction, veterans with complex cases, particularly those that involved a mental health diagnosis, reported significantly lower satisfaction with community care as compared to VA direct care.[54] This was most pronounced in their lack of satisfaction with the ability to communicate effectively with their provider about their medical needs, and the coordination between mental and physical healthcare.

---

[52] American Psychological Association et al., *Multi-Organizational Statement for the Record*, Senate Committee on Veterans Affairs hearing on "Protecting Veteran Choice: Examining the VA Community Care Program," January 28, 2025.
[53] Brett A. Erickson, Ryan M. Hoffman, Jacob Wachsmuth, Vipul T. Packiam, and M. S. Vaughan-Sarrazin, "Location and Types of Treatment for Prostate Cancer After the Veterans Choice Program Implementation," *JAMA Network Open* 6, no. 10 (October 2023): e2338326, https://doi.org/10.1001/jamanetworkopen.2023.38326.
[54] Megan E. Vanneman et al., "Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions," *JAMA Network Open* 8, no. 5 (May 1, 2025): e2511548, https://doi.org/10.1001/jamanetworkopen.2025.11548.

Community Based Outpatient Clinics - An opportunity for expanded care access worthy of investment

It has been well established that VA direct care is superior to community care on a number of dimensions. However, there remains the question of the need for care in areas where it is difficult for veterans to get to one of the 170 VA medical centers. VA run Community Based Outpatient Clinics (CBOCs) provide a viable option that should be expanded upon and invested in, yet they are too often misunderstood and misrepresented. CBOCs were established in the mid-1990s to expand direct VA primary care in areas geographically distinct from main VA hospitals.[55] CBOCs provide primary care, some preventative medicine service, mental health care, and may include regular visits from some specialists, primarily ophthalmology and geriatric medicine.[56] CBOCs were never intended to be specialty care providers or provide prolonged or extensive inpatient care. However, anecdotal complaints about the VA have often centered around the lack of specialty or inpatient services available at these locations.

It is important to differentiate the role of CBOCs in expanding access to care. While many CBOCs are strategically located in smaller towns and cities to bring VA services closer to Veterans, they typically serve areas with a certain population density that can support their operations. For Veterans residing in truly rural and remote locations, where the establishment of a CBOC may not be feasible due to geographic isolation or sparse population, community care often becomes the primary or only viable option for accessing necessary healthcare services, as outlined by the VA's own guidelines on community care eligibility for rural Veterans.[57]

CBOCs have provided vital care for veterans,[58] but can be further utilized to improve care, especially for the post-9/11 generation of veterans. The Independent Budget veterans service organizations (IBVSOs) highlight areas where the role of CBOCs is currently underutilized and can be significantly enhanced.[59] Better utilizing CBOCs may result in more veterans receiving

---

[55] Michael K. Chapko et al., "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics," *Medical Care* 40, no. 7 (July 2002): 555–560, https://doi.org/10.1097/00005650-200207000-00001.

[56] Camilla B. Pimentel et al., "The Role of Department of Veterans Affairs Community-Based Outpatient Clinics in Enhancing Rural Access to Geriatrics Telemedicine Specialty Care," *Journal of the American Geriatrics Society* 72, no. 2 (February 2024): 520–528, https://doi.org/10.1111/jgs.18703

[57] U.S. Department of Veterans Affairs, "Community Care – Eligibility for Rural Veterans," accessed July 11, 2025, https://www.va.gov/communitycare/pubs/factsheets/eligibility-rural-veterans.pdf.

[58] Camilla B. Pimentel et al., "The Role of Department of Veterans Affairs Community-Based Outpatient Clinics in Enhancing Rural Access to Geriatrics Telemedicine Specialty Care," *Journal of the American Geriatrics Society* 72, no. 2 (February 2024): 520–528, https://doi.org/10.1111/jgs.18703.
Michael K. Chapko et al., "Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics," *Medical Care* 40, no. 7 (July 2002): 555–560, https://doi.org/10.1097/00005650-200207000-00001.

[59]The Independent Budget veterans service organizations (Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars), *The Independent Budget: Fiscal Years 2026 and 2027 for the Department of Veterans Affairs* (Washington, DC: The Independent Budget veterans

the benefits of VA direct care, reduced costs to the government, and increased veteran patient satisfaction.

Recommendations for Better Utilizing CBOCs:

- **Expand Mental Health Staffing**: The IBVSOs recommend that VA aggressively recruit and retain mental health providers, care coordinators, and administrative support staff.[7] Specifically, they call for the addition of mental health providers in every VA medical center (VAMC) and CBOC. This aims to address the rising demand for mental health services, with an 8.7% growth in veterans enrolling in VHA care for mental health since the PACT Act, and ensure timely, high-quality mental health care within a competitive medical market. For FY 2026, the IBVSOs recommend adding 1,000 mental health personnel at an approximate cost of $154 million.

- **Increase Women's Health Capabilities**: To meet the needs of the growing population of women veterans, who represent more than 30% of the increase in enrolled veterans over the past five years, the IBVSOs recommend that there should be a women's primary care health provider at every CBOC. This is part of a broader recommendation for an overall investment of $190 million in FY 2026 to meet the current and future health care needs of this growing population, with $130 million allocated to Medical Services. The funding is intended to recruit and train more clinical providers with expertise in gender-specific care, addressing attrition, increasing demand for services, and improving access to care for women veterans.

- **Enhance Dental Care Capacity**: VA's current dental care program is constrained by the lack of clinical personnel and treatment space, which has driven up spending on community dental care contracts. To address this, the IBVSOs recommend appropriating an additional $75 million for minor construction to expand and modify treatment space in existing VA facilities, which would include CBOCs, and to support additional leased space. This aligns with the IBVSOs' broader recommendation in the Medical Services section to increase staffing in VA's currently authorized programs to expand dental care to all enrolled veterans.

- **Reinstate and Support Self-Service Kiosks for Transportation**: While not exclusively for CBOCs, the IBVSOs recommend that every VA health care facility and CBOC have at least one fully functioning kiosk. This would require an estimated $15 million in additional funding for VA's FY 2026 budget. The previous online and application-based system (BTSSS), introduced in 2020, has proven problematic for veterans and staff, with veterans using BTSSS for just 49% of all claims through mid-2022 and only 17% of claims automatically decided from February 2021 through July 2022. Reinstating accessible

---

service organizations, February 2025), https://independentbudget.org/wp-content/uploads/2025/02/IB_FY26_27_D7_w.pdf

kiosks at CBOCs would enhance convenience and ensure veterans can easily file for reimbursement of travel expenses, thus better utilizing transportation support for accessing care at these local clinics.

By focusing on these targeted expansions and improvements, especially in staffing and infrastructure for primary care, mental health, and specific services like women's and dental care, CBOCs can more fully realize their designed role and reduce the current underutilization of their critical function in the VA healthcare system.

Conclusion

It should be clear now that while community care has a role in veteran health care, it cannot and should not replace the superior treatment veterans receive with VA direct care. Community care is best used as it was originally intended — in remote and rural areas where healthcare options are limited, and in locations where unique specialists and infrequently used equipment are required and would not be cost effective for the VA to directly own and maintain. For the majority of veterans healthcare needs, the evidence presented above indicates that VA direct care provides better care coordination, costs less, and leads to better patient outcomes.

STATEMENT FOR THE RECORD

Prepared Statement of Cohen Veterans Network

As the committee examines the best ways to ensure our Nation's veterans have access to the highest quality care, particularly as it relates to mental health, I wanted to provide some background for you on how Cohen Veterans Network (CVN) is working with the Department of Veterans Affairs (VA) to provide mental health services to Veterans and their families. Our clinics strive to be the "right time, right place, right treatment" model for community care that the committee seeks to strengthen for veterans and their families.

CVN is a not-for-profit philanthropic organization founded in 2016 that serves veterans, service members, and military families through a nationwide system of mental health clinics. CVN operates 22 clinics that provide care across 20 states, including telehealth services. Our clinics provide treatment for depression, anxiety, adjustment issues, substance misuse, anger, PTSD, grief and loss, family issues, transition challenges, sleep problems, relationship problems, and children's behavioral problems. We also provide comprehensive case management services to address social drivers of health issues, including unemployment, food insecurity, finances, housing, and more.

While the VA has invested heavily in expanding mental health services, significant challenges remain in the Community Care program and the suicide epidemic persists. Veterans often face long delays, limited local access, and administrative hurdles that discourage them from pursuing care when they need it most. CVN helps relieve this pressure by serving the whole family (as defined by the veteran or service member) and providing barrier-free, high-quality outpatient treatment in trusted community settings. CVN does not turn veterans away based on discharge status or insurance.

Since its inception in 2016, CVN has served nearly 90,000 clients in almost 800,000 clinical sessions and provided more than 440,000 telehealth sessions. More than 56 percent of the clients served have been veterans and service members. Approximately 29 percent have been non-veteran adult family members and 15 percent of family members were children. 31 percent of our veteran clients to date are female veterans.

Over the past decade, the demand for high-quality, accessible mental health care for veteran and military families has only grown. Through public-private partnerships, CVN has worked to fill gaps where and when they exist. Our care model is focused on being military culturally competent and is based on both data analytics and operational research.

Our clinicians are trained in evidence-based practices and deliver measurable outcomes. As part of our mission to continually improve and enhance care, we track satisfaction and clinical improvement across all clinics. According to our metrics, over 90 percent of our clients would recommend CVN services to others.

CVN is proud to complement the VA's mission and extend its reach in the community. To strengthen and scale this kind of work, we support pending legislation like the **RECOVER Act (H.R. 2283)**, which would establish a pilot grant program to support non-profit clinics delivering culturally competent, evidence-based mental health care at no cost to the veteran. By encouraging public-private partnerships, the RECOVER Act can help close access gaps, especially in underserved areas, and provide a lifeline to family members who are too often left out of the traditional VA system.

A recent study entitled *Experiences With VA-Purchased Community Care for US Veterans With Mental Health Conditions* (JAMA Network Open, 21 May 25) observed, "These findings underscore the challenges vulnerable veterans experience when navigating and receiving community care and highlight an opportunity for targeted quality and care coordination strategies. (p.9). CVN strongly agrees.

Community care for veterans is a critical resource and mechanism for filling gaps in care and improving access. To fully address the need, the VA and Community Care must continue to function as complementary elements with each providing

vital resources which jointly offer improved access and options for veterans while maintaining an appropriate standard of care.

CVN stands ready to continue supporting these efforts and pledges to work with the committee and administration to help veteran and military families. Thank you for your leadership and for advancing solutions that meet the full scope of veterans' mental health needs, including their families.