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FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED

STATEMENT OF
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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

[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.

care 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

[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.

[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

[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.