EXAMINING ACCESS AND QUALITY OF CARE AND SERVICES FOR WOMEN VETERANS

HEARING

BEFORE THE

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EXAMINING ACCESS AND QUALITY OF CARE AND SERVICES FOR WOMEN VETERANS

Thursday, April 30, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to other business, at 10:42 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Radewagen, Bost, Brown, Takano, Brownley, Titus, Ruiz, Kuster, O'Rourke, Rice, McNerney, and Walz.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. The full committee will come to order. I appreciate again you all being here this morning for this oversight hearing, Examining Access and Quality of Care and Services for Women Veterans.

Women have been serving our Nation in the Armed Forces since the Revolutionary War, but today more than ever. They are an important and an increasing population of veterans served by the Department of Veterans Affairs with their numbers expected to grow even as the veteran population as a whole in our country is slated to shrink.

Women of the modern military excel in a variety of roles, as medics, pilots, civil affairs specialists, as officers, and enlisted. They follow in the footsteps of the WAVES and the WACs of World War II and the Nurse and Medical Specialist Corps of the Korean and the Vietnam wars.

The service they provided was not dependent on their gender and the services the VA is charged to provide them while being respectful of their unique prospective needs and concerns should not be either.

Women veterans are just that. They are veterans and as such, they are deserving of the same respect, the same attention, the same consideration that is afforded to the male veterans with whom they have served alongside.

However, last year, the Disabled Veterans of America released a report that found serious gaps in every aspect of programs that serve women veterans. According to the DAV, the vast majority of these deficiencies result from a disregard for the differing needs of women veterans and are focusing on the 80 percent solution for

men who dominate in both numbers and in the public's consciousness. This is unacceptable.

Today I will be requesting the Government Accountability Office to conduct an assessment of VA's ability to improve the healthcare access and quality of our women veterans. GAO last conducted an investigation on healthcare for women veterans in 2010 and found that availability of services for women varied significantly across the VA healthcare system and that VA faced a number of key challenges in providing healthcare to women veterans.

In the intervening five years, VA has made some strides in improving healthcare for women veterans, but too many gaps still remain, especially considering that just yesterday, GAO informed me that VA had yet to provide documentation to show that VA has, in fact, implemented two of the five recommendations that were made in that report.

I am hopeful that through GAO's effort and this hearing we will discover the extent to which VA has improved services for women veterans, where challenges to quality care and services still exist, and how those gaps can be overcome once and for all both for the women who are in VA care today and for the thousands of women who will transition into VA care over the next several years.

I again want to thank everybody for being here today, and I recognize Mr. Takano, for any opening statement he may have.

[THE PREPARED STATEMENT OF CHAIRMAN JEFF MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. MARK TAKANO

Mr. TAKANO. Thank you, Mr. Chairman, for holding this hearing, this important hearing on women veterans' health issues and the access to healthcare within the Veterans Administration.

I know only too well the consequences of the increasing role that our women play in our Nation's defense. Within my own caucus, Tammy Duckworth of Illinois is a living example of women being put in the line of fire and the sacrifices they are making for our country.

And there are women on both sides of the aisle who are serving our country valiantly and, as you say, their role is only going to increase as the nature of our voluntary military is going to need the increased participation of women in our Nation's defense.

In particular today, I hope to explore issues such as an interoperability of record systems as a way of making a more seamless effort to connect healthcare services that women need that may be outside the VA. I see that as a major impediment. If we can make the electronic healthcare records more interoperable and more seamless, it will give us, I think, greater options to cooperate, have the VA cooperate on a private-public partnership basis.

I am concerned about the payment delays. I was reading through some of the testimony of one of the women who was trying to obtain OB/GYN services and since there is a shortage within the VA, something we must address, we have to contract out. But the problem of contracting out is the fact that the VA is not timely in their payment.

So these are all a bunch of, you know, important issues that we need to discuss. I know my colleagues have a lot of questions on both sides. I am very, very eager to begin this hearing.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Takano.

And every member on this committee on both sides of the aisle wants the best for the veterans that have served this Nation regardless of party affiliation, regardless of gender, and I think it is an appropriate time that we take today to hear from some of those who have worn the uniform of this Nation.

So I would call our first panel of witnesses to come forward to the dais, if you would, and I will call you, the first and only panel.

First on the panel is Dawn Halfaker, a veteran, a business owner, and a strong voice in the veteran community; Joy Ilem, a veteran and the Deputy National Legislative Director for the National Service and Legislative Headquarters of the Disabled American Veterans; Lauren Augustine, a veteran and a Legislative Associate for the Iraq and Afghanistan Veterans of America; Dr. Patricia Hayes, the Chief Consultant for Women's Health Services for the Department of Veterans Affairs' Office of Patient Care Services.

Dr. Hayes is accompanied by Dr. Susan McCutcheon, VA's National Mental Health Director for Family Services, Women's Mental Health and Military Sexual Trauma, and Curtis Coy, VA's Deputy Under Secretary for Economic Opportunity.

I appreciate you all being here today. Ms. Halfaker, you are recognized for your opening testimony.

And I have to ask before how is the little one doing that I spent time with at the dedication of the Disabled for Life Memorial?

Ms. HALFAKER. Very good. Thanks for asking.

The CHAIRMAN. Very good.

STATEMENT OF DAWN HALFAKER

Ms. HALFAKER. Mr. Chairman and members of the committee, thank you for holding this hearing and for inviting me to testify.

The issues you are reviewing are of great concern to me as one whose military career was cut short after I was severely wounded in Iraq while serving there in 2004.

I am very proud to have served in uniform and to continue to serve as an advocate for my fellow wounded warriors, veterans, and their families through affiliations with nonprofits like USO, Wounded Warrior Project, as well as my own service-disabled, veteran-owned business where I employ a lot of veterans and wounded warriors. I am also pleased to be able to advocate for my fellow women veterans by testifying today.

Looking back and while the VA has come a long way since just a generation ago where there was no women's program and VA hospital could not provide women patients the most basic privacy, they have absolutely come a long way, but the department still has much to do and more work to close the gaps that DAV portrayed in its report, The Long Journey Home.

VA care is an entitlement and a promise for those of us who served and I use its medical system proudly. I want the system to work to help our veterans and to ensure that the promise is kept for all veterans.

My testimony today reflects what I have learned as a VA patient and focuses on my recent experience in getting maternity care through the VA. As the chairman alluded to, he had the pleasure of meeting my little guy. He is about a year old now and he is doing great. So thanks again for asking.

Understandably the VA outsources maternity care, but its administrative stewardship of this service is so hands off that women veterans don't get enough support during this vulnerable period.

The problems I have encountered are systemic, largely due to a wide gap between VA's detailed written directives and what the veterans actually experience. Consider VA's policy which among other things states that women veterans continue to get care through VA facilities during their pregnancies for management of any other conditions, coordination of care and information sharing between non-VA and VA providers is critical, and each facility must ensure seamless coordination of non-VA maternity care with VA care.

While these are very sound policies, the expectations they set are largely piled on a single individual at each medical center called the maternity care coordinator. That individual actually has more than a dozen specific responsibilities.

My coordinator failed to meet several of these responsibilities at critical points. So instead of experiencing seamless coordination of care, I felt abandoned at times and had to navigate some difficult challenges on my own.

So where did things go wrong? Well, from the start, my maternity care coordinator handed me a list of DC area maternity care providers, but quickly warned that she couldn't really endorse any of these providers and I would need to go find a doctor on my own who would accept the VA contract at Medicare rates and would sign it.

I had expected the medical center to have a network of OB/GYN providers with whom it contracts. I was surprised to learn that it hadn't established any maternity care contracts which left me on my own to find obstetrical care.

As it turned out, my choosing a George Washington University Hospital physician proved lucky because her office had actually treated another veteran patient, only one, but at least had learned how the VA contract works and was willing to sign it.

I was also surprised to discover that VA is essentially a maternity care bill payer, but it doesn't even carry out that role very efficiently. For example, over the course of my pregnancy, my doctor routinely had lab work done. But because VA was very slow in paying the bills, the lab company began billing me directly.

My maternity care coordinator apparently couldn't fix the problem and I soon got collection notices that nonpayment would jeopardize my credit.

Things got worse. During the pregnancy, my doctor became concerned by signs suggestive of a fetal heart problem and referred me to Children's Hospital for an echocardiogram. That is the only facility in this area that does those.

I notified my maternity care coordinator to get the needed approval but was told that it would take several weeks because the DC, VA had no established relationship with Children's.

With my child's well-being potentially at risk, the idea of waiting weeks to get an okay just didn't seem right, but my coordinator wouldn't budge until I said I would record our conversation and alert my congressman. That finally sparked action and led to VA's arranging with Children's for the procedure. So thank you, Congress.

The good news was that the testing revealed that there was no cardiac abnormality, but I was soon stuck in the middle again now getting bills from Children's. It took eight weeks and a conference call with the VA officials in two different offices to clarify that VA had paid Children's. But because its payment only covered a fraction of the charges, Children's demanded that I pay the difference, more than $1,700.

After trying to unsuccessfully get my maternity care coordinator to resolve this Catch-22, I eventually learned that she had been out for several weeks with her own prenatal issues. Surprisingly nobody had been assigned to serve as a backup, so luckily my VA OIF/OEF coordinator and case manager happened to contact me and was willing to step in and resolve the problem.

There is much room for improvement, so let me offer a few recommendations. Women veterans should be afforded access to high-quality maternity care. The burden should not be on the veteran to go find qualified OB/GYN care. Obstetrical care should not start with a pregnancy test as outlined in the VA handbook. It should start with preconception counseling to assure a woman is as healthy as possible before conception to promote her health and the health of her future children.

If VA is going to outsource maternity care, it should be seamless and it must include the full range of maternity-related service that a veteran may require. VA medical centers should contract with a single high-quality provider such as GWU or a network of providers similar to TRICARE so that the veterans can be assured of receiving excellent care where experienced clinicians are sensitive to the unique needs of women veterans and that veterans do not bear the cost associated with that care.

Pregnancy is a vulnerable period in which women veterans should have reliable ongoing support and there can't be a single point of failure. I applaud VA's direction that pregnant veterans be assigned a maternity care coordinator, but that requires both adequate staffing and appropriate training to assure high-quality, consistent, ongoing, 24/7 service.

Mr. Chairman, women veterans look to you and this committee to help assure that VA meets these challenges. Thank you for the opportunity to share my perspective and I am pleased to answer your questions.

[THE PREPARED STATEMENT OF DAWN HALFAKER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Ms. Ilem, you are recognized for five minutes.

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Mr. Chairman, for inviting DAV to testify at this important hearing.

Over the past decade of war, women have been a rapidly increasing and important component of the military services as you have noted. Women now routinely serve in occupations that put them in harm's way and combat and resulting in trauma, injury, and environmental exposures associated with modern warfare.

And as you know and are aware, following military service, women are turning to VA in record numbers. In fact, the number of women seeking VA care has doubled, more than doubled in the past decade and continues to rise.

As a disabled veteran and user of the system, I know firsthand what issues women veterans face when they seek care. The experiences of current wartime deployments have contributed to a number of new challenges and transition reintegration challenges for these servicemembers.

As a result, DAV commissioned a study in 2014 to look at women transitioning from the military and the existing federal programs and services available to aid them in that transition. Our report, Women Veterans, The Long Journey Home, represents a comprehensive assessment of the existing policies and programs serving women across the federal landscape.

One of DAV's key legislative priorities has been to ensure that women veterans are properly recognized for their military service and receive equal benefits and high-quality medical care services in the VA healthcare system.

DAV's report notes that despite a government that provides a generous array of benefits to assist veterans with transition and readjustment following military service, gaps are evident for women in existing programs. And these gaps can impede a successful transition and negatively impact their health outcomes.

The majority of these deficiencies, as you noted, result from a disregard from the differing needs of women veterans and historic focus on developing programs for men who are prominent in numbers and public consciousness.

Research demonstrates that when compared to men, women veterans returning home from current wartime deployments are more likely to be divorced, a single parent, and unemployed after the service. They have higher rates of homelessness, at least twice as high as women nonveteran.

Some have limited access to transitional and safe housing options, especially for homeless women with minor children, high rates of military sexual assault, and higher use of VA mental health services. Women also continue to report limited access to child care services as a barrier to needed healthcare.

Despite the fact that VA has made tremendous progress to improve services for women, they still lack consistent access to a full range of gender-sensitive healthcare benefits and services.

To correct these deficiencies, DAV makes a number of key recommendations including requiring every VA medical center to hire a gynecologist and appropriate staffing levels to meet demand for gender-specific services; implementation of gender-specific clinical IT tools; improving access to gender-sensitive mental health pro-

grams; tailored transition assistance, education, and career guidance programs; increased access to safe transitional beds and housing for homeless women veterans with children; improved access to specialized prosthetic items and treatment for MST; permanent authorization for child care services and women-focused post deployment readjustment retreats; and an effective plan for systemic culture change to ensure women experience a welcoming, safe, and private environment of care at all VA facilities.

Over the history of our country, millions of women have answered the call to duty and put themselves at risk to preserve our Nation's security. They have kept their promise and served this country faithfully, many with distinction. Now it is time we keep our promise to them and we can do that by acknowledging their dedicated military service and serving them with greater respect, consideration, and care.

Given the fact that more than half of the women veterans under VA care are service disabled, the department must step up its efforts to address their unique health maintenance needs, reallocate resources to do so, and ramp up clinical training for these high-priority VA beneficiaries with age-appropriate, customized care.

This is a transformative moment for the VA. Secretary McDonald is leading an ambitious effort to change the department's overall culture and to direct resources where they will ensure VA healthcare services can meet the needs of every veteran who needs them. That cannot happen without a strong focus on women veterans and a detailed plan of action.

For these reasons, we call on Congress to legislate and set a firm deadline of Memorial Day 2016 for action by the department to complete the steps outlined in DAV's report. This will ensure that women veterans have equal access to comprehensive, high-quality, gender-sensitive healthcare and benefits.

Again, DAV appreciates the opportunity to testify before the committee today and I am happy to answer any questions you may have.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Ms. Augustine, you are recognized for five minutes.

STATEMENT OF LAUREN AUGUSTINE

Ms. AUGUSTINE. Chairman Miller and distinguished members of the committee, on behalf of Iraq and Afghanistan Veterans of America, we would like to extend our gratitude for the opportunity to share our views and recommendations on improving women veterans' access to quality healthcare and service.

As the leading post-9/11 veterans' empowerment organization with the most diverse and rapidly growing membership in America, we are proud to have a diverse group of women veteran members and leaders as part of our organization.

This March, we launched our first women veterans' survey as part of an effort to understand more about women's experiences during and after service. Over 1,500 women veterans have responded so far.

In addition to the survey, IAVA's research department traveled to seven cities across the country and spoke with dozens of women veterans in an ongoing series of focus groups. In speaking with our members across the country, we have narrowed our suggestions here today to three main points.

First, VA, DoD, and the Nation at large must recognize women for their ongoing service to this country. Second, the VA specifically needs to expedite planned improvements to VA facilities to support and improve services and care for women at these facilities. And, finally, there must be a renewed focus on research to fully understand where gaps in services exist.

Women have played a vital role in our military throughout history and their impact and contributions are continuing to grow and, yet, what IAVA has learned while traveling the country is that women veterans continue to encounter barriers to care and benefits including an overall culture that does not fully recognize or accept them as veterans.

Last year during IAVA's advocacy campaign, Storm the Hill, one of our own leaders experienced a group of fellow veterans thanking her for her support while thanking her male colleagues for their service.

Recent IAVA focus group data illustrate this type of disconnect is widely reported with less than 40 percent of women veterans reporting that they felt the U.S. treats their military service with respect.

These frequent instances of dismissing or ignoring women's military service must change and nowhere is that more necessary than inside the walls of VA facilities. We suggest that as a first step, VA medical centers implement staff training programs to counter these assumptions.

Additionally, the role of the women veterans' program manager should be strengthened to ensure this position is given the necessary authority to implement policies. The need for an inclusive environment is not restricted to the staff at the VA. Patient advocates must also be prepared to handle complaints related to harassment or individuals creating a hostile environment in order to enact actual culture change.

Second, VA medical centers need specific operational and structural changes that support the needs of all veterans. In our recent focus groups, women consistently pointed out that they have had to endure long wait times to get care from a provider that they trust or who are trained in women-specific medical fields.

While our women veterans' survey is still open, our initial analysis shows that about 70 percent of our respondents rate the VA as fair, poor, or very poor in their support provided to women veterans. Among those who have used private healthcare, only one in four rated private healthcare in the same satisfaction levels.

And while the VA has made great strides to address these types of issues, there is still a need to ensure every VA medical center has appropriate facilities that are fully staffed to support the needs unique to women.

From our initial survey results, only about half of those enrolled in VA care said the facility they last visited had a gynecologist on site and less than half reported a women's VETS coordination or

program manager on site. These statistics and issues are not new, but the need to address the disparity in gender-specific care remains.

Third and finally, there must be renewed emphasis on good data and reliable research into the experiences of women veterans. Gaps in services and improvements in care cannot be fully achieved unless they are fully defined.

The VA has already taken steps in the right direction here with the establishment of the Center for Women Veterans, the renewal of the charter for the Advisory Committee on Women Veterans, and the recent Women's Health Research Conference.

But the VA, DoD, and Department of Labor among other government agencies should make additional improvements to their research by incorporating gender and minority analysis into all reports to better inform gaps in services and programs. Specifically focusing on the VA, VBA must track and analyze all rating decisions by gender to ensure accurate, timely, and equitable rating decisions.

I think what most sums up this testimony is the observation of a Vietnam veteran who attended one of our focus groups. She noted that while there may have been some progress, by and large, it has not been enough and certainly not fast enough. Many of the challenges that existed when she transitioned to VA care decades ago still exist.

With the women veteran population only projected to increase, the time to address these issues is now. IAVA would like to thank you for bringing these issues to the forefront and giving us the chance to offer our views and the views of our members here today. Thank you for your time and attention.

[THE PREPARED STATEMENT OF LAUREN AUGUSTINE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Dr. Hayes, you are recognized for five minutes.

STATEMENT OF PATRICIA HAYES, ACCOMPANIED TODAY BY MR. CURTIS COY, VETERAN BENEFITS ADMINISTRATION, DEPUTY UNDER SECRETARY FOR ECONOMIC OPPORTUNITY, AS WELL AS DR. SUSAN MCCUTCHEON, THE VHA'S NATIONAL MENTAL HEALTH DIRECTOR FOR FAMILY SERVICES, WOMEN'S MENTAL HEALTH, AND MILITARY SEXUAL TRAUMA

STATEMENT OF PATRICIA HAYES

Ms. HAYES. Good morning, Chairman Miller, Mr. Takano, and distinguished members of the House Committee on Veterans' Affairs. Thank you for the opportunity to discuss the high-quality care and support that VA is providing to our women veterans.

The number of women veterans enrolling in VA healthcare has increased rapidly, placing new demands on a VA healthcare system that has historically treated mostly men.

In fiscal year 2014, there were more than two million women veterans in the United States and of those women veterans, over 635,000 are enrollees to include more than 400,000 users of VA healthcare services.

To address this growing number of women veterans who are eligible for VA healthcare, VA is strategically enhancing services and access for women veterans.

In 2008, VA first identified the necessary actions for ensuring that every woman veteran has access to VA primary care. Since then, our plan for delivering care to women veterans has basically come to fruition.

VHA's Women's Health Services oversees program and policy development for women's health and provides strategic support to implement positive changes in the provision of care for all women veterans.

Women's Health Services works to ensure that timely, equitable, high-quality, comprehensive healthcare services are provided in a sensitive and safe environment at VA facilities nationwide.

VA Women's Health Services' programs include comprehensive primary care, women's health education, reproductive health, communication, and partnerships. To provide the highest quality of care to women veterans, VA offers women veterans trained and experienced, designated women's health providers who can provide general primary care and gender-specific primary care in the context of a long-term patient and provider relationship.

Today designated women's health providers are available at all VA medical centers and 90 percent of community-based outpatient clinics. With the launch of such a large-scale change in services, Women's Health Services recognized the need to assess the progress towards implementation of high-quality programs focused on women veterans.

We evaluate all our women veterans' health programs through several mechanisms and in addition, VHA uses an independent contractor to conduct detailed site visits to objectively assess the implementation of services for women veterans nationwide.

Also, recent analysis indicates that VHA outperforms private and public sector healthcare in many quality performance measures. As a recognized leader in the provision of high-quality healthcare, VHA initiated efforts to address gender disparity, a problem that actually affects healthcare nationwide.

Since 2006, VHA's Office of Informatics and Analytics has analyzed all the external peer-review program data by gender and published a quarterly gender report on the Web site. Over the years, we have been working very hard to close the gender disparities gap.

In fiscal year 2008, VHA launched a concerted women's health improvement effort focusing on providers' attention on gender disparity data. And from 2008 to 2011, VA saw a significant reduction in gender disparity for many measures.

At the close of 2013, small gender gaps existed in only a few measures including cholesterol management in high-risk patients, diabetes care, and rates of influenza vaccination. VA continues to address such key clinical issues and others including cardiac care to improve women veterans' health.

VA recognizes the importance of providing services to women veterans over their life span. VA provides a full continuum of mental health services to women veterans including outpatient, inpatient, and residential treatment options. VA also recognizes the signifi-

cance that support groups and partnerships with our local communities have in the transition and recovery of women veterans.

A number of programs connect women veterans and veterans with families with healthcare, employment, financial counseling, and housing.

In conclusion, our mission at VA is to care for those who shall have borne the battle as well as their families and survivors. We are providing the highest-quality healthcare for today's women veterans while actively working to meet the needs of those who will come to us in the future.

We have made significant strides in recent years. However, we still have much to do as VA continues to focus on the nationwide effort to enhance the language, the practice, and the culture of VA to be more inclusive of women veterans. We will continue to improve our efforts to provide high-quality, timely healthcare to our women veterans and we appreciate this committee's ongoing support in doing so.

Mr. Chairman, this concludes my testimony and my colleagues and I are prepared to answer any questions that you or other committee members may have.

[THE PREPARED STATEMENT OF PATRICIA HAYES APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Dr. Hayes.

I will yield myself five minutes for questioning.

Dr. Hayes, I would go to your written statement where you say that VA intends to address the hiring of gynecologists and improve access by expanding on-site gynecological services and the support as we implement the Choice Act.

My question is, how many gynecologists does VA anticipate hiring using the funds that were provided in the Choice Act for staffing and how much Choice Act funding totally will be allocated to this effort?

Ms. HAYES. Sir, I would like to first make sure that we understand that gender-specific healthcare for women is available at every site both through the primary care gender provider, that is the designated women's health provider is going to do the PAP smears, mammograms, birth control, and preconception counseling.

In addition, we now have access to gynecology at 117 of our facilities on site. Everywhere else, they are referred to community providers in order to have the highest-quality care for women in that community.

We are right now in the process of looking at those 35 sites. As you know from our work on the Choice staffing, Section 301, we are looking at a workforce management model that will tell us exactly how many gynecologists we need at each and every site, not just the ones that have only one at this time and those that have none on site.

So I am not able to answer your question directly about the number and about the money that we will be using for those sites.

The CHAIRMAN. If you would as you go through the process provide the committee with the data that you do develop.

How many of the gynecologists that you intend to hire are going to be full time versus part time?

Ms. HAYES. I also don't know the exact answer to that. We are recognizing that a gynecologist on site has many roles. One is to conduct gynecology clinic and to perform surgeries both inpatient and outpatient. But they also have the role of helping to oversee the care of women in the emergency department and also to help teach primary care providers in the best care of women.

So it may well be possible that these could be full-time providers with part of their time providing on that site, emergency room, and one of the things that we would also like to enhance is the use of telehealth gynecology so that women in the remote areas can be seen in those clinics without having to travel to the main site.

The CHAIRMAN. In her written statement, Ms. Halfaker paints a powerful illustration for how she puts it, VA's administrative stewardship of maternity care is poor and causes unnecessary trauma.

Dr. Hayes, I hope that you take her testimony and use it as a guide on how to improve maternity care for women veterans which will become increasingly important as the committee continues to examine how to expand fertility service for service-disabled veterans.

And at one point in her testimony, and I actually wrote it down, she talked about some of the most critical maternity care expectations are piled on a single individual, the medical center's maternity care coordinator, who in Ms. Halfaker's case failed at critical points to meet her responsibilities at very key times.

Ms. Halfaker.

Ms. HALFAKER. Thank you, Mr. Chairman.

I would say that, and I apologize for going over the time a little bit, so I had to cut my oral testimony short, but what I wanted to say was include a couple of my fellow combat veterans, women who have also had children, one of those members serves in Congress, both use the VA at a different location. I was here at the DC, VA. And both had the same issues.

And, in fact, I will just say Melissa Stockwell, one of our other combat veterans, she is still kind of in, I guess, financial peril trying to, you know, juggle bill paying, that she has gotten a lot of bills from the VA and—or, excuse me, not from the VA, but from wherever she got her care, that the VA has not paid and it has been several months since she had her child. And so I know that that has been very hard on her and her family.

So, you know, I have a couple data points. I haven't interviewed, you know, a lot of women veterans, but I know that the ones I have talked to, they all really focus in on the bill paying issue where, you know, women veterans are stuck in the middle between the VA's fee office and the providers that are providing the care and somehow end up getting a lot of those bills.

So I think that is one of the biggest issues and then trying to find a provider is the other big issues. There is a lot of great facilities in this area, so I was very lucky to end up at George Washington University Hospital where I got great care, but, unfortunately, for other women veterans, they may not know where to go and that can very much be a problem for them.

The CHAIRMAN. Thank you very much.

My time has expired, but I was struck by Ms. Halfaker's comments that not only had VA failed to establish contracts with local

providers to provide maternity care to women veterans, but was so slow in reimbursing one of the non-VA care providers that she was forced to be billed. And the consternation that caused was probably not a good thing. And in a second round, I probably will talk about that issue.

Mr. Takano.

Mr. TAKANO. Mr. Chairman, before I begin, I would like to ask unanimous consent that Ranking Member Brown's full written statement be entered into the record.

The CHAIRMAN. It will be entered into the record in the appropriate place without objection.

[THE PREPARED STATEMENT OF RANKING MEMBER CORRINE BROWN APPEARS IN THE APPENDIX]

Mr. TAKANO. Thank you, Mr. Chairman.

Ms. Halfaker.

Can you also tell me, besides the billing issue, was there an issue also with your medical records being available to the VA and how did that play into your care?

Ms. HALFAKER. Sure. So as far as the medical records go, I think in the VA handbook there is a policy that states that the provider will have to send the medical records back to the VA. I don't really have any visibility into that process, whether that did or didn't happen.

But I know that I have tried to get a follow-up appointment at the VA numerous times and there continues to be a lot of delays. I think that they are experiencing a large number of women veterans at the DC, VA right now and so it has been hard to get a follow-up appointment. Some of that is on me with my schedule, but it is also, you know, a several-month wait time right now.

So they are advising us to use the Veterans Choice Act and get purchased care, so I am trying to get signed up for that right now which is also another process within itself. So since having my child a year and a month ago, 13 months ago, I have not been able to get back into the VA to find out whether or not they have my medical records and follow-up with kind of a routine OB/GYN appointment.

Mr. TAKANO. Is the delay in your appointment somehow related to the medical records issue or is that not relevant or you don't know?

Ms. HALFAKER. Sir, I don't know.

Mr. TAKANO. Ms. Ilem, you have insight into this?

Ms. ILEM. I mean, it sounds like from talking with Ms. Halfaker, you know, it could be an issue of demand as well. You know, when they are telling you it is going to be several months for, you know, a basic appointment in a facility, the volume has increased, you know, for a number of people.

But I would add, you know, for a long time, the DC, VA did not have mammograms on site and we went right across the street to have those done. The unfortunate thing is when you would come back for your appointment, the VA clinician would ask you did you have your mammogram and what were the results.

And, you know, we would constantly say, I mean, you have a contract across the street. Why are you not getting those results and

why are they not being forwarded and put in my record in a timely manner?

So I think that continues to be a problem at sites where they have to go off site for mammograms.

Mr. TAKANO. Dr. Hayes, can you at all shed some light on to the untimeliness of the payments and just what we can do to get this unstuck?

Ms. HAYES. Certainly, Mr. Takano. We have known previously because of the fact that about 30 percent of women do have to use non-VA care that there have been difficulties in care coordination and payment.

Some of these issues actually have been dealt with very directly by the move to the Chief Business Office from all of the remote fee-basis personnel now being under the management of VA's Central Office, Chief Business Office in the last couple of months that that change has occurred.

I think the more important thing is that with the advent of the PC3 contract, within the contract, there are guidelines for timeliness of getting the person into care within—a consult within seven days, making sure that the bill now goes through the PC3 contractor. And so the VA is paying the contractor directly and they are resolving the issues locally.

That hasn't fixed it. We knew for quite some time that payment and slow payment has been a challenge. We also know, though, and what is disappointing about this case is that there has not been the right kind of case management and care coordination from the side where our women veteran program manager and others have failed the veteran in this case and it sounds like in others to navigate that so that we do have ways that balance billing should not happen for veterans. They shouldn't be getting bills from private sector providers.

Mr. TAKANO. What do you have to say about Ms. Halfaker's suggestion that VA contract with, you know, a single source, a big source where there may be, you know, a large array of OB/GYN or gender-specific services available?

Ms. HAYES. There is a couple of angles to that. One is in our larger sites, there have been contracts in place and they must follow all of the GSA contracting rules which are very complex, of course, but they do allow for that.

The other thing, though, as I said about the PC3 contract, that does, in fact, enroll a network of providers. Some of the problems with having a central contract in the past have been that it has been, say, at University of Philly, but those who live further away can't, therefore, participate in that. The OB/GYN care needs to be relatively close to their home so that when they deliver, they are nearby.

So we actually think that the network of a PC3 type contract is the better way to enroll outside providers into VA OB/GYN care and that has been happening.

Mr. TAKANO. Mr. Chairman, my time is up. Thank you.

The CHAIRMAN. Thank you.

Dr. Roe, you are recognized.

Dr. ROE. Thank you, Mr. Chairman.

Having spent 31 years in this business of delivering babies and so forth, this is something I happen to finally know something about. So I have a lot of questions and really amazing to hear Ms. Halfaker. And for you veterans out there, thank you for your service and I say that as a fellow veteran. Thank you.

I found it astonishing that you wouldn't have—at home where I am, the VA, we have a VA. We have a group of OB doctors in my practice, 11. At the time I was in practice, five of us were veterans and so we coordinated with them. I don't know that I ever got a record from the VA. If I had a question, I just called the provider out at the VA which was a nurse practitioner and said why did you send this patient over here.

That has been an issue getting the information from the VA to me. Why in the world the VA—Medicare actually, they don't pay a lot, but they pay pretty timely. And I can't imagine why the VA can't write a check. How hard is that to do? And you should have a contract like any other insurance plan does that you agree to, the physician agrees to, and we take that on.

And, look, most of us out there, either veteran physicians or non-veterans, are more than happy to take care of veterans. I can tell you right now our practice takes care of any veteran that wants to show up.

And what I just heard Dr. Hayes say the GSA contracting rules are very complicated. Well, that runs a lot of providers off. You just don't want to fool with it. I mean, it is such a hassle. That should be easy as pie to do and it ought to happen yesterday.

And the fact that you had to have an echo, and thank goodness your baby was fine, didn't have to have any further treatment or anything, that should be the least of your worries. The fact is you should be worrying about your pregnancy and your outcome of your baby, not the Children's Hospital sending you a bill. And that ought to be fixed yesterday so you don't worry about that anymore.

And, Dr. Hayes, a question to you. How do you explain when you tell me about all these things that the VA—and, by the way, they are doing a lot better. I want to thank you for that. But how do you explain in the focus group that Ms. Augustine talked about 70 percent of the support services they describe as fair, poor, or very poor?

I mean, if I had an evaluation of my practice was that, I would have been making some changes ASAP.

Ms. HAYES. Yes.

Dr. ROE. How when your testimony was very rosy, there is a provider everywhere, but that is not the perception these patients are having——

Ms. HAYES. I understand your question.

Dr. ROE [continuing]. How do you explain that?

Ms. HAYES. I can't speak to the survey that they have, but I do know that we do have sites. As I said, ten percent of our community-based outpatient clinics do not have designated women's health providers yet, so I don't know to what extent the veterans who responded to the survey may be represented of folks attending those clinics. We are working to increase that.

We also know that those who have designated women's health providers are very highly satisfied. So, yes, it is a contrast in data,

but I think, you know, we can't just focus on the data but on fixing the problem.

Dr. ROE. Well, I mean, if you don't know what the problem is, you can't fix it. I think——

Ms. HAYES. Right.

Dr. ROE [continuing]. You have to know what the data is. And, Ms. Augustine, I think you had what, 1,500? Maybe it wasn't a double blind, randomized trial that we would, but still surveying 1,700 people or 1,500, whatever it was, is pretty accurate. Could you comment on that?

Ms. AUGUSTINE. So the survey is still ongoing and the analysis is still being done on that. And I would like to speak to the point that was brought up about the 70 percent of respondents. That was with the VA as a whole rating the VA as fair, poor, or very poor in their support provided to women veterans.

We also have a data point that—once again, the survey is still open, so respondents are still coming in and the analysis is still being done, but thus far, about 65 percent feel the VA adequately provides female practitioners and access to female-specific care. So approximately one in three do not. So that would be in line with what Dr. Hayes is mentioning. The 70 percent is the VA overall.

Dr. ROE. Overall. Thank you for that.

And I think basically when you see a volume increase, in our practice, what we did when we would—I would go to church and somebody would say I can't get an appointment with you for four or six months. We would hire a new provider and we knew that pretty quickly. And we responded to that because we had to provide those services in the community.

And I think the VA has been very slow to respond to the demand. Any comments, Dr. Hayes.

Ms. HAYES. I think it follows with my comments that we are aggressively looking at the workforce issues, exactly where do we strategically expect additional increase, where do we have gaps right now, and proposing that we make sure we hire up in those sites. That really is part of our workforce planning right now.

Dr. ROE. And I think the physician-patient relationship, back to Ms. Halfaker, I was the maternity care coordinator for my patients for 30 years and if you came to me, I made sure that you got the services you needed to take care of you. And that is what somebody needed to do and fell down on that. I think that is exactly what you pointed out was this gap that was missing there.

If you were my patient, you knew exactly who to come to with your problems and our office took care of those problems so you didn't have to walk out thinking about that. What was happening to you was that was not happening. When this person was removed or was gone or for whatever reason, there was no one to step in and fill that void for you as I understand that.

Ms. HALFAKER. Congressman Roe, if I could just add to that. I think an important point was made by Ms. Augustine about, you know, there is the policies that are written in the Women's Health Program Office which are excellent and they have done an excellent job in trying to push this out.

But it does take the larger organization at the leadership level, at the VISN level to say we are going to hire these people. We are

going to be in tune with our women veteran program managers that are telling us these are the services that are needed.

And I think that point is really important that we need throughout the system to make sure they get the support they need for what they know. They have put down the policies. They put down the programs, but the reality on the ground is what is showing here.

Dr. ROE. I yield back, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you.

Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman.

I wanted to talk a little bit about child care for our veterans. And last week, I introduced legislation and many of my colleagues here who are supporting that legislation to make permanent and expand the VA's successful child care pilot program.

I want to particularly thank you, Ms. Ilem, and the disabled vets for your support on the bill.

I just wanted to ask maybe all of you if you want to weigh in on what we have learned from the pilot program and what we know of the role of child care for women in terms of accessing timely health services.

Ms. HALFAKER. Well, I will start out, but we thank you so much for introducing that bill. This has been an ongoing issue over the last decade. Any surveys, major surveys that were done identified child care, access to child care as a barrier for many veterans in general, both men and women.

And the pilots that were done have been deemed to be very successful and I think Dr. Hayes could talk more about that. But as it is an issue, you know, we have seen the new clinic out at DC. We were so pleased to see is they renovated and revised that clinic to include area for child care there as well. And we are hearing from more women, DAV's Women Veterans' Advisory Committee, that are coming in. Some facilities having even done it not just in the women's clinic but various areas around the facility.

We see more and more a younger population of women coming into the system and older veterans that may be grandparents that are now responsible for the children and having that, being able to bring them along in an environment that they feel comfortable in, you know, has been very helpful, I think, for so many women and men.

Ms. BROWNLEY. Any others?

Ms. AUGUSTINE. I can also echo similar statements from IAVA's perspective. Our members have consistently said that child care is a barrier to care and providing child care helps to remove some barriers. And for several years now, it has been a policy agenda statement of ours to expand child care services at VA facilities because the pilot program has been so successful and so widely appreciated.

Ms. BROWNLEY. Thank you.

Ms. HAYES. VA has recommended that we be given permissive authority to provide child care in order to meet the exact kinds of needs that we are seeing here and that locally, veterans could have a voice in how to set that up, how communities might participate in it.

Ms. BROWNLEY. Thank you.

Dr. Hayes, I wanted to ask you. You talked a little bit about the closing of the gender disparity gap, as you called it. And I wanted to understand sort of the measurement of that and what that kind of means.

And is it sort of an average of overall services for women within the VA? Are you able to disaggregate more rural areas where I think we might have, you know, bigger issues than we do in the urban areas? Could you talk a little bit about that measurement? And we are always looking for tools of how we monitor these issues to make sure that we are on the right trajectory for improvement and is this a measurement that we can be looking at?

Ms. HAYES. Certainly. When we talk about gender disparity data, we are actually looking at clinical prevention measures, so whether you get your flu shot or not, whether you get mammograms or not, and whether you have your lipids measured. These are health measures that are put out by national groups outside the VA and VA has always been higher than the private sector or Medicare, Medicaid on these measures.

One of the things that hasn't been addressed nationally outside of the VA or earlier in the VA is that women actually—overall, women's healthcare is poor. We don't do as good a job on cardiac disease in women, on flu shots in women nationally. And so VA saw that while we did better across the board, we didn't do as well in these issues regarding prevention measures in men and women. We have basically set forth to tackle that measure.

I do want to address another part of your question which is we are looking at implementation of women's healthcare, what are we offering for women at various sites, and the variability in how well we provide healthcare for women.

We have a number of different measures including site assessments and a dashboard, as we call it, for looking at how well are we getting these policies in place, how many women are assigned to designated women's health providers. We have these types of measures and we are putting those out now on a semi—the dashboard is once every six months. The other measures are annual and we have roll-up reports on those. So we are looking at the variability across our system and how well we do those.

Ms. BROWNLEY. Thank you, Doctor.

And I yield back.

The CHAIRMAN. Thank you very much.

Mr. Coffman, you are recognized.

Mr. COFFMAN. Thank you, Mr. Chairman, for holding a hearing on this important subject.

And thank you, members of this panel, for sharing your views with our committee.

I believe it is absolutely critical that the VA adopt policies to meet the needs of our Nation's growing number of women veterans. The rapidly increasing demographic shift of the American veteran population is really quite stunning. The number of women veterans using VHA between 2003 and 2012 nearly doubled. Twenty percent of new recruits now are women while in 2012, it was only 6.5 percent of VA's patient population were women.

To address this dramatic shift last month, I introduced the Women Veterans Access to Quality Care Act. The bill requires VA to ensure the availability of OB/GYN healthcare services at all VA medical centers to improve its healthcare facilities to meet the needs of our women veterans and to hold hospital directors publicly accountable for women's healthcare outcomes at their facilities.

I am thrilled that the Vietnam Veterans of America signaled its full support for my bill in its statement for the record submitted to the committee today, and I look forward to working with all of you on the panel as well and with my colleagues on the dais to make sure that we get the bill right and ensure our women veterans are getting the healthcare that they deserve and invite all my committee members to join me in this effort.

Ms. Augustine, in your testimony today, you noted the survey conducted by the Iraq and Afghanistan Veterans of America that found 56 percent of respondents felt that the VA provided an adequate number of women practitioners. Only 41 percent believe the VA provided an adequate number of doctors specializing in women's care and only 34 percent said the VA adequately provided specialized facilities for women.

Do you think that VA's current policies to place, quote, "designated women's health providers," unquote, is adequate to address the needs of your membership?

Ms. AUGUSTINE. Based on what we are hearing from our members like you read in our new survey which is updated data, there is still a population that is being under-served in those needs. We know that the VA is doing their due diligence to try to meet those needs.

What we are hoping to see is that it is done quickly, that there is adequate staffing levels to meet the demands so that there aren't situations like we have heard about this morning, and that moving forward, the increasing number of women veterans, particularly the younger generation coming in that is that increase, is getting the services that they need in a timely manner.

Mr. COFFMAN. Okay. And thank you for your service as well.

Ms. AUGUSTINE. Thank you.

Mr. COFFMAN. Ms. Halfaker, thank you for your service to the United States Army as an MP. Was that in Iraq?

Ms. HALFAKER. Yes, sir.

Mr. COFFMAN. Do you think that the VA's designated women's health providers are adequate given these figures?

Ms. HALFAKER. I would say no.

Mr. COFFMAN. Okay. In 2010, the GAO found that VHA was not complying with its own privacy policies for women veterans. For example, check-in areas were in busy, mixed gender areas. Gynecological exam rooms did not have adjacent restrooms and examination tables were facing entryways.

Anybody in the panel, based on your personal experiences or based on the feedback of your membership, if GAO did the same review today, what would they find?

Ms. AUGUSTINE. I can speak to a member I talked with last week said that exact same thing. The women's clinic in her local medical facility was located directly next to the pharmacy, right next to the front door. It was always busy. In fact, there was people from the

pharmacy who then came into the women's clinic because there was no longer seating available in the pharmacy. So there was certainly a lack of privacy that she shared concerns with.

Mr. COFFMAN. Okay. Yes.

Ms. ILEM. I would just say some of the infrastructure issues that are throughout VA, you know, have especially impacted on women's health with the safety and privacy issues. Many of the facilities had very small locations for their women's clinic initially.

They have been moved around a lot and being able to put in for construction and infrastructure changes, you know, is, you know, a slow process, as you know, throughout VA. So I think that has been a problem, an overarching problem for women's health clinics.

Mr. COFFMAN. Yes.

Ms. HALFAKER. And so I would just say that that was my experience about two years ago at the DC, VA Medical Center which is the only place that I have gotten care at the VA, but now they have built a new state-of-the-art facility that does not have those issues and is adequate.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

Ms. WALORSKI [presiding]. Thank you.

The chair recognizes Ms. Titus for five minutes.

Ms. TITUS. Thank you.

I also want to thank the chairman for holding this hearing. He may recall that I sent him a letter last October that was signed by all the members on this side asking for us to look into the issue of women's health. So I am very glad that we are doing that.

I am also awaiting the results of an IG's investigation that we requested that looks into some of these very same topics, the issues of privacy, gender-specific care, and meeting other kind of healthcare needs.

I would just ask first very quickly, Dr. Hayes, Nevada has about 22,000 women veterans and that is probably a low estimate. We have got a brand new hospital in Las Vegas. Can you tell me how many gynecologists we have on staff?

Ms. HAYES. I know that you have at least one, but I don't know how many full-time positions you have for gynecology, you have both in Reno and in Las Vegas.

The issue sometimes, though, doesn't look that clear when we look at making sure that we have the right healthcare for women at all the sites and that we make sure we have enough primary care providers. As you have heard here, we still have some gaps to fill with regard to that.

And as we make sure that gynecology is used for the scarce resource that it is in our country which is the abnormal conditions, making sure that we can do surgery for women, for hysterectomies, so we are still trying to manage that in the way that makes for the best sense for our women.

Ms. TITUS. If you would get me those numbers, I would appreciate it. Thank you.

Ms. Augustine, you know that far too often women aren't recognized as veterans by their peers. They don't even really self-identify as veterans so they don't receive the respect that they deserve. Also, they don't tend to get the information they need about what services are available and then they don't use those services. So I

think this is a cycle that we need to break, especially for our new young women veterans, the newest generation post 9/11.

Do you have any advice to the VA about what we can do to bring about some kind of cultural transformation?

Ms. AUGUSTINE. Sure. So the culture change that I mentioned in my testimony is certainly a first step. There are some additional things that can always be done. For starters, every time I receive mail from the VA, it has the wonderful quote from Abraham Lincoln, but the male pronouns are an initial telling me right away this is for he and him and not for me as a her.

So I think that would be a great step. I have appreciated the change in vocabulary from VA personnel. I have heard several times over the past month for those instead of using he. But when I get mail that says he, that is an initial something telling me right off the bat that it is not for me.

I also think from our members' perspective that 90 percent of them have not participated in the peer support program but would like to. And I think that opening up peer support programs for women would help bring them together and get them to have a cultural change within themselves and ourselves, I should say, to be proud of their service and to be more willing to self-identify.

Ms. TITUS. Thank you. I think that is a very simple change that we should make in our correspondence.

Ms. Ilem, I would also thank you for all the work that DAV has done on this topic and your report, The Long Journey Home, is a good play book for us to use as we continue to address this topic.

One of the challenges that I hear, too, is that when women have a bad experience at the VA, then they don't want to go back. Is there some way that we can get the word out that things are changing, that things are improving, and that they should give it another shot?

Ms. ILEM. We absolutely want, you know, to make sure that women can take advantage of all of the positive things that VA has to offer, especially in the very specialized services that they provide oftentimes for PTSD, for military sexual trauma treatment, for blindness, burns, amputations.

And we want VA to be that provider and they do need to step up their efforts in terms of this cultural change and especially during this big transformative moment. It is a real opportunity for them to make sure that throughout the organization that they are looking at every program office to say are we meeting the needs of our women veterans and they should invite women veterans in to talk about their experiences with VA and embrace that to be able to improve those services.

Ms. TITUS. Thank you.

Just one last thing to anybody on the panel. I would like to go back to Ms. Brownley's comments about child care. I am very supportive of her bill. Another thing I hear from women veterans, though, or student veterans that they need child care support so they can go back to school and take advantage of the GI Bill to get an education to better provide for their family.

Is this something that you hear about? I am working on a bill on that. I would appreciate your help and your advice. Do you hear

women talk about the need for child care when they go back to college?

Ms. ILEM. We are hearing through Student Veterans of America and some of the organizations that are working more closely on the campuses that that can be an issue. Certainly I think it is something, you know, that we really, you know, need to look at and we are certainly happy to work with your staff in looking into that more.

Ms. TITUS. Thank you.

Ms. AUGUSTINE. The same comment, yes.

Mr. COY. I am sorry. I would also suggest that—I visit lots of college campuses with our GI Bill students and you are right. It is not a woman veteran issue. It is a family issue for many of our student veterans. And we look at many of these campuses. We promote that kind of thing. We look forward to working with you on your bill to see if we can do even more.

Ms. TITUS. Thank you very much.

Thank you, Madam Chairman.

Ms. WALORSKI I wanted to add my thanks as well, ladies, for being here, for all of you for coming today, and thank you for your service.

I worked a little bit with military sexual assault and I am wondering, I guess to anybody on the panel, but to Dr. Hayes, it seems that when we really just a couple of years ago started really working together on solutions for this unbelievable amount of military sexual assault, and I also serve on the Armed Services Committee which it really came to my attention there and many of us have been involved with that nationwide, so do you see long-term—you know, it seems like right now we have got a lot of military sexual assault women coordinators in a lot of facilities now in the VA and especially the larger ones. Some of the CBOCs even in my area have service coordinators as well. That seems to have tied up so many of these loose ends about coordination of care, about the vulnerability of feeling like nobody is following up.

When you look at the kind of issues that Ms. Halfaker described, when the VA looks at the model for success for being able to treat female veterans, is the MST kind of a model of what you are following as you are kind of putting these building blocks together to deal with more women coming in and be able to treat them adequately and with first-class healthcare?

Ms. HAYES. Absolutely. I appreciate the fact that the MST points of contacts have really shown a way to coordinate care within our system. And I would actually like to turn to Dr. McCutcheon a little bit about some of those points in terms of what we have learned.

Ms. MCCUTCHEON. Thank you, Dr. Hayes.

And thank you for your recognition of the MST coordinator.

Yes, we do have an MST coordinator at every facility across the country. As you mentioned in some CBOCs, we also have MST coordinators. I think it is a wonderful infrastructure for us and we have been taking care of those veterans who have experienced MST. More and more veterans are actually seeking treatment who have screened positive in our system.

So we see that as good news. It is a collateral position and some of the positions that Dr. Hayes has spoken about are actually full-time positions. And so there is more dedication. If you know any of our MST coordinators, they are typically psychologists or social workers, so they also have responsibilities as clinicians to provide mental healthcare.

So the MST coordinator is an administrative position, but thank you for recognizing them.

Ms. WALORSKI Absolutely. And I don't know if this question would be for you, Dr. McCutcheon, or Dr. Hayes. So as more women are coming into the military and more OB/GYN services need to be available, more pregnancies identified, more women accessing that kind of help, what happens, for example, for—and I was just asking this question to my colleague, Dr. Wenstrup—what happens when a woman becomes pregnant in the field somewhere?

She is active duty. She becomes pregnant. She leaves. And are there specialists in the VA as there are for the whole area of prosthetics, Walter Reed, you know, one of the best places in the world that has become the prosthetic maker?

What if these women are coming from areas of harm, toxicities, things that could be identified that could be harmful passed on to a child? Is there anybody in the country that the VA looks at and says, you know, if there is a question about what she was exposed to prior to this birth or even after this birth, where does she go?

And if that is not available in your area or you are in a rural area, what do you do? Who do you ask and is that a fee-based service to a specialist somewhere and who would that be?

Ms. HAYES. Well, you ask excellent questions because we have been very attuned to the issues about what are the effects of military service on women. And so there is a number of points in which this is critical.

One is our whole department that does look at exposure issues in the Office of Public Health and we work very closely with them about whether any of these toxins could have a reproductive health effect. And for quite a few years now, we have looked at everything from depleted uranium to water to airborne issues.

Ms. WALORSKI. Yes.

Ms. HAYES. The other thing is I have an OB/GYN on my staff who is director of reproductive health and we have consistently looked at how to get information to the field about how to evaluate the military experience. Where was this woman?

The good news is at this point in time, we do not see patterns of reproductive health effects from military service. That is a really important message, but we are not stopping to look. You know, it continues to be an active issue for VA. If someone were to have a consideration about that possibility, we certainly would hook them up with a high-risk OB if we thought there was something going on.

Ms. WALORSKI. I appreciate it. Thank you very much.

And the chair yields to Ms. Kuster for five minutes.

Ms. KUSTER. Thank you very much.

And I want to thank the chair for her leadership on the military sexual assault issue and we continue to work on this as a bipar-

tisan issue and one that men and women on both sides of the aisle care a great deal about.

Thank you all for your service to our country and to those of you at the VA for your service to our veterans.

I want to focus in. We are very fortunate. I am from New Hampshire. We work out of the White River Junction VA Hospital and the Manchester, New Hampshire. It is not a full-service hospital, but one of the things that we have in both of those locations is brand new facilities in very old historic hospitals but brand new facilities for women.

And I just want to commend to my colleagues the notion that when these were being designed, they actually brought in women veterans, worked very, very closely particularly around I would say sort of mental health and level of comfort issues.

The design for the White River Junction for the entrance was very carefully thought through so that women would feel safe in this facility, would feel safe coming and getting care. I believe it is an all female staff for the services. So just a lot of thought went into asking the women veterans what is it that you need to come in and get the care that, you know, we are here to provide.

And I want to commend that all around the country that approach and to be, as we always talk about on this committee, veteran-centric and in this very case very sensitive.

I have worked with the chair on her concerns on military sexual trauma and I just wanted to follow-up with all of you about the availability of care for sexual assault survivors and what more we could be doing. Do you see any gaps? We would be more than happy to follow-up with legislation, but just if you have any thoughts on that topic or more broadly mental health issues generally, PTSD, traumatic brain injury, any of those thoughts that you might have.

Ms. ILEM. I would first say, you know, VA provides some of the state-of-the-art best care for survivors of sexual assault, male and female population. And in that vein, you know, we want to make sure that the providers themselves have the time to provide the evidence-based treatments that we know work in treatment and be able to spend the time with these veterans that they need.

They are often very complex cases, you know, suicidal ideation, other substance use disorders associated with depression, you know, along with PTSD. So we have expressed some concern, you know, to really want to look at those staffing levels in terms of, you know, VA has said that they have met a minimum standard across the country.

And Dr. McCutcheon could probably talk to that more, but I think our concern is, you know, has there really been an independent study done about staffing levels and the number of hours that it takes for the prescribed treatments that VA, you know, does have available in their arsenal.

And we have heard from providers in the past that they don't, you know, feel that they have the time to spend with veterans that they want and to do PTSD treatment. So that would be my point on that.

Ms. KUSTER. Thank you.

Any of the others or, Dr. McCutcheon, if you would like to weigh in.

Ms. MCCUTCHEON. If I may follow-up from some of the comments from Ms. Ilem. We report to Congress every year on our capacity to provide MST-related mental healthcare. And the report this year shows that every facility across the country does have that capacity to provide that care.

And also what Ms. Ilem said is that we are very proud that we are able to offer the gold standard of treatment for our veterans who have experienced MST. As you know, MST is not a diagnosis, but there are many diagnoses associated with MST with posttraumatic stress disorder being the most frequently, most prevalent diagnosis.

And so at the VA, we do train our clinicians on these gold standards of cognitive processing therapy, prolonged exposure. We also provide evidence-based therapies for depression. So we have this as part of our clinical treatment.

And you are right also to mention that we have many men in our system that have also experienced MST. And up to three years ago, there were actually more males in our healthcare system than women. And so we also give the same attention to our males who have had this experience.

Ms. KUSTER. Well, I just want you all to know that we have a focus on this, that we want to make sure to first of all stop the practice completely and protect all of our servicemen and women, but that we will continue to follow this very closely.

And thank you. I yield back.

Ms. WALORSKI. Thank you.

The chair recognizes Dr. Wenstrup for five minutes.

Dr. WENSTRUP. Thank you, Madam Chair.

If I may for a second go to one of your points you were making if someone becomes pregnant while on active duty in the field that initially they would be treated. They would go to DoD care rather than VA, but the same issues apply whether it is, you know, immediately at that time or down the road once they are out of uniform.

And I want to thank all of you for your service in uniform and what you are doing today.

And, Mr. Coy, welcome back. It is good to see you.

Ms. Augustine, you brought up a very good point about the words of Lincoln as you enter the building. And, you know, I was pleased when the secretary came in. That was one of the first things that he did is address that issue and make it ubiquitous for both male and female. And I think that is important today.

Obviously, you know, our highest priority is to get people into care and the situation that we are faced with today in the VA is understanding that we have, I use this figuratively, we have patients in the ambulance and they need to get to care. So the discussions of the changes we are making and expanding and things like that, those are all good, but does it help someone today.

So my question is, how much demand are you seeing for women to go outside the VA and is the demand there because the services aren't there or they prefer to go outside the VA for whatever reason? What are you finding in that regard?

Ms. HAYES. Women have had to use outside VA services in the VA system now for quite a number of years and, as I said, about 30 percent of women in a given year do use non-VA care whether it is through the contract PC3 fee basis and now we certainly openly use the Choice card for women as well as men. There is a slightly higher number of women proportionately using the Choice card than men. We are tracking it. We are just beginning to look into it.

Dr. WENSTRUP. Yes.

Ms. HAYES. But as part of our ongoing look at what is it that women need and how are we going to be able to best get it for them. Surprisingly, though, not all of the care has always been for gender-related care. When we look at care outside the VA, women need the whole gamut of care.

Dr. WENSTRUP. Yes.

Ms. HAYES. And I think that kind of reflects things like the high musculoskeletal injuries, so we have women using physical therapy outside the VA, home health assistance in the elderly veteran. You know, our range of veterans is the whole age range.

And so we continue to study what it is and to increase services in-house. I think sometimes there is a question about why we use so much non-VA care for women and it really isn't a budgetary issue. It is an issue of making sure we have the highest quality for care inside the VA.

So we don't set up a mammogram until we have a critical mass of women and we can bring the right specialists in-house, for example. And I think sometimes that gets confusing when we look at, well, why do we have such high non-VA care use. And it is really about making sure that we have the right providers in place to provide the high-quality care. And sometimes that means in the community.

Dr. WENSTRUP. Yes. And I appreciate that. I mean, what is best for the patient——

Ms. HAYES Right.

Dr. WENSTRUP [continuing]. And what do we need right now. And to be honest with you, you know, and in other hearings and as we probe into where we are going with the VA, we don't even really know what it costs within the VA compared to private sector because they can't really tell how much we are spending on all our physical plant and everything else.

So that is down the road. We need to get to that point and so that we can provide not just with women's care but all care and how we are doing it the best, but I appreciate it.

Mr. Coy, a question for you, if I could. There are steps that the Department of Labor Veterans' Employment and Training Services are taking and also Vocational Rehab and Employment Services.

Are there differences per se in the counseling that a woman gets compared to a man? Are there certain things that are different there as we look ahead or as we are doing it today?

Mr. COY. Thank you, Doctor.

I have got two or three different ways to answer that with respect to transition and then with respect to just sort of everyday situations.

With respect to transition, we, as you know, have completely revamped the Transition Assistance Program in the last couple years. And what we are dedicated to do is making sure that all of our departing servicemembers are informed consumers of their VA benefits.

We have over 300 benefits advisors that do these TAP classes. Thirty-five percent of them are women, 90 percent are veterans, and four percent are spouses of servicemembers as we are out there. So each one of those benefits advisors is keeping an eye out for some of those things that women, those women, departing women servicemembers may need or want.

With respect to VRE and those services, as you know, VRE services are case management services. They are individualized services for each of those veterans, whether they are a man or a woman. So we do that case management on an individual basis there.

Dr. WENSTRUP. Thank you. I yield back.

Dr. ROE [presiding]. Mr. O'Rourke, you are recognized for five minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

I yield one minute of my time to Mr. Walz.

Mr. WALZ. I thank the gentleman for the courtesy.

And thank you all for being here and help us tackle this issue.

Dr. Hayes, I understand cultural change takes time, but I am wondering if you could do one thing for me. I wonder if you could capture the name of this warrior that Ms. Halfaker talked about, capture that the bills weren't paid, give it to one of your assistants here and pay the bill this week. That is one less thing they should worry about and that lets us solve that.

I thank the gentleman. I give him back his time.

Ms. HAYES. We will absolutely take care of that. Thank you.

Mr. O'ROURKE. Thank you, Mr. Walz. Thank you.

Dr. Hayes, reclaiming my time, I was noting my colleague from New Hampshire's comments about a women's clinic at the VA there and she talked about an all female staff who are helping veterans in her community.

In El Paso, Texas, the community I serve and represent, I hear persistently from veterans about our women's clinic and its shortcomings, one of which is that there is one OB/GYN provider who is part time, who is male, and many of the veterans who speak at my town hall meetings, women veterans say that those who have experienced military sexual trauma are very uncomfortable with that situation.

When we talked to the VA about that, they say that they cannot discriminate based on gender in hiring and they are not going to make any changes to that situation.

In addition, we have the problem that we only have a half-time provider and you have wait times to get an OB/GYN appointment of up to six months, maybe longer, but six months is a number that we know to be true from some of the veterans we work with.

Dr. Hayes, how do you respond to that? How would you guide me in improving that situation and working with VA to make it better?

Ms. HAYES. I would like to work very closely with you on that particular issue and anyone that is having that issue about gender

of provider because of a number things. As I think Ms. Ilem pointed out, we already have a policy that says that we will honor a veteran's request for gender of provider whether it is in-house or whether we use non-VA care for that.

So that only sort of stop gaps the measure, though. The other one I would question is the issue about hiring and we already know that we have received waivers from the Office of Personnel Management when we know that we have a preponderance of a need for a female provider. And so we can go directly to that situation.

It does show the need that we have to look at each provision of gynecological care and we are starting to do that. I have already got appointments for a number of places. We are talking to the directors about this. We realize that our policy isn't making it to the ground in terms of the needs.

And so we will look at the need there, how many GYNs do they have. Some women do not have the preference for a female GYN, but many do and we are looking at being able to provide that in-house wherever possible.

Mr. O'ROURKE. Thank you.

You know, your answer alone right now is helpful to us. Perhaps there is a communication breakdown in El Paso in terms of what they believe they can or cannot do——

Ms. HAYES. Right.

Mr. O'ROURKE [continuing]. When it comes to serving the needs of women veterans in El Paso. So appreciate your answer. But, yes, I want to followup with you and let's make this situation better.

Ms. HAYES. Let's do it.

Mr. O'ROURKE. So thank you.

And then for the other panelists in the remaining two minutes that we have, I would love to get your thoughts on whether the focus should be to continue to build up capacity within the VA or, Ms. Halfaker, I thought you made some important comments about creating or pushing for excellence in how that care is referred, how it is paid for, and how it is coordinated.

When I read that the secretary is trying to hire 28,000 unfilled positions within the VA, I worry about focusing on building something up and not capitalizing on capacity that is within the community. So if you wouldn't mind addressing that. And if there is time, I would love to hear from Ms. Ilem and Ms. Augustine as well.

Ms. HALFAKER. Sure. Thank you.

I firmly believe that I think that it is taking too long to staff. I mean, we have been hearing about these staffing issues for quite some time. There has always been issues at the DC, VA where I go. And, you know, they can't seem to resolve those staffing issues and so, you know, we continue to wait six months. You know, five to six months is usually the average wait time at least for me. So I would say that, you know, we are better served.

Finally I called just very recently to try to make an appointment as I alluded to earlier in my testimony and, you know, they referred me to the Veterans Choice and said that I could call this 1–800 number if I wanted to try to get an appointment sooner if I was eligible to get enrolled in that.

And I have not followed up on that yet to call that 1–800 number, but, you know, given all that, I would think that, you know,

the VA is best served to have some kind of network where care can be provided seamlessly and, you know, information can be efficiently shared between the VA and, you know, the outside provider.

Mr. O'ROURKE. Thank you.

And, Ms. Ilem and Ms. Augustine, I am out of time. So if you wouldn't mind, I would love to get your responses for the record or we could follow-up after the hearing.

Thank you. Mr. Chair, I yield back.

Dr. ROE. Thank you, Mr. O'Rourke.

Mr. Costello, you are recognized for five minutes.

Mr. COSTELLO. Thank you, Dr. Roe.

First let me just say that as a new member of the Veterans' Affairs Committee that it is very gratifying to be able to work on issues like this with Congresswoman Brownley and Titus and Ranking Member Brown, Congresswoman Rice, Congresswoman Walorski, as well as Congressmen O'Rourke, Coffman, Roe, Wenstrup, Walz, and others.

The bipartisan focus on what is the most nonpartisan of issues which is making sure that those unique issues to female veterans related to healthcare access and opportunity and our collective desire to improve them is something that I think we should emphasize indicates that we do want to solve problems and make improvements in our country and that this committee is doing that. And I applaud Chairman Miller and Ranking Member Brown for this hearing.

I have a broad brush of a question for all of you collectively. As we await review and recommendations from the IG on the letter that we had transmitted, what are the few areas where we need to focus our efforts in the next several years for female veterans? And I would open that up both on the employment side and obviously on the access to healthcare side.

Ms. ILEM. I would just say one major gap that I think VA really needs the committee's support on is making sure about the implementation of the gender-specific clinical IT tools. There are a number of IT tools that are, you know, very gender specific that I know some of them have been pending for years in terms of the implementation and if you are able to provide some sort of push forward to make sure those go to the front of the line because many of them are life safety issues and providing better care for women.

Ms. AUGUSTINE. I will add to that and say that from our members, we are hearing that mental healthcare is one of the most critical aspects for improvement within the VA in addition to meeting the capacity of the need that is continuing to grow.

Ms. HAYES. I think that you can tell from our focus that we know we need to meet the gaps in terms of resources and staffing primary care, boots on the ground to serve our women veterans. That is absolutely number one.

We are implementing some of the changes that Ms. Ilem responded to and this will help us do better care coordination. We also have a number of apps and other ways for maternity tracking, maternity care coordination, some of these issues that have been brought up today. We already have some of the fixes in the pipeline, but the pipeline needs to move fast. I think those are really the key points for us and mental health.

Mr. COY. I will just add. You mentioned employment. As the DAV report pointed out, you know, there is really no good definitive data as to why women veterans seem to have a higher unemployment rate, although we know the demographics of women are much different than—of women veterans than they are of male veterans. Women veterans certainly are younger, more diverse, and certainly more educated than their male counterparts.

We have seen, though, employment figures drop somewhat dramatically since 2011 to 2014. In fact, 9.7 to about 5.3 today. But I think there is a lot more information that we need to get with that respect and we need a bigger push on making sure that women veterans are afforded all of those employment opportunities that everyone else is.

Mr. COSTELLO. So following up Congressman Wenstrup's question related to DoL Veterans' Employment and Training Service, is it just a function of focusing more within the framework of what exists to make sure that female veterans receive the attention or is even more of a curriculum change or something additive? I mean, I know that you said you are still looking into that, so that may be an unfair question because you are still looking into that, but any illumination on that point I would appreciate.

Mr. COY. I think it is a vexing question that we have been looking at and trying to understand as well. I think in the TAP curriculum, we have a number of things going for and some things going against.

For example, a lot of times people are six months out or four months out. They are thinking about getting out and moving and doing all those things and not focused on those kinds of things. How do we make sure that those benefits and those things that we can help veterans including women veterans are done after they transition out as well?

Mr. COSTELLO. Thank you.

Dr. ROE. Thank you.

Ms. Brown, you are recognized for five minutes.

Ms. BROWN. Thank you.

First of all, let me just say I want to thank the chairman because I have wanted this hearing for over a year and I am very excited about having it.

Thank all of you for your service and for being here today because I think this is very helpful.

As we develop a comprehensive program for women and as, women are the fastest growing group of veterans, how are we going to best address the needs as, I understand that there will be some challenges?

I personally used to go through to Bethesda for treatment. Now I go to George Washington Hospital. I like going where it is all women in the facility. Several years ago, women told the committee they didn't like going into the VA because men—would do catcalls.

So I say how in the world can we address that? We did in Jacksonville at the clinic because women have a separate entrance which works. Some of the other women say they don't want that.

So as we develop this program, what is the best to alleviate this? I think in some of the programs if the program is in the commu-

nity, we have the Choice Program, so that a veteran can go outside of the system if the system is not working.

So we can start with Dr. Hayes.

Ms. HAYES. Certainly. Your point is well taken, Representative Brown, because of the issues that women veterans need to have a voice in what is happening at their site. And so we heard about women being able to talk about how they wanted the women's center set up.

But I also would say that there are a number of women who say I don't want——

Ms. BROWN. Yes.

Ms. HAYES [continuing]. A separate women's clinic. And so what has to happen at that site is what we do have at many sites. We have a separate women's clinic and we have women's providers in the more general gender neutral primary care clinics integrated with the clinic so a women veteran does have a choice within our system as to how to receive her care.

But listening to the women in that site, in that community, I think is the only way we can provide the best care.

Ms. BROWN. Anyone else?

Ms. AUGUSTINE. Sure, I can add to that. I will say based on our preliminary survey data that 70 percent of women veterans that responded feel that VA provides a comfortable and safe environment and 30 percent do not. And I think what that reflects is the need to really listen to the women veterans on the ground as has been repeated so far.

And I think another point where that can be gathered is in peer support groups. We had a vast majority of respondents who wanted that sort of system where they could provide feedback about many different things including the care they are receiving at the VA. And I think that would be a wonderful opportunity to receive that feedback and implement community-based solutions.

Ms. ILEM. Absolutely. And the culture just at the highest levels and throughout the organization is important because women veterans aren't just going to be exclusively in that women's clinic. I mean, they may be able to provide all those primary care and some gender specific. They may have to go to lab, X-ray throughout the system to specialty clinics.

We want to make sure that throughout that system, that VISN director, the hospital director, and each department is really looking out for women and making sure that their attention, you know, has been paid to them and their needs and that they are not being called out or there is something inappropriate happening that needs to, you know, be addressed immediately at the, you know, location.

Ms. BROWN. I am very interested in your comments because you indicated that you received a Choice card and you didn't follow-up, You have yet to enroll.

Ms. HALFAKER. Yes, ma'am. I have not actually enrolled in the Choice Program yet. My understanding, there is an enrollment process. And so I literally had a conversation with the VA women's clinic a couple days ago and just haven't had time because they told me that I couldn't get an appointment for several months be-

cause they were full and that they were, you know, experiencing high volume patients.

And so they told me to call the 1–800 number for the Veterans Choice Program. So I haven't done that yet, but just to me, that is not a very efficient way to refer patients into that program. You would think that they would have kind of a more defined protocol as to how I would then, you know, go get my care through the Veterans Choice.

Ms. BROWN. I learned at my workshop in Jacksonville if a veterans calls that number, they get a list of physicians in the area and they can make a referral right then. With a wait time less than 30 days.

I would like for you to follow-up and then follow-up with us because I want to know because it is supposed to be seamless.

Ms. ILEM. And——

Ms. BROWN. Yes.

Ms. ILEM [continuing]. I would just mention, too, because Ms. Halfaker had noted earlier that when she was referred out for her maternity——

Ms. BROWN. Yes.

Ms. ILEM [continuing]. Care originally that she was asked to go find a provider and to negotiate that contract with that provider to see if they would accept the VA Medicare rate. And, you know——

Ms. BROWN. That was the Choice Program. That is not necessary.

Ms. ILEM. Right. But it shouldn't even be for fee basis if they wanted to use that method. I mean, the veteran should not be put in the middle of trying to negotiate that contract.

Ms. BROWN. Absolutely. That is right.

Ms. ILEM. VA should be doing that once they have selected a provider, but I think also the point taken that often women veterans want the referral of VA——

Ms. BROWN. Yes.

Ms. ILEM. —to make sure they are going to go to a quality provider that is certified and, you know——

Ms. HAYES. I would also like to add, though, that we won't want to lose Ms. Halfaker to VA care. She is a VA patient in our clinic. What has failed here is that we didn't make her a follow-up appointment. We knew when her baby was going to be born. We didn't make her the follow-up appointment she needed nine, ten months down the road.

I think the real issue here is about our care coordination. And while she certainly has the choice to find a new primary care provider, I would rather have us bring her back into our fold in an appropriate way and not be told that she has to wait months for an appointment. She is an established patient with us.

Ms. BROWN. What are your feelings about that, Dr. Hayes.

Ms. HAYES. Well, our maternity care coordinator——

Ms. BROWN. Yes.

Ms. HAYES [continuing]. Which we already heard were major problems in her case, but that person should be calling her monthly following up on how she is doing, should set up her follow-up appointments with the VA, and know if something goes wrong, know how she is doing, see if she needs supports after her pregnancy,

talk to her about her mental status and her psychosocial issues and her supports all the way along.

That is our model for maternity care coordination because we know they are outside our system. It is a fragmented system. We didn't do what we needed to do for her and that is what I am saying. Clearly she is our patient. We want her to be part of our fold. If she wants Choice, that is fine, but I am hearing her say that wasn't the answer to what she wanted.

And so we can go both ways with her, but I would like to say that we need to do a much better job in maternity care coordination, have more people in place, and make sure this happens for our veterans.

Ms. BROWN. Absolutely. Absolutely.

Dr. ROE. Thank you.

Dr. Benishek, you are recognized for five minutes.

Dr. BENISHEK. Thank you, Mr. Chairman.

Well, I am a father of a female veteran, so I certainly understand some of those issues. And, frankly, I am a little chagrined to hear the story about, you know, call this 800 number and then see what happens. And it seems like she should be able to get an appointment, you know, not have to make another call and then you don't know who is going to be at the end of that call or what is going to happen.

It seems like we need to have a better system of referral when we are dealing with providers outside the VA system. And I certainly understand that that would maybe need to be because, I mean, you are not going to have a gynecologic or obstetric service at a VA hospital because it is going to be sporadic as far as the need.

But I am somewhat concerned about the availability of staff. So what has changed? Ms. Hayes, you are sort of a part of it, right? Have they improved the number of providers in areas around the country so that you don't have to call an 800 number? Can a patient get a gynecologist referral without, you know, an actual appointment, without having to call around?

Ms. HAYES. Absolutely. We have increased the number of providers many, many fold. You know, we went from having only about 30 sites that had women's clinics. Now we have 2,500 trained providers over the last several years. Our issue is we haven't been going fast enough for the number of women coming in our doors.

And, you know, we have been aware of that, but it hasn't gotten down to every level, every community-based outpatient clinic, every main site. They haven't——

Dr. BENISHEK. Are you talking about physicians that are in your clinics or this is physicians in the community that are taking care of veteran patients through some contract or through the Choice Program?

Ms. HAYES. There are a number of ways that we can take care of veterans in the community. One is what used to be called fee basis, the non-VA care. Those are not contract. Those are individual authorizations.

In addition, we have what is called contract. PC3 is our acronym for it. That is a network of providers that are contracted through the PC3 provider. What that means is——

Dr. BENISHEK. No. I am familiar.

Ms. HAYES. Right.

Dr. BENISHEK. I am familiar. What I want to know is——

Ms. HAYES. So the veteran can be sent to a specific provider. And then the third option for veterans is the Choice card. And right now it is set up so that if the clerk is saying you have—what Ms. Halfaker said is accurate. They are provided a phone number because they are called and they are saying I need a Choice option. And the 800 number gives them a list of providers that they can see in their area for that condition.

Dr. BENISHEK. It doesn't sound like the best of techniques because it leaves the onus on the patient to find the provider. I mean, it seems to me that a patient is seeing a provider within the VA, here, call this number and make an appointment. Why can't the appointment just be made while the patient is in contact with you?

Ms. HAYES. I think it is in terms of what many of our veterans want about an outside provider that they actually want to see. That is part of why the system was set up that way. But I appreciate your comment that for a veteran who doesn't know exactly, rather would see VA, we need to do something different in terms of care coordination on that end.

Dr. BENISHEK. All right. Thank you.

Where are you in your hiring for providing specialty care like gynecology? I mean, where are you in your process? Do you have enough of those providers or what is the story there?

Ms. HAYES. We are not clear on whether this issue is really recruitment. We are looking at the 35 sites that do not have gynecology on site. And many of them have fewer than a thousand women. So in terms of workload, that is not why we are looking at this. We are looking at it in terms of making sure the knowledge base is on site.

And so the issue of our workforce and what we exactly need is one that we are doing a close study on right now as part of our overall workforce planning model. And I don't have the answers for you right now exactly what we need at those sites.

Dr. BENISHEK. But do all the CBOCs have a staffing plan or do they have a referral plan? I mean, if Ms. Halfaker walks into a CBOC in my district, is she going to get an 800 number? Where will the gynecologist be?

Ms. HAYES. She will be referred through the non-VA care or the PC3. It would be only if she said I want to use the Choice Act because in a community-based outpatient clinic, we don't have gynecology on site.

Dr. BENISHEK. Right.

Ms. HAYES. Likely either the main facility or they would use telehealth or they would use a non-VA care arrangement in order to get the gynecologist that they are working with.

Dr. BENISHEK. All right. Thank you. I am out of time.

Dr. ROE. Dr. Benishek, thank you.

If anyone has any further questions, I will open a second round, but only for two minutes because we have a fairly busy agenda this afternoon. I guess Ms. Titus should be first, yes.

Ms. TITUS. Thank you all. I appreciate the information you provided us.

One thing that bothers me is when you say you don't have a gynecologist, but you have a person who will give a PAP smear and a mammogram. I would ask every woman in this room how many of you go for those annual exams to a general practitioner as opposed to a gynecologist? I do not think you would see very many hands go up.

Ms. HAYES. Well, if I could say, one of the things that VA——

Ms. TITUS. No. I just want to make that point.

The second point I want to make, though, is to give a shout out to a young woman whose name is Nadine Noky and she lives in Venice, Florida. And she is an Iraq veteran. And it goes to that point of culture transformation.

She said she wanted people to know she was a veteran. She was proud of that, but she couldn't find anything to wear. Everything was designed for men. So she started her own T-shirt company called Lady Brigade. She prints T-shirts that say this is what a veteran looks like that fit women or one that says any girl can wear heels, but it takes a woman to wear combat boots or another one that says mother, sister, soldier.

I got to give her credit for that. I mean, what a great way to wear your pride on your T-shirt. I just want to tell her I think that is great that she is doing it.

Thank you, Mr. Chairman.

Dr. ROE. Thank you.

Mr. O'ROURKE. Thank you, Mr. Chair.

So I do get a chance to hear from Ms. Ilem and Ms. Augustine on how we balance staffing up to an adequate level within the VA, but also acknowledging that we are unlikely to get to the idea on the near future and that as Ms. Halfaker suggested, we need to promote excellence and coordination of care.

And so, Ms. Ilem, if we could start with you.

Ms. ILEM. I think the coordination of care point is absolutely essential and I think Dr. Hayes has referred to that. You know, I think, you know, keeping women veterans in the VA system to make sure that they can have comprehensive care and the benefits from the system, everything that it has to offer, especially for service-disabled veterans, and when there is an issue of, you know, staffing levels, I mean, we know people leave, we know people—they have trouble recruiting in certain locations.

I think assisting that woman veteran and making sure that there is really that care coordination piece which is an overall problem, not just for women, but I think for women veterans, it is especially important is because a high number or a high percentage have to use outside care.

And that is really what VA researches have indicated. We don't know what happens when you go outside of VA. We don't have the data. And they are working hard now to really look at women, specifically women veterans and the impact of military service on their care, so they are going to have better care at VA, a better opportunity, and to keep them in when they can and better coordinate that care when they can't.

Ms. AUGUSTINE. I would echo what Ms. Ilem said. We think that the VA can provide excellent care for veterans that is specific for veterans and unique to veterans, but we also want to make sure

they are receiving that care in a timely manner. And if that is not being met, then outside care is necessary. And above all of that, coordination between that outside care and the VA is critical to maintaining a strong bridge between the two groups.

Mr. O'ROURKE. Thank you.

Dr. ROE. I thank the gentleman for yielding.

Ms. Brown, you are recognized.

Ms. BROWN. Thank you.

I have to tell this quick story. When I was first elected in 1992, the Orlando Hospital was closing because of BRAC. We contracted the Department of Defense and the facility was given to VA. Female veterans need separate facilities where their examination can be conducted. There is a lot that goes into the planning and making sure that the facilities is accommodating for women veterans.

But, Dr. Hayes, my question pertains to research. Very little research has been done on women veterans, whether it is through VA or through the National Foundation of Health.

What are we doing to make sure that certain ailments pertaining to women veterans that benefit the entire American fabric once we do this research, where are we?

Ms. HAYES. I would thank you for the question because I think actually we have done a significant amount of research. And my office works very closely with VA office research and also with NIH and the Office of Women's Health and HHS in order to put forth an agenda for research on women.

And about half of that research has been on mental health issues in women veterans and making sure that our treatments for women are as robust as they are, have already been shown as they are for men.

We have published more research on women veterans in the last four or five years than in the previous 25 years combined. But more than that, we have established a practice-based research network in VA so that now any research, you can't say, well, I don't have enough women to do research on because we have about 150,000 women veterans that are subject to that possible pool of research subjects.

So I would say that we need to continue to look at our research agenda, but that we have really done a lot to make sure that the issues for women veterans are represented in the research portfolio.

Ms. BROWN. Good. Would you give us an update as to where we are on some of the research that has been done? You say you published it, but we would like to have that information so we could share it with other members.

Ms. HAYES. Certainly. We can certainly provide that to you. And we also have a Web site that we have for veterans and for the public that is a synthesis of research in the VA. Be happy to send you that as well.

Ms. BROWN. Thank you.

And thank you, Mr. Chairman. And thank you—yes, ma'am.

Ms. ILEM. And if I could just mention one thing on the research. They have included the VSOs on that. Some of the premier researchers, Dr. Becky Yano within VA have reached out to the VSO

community. And I have made recommendations to IAVA and others to make sure that they have us included on their work groups.

Ms. BROWN. A lot has changed because at one point, women were not included in a lot of the research and in the specimens, the trial specimens. So that has changed.

Ms. HAYES. Absolutely it has changed. And I appreciate your reminder that we reached out and we have an oversight or a commentary committee of veterans about the research, about the direction of the research, about the issues that we are looking at in research because that is really critical to us being able to do the right research on women veterans.

Ms. BROWN. Thank you.

Thank you, Mr. Chairman.

Dr. ROE. Thank you.

And I would ask the ranking member if she has any closing remarks?

Ms. BROWN. I just want to thank you all for your service and thank you for your testimony. I am looking forward to the second panel.

Dr. ROE. Thanks very much. This is the only panel.

In closing, Dr. Hayes, thank you for your work that you are doing. Obviously things have improved, I think dramatically to VA as far as women's health issues are concerned. So thank you for your perseverance in doing that.

Always take some bullet points away from the hearings when you hear the testimony. And one is pay the bills. That is not very hard. Well, bill will do that. That should be fixable today, tomorrow, whatever.

Number two, just like any other insurance plan, if I have a private insurance plan, I have a group of providers on there that my insurance plan has worked out for me to go see. And if I don't like that, next year when I get my insurance plan, I will get a different plan.

So I think the VA ought to be looking at trying to provide a list of providers. That was clearly a problem when they had to go out and seek these on their own. I think that is something the VA can do for the veteran.

And thirdly, I heard that we need someone to make sure that there is a—I mean, in my situation, it is a physician-patient relationship—to make sure that someone coordinates that care. And there is care that the VA needs to send out because, as you pointed out, maybe in some places, there is just not enough patients to keep somebody there. So we need to have someone in those facilities and make sure that you knock all those hurdles away from people so it doesn't get so frustrating that some of them will just quit looking.

So I think those are the few things I would like to see. And then on the Veterans Choice card, I was informed that we are going to have a hearing in a couple of weeks on that which I think we should. There are certainly some hiccups out there that have been pointed out to me already.

But I want to thank all of you all for being here and your great testimony has really been helpful to me. The committee will be pos-

sibly submitting further questions to you all. I would appreciate a quick response on that.

Without any further comments, the meeting is adjourned.

[Whereupon, at 12:33 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN JEFF MILLER

The Committee will come to order.

Thank you all for joining us for today's oversight hearing, "Examining Access and Quality of Care and Services for Women Veterans."

Women have been serving our nation in the Armed Forces since the Revolutionary War but—today more than ever—they are an important and increasing population of veterans served by the Department of Veterans Affairs with their numbers expected to grow even as the veteran population as a whole is projected to shrink.

The women of the modern military excel in a variety of roles—as medics, pilots, civil affairs specialists—as officers and enlisted.

They follow in the footsteps of the WAVES and the WACS of World War II and the Nurse and Medical Specialist Corps of the Korean and Vietnam wars.

The service they provided was not dependent on their gender and the services the VA is charged to provide to them—while being respectful of their unique perspectives, needs, and concerns—should not be either.

Women veterans are just that—veterans—and, as such, they are deserving of the same respect, attention, and consideration that is afforded to the male veterans with whom they served alongside.

However, last year, the Disabled American Veterans (DAV) released a report that found serious gaps in every aspect of programs that serve women veterans.

According to DAV, "[t]he vast majority of these deficiencies result from a disregard for the differing needs of women veterans and a focusing on the eighty-percent [80] percent solution for men who dominate in both numbers and the public consciousness."

That is unacceptable.

Today, I will be requesting the Government Accountability Office (GAO) conduct an assessment of VA's ability to improve the healthcare access and quality of women veterans.

GAO last conducted an investigation on healthcare for women veterans in 2010 and found that availability of services for women varied significantly across the VA healthcare system and that VA faced a number of key challenges in providing healthcare to women veterans.

In the intervening five years, VA has made some strides in improving healthcare for women veterans but too many gaps remain.

[Especially considering that, just yesterday, GAO informed me that VA had yet to provide documentation to show that VA had implemented two of the five recommendations made in that report. Awaiting Final GAO Confirmation]

I am hopeful that, through GAO's effort and this hearing, we will discover the extent to which VA has improved services for women veterans, where challenges to quality care and services still persist,

and how those gaps can be overcome once and for all—both for the women who are in VA care today and for the thousands of women who will transition into VA care over the next several years.

PREPARED STATEMENT OF RANKING MEMBER, CORRINE BROWN

Thank you, Mr. Chairman, for calling this hearing today.

In the 14 years of war and sacrifice following 9/11, American women have stepped up in greater numbers than ever before to defend their country by joining the military.

Across the services, women have put their lives on the line in Iraq and Afghanistan. One hundred sixty one have lost their lives in the effort. Another 1,003 have suffered life-altering physical wounds. And in all, 280,000 have served and returned home to transition back into civilian life.

Today, women are the fastest growing group of veterans. There are currently 2.2 million of them who are eligible for benefits and services through the Department of Veterans Affairs. These are hard earned benefits designed to assist female veterans through the all too often difficult transition process. However, according to the Department of Veterans Affairs, more than one-third don't even self-identify as veterans. It is taking time for the country as a whole to recognize, understand and acknowledge their contributions because with less than one percent of the population serving, so few Americans are in direct contact with any servicemember, much less a female servicemember.

I would like to applaud the VA for their hard work and dedication in this area. I know that Patricia Hayes has been the lightning rod for VA focusing on the needs of women veterans. VA has taken great strides in the past two decades to ensure facilities and services are available for those who choose to seek services at VA and close the gender gap.

Having said that, Mr. Chairman, we know much more needs to be done. I am somewhat amazed that even at the VA, we hear women veterans are often sidelined by VA employees and other veterans who assume they are the wives or daughters accompanying the male veterans there. The VA has had to retool its signage because until recently, women soldiers were not represented in the photographs on the walls or depicted in the pictures in the pamphlets veterans receive at VA facilities.

When asked, women veterans say they want timely, high quality, gender-specific care. They want it in an atmosphere of recognition and respect where there are opportunities for social interaction, and they tend to need help with child care and transportation to make appointments. What this means is that if the VA is to fulfill its obligation to all veterans, primary care, mental health and specialty care must be gender-specific, comprehensive and integrated specifically to meet women veterans' needs.

I have three bills I want to mention at this hearing today that I believe will help VA in this mission.

The first is H.R. 1575, a bill I introduced that would expand and make permanent a successful pilot program providing mental

healthcare in retreat settings for recently returned women warriors who have been diagnosed with PTSD.

The second bill, H.R. 1948, introduced by Health Subcommittee Ranking Member Brownley, extends the VA's authority to provide drop off child care at VA medical centers and Community Based Outpatient Clinics so veterans caring for children do not have to miss appointments. I am pleased to be an original cosponsor of this legislation.

The third bill, H.R. 2054 I have introduced, requires that gender specific services be continuously available at every VA medical center and community based outpatient clinic. It also directs that the necessary personnel be hired and contracts signed to provide gender specific services based on Departmental standards, demand, and the projected growth of the demand.

Mr. Chairman, I want to thank the witnesses for being here this morning. I look forward to the ideas and suggestions and yield back.

TESTIMONY

OF

DAWN HALFAKER

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

"EXAMINING ACCESS AND QUALITY OF CARE AND SERVICES FOR WOMEN VETERANS"

APRIL 30, 2015

Mr. Chairman and Members of the Committee:

Thank you for holding this hearing and for inviting me to testify. I've come to appreciate how vital this Committee's oversight has been to beaming a spotlight on the unique challenges facing women Veterans and to developing important legislation to meet those needs. Yet women Veterans continue to confront serious gaps in government programs, as you have acknowledged in convening this hearing.

This morning's testimony raises issues that have long been of deep concern to me. I began a military career after graduating from West Point in 2001 which was cut short after being seriously wounded in combat while serving in Iraq in 2004. Though no longer in uniform, I've continued to advocate for my fellow Wounded Warriors, Veterans and their Families through my affiliation with several nonprofit organizations such as USO and Wounded Warrior Project as well as my own Service Disabled Veteran Owned small business where I employ Veterans and Wounded Warriors.

My testimony today reflects some of what I've learned as a volunteer and advocate; but most of what I'll share with you reflects what I've learned as a patient in the VA medical system.

I use that system proudly, recognizing that VA care is an entitlement and a promise for those of us who served. I want the system to work, to help our Veterans and to ensure that this promise is kept for all Veterans. And I welcome the opportunity to share the observations and insights I've gained as a VA patient and beneficiary. In doing so, I've tried to be fair in applauding VA's successes while relating its failings.

I do recognize the progress that's occurred in just a generation from a time when there was no VA women's program, and where VA hospitals couldn't provide women patients even the most basic privacy. VA has really come a long way. Yet the Department still has a way to go to close the gaps DAV has ably portrayed in its excellent report, "Women Veterans: The Long Journey Home."

My own contribution to this dialogue is probably best focused on my recent experience receiving maternity care through the VA. While the DAV has done the Committee a great service with its panoramic overview of government programs, there is something to be said for drilling down to examine particular problem areas. Maternity care is an instance of an almost hands-off approach that leaves women Veterans without sufficient support during a particularly vulnerable period. Overall, VA's administrative stewardship of maternity care is poor, and causes unnecessary trauma. I believe the problems I encountered are largely systemic in origin and I know my experience was not unique. In short, I believe my experience holds important lessons that beg for changes I hope you'll elect to champion.

Providing maternity care is, of course, not a VA pilot program or something VA has just started up. To the contrary, maternity benefits have been included in VA's medical benefits package since 1996. The Veterans Health Administration (VHA) has also published detailed procedures for furnishing and coordinating maternity care for women veterans.[1] Importantly, VHA states that "[t]hese procedures establish a VA-wide standard of practice for maternity care and its coordination."[2] And it emphasizes to field staff the likelihood that their facilities' patients will include pregnant veterans. This is "[b]ecause women Veterans are the fastest growing group of new users of VA health services."[3] VHA's directives for maternity care set very clear expectations:

- Benefits begin with confirmation of pregnancy and continue through the postpartum visit;
- Maternity care will typically be delivered by non-VA providers in accredited non-VA facilities;
- Women Veterans continue to receive care through VA facilities during their pregnancies either for management of co-existing conditions, for lab-testing, or medication management;
- "Coordination of care and information sharing between all providers, including non-VA and VA providers, is critical to patient safety;" and
- "Each facility must ensure seamless coordination of non-VA maternity care with VA care."[4]

On the face of it, VA's expectations for maternity care as set out in these required procedures look great. But they fall short in what they fail to require. And just as important, while they set an appropriately high bar on paper, some of the most critical of those expectations are piled on a single individual, the medical center's Maternity Care Coordinator. (VHA identifies more than a dozen specific tasks for which the coordinator is responsible.[5]) In my case, certainly, that individual failed at critical points to meet key responsibilities. So rather than experiencing

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[1] Veterans Health Administration, "VHA Handbook 1330.03: MATERNITY HEALTH CARE AND COORDINATION," Oct. 5, 2012.
[2] Id., sec. 1.
[3] Id., sec. 3.a.
[4] Id., secs. 3, 5.
[5] Id., sec. 10.

seamless coordination of my maternity care, I felt abandoned at times during this emotionally vulnerable period -- left alone to navigate some difficult challenges and to advocate for myself.

Where did things go wrong? At the outset, my VA Maternity Care Coordinator handed me a list of DC-area maternity-care providers, though quickly warned, "we can't really make any endorsement and you need to find a Doctor who will sign this VA contract…which pays Medicare rates." Surely, even if it wouldn't endorse anyone, I thought the medical center would have had a network of OB/Gyn providers with whom it contracts for maternity care, and that I wouldn't have to find a provider who was willing to accept VA's terms. So I was surprised to learn that the DC VA hadn't established a contract with any of these providers, not even with facilities with which it had long-established formal relationships like George Washington University Hospital Medical Faculty Associates (GWU) where I ultimately elected to get care. As it turned out, I was lucky to have chosen a GWU physician, as her office had previously treated another Veteran patient, and had learned how VA operates. That office showed a sensitivity and compassion that, unfortunately, I didn't experience from my VA care coordinator.

While my maternity and obstetrical care were excellent, I soon learned the implications of the VA's administrative process, or seeming lack of process. VA is simply a maternity-care bill-payer. But it doesn't carry out even that limited role very efficiently. For example, my doctor routinely had lab work done with each of my office visits, and I'd receive copies of each bill the lab-services company, LabCorp, sent VA. But because VA was exasperatingly slow in paying bills, LabCorp began billing me. This might have been understandable, had it been a one-time snafu. But since my care-coordinator didn't or couldn't fix the problem, the unpaid bills kept mounting. I was soon getting collection notices that nonpayment would jeopardize my credit. (I'd be pleased to provide for the record copies of these notices or other pertinent documents.)

This wasn't the only instance of being stuck in the middle of a tug of war between a provider of medical services and VA. During the pregnancy my doctor was concerned by signs suggestive of a fetal heart problem, and urged that I get an echocardiogram. She referred me to Children's Hospital for this procedure. I knew that VA's policy in such situations required advance notification and pre-treatment approval. But my Maternity Care Coordinator's response to my notifying her of the referral to Children's was anything but helpful. Approval would take several weeks, she advised, because the DC VA had no previously established relationship with Children's. I was both incredulous and alarmed. I remain amazed that with its busy women's clinic, the VA medical center had no relationship with nearby Children's Hospital and its specialized services. But, with my child's well-being potentially at risk, the prospect of waiting "weeks" to get an okay for a needed procedure was just not right, prior relationship or not. It apparently would have taken weeks if I hadn't been able to advocate for myself. In fact, it wasn't until I insisted that I would record our conversation and bring it to the attention of my Congressman that my Coordinator took action, and VA finally did arrange with Children's for the procedure.

The good news was that the testing revealed that there was no cardiac abnormality. But soon I was again stranded in the middle and getting bills, this time from Children's Hospital. It took some eight weeks and a conference call with VA officials in the local fee-basis office and in

Austin, TX, to clarify that VA had paid Children's. But I finally also learned that VA's payment had covered only a small fraction of the hospital's charges. Children's demanded that I pay the difference of $1,719.60!

In reaching out unsuccessfully to my maternity care coordinator to help resolve this "catch-22," I eventually learned that she'd been out for several weeks with her own pre-natal issues. (Not only was maternity care a single person's responsibility, but there was apparently no back-up in the event of this individual's absence, and no mechanism to alert patients to her unavailability.) I was very lucky to have been contacted during this period by my VA OIF/OEF case manager (who reaches out periodically). After I explained the problems I'd been having and asked for his help, he stepped in and essentially took over my maternity care coordinator's job.

With VA appearing to place increasing reliance on purchased care, VA patients should not have to rely on good luck to have a successful experience. I was lucky to have gotten help from a VA employee who went beyond his job description to help solve a problem. And I was lucky that I was in overall good health during my pregnancy and did not have to depend on VA clinical staff coordinating with my non-VA physician, as I got no indication as to who would manage any needed coordination.

I don't want to make too much of my own frustrations. My real concern is for the many others who may confront similar problems, and particularly for those who lack the tools to navigate through such challenges. Who are these Veterans? One large VA study found that of more than 43,000 women Veterans under 50 enrolled in VA care from October 2001 through April 2008, the more than 2900 with a pregnancy tended to differ significantly from those without a pregnancy. Among those differences, those with a pregnancy were more likely to be younger, unmarried, to have less education and more likely to have been enlisted than officers. Veterans with a pregnancy were also more likely to have a service-connected disability and more likely to have one or more distinct mental health diagnoses (32% vs. 21%). The most common diagnoses among those with a pregnancy were anxiety, depression and PTSD. Surely this is a vulnerable population.[6] This study raises other real concerns. Among them is the finding that rates of anxiety, depression and PTSD were twice as high among pregnant women Veterans as among those who were not pregnant. The study authors note that "because VHA does not provide routine prenatal care at most of its locations, we were unable to determine if the women were receiving prenatal care or the degree to which prenatal care was coordinated with ongoing VHA mental health care."[7] I would echo the concern the study authors voice regarding what amounts to a dual system of care when pregnant Veterans get VA care for mental health and other problems and prenatal care through non-VA providers. They caution that "[t]his…may lead to lack of coordination among care providers, which may present problems for management of pregnancy if non-VHA obstetrical providers are unaware of women Veterans' mental health problems or medications they may be taking for these problems."[8]

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[6] Kristin Mattocks et al., "Pregnancy and Mental Health Among Women Veterans Returning from Iraq and Afghanistan," 19 Jnl of Women's Health 12, (2010)
[7] Id., 2163.
[8] Id., 2160.

We have, of course, seen improvements in VA's care of women Veterans, but at what pace? We're often reminded that "this is not your father's VA." That's certainly true of the DC VAMC, where the women's clinic serves about seven thousand women Veterans today. Unprecedented numbers of women have served in the military during Operation Iraqi Freedom and Operation Enduring Freedom, and been deployed to these war zones. Studies suggest that OEF/OIF women Veterans are among the fastest growing segments of new VHA users.[9]

With those developments, I'm troubled by a response from a VA official to systemic problems regarding women Veterans' care that says "the good news for our health care system is that as the number of women increases dramatically, we are going to continue to adjust to these circumstances quickly."[10] I'd suggest that the time for "adjustment" is now, particularly with respect to maternity care.

Let me offer the following recommendations relating to my experience for your consideration:

1. Women Veterans should be afforded access to high quality maternity care. The burden should not be on the veteran to find qualified obstetrical care.

2. Obstetrical care should not start with a pregnancy test; it should start with pre-conception counseling to ensure a woman Veteran is as healthy as possible before conception to promote her health and the health of her future children.

3. If VA is going to outsource that care, it must be seamless. VA medical centers should contract with a single high-quality provider, such as GWU, or network of providers, so that the Veteran can be assured of receiving excellent care where experienced clinicians are sensitive to the unique needs of Women Veterans and the Veteran does not bear any burden or cost associated with that care.

4. Pregnancy is a vulnerable period during which the woman veteran should have reliable, ongoing support; there cannot be a single point of failure. I applaud VA's direction that pregnant Veterans be assigned a maternity care coordinator, but that requires not only an adequate level of staffing, but appropriate training to assure a high quality and consistent level of 24/7/365 service.

The adoption of these recommendations would address only one of a number of important issues facing women Veterans. But the underlying principles have wider application as VA places greater emphasis on purchased care. VA's reliance on outsourcing care must not place the veteran-patient in financial peril. Purchasing care, particularly where VA is managing aspects of a veteran's care and a non-VA provider is managing other aspects, is likely to require real coordination and dialogue, not simply exchanging treatment records weeks after care-delivery.

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[9] Id.

[10] Garance Burke quoting Dr. Patricia Hayes, "VA Falls Short on Female Medical Issues," Associated Press (June 22, 2014), accessed at http://bigstory.ap.org/article/ap-impact-va-falls-short-female-medical-issues

In these circumstances, case-management is critical. These represent real challenges that will not be met simply by publishing directives.

Women Veterans look to you and to your oversight to help ensure that VA meets these challenges

Thank you for the opportunity to share my perspective.

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STATEMENT OF
JOY J. ILEM
DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 30, 2015

Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this hearing examining the unique barriers women veterans face accessing health care, benefits and services at the Department of Veterans Affairs (VA). Ensuring that women veterans gain equal access to benefits and high quality health care services is a top legislative priority for DAV. We have a long-standing resolution from our membership of 1.2 million service-disabled wartime veterans that seeks to ensure VA health care services for women veterans, including gender-specific care, are equitable and provided to the same degree and extent that VA services are provided to male veterans.

As a service-disabled veteran, I know first-hand the challenges women face during military service and when they return home. I, like many women who served, did not understand on leaving military service the benefits and services to which I was entitled, despite the fact that I suffered an injury during my service as an Army medic while stationed at the Army 67th evacuation hospital in Wurzburg, Germany. It was not until nearly a decade after I had discharged from the military that a fellow veteran contacted me and told me about DAV. I had sought care in the community for years for my service-related injury, so he urged me to file a VA disability claim and seek VA treatment. I resisted for months and remember asking him, "are you sure I can use the VA health care system?" I didn't think of myself as a veteran, and knew next to nothing about filing a disability claim or for which benefits I might be eligible. Today, many women who have served still do not readily self-identity as veterans. The good news is a concerted effort is underway to change this trend and ensure that women veterans are recognized for their military service and gain information about their rightful benefits.

The number of women serving in the military, their roles, and their exposure to combat has dramatically changed during our war years in Iraq and Afghanistan. Likewise, over the past decade we have seen a dramatic rise in the number of women seeking health care and other benefits from VA which placed new demands on the system. According to VA, the number of women veterans using Veterans Health Administration (VHA) services increased by 80 percent between fiscal year (FY) 2003 and FY 2012.[1] Currently, over 635,000 women veterans are enrolled in the VA health care

[1] U.S. Dept. of Veterans Affairs, VHA, Office of Patient Care Services, Women's Health Services, "Sourcebook: Women Veterans in the VHA, Vol. 3: Sociodemographics, Utilization, Costs of Care, and Health Profile." Feb 2014.

system, and over 400,000 actively use VA health care; more than double the number of women who used VA health care in the year 2000 (160,000).[2]

Along with this significantly increased demand, VA experienced a shifting age demographic and inclusion of younger women veterans enrolling in VA health care, which required significant changes in both policies and clinical practice. According to VA, the number of women veteran patients under 35 years of age has increased by 120 percent between FY 2003 and FY 2013.[3] New providers with expertise in women's health were needed; clinical space in many locations was insufficient to meet rising demand; and privacy and safety concerns were prevalent. VA providers suddenly needed to be knowledgeable about reproductive health services, conducting breast and gynecological examinations and awareness about the possibility of pregnancy when treating younger women of child-bearing age to ensure medications and recommended treatments did not pose a risk of birth defects. Many VA providers were not seeing enough women patients to be proficient in women's health, necessitating VA to institute a mini-residency program to help clinicians refresh their knowledge and skills. Prenatal and obstetric care is almost exclusively referred to private providers, and mammography services are provided by non-VA providers for about 75 percent of enrolled patients through VA's fee basis medical care program, complicating coordination of care for women veterans.[4] Other new trends in this population that impact health policy and planning became evident as well.

According to VA, more than half (57 percent) of women veterans under VA care are service disabled, some of whom are very young.[5] These women will be eligible for lifelong VA care for their service-connected conditions. Women veterans were also presenting with unique post-deployment health care and mental health needs. More than half (57 percent) of the women who served in the wars in Iraq and Afghanistan (OEF/OIF/OND) have sought VA care following military service and have targeted health care needs, including chronic musculoskeletal pain; mental health conditions including post-traumatic stress disorder (PTSD), anxiety, depression, and substance-use disorders (SUD); genitourinary, endocrine and metabolic disorders; and respiratory conditions.[6] Given the greater exposure of service women to combat, the specific medical profile of this group, and women who have sustained traumatic war-related injuries, it became clear there was a need for adjustments to not only primary care services but specialized care, transition services including supportive counseling, and psychological services.

To address these challenges, VA launched a five-year plan to redesign the women's health care delivery system in 2008, with a goal of reducing fragmentation of care and ensuring women receive comprehensive primary care services, including gender-specific care, by competent clinicians. To date, significant progress has been made to implement comprehensive primary care and patient-centered medical home programs (patient aligned care teams, or PACTS, to include

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[2] United States. Cong. House. Committee on Veterans' Affairs. U.S. Dept. of Veterans Affairs Budget Request for FY 2016. Hearings, Feb. 11, 2015. 114th Congress. 1st Sess. Washington (Statement of Robert McDonald, Secretary, U.S. Dept. of Veterans Affairs.)

[3] U.S. Dept. of Veterans Affairs, "Sourcebook: Women Veterans in the VHA, Vol. 3." Feb 2014.

[4] Elizabeth Yano, PhD, MSPH. VA Women's Health Research Network, Center for the Study of Healthcare Innovation, Implementation & Policy, Spotlight on Women's Health Cyberseminar "Women's Health CREATE Overview." January 27, 2014. PowerPoint presentation.

[5] U.S. Dept. of Veterans Affairs, "Sourcebook: Women Veterans in the VHA, Vol. 3." Feb 2014.

[6] Dept. of Veterans Affairs, VHA, Office of Public Health, Epidemiology Program, "Analysis of VA Health Care Utilization Among OEF, OIF and OND Veterans." 4th Qtr FY 2014. Released Jan. 2015.

integrated mental health, clinical, pharmacy, and social work support) for women, to increase capacity in women's clinical services, and to ensure that VA health professionals are properly trained and skilled in women's health through its mini-residencies in women's health programs. Nevertheless, VA is still working to ensure that women gain access to comprehensive primary care services throughout its health care system as evidenced by the absence of a Designated Women's Health Provider (DWHP) at 10 percent of VA community-based outpatient clinics (CBOCs) and no gynecologists at one-third of VA centers, as well as continuing deficits in safety, privacy and related physical space.[7] While these primary care clinicians are able to provide basic gender-specific care, gynecologists are still necessary to provide women specialized care such as surgery and more complex procedures.[8]

Even though gaps in services still exist for women, we applaud VA's efforts to date and the exceptional work done by the Women's Health Services (WHS) program office in collaboration with VA's women's health researchers, to improve access and quality. We are especially pleased about VA's efforts to improve reproductive services and its specialty workforce for women including the development of "Maternity Tracker" software to enhance coordination of care between VA and community providers in caring for women veterans who are pregnant, as well as VA's focus on enhancing the quality of care delivered in VA emergency departments.[9] Measurable progress has been made and we now urge the new leadership in VA to develop a specific timeline and include targeted resources to complete the goals set out by the WHS.

Despite all of the positive changes over the past decade, women are still frequently under-recognized for their military service. Transitions can be more complex for women who served in a combat theater as they process what they experienced while deployed, and return home to deal with societal assumptions that women are not exposed to direct combat. Today women serve on female engagement teams; as military police; truck drivers; fighter pilots; combat medics; trauma nurses and physicians; and a variety of other occupations that expose them to the same dangers as male service members. It became clear to DAV that if we wanted women to be valued and recognized for their military service, and have VA meet their unique needs, it was essential for VA staff and care providers to be aware of the diverse range of modern military experiences of women.

For these reasons, over the past decade-plus of war DAV has made it a priority to highlight and celebrate the stories and experiences of women serving in the military and to address the distinctive issues and barriers they face when they return home. We have sponsored three Congressional screenings of documentaries focused on women veterans—followed by panel discussions with the women featured in the films to spark dialogue among policy makers. DAV sponsored a "Stand up for Women Veterans" campaign and produced two special edition magazines highlighting service-disabled women veterans. DAV's efforts are aimed at ensuring that women are treated with the same dignity and respect provided to male veterans and that they receive equitable benefits and services. Women veterans consistently tell us they do not want or need *special* treatment—but simply access to the *same* treatment and consideration afforded to male veterans.

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[7] DAV Special Report, "Women Veterans: The Long Journey Home." September 2014.

[8] United States. Cong. Senate. Committee on Veterans Affairs. Fulfilling the Promise to Women Veterans. Hearings, Apr. 21, 2015. 114th Congress. 1st Sess. Washington (Statement of Dr. Patricia Hayes, Chief Consultant, Women's Health Services, Veterans Health Administration.)

[9] Ibid.

In 2014, with the wars in Iraq and Afghanistan winding down and women turning to VA in record numbers, DAV commissioned a special report on women transitioning from military to veteran status. *Women Veterans: The Long Journey Home* (hereafter Report) presents a comprehensive assessment of the existing programs and services women veterans are provided by the VA, and the Departments of Defense, Labor and Housing and Urban Development (HUD). The Report highlights that despite a generous array of government provided benefits to assist veterans with transition and readjustment, serious gaps are evident for women in nearly every aspect of current federal programs. Although DAV's Report addresses programs across the federal landscape, I will focus my testimony and recommendations primarily on the services that involve VA.

Since the release of our Report, we have been repeatedly asked why so many identifiable gaps exist in services for women. The answer is simple—the vast majority of these deficiencies result from a disregard for the differing needs of women veterans and a historic focus on developing programs to meet the health care needs of men, who are prominent as veterans in both numbers and public consciousness. Although there has been dramatic growth in the number of women coming to VA, they will always be a statistical minority within the system. VA has an estimated 6.6 million users; of these, women represent only about 6.8 percent of the patient population.[10] This reality poses a number of specific and ongoing challenges for VA, but these challenges can and must be resolved.

DAV's Report identifies 27 key policy and programmatic recommendations necessary to overhaul the culture and various services provided by the federal agencies mandated to assist veterans. I urge the Committee to review our Report in its entirety; however, for the sake of brevity in my statement I will focus on three areas of key concern:

- Today, women veterans lack consistent access to a full range of primary care and gender-sensitive benefits and services.
- Many specialized transition programs developed to assist veterans have not been tailored to meet the unique needs of women veterans—especially those returning from war-time military service.
- The federal government has not ensured that the staffs of each agency responsible to serve veterans, and the elements within them, are promoting a culture that fully supports women veterans.

Access to Equitable Quality Health Care

We recognize that some VA health care facilities serve only a small number of women, or have experienced difficulty in recruiting or retaining specialty providers in certain locations; however, these services are essential to providing comprehensive health care. We urge the Department to reallocate the necessary resources to ensure women veterans gain access to a full continuum of gender-specific, age-appropriate, high quality health care at all VA facilities.

- VA needs to ensure access to gender-specific health care services for women veterans by requiring every VA medical center to employ a part-time or full-time gynecologist and ensure round-the-clock access to such services in emergencies. VA should explore the wider use of e-consults and tele-gynecology to address existing limitations to veterans' access to these gender-specific services in certain locations.

[10] U.S. Dept. of Veterans Affairs, "Sourcebook: Women Veterans in the VHA, Vol. 3." Feb 2014.

The last Government Accountability Office (GAO) report on women veterans programs, in 2009, reported on the extent to which VA personnel were following existing health care delivery policies, and identified key challenges that VA facilities were experiencing in providing care to women. GAO conducted a series of site visits to VA medical centers, CBOCs and Vet Centers, and identified variability in delivery of gender-specific services and documented a number of related challenges including space constraints that impacted patient privacy; difficulty in hiring providers with specific training and expertise in women's health care; and, unmet needs for specialized mental health services for survivors of sexual assault.[11]

We appreciate the recent request made by some Members of the Committee to the Deputy Inspector General (IG) of the VA, requesting an inspection of its compliance of certain established policies related to women veterans, including privacy standards and the ability to deliver comprehensive, gender-specific care to women. While we support the request, DAV also recommends a more in-depth assessment be completed by GAO to produce a full picture of the overall progress VA has made since GAO last reviewed these issues.

- DAV urges the Committee to request GAO conduct a follow-on study and comparative review from its work in 2009 to evaluate VA's current ability to meet the needs of all eras of women veterans across the array of VA services, including current findings on compliance with privacy and safety policies.

VA's Specialized Health Services

The Committee should also request that GAO assess VA's specialized services for women with amputations, PTSD, SUD, blindness, spinal cord injury, traumatic brain injury (TBI), and burns to determine whether these programs meet the needs of women veterans who use them. With the wars in Iraq and Afghanistan, we saw for the first time a number of women with war-related blast injuries resulting in TBI, single and bilateral traumatic amputations, and other life-altering injuries. Although the number of women who have suffered war-related amputations is small compared to men (23 vs. 1,626 respectively[12]), according to VA, women veteran amputees use more health care and rehabilitation services, and are seen more frequently than men. Research also indicates women are more likely to be unsuccessful in fitting of their prostheses and present other distinct needs. Women veterans with traumatic war injuries note that the social dialogue about combat experiences and the impact of these injuries often omits them from the discussion. Women veterans with limb loss also stressed the psychosocial differences in how war-related amputations are viewed by the public for women versus men, and the resultant impact on self-esteem, mental health and intimate relationships.

While there are a relatively small number of war-related amputations noted for women veterans, there is a much larger population of women who have non-war-related medical conditions that required amputations, such as diabetes. DAV has received numerous calls from women veterans complaining about the quality of VA prosthetic care; the apparent lack of knowledge about specialized prosthetic appliances for women; various challenges related to properly fitting prosthetic

[11] U.S. Govt. Accountability Office, "VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans." GAO 09-899T. Released July 16, 2009.
[12] DOD-VA Extremity Trauma and Amputation Center of Excellence Registry (EACE-R), excludes finger(s), thumb(s); includes partial foot and hand amputations. Aug. 1, 2014.

items and VA's unwillingness in certain cases to order special gender-specific prosthetic hardware, such as items used in knee replacements. Special prosthetics needs occur in women, especially during pregnancy. Weight fluctuation directly impacts the fitting of prostheses—providers must be aware when women become pregnant that they will likely need more frequent prosthetic modifications and adjustments during and after pregnancy. Women with above-the-knee leg amputations who require delivery by caesarian section need a higher abdominal incision than would normally be expected to avoid irritation of the socket brim.[13] Women veterans needing prosthetic items would be better served by VA if it appointed a clinical advisor that has special expertise in prosthetics and women's health, who would be available for consultation and develop a guide on various vendors and options for items needed by women.

Women veterans with poly-traumatic injuries, including spinal cord injury, also present special challenges. Modernized medical equipment for gynecological examinations is necessary for VA to provide comprehensive care and to ensure safety. Women with spinal cord injury and dysfunction, and those with other severe wartime injuries, also express concern about the impact of their injuries related to the aging process such as out-living their spouses, the ability to conceive children, and to gain access to comprehensive reproductive and long-term care services. Despite the type or level of injury, it is important for women, like men, to have peers provide a source of support and experience post-injury and during the rehabilitation phase, and for individualized treatment plans to be developed for women by providers who have an understanding of these factors.

- VA should assess the specialized services it offers to ensure all existing programs meet the unique needs of women veterans and consider appointing clinical advisors with expertise to act as a resource and consultant for other providers related to the special needs of women patients seeking care for amputations, PTSD, burns, blindness, spinal cord injury or TBI.

The Impact of Information Technology and Infrastructure on Women's Health

The VA's Office of Public Health and Environmental Hazards and the Women Veterans Health Strategic Health Care Group developed a roadmap in November 2008, entitled *Provision of Primary Care to Women Veterans*, to correct many of the gaps identified. However, it appears that competing budgetary priorities in many locations stalled the full implementation of necessary changes and modernization that were recommended. Two prime examples: the aging infrastructure of VA has made it difficult to ensure privacy, safety and appropriate clinic space for women at many locations; and, competing information technology (IT) priorities have delayed full implementation of an electronic clinical reminder about prescribing certain medications to women of childbearing age at risk of potential birth defects. We understand the addition of this clinical tool is part of the upgrade being made to VA's electronic computerized patient records system (CPRS) later this year. Such an important life-safety tool is critical to ensuring high quality care for women and we look forward to its implementation following years of delay. Likewise, the implementation of two other important IT programs, the Breast Care Registry and the System for Mammography Results Reporting for breast cancer screening and tracking abnormalities and a registry for breast cancer are still pending. These electronic health care tools would allow for timelier tracking of testing and appropriate follow-up of abnormal results.

Delays have the potential to negatively impact direct patient care and can result in poor health outcomes for women patients. VHA acknowledged that it is a challenge for clinicians to track

[13] DAV Special Report, "Women Veterans: The Long Journey Home." September 2014.

the results of mammograms that are performed outside the VA. For example, the majority of mammograms (75 percent) are done in the private sector[14] and although VA pays for those services and is provided test results, a number of steps are required to scan private reports into VA's CPRS.

- VA should request and Congress should authorize and appropriate funds needed for IT clinical updates, and major and minor construction projects to correct identified environment-of-care deficiencies that directly impact the care of women.

Need for Culture Change

One of the most perplexing problems is a culture in VA that is not perceived by women as welcoming, and does not afford them or their needs equal consideration. VA's own Women Veterans' Task Force noted the "...need for culture change across VA to reverse the enduring perception that a woman who comes to VA for services is not a veteran herself, but a male veteran's wife, mother, or daughter."

VA deserves praise for its excellent targeted communications initiatives such as "She Wore These" [combat boots], "Please Don't Call Me Mister," "She Was There," and "She Earned These" [military decorations]. While these public service announcements and poster campaigns are helpful, VA has not conducted a full assessment by all service lines to assure that women veterans' needs are incorporated into strategic plans, performance measures and policies at all levels of the organization. We fully concur with VA's Advisory Committee on Women Veterans 2014 Report findings and recommendations that Women Veterans Program Managers (WVPMs) located at each VA medical center are instrumental in coordinating services for women veterans, and the Lead WVPM should be part of the strategic planning process to ensure each Veterans Integrated Service Network (VISN) is involved in addressing the gender-specific gaps and needs of women and how they will be met and resourced. While VA reports that 96 percent of facilities now have a Women's Health Strategic Plan, it notes that only 50 percent of WVPMs are involved in strategic planning at the health care system level. Likewise, VA states that in 2012, as VISNs reorganized, Lead WVPMs were decreased to part-time positions and subsequently six of the 11 who did have full-time positions (in the 21 VISNs) either retired or left the position.[15] DAV's goal is for VA to be the health care system of choice for women veterans so they, too, can benefit from the specialized services and care VA provides. Therefore, it is essential that the system fully recognize and meet the primary and specialized health care needs of women veterans, has sufficient staffing levels, is focused on women's unique health needs, and undergoes a culture change that is more sensitive to women's care.

- We recommend that VA examine the role, responsibility and impact of the Lead Women Veterans Program Manager on the Women's Health Program and aggressively pursue staffing, cultural and organizational changes to ensure that experiences of women in the military are understood by health care providers and staff, that women veterans are treated with respect, and that they encounter a safe, welcoming environment as they seek VA services.

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[14] Elizabeth Yano, PhD, MSPH. Cyberseminar "Women's Health CREATE Overview." January 27, 2014. PowerPoint presentation

[15] U.S. Dept. of Veterans Affairs, Advisory Committee on Women Veterans, 2014 Report, "Women Veterans—Proudly Breaking Barriers." Sept. 2014 (9, 16)

Employment

The Department of Labor (DoL) has conducted research on how to best serve the employment needs of women veterans and provide them with many customized programs, communications and supports; however, despite these targeted efforts, the unemployment and under-employment rates for women veterans are slightly higher than their male counterparts.[16] While DoL found no employment challenges that are exclusive to women veterans, it indicated that the demographics of this group make it more likely they are in subpopulations that have higher unemployment rates.[17] Innovative outreach efforts to ensure women are aware of these services are necessary. Additionally, employment assistance will become even more pressing as DoD executes its current downsizing plan. Some service members who may have expected to complete full military careers will be thrust, with little preparation, into civilian communities and job markets.

With an estimated 200,000 women expected to leave the military over the next four to five years, it is imperative that we improve our efforts and support for women veterans' employment. We are pleased that organizations such as the Business and Professional Women Foundation and the VA's Center for Women Veterans have focused on helping women veterans better prepare for the civilian workforce, utilize their military experience, and refine skills to improve their competitiveness in the civilian work force so they have optimal employment opportunities and can obtain and sustain rewarding careers.

Homelessness

Another troubling trend that has emerged is the fact that women veterans experience higher rates of homelessness—at least twice as high as women who have not served. Most women who return from deployments are stronger from their military experience, but some have difficulty in their transitions and are not fully supported by existing programs. VA research shows that unemployment, disability and unmarried status are among the strongest predictors of homelessness for women. Women without strong support systems, those who have a service-connected disability and chronic health issues, or experienced sexual or physical trauma in the military or who have significant mental health or substance-use challenges can easily spiral downward losing connection with family, friends and community—and even becoming homelessness.

VA's efforts to eliminate veterans' homelessness have been impressive and are showing significant success. However, women veterans, especially single women with children, are often not able to take full advantage of VA's comprehensive array of services to regain health, improve work skills, and secure stable employment—or housing opportunities are not suitable to women veterans with children. GAO's 2011, report on Homeless Women Veterans noted that women veterans face barriers to accessing and using veterans housing, including lack of awareness about existing programs, lack of referrals for temporary housing while awaiting placement in a HUD-VASH arrangement, limited housing for women with dependent children and continuing concerns about

[16] U.S. Dept. of Labor, Economic News Release, "Employment Situation of Veterans – 2014." Mar. 18, 2015
[17] U.S. Dept. of Labor, Fact Sheet, "Women Veterans: Equally Valued. Equally Qualified. Equally Served." Retrieved Apr. 2015.

personal safety and security.[18] In 2010, nearly 40 percent of women veterans served by HUD-VASH entered the program with their dependent children.[19]

While women veterans continue to report access to child-care services as a key barrier to needed health care, mental health care, and other supportive services, we were pleased to see VA's March announcement awarding nearly $93 million to the Supportive Services for Veteran Families (SSVF) program in the form of three-year grants to help at-risk veterans and their families stay in their homes.

- Based on the success of the VA's congressionally mandated child-care pilot program, authorized by Public Law 111-163, DAV urges Congress to establish child-care services as a permanent program to support better access to health care, vocational rehabilitation, education, and supported employment services. Also, VA and HUD should invest in additional safe transitional and supportive beds designated for women veterans. Finally, VA should work with community partners to provide housing programs to accommodate women veterans with dependent family members, and especially targeted on those with minor children.

Mental Health Services

VA offers a comprehensive array of mental health and specialized post-deployment mental health services. VA's Uniform Mental Health Services Handbook requires that mental health services be provided as needed to women veterans at an equivalent level to that of their male counterparts system-wide, and that providers be capable and competent to meet the unique needs of women. According to VA, mental health providers need to be aware of physiological and hormonal changes that occur during a woman's lifespan, and the possible impact of those changes on mental health. This is especially important since 40 percent of women veterans seen in VHA are in their childbearing years (ages 18-44) and over 25 percent are aged consistent with perimenopause (ages 45-55).[20]

Women's military and wartime deployment experiences and reintegration processes are inherently different from those of their male peers. Research indicates that women differ from men in their prevalence and expression of certain mental health disorders[21]. For example: between men and women may develop PTSD as a response to combat exposure, women are more likely to manifest depression as a co-occurring disorder, but are less likely to display anger and resort to substance use. Women are also more likely than men to experience depression or develop an eating or anxiety disorder without a diagnosis of PTSD.[22] Findings also show that when women return from deployment, the camaraderie and support from their male peers is often curtailed—resulting in

[18] U.S. Govt. Accountability Office, "Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing." GAO 12-182. Published Dec, 23, 2011. Released Jan. 23, 2012.
[19] Syracuse Univ. Inst. for Veterans and Military Families, Natl. Veterans Tech. Asst. Center. "Lessons learned from the U.S. DOL grantees: Homeless female veterans and homeless veterans with families." Syracuse, NY. 2013.
[20] United States. Cong. Senate. Committee on Veterans Affairs. Fulfilling the Promise to Women Veterans. Hearings, Apr. 21, 2015. 114th Congress. 1st Sess. Washington (Statement of Dr. Patricia Hayes, Chief Consultant, Women's Health Services, Veterans Health Administration.)
[21] Maguen, S., Luxton, D.D., Skopp, N.A., Madden, E. (2012). Gender differences in traumatic experiences and mental health in active duty soldiers redeployed from Iraq and Afghanistan. J Psychiatr Res, 46(3): 311-6 .
[22] Ibid.

isolation for many. Studies have shown that peer support is important to a successful transition, but women report they often experience difficulty finding a network of women who relate to their military or wartime experience. While VA is recognized for its long-standing expertise in specialized mental health and post-deployment mental health services, it continues to lag in establishing system-wide access to gender-specific group counseling, residential treatment, and specialty inpatient programs that serve women. Improved access to these programs is essential for recovery and effective reintegration. Existing programs should be re-evaluated to ensure they are appropriately tailored to meet the unique mental health care and post-deployment transition challenges women experience related to wartime service and trauma.

DAV recognizes the challenges VA faces in establishing and maintaining specialized programs in every treatment location for a highly variable population cohort; therefore, we recommend that VA and DoD work collaboratively to:

- Explore innovative programs such as telehealth for providing gender-sensitive mental health programs for women. An interagency work group should be tasked to review options, develop a plan, fund pilots, and track outcomes.
- Coordinate structured women transition support groups to address unique issues of deployment, post-deployment readjustment, marriage, reintegration with children and spouses, child care and living as a dual military family.
- Establish joint group therapy options, peer-support networks, and inpatient programs for women.
- Develop a standardized approach to transition women with serious mental health issues and those who have experienced sexual assault from DoD to VA care.

While the VA's women veterans' mental health retreat pilot program, established under Public Law 111-163, has been a resounding success in reducing stress, improving coping skills, and improving women's sense of psychological well-being, it is only a small pilot effort and has served a limited number of women. In its report to Congress, VA noted that 85 percent of participants showed improvement in psychological well-being, 81 percent showed significant reduction in stress symptoms, and 82 percent showed an improvement in positive coping skills. These findings warrant permanent reauthorization of the program, and justify a research study of long-term outcomes of participants.

- Congress should make permanent and expand the authority for the VA Readjustment Counseling Service's women veterans retreat program. The VA Office of Research and Development should study the program to determine its key success factors, its effectiveness as an alternative treatment regimen, and whether it can be replicated in other settings.

Military Sexual Trauma

Military sexual trauma (MST), while not exclusively a women's issue, is also of special concern to DAV. Sexual assault and rape are crimes. In order to successfully eliminate rape, other forms of sexual assault, and sexual harassment in the armed forces, DoD must address organizational, cultural, and preventive solutions.

VA testified in February 2014 that in FY 2013, 93,439 veterans (of both sexes) received MST-related care in the veterans health care system—a 9.3 percent increase from FY 2012. There

was also a 14.6 percent increase in the total number of MST-related visits during the same period—an increase from 896,947 visits to 1,027,810 respectively. Research has found that both men and women are at increased risk of developing PTSD after sexual assault. MST screening and related services are mandated by policy to be made available at all VA medical centers, and that VA facilities provide specialized MST-related PTSD care in a variety of settings. According to VA, in FY 2013, among the 77,681 women veterans who screened positive for MST, 58.7 percent received outpatient MST-related services compared to 57,856 male veterans who screened positive, and 44.3 percent received outpatient treatment.[23]

There is also an indication that MST is significantly associated with risk of suicide for both men and women. DAV's Report noted that while 10 percent of all patients in VA's specialized outpatient PTSD treatment programs are women, VA operates only three women's stress disorder treatment teams across the entire VA system. They are similar in structure to specialized PTSD clinical teams and provide individual and group treatment to women veterans. VA also has two women's trauma recovery programs; these are 50-day live-in rehabilitation programs that include PTSD treatment and coping skills for re-entering the community. In 2012, the two programs served only 73 women.[24] Given the high rates of PTSD and other mental health conditions in women, and the number of men and women seeking care for MST-related conditions, the current number of specialized programs that serve them is inadequate.

Additionally, although VA has excellent evidence-based treatments for MST survivors, preliminary information suggests VA needs more qualified providers with specific training and expertise in treating the consequences of MST and helping veterans recover. In 2013, VHA reported that 31 percent of VAMCs and CBOCs were challenged to provide adequate care for MST, often because of staffing shortages.[25] Experts note that MST-related cases are frequently complex, with high rates of comorbidity including alcohol misuse, depression, suicidal ideation and other mental health problems requiring intensive case management, frequent clinic visits, and comprehensive treatment.

VA recently testified that all its "health care systems" (groupings of VAMCs and clinics) were above VA's required minimum staffing threshold for providing MST-related mental health care.[26] It is our understanding that this standard assumes a clinician spends 20 percent of available treatment time to maintain a caseload of 100 MST-positive patients. Under VA's standards, the average clinician would spend less than four hours per year with each patient. MST patients based on research by VA experts, are very complex patients. Many suffer with PTSD, depression and suicidal thoughts. VA's own clinical guidelines for treating PTSD call for patients to receive evidence-based psychological care that can require over 20 to 30 hours dedicated annually to a single patient. In our judgement, VA's standard for MST mental health care appears to be inadequate and needs to be

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[23] United States. Cong. Senate. Committee on Armed Services. Subcommittee on Personnel. The Relationships Between MST, PTSD and Suicide, and on DOD and VA Medical Treatment and Management of Victims of Sexual Trauma. Hearings, Feb. 26, 2014. 113th Congress. 1st Sess. Washington (Dr. Susan J. McCutcheon, Natl. Mental Health Dir., Family Services, Women's Mental Health and MST, Dept. Of Veterans Affairs)

[24] Institute of Medicine. Treatment for PTSD in Military and Veteran Populations: Final Assessment. National Academies Press. June 20, 2014.

[25] Ibid.

[26] United States. Cong. Senate. Committee on Veterans Affairs. Fulfilling the Promise to Women Veterans. Hearings, Apr. 21, 2015. 114th Congress. 1st Sess. Washington (Statement of Dr. Patricia Hayes, Chief Consultant, Women's Health Services, Veterans Health Administration.)

addressed. We recommend an independent study be conducted by a respected body such as the Institute of Medicine to evaluate the adequacy of VA mental health staffing standards, clinical guidelines to treat MST, and care for veterans who experienced MST.

- Congress should require an independent study to evaluate the staffing levels and ability of VA providers with expertise to deliver appropriate MST-related care to survivors of sexual assault. VA should develop a clinical standard and staffing model that ensure a sufficient number of trained providers are made available and deployed to meet full demand for these specialized services.

Transition Assistance Program

No comprehensive studies have been completed that evaluate the effectiveness of the long-standing Transition Assistance Program (TAP). The hallmark of learning is that individuals seek out and absorb information when they perceive they need it, not necessarily when it is made available. Some transitioning service members may not be prepared to absorb TAP training during their pre-separation periods but would be more receptive once they are actively seeking help and assistance several months or more after their discharge. [27]

- To judge the success of TAP, data on participation, satisfaction, effectiveness, employment outcomes and educational attainment should be tracked and reported on a rolling basis, stratified by gender, ethnicity, and race, for all separated service members.
- TAP partners should conduct an assessment to determine unique needs of women veterans and incorporate specific breakout sessions during the employment workshops, or add a specific track for women in the three-day sessions to address identified needs.
- VA should evaluate the effectiveness of transition support groups that address issues with marriage, deployment, changing roles, child care, and life for dual military families, and determine whether these efforts help achieve more successful outcomes for women.
- VA and DoL should provide gender-sensitive follow up with all service members six to 12 months after separation to offer additional support and services, if needed.

Disability Compensation

The burden of wounds, illness and injury in post-9/11 veterans is high, and nearly half who served have applied to VA for disability compensation. Regarding MST-related PTSD claims, VA confirmed that approval rates for service connection were lower for women veterans than for men who made PTSD claims based on combat exposure. The Veterans Benefits Administration (VBA) took action to educate and retrain staff on existing policy and proper adjudication of these specific claims. We are pleased that VBA acknowledges the need to do further data collection and analysis in this regard, and we encourage additional analysis to assure that women are receiving fair and equitable adjudication of all their claims, for whatever disability is being claimed.

- The VBA should track, analyze, and report all its rating decisions separated by gender to ensure accurate, timely, and equitable decisions on claims filed by women veterans.

[27] DAV Special Report, "Women Veterans: The Long Journey Home." September 2014.

The Need for Data Collection by Gender

In order to better understand the experience of women in the military, data needs to be routinely collected, analyzed and reported by gender and minority status. DAV recommends improved data collection on women and minorities for health care, disability compensation, justice involvement, education, transition assistance, sexual trauma, employment, and housing programs. Congress, policy makers, program directors, and researchers need this information in order to monitor and appropriately enhance services for women veterans.

- The federal government should collect, analyze, and publish data by gender and minority status for every program that serves veterans, to improve understanding, monitoring, and oversight of programs that serve women veterans.

Women's Health Research

VA's Health Services Research and Development (HSR&D) function continues to contribute to a growing body of women's health research that is aimed at improving the health and health care of women veterans. This research effort focused on women's health became a priority in the early 1990s and has increased dramatically over the past two decades. Early on, a VA Women's Health Research Planning Group was established and worked to develop a comprehensive research agenda for women veterans. Key research priorities were identified in November 2004, and a special supplement on VA research on women's health was published in the *Journal of General Internal Medicine* with several contributions from VA HSR&D investigators.

VA researchers began to focus on chronic illnesses and mental health conditions in women and in 2010 sponsored a conference titled, "Using Research to Build the Evidence Base for Improving the Quality of Care for Women Veterans." In 2014, VA hosted a Women's Health Research Conference, bringing together investigators interested in pursuing research on women veterans and women in the military, with a goal to advance the state of and potential impact on VA women's health research. VA recently published a second women veterans' research journal supplement in *Medical Care* and announced that Phase 2 of the Women Veterans Cohort Study has begun. VA researchers have been studying women and the impact of exposure to combat during the wars in Iraq and Afghanistan—specifically the impact of military service on women's physical health, unique health care needs, and subsequent utilization of VA services. In addition to ongoing research in women's health and health care, HSR&D is funding a women veterans Practice-Based Research Network and established the Women's Health Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE) initiative to focus on accelerating implementation of research findings into practice.

All of these targeted research efforts and studies to date have provided a solid foundation on which to shape national policy and improve the overall health of women veterans.

- We urge Congress to provide sufficient resources to support VA research efforts.

Closing

Millions of women have answered the call of duty and put themselves at risk to preserve our nation's security and our way of life. They served this country faithfully and many with distinction.

Acknowledging their dedication and resilience and serving women veterans with greater respect, consideration, and care must become a priority.

This is a transformative moment for the VA—Secretary Robert McDonald is leading an ambitious effort to change the culture at the VA and to direct resources where they will ensure that VA health care can meet the needs of every veteran. That cannot happen without a strong focus on women veterans and a detailed, action-orientated plan. For these reasons, we call on Congress to set a firm deadline for action by the Department to ensure that women veterans have equal access to high-quality health care services and benefits.

While DAV's report makes a number of key recommendations, today, we call on Congress to authorize or exercise its oversight authority and responsibility and require that, by Memorial Day, 2016, at a minimum, the following steps are completed by VA:

- Every VA medical center must employ a part-time or full-time gynecologist.
- VA must complete implementation of IT solutions that directly impact women's health including clinical reminders in its electronic medical record system on prescribing teratogenic medications to younger women and capturing vital gender-specific information, such as breast and cervical cancer screening results and abnormalities.
- VA must develop standards to ensure VA health care facility infrastructure meets the specific needs of women veterans. These standards should be integrated into prioritization for VA construction projects under VA's Strategic Capital Investment Plan.
- Authorize child-care services as a permanent program to support better access to VA health care, mental health programs, vocational rehabilitation, education, supported employment and other specialized services.
- Create a VA-DoD interdisciplinary work group to assess access to specialized MST programs and gender-sensitive mental health programs for women veterans, including peer-to peer support and services for post-deployment transition challenges. A full report, including recommendations of the work group, must be provided to Congress by the deadline.
- Increase the number of safe transitional and supportive beds designated for women veterans to meet demand and the number of housing programs available to women veterans with dependent family members, especially minor children.
- Conduct a GAO study on VA's ability to meet the health care needs of women veterans including an assessment of specialized programs for women seeking care for amputations, PTSD, burns, blindness, spinal cord injury and TBI.

In closing, DAV is pleased to support H.R. 1356, the Women Veterans Access to Quality Care Act introduced by Representative Coffman (R-CO). We appreciate the introduction of this measure, which seeks to ensure VA adapts programs and services to meet the needs of women veterans, and that women veterans can access safe, comfortable and high quality care at all VA health facilities. We also support H.R. 1948 introduced by Representative Brownley (D-CA), the measure seeks to make permanent the highly successful child care pilot program in VA. Both of these bills reflect the recommendations put forth in DAV's Women Veterans Report and DAV Resolution Number 040, which supports enhanced medical services and benefits for women veterans.

Again, DAV appreciates the opportunity to testify before the Committee today on this important topic. I will be pleased to address any questions from the Committee related to this statement.

Statement of
Iraq & Afghanistan Veterans Of America
before the
House Committee on Veterans' Affairs
for the hearing on
Examining Access and Quality of Care and Services for Women Veterans

April 30th, 2015

Chairman Miller, Ranking Member Brown and Distinguished Members of the Committee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA), we would like to extend our gratitude for the opportunity to share our views and recommendations on improving women veterans' access to quality health care and services.

IAVA recognizes the important contributions of women veterans, who have a long history of serving honorably in the armed forces. As the leading post-9/11 veteran empowerment organization (VEO) with the most diverse and rapidly growing membership in America, we have a diverse group of women veteran members and leaders in our midst. We are proud to have them as a part of our organization, we value their voices, and we value their service.

This March, we launched our first ever women veterans survey as part of an effort to understand more about women's experiences during and after service. Over 1,500 women veterans have responded so far, sharing their experiences with VA healthcare as well as more broadly the challenges they've experienced as women veterans transitioning back into the civilian community.

In addition to this survey, IAVA's research department traveled to seven cities across the country and spoke with dozens of women veterans in an ongoing series of women veterans' focus groups. We've had women from all eras of service attend these groups, and they have provided us with vital information for this hearing today.

In speaking with our women veterans across the country, we've narrowed our suggestions here today to three main points. First, VA, DoD, and the nation at large must recognize women for their ongoing service to this country. Second, the VA specifically needs to

expedite planned improvements to VA facilities to support and improve services and care for women at these facilities. And finally, there must be a renewed focus on research to fully understand where gaps in services exist for women veterans.

Women have played a vital role in our military throughout history, and their impact and contributions are continuing to grow. In the recent wars alone, nearly 280,000 women have served. While the number of male veterans is expected to decline in the next five years, the women veteran population will increase and is estimated to reach 11 percent by 2020.

And yet, what IAVA has learned while traveling the country is unfortunately not surprising. Women veterans continue to encounter barriers to care and benefits, including an overall culture that does not fully recognize or accept them as veterans.

Far too often, women are not recognized as veterans and are even confronted with individuals that seem to ignore their service. Last year, during IAVA's advocacy campaign, Storm the Hill, one of our own IAVA veteran members experienced a group of fellow veterans thanking her for her support while thanking her male colleagues for their service. Recent IAVA focus group data illustrates this type of disconnect is widely reported, with less than 40% of women veterans reporting they felt U.S. public treats their military service with respect.

These frequent instances of dismissing or ignoring women's military service must change, and nowhere is that more necessary than inside the walls of VA medical facilities. As one woman told us, when she tried to sign up for veteran-specific mental health services, administrators told her "Oh, no. That's not for you. Those are for veterans," almost going as far as to slap her hand away. From our initial analysis of the women veterans survey, which is still open, less than half of respondents (45%) agreed or strongly agreed with the statement that VA employees treat women vets with respect.

Other veterans are constantly addressed as "Mr," regardless of whether or not this is correct. As one of our members describes it, VA has "made great strides in instituting women's clinics, program coordinators. But it is difficult to believe it is changing when I get letters addressed to "Mr." When I read my medical chart, and I am referred to as "him", when I enrolled at this VA, Eligibility listed me as male...simple things but what it says to me is that we still don't matter as much." These women are tired of having to defend their service because they don't look like the stereotypical veteran.

There is no reason that these women should not be recognized in the same manner as men who have served, especially when seeking care at the VA. Our members are active users of VA medical services - the initial results of our women veterans survey show that 70 percent of respondents are enrolled in VA healthcare, and the majority have been enrolled for over 2 years and have sought care within the last 6 months. Military service is

not dependent on gender – and we need all VA leadership and employees to know this. It is clear that in reaffirming its values and mission, the VA must ensure it is reaffirming its commitment to ALL veterans.

We suggest that as a first step, VA medical centers implement staff training programs to counter these assumptions and emphasize the importance of women's service being recognized. Additionally, the role of the women veterans' program manager should be strengthened within to VA to ensure this position is given the necessary authority to implement policies. Building on this culture change, the need for an inclusive and welcoming environment is not restricted to the staff at VA centers, the VA must also allow patient advocates to be trained and prepared to handle complaints at every VA medical facility related to harassment or individuals creating a hostile environment in order to enact real culture change.

Second, VA medical centers need specific operational and structural changes that support the needs all veterans. Only 56 percent of women veterans who responded to IAVA's latest member survey felt the VA provided an adequate number of women practitioners, only 41 percent believed the VA provided an adequate number of doctors specializing in women's care and only 34 percent said the VA adequately provided specialized facilities. These statistics or issues are not new and are well known throughout the veteran community, but the need to address the disparity in gender-specific care remains.

In our recent focus groups, women consistently pointed out that they've had to endure long wait times to get care from a provider that they trust or are trained in women-specific medical fields. While our women veterans survey is still open, our initial analysis shows that about 70 percent of respondents rated the VA as fair, poor or very poor in their support provided to women veterans. Among those who have used private healthcare, only one in four rated private care as fair, poor or very poor.

Our veterans deserve providers who are fully trained and able to provide care to both men and women, professionally and effectively. The VA has made great strides to address these types of issues, but there is still a need for the VA to ensure every VA medical center has appropriate facilities that are fully staffed to support the needs unique to women veterans, such as women's clinics. From our initial women veterans survey results, only about half of those enrolled in VA care said the VA facility they last visited had a gynecologist on site and less than half reported a women vets coordinator or program manager on site.

We have also heard about the impacts of a lack of privacy on the quality of care provided. In the words of one of our members, "The VA should understand that women and men have different needs and at times may need their privacy. Being at the doctor or in a hospital can be traumatic at times, but worrying about your privacy can make it worse - for any person." The VA already has the tools to implement best practices for safety and

privacy for women veterans, which were outlined in the March 2010 Government Accountability Office Report on VA women's health care policies and oversight, now the VA must establish and enforce deadlines to meet those best practices.

Third and finally, there must be renewed emphasis on good data and reliable research delving into the experiences of women veterans. Gaps in services and improvements in care cannot be fully achieved unless they are fully defined. If we are to move forward as a nation that honors the service and sacrifices of women veterans, we will need to actively include these women by inviting them to drive the conversation through participation in research, program evaluation and policy implementation. The VA has already taken steps in the right direction here, with the establishment of the Center for Women Veterans, the renewal of the charter for the Advisory Committee on Women Veterans and the recent Women's Health Research Conference.

There is much work to be done with regards to understanding women veterans. The VA, DoD, and Department of Labor, among other government agencies, should make additional improvements to their research by incorporating gender and minority analyses into all reports to better inform gaps in services and programs. Specifically focusing on the VA, VBA must track and analyze all rating decisions by gender to ensure accurate, timely and equitable decisions by rating specialists. To date, VBA does not as part of its regular analyses consider gender. And so, while there is anecdotal information of women having difficulty filling for these benefits, there is no data to identify whether a problem truly exists.

I think what most sums up this testimony is the observation of a female veteran of Vietnam who attended one of our focus groups. As she left, she noted that while there has been some progress, by and large it has not been enough, and certainly not fast enough. Many of the challenges that existed when she transitioned to VA care decades ago still exist. With the women veteran population only projected to increase, the time to address these issues is now.

IAVA would like to thank you for bringing these issues to the forefront, and giving us the chance to offer our views and the views of our members here today. We look forward to continuing to work with each of you to recognize the contributions of women veterans and improve their access to high quality healthcare.

Thank you for your time and attention.

Statement of Iraq & Afghanistan Veterans of America
before the House Committee on Veterans Affairs
Thursday, April 30th, 2015

Biography of Lauren Augustine
Legislative Associate, Iraq and Afghanistan Veterans of America

As Legislative Associate, Lauren maintains Congressional relationships, supports advocacy programs, and comments on policy matters in the media. She is a U.S. Army veteran that has extensive experience working on veteran policy issues focused on education, health care, disability claims benefits, and employment.

Statement on Receipt of Grants or Contract Funds

Neither Mrs. Augustine, nor the organization she represents, Iraq and Afghanistan Veterans of America, has received federal grant or contract funds relevant to the subject matter of this testimony during the current or past two fiscal years.

STATEMENT OF

DR. PATRICIA HAYES

CHIEF CONSULTANT FOR WOMEN'S HEALTH SERVICES

VETERANS HEALTH ADMINISTRATION (VHA)

DEPARTMENT OF VETERANS AFFAIRS (VA)

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

April 30, 2015

Chairman Miller, Ranking Member Brown, and Distinguished Members of the House Committee on Veterans' Affairs, thank you for the opportunity to discuss the high quality care and support VA is providing to our women Veterans. I am accompanied today by Dr. Susan McCutcheon, National Mental Health Director for Family Services, Women's Mental Health and Military Sexual Trauma, as well as Mr. Curtis Coy, Deputy Under Secretary for Economic Opportunity for the Veterans Benefits Administration (VBA).

Overview of Women's Health

The number of women Veterans enrolling in VA health care is increasing, placing new demands on a VA health care system that historically treated mostly men. There are more than 2.0 million women Veterans in the United States accounting for more than 400,000 users of VA health care services in fiscal year (FY) 2014. To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and access for women Veterans.

VHA's Women's Health Services (WHS) oversees program and policy development for women's health and provides strategic support to implement positive changes in the provision of care for all women Veterans. WHS works to ensure that timely, equitable, high quality, comprehensive health care services are provided in a sensitive and safe environment at VA facilities nationwide. WHS programs include

comprehensive primary care, women's health education, reproductive health, communication, and partnerships. WHS' goals are to:

- Transform health care delivery for women Veterans using a personalized, proactive, patient-centered model of care;
- Develop, implement, and influence VA health policy as it relates to women Veterans;
- Ensure a proficient and agile clinical workforce through training and education;
- Develop, seamlessly integrate, and enhance VA reproductive health care; and
- Drive the focus and set the agenda to increase understanding of the effects of military service on women Veterans' lives.

Implementing Comprehensive Primary Health Care Model for Women Veterans

To provide the highest quality of care to women Veterans, VA offers women Veterans assignments to trained and experienced Designated Women's Health Providers (DWHP) who can provide general primary care and gender-specific primary care in the context of a long-term patient/provider relationship. In 2009, we had women's health providers at 33 percent of medical centers. Today, DWHPs are available at 100 percent of VA medical centers (VAMC) and 90 percent of Community-Based Outpatient Clinics (CBOC). National VA satisfaction and quality data from 2014 indicate that women who are assigned to DWHPs have higher satisfaction and higher quality of gender-specific care than those assigned to other providers. VA's plan is that whenever a woman Veteran enters the health care system, she will have access to a DWHP. To meet this plan, VA must ensure that all new primary care hires are proficient in the care of women as well as men. VA is continuing to train and update skills of current VA primary care and emergency providers in the care of women. Since 2008, VA has provided intensive training to over 2,000 women's health providers and provided over 50 different online, accredited women's health classes, which can be taken 24/7 to enhance the flexibility of learning opportunities for employees. The combination of educational offerings provides not only basic training in women's health but advance courses so that providers and other staff can keep their skills and knowledge up-to-date.

Assessing Women's Comprehensive Health

With the launch of such a large scale change in services, WHS recognized the need to assess the progress towards implementation of high quality programs focused on women Veterans. WHS evaluates all women Veterans' health programs through several mechanisms. Every VAMC completes an annual self-assessment of the implementation of comprehensive women Veterans' services through the Women's Assessment Tool for Comprehensive Health. This tool includes an assessment of the Enrollee Health Care Projection Model's current and future enrollment and utilization projections, strategic planning for women Veterans' services, and reports on the providers and capacity for clinical services, such as primary care, gynecology, and emergency services.

In addition, VHA uses an independent contractor to conduct detailed site visits to objectively assess the implementation of services for women Veterans nationwide. Over the course of each year, the independent assessment team conducts a more intense review at 25 VAMCs. Each year, the independent contractor provides an evaluation of the state of implementation and a national roll-up report highlighting both areas where capacity has been built and areas that still need development. The annual reports have been provided to VHA Central Office and Veterans Integrated Service Network (VISN) leadership teams. This allows leadership to examine trends in implementation and to identify and address gaps in services available for women Veterans.

Narrowing Gender Disparities

Recent analysis indicates that VHA outperforms private and public sector health care in many quality performance measures[1]. As a recognized leader in provision of high-quality health care, VHA initiated efforts to address gender disparity, a problem that affects health care nationwide[2]. In an effort to measure the quality of care provided to women Veterans, since 2006 VA's Office of Informatics and Analytics (formerly Office

[1]Gender Differences in Performance Measures VHA 2008-2011 Women Veterans Health Strategic Health Care Group, Patient Care Services, VHA, Washington DC, June 2012

[2] JGIM Vol 28 Supp 2 July 2013. Women's Health During Health Care Transformation, Clancy and Sharp

of Quality and Performance) has analyzed all External Peer Review Program Data (EPRP)[3] by gender and published the quarterly Gender Report on its website. Starting in 2006, a number of gaps were identified in the quality of care for men and women, including disparities in measures for screening, prevention, and chronic disease management.

In FY 2008, VHA launched a concerted Women's Health improvement effort, focusing providers' attention on gender disparity data. From 2008 to 2011, VA saw a significant reduction in gender disparity for many measures, including hypertension, diabetes, pneumococcal vaccine, and influenza prevention. Improvements were also made in screening measures for colorectal cancer, depression, posttraumatic stress disorder (PTSD), and alcohol misuse. In FY 2011, VA included Gender Disparity Improvement as a performance measure in the VISN Director Performance Plans, which concentrated management attention on systems to continuously reduce gender disparity. WHS has continued to publish reports on these efforts; the FY 2013 report illustrates that VA has made continued progress in closing the gap in gender disparities. At the close of FY 2013, small gender gaps existed in only a few measures including cholesterol management in high-risk patients, diabetes care, and rates of influenza vaccination.

Women Veterans Economic Outcomes

In addition to addressing women Veterans' health care concerns, VA is committed to working with our partner Federal agencies to help transition female Servicemembers and Veterans achieve strong economic outcomes through meaningful employment and suitable housing.

In January 2015, VA's Veterans Economic Opportunity Report examined how Veterans compare to their non-Veteran counterparts in obtaining meaningful employment, increasing their income, accessing education, and other indicators of success. VA reported that female Veterans are doing well compared to their non-

[3] EPRP is designed to provide medical centers and outpatient clinics with diagnosis and procedure-specific quality of care information. It provides a database for analysis and internal and external comparison of clinical care. Data used for these analyses are abstracted from a random sample of both paper and electronic medical records. EPRP data is primarily used for quality improvement, evaluation and benchmarking with external organizations. (VHA DIRECTIVE 2008-032)

Veteran female and Veteran male peers in both career earnings and education. Specifically, VA's Economic Opportunity Report [4] cited that female Veterans attain 14 percent higher median earnings than the non-Veteran female population with similar demographic characteristics; and that female Veterans participating in the GI Bill had a 10 percent higher program completion rate compared to male Veterans for all ages combined, an 8 percent higher program completion rate across all individual age groups, and a 5 percent higher program completion rate when compared to female students in the general population. This report provides valuable insight, and VA continues to work with our Federal partners to ensure all women Veterans, like their male counterparts, are empowered with the tools necessary to gain meaningful employment and career mobility.

One program contributing to this effort is the interagency Transition Assistance Program (TAP), through which VA equips Servicemembers and their families with the tools they need to make a smooth, successful transition to civilian life. A key component of TAP is Transition Goals, Plans, Success (GPS), a curriculum jointly managed by VA, DoD, and DOL, designed to help transitioning Servicemembers connect with jobs, training, and other benefits prior to leaving service. To support TAP, VBA has more than 300 VA benefits advisors permanently located at more than 100 military locations world-wide. From beginning of FY14 to date, VBA has conducted 12, 342 briefings to an estimated 329,400 separating Servicemembers. As part of Transition GPS, VA benefits advisors not only provide a day long briefing on VA benefits and services but also provide the Career Technical Training Track, an optional 2-day workshop, which helps transitioning Servicemembers identify relevant civilian occupations, establish career goals, and begin applying for credentials and vocational training. Additionally, VA benefits advisors work to ensure Servicemembers are referred to appropriate services such as VA's Vocational Rehabilitation and Employment (VR&E) Program.

The VR&E Program provides comprehensive services and assistance to enable Veterans with service-connected disabilities and an employment handicap prepare for,

[4] VA's Economic Opportunity report:
http://www.benefits.va.gov/benefits/docs/VeteranEconomicOpportunityReport2015.PDF

find, and maintain suitable employment. For Veterans with service-connected disabilities so severe that they cannot immediately consider work, VR&E offers services to improve their ability to live as independently as possible in their homes and communities. Vocational rehabilitation counselors and employment coordinators work closely with their DOL counterparts to help Women Veterans find meaningful, sustainable careers. Services provided include training and career assessment to help them reach their career goals, individual counseling and direct assistance to VA-specific services, homeless placement services, and referrals for VA medical services.

VA, DoD, and DOL also partnered to launch the Veterans Employment Center (VEC) in April 2014. The VEC provides transitioning Servicemembers, Veterans, and their families with a single authoritative Internet source that connects them with job opportunities, and provides tools to translate their military skills into plain language and build a profile that can be shared – in real time – with employers. Over 1.7 million private and public-sector jobs are listed on the VEC. As of February 15, 2015, 844 employers made public hiring commitments to hire over 553,500 individuals. In addition, committed employers have reported hiring over 286,000 Veterans and family members.

VA has also initiated an aggressive rollout of innovative public-private partnerships that are leveraging best practices and tools of premier companies in private industry to provide unique support to transitioning Servicemembers, Veterans, and their families and to help bridge the cultural gap. For example, VA has strategic partnerships with LinkedIn and Coursera. Most recently, VA partnered with TriWest Healthcare Alliance to connect women Veterans who are homeless or at risk of being homeless with meaningful and stable employment.

VA is also exploring various learning opportunities as potential alternatives or supplements to traditional education that yield career competitive skills and employment opportunities for Veterans. VA will be opening accelerated learning opportunities this fiscal year to help bridge the gap between Veterans' separation from service and successful civilian employment outcomes. Additionally, VA is establishing 20 learning hubs that will provide space and resources, such as computers for Veterans,

transitioning Servicemembers, and military spouses to complete the online educational courses available in a classroom environment.

VA's efforts to improve economic outcomes for women Veterans include providing greater access to suitable housing through VA's Home Loan Guaranty Program. The Home Loan Program assists eligible Veterans in obtaining, retaining, and adapting their homes. In each of the past 10 fiscal years, the numbers of VA loans to women Veterans averaged between 10 and 12 percent of the VA guaranteed loan portfolio. Over the last decade, VA has guaranteed 3.5 million home loans, including loans for nearly 400,000 women Veterans. This figure does not include women Veterans who have entitlement, but elected to use their spouse's eligibility for the home loan benefit.

Additionally, VA pursued, and Congress passed as Public Law 112-154, legislation that affords more single, active-duty Veterans with children the opportunity to obtain a home using their VA home loan benefit. This law expanded the occupancy requirement attached to VA home loans to include not just the Veteran or a spouse but also a dependent child of an active duty Servicemember. A key impact of this legislative change is that single Veterans with children, many of whom are women, are not adversely impacted by their active duty service and can provide housing for their children, and as necessary, caretakers and guardians.

Disability Assistance and Benefits

Women Veterans are eligible for the wide variety of VA benefits available to all U.S. Military Veterans. These benefits include disability compensation, pension, education, vocational rehabilitation, home loan guaranty, and life insurance as well as monetary burial allowances.

VA is committed to ensuring that all Veterans, Servicemembers and their families are aware of and know how to access the benefits they have earned and deserve. VA conducts targeted outreach to women, minorities, elderly, and homeless. VA also uses social media such as Twitter and Facebook and electronic communication through GovDelivery for targeted messaging. Of the 4.3 million registered eBenefits users, 24 percent are women. Through these outreach efforts, VA has seen an increase in

utilization of benefits by women Veterans. In 2014, 356,748 women Veterans received compensation benefits; an 8 percent increase over 2013. In addition, 12,624 women Veterans received pension benefits, 128,800 used Post-9/11 GI Bill education benefits, and 46,714 received VA guaranteed home loans totaling $10.5 billion in FY14.

One of VA's outreach goals is to ensure the National Guard and Reserve population receive information about VA health care, benefits, and services. This is accomplished through consistent dialogue with leadership within the Reserve Components and the Army and Air National Guard and participation in Yellow Ribbon Reintegration Programs (YRRP). VA participated in over 1,600 of these events throughout the United States and territories, providing more than 190,000 OEF/OIF/OND Servicemembers, Veterans and their families with vital information. Additionally, VA staff frequent demobilization events (post-deployment health reassessments), job fairs, stand down events for homeless Veterans, and activities on active duty bases as well as Reserve and National Guard Armories.

Military Sexual Trauma (MST) Claims

VA is committed to serving Veterans by accurately adjudicating claims based on military sexual trauma (MST) in a thoughtful and caring manner, while fully recognizing the unique evidentiary considerations involved in such an event. The Under Secretary for Benefits has spearheaded the efforts of VBA to ensure that these claims are adjudicated compassionately and fairly, with sensitivity to the unique circumstances presented by each individual claim.

VA is aware that, because of the personal and sensitive nature of MST stressors in these cases, it is often difficult for the victim to report or document the event when it occurs. To remedy this, VA developed a regulation (38 C.F.R. § 3.304(f)(5)) and procedures specific to MST claims that appropriately assist the claimant in developing evidence necessary to support the claim. As with other posttraumatic stress disorder (PTSD) claims, VA initially reviews the Veteran's military service records for evidence of the claimed stressor. VA's regulation also provides that evidence from sources other than a Veteran's service records may corroborate the Veteran's account of the stressor incident, such as evidence from mental health counseling centers or statements from

family members and fellow Servicemembers. Evidence of behavior changes, such as a request for transfer to another military duty assignment, deterioration in work performance, and unexplained economic and social behavior changes, is another type of relevant evidence that may indicate occurrence of an assault. VA notifies Veterans regarding the types of evidence that may corroborate occurrence of an in-service personal assault and asks them to submit or identify any such evidence. The actual stressor need not be documented in service records. If evidence of a stressor is obtained, VA will schedule an examination with an appropriate mental health professional and request an opinion as to whether the evidence indicates that an in-service stressor occurred.

When a Veteran files a claim for mental or physical disabilities other than PTSD based on MST, VA will obtain a Veteran's service medical records, VA treatment records, relevant Federal records, and any other relevant records, including private records, identified by the Veteran that the Veteran authorizes VA to obtain. VA must also provide a medical examination or obtain a medical opinion when necessary to decide a disability claim. VA will request that the medical examiner provide an opinion as to whether it is at least as likely as not that the current symptoms or disability are related to the in-service event. This opinion will be considered as evidence in deciding whether the Veteran`s disability is service connected.

VBA has placed a primary emphasis on informing VA regional office personnel of the issues related to MST and providing training in proper claims development and adjudication. Women Veterans Coordinators are located in every regional office to assist Veterans. In December 2014, MST Coordinators were assigned at each regional office to address MST-specific concerns of both male and female Veterans. In addition, under VBA's new standardized organizational model that has been implemented at all of our regional offices, all MST-related claims are now processed in the special operations lane, ensuring that our most experienced and skilled employees are assigned to manage these complex claims.

Gender-Specific Health Screenings

VA exceeds the private sector in gender-specific health screening rates including cervical cancer screening and mammography[5]. Mammograms for women Veterans can be provided on-site at 52 VHA health care sites where digital mammography is available. When VA or other Government facilities cannot provide these services, VA may contract for non-VA medical care using applicable statutory authority, i.e., 38 United States Code §§ 1703, 8153, 8111. WHS has also convened a task force of subject matters experts from women's health, oncology, radiology, surgery, and radiation oncology to develop guidance to standardize and enhance breast cancer care in VA facilities nationally. Despite these accomplishments, VHA agrees with a recent VA Office of Inspector General (OIG) report that tracking the results of mammograms performed outside VA has been a challenge. Recently VA completed work on breast cancer treatment guidance which advises the field of optimal pathways and processes to ensure that mammography orders are standardized and that results are tracked and communicated to patients appropriately.

VA has been working to ensure that test results from studies done outside of VA are documented in the Computerized Patient Record System and that patients are notified of normal and abnormal mammography results within an appropriate timeframe. VA has two information technology (IT) projects underway that will revolutionize tracking and results reporting for breast cancer screening and follow-up care: the Breast Care Registry and the System for Mammography Results Reporting. Both IT enhancement projects are scheduled for completion by the end of 2015. These systems are designed to work together to identify, document, and track all breast cancer screening and diagnostic imaging (normal or abnormal), orders results, patient notification, and follow-up to ensure that all women Veterans receive high-quality, timely breast care whether treatment is provided within or outside of VA.

Improving Coordination and Access: Women Veterans Program Managers

In order to ensure improved advocacy for women Veterans at the facility level, VA has mandated all VAMCs appoint a full-time Women Veterans Program Manager

[5] http://www.womenshealth.va.gov/WOMENSHEALTH/docs/OIA-BRCO_GenderHealthCareReport.pdf

(WVPM). These WVPMs increase outreach to women Veterans, improve quality of care provision, and develop best practices in organizational delivery of women's health care. They serve as advisors to facility directors in identifying and expanding the availability and access of inpatient and outpatient services for women Veterans and provide counseling on a range of gender specific care issues. WVPMs also provide appropriate local outreach initiatives to women Veterans. Each of VA's 144 health care systems have appointed a full-time WVPM, and VHA carefully tracks this position with regard to orientation and training.

Improving Access to Women's Health through Technology

Women's Health Telehealth Programs and Mobile Applications

Since 2011, WHS has awarded funding to 26 VHA facilities for projects that offer telehealth programs to female Veterans. Telehealth projects that received funding involve tele-mental health, tele-gynecology, tele-pharmacy, and telephone maternity care coordination.

VA is currently developing six mobile applications (apps) for women Veterans' use. Patient-facing apps will provide information on VA eligibility and services and health information for women Veterans. Provider-facing apps will provide information to enhance knowledge of both VA and non-VA medical care providers about special health issues of women Veterans.

Women Veterans Call Center

The Women Veterans Call Center, 1-855-VA-WOMEN (1-855-829-6636), was created to increase women's knowledge of VA benefits and services, enrollment, and utilization of health care services. We are pleased to see that the Call Center is being utilized. In FY 2014, the Call Center received nearly 15,000 incoming calls and made over 190,000 outbound calls, successfully reaching over 100,000 women Veterans. The Call Center is staffed by trained operators who provide information on VA's benefits and services. Call Center staff make referrals to WVPMs, the VHA Health Eligibility Center, VBA, and suicide and homeless crisis lines as needed. The outbound, outreach

Call Center was moved to the Canandaigua VAMC in October 2012, and the inbound Call Center launched in April 2013.

Readjustment and Integration

Vet Center Services

Life is not always easy for women Veterans after a deployment, and Vet Centers have developed services to assist Veterans in re-integration. Vet Centers across the country provide a broad range of counseling, outreach, and referral services to women combat Veterans, Servicemembers, and their families. Vet Centers guide women Veterans, Servicemembers, and their families through many of the major adjustments in life that often occur after they return from combat. Services for a woman Veteran or Servicemember may include individual and group counseling in areas such as the symptoms associated with PTSD, Military Sexual Trauma (MST), alcohol and drug assessment, and suicide prevention referrals. All services are free of cost and are strictly confidential.

The Vet Center program was established by Congress in 1979 out of the recognition that a significant number of Vietnam-era Vets were still experiencing readjustment problems. Over time, Congress extended eligibility to all Veterans who served in a combat zone or area of hostility or who have experienced MST.

Recent legislation now authorizes Vet Centers to provide readjustment counseling services to certain active duty Servicemembers and their families. Vet Centers are community-based and part of VA. Vet Center program staff welcome home war Veterans and Servicemembers with honor by providing quality readjustment counseling in a caring manner. Vet Centers understand and appreciate these individuals' war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community. Recognizing the increased roles for women in the military, the Vet Centers provide an important place outside of the traditional sites of care for women Veterans to receive services related to those experiences.

Women Veterans Reproductive Health

Reproductive health is a critical component of women's health. It encompasses gynecologic health throughout life such as pre-conception care, infertility care, maternity care, cancer care, and the interaction of these with other health conditions (e.g., mental health). VHA's Reproductive Health Program initiatives include enhancing VHA's reproductive health workforce; providing high quality maternity and mental health care; delivering high-quality emergency services for women; and ensuring safe prescribing, pre-conception care, and care for aging women Veterans. WHS has several key accomplishments specific to reproductive health including:

- Decreasing fragmentation of maternity care in VHA through the implementation of Maternity Health Care and Coordination policy and supporting the development of Maternity Care tele-health pilots at 11 VA Healthcare Systems serving over 500 women Veterans.
- Developing a prototype maternity dashboard named "Maternity Tracker" that will enhance the delivery of high-quality maternity care and facilitate care coordination between VA and non-VA medical care providers. The "Maternity Tracker" is set to pilot in a VHA facility during FY 2015.
- Awarding funds to VHA facilities to support the development of innovative tools and purchase of gynecologic equipment to enhance the quality of care delivered to women in VA emergency departments and launching and disseminating the VA Emergency Services for Women (ESW) Toolkit, an online database of searchable tools and resources for VA Emergency Medicine providers and staff.

Gynecological Care - Enhancing the Reproductive Health Workforce

VA recognizes the availability of on-site gynecologists plays a critical role in providing comprehensive care to women Veterans. In collaboration with primary care, emergency medicine, mental health, and other subspecialty providers, obstetrics and gynecology providers strengthen the team of providers caring for women Veterans. VHA provides high-quality gynecologic care to all women Veterans, either in VHA facilities or locally through non-VA medical care mechanisms.

However, gynecology specialty providers are not available on-site at all VA health care centers. Therefore, VA intends to address the hiring of gynecologists and improved access by expanding on-site gynecologic services and support as we implement the Veterans Access, Choice, and Accountability Act of 2014.

Reproductive health also includes care related to infertility, menopause, and subspecialty gynecology care including female pelvic medicine (urogynecology) and reconstructive surgery, high-risk maternity care, and gynecologic oncology. We are planning to expand the scope of VA practice in reproductive health through additional resources and innovative technologies and partnerships with local experts and key stakeholders particularly in areas of urogynecology and infertility care. We also plan to address key issues in specialty gynecological care coordination for women with gynecologic cancers to improve delivery and coordination of care between VA and non-VA medical care settings.

VHA is already enhancing gynecology care to women in rural areas through innovative technologies such as e-consults, tele-gynecology, and tele-maternity services. Expansion of these innovative technologies is being explored as a mechanism to ensure access to gynecology care in parts of the country where recruitment of gynecologists is a challenge.

Military Sexual Trauma

Military sexual trauma (MST) is a VA term that refers to sexual assault or repeated, threatening sexual harassment experienced during military service. In FY 2014, 85,033 or 25.04 percent of female Veterans seen for VA health care had reported a history of MST when screened by a VA health care provider. Not all MST survivors have long-term difficulties, but some experience chronic physical and mental health problems, including PTSD, depression, and substance use disorders.

All VA treatment for physical and mental health conditions related to MST is provided free of charge. Service connection is not required, and Veterans may be able to receive free MST-related care even if they are not eligible for other VA services. VA offers a wide range of treatment services: Outpatient MST-related mental health care is available at every VAMC, and residential and inpatient programs are available for

Veterans who need more intense treatment and support. Community-Based Vet Centers also offer MST-related counseling and services. Among Veterans who screen positive for MST in VA, rates of engagement in care and amount of care provided continue to increase every year. In FY 2014, 64,696 or 76.1 percent of women who screened positive for MST received outpatient care for either a mental or physical health condition related to MST. This is an increase of nearly 11 percent from FY 2013, where 58,061 or 74.7 percent of women who screened positive for MST received MST-related outpatient care. These women Veterans had a total of 735,608 MST-related visits in FY 2014, which represents an increase of 11.4 percent (from 660,398 visits) from FY 2013.

Every VA health care system has a designated MST Coordinator who serves as the local point person for MST-related issues. In FY 2014, VA initiated a continuation and expansion of its successful National Review of the Accessibility of MST Coordinators. This program is an innovative "secret shopper" initiative to survey the experiences a Veteran would be likely to have in attempting to reach an MST Coordinator via telephone. This initiative was expanded in FY 2014 to include calls to one CBOC as well as one VAMC for each health care system. In early FY 2014, over 80 percent of VA health care systems received a satisfactory rating, a nearly 30 percentage point improvement since the review began.

In order to ensure VA's capacity to provide MST-related care, VA annually evaluates the number of full-time equivalent employees required to meet the outpatient MST-related mental health treatment needs of Veterans. In the most recent analyses (based on FY 2013 data), all 140 VA health care systems were above the minimum threshold indicating adequate capacity to provide MST-related mental health care.

The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) contained several provisions relevant to VA MST services. VA now provides free treatment for conditions related to sexual assault or sexual harassment during inactive duty training (primarily drill weekends for Reservists and National Guard members). The new law also allows VA to provide MST services to active duty Servicemembers without a referral from DoD; VA is working with DoD on plans for implementation. Finally, VA will produce two new reports for Congress on its MST services. The first

compares VA MST services available for male and female Veterans. The second describes processes for transitioning care for MST Survivors from DoD to VA and joint efforts to assist Veterans in filing a disability claim related to MST.

VA is committed to ensuring that providers and key staff receive appropriate training to address the needs of Veterans who have experienced MST and may be at risk of suicide. VA's Veterans Crisis Line (VCL) is a hotline for Veterans experiencing suicidal thoughts. In FY 2014, specialized materials were developed to further enhance VCL staff's understanding of issues specific to MST and facilitate sensitive and effective handling of calls from Veterans who experienced MST. Additionally in FY 2014, an initiative was developed to strengthen collaboration between MST Coordinators and Suicide Prevention Coordinators, who serve as local points of contact and facilitators of MST and suicide prevention program efforts, respectively, at every VAMC. Finally, all VA mental health and primary care providers are required to complete a mandatory training on MST. The training includes clinically relevant topics such as working with Veterans who have experienced MST and may exhibit self-destructive behavior or are at risk of suicidal ideation. This training program will receive a major update in FY 2015 that will provide an opportunity to further strengthen and expand upon content on suicidal behavior and self-harm.

Mental Health Services

VA provides a full continuum of mental health services to women Veterans, including outpatient, inpatient, and residential treatment options. Evidence indicates that women differ from men in the prevalence and expression of certain mental health disorders, as well as in their responses to treatment. These differences may be due to biological sex differences, such as the impact of the female reproductive cycle on mental health, or social and cultural differences, such as the impact of gender-related violence. Awareness of these differences informs VA's Women's Mental Health Services. VA policy requires that mental health services be provided in a manner that recognizes that gender-specific issues are indeed important components of care.

Gender-Sensitive Mental Health Care

In 2012, VHA surveyed mental health leadership within each VA health care system (N = 141) to determine the availability of gender-sensitive mental health care for women Veterans. VA conceptualizes gender-sensitive mental health care as containing these key components:

- *Comprehensiveness*: Includes full continuum of service availability for women (e.g., general mental health, specialty mental health, residential/inpatient);
- *Choice*: Considers treatment modality (e.g., mixed-gender, women-only service options);
- *Competency*: Addresses women's unique treatment needs, and;
- *Innovation*: Provides creative options and settings for subgroups of women, especially when caseloads of women are small.

Survey results indicate that women Veterans have access to general and specialty outpatient mental health treatment options at all VHA health care systems. Findings also indicate that mental health services for women Veterans are most commonly provided in mixed-gender settings. Individual therapy was the most frequently reported alternative, when clinically indicated, to mixed-gender group therapy. Other frequently reported alternatives to mixed-gender outpatient care included tele-mental health, referrals to Vet Centers or community resources, and non-VA medical care. Overall, survey results indicated numerous and varied general and specialty outpatient options are offered to female Veterans seeking VA mental health services.

Mental Health Across the Life Span

Life transitions and physiological hormonal changes that occur during a woman's life cycle may serve to increase her risk of developing a mental health disorder. For example, sex-specific hormonal differences and reproductive life-cycle stages, such as pregnancy and perimenopause, can have effects on mental health. These changes across the reproductive life-cycle are particularly relevant for VHA, as over 40 percent of women Veterans seen in VHA are within their reproductive years (ages 18–44), and over 25 percent are aged consistent with perimenopause (ages 45–55).

Physiological changes across the life cycle can complicate treatment decisions; for example, maternal and fetal benefits and risks must be considered in medication management among pregnant women. Because of this, it is critical that providers for women Veterans are aware of the impact of biology on mental health and knowledgeable about the implications and efficacy of pharmacologic and behavioral intervention choices.

To ensure this, VHA has initiated collaborations between mental health, primary care, pharmacy, and women's health. We have assessed needs across VA for training about the impact of life cycle biological changes on women's mental health; over 600 providers were surveyed. Based on the results of this assessment, we have developed and disseminated educational tools for VA providers in the form of six module curricula. Currently, there are virtual pilots at two VA health care facilities and five VA virtual university trainings taking place.

Supporting Women's Transitions from Military to Civilian Life

VA recognizes the importance of coordination with DoD to support Veterans' reintegration and transitions from military to civilian life. DoD and VA Integrated Mental Health Strategy (IMHS) Strategic Action #28 examined gender differences in delivery and effectiveness of mental health services for female Servicemembers and Veterans, and those who have experienced military sexual assault (MSA), military sexual harassment (MSH), or MST. Findings from the Strategic Action #28 Task Group informed the development of recommendations to address identified gaps, developed strategies for overcoming health care disparities and barriers to care, identified the need for further research, and improved quality of care for these populations. The final report (still in the review /concurrence process) presents recommendations to address key research, surveillance, prevention and treatment gaps, and proposes a structure and processes for the continuation of DoD and VA collaboration in support of this initiative.

Women's Transition Support Groups

VA recognizes the significance that support groups have in the transition and recovery of Veterans and especially in the transition and recovery of women Veterans.

VA is able to offer a broad range of resources and programs for women Veterans within the scope of current legal authority. VHA has implemented a number of services to address the unique needs of women Veterans. The graduated continuum of family member services include:

- Family Education
- Support and Family Education (SAFE)
- National Alliance on Mental Illness (NAMI) Family-to-Family Education Program
- Family Consultation
- Family Psychoeducation
- Marriage and Family Counseling
- Coaching Into Care
- AboutFace
- Military Kids Connect
- Caregiver Support Program
- Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Care Management Teams
- The Federal Recovery Coordination Program (FRCP)
- VA's Fisher House and Temporary Lodging Program
- The Domestic Violence/Intimate Partner Violence (DV/IPV) Assistance Program
- Family Readjustment Counseling

Local Partnerships and Outreach for Women Veterans

VA recognizes the importance of outreach and partnership with our local communities. Several VHA specialized homeless programs include efforts designed to connect Veterans. These include connecting women Veterans and Veterans with families with health care, employment, financial counseling, and housing. Initiatives within VHA's continuum of homeless programs and services include:

- The Health Care for Homeless Veterans (HCHV) program:
    - During FY 2014, the total number of unique homeless Veterans served through HCHV outreach was over 158,000; of which 11 percent were

females as compared to 10 percent of the total from the previous fiscal year.

- The Supportive Services for Veteran Families (SSVF) program:
    - SSVF continues to serve women in greater proportion than they appear in the general homeless population (15 percent in SSVF versus 10 percent in the general homeless population). Also, as women are more commonly the custodians of dependent children, SSVF serves many female Veterans and their dependent children. Fifteen percent (11,702 of 79,449) of Veterans served were female – the highest proportion of women Veterans served of any VA homeless initiative. Nearly one quarter (29,884 of 127,829) of all those served were dependent children.
- Grant and Per Diem (GPD) funded outreach programs:
    - In FY 2014, more than 200 GPD projects had some capacity to serve women Veterans. Of those projects, approximately 40 were women-specific and 38 had the capacity to serve women with dependent children; although per diem was only paid for the women Veterans. In FY 2014, over 45,160 Veterans were served through the GPD program; of these, approximately 7 percent were women. In the first 4 months of FY 2015, over 24,000 unique Veterans were provided services through GPD; the percentage of homeless women Veterans has remained consistent at approximately 7 percent.
- The Department of Housing and Urban Development – VA Supportive Housing (HUD-VASH) program:
    - During FY 2014, about 12 percent of those admitted to HUD-VASH were women. In FY 2014, there were 17,829 families served by HUD-VASH an increase of 3,195 new families housed with the Veteran by HUD-VASH. At the time of entry into the program, approximately 36 percent of females and 13 percent of males planned to live with their children and/or other family members when housed.

- Veterans Justice Programs (VJO):
    - In FY 2014, HCRV provided services to over 16,700 Veterans of which 2.2 percent were women. In FY 2014, VJO served to nearly 41,700 justice-involved Veterans, of which 5.6 percent were women.
- Community Employment Coordinators (CEC) for homeless Veterans program:
    - Of the 121 CECs who have been hired thus far, 10 percent are women Veterans, and 7 percent are women Veterans who have exited homelessness.

Conclusion

Our mission at VA is to care for those "who shall have borne the battle" and their families and Survivors. While we have made significant strides in recent years, we still have much to do as VA develops a nationwide effort to enhance the language, practice, and culture of VA to be more inclusive of women Veterans. We will continue to improve our efforts to provide high-quality, timely health care to our women Veterans and we appreciate this Committee's ongoing support in doing so.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions you or the other Members of the Committee may have.

STATEMENT OF

ALEKS MOROSKY, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

FOR THE RECORD

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

Examining Access and Quality of Care and Services for Women Veterans

WASHINGTON, D.C. April 30, 2015

Chairman Miller, Ranking Member Brown and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, I want to thank you for the opportunity to present the VFW's perspective on the state of women veterans' health care and services at the Department of Veterans Affairs (VA).

Recent years have seen unprecedented levels of women serving in the U.S. military. Today, over 1.3 million women wear our nation's uniform, comprising over 15 percent of the total force. Likewise, the demand for VA services by women veterans has increased dramatically. According to VA statistics, the number of women using VA services grew from just over 200,000 in 2003 to over 362,000 in 2012, an increase of approximately 80 percent. By 2014, that number had grown to over 400,000. In addition, the most recent VA data shows that approximately 19 percent of women using VA health care today served in either Iraq or Afghanistan, compared to only 9 percent of men. Accordingly, women veterans receiving VA care are younger than their male counterparts, with 42 percent of women under the age of 45, compared to only 13 percent of men. As a result, the number of women using VA services as a percentage of the total population will only continue to grow in the coming years, along with their need for health care.

In 2008, VA launched its Women's Health Services initiative in order to increase capacity and quality of women's health care. The initiative included the establishment of a Women Veterans Program Manager in every VHA health care system, along with expanding women's health clinics and improving provider training on gender-specific services. This was in response not only to the growing demand, but also in recognition of the fact that VA had historically been a male-centric institution. As a result, access and quality of women's health care has greatly improved across the Department. In 2009, Designated Women's Health Providers (DWHP),

doctors trained in both general and gender-specific primary care, were available in only one third of Department facilities. Today DWHPs are available at every VA Medical Center (VAMC).

Still, gaps in services remain for women enrolled in VA, particularly in gender-specific specialty care. Today, only 52 VA facilities provide on-site mammography. According to VA testimony given on April 21, 2015 before the Senate Veterans Affairs Committee, 35 VAMCs still have no on-site gynecological services. Of those that do, many of the doctors work part-time, and VA is unable to determine which sites are able to meet demand, since they have had no effective staffing model up to now. The VFW recognizes that VA has implemented a workforce planning model to correct this problem in accordance with section 301 of the Veterans Access, Choice and Accountability Act. In doing so, VA must be able to not only determine the current need for gender-specific care, but project the future need of this growing population and anticipate the necessity to hire accordingly. Non-VA care must continue to be fully utilized in the meantime, but full staffing of gender-specific service must remain the goal.

Another unresolved issue for women veterans is unemployment. This is especially true for women veterans of the current conflicts. The VFW recognizes that reentering the civilian workforce after service presents barriers for all recently returning veterans; however, female veterans statistically face a greater challenge. According to the most recent data from the Bureau of Labor Statistics, the unemployment rate for women Post-9/11 veterans stands at 8.5 percent. This is noticeably higher than the 6.9 percent unemployment rate of their male veteran counterparts, and significantly higher than the 5.9 percent rate of civilian women.

It should be noted that women veteran unemployment cannot be easily linked to lack of education. The most recent VA data shows that women veterans using GI Bill benefits achieve a 10 percent higher completion rate than male veterans, and a 5 percent higher completion rate than civilian women. The VFW suspects that women veteran unemployment must emanate from access to employment resources. To address this issue, we recommend that Transition Assistance Programs institute gender-specific satisfaction surveys in order to ensure that women are receiving quality, usable training before separating from service. In addition, we recommend that VA and the Department of Labor develop outreach campaigns specific to current era women veterans in order to ensure that they understand and utilize all available programs and services designed to assist them in translating their valuable military training into high quality civilian employment.

Women veterans' homelessness is another area that requires specific focus. Every effort must be made to ensure that homeless women veterans are provided with the specific service it will take to fully reintegrate them into society. While the Project Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) identified that unmet needs of homeless women veterans are the same as men on eight of the top ten issues, it's important to keep in mind that closing these gaps in services may take a different approach for each gender. One size does not fit all. Homeless women need adequate shelter and housing options that are safe and separated from their male counterparts. Child care service must be integrated into reintegration programs so parents and children can stay together. Lastly, family reconciliation assistance must be prepared to provide gender specific assistance during the reintegration process.

Funding must be set aside to ensure adequate housing options are available in all communities for homeless woman and homeless veterans who have children. As VA and HUD work to close the gap in family reconciliation assistance, effectiveness surveys must by conducted to ensure that gender specific issues are being addressed.

In drafting this testimony, we sought the input of women VFW members from across the country. While many are very pleased with the progress made by VA in addressing their specific needs, they also identified several areas in need of improvement. The VFW believes that in no instance should women veterans receive care that is inferior to male veterans or in an environment that is less welcoming. Although anecdotes about unfriendly staff, sub-par facilities, and lack of privacy persist throughout the veterans' community, we are pleased to report that nearly every VFW member we spoke with feels that women's services have greatly improved in recent years, and the majority of them are satisfied with their VA experiences, overall.

In speaking to VFW members about their VA experiences, certain positive recurring themes became apparent. Nearly all were very satisfied with the responsiveness and effectiveness of their Women Veterans Program Managers. By and large, the veterans that we spoke to were happy with the quality, safety and privacy of the facilities of their women's clinics, as well as the availability of female primary care providers upon request. Specifically, a veteran enrolled at the St. Louis VAMC gave her women's clinic nothing but praise, stating that the access and quality of care are exceptional. A veteran enrolled at the Albuquerque VAMC had similar praise for the services she receives, recalling that she was recently scheduled for surgery to repair a deviated septum within two weeks of receiving a referral, and that her primary care provider called her at home that weekend to make sure she was recovering comfortably. Still, almost all veterans we interviewed pointed out that the access and quality of services they receive have improved only in recent years, and several veterans offered recommendations on areas which still need improvement.

A VFW member enrolled at the Buffalo VAMC told us that, although she is very satisfied with the primary care she receives from her primary care provider, obtaining referrals for specialty care outside of the women's clinic is often challenging. She told us that she recently waited four months to see a podiatrist to address nerve pain in her feet. The VFW sees this problem as two-fold. First, VA must complete its workforce staffing model for all specialties, and hire the necessary staff accordingly. If VA cannot accurately identify the demand for each service at each facility, long wait times for specialty care will persist for all veterans. Second, veterans who receive primary care at women's clinics should not feel like they are cut off from other services at the VAMC. The purpose of gender specific clinics should be to provide the best possible gender-specific care in an environment where veterans feel comfortable, not to segregate them form other services.

Another issue identified by a VFW member enrolled at the Salt Lake City is the high turnover rate of primary care providers that her women's clinic has experienced recently. It is important that all veterans are able to build rapport with their physicians. This is particularly critical for women veterans, many of whom have had negative VA experiences in the past, feeling that the environment where they received care was often unwelcoming and lacked an appreciation of their unique issues and their military service. The VFW realizes that the issue of high turnover is one that persists throughout VA. To solve this problem, VA must have the tools to offer

attractive financial incentives and cultivate the positive work environment necessary to recruit and retain high quality providers.

A persistent issue for the VFW has been the lack of child care available to veterans during their appointments. This concern was recently brought to our attention when speaking to a VFW member enrolled at the Manchester VAMC. She correctly pointed out that many veterans are single parents. Without access to any sort of child care services and often reluctant to bring their small children to medical appointments with them, many veterans choose to simply forgo the care they need and deserve. The VFW strongly believes that no veteran should be forced to choose between his or her own wellbeing and that of her child. For this reason, we continue to call on Congress to fully expand the VA child care pilot program to all facilities across the Department.

Our final recommendation is to obtain updated information the state of women's health care at VA. The last comprehensive report by the Government Accountability Office (GAO) on VA gender specific services was published in 2009. In order to ensure that gender specific services are meeting the obligation to provide exceptional care to all veterans at all facilities, we must have accurate data to show where the gaps in service lie. For this reason, we join our Independent Budget Veteran Service Organization partners in calling for a follow-on report to the GAO study on all women veteran services across VA.

Chairman Miller, Ranking Member Brown, this concludes my testimony.

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

Pursuant to Rule XI2(g)(4) of the House of Representatives, VFW has not received any federal grants in Fiscal Year 2014, 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.

Statement for the Record

Of

VIETNAM VETERANS OF AMERICA

Submitted by

Kate O'Hare Palmer

Chair, Women Veterans Committee

Before the
House Veterans Affairs Committee

Regarding

Examining Access and Quality of Care and Services for Women Veterans

April 30, 2015

Good morning Mr. Chairman, Ranking Member Brown, and distinguished members of the House Veterans Affairs Committee. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to submit our statement for the record Examining Access and Quality of Care and Services for Women Veterans.

Since 1982, Vietnam Veterans of America has been a leader in advocacy and championing appropriate and quality health care for all women veterans. The Department of Veterans Affairs (DVA) has made many innovations, improvements and advancements over the past thirty years. However, some concerns remain respective of its policies, care, treatment, delivery mode, and monitoring of services to women veterans.

MEDICAL TREATMENT OF WOMEN VETERANS BY DEPARTMENT OF VETERANS AFFAIRS (DVA)

Department of Veterans Affairs eligible women veterans are entitled to complete health care including care for gender specific illnesses, injuries and diseases. The DVA has become increasingly more sensitive and responsive to the needs of women veterans and many improvements have been made. Unfortunately, these changes and improvements have not been completely implemented throughout the entire system. In some locations, women veterans experience barriers to adequate health care and oversight with accountability is lacking. Primary care is fragmented for women veterans. What would be routine primary care in the community is referred out to specialty clinics in the VA. Over the last five years the per cent of women veterans using the VA has grown from 11% to 17%, with 56% of OEF/OIF women Veterans having enrolled in the VA. Their average age of women Veterans using the VA is 48.

Vietnam Veterans of America will continue its advocacy to secure appropriate facilities and resources for the diagnosis, care and treatment of women veterans at all DVA hospitals, clinics, and Vet Centers and we ask the Secretary of Veterans Affairs ensure senior leadership at all facilities and Regional Directors be held accountable for ensuring women veterans receive appropriate care in an appropriate environment. Further, we seek that the Secretary ensures:

- The competency of staff who work with women in providing gender-specific health care.
- That VA provides reproductive health care.

- That appropriate training regarding issues pertinent to women veterans is provided.
- That there is the creation of an environment in which staff are sensitive to the needs of women veterans; that this environment meets the women's needs for privacy, safety, and emotional and physical comfort in all venues.
- Those privacy policy standards are met for all patients at all VHA locations and the security of all Veterans is ensured.
- That the anticipated growth of the number of women Veterans should be considered in all strategic plans, facility construction/utilization and human capital needs.
- That patient satisfaction assessments and all clinical performance measures and monitors that are not gender-specific, be examined and reported by gender to detect any differences in the quality of care.
- That the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value report any significant differences and forward the findings to the Under Secretary for Health, Under Secretary for Operations and Management, the Regional Directors, facility directors and chiefs of staff, and the Women's Health Services Office.
- That every woman veteran has access to a VA primary care provider who meets all her primary care needs, including gender-specific and mental health care in the context of an ongoing patient-clinician relationship.
- That general mental health care providers are located within the women's and primary care clinics in order to facilitate the delivery of mental health services.
- That sexual trauma care is readily available to all veterans who need it and that VA ensure those providing this care and treatment have appropriate qualifications obtained through course work, training and/or clinical experience specific to MST or sexual trauma.
- That an evaluation of all gender specific sexual trauma intensive treatment residential programs be made to determine if this level is adequate as related to level of need for each gender, admission wait times, and geographically responsive to the need.
- That Vet Centers are able to adequately provide services to women veterans.
- That a plan is developed for the identification, development and dissemination of evidence-based treatments for PTSD and other co-occurring conditions attributed to combat exposure or sexual trauma.

- That women veterans, upon their request, have access to female mental health professionals, and if necessary, use VA outsource to meet the women veteran's needs.
- That all Community Based Outpatient Clinics (CBOC) which do not provide gender-specific care arrange for such care through VA outsource or contract in compliance with established access standards.
- Evidence-based holistic programs for women's health, mental health, and rehabilitation are available to ensure the full continuum of care.
- That the Women's Health Service aggressively seek to determine root causes for any differences in quality measures and report these to the Under Secretary for Health, Under Secretary for Operations and Management, the Regional Directors, facility directors and COS, and providers.
- That legislation be enacted to ensure neonatal care is provided for up to 30 days as needed for the newborn children of women veterans receiving maternity/delivery care through DVA.

Congressman Mike Coffman (CO-6) (for himself and MS. Speier) has introduced H.R. 1356 the Women Veterans Access to Quality Care Act, when enacted d into law would improve the provision of health care for women veterans by the Department of Veterans Affairs, and for other purposes and based on our recommendations above VVA fully supports the bill.

HOMELESS WOMEN VETERANS

Over the past two decades we have become increasingly more vested in the recognition and address of the situation of homelessness among Veterans. In looking back VVA well remembers the time when the VA acknowledged that as many as 275,000 Veterans filled these roles. With the legislative creation of the VA Homeless Grant and Per Diem HGPD program and its program growth, the VA and community Veteran service providers have been able to chip away at this deplorable situation of life that existed for so many who served this county in its armed forces. Startling is the fact that the percentage of homeless women Veterans has raised from 2% to 6% of the homeless Veteran population and that over the past four years the actual number has doubled.

Currently the VA sites that the number of homeless Veterans has been reduced to 49,933 as reported by the most recent Point in Time count. VVA recognizes this as a useful tool but doubts that this number is necessarily a solid number. It is a snap shot because it is impossible to have on record all the Veterans who are homeless.

Nonetheless it is a true indicator that all the energy surrounding the above mentioned programs has made a difference. It is undeniable that the number of Homeless women veterans has been climbing; however, collection data on homeless women Veterans is not reliable as indicated in the Government Accounting Office's (GAO) 2011 report "Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing. The report also cited some significant barriers to access of housing for homeless women Veterans are:

- They are not aware of the opportunities available
- They don't know how or where to obtain housing services.
- They are not easily found/identified in the community. They often "couch surf."
- They have children and avoid shelters because of the safety factor;
- They avoid social service agencies for fear of losing their children to the system.
- 24 percent of VA Medical Center homeless coordinators indicated they have no referral plans or processes in place for temporarily housing homeless women veterans while they await placement in HUD-VASH and GPD programs.
- Nearly 2/3 of VA HGPD programs are not capable of housing women with children.
- The program expense of housing women with children is a disincentive for providers.

VVA believes that it is a very ambiguous plan of the Ending Homeless among Veterans by 2015, but asks the questions? Are women Veterans and their needs truly being met by the programs that exist for them today? "What will be done to reach them, to know them, to meet their needs and provide them a safe environment in which to address them?" VVA believes that a coordinated plan needs to be developed at the local level by the leadership of the respective VA medical center within its homeless Veteran program to address these needs. The influx of women in the military and one of every ten soldiers serving in Iraq a woman, the female homeless population will only grow and or facilities dedicated to women are vital.

WOMEN VETERANS RESEARCH

Because women veterans have historically been a small percentage of the veteran population, many issues specific to women veterans have not been researched. General studies of veterans often had insufficient numbers of women veterans to detect differences between male and female veterans and/or results were not reported by gender. Today, however, women are projected to be more than 11 % of the veteran population by 2020 and 12% by 2025.

Vietnam Veterans of America asks the Secretary to conduct several studies specific to women veterans and that Congress pass legislation to mandate such studies if the Secretary does not act:

- A comprehensive assessment of the barriers to and root causes of disparities in the provision of comprehensive medical and mental health care by DVA for women veterans.
- A comprehensive assessment of the capacity and ability of women veterans' health programs in VA, including Compensation and Pension examinations, to meet the needs of women veterans. (GAO: March 2010: VHA).
- A comprehensive study of the relationship of toxic exposures during military training and service, and the infertility rates of veterans.
- A comprehensive evaluation of suicide among women veterans, including rates of both attempted and completed suicides, and risk factors, including co-morbid diagnoses, history of sexual trauma, unemployment, deployments, and homelessness.
- VA evaluation of the integration of services to support veterans.

CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE

VVA asks that particular reflective consideration be given to the following -- VVA seeks a change in this section of the proposed legislation that would increase the time for the provision of neonatal care to 30 days, as needed for the newborn children of women veterans receiving maternity/delivery care through the VA. Certainly, only newborns with extreme medical conditions would require this time extension. VVA believes that there may be extraordinary circumstances wherein it would be detrimental to the proper care and treatment of the newborn if this provision of service was limited to less than 30 days. The decision for extended would require professional justification. If the infant must have extended

hospitalization, it would allow time for the case manager to make the necessary arrangements to arrange necessary medical and social services assistance for the women veteran and her child. This has important implications for our rural woman veterans in particular. And this is not to mention cases where there needs to be consideration of a woman veteran's service-connected disabilities, including toxic exposures and mental health issues, especially during the pre-natal period, multiple births and pre-mature births. Prenatal and neonatal birthrate demographics (including miscarriage and stillborn data) would seem to be an important element herein.

WOMEN VETERANS AND VETERANS BENEFITS

The Veterans Benefits Administration (VBA), and to a lesser extent, the National Cemetery Administration (NCA), have been less proactive than the Veterans Health Administration in targeting outreach to women veterans and in ensuring competency in managing claims filed by women veterans.

Vietnam Veterans of America will continue its advocacy to secure benefits for all eligible veterans. VVA asks the Secretary to ensure:

- That leadership in all VA Regional Offices (VARO) is cognizant of and kept current on women veterans' issues; that they provide and conduct aggressive and pro-active outreach activities to women veterans and; that VBA leadership ensures oversight of these activities.
- That a national structure be developed within VBA for the Women Veteran Coordinator (WVC) positions, located at each VARO.
- That VBA establish consistent standards for the time allocated to the position of Women Veteran Coordinator (WVC) based on the number of women veterans in the area the VARO serves.
- That VBA develop a clear definition to the job description of the WVC and implement it as a full time position with defined performance measures.
- That VBA identify a subject matter expert on gender specific claims as a resource person in each regional office location.
- That the WVC is utilized to identify training needs and coordinate workshops.
- That the WVC have a presence in the local VHA system.

- That VBA ensure that all Regional Offices display information on the services and assistance provided by the Women Veteran Coordinator with clear designation of her contact information and office location.
- That VBA establish a method to identify and track outcomes for all claims involving personal assault trauma, regardless of the resulting disability, such as PTSD, depression, or anxiety disorder.
- That VBA perform an analysis and publish the data on Military Sexual Trauma (MST) claims volume, the disparity in the claim ratings by gender, assess the consistency of how these claims are adjudicated, and determine if increased training and testing is needed in this regard.
- That all claim adjudicators who process claims for gender-specific conditions and claims involving personal assault trauma receive mandatory initial and regular on-going training necessary to be competent to evaluate such claims.
- That the VARO create an environment in which staff are sensitive to the needs of women veterans, and the environment meets the women's needs for privacy, safety, and emotional and physical comfort.
- That National Cemetery Administration enhances its targeted outreach efforts in those areas where burial benefits usage by women veterans does not reflect the women veterans' population. This may include collaboration with VBA and VHA in seeking means to proactively provide burial benefits information to women veterans, their spouses and children, and to funeral directors.

WOMEN VETERAN PROGRAM MANAGERS

Women Veteran advocates call for Congressional oversight and accountability during this congress. We are weary of hearing that the position of facility Women Veteran Program Managers would be full time positions, while in reality, after all this time, this isn't necessarily true. As a system wide directive the VA 2010, Handbook 1330.01, Health Care Services for Women Veterans defines the responsibilities of both the VA Veterans Integrated Service Network (Regional) Director and the Medical Center (VAMC) Director and its enforcement demands this attention. Additionally, both WVPM positions are further defined in the VA 2012, Handbook 1330.02 Women Veteran Program Managers.

MILITARY SEXUAL TRAUMA (MST)

Currently, instances of sexual assault in the military must be reported through the chain of command. The creation of a separate and independent office to address such crimes would remove barriers to reporting and provide additional protection and safety for the victims.

According to DoD Sexual Assault Prevention and Response Office (SAPRO), the majority of survivors of MST (71%) are under 24 years old and of lower ranks; whereas the majority of assailants (59.5%) are between 20 and 34 years old and of a higher rank than the survivor. Military groups are extremely small communities and when reports of assault must proceed through the chain of command, it is impossible to guarantee that confidential information will stay with those who have a 'need-to-know'. Additionally, survivors may fear that their own actions may be cause for punishment. The threat of retaliation or fear of being reprimanded is enough to silence many survivors or have them recant their stories. A defined system of checks and balances is needed to level the playing field. This office should also have a legal advisor on the team.

VVA will pursue legislation that reassigns complaints of military sexual trauma by service members and all alleged perpetrators outside of their immediate chain of command.

TRAVEL FOR VHA TREATMENT

The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. This Directive is not aligned with the military sexual trauma (MST) policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

In light of the limited intensive residential treatment programs within the VA that are both MST specific and gender specific, many women veterans, especially those who are homeless and/or have limited income have difficulty seeking and accessing programs that meet their clinical needs.

Vietnam Veterans of America calls on the Under Secretary for Health to review and reexamine existing VHA policy pertaining to the authorization of travel for veterans, who have been referred by their mental health clinician, to a MST-related

specialized inpatient intensive residential treatment programs outside the facilities/Regions where they are enrolled. Additionally, VVA calls for the provision of these travel funds whether the Veteran is an in-patient or an outpatient also that all medical center clinical staff are advised and fully understand the implementation of this policy.

WOMEN VETERANS STRATEGIC PLAN

The strategic plan FY2010-2014 and Addendum FY 2011-2015 stated that the goals and integrated objectives were to be implemented and analyzed with published outcomes of performance measures. However, not all programs that serve women veterans have specific performance measures that track the outcome of programs initiated to respond to the needs of women veterans.

Originally, in the Department of Veterans Affairs (VA) Strategic Plan for FY 2010-2014, the only objective that dealt with the women veterans directly was the Integrated Objective 2: Empower Women Veterans. The purpose of the objective is: Promote recognition of contributions of women, ensure VA programs are responsive to the needs of women veterans, and educate women about VA benefits and services.

The Vietnam Veterans of America will continue its advocacy for women veterans. We recommend the VA should collect, analyze and publish data by gender and minority status for every program that serves veterans to improve understanding, monitoring and oversight of programs that serve women veterans. The data collected must be measured and reported to ensure that the needs of women veterans are met.

IN CLOSING

Vietnam Veterans of America has as its' number one legislative priority the issue of accountability; accountability at every level of any agency, federal, state, or local, that impacts Veterans and their families. It is through this accountability that Vietnam Veterans of America hopes to improve the quality of care and life for all of our nation's Veterans.

VIETNAM VETERANS OF AMERICA

Funding Statement

April 30, 2015

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

Executive Director of Policy and Government Affairs
Vietnam Veterans of America.
(301) 585-4000, extension 127

KATE O'HARE-PALMER

Commissioned as an RN in the Army Nurse Corp in 1967 from Seal Beach, California. Served as an operating room nurse and emergency room nurse at 2nd Surgical Hospital and 312th Evacuation Hospital in Chu Lai, RVN 1968, and at the 2nd Surgical Hospital, Lai Khe, in 1969.

Worked in Bay area community hospitals in the operating room while attending college. Received Diploma Nursing Program, Los Angeles County Hospital. 1967. UC Berkeley 1974 with BSc. Nutrition. Certified Registered Dietitian 1975. Jin Shin Jyutsu Certification. 1997. Holistic Health modality and BA Music Education. Sonoma State University. 2004.

Worked at the San Francisco VA Medical Center for sixteen years in a variety of positions including: staff nurse, head nurse-medical/surgical, head nurse on Human Studies/Research unit, developed the Nutritional Support Team, Head nurse of out -patient clinics. Also worked as nursing supervisor at Kaiser Permanente Hospitals, VNA and Home Hospice and developed their 5 county Flu Shot Programs

Worked with Vet Connect, education committee, stand downs, grants writing, and coordinate some women veteran activities with California Department of Veteran Affairs. Women Veteran Committee Chair at California State Council for past 5 years. Also a member of the American Legion and AMVETS and joined VVA Chapter 223 in 1994.

Currently retired and live in Petaluma, CA with my daughters

STATEMENT OF THE
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON "EXAMINING ACCESS AND QUALITY OF CARE AND SERVICES FOR WOMEN VETERANS"

APRIL 30, 2015

Mr. Chairman and Members of the Committee, thank you for the opportunity to provide information on the work of the Office of Inspector General (OIG) regarding the access to and quality of care and services for women veterans from the Department of Veterans Affairs (VA).

BACKGROUND

The National Center for Veterans Analysis and Statistics (NCVAS) estimates that as of September 30, 2014, women veterans made up 9 percent (2 million) of the total living veteran population (22 million).[1] NCVAS projects that by 2043, one in every six veterans will be a woman.[2] As both the population of and proportion of women veterans continue to grow, VA must anticipate ways to meet the rising demand to provide for the comprehensive and unique health care needs of women veterans. Since 2010, the OIG has reviewed various aspects of women's health care provided by VA through our national reviews and as part of our cyclical Community Based Outpatient Clinic (CBOC) reviews. Appendix A provides a list of OIG reports regarding women veterans. As part of the OIG's continued commitment to addressing issues of significance for women veterans, we also have two national reviews underway.

ONGOING REVIEWS

In March 2015, at the request of several Members of this Committee, we initiated a national review to determine how VA can better address the needs of women veterans using VA health care services. Specifically, our review will examine VA's ability to provide gender-specific care for women veterans and assess the efficacy of and compliance with privacy standards. We expect to complete this work by September 2015. We have also initiated another, more focused national review of military sexual trauma (MST) that will look at transitions from the Department of Defense (DoD) to VA and assess VA's outreach efforts to veterans who have experienced MST. We are working with DoD to obtain data so that we can examine VA medical care delivered to veterans with a history of military sexual trauma from DoD. We are currently working with DoD on a Memorandum of Agreement for data sharing; once signed, we anticipate

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[1] Veteran Population Projection Model 2014 (VetPop2014), http://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/1L_VetPop2014.xlsx (accessed 4/23/2015).

[2] NCVAS data estimates that 2.4 million out of 14.5 million living veterans will be women. VetPop2014, http://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/1L_VetPop2014.xlsx (accessed 4/23/2015).

completing this work within 8 months. We will issue reports when our work is complete, and we will brief Members of Congress who have expressed an interest in these topics.

NATIONAL REVIEWS

The OIG has conducted two national reviews related to specifically women veterans. At the request of the Senate Veterans' Affairs Committee, we reviewed Veterans Health Administration (VHA) services available to women veterans who had experienced MST.[3] We reviewed mental health services provided to 166 women with a history of MST treated at 14 residential and inpatient programs identified by the VHA MST support team website as resources for women veterans. We also reviewed patient electronic health records (EHR), VHA policy, and program self-assessments and conducted onsite visits at eight programs.

We found that patients were complex in terms of treatment, often with more than one mental health diagnosis. Ninety percent had received VHA mental health care within 3 months of program admission and largely from a female mental health provider. The programs reviewed provided evidenced-based psychotherapy techniques, gender-specific care, and same gender therapists. We also found that women were often admitted to programs outside their Veterans Integrated Service Network yet obtaining authorization for travel funding was frequently cited as a problem for patients and staff. We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled. A decision on whether to change the travel policy is still pending with the Interim Under Secretary for Health.

As required by the *Conference Report to Accompany the Consolidated Appropriations Act of 2010* (Public Law 111-117), we assessed women veterans' use of VA health care for traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and other mental health conditions.[4] Based on integrated data from VA and DoD, we characterized the population of nearly 500,000 veterans discharged from active military duty between July 1, 2005, and September 30, 2006, and we described their experience transitioning to VA and using VA health care and compensation benefits through March 31, 2010. We observed that, with variations in degree, female veterans generally were more likely to use VA health care than male veterans. They were also more likely to continue using VA health care services—even years after separating from active military service, and to use it more frequently.

Further, we noticed that VA generally diagnosed higher proportions of female veterans with mental health conditions after separation, but lower proportions were diagnosed with the specific mental health condition of PTSD or TBI. These patterns corroborated our findings from our data analysis and from our review of compensation claims files

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[3] *Healthcare Inspection - Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma* (December 5, 2012).

[4] *Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits* (December 16, 2010).

that higher proportions of female veterans generally were awarded disability for mental health conditions other than PTSD, and a higher proportion of male veterans were generally awarded disability for PTSD or TBI. Our data analysis of the study population indicated that the Veterans Benefits Administration denied females more often for PTSD and denied male veterans more often for a mental health condition other than PTSD, although the denial rates for male and female veterans for all mental health conditions were almost the same.

COMMUNITY BASED OUTPATIENT CLINIC REVIEWS

In fiscal year (FY) 2009, the OIG began a systematic review of CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures for selected clinical and administrative operations.

In 2010, VHA established minimum clinical requirements to ensure that all eligible and enrolled women veterans, irrespective of where they obtain care in VA, have access to all necessary services as clinically indicated.[5] For FY 2012 through 2014, CBOC reviews focused in these areas:

- Women veterans' privacy and security
- Breast cancer screening
- Cervical cancer screening
- Proficiency of designated women's health providers (DWHP)

Women Veterans' Privacy and Security

The health care environment directly and indirectly affects the quality of care provided to women veterans. It affects their comfort and sense of security, as well as their perceptions of care received. VA policy requires that privacy be provided to women veterans in all health care settings, and measures must be taken to maintain and adjust care environments to support their dignity, privacy, and security.[6] In the outpatient care setting, veterans must be provided adequate visual and auditory privacy at check-in and in the interview area. In the examination rooms, patient dignity and privacy must be maintained at all times during the course of a physical examination. Privacy curtains must be functional and shield the actual examination area. Placement of the examination table needs to minimize inadvertent exposure of the patient during a physical examination. Examination room doors must also have electronic or manual locks.

For FY 2013, of the 95 CBOCs we evaluated, 93 percent were compliant with women veterans' privacy and security standards. Of those that were noncompliant, deficiencies included lack of privacy curtains installed in the examination rooms and misplacement of examination tables where the patient's feet faced the entry door. We made recommendations in five local facility-based CBOC reports, improvements were made, and we closed all the recommendations.

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[5] VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
[6] VHA Handbook 1330.01.

For FY 2014, of the 93 CBOCs we evaluated, 78 percent provided adequate privacy for women veterans. Five CBOCs that had examination rooms designated for women veterans were not equipped with an electronic or manual door lock and one CBOC had no privacy curtains. We also noted 15 CBOCs with physical settings where gowned women veterans could not access gender-specific restrooms without entering public areas and no alternative measures were in place. Recommendations were issued in 15 local facility-based CBOC reports, improvements are being made, and 7 of the reports have been closed.

Breast Cancer Screening Through Mammography
Breast cancer is the second most common type of cancer among American women, with approximately 232,000 new cases in FY 2015.[7] Timely screening, diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. Screening by mammography has been shown to reduce mortality by 20–30 percent among women age 40 and older.

VA requires that the Women Veterans Program Manager ensure that local policies and procedures guarantee proper and timely notification of gender-specific diagnostic study results. Each CBOC must also have a Women's Health Liaison who collaborates with the Women Veterans Program Manager to coordinate women's issues. All breast imaging and mammography results must be linked to the appropriate radiology breast study or mammogram order and entered into the Computerized Patient Record System (CPRS). The linking of the results to the orders is important because it enables providers and other clinical staff to find needed mammography results quickly and easily. Each VHA facility is also required to establish and document processes to track both the results of procedures performed offsite and the follow-up of abnormal results.

For patient notification, each certified VA Mammography Program and offsite non-VA mammography provider must establish a documented procedure to provide a summary of the written mammography report to the patient within 30 days from the date of the procedure. The VA ordering practitioner must communicate mammography results to the patient within 14 calendar days from the date on which the results were available to the ordering provider. When the mammography report assessment is "suspicious" or "highly suggestive of malignancy," the summary results and recommended course of action should be communicated to the patient as soon as possible but no later than 5 business days after the mammogram. This may be achieved through documented verbal communication, but the provider is still required to provide written communication to the patient within 30 calendar days of the date of the mammogram.

When mammography services are outsourced, the site performing the mammogram is required to communicate the result directly to the patient. There is no additional requirement for the referring VA health care facility to provide written communication directly with the patient, unless local facility policy requires one. However, if additional

[7] American Cancer Society, Cancer Facts & Figures 2015.

follow-up, treatment, or care is recommended, it is the responsibility of the ordering VA practitioner to attempt to contact the patient, continue the appropriate treatment regimen, and maintain continuity of care. Mammography studies that are completed by a fee provider, contract, or VA-certified mammography centers must also be linked to the provider order in CPRS to ensure that the study is complete and the patient receives the required notification.

During FY 2011, we evaluated the availability of assigned Women's Health Liaisons and the communication of mammography results to patients. We found 89 percent of the CBOCs had a Women's Health Liaison. We also found just over 11 percent compliance with the linking of mammogram results to the breast study order in CPRS. This compliance rate indicated to us that providers did not always have consistent access to comprehensive information needed to determine treatment plans for their patients. We noted that almost 73 percent of the patients were notified of their normal results, and approximately 96 percent of patients were notified of their abnormal results. We recommended that the Under Secretary for Health ensure that each CBOC has a Women's Health Liaison and that all breast imaging and mammography results are linked to the appropriate radiology mammogram or breast study order in CPRS. The Under Secretary for Health concurred with our recommendations, VHA completed their action plans for improvement, and we have closed the recommendations.

During FY 2012, we continued to evaluate the communication of mammography results to patients. We found about 93 percent with the documentation of mammography results in the radiology software package of CPRS. We also noted that 55 percent of the results of mammograms performed by a fee-basis or contract provider were linked to the provider order in CPRS and that 40 percent of the CBOC patients' EHRs contained documentation of patient notification of their mammogram results within 14 days. We recommended that the Under Secretary for Health ensure that CBOC managers establish processes to consistently link breast imaging and mammography results to the appropriate mammogram or breast study order for all fee basis and contract patients, to notify patients of mammogram results within the allotted timeframe, and document notification in the EHR. The Under Secretary for Health concurred with our recommendations, VHA completed their action plans for improvement, and we have closed the recommendations.

Cervical Cancer Screening through Papanicolaou Tests
Each year, approximately 13,000 women in the United States are diagnosed with cervical cancer.[8] The first step of care is screening women for cervical cancer with the Papanicolaou test or "Pap" test. Screening by the Pap test is one of the most reliable and effective cancer screening tests available. With timely screening, diagnosis, notification, and treatment, the cancer is highly preventable and associated with long survival and good quality of life.

Women should have cervical cancer screening at regular intervals. According to the

[8] American Cancer Society, Cancer Facts & Figures 2015.

American Medical Association, "the American College of Obstetricians and Gynecologists recommended postponing Papanicolaou testing until age 21 years and extending the rescreening interval from 1 to 2 years, citing concern about harms." In October 2011, the American Cancer Society and two pathology societies recommended that women reduce the lifetime number of Pap tests to ensure that they "receive the benefits of testing while minimizing the risks."

VA outlines specific requirements that must be met by facilities that perform cervical cancer screening services for women veterans. The results of normal cervical pathology results must be reported to the ordering provider within 30 calendar days of the pathology report being issued. The interpreting physician must ensure the ordering provider is contacted with abnormal results within 5 business days. The cervical pathology report with normal results must be communicated to the patient in terms easily understood by a layperson within 14 days from the date of the pathology report becoming available. Documentation of a letter and/or verbal communication with the patient must be entered into CPRS. For any abnormal cervical pathology report, the results must be communicated within 5 business days of the report being issued.

During FY 2013, we evaluated the communication of cervical cancer screening results to both providers and patients. We found 99 percent compliance with the documentation of test results in the laboratory package of CPRS and about 91 percent compliance with provider notification of normal results as documented in CPRS. We also noted 81 percent compliance with the provider notification of abnormal results within 5 business days, 84 percent compliance with patient notification of normal results within 14 days of pathology report availability, and about 68 percent compliance with patient notification of abnormal results within 5 business days of the pathology report availability. We recommended that the Under Secretary for Health ensure that a consistent process is established for notifying ordering providers of abnormal screening results within the required timeframe and that notification is documented in the EHR. We also recommended that the Under Secretary for Health ensure that a consistent process is established for notifying patients of normal and abnormal screening results within the required timeframe and that notification is documented in the EHR. The Under Secretary for Health concurred with our recommendations, and as of April 2015, VHA was still implementing their action plans.

Designated Women's Health Providers' Proficiency
VA requires designated women's health providers (DWHP) to maintain proficiency in the core concepts of women's health so that comprehensive primary care may be provided to women veterans. DWHPs must be fully proficient in providing the complete range of primary care. This may involve retraining of primary care practitioners (PCPs) or the hiring of new PCPs who can provide comprehensive primary care to both men and women veterans. To maintain proficiency in women's health, VA requires that the DWHPs' patient panels comprise at least 10 percent female patients so that they will spend at least one-half day every week (or its equivalent) practicing or precepting (i.e. training a less experienced provider and overseeing the care he or she provides) in a women's health practice. Facility Chiefs of Staff must also ensure that DWHPs are

designated with the "WH" indicator in the Primary Care Management Module, the software program that tracks and reports on health care team assignments and the assignment of patients to providers.[9]

During FY 2014, we evaluated the proficiencies of VA's DWHPs. We found that 91 percent in the CBOCs and primary care clinics at the parent health care systems had maintained proficiency requirements as established by VA. We also noted that 89 percent of these providers were designated with the "WH" indicator in VA's Primary Care Management Module as required. We made recommendations at nine facilities to ensure DWHPs maintain proficiency and that DWHP providers are designated with the "WH" indicator. As of April 2015, seven facilities had taken appropriate actions, and we closed the recommendations. Two facilities were still implementing actions to address the recommendations.

CONCLUSION

According to VA data, the number of women veterans served by VA will continue to grow, and VA continues to explore ways to enhance health care for women veterans. Through our national reviews and ongoing cyclical reviews, the OIG has recognized the importance of ensuring women veterans have access to high-quality health care in a safe and dignified manner. Since 2010, the OIG has made recommendations to the Under Secretary for Health regarding women's health care delivery processes. It is critical that VHA remains vigilant in maintaining improvements in the provision of examination room and restroom privacy, the designation of a Women's Health Liaison at each CBOC, the linking of all breast imaging and mammography results to the appropriate radiology mammogram or breast study order in CPRS, and the timely patient notification of mammogram results within the allotted timeframe with documentation in CPRS. We will also continue to monitor VHA's action plans for improving provider notification of abnormal cervical cancer screening results and patient notification of both normal and abnormal cervical screening results with documentation in CPRS until the open recommendations in our reports are fully implemented.

The OIG will maintain its commitment to provide independent oversight of various aspects of care delivery, access, safety, privacy, and quality. We look forward to sharing with the Committee the results of our current work on significant women's health care issues in several months. Thank you, Mr. Chairman, for the opportunity to submit this statement.

[9] VHA Handbooks 1330.01 and 1101.02, *Primary Care Management Module*, April 21, 2009.

APPENDIX A

VA Office of Inspector General
Reporting on VA Care for Women Veterans

National Reports

December 5, 2012	Healthcare Inspection – Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma http://www.va.gov/oig/pubs/VAOIG-12-03399-54.pdf
December 16, 2010	Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits http://www.va.gov/oig/52/reports/2011/VAOIG-10-01640-45.pdf

CBOC Summary Reports

September 23, 2014	Community Based Outpatient Clinic Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting http://www.va.gov/oig/pubs/VAOIG-14-02198-284.pdf
September 30, 2013	Healthcare Inspection – Evaluation of VHA Community Based Outpatient Clinics Fiscal Year 2012 http://www.va.gov/oig/pubs/VAOIG-13-00090-346.pdf
August 16, 2012	Healthcare Inspection Evaluation of Community Based Outpatient Clinics Fiscal Year 2011 http://www.va.gov/oig/pubs/VAOIG-11-01406-247.pdf

Individual CBOC Reports

November 10, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Miami VA Healthcare System, Miami, Florida http://www.va.gov/oig/pubs/VAOIG-14-00939-27.pdf
August 12, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin http://www.va.gov/oig/pubs/VAOIG-14-00923-237.pdf
July 23, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at West Texas VA Health Care System, Big Spring, Texas http://www.va.gov/oig/pubs/VAOIG-14-00916-218.pdf

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July 8, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Robert J. Dole VA Medical Center, Wichita, Kansas http://www.va.gov/oig/pubs/VAOIG-14-00915-206.pdf
July 7, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington http://www.va.gov/oig/pubs/VAOIG-14-00910-205.pdf
July 2, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Black Hills Health Care System, Fort Meade, South Dakota http://www.va.gov/oig/pubs/VAOIG-14-00909-191.pdf
June 26, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Wilmington VA Medical Center, Wilmington, Delaware http://www.va.gov/oig/pubs/VAOIG-14-00235-195.pdf
June 26, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Eastern Kansas Health Care System, Topeka, Kansas http://www.va.gov/oig/pubs/VAOIG-14-00914-190.pdf
June 10, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Huntington VA Medical Center, Huntington, West Virginia http://www.va.gov/oig/pubs/VAOIG-14-00905-182.pdf
May 22, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Aleda E. Lutz VA Medical Center, Saginaw, Michigan http://www.va.gov/oig/pubs/VAOIG-14-00231-158.pdf
May 13, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at James E. Van Zandt VA Medical Center, Altoona, Pennsylvania http://www.va.gov/oig/pubs/VAOIG-14-00236-153.pdf
April 28, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Southern Arizona VA Health Care System, Tucson, Arizona http://www.va.gov/oig/pubs/VAOIG-14-00240-129.pdf
March 13, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Caribbean Health Care System, San Juan, Puerto Rico http://www.va.gov/oig/pubs/VAOIG-14-00233-96.pdf

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February 28, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Salt Lake City Health Care System, Salt Lake City, Utah http://www.va.gov/oig/pubs/VAOIG-13-03420-85.pdf
February 27, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri http://www.va.gov/oig/pubs/VAOIG-13-03424-74.pdf
December 5, 2013	Community Based Outpatient Clinic Reviews at James H. Quillen VA Medical Center, Mountain Home, TN http://www.va.gov/oig/pubs/VAOIG-13-00026-24.pdf
September 18, 2013	Community Based Outpatient Clinic Reviews at James A. Haley Veterans' Hospital, Tampa, FL http://www.va.gov/oig/pubs/VAOIG-13-00026-314.pdf
August 19, 2013	Community Based Outpatient Clinic Reviews at Charlie Norwood VA Medical Center, Augusta, GA http://www.va.gov/oig/pubs/VAOIG-13-00026-285.pdf
May 31, 2013	Community Based Outpatient Clinic Reviews at North Florida/South Georgia Veterans Health System, Gainesville, FL http://www.va.gov/oig/pubs/VAOIG-13-00026-207.pdf
February 20, 2013	Community Based Outpatient Clinic Reviews at John J. Pershing VA Medical Center, Poplar Bluff, MO http://www.va.gov/oig/pubs/VAOIG-12-03851-102.pdf

TESTIMONY FOR THE RECORD OF
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

"Examining Access and Quality of Care and Services for Women Veterans"

April 30, 2015

Chairman Miller, Ranking Member Brown and distinguished Members of the Committee, on behalf of National Commander Mike D. Helm and the 2.3 million members of The American Legion, we thank you and your colleagues for the work you do in support of service members, veterans and their families. The American Legion commends you for holding this hearing to address women veterans' health care needs.

Women veterans are the fastest growing demographic that is serving in the military[1] and need a robust and comprehensive healthcare system to be there when they transition out of the service. Over the years, the Department of Veterans (VA) has made improvements in the advancement of women veteran's health care in VA Medical facilities nationwide. However, there is still much work to be done to meet the overall health care needs of women veterans. Even though the military has seen a significant increase in the number of women veterans joining the military, the number of women veterans enrolling in the VA health care system still remains relatively low when compared to their male counterparts.

Despite the many improvements that VA has taken to improve their health-care programs for women veterans, there are still numerous challenges and barriers women veterans face with enrolling in the VA including:

- Women veterans often do not identify themselves as veterans,
- Women veterans are often not recognized by VA staff as being a veteran,
- Among women veterans, there can be a lack of awareness, knowledge, and understanding of their VA benefits,
- There is a stigma associated with the VA healthcare system as a being an "all male" healthcare system.

As a result, The American Legion, through its Veterans Affairs and Rehabilitation Division, advocates ensuring that women veterans are receiving the highest quality of care from the VA for their injuries and illnesses incurred from their military service.

In 2010-2011, The American Legion conducted a Women Veterans Survey with 3,012 women veterans in order to better understand their healthcare needs through VA. The survey found while

[1] "The number of women Veterans using VHA nearly doubled in the past decade, from 200,631 in FY03 to 362,014 in FY12 (an 80% increase)" – VHA Sourcebook Vol. 3 Women Veterans in the Veterans Health Administration, FEB 2014

there were improvements in the delivery of VA healthcare to women veterans, challenges with service quality in the following areas remained.

The survey addressed the following service qualities: tangibles, reliability, responsiveness, competence, courtesy, communication, credibility, security, access and understanding. Since, the survey was completed The American Legion continues to utilize the results to advocate for improvements on how the VA delivers timely access and quality health care to their enrolled women veterans.[2]

In 2013, The American Legion through "System Worth Saving" Task Force Program conducted 15 VA medical center site visits nationwide in order to evaluate the quality of care as well as access to care that is provided for women veterans. The goals and objectives of the report were to understand what perceptions and barriers prevent women veterans from enrolling with VA; determine what quality of care challenges women veterans face with their VA health care; and to provide recommendations and steps Congress and VA can take to improve these access, barriers, and quality of care challenges.

During these site visits, the Task Force met with each facility's executive leadership team, women veterans program manager, patient advocate, enrollment and business office, mental health staff, homeless veteran's coordinator, military sexual trauma coordinator, suicide prevention coordinator and women veterans' health committee, and reviewed the environment of care.

Throughout the course of the visits, the Task Force observed many VA best practices in its care of women veterans, as well as receiving positive comments from women veterans about their care and services. However, the VA still has work to do to meet the overall health care needs for our women veterans.

In the 2013, *"Women Veterans Health Care Task Force Report"*, the following areas were identified as challenges and barriers to women receiving quality health care:

- VA medical centers do not currently have baseline, one-, two- or five-year outreach and marketing plans on how to close the gap between the numbers of women veterans in their facility catchment areas and those enrolled;
- Additional research is needed to determine the purpose, goals, and effectiveness of the three models of care on overall outreach, communication and coordination of women veterans health services;
- Women veterans do not receive their mammogram results in a timely manner; and VA needs to extend or make permanent the child care pilot programs.
- While VA has improved outpatient care and services, there is a need to increase the number of inpatient mental health treatment programs (e.g. military sexual trauma, post-traumatic stress disorder, substance abuse, etc.) for women veterans and ensure these programs are available within each Veterans Integrated Service Network (VISN) and at

[2] The American Legion Women Veterans Survey Report-March 2011: http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf

VA medical centers with a high demand for women veterans specialized inpatient mental health-care services.[3]

Since the systematic failures revealed in the VA Access to Care scandal in 2014, The American Legion continues to be active visiting locations and setting up Veterans Benefits centers (VBCs) to assist veterans who are experiencing long-wait times for health care or having difficulties in receiving their VA benefits. From the first Crisis center in Phoenix, Arizona in June 2014 to the most recent VBC in Memphis, Tennessee April 20-23, 2015 The American Legion has held 16 centers nationwide and helped thousands of veterans receive benefits and understand how to address access obstacles.[4]

In Fayetteville, NC and in West Los Angeles, CA, the Crisis Centers provided direct help to homeless women veterans;[5] the number of homeless women veterans has doubled from 1,380 in FY 2006 to 3,328 in FY 2010.[6]

In Bay Pines, Florida, the major concern for the clinic was the Cardiology grant proposal for the prevention of cardiovascular (CV) disease in women. The three components consisted of screening by primary care physicians to identify women veterans who are intermediate or high risk for CV disease through an easy-to-see Computerized Patient Record System (CPRS) tool; referral to the women's preventative cardiovascular clinic to discuss individual risk factors and possible modifications; participation in group health education classes about cardiovascular disease and stroke, nutrition exercise, stress management and other cardiovascular health related issues.

In Philadelphia, The American Legion staff met with VA staff to discuss issues and concerns regarding the Women's Clinic. The major issue at that facility was the need for more space to accommodate the growing number of enrolled women veterans. The facility currently clinic is open on Saturday to accommodate the busy practice and to maintain the continuity of care.

Conclusion

American women have been great patriots, warriors, and healers for this Nation's military efforts. They have served in many capacities from the time of the Revolutionary War to the present. American women have answered the call to serve with the same honor and integrity as their male counterparts, but often do not identify themselves as veterans. The American Legion is working to change this. While things have improved over the past few years, there is much that remains to be done in getting these veterans the services and treatment they need and deserve.

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[3] The American Legion System Worth Saving 2013 Women Veterans Health Care Report: http://www.legion.org/sites/legion.org/files/legion/publications/2013-SWS-Report-WEB.pdf

[4] "From Crisis to Confidence" http://www.legion.org/sites/legion.org/files/legion/publications/American%20Legion%20-%20From%20Crisis%20to%20Confidence.pdf

[5] Ibid

[6] National Coalition for Homeless Veterans http://www.nchv.org/images/uploads/HFV%20paper(1).pdf

As always, The American Legion thanks this committee for their diligence in addressing the care of women veterans.

For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division at (202) 861-2700 or wgoldstein@legion.org.

STATEMENT FOR THE RECORD

EXAMINING ACCESS AND QUALITY OF CARE AND SERVICES FOR WOMEN VETERANS

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

KEITH KELLY
ASSISTANT SECRETARY FOR
VETERANS' EMPLOYMENT AND TRAINING SERVICE
U.S. DEPARTMENT OF LABOR

April 30, 2015

Introduction

Chairman Miller, Ranking Member Brown, and distinguished Members of the Committee: thank you for the opportunity to provide a statement for today's hearing. I commend you all for your tireless efforts to ensure that America fulfills its obligations to our current service members, veterans, and their families. The Department of Labor (DOL, or The Department) also works hard every day to ensure all veterans are prepared to meet their employment objectives. The employment situation facing women veterans is of particular importance for us.

The population of women veterans grows steadily each year. Of the 10.7 million veterans participating in today's civilian labor force, 13% or 1.4 million are women. Overall, the unemployment rates for women veterans are trending downward and are statistically no different than for women non-veterans. Annual unemployment averages reveal that women veterans are younger, more educated, and more likely to be of ethnic minority status than their male veteran counterparts.[1]

The Department has closely integrated the efforts of our Veterans' Employment and Training Service (VETS) and the Women's Bureau (WB) to address the full spectrum of issues facing women veterans in the workforce. WB formulates standards and policies that promote the welfare of working women. VETS' mission is focused on four key areas: (1) preparing veterans for meaningful careers; (2) providing them with employment resources and expertise; (3) protecting their employment and reemployment rights; and, (4) promoting the employment of veterans and related training opportunities to employers across the country.

[1] The preceding information was compiled using data from the Bureau of Labor Statistics, Employment status, 2013- 2014 annual averages. http://www.bls.gov/news.release/vet.toc.htm

The Women Veterans Program (WVP)

The WVP was established in VETS in 2014, in collaboration with the WB, to ensure that DOL's employment services are meeting the needs of women veterans. The WVP also serves in an advisory role on the status of women veterans and employment for the VA's Advisory Committee on Women Veterans and interagency workgroups including the White House Council on Women and Girls - Women Veteran Working Group and the Council on Veterans Employment - Women Veteran Initiative. Our collaborative relationships with VA's Center for Women Veterans, Center for Minority Veterans, Office of Rural Health, and others ensure that service providers and other influencers of women veterans are educated on the full suite of employment services that their women veteran clientele may need. Other collaborative relationships include non-profit organizations that also provide services to women veterans. This cooperative approach has allowed VETS to "meet her where she is" while continuing VETS' core focus on employment, remaining the authoritative voice on employment issues, and making referrals for employment supports as appropriate.

VETS' WVP will continue its outreach to organizations that work with and advocate on behalf of women veterans, and will review existing programs and policies to ensure that women veterans are given opportunities to be successful in their employment and training opportunities.

Employment Resources and Expertise (Competitive and Formula Grants)

The Department provides a vast array of services to transitioning service members, veterans, and eligible spouses to help them with job searching, accessing training programs to bridge skills gaps, and identifying employment opportunities. Through core programs, such as Wagner-Peyser Employment Services, more than 1.1 million veterans receive services annually, including more than 170,000 (14.5%) who are female veterans. At the center of the Department's efforts are two VETS-administered grant programs: Jobs for Veterans State Grants (JVSG), a formula program that supports State staff positions at approximately 2,500 American Job Centers (AJCs) across the nation to promote veterans employment; and the competitive Homeless Veterans Reintegration Program (HVRP). The President's 2016 Budget maintains FY 2015 funding levels for VETS' grant programs ($175 million for JVSG, and $38.1 million for HVRP and programs under 38 U.S.C. 2021A and 2023).

Jobs for Veterans State Grants (JVSG)

Although all veterans, including women veterans, receive priority of service through American Job Centers, JVSG provides additional funding to 54 states and territories so they can exclusively serve eligible veterans, as defined in 38 U.S.C. 4101(4) and 4211(4), and other eligible spouses as defined in 38 U.S.C. 4101(5) and can perform outreach to employers. JVSG funds are provided to fund two staff positions at American Job Centers: Disabled Veterans' Outreach Program (DVOP) specialists and Local Veterans' Employment Representative (LVER) staff:

- DVOP specialists are authorized by 38 U.S.C. 4103A and must provide intensive services to eligible veterans and eligible spouses to meet their employment needs, prioritizing service to special disabled and other disabled veterans, as defined by 38 U.S.C. 4211, and

to other eligible veterans in accordance with priorities determined by the Secretary. The statute also requires that DVOP specialists place maximum emphasis on assisting veterans who are economically or educationally disadvantaged.

- LVERs perform a wide range of duties on behalf of our veterans specifically related to outreach to the employer community and facilitation within the state's employment service delivery system. These duties are outlined in law in 38 U.S.C. 4104(b). LVERs must be assigned duties that promote the advantages of hiring veterans to employers, employer associations, and business groups.

JVSG Performance Metrics for Women Veterans

JVSG services are successful and effective because they are tailored to suit individual veterans, regardless of sex.

Table 1. JVSG Employment, Employment Retention, and Average Nine-Month Earnings by Veteran Status for Program Year (PY) 2013*

Performance Outcomes	All Veterans	Women Veterans
Entered Employment Rate	54.9%	54.3%
Employment Retention Rate	80.2%	79.62%
Nine-Month Earnings	$15,748	$13,721

* Table 1: VETS-200C: Participant Services and Outcomes of DVOP/LVER, and by the ETA form 9133 for the States of Texas and Pennsylvania.

In Program Year (PY) 2013 (July 1, 2013 through June 30, 2014), 13% of the veterans served through JVSG were women, an increase from 12% in PY 2012. A recent independent data analysis commissioned by the Department's Chief Evaluation Office found that JVSG services are associated with better outcomes, specifically for women veterans. Every woman veteran has different experiences and needs, and JVSG services are responsive to the diverse needs of each veteran. Women veterans who utilize these services experience higher entered employment rates and higher wages than their non-veteran female peers. The gender wage gap is also considerably smaller for women veterans served by JVSG than it is for non-veteran women, according to DOL research. It is critical that each woman veteran struggling with unemployment come to an American Job Center where she will meet one-on-one with a workforce development professional and receive personalized assistance, guidance, and support.

Homeless Veterans Reintegration Program (HVRP)

The Department is committed to the Administration's goal of ending homelessness among veterans by the end of 2015. In leading this effort, the U.S. Interagency Council on Homelessness (USICH), currently chaired by Secretary Perez, has generated powerful national partnerships at every level to work toward ending homelessness across the nation. While homelessness among veterans has declined, much work remains. Homelessness among female veterans accounted for 10% of both the sheltered and unsheltered homeless veteran population in

the 2014 Point in Time Count. The 2014 count was the first year in which the Department of Housing and Urban Development required all of its Continuums of Care to count the number of female veterans experiencing homelessness.

HVRP operates on the principle that when homeless veterans attain meaningful and sustainable employment, they are on a path to self-sufficiency and diminished susceptibility to homelessness. HVRP is employment-focused; each participant receives customized services to address his or her specific barriers to employment. Services may include occupational, classroom, and on-the-job training, as well as job search support, placement assistance, and post-placement follow-up services.

Homeless Female Veterans and Veterans with Families (HFVVWF) Grant Program

The Homeless Female Veterans and Veterans with Families (HFVVWF) grants are competitive grants that specifically assist the subpopulation of homeless female veterans and veterans with families. The HFVVWF grant was developed to address the particular employment issues of homeless women veterans recognizing that their needs may be different from their male counterparts. The grants support direct services through a case management approach that leverages federal, state, and local resources. Eligible veterans and their families are connected with appropriate employment and life skills support to ensure a successful integration into the workforce.

HVRP Performance and Analysis for Women Veterans

In PY 2013, 1,958 female veterans were enrolled in HVRP. Of those, 1,161, or 59.3% were placed into employment. HVRP's engaged, client-centric approach has successfully placed thousands of previously-homeless veterans, some of whom were chronically homeless, on a path to self-sufficiency. In FY 2014, the HVRP program received an appropriation of $38,109,000 with which the Department awarded 37 new HVRP grants, 101 option year HVRP grants, 18 HFVVWF grants, and 66 Stand Down grants.

Employer and Stakeholder Outreach

VETS' Office of Strategic Outreach (OSO) was chartered to develop a national engagement and integration strategy that informs and coordinates action within and between the government, private sector and communities to enhance veterans' employment opportunities and leverage the national workforce system. OSO conducts engagements with federal, state, and local governments; private sector employers and trade associations; institutions of higher learning; non-profit organizations; and Veteran Service Organizations (VSOs) to establish and develop a network that enables service members, veterans, and families to successfully integrate into their communities. This office provides a valuable bridge between national and regional employers who are eager to commit to hiring veterans and workforce development staff at American Job Centers who are tasked with building local employer relationships and assisting veterans in entering gainful employment. OSO is also responsible for conducting outreach on behalf of women veterans, as well as other focus populations, including disabled veterans and Native American veterans residing on tribal lands. Through VETS' outreach efforts, partnerships with

regional and local organizations who serve these populations are being created and strengthened to best address these demographics' specific employment and training needs.

Advisory Committee on Veterans' Employment and Training and Employer Outreach (ACVETEO)

One of the primary means by which the Department engages with key stakeholders from both the public and private sectors and VSOs is through its ACVETEO. The ACVETEO is a non-discretionary advisory committee established under 38 U.S.C. 4110 that is required to assess the employment and training needs of veterans and their integration into the workforce; determine the extent to which DOL programs and activities are meeting such needs; assist the Assistant Secretary for VETS in conducting outreach activities to employers with respect to the training and skills of veterans and the advantages afforded employers by hiring veterans; make recommendations to the Secretary, with respect to outreach activities and employment and training needs of veterans; and carry out such other activities necessary to make required reports and recommendations.

For FY 2014, the ACVETEO focused its efforts on considering how, and with what effect, VETS could best advance the employment situation of veterans. Specifically, the Committee focused on the following themes: (1) veterans and employer outreach activities, (2) transition assistance and support (employment), and (3) employment and training activities/needs impacting focused populations, including women veterans. For example, the Committee requested the Department conduct an audit of the current Transition Assistance Program (TAP) Employment Workshop curriculum to ascertain whether there is a need for specialized training to address the particular needs of veterans with disabilities, women veterans, and Native American veterans in the workforce. Curriculum review will begin in April 2015, in conjunction with planned review of the entire Transition GPS curriculum to ensure we are meeting the needs of all current and future service members and veterans. This curriculum review will ensure that the employment workshop includes the latest information and best practices to assist transitioning service members entering the civilian workforce. In support of this ACVETEO recommendation, VETS will provide the Committee with the results of the review/audit. The ACVETEO's Annual Report to Congress was submitted to both Senate and House Veterans Affairs Committees on January 9, 2015. On April 3, 2015, the Secretary submitted his concurrence with the ACVETEO Annual Report's recommendations to Congress. Currently, VETS' staff is working with the ACVETEO to address each of their Report recommendations.

Conclusion

Creating opportunity for our veterans to thrive in the civilian economy through meaningful employment is a priority for DOL leaders and for every agency within the Department. DOL also works closely with our other federal partners at the Departments of Veterans Affairs and Defense to promote employment opportunities for all veterans. Moreover, DOL knows that when women succeed, America succeeds, and we must ensure that women veterans have equal and full access to VETS resources. DOL's connection with the State Workforce Agencies via nearly 2,500 American Job Centers across the nation facilitates veterans' employment with large national employers as well as the small- and medium-sized businesses that do a large share of

our nation's hiring. DOL's long-established relationship with State Workforce Agencies is a partnership that delivers proven and positive results. The Administration wants to ensure that we build on these established relationships and the improvements called for in the Workforce Innovation and Opportunity Act of 2014 to build a workforce system and American Job Centers that better help transitioning service members and veterans move into middle class, family-sustaining jobs.

The Department looks forward to working with the Committee to ensure that all of our transitioning service members and veterans, regardless of gender, have the resources and training they need to successfully transition to the civilian workforce and support themselves or their families.

Chairman Miller, Ranking Member Brown, distinguished Members of the Committee, this concludes my written statement. Thank you for providing us the opportunity to contribute to this hearing.

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