Dear Senators Boquist:

As you know I am the military liaison for Cedar Hills Hospital in Portland, Oregon.

That said, and as you also know, I am the Pacific Northwest ambassador for the Green Beret Foundation (www.greenberetfoundation.org).

I am a Wounded Warrior myself, and a long time community advocate for increased availability and services for our Oregon veterans, specifically in the area of inpatient psychiatric services and chemical dependency.

In 2005, I was appropriately diagnosed with chronic combat PTSD after a 24-year military career in Special Forces to include two wartime campaigns, El Salvador and Iraq. At the time l was living/working in Bend, Oregon, where VA care and treatment for my invisible wounds were rudimentary at best, as they remain today for much of Oregon rural and remote Veteran populations.

Fortunately my wife and I were able to relocate to the Portland area where I could begin appropriate out-patient care and treatment. That process required nearly three years before I was able to return to the work force as a Department of Defense regional care coordinator.

With now 9 years working on behalf of our nation's Wounded, Injured, and Ill from All Services to include the Oregon Army and Air National Guard, and in support of our large current and retired Special Forces community here in Oregon as represented by Chapter 47 of the Special Forces Association, I strongly urge swift passage of this bill.

I can personally attest to the present dire situation your bill's language describes state-wide. Our serving military and Veteran populations are experiencing record levels of suicide, suicide attempts, alcoholism, drug dependency, divorce, job loss, combat PTSD, and military sexual trauma both female and male. In-patient VA behavioral health and chemical dependency are overwhelmed and the availability of beds for such patients does not come close to meeting the need of this unique culture (military) and the circumstances and experiences that bring these wounds and illnesses into their lives.

Your bill streamlines the measures to see Oregon take the lead in providing new and expanded healthcare outside of the VA's over-taxed medical system and for the benefit of our Wounded Warriors and their families.

Respectfully,

Greg Walker (ret)
USA Special Forces
AMB, Green Beret Foundation
541 788 8980

"Many virtues - like courage and compassion - can be displayed in a moment. Make that moment happen!"

Status of Veteran Healthcare in Central Oregon as published today, 4-13-2017, in the Bend Bulletin. Please consider for entry as exhibit reference this issue,

Bend veterans face state's longest wait times

VA says waits prompted by provider vacancies

By Tara Bannow, The Bulletin, @tarabannow

Published Apr 12, 2017 at 11:21AM / Updated Apr 12, 2017 at 07:40PM

Established patients at Bend's Veterans Affairs medical clinic waited longer for appointments than any other VA patients in the state as of last summer. New patients: the second longest.

That's according to a Veterans Affairs Office of Inspector General report on the VA Portland Health Care System that analyzed several aspects of patient care at the main medical center in Portland and the smaller, outpatient primary care clinics scattered throughout Oregon.

Returning patients in Bend waited nearly 21 days to see primary care providers as of June 2016. That's more than five times the amount of time they waited in July 2015.

New patients must wait even longer: about 38 days in the same time period, more than double their wait time a year earlier.

Dan Herrigstad, a spokesman for the VA Portland Health Care System, said long wait times happen when doctors, nurses and other providers leave the clinic.

"As soon as you have a doc leave who has somewhere between 900 and 1,100 veterans on their panel, then you have to spread that out amongst the other docs and/or you bring in somebody new and then you slowly build up their panel," he said.

The Bend clinic, which serves nearly 7,000 veterans, still has nine provider vacancies, although selections have been made for four of them, Herrigstad said. The clinic currently has six full-time providers, which includes physicians and nurse practitioners, and 33 support staff members, which includes nurses, medical support assistances and technicians.

Three days after moving to Bend in August 2016, 63-year-old Navy veteran Scott Janke called the Bend VA clinic to establish himself as a patient and to see a primary care provider there. He finally got an appointment about 50 days later in mid-October. When he did, he discovered that the staff — while they provided good service — lacked the equipment to perform the services he needed.

"The VA is just too big of a bureaucracy," he said. "It's just crazy."

John Shea, the manager of the Bend VA clinic, did not respond to requests seeking comment.

Having trouble attracting and retaining providers is not unique to Bend. A recent Government Accountability Office report found the number of doctors, nurses, physician assistants, psychologists and physical therapists who left the VA increased from about 5,900 employees in fiscal year 2011 to 7,700 in fiscal year 2015. The VA's fiscal year operates Oct. 1 through Sept. 30.

The Bend clinic also had the lowest rate of follow-up contact from primary care providers after patients were discharged from inpatient VA facilities, most likely those in Portland or Vancouver. About 42 percent of patients who were discharged received calls within two days as of June 2016, down from 91 percent in July 2015. The state average in June was 65 percent.

The OIG report also turned up several deficiencies in the VA Portland system overall as part of an inspection that included surgical areas, inpatient units, emergency care and two unidentified primary care outpatient clinics. In five of eight patient care areas inspected, the report said items like bedside tray tables, bed frames and blood pressure machines were dirty and exam table bases were dusty in three out of nine areas inspected. All applicable buildings did not have at least one fire drill per shift per quarter.

The inspection also found some staff members did not document whether providers had obtained the necessary lab tests before starting patients on blood thinners. It also noted that the records of 93 percent of transfers between inpatient VA care to other facilities were missing the dates and times of those transfers. Some patient records were also missing evidence that providers had properly evaluated their conditions before sedating them.

— Reporter: 541-383-0304,

tbannow@bendbulletin.com

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"Many virtues - like courage and compassion - can be displayed in a moment. Make that moment happen!"

Please consider the following as an exhibit for today's hearing.

By Rob Davis | The Oregonian/OregonLive
Email the author | Follow on Twitter
on March 28, 2017 at 7:00 AM, updated March 28, 2017 at 2:06 PM
comments

With two hours until her husband, Aaron, is due at the Salem VA clinic, Jennifer Olivas needs to make sure everything is just right if he's going to make it out the door.

It's been days since Aaron Olivas left the house. His trip for eggs last week was cut short by a panic attack.

Aaron, a 32-year-old Iraq veteran, has been waiting more than a year to see a VA primary care doctor. He was late once and got bumped. He can't miss this one.

Aaron, a former infantry sergeant, was repeatedly struck by explosions in Iraq. One improvised bomb went off while he was eating. Ever since, he's struggled to swallow. Thinking about food makes him anxious. His weight has dropped more than 60 pounds since he was deployed in 2007.

Starting in 2012, his recovery was aided by a Veterans Affairs program called Comprehensive Assistance for Family Caregivers. It recognized that family members of seriously injured post-9/11 veterans often substituted for home health care nurses, providing vital assistance with daily activities including feeding, planning and remembering tasks.

But the program in Portland is an outlier. VA officials here are more likely to kick veterans out of the caregiver program than elsewhere. Although the decision can be appealed, vets in Portland are forced to rely on an opaque system that offers little explanation. Not a single appealed case has been reversed here.

As Aaron's early afternoon appointment nears, Jennifer starts his coffee, makes him a sandwich (no crust), then carries his breakfast upstairs, where he is waking.

The dishwasher is whirring. She checks on their 4-year-old son, packs a bag with Tums, granola and snacks he'll need. Upstairs, the shower chokes to life. Jennifer again goes up to look after Aaron and tells him she'll return if he forgets to stop the water.

Until last June, Jennifer was paid $2,020 a month to be Aaron's caregiver. He returned from Iraq with a traumatic brain injury and post-traumatic stress disorder that leave him unable to work.

Jennifer provided a watchful eye. She says she calmed Aaron down during panic attacks, helped regulate his moods, developed a meal plan. Along with his $3,100 monthly disability check, the stipend helped them have enough to buy a home. Aaron says his wife's care made their lives less stressful. It let him focus on his recovery.

Last June, the money stopped. The Olivas family's participation in the caregiver program was revoked.

Aaron and his wife quickly felt the financial pinch. Nearly five months after they lost the payments, one of their two cars was repossessed.

The tow truck came on Veterans Day.

The VA's family caregiver program was overwhelmed from the moment Congress created it seven years ago.

A 2014 analysis by the nonpartisan Government Accountability Office found demand from the flood of vets returning from Iraq and Afghanistan caught the VA flat-footed, leaving medical centers across the country unable to manage the workload.

"We're unfortunately learning a lot as we go," says Meg Kabat, the national director of the caregiver program. "At the beginning, it was very difficult to get everyone up to speed rapidly and make things work efficiently."

Share your story
We want to hear from other veterans who've been revoked from participating in the VA's caregiver program. E-mail our watchdog reporter Rob Davis.

VA officials say the growing program, which now has a $725 million budget and 22,414 participants, is running better. The agency has increased support staff and eased requirements that called for a coordinator to conduct a home visit every 90 days.

But the Olivas family's struggle highlights one criticism that has plagued the program since before it was created: Local bureaucrats have sweeping discretion to remove participants with little explanation or recourse.

When the VA decides that veterans like Aaron Olivas no longer merit caregiver payments, the vets are allowed to appeal. But those reviews are routed through different processes depending on where vets live. The GAO warned that disparities were possible among medical centers whose leaders didn't think the caregiver program should be a priority.

On average, VA officials in Portland are more likely to decide a veteran is no longer eligible to participate in the caregiver program than other medical centers around the country. It's unclear why.

Nationwide, just 16 percent of all participants have been kicked out of the program because the VA decided they no longer met the requirements.

VA stats show it's far higher in Portland, where more than half of participants have lost caregiver payments because they were deemed ineligible.

Leah Christensen, the Portland VA's caregiver support coordinator, says the agency is not under any directive to cull the ranks of participants. She says the way Portland evaluates whether vets are eligible is considered a model for other regions.

"We do what we can here to treat everyone equally according to the guidance that comes down," she says.

But in response to questions from The Oregonian/OregonLive, a Portland VA spokesman, Daniel Herrigstad, said his agency had asked the national VA office to review its administration of the program.

Aaron and Jennifer Olivas aren't alone. Other veterans around the country have raised similar concerns when they've been removed from the program. A 2015 bill in Congress would have established an objective third party to adjudicate appeals. It passed the House of Representatives but went no further.

A spokesman for Rep. Elise Stefanik, the New York Republican who authored the bill, says the legislation will be reintroduced soon.

When Olivas returned from Iraq in 2008, he was assigned to Washington's Fort Lewis. Jennifer quit her job in Georgia, where they'd lived before, and moved west. He remained on active duty, but the problems he returned with prevented him from re-deploying to Iraq. He did administrative jobs and worked a desk while he waited for his medical retirement.

Jennifer soon began helping him manage the anxiety he came back with, taking only temp jobs. But it wasn't until mid-2012, shortly after his medical retirement from the Army, that she was paid to be his caregiver. Aaron says his problems got worse after he left the military.

"My brain had a lot of time to think about stuff," Aaron says. "My circles got smaller and smaller."

Enrolling in the caregiver program, then just a year old, was as simple as answering a few questions in a 10-minute phone call, Aaron says.

The appeals process after the payment was revoked was far more difficult to navigate.

Aaron filed two appeals after he was removed. Each time they were rejected, decision-makers offered him no explanation. It's still not clear why he was determined to be ineligible.

Decisions about disability benefits for vets can be appealed to an independent body called the Board of Veterans Appeals. The quasi-judicial process allows veterans to present evidence and receive exhaustive rulings, detailing exactly why a disability is or isn't related to an injury sustained in service.

That's not true of the family caregiver program. Because of the way the law was written, the payment was deemed a medical treatment, not a benefit - explicitly putting it outside the reach of the rigorous appeals process.

That small bureaucratic difference sends veterans like Aaron Olivas into an opaque process.

VA rules say veterans must be given a fair and impartial review of their loss of caregiver payments and a detailed rationale when appeals are decided.

Olivas appealed first to the director of the Portland VA, then to a VA official at the Pacific Northwest regional level.

Both denied Olivas' appeal without explaining why, saying only that he no longer met the requirements. He received little more than form letters, which he shared with The Oregonian/OregonLive.

Since the caregiver payments started in 2011, 24 of the 207 Portland veterans kicked out of the program have appealed their removal. None has been reversed on appeal.

A VA spokeswoman said the agency couldn't say how many appeals have been granted nationally without opening every single case file. The VA is working on a way to better track the information, she said.

By the time Olivas filed his second, final appeal with regional officials, two VA psychologists had examined him, according to medical records he also provided to The Oregonian/OregonLive.

One wrote in a letter that Olivas should stay in the program.

"He should have been in the program without disruption," wrote the clinical psychologist, Krista Rodriguez. "His symptoms have become worse since he stopped receiving benefits from the program."

The other psychologist signed off on his removal.

Olivas' final denial, received in February, did not explain why VA officials rejected one of their own psychologists' recommendations.

Though VA patient advocates are supposed to be available to guide vets through their appeals process and mediate disputes, Olivas says he didn't get a call back from one until after his final appeal had been rejected.

Now he has asked for Rep. Kurt Schrader, a Salem Democrat, to review his case. The VA has said Olivas can apply again, but he isn't sure whether he will.

Portland VA officials declined to discuss specifics of Olivas' case, despite being told by a reporter that the former soldier was willing to grant written permission. A VA spokeswoman,

Megan Crowley, also refused to disclose the names of the officials that review appeals like his, citing privacy laws.

As a result of The Oregonian/OregonLive's inquiries, VA officials say they plan to change how they notify veterans whose caregiver appeals are denied. Christensen says the VA wants to "make sure we are using language that's descriptive and easy-to-understand."

Aaron says he had no problem understanding the form letters telling him about his rejection.

"I couldn't understand *why*," he says. "We could never get any answers."

After the caregiver payments stopped, Jennifer started a small dessert shop, working full time to help make ends meet. Her mother and Aaron's sister fill in as his caregiver, and Jennifer stays home with Aaron when she can. Still, she worries about him when she's gone.

"We know we need it," Jennifer says. "I need to be here."

Jennifer is home with Aaron as he readies for his doctor visit. With 30 minutes left before they leave, she sits down for the first time in more than an hour, to put her shoes on. She walks outside to start the car. The engine roars. She returns and sits alongside her husband.

"How you feelin'?" she asks.

"I'm getting there," he says.

Aaron nurses his coffee and a glass of water. He tunes his guitar, his way of focusing and calming himself, and plays a few chords.

"What time is it, love?" he asks.

"Ten 'til. We're doing good."

They have a code they use to communicate his stress levels that goes from one (normal) to 10 (I can't breathe).

"I'm an 8-and-a-half," he tells her. "An 8-and-a-half."

"It's all right," she says.

And then it is time for the 1.1-mile trip to the clinic. Four minutes. He puts his shoes on. Three minutes. He grabs his jacket.

Two minutes. Aaron grabs the bag that Jennifer has prepared.

And then they move toward the front door. Together, they walk out into the rain.

-- Rob Davis

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"Many virtues - like courage and compassion - can be displayed in a moment. Make that moment happen!"

Please consider this final submission as an exhibit for today's hearing on the emergency state of Veteran Healthcare in Oregon. It is a recent article on the barriers female veterans in Oregon face regarding many issues to include behavioral health and chemical dependency.

Female veterans face barriers to health care

Critics in Oregon say VA not responsive to women's needs

By Tara Bannow, Wescom News Service, @tarabannow

Published Jan 27, 2017 at 06:36PM

photos in downloads

Female veterans face barriers to health care

Critics say VA not responsive to women's needs

By Tara Bannow, The Bulletin, @tarabannow

Rhonda Gleason thought the Veterans Affairs doctor wasn't listening. Turns out, she was right.

She'd driven more than three hours from her centeral Oregon home to the VA medical center in Portland, where most veterans are sent for cancer treatment. At 45 years old, she had been diagnosed with breast cancer for the second time in six years.

Since her last visit, she'd paid out of pocket to get a second opinion from a cancer doctor in Bend, who agreed she didn't need chemotherapy, a crippling treatment she desperately wanted to avoid.

Her cancer is hormone dependent, so the only way to kill it is to deplete her body of estrogen.

"No. 1, she wouldn't have needed chemotherapy and No. 2, it wouldn't have worked anyway," said Dr. Robert Boone, Gleason's oncologist at the St. Charles Cancer Center.

Gleason relayed all this to the doctor in front of her. As if not hearing her, he grabbed the phone next to him and called a nurse. He asked when a room would be available for chemotherapy that afternoon.

"I go, 'I'm not taking a port from you,'" Gleason said, referring to the devices used to infuse chemotherapy.

“He schedules the appointment, completely ignoring me. He goes, ‘I think you need to go walk around, really consider and come back. I’m sure you’ll come to your senses on this decision and get chemotherapy.’”

The VA declined to allow interviews with Gleason’s physician.

Barriers

Female veterans for decades have faced significant barriers to accessing health care and mental health services through the Department of Veterans Affairs, which provides discounted health care to men and women who served in the military and were discharged under conditions other than dishonorable.

Advocates charge it’s a system still largely devoted to men — a population that comprises roughly 90 percent of veterans — and its providers don’t always understand female-specific services and needs.

Not only do veterans clinics not offer the physical services women need in some cases, but many women say its providers aren’t well educated on women-specific services.

Women are far more likely to be sexually assaulted during military service than their male counterparts, creating a unique set of needs and challenges, including post-traumatic stress disorder, which compound the difficulty of obtaining health care services. Many say they’ve had to jump through several hoops before being able to access sexual assault counseling.

Gleason thinks the doctor she saw at the VA treats far more cancer-stricken males than he does females with breast cancer — likely why he ordered for her the same generic treatment he might give to all breast cancer patients, rather than designing one that made sense for her case.

“He’s still in the old days,” she said, “because he serves men, not women.”

A growing role

Elizabeth Estabrooks in January became Oregon’s first women veterans coordinator, a new position within the Oregon Department of Veterans Affairs (ODVA) mandated by a 2015 state law.

The Army veteran spends most of her time traveling around the state hearing from female veterans who say they don’t get appropriate treatment through the VA.

“The VA was formed by men, for men, about men and still continues to be that every day,” she said.

A section of the VA’s motto reads, “To care for him who shall have borne the battle and for his widow, and his orphan.”

Estabrooks despises that motto. “But what about us?” she asks.

Women participated in U.S. war efforts long before Congress passed the 1901 law that formally carved out a role for them as nurses. Early on, however, the idea of women serving in non-nursing roles was controversial.

The need for women to serve in the military finally outweighed that controversy in 1942 when, about five months after the Japanese military attacked the U.S. at Pearl Harbor, Congress allowed women to enlist in noncombat roles. More than 400,000 women served in World War II, according to the National Women’s History Museum. Of those, 432 died.

Six years later, another law granted women access to veterans benefits.

Women are among the fastest growing subgroups of veterans. VA forecasting shows the number of male veterans will decline from about 18 million in 2020 to about 12.7 million in 2040. Meanwhile, the number of female veterans will increase from 2.1 million to about 2.4 million.

Between 2002 and 2012 alone, VA data show the number of female veterans using VA health care services had nearly doubled.

Of the roughly 321,000 veterans in Oregon today, just under 29,000 are women, according to the ODVA.

There are lots of differences between male and female veterans — some obvious, some not so obvious. Female veterans, for example, have higher rates of unemployment than their male counterparts: 5.4 percent in 2015 compared with 4.5 percent among males, according to the Bureau of Labor Statistics. That trend is reversed among nonveterans.

Women veterans kill themselves at nearly six times the rate of nonveteran women, according to a 2015 VA study that tracked about 174,000 suicides between 2000 and 2010. Among male veterans, the suicide rate was one and a half times that of nonveteran men.

Homelessness appears to be growing at a faster rate among female veterans compared with male veterans. The estimated number of homeless women veterans grew by more than 140 percent between 2006 and 2010, from 1,380 to 3,328, according to a Government Accountability Office report.

The report conceded that its data on the subject was limited, and likely did not encompass the entire homeless female veteran population.

During the same time period, the estimated number of homeless male veterans increased 45 percent, from 34,137 to 49,373.

Having experienced military sexual trauma greatly increases one’s risk of becoming homeless upon discharge. Military sexual trauma, or MST, is the term the VA uses to refer to sexual

assault or harassment that happened while the veteran was in the military. It includes any sexual activity in which someone was involved against his or her will.

While MST strikes both men and women, VA data show 1 in 5 women seen at VA facilities experienced MST compared with one in 100 men.

In Oregon, 59 percent of female veterans reported experiencing sexual assault or harassment in the military, according to an ODVA survey published in October of about 600 female veterans.

Estabrooks was among the second wave of women to serve in the fully integrated Army in 1978, the year after a women-only branch of the Army disbanded and females began to serve side-by-side with males, except for in combat.

When she and her comrades got off the bus to begin basic training, five drill sergeants told them there was no place in the Army for women and the sergeants would do their best to make sure the women failed.

At that time, she said sexual harassment was “unrelenting and incessant.”

“They would literally hang out the windows and yell at me,” Estabrooks said. “They would form gauntlets when we had to walk past them to go to work and they would grab themselves, make obscene comments. If we were walking down the street, they would say something. We had no place to go.”

Different needs

In recent years, women veterans and their advocates have helped turn the tide on women veterans’ treatment in the VA and their access to health care services.

One of the first big victories came in 1994, when Congress passed a law requiring the VA to create a Center for Women Veterans, whose role was to monitor and coordinate health care services for women veterans nationwide.

The Portland VA Health Care System, which serves Central Oregon, established its own Center for Women Veterans Health in 2010. The Center includes a women-only health care clinic in Portland, a feature many female veterans say is the only way they’ll access care.

Christine Krugh, a licensed independent social worker who took over as the Center’s manager in June, said VA providers tend to grow accustomed to caring for male patients. Her job is to make sure female veterans aren’t lost in the system.

“They have to stop and say, ‘Oh, women have different needs,’” she said. “It’s not like a provider in the community who has 50 percent men and 50 percent women, and they’re dealing with both populations on an equal basis every day.”

But the Center lacks a full-time gynecologist on staff. Instead, two gynecologists from Oregon Health & Science University spend one and a half days a week at the clinic, which had a wait time of about 12 days in October.

Portland is not alone in that respect. An Associated Press investigation in 2014 found nearly 1 in 4 VA hospitals did not have a full-time gynecologist on staff. The investigation also found about 140 of the 920 community-based VA clinics in rural areas did not have designated women's health providers, despite the VA's goal that every clinic would have one.

In Oregon, female veterans can choose to receive care at the women's clinic in Portland or at their local outpatient clinic. Both clinics have what's called "women proficient providers," meaning they receive training specific to providing care to female patients, Krugh said. The training includes education on services such as contraceptives, menopause, breast and pelvic examinations, bone-density testing and infertility.

Krugh said access is limited by the fact that few primary care providers have the training — only 22 in the Portland VA system, which covers Oregon and southwest Washington — have such training. Four of those are male.

Female patients who wish to see providers with female-specific training at outpatient VA clinics in Oregon, Washington state and Alaska wait about eight days on average, according to data provided by the VA.

To improve the situation, the system has hired an additional recruiter and set up a team that will study provider access issues, Krugh said. Provider salaries have also been increased to become more competitive.

President Barack Obama in 2010 signed a law calling on the VA to conduct an independent study into nine barriers female veterans said prevent them from receiving health care through the VA. The barriers were identified through about 8,400 interviews. Some apply to men as well.

The barriers include:

•The availability of child care while using VA services.

•The acceptability of integrated primary care, women's health clinics or both.

•The gender sensitivity of health care providers and staff to issues that particularly affect women.

•The perception of personal safety and comfort in inpatient, outpatient and behavioral health facilities.

•The effectiveness of outreach for health care services to women veterans.

•The location and operating hours of health care facilities that provides services to women veterans.

•The comprehension of eligibility requirements for, and the scope of services available under, hospital care and medical services.

•The perceived stigma associated with seeking mental health care services.

•The effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care.

Lack of expertise

A common complaint among female veterans is that the VA's physicians are so accustomed to treating male patients, they don't have as much expertise when it comes to female-specific issues, such as fertility or menopause.

Female veterans can receive services like Pap smears, a procedure that screens for cervical cancer, and primary care through the VA. The VA does not offer obstetrics services or mammography, and instead pays for its female patients to receive those services from private providers. That's not uncommon for civilian women, however, most of whom receive mammography screenings in separate clinics from where they receive primary care.

Some female veterans who have experienced military sexual trauma report feeling uncomfortable in typical VA clinic waiting rooms. Several women interviewed for this article said being surrounded by men who remind them of their assailants can trigger flashbacks, especially if the other patients try to talk to them or sit by them.

VA clinics aren't necessarily safe spaces for women, Estabrooks said. She's personally been to five VA hospitals, and Portland was the only one in which she wasn't verbally harassed by other patients.

Being a female veteran going into a VA clinic, you try to make yourself invisible, she said.

"You have your earbuds, you have your reading material," Estabrooks said. "You sit away from them. You don't make eye contact with anybody."

Military sexual trauma

One thing Estabrooks sees as a pivotal part of her role is removing some of the unnecessary red tape around seeking the VA's assistance for military sexual trauma, thereby avoiding the chance that the veteran will have to go through the excruciating task of retelling the story to several different providers.

"Women don't want to have to tell their story," she said. "They don't want to tell those gruesome details, but they feel like they have to."

At one VA clinic, for example, the system was set up so that patients first had to make appointments with their primary care providers in order to be referred to a military sexual trauma coordinator, who would then refer them for counseling.

“So not only did she have to tell her story to each of those contact points, then she had to wait three to four weeks for an appointment with a primary care provider then wait again for an appointment with a military sexual trauma specialist,” she said.

Today, any veteran, even if that person does not have a claim for service-connected disability, can get counseling for military sexual trauma without having to first get approval from a doctor.

Every VA clinic is required to have an MST coordinator to answer questions about the issue and the services available through the VA, including counseling and support groups.

There are several ways to arrange an appointment to arrange counseling for MST, Krugh said. A veteran could either call their system’s MST coordinator, call the mental health clinic directly or call their primary care provider and tell them what type of referral is needed. Veterans can also call a crisis line to be connected with counseling, she said.

“There are a lot of doors to get to the services you want,” Krugh said. “We want to make things easy.”

Military sexual trauma is very different from sexual assaults that happen outside the military, Estabrooks said. Some people say it’s almost more like incest, because from day one, you’re told your comrades are your siblings, she said. Your superiors are your parents.

“When you’re raped or assaulted or sexually harassed, oftentimes it’s by the people you have been told are your family members that you’re safe being with, or it’s by somebody who is considered your mommy or daddy or next up the line,” she said. “When you try to get help, there is no help there.”

‘There are female vets’

Whenever Gleason shows up at a VA clinic, she said the person behind the front desk assumes she’s there for her husband. One time, she went to the VA medical center in Portland to pick up medical records. She provided her name and the last four digits of her social security number, and then was told to wait.

“He calls me back up and said, ‘Do you have authorization to pick this up? I understand you’re his wife, but you have to have actual written authorization from him,’” Gleason said. “I’m like, ‘For who? Let me educate you. There are female vets.’”

Gleason showed him her veteran ID card. She didn’t get an apology.

Shortly after her second breast cancer diagnosis, she had her ovaries removed, per her doctor’s recommendation. She has completed radiation treatments, but is still taking a medication to

block estrogen production – which happens in the body's adrenal glands in addition to the ovaries — and another that makes it more difficult for her cells to respond to the hormone.

Boone, her oncologist at St. Charles, said she'll likely be cured. He praised Gleason for sticking to her guns and refusing chemotherapy.

"I think if Rhonda was less of an aggressive woman, she might have just said, 'Well, the doctor said I need chemo, I'm just going to go ahead and have it,'" he said. "When that happens, the doctor is being what we call paternalistic. Like, 'You don't know what you're doing. I'm the boss. This is what we're going to do.'"

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"Many virtues - like courage and compassion - can be displayed in a moment. Make that moment happen!"

Please consider this recent article regarding the increasing rate of suicide among Oregon National Guard members and Oregon Veterans due to the inability of the VA in Oregon to provide timely and high quality behavioral health and chemical dependency in-patient services.

The purpose of SB 1054 is to dramatically affect for a two year period a viable partnership between VA contracted private sector providers and the over-burdened, under-resourced VA medical system in Oregon.

Suicide rates show that Oregon veterans need help

- The Eugene Register-Guard

- Sep 4, 2016

- (0)

Two years ago, the Oregon Health Authority released a study of suicide among military veterans in the state.

The findings were shocking: Suicide was the leading cause of death among veterans under 45 years of age. Veterans made up 8.7 percent of Oregon's population but

accounted for approximately 23 percent of suicides. Even when the number of veterans in Oregon declined between 2001 and 2012, the number of suicides among veterans remained steady. The suicide rate varied from county to county, with Lane County being higher than the statewide average.

Today, many veterans still have significant needs that are not being met when it comes to suicide prevention.

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A national study released (in August) by the U.S. Department of Veterans Affairs found that the risk of suicide for veterans nationally is 21 percent higher than for adults who have never served in the armed forces, averaging 20 per day for veterans. These differences were particularly noticeable in the younger — ages 18 to 39 — and older — 50 to 69 and 80 and up — age groups, with veterans having significantly higher rates.

And the suicide risk for veterans may be higher than the studies show. These statistics do not capture, for example, deaths by drug overdoses or high-risk behavior that can in themselves be a form of suicide.

The question is, how can we do a better job of reducing the risk of suicide among veterans?

About 326,000 veterans live in Oregon, with the largest concentration along the Interstate 5 corridor. Veterans in Eastern Oregon, on the Coast and in other rural areas — including rural Lane County — often have difficulty gaining access to the services to which they are entitled, including mental and physical health care.

Of special concern are members of the Oregon National Guard, who have frequently been deployed to the worst areas of fighting in the Middle East and central Asia, often alongside active duty military units, due to the high percentage of National Guard members who have military experience or are experienced first responders, veterans' representatives say.

Another thing to keep in mind is that Oregon veterans are not coming home to an active duty base, such as Lewis-McChord in Washington, where there is a support structure, a concentration of services, and people with a shared background.

Cameron Smith, the director of the Oregon Department of Veterans' Affairs, and himself a Marine, says there have been strides made in recent years in suicide prevention, including diminishing the stigma that some attach to seeking mental health care.

But too many veterans are still not seeking the help to which they are entitled, often because it is not readily available or because they are not aware that it is available. This ranges from a 24-hour, confidential Veterans Crisis Line (1-800-273-8255 or text 838255) to benefits that are going unclaimed — including housing and health care — federal dollars that could come to Oregon to better serve veterans. (Veterans groups are supporting a state ballot measure that would allocate 1.5 percent of lottery proceeds to support for veterans.)

There is also a need for more advocates to help veterans gain access to and navigate the mental health services available to vets in crisis, particularly providers who understand the military culture. And there need to be locally based resources for veterans in crisis, whose first point of contact may otherwise be law enforcement officers who are not trained mental health providers.

Oregon's veterans have slipped off the radar screen of many Oregonians, who are consumed by the drama of the presidential election, the threat of terrorism and an economy that still hasn't fully recovered.

But the people who were willing to put themselves in harm's way should not be forgotten, particularly if their war is not over. We owe them.

Greg Walker (Ret)
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"Many virtues - like courage and compassion - can be displayed in a moment. Make that moment happen!"