STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee:

On behalf of the Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to be here today to present our views on a recently released Government Accountability Office (GAO) report (GAO-11-530)—*Actions Needed to Prevent Sexual Assaults and Other Safety Incidents* (herein after GAO report or Report) to the Committee on the issue of the prevention of sexual assaults and other related safety incidents occurring in Department of Veterans Affairs (VA) health care facilities.

In reading the GAO Report we were disturbed to find that between 2007 and 2010, GAO identified 284 alleged sexual assaults reported through one of two reporting streams. However, many times, the victims' reports were mishandled or inappropriately acted upon based on decisions made by local physicians or administrators and most had not been reported to appropriate program officials and leadership in VA—even though rape allegations are considered potential felonies and are required by regulation to be reported to the VA's Office of the Inspector General (OIG). Although VA officials at one sampled facility noted they did expect to be notified of all sexual assault incidents—this expectation was not specifically documented in their policy.

At the outset, let it be known that DAV believes in the strongest possible terms that veterans, VA employees, visitors and others who occasion visits to VA facilities should always be assured of their physical safety and personal security. Likewise, every veteran hospitalized or housed at a VA medical center (VAMC) or treatment facility should be afforded a safe, secure environment and be treated with respect and dignity. In addition to the Veterans Health Administration's (VHA's) benchmark of continuous quality improvement programs ensuring that patients receive safe and effective health care, VA must reevaluate and strengthen its safety program to ensure that the environment of care at VA health facilities keeps veterans, staff and visitors safe from physical harm, including sexual assaults.

VA has received numerous prestigious national awards and been lauded by the National Academy of Science's Institute of Medicine for its outstanding patient safety programs, including alerts embedded in its Veterans Health Information Systems and Technology Architecture (VistA)/Computerized Patient Record System (CPRS) electronic health record, its barcode medication administration program that reduces medication errors, and its patient safety reporting systems. It is therefore surprising that the National Patient Safety Center has not

encouraged VAMCs to perform: 1) a root cause analysis on incidents involving sexual assaults, 2) a national data roll-up and analysis of methods to prevent or mitigate the risk of sexual assault, or 3) further study of this important patient safety issue.

GAO's report concerns us on several levels. Initially, it documents loose and inattentive reporting of incidents of personal violence committed in VAMCs against veterans, staff and visitors; the failure of or reluctance to share information about these incidents; inadequate police staffing and monitoring of security cameras in certain facilities; the lack of proper investigative procedures and follow up; the lack of a uniform definition of sexual assault to ensure consistent reporting; lack of a centralized database for tracking and trending assault incidents; destruction of incident reports and police records; and lack of information sharing by VHA Operations and Management staff with other internal stakeholders. We are also concerned that the lack of information sharing could be further complicated with the recent VHA reorganization that has separated the operations and policy functions of many service lines, including mental health programs, if recommended policy changes are not implemented. We concur with GAO that without the regular exchange of sexual assault report incidents that occur within their areas of programmatic responsibility, VHA officials cannot effectively address potential risks in their programs and local facilities do not have the opportunity to identify ways to prevent such incidents. These critical deficiencies identified by GAO have uncovered not only the individual program and policy gaps noted, but also highlight VHA's lack of a methodical and systematic approach to eradication of sexual assaults from its facilities.

In addition to its failure to communicate with VHA Program Offices, it appears VHA lacks an open approach to communication regarding sexual assaults with other VA offices, including the OIG. According to the report, by regulation, all potential felonies, including rape allegations, must be reported to VA OIG investigators. GAO also found that VAMC Police are not consistently reporting felony sexual assaults to the other VA offices with responsibility for investigating crimes.

These practices and lack of systemic consistency cannot be defended and must be addressed by VHA with a sense of urgency. VA must establish a comprehensive, consistent approach to documenting, investigating and reporting sexual assaults—a serious crime of personal violence apparently occurring at several VA health care facilities. Given the limited number of facilities surveyed by GAO, we are concerned about the extent of the problem system wide. For these reasons we suggest the creation of a task force to ensure the VA adopts a culture of safety and promptly develops a uniform policy for the reporting of all sexual assaults. It is clear these reports cannot be solely handled by the local facility involved and that mandatory reporting of these incidents to all the appropriate officials is necessary. We are pleased to see that VA has established a "multi-disciplinary workgroup" to define what actions need to be taken to prevent sexual assault incidents and to respond to reports and allegations of sexual victimization of veterans and VA employees.

We noted in the report a footnote on page 13 that indicates VA police routinely destroy their investigation reports of VA sexual assaults three years after making such reports, under a records retention policy of the National Archives and Records Administration. We oppose the destruction of these reports on the same basis that we oppose the destruction of reports of

military sexual trauma (MST) that occur within the military services. More information on our position with respect to destruction of MST records may be found in DAV's testimony before this Subcommittee on May 20, 2010. The destruction of these reports contributes to the problem of the lack of consistent information and information sharing, and obstructs analysis that could be immensely helpful not only to improve safety in VA facilities but to promote a better understanding of the incidence of sexual assaults in VA. Also, a number of these cases could result in tort claims or VA disability claims. The lack of documentation can contribute to loss of benefits and equity for these victims.

GAO noted in its analysis that VA is experiencing significant demographic changes in its health care programs due to initiatives targeting several specific veteran populations—including women veterans, veterans who have served in Operations Enduring and Iraqi Freedom (OEF/OIF), and veterans facing legal issues or those currently incarcerated. New VA enrollees are trending younger, with a more visible presence of women veterans. According to VA, about one-half of all women who served in OEF/OIF and separated from the military since September 11, 2001, are enrolled in VA health care. VA is also outreaching to justice-involved veterans with post-deployment mental health problems, such as combat-related post-traumatic stress disorder (PTSD) to help them avoid incarceration and enter into appropriate specialized VA programs for PTSD, traumatic brain injury (TBI) and substance-use disorder treatment. The same holds true for homeless veterans and family caregivers of severely injured and ill veterans. VA is also seeing a significant new workload in mental health care while trying to use the least-restrictive environment to do so.

VA is also under stress to treat a seriously and moderately disabled young veteran population returning from war with myriad unmet needs and high expectations for state of the art services across the continuum of health care and rehabilitation. This changing demographic and the need for comprehensive mental health care and polytrauma care has made it even more crucial that VA address the safety and security issues raised by GAO. Of the 1.2 million individuals who have served in the wars in Iraq and Afghanistan, over 654,000 (more than 50%) have enrolled in VA health care since fiscal year 2002. Although these patient populations are a small percentage of the overall enrolled population using VA, we believe these changes have affected VA's environment of care, in both expected and unexpected ways.

In addition to the environment of care issues, VA must also raise awareness among its staff through education and training in order to enhance its climate and culture of safety. VA's clinical care staff are accustomed to caring for a predominantly older, male population with chronic medical conditions rather than the one they are now being charged to treat. These shifts and pressures produce stresses that VA has not previously or recently experienced and may be contributing to the culture of safety challenges that GAO aptly uncovered and documented in this report. These demographic changes are projected to continue in the foreseeable future.

GAO primarily focused on three distinct VA settings in its report—residential rehabilitation treatment programs (RRTP), inpatient and residential mental health units and compensated work therapy/transitional residence (CWT/TR) settings. For years GAO has addressed safety and privacy deficiencies in VA health care facilities, specifically related to women veterans. We see in the current report, in relationship to the residential program sites,

that only one of the three CWT/TR programs evaluated accepted women due to safety and privacy concerns. These safety concerns continue to negatively impact women veterans—in essence they are denied access to needed specialized services because VA is not confident they can provide a safe environment for women. Likewise, GAO notes that several clinicians they interviewed for a previous report on women's health services in VA expressed concern for the safety of women veterans placed in VA inpatient mental health programs. These types of concerns highlight an inequity in access to care for women veterans and the potential for further assaults unless corrective action is taken. Among the security precautions that must be in place for residential programs are secure accommodations for women veterans with periodic assessments of facility safety and security issues. We have brought this issue to the attention of the Subcommittee over the years and hope you will consider oversight to ensure as VA moves forward to improve their overall culture of safety in VA facilities, and that VA specifically address these safety issues related to care for women veterans.

While acknowledging its findings could not be generalized to VA as a whole, and that the report was based on visits to only five VA medical centers in four networks of care, GAO tendered eight recommendations from its review. We endorse these ideas and note that VA has concurred in each of them as well. Given the seriousness of this issue, we urge VA to move forward expeditiously to implement them within the spirit in which they were made. While not one of the recommendations, we also believe that the organizational placement of VA's police force should be a subject of review, as well as the sufficiency of its staffing levels across the system and its operating mandate. Historically, VA police officers were VA medical center employees, appointed locally and directly responsible to the VAMC director to ensure safety of persons and property, including real property. In recent years, however, the VA police force has been organizationally centralized to report to a Deputy Assistant Secretary for Law Enforcement.

Madam Chairwoman, every veteran should be assured of the highest level of quality care and patient safety while receiving health care in a VA facility. A veteran should never fear for his or her own personal safety while visiting a VA facility. VA was established as a place of care, not a place of fear, for veterans, visitors and staff. We concur with GAO that when a veteran has a history of sexual assault or violent acts, VA must be vigilant in identifying the risks that such veterans pose to the safety of others at its medical facilities. VA needs to take decisive actions to improve personal safety and promote an environment of care that includes protection from personal assaults, including sexual assaults. To do so will take a commitment from all levels of VA and especially VA's senior leadership. We commend GAO for making this critical report. Hopefully, GAO's findings can serve VA and veterans well in providing a roadmap to promote a new environment of care that encompasses a strong consistent culture of safety, and one that can be closely monitored by this Subcommittee as VA completes the recommended changes.

Madam Chairwoman, this concludes my statement, and I would be pleased to consider questions from you and other members of the Subcommittee.