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VA HEALTH CARE SERVICES FOR WOMEN VETERANS: BRIDGING THE GAPS IN CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

JULY 14, 2009

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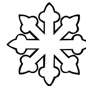

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VA HEALTH CARE SERVICES FOR WOMEN VETERANS: BRIDGING THE GAPS IN CARE

TUESDAY, JULY 14, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:33 A.M., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Begich, Burris, and Burr.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. This hearing of the Senate Veterans' Affairs Committee will come to order.

Aloha and good morning to all of you. Welcome to this important hearing on VA's Health Care Services for Women Veterans. We will be looking at programs already in the works to improve access to and the quality of care and other unique issues facing women veterans.

Women veterans are the fastest-growing segment of veterans. In 1988, when VA first began providing care to women, they were only 4 percent of the veteran population. Today, the percentage of women veterans is nearing 8 percent and expected to rise substantially over the next two decades. So, it is appropriate that we ask now, "Is VA meeting the needs of women veterans?"

Many women veterans in need of services fall through the cracks because VA does not have a thoroughly gender-focused range of care set up to catch them. There are many obstacles that veterans face. Access to health care and homelessness are two, and many veterans—women veterans in particular—are struggling to get the services they deserve. For too long, the approach to helping veterans avoid obstacles through veteran benefits and services has been predominantly focused on men. Today, the Committee will review these issues and how they affect women veterans.

While I applaud VA for the progress it has made in recent years to ramp up services for the rapidly growing number of women veterans, there is much still to be done to bridge the gaps in access to care that women veterans face compared to their male counterparts.

I am pleased that the Committee, with the leadership of Senator Murray, recently approved legislation designed to enhance the understanding of women veterans' need for health care and to im-

prove the delivery of that care. I hope to bring this legislation before the full Senate during this work period.

Today's hearing gives us a chance to better understand the current situation with an eye toward fixing what is not working and expanding what is.

And now I'd like to call on our Ranking Member for his opening statement.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Mr. Chairman, thank you. I hope you're doing well this morning. Aloha.

Chairman AKAKA. Aloha.

Senator BURR. Welcome to our witnesses.

We're here to look at the advocacy of health care services VA provides to a growing number of individuals who have proudly worn the Nation's uniform: women veterans. The statistics do not lie. In 1990, there were 1.2 million women veterans. Today, there are 1.8 million, a number that continues to grow. In 1990, women represented 4 percent of the veterans' population. Today, they represent 8 percent.

North Carolina is no stranger to this growth. My State ranks sixth in the total number of women veterans, with just over 67,000 residing there. Fourteen percent of the active duty force is comprised of women, many of whom have served in combat or war zones. They fly combat aircraft, man missile placements, serve on ships in dangerous waters, drive convoys in areas at risk of ambush.

In short, our military and our country are heavily dependent on the service of women. We must honor their service by ensuring VA health care systems meet their unique needs.

As we move forward to do that, there is one more statistic that I would like to call to the attention of everyone—one that suggests we have some work to do. According to the VA budget submissions, in 2007, just over 146,000 women veterans used gender-specific health care services at the Veterans Administration.

In 2008, despite the growing number of women veterans that I talked about, there were over 141,000 users of the system, a decline of 3 percent from just 1 year ago.

The question this Committee must ask is why? Why do women veterans feel uncomfortable coming to a hospital system largely comprised of male patients, or do they? Does the VA provide the unique services required by women veterans? Does it provide these services in enough locations to make travel convenient?

When VA cannot provide quality care, does it use services that already exist in the community that are specific to the needs of women? These are all questions that I am hopeful our panelists will help us find the answers to.

Mr. Chairman, just across the Potomac River stands the Women in Military Service for America Memorial. The memorial serves as the ceremonial entrance of Arlington National Cemetery. I think its placement at the front gate of American's most hallowed military cemetery is symbolic.

For many years, the service of military women often went overlooked and unheralded. We now know better. As Former Senator Bob Dole said at its dedication 12 years ago, the memorial serves as "a lens through which we can better see and appreciate the dedication and sacrifice of American service women."

I look forward to hearing from our witnesses today, and I hope that this will serve as a lens through which this Committee can see where improvements need to be made for women who have served their country and their military.

I thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burr.

Now I'd like to call on Senator Burris for his opening statement.

STATEMENT OF HON. ROLAND W. BURRIS, U.S. SENATOR FROM ILLINOIS

Senator BURRIS. Thank you very much, Mr. Chairman, Ranking Member Burr.

Unfortunately, Members, I am scheduled to preside over the Senate in just a few moments. But, before I go, I would like to recognize the importance of this hearing.

As someone who has fought for the quality and diversity throughout my career, I believe this hearing is long overdue. Too often the role of women in military has been misunderstood; their accomplishments and needs overlooked.

In the VA health system, women's status as a minority has lead to disjointed, gender-specific care that can be difficult to access and hard to navigate. There is no reason why a woman seeking basic, primary care should have to go to two or three different providers in order to meet their needs.

Women make up the largest-growing segment of the veterans' population, which is all the more reason for us to move forward toward integrated services, including mental health providers that recognize the unique needs of women, such as military sexual trauma.

I commend the work of the VA thus far at addressing these issues. Tremendous progress has been made, but I am concerned that only one-third of the Veterans' health facilities provide for the one-stop shop approach, an approach which shows the highest level of patient satisfaction. All of our female veterans deserve the highest quality of care, and we must work toward that day when every VA facility is fully equipped to address these needs.

Mr. Chairman, I recall a presentation on the floor by Senator Kay Bailey Hutchison from Texas about these women who were in the Air Force in World War II—and there are a few of them still around—and what the trauma was from Senator Hutchison's presentation, which she was trying to get resolution.

I became a cosponsor, so I really want to know just where that is because women flew those missions while the men were fighting the wars. They flew the supply missions on those airplanes, and they paid their way to Texas. Then, when they were discharged—unbelievably, as Senator Hutchison said—they had to pay their way back home. Some of these women are still alive. And after hearing that speech, I told her to put me on that bill as a cosponsor, because we have to recognize those women, the same way we

recognize the Tuskegee Airmen for their dedicated service to this country.

So, I am going to still try to follow-up on that, Mr. Chairman, find out what is really happening to that resolution that Senator Hutchison presented to the Senate because we need to recognize those women that are still alive and give respect to those who passed on for their service to this country.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burris.

And now we'll hear from Senator Murray with an opening statement.

STATEMENT OF HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Chairman Akaka and Senator Burr for holding today's hearing to have a chance to really examine the status of the VA's health care services to women veterans. I want to thank today's witnesses for all of their hard work to both improve the level of care provided to women veterans and to increase the public awareness of this important issue, as well.

As has been said very well by my colleagues here, since the founding of our Nation, women have always played a role in our military, and that role, of course, has changed over time. In today's conflicts, women are playing a far different and far greater role. And, while they have historically remained as a very small portion of the veteran population and a small minority at the VA, women veterans now total about 1.8 million, and they make up nearly 8 percent of the total veteran population in the United States.

That percentage, we all know, is expected to increase more than 14 percent by 2033, and the number of women veterans enrolled in the VA System is expected to double in the next 2 to 4 years. That makes female veterans one of the fastest growing demographics of the veterans today, and I think it is really important at this hearing and always that we remember that behind those statistics are real women. These are women who sacrificed for their country, they have borne the burden of battle, and they now deserve the respect and the benefits that their service has earned.

Earlier this year, as has been referenced, the Committee passed my bill, the Women Veterans Health Care Improvements Act of 2009. More recently, the full House has passed similar legislation. I think this is very important progress. I hope we can pass this out of the Senate soon because that bill will encourage women to access the VA, increase the VA's understanding of the needs of women veterans and, really, the practices that helped them get the best kind of care.

But we cannot stop there and we are not stopping there. I know that the VA is recognizing the need to improve services to women veterans and are taking steps to ensure equal access to benefits and health care for them.

So, I look forward to today's hearing for the steps the VA is taking and what else we need to be doing to achieve that goal.

I would say to Senator Burris, I believe that the bill that Senator Hutchison was talking about was a Congressional Gold Medal that

has been sent to committee. I appreciate you bringing that up and hope that it can move forward.

Senator BURRIS. Mr. Chairman, my staff said the resolution was approved, but we need to get the Gold Medal part for the women. So, that is what is pending. That is correct, for the record.

Thank you very much, Senator Murray. We must do that.

Chairman AKAKA. Thank you very much, Senator Murray.

I want to welcome our principal witness from VA, Dr. Patricia Hayes, Chief Consultant of the Women Veterans Health Strategic Health Care Group. She is accompanied by Dr. Irene Trowell-Harris, Director of the VA Center for Woman Veterans.

Following Dr. Hayes, we have GAO's Director of Health Care Issues, Mr. Randall Williamson.

Thank you, all, for being here this morning. Both VA and GAO's full testimony will appear in the record.

Before I call on Dr. Hayes for her testimony, I call on Senator Brown for an opening statement.

STATEMENT OF HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Yes. Thank you, Mr. Chairman. I appreciate that. I appreciate the work that Senator Murray has done in the Women Veterans Health Care Improvement Act of 2009; and thank you, Mr. Chairman, for holding this meeting.

I wanted to mentioned briefly, we know what the issue is, we know how important it is that there be more parity—if that is the right word—more equality in everything from the big VA Centers to the CBOCs to veterans' health care generally, but I wanted to tell a real quick story.

A woman by the name of Loretta Schimmoler of Crawford County, Ohio—a rural county halfway between Columbus and Cleveland—was one of the first woman to be inducted in the Ohio Veterans Hall of Fame, helped to lead the way in what was to become the Flight Nurses Corps. Her story mirrors in many ways what women have faced in the military dealing with VA care.

She was a dedicated patriot, intent on making our Nation and our military better. Despite the hurdles she faced, she was able to change the way our military did business to the betterment of all those who served. She began flying in 1932 for her service. At that time, nurses, of course, were almost exclusively women, and would serve on planes and helicopters that provided care and evacuation to wounded servicemembers. It was not until World War II that the program became a reality, due in large part to her persistence and her vision.

The VA of her day, of Loretta Schimmoler's day, looked a lot different from the Department of Veterans Affairs today in meeting the needs of our women veterans, but much more needs to be done.

This hearing is a major step in doing that.

I thank the Chairman and thank Senator Murray for her work.

Chairman AKAKA. Thank you very much, Senator Brown.

Again, let me call on Dr. Hayes and ask for your testimony.

STATEMENT OF PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP; ACCOMPANIED BY IRENE TROWELL-HARRIS, M.ED, ED.D, DIRECTOR, CENTER FOR WOMEN VETERANS, U.S. DEPARTMENT OF VETERANS AFFAIRS

Ms. HAYES. Good morning, Mr. Chairman and Ranking Member. Thank you very much for the opportunity to discuss how VA has provided and will continue to improve the health care for women veterans.

As you mentioned, I am accompanied by Dr. Irene Trowell-Harris, the Director of the Center for Women Veterans. Thank you for submitting my written testimony into the record.

I also want to thank you, Chairman Akaka and Senator Murray specifically, again for your interest in working with VA to ensure that the quality of care for women veterans is improved and that they do get what they deserve for service to their country.

Secretary Shinseki recently testified before this Committee that enhancing the primary care for women veterans is one of VA's top priorities. Women who were deployed and served in the recent conflicts in Afghanistan and Iraq are enrolling in VA at record numbers.

Of all the women veterans who are deployed and served in Afghanistan or Iraq, VA knows that 44 percent have enrolled in VA health care, which suggests that many of these newly-enrolled women veterans really rely on VA for their health care needs.

Women veterans are entering VA's health care system younger, and they have health care needs distinct from their male counterparts. The average age of women veterans is 48-years-old compared to 61-years-old among men. Nearly all newly-enrolled women veterans are under age 40 and they are of childbearing age. This obviously means a trend that will create a shift in how we provide their care.

This shift will move primary care and gender-specific care needs of women veterans from the multi-visit, multi-provider model that has been mentioned here—which does not achieve the continuity of care that we desire—to a more comprehensive, primary care delivery model. VA recognizes many current challenges and has initiated new programs, including the implementation of comprehensive primary care, enhancing the health care environment for women veterans, creating a mini residency education program among women's health, staffing every VA Medical Center with a Women Veterans Program Manager, and improving communication and outreach to women veterans.

Most importantly, VA is implementing an innovative approach to women's health care that will address the concerns about fragmented care, quality disparities, and lack of provider proficiency in women's health by fundamentally changing the experience for women veterans in VA.

To achieve the goal of providing comprehensive primary care, we have designed three models to promote the delivery of optimal primary care, and we recognize that more than one model might be needed even within various facilities in order to meet the needs to deliver comprehensive care to women veterans.

All three models ensure that every women veteran, wherever she comes to VA, has access to a VA primary care provider who is capable of meeting all of her primary care needs in the one-stop shop model that we have described. A site-level evaluation will also begin so that we can be certain that this program is effective. We are going to start that in fiscal year 2010.

All women veterans need to feel welcomed in their VA setting. The health care environment directly and indirectly affects the quality of the care that is provided to women veterans, and a part of redefining our comprehensive care to be delivered means that we have to have improvements in the health care environment which are being made in order to support dignity, privacy, and sense of security.

VA recognizes many primary care providers need to update their women-specific clinical experience. VA is offering many residencies in women's health across the country. Early results from this program indicate success in increasing competencies in 12 areas of women's health care.

As of June 2009, 216 participants from 90 VA medical centers and 28 community-based outpatient clinics have completed the program. In order to ensure improved advocacy at the facility level, VA has mandated that all medical centers appoint a full-time Women Veterans Program Manager. These managers support increased outreach to women veterans, improve the quality of care, and develop best practices in the organizational delivery of women's health care.

Effective internal and external communication is also important in terms of outreach and our success of implementing comprehensive care. VA Center for Women Veterans will continue to expand its ongoing outreach and communications plan to ensure not only public awareness of women veterans' service to our country, but making sure that women veterans are aware of their eligibilities and access to VA health care.

Mr. Chairman, VA's commitment to women veterans is unwavering, and while significant efforts are underway, we know that we have to do a lot more to improve the care. A lot more needs to be done. We stand at a really unique moment in time where our actions and plans today will build this system that will provide equal care for all of American veterans regardless of gender.

Thank you once again for this opportunity to testify, and we now are very prepared to answer any addition questions that you may have of us.

[The prepared statement of Ms. Hayes follows:]

PREPARED STATEMENT OF PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Good morning, Mr. Chairman and Ranking Member. Thank you for the opportunity to discuss how the Department of Veterans Affairs (VA) has provided, and will continue to improve, health care availability for women Veterans. I would like to thank the Chair, this Committee and Senator Murray specifically for your interest in working with VA to ensure women Veterans receive the care they have earned through service to their country.

The Secretary has recently testified before this Committee that enhancing primary care for women Veterans is one of VA's top priorities. VA recognizes that the number of women Veterans is growing with women becoming increasingly depend-

ent on VA for their health care. Of the 1.8 million women Veterans in the United States more than 450,000 have enrolled for care. This number is expected to grow by 30 percent in the next 5 years. Women currently comprise approximately 14 percent of the active duty military, 17.6 percent of Guard and Reserves and 5.9 percent of VA health care users.

Women who were deployed and served in the recent conflicts in Afghanistan and Iraq are enrolling in VA at historical rates. Of all women who were deployed and served in Afghanistan or Iraq, 44 percent have enrolled and 43 percent have used VA between 2 and 11 times. This suggests that many of our newer women Veterans rely more heavily on VA to meet their health care needs.

My testimony will describe how VA plans to continue to enhance the delivery of high quality health care to this fastest growing cohort of Veterans and ensure today's heroes and tomorrow's Veterans receive the care they need. Women Veterans served; they deserve the best care anywhere.

CURRENT CHALLENGES

Women Veterans entering VA's system are younger and have health care needs distinct from their male counterparts. The average age of women Veterans is 48 years old, compared to 61 years old among men. Nearly all newly enrolled women Veterans accessing VA care are under 40 and of childbearing age. This trend creates a need to shift how we provide health care.

General primary care and gender-specific care needs of women Veterans are currently provided through a multi-visit, multi-provider model that may not achieve the continuity of care desired. Additionally, some VA facilities rely on outside providers for gender- specific primary care and specialty gynecological care through the use of fee-basis care. This approach to women's health delivery can provide challenges in providing continuity of care.

Moving to a more comprehensive primary care delivery model could challenge VA clinicians, who may have dealt predominately with male Veterans and sometimes have little or no exposure to female patients. VA facilities may also need to increase both focus and resources on women's health (e.g., space, staffing, appropriately equipped exam rooms) to ensure adequate privacy for women during examinations. Initiatives are underway and under development to address these and other changes brought on by the increasing number of women Veterans seeking care from VA.

The quality of health care VA provides to women Veteran's exceeds the care many would receive in other settings (including commercially managed care systems, Medicare and Medicaid). For example, VA's system of quality management and preventive patient care, supported by technology like our electronic health record and clinical reminders, ensures women are screened for unique health concerns like cervical cancer or breast cancer at higher rates than non-VA health care programs. On the other hand, VA is aware of existing disparities between male and female Veterans in our system. The Department is particularly concerned with performance measures related to cardiovascular disease, the leading cause of death in women. Performance scores for several quality measures, including high blood pressure, high cholesterol and diabetes, all of which contribute to cardiovascular disease risk, show a consistent difference between men and women Veterans. Gender-neutral prevention measures such as colon cancer screening, depression screening and immunizations show a disparity between men and women Veterans as well. For example, although VA significantly outperforms Medicare on colorectal cancer screening, only 75 percent of women Veterans are screened compared with 83 percent of male Veterans. These issues and other quality issues are being addressed.

Some women report that lack of newborn care and child care forces them to seek care elsewhere. VA recently supported section 309 of S. 252, which would authorize VA to furnish health care services up to 7 days after birth to a newborn child of a female Veteran who is receiving maternity care furnished by VA if the Veteran delivered the child in a VA health care facility or in another facility pursuant to a contract for service related to such delivery. We similarly supported a companion measure in the House. We believe benefits such as these will help improve women Veterans' perception that VA welcomes them and will provide complete, effective and compassionate care.

CURRENT INITIATIVES

VA recognizes the need to continually improve our services to women Veterans, and has initiated new programs including the implementation of comprehensive primary care throughout the Nation, enhancing mental health for women Veterans, staffing every VA medical center with a women Veterans program manager, creating a mini-residency education program on women's health for primary care physi-

cians, supporting a multifaceted research program on women's health, improving communication and outreach to women Veterans, and continuing the operation of organizations like the Center for Women Veterans and the Women Veterans Health Strategic Healthcare Group.

Comprehensive Primary Care for Women Veterans

VA is implementing an innovative approach to women's health care that seeks to reduce the possibilities of fragmented care, quality disparities, and lack of provider proficiency in women's health by fundamentally changing the experience of women Veterans in VA.

In March 2008, the former Under Secretary for Health charged a workgroup to define necessary actions for ensuring every woman Veteran has access to a VA primary care provider capable of meeting all her primary care needs, including gender-specific and mental health care, in the context of a continuous patient-clinician relationship. This new definition places a strong emphasis on improved coordination of care for women Veterans, continuity, and patient-centeredness. In November 2008, the workgroup released its final report identifying recommendations for delivering comprehensive primary care. These recommendations included: (1) delivering coordinated, comprehensive primary women's health care at every VA health care facility by recognizing best practices and developing systems and structure for care delivery appropriate to women Veterans; (2) integrating women's mental health care as part of primary care, including co-locating mental health providers; (3) promoting and incentivizing innovation in care delivery by supporting local best practices; (4) cultivating and enhancing capabilities of all VA staff to meet the comprehensive health care needs of women Veterans; and (5) achieving gender equity in the provision of clinical care.

To implement these goals and recommendations, the Women Veterans Health Strategic Health Care Group developed a women's comprehensive health implementation planning (WCHIP) tool to assist facilities in analyzing its own current health care delivery for women Veterans and plans for primary care delivery enhancement. Every VA health care facility was requested to convene a multidisciplinary planning and implementation team to address comprehensive primary care for women Veterans. The WCHIP tool outlines an analysis of current services and projected use, a market analysis and a needs assessment, which facilitated the development of a business plan. This plan includes resource needs, goals, timelines, budgets, training needs and program evaluation metrics to deliver comprehensive health care to women Veterans. No later than August 1, 2009, facilities will finalize their analyses and action plans based on the WCHIP tool. These plans will be instrumental in decisions for directing resources for fiscal 2010 and 2011.

To achieve the goal of providing comprehensive primary care for women Veterans, VA has designed three models to promote the delivery of optimal primary care. Under the first model, women Veterans are seen within a gender neutral primary care clinic. Under the second model, women Veterans are seen in a separate but shared space that may be located within or adjacent to a primary care clinic. Under the third model, women Veterans are seen in an exclusive separate space with a separate entrance into the clinical area and a distinct waiting room. In this scenario, gynecological, mental health and social work services are co-located in this space. Each of these models can be tailored to local needs and conditions to systemize the coordination, continuity, and integration of women Veterans' care. One-third of VA facilities have already adopted the third model of comprehensive primary care delivery and found it to be very effective. Access and wait times are better at sites where gender-specific services are available in an integrated women's primary care setting, regardless of whether the care was delivered in a separate space (such as a women's clinic) or incorporated within general primary care clinics. VA facilities that have established a "one-stop" approach to primary care delivery have already reported higher patient satisfaction on care coordination for contraception, sexually transmitted disease screening, and menopausal management.

In addition to improving the primary care infrastructure for women Veterans, VA is committed to advancing the entire range of emergency, acute, and chronic health care services needed by women Veterans to develop an optimal continuum of health care. Such a continuum of health care includes: enhancing and integrating mental health care, medical and surgical specialty care, health promotion and disease prevention, diagnostic services and rehabilitation for catastrophic injuries.

Enhancing Mental Health

VA has identified that 37 percent of women Veterans who use VA health care have a mental health diagnosis; these rates are higher than those of male Veterans. Women Veterans also present with complex mental health needs, including depres-

sion, post- traumatic stress disorder (PTSD), military sexual trauma (MST), and parenting and family issues.

In response, VA has instituted policy requirements, such as that outlined in its Handbook on Uniform Mental Health Services in VA medical centers and Clinics, to emphasize the importance of being aware of gender-specific issues when providing mental health care. In particular, the Handbook identifies services every health care facility must have available for women Veterans to ensure integrated mental health services as a part of comprehensive primary care for women Veterans. For example, the services provided optimally involve a designated, co-located, collaborative provider (psychologist, social worker, or psychiatrist) and care management with an emphasis on the need for safety, privacy, dignity, and respect to characterize all gender-specific services provided. Facilities are strongly encouraged to give patients treated for other mental health conditions the option of a consultation from a same-sex provider regarding gender-specific issues. All inpatient and residential care facilities must provide separate and secured sleeping accommodations for women. Every VA facility has a designated MST coordinator who serves as a contact person for related issues. VA is ensuring a concerted effort to provide quality mental health care appropriate to the needs of women Veterans.

Women Veterans Program Managers

In order to ensure improved advocacy for women Veterans at the facility level, VA has mandated all VA medical centers appoint a full-time Women Veterans Program Manager. These Women Veterans Program Managers support increased 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. Women Veterans Program Managers also coordinate and provide appropriate local outreach initiatives to women Veterans. As of June 2009, each of VA's 144 health care systems has appointed a full-time Women Veterans Program Manager.

Mini-Residency Training in Women's Health

As the number of women Veterans continues to grow, particularly women of child-bearing age, VA recognizes many primary care providers need to update their women-specific clinical experience. VA is offering waves of mini-residencies in women's health across the country in strategic geographic locations. Each mini- residency lasts two and a half days and is taught by national women's health experts. Clinical staff receive presentations on contraception, cervical cancer screening and sexually transmitted infections, abnormal uterine bleeding, chronic abdominal and pelvic pain, post-deployment readjustment issues for women Veterans, and other womens' health topics. Early results from this program indicate its success in increasing competencies in 12 areas of women's health care. As of June 2009, 216 participants (119 physicians, 77 nurse practitioners, 10 physician assistants, 9 registered nurses and 1 therapist) from 90 VA medical centers and 28 community-based outpatient clinics have either scheduled or completed this program.

Research on Women Veteran's Health Issues

VA has clearly established women's health as a research priority and intensified its efforts in the last decade. Currently, VA's Office of Research and Development supports a broad research portfolio focused on women's health issues, including studies on diseases prevalent solely or predominantly in women, hormonal effects on diseases in post-menopausal women, and health needs and health care of women Veterans. VA's Office of Health Services Research and Development is funding 27 research projects in this area. VA is also conducting a study that will survey 3,500 women Veterans (both those who use VA health care and those who do not) to identify the changing health care needs of women Veterans and to understand the barriers they face in using VA health care. We anticipate receiving the results of this study within the next several months, and we will share these findings with the Committee. VA is also conducting risk assessments to track the effects of deployments on women Veterans and improve our epidemiological data on Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) women Veterans through the National Health Study for a New Generation of U.S. Veterans (an OEF/OIF cohort study). We are enrolling 60,000 Veterans for this study—of these 12,000 are women.

Outreach Initiatives

Effective internal and external communication and outreach to women Veterans is critical to the success of implementing comprehensive care. Surveys and research show that women Veterans are often not aware of the services and benefits avail-

able to them. VA is engaging in multiple efforts to correct this. For example, VA's Center for Women Veterans and the Women Veterans Health Strategic Health Care Group will continue to expand its ongoing outreach and communications plan to ensure increased public awareness of women Veterans and their service to our country and increased awareness by women Veterans of VA health care.

Center for Women Veterans

The Center's mission is to ensure that women Veterans have access to VA benefits and services on par with male Veterans; that VA programs are responsive to the gender- specific needs of women Veterans; that joint outreach is performed to improve women Veterans' awareness of VA services, benefits, and eligibility criteria; and that women Veterans are treated with dignity and respect. The Center coordinates and collaborates with Federal, State and local agencies, Veterans service organizations and community- based organizations.

Women Veterans Health Strategic Healthcare Group

VA has developed a women Veterans health care "brand" within VA and among women Veterans. VA has made available upgraded communication resources, processes, and tools to Veterans Integrated Service Networks (VISN) and facilities. VA is building on the OEF/OIF call center to reach out to women Veterans. New scripts, new outreach materials and training are being developed to ensure women Veterans are aware of VA's services and benefits. While these efforts have created an important foundation upon which to build, it will take sustained and coordinated planning to successfully reach out to women Veterans.

FUTURE PLANS

While significant efforts are underway, we recognize that more must be done. VA must provide recurring funds to build adequate infrastructure for primary care and expand services to provide a full continuum of care for women Veterans at its secondary and tertiary care facilities. This investment of resources will contribute to the continuing goal of delivering quality health care focused on privacy, safety, sensitivity, dignity and continuity.

Expanding Access to Gynecology

Gynecologists are indispensable in providing care for women with abnormal findings on pelvic exams, such as abnormal pap smears, complicated cases of pelvic pain and abnormal vaginal bleeding in addition to specialized services in urology-gynecology, gynecology-oncology and obstetrics care. As VA primary care physicians increase their proficiency in women's health care to meet the needs of the growing numbers of women Veterans, primary care physicians will need to have on-site gynecologists available to act as experts, consultants and teachers. VA plans to have a gynecologist available at each of VA's 144 health care systems by 2012.

Expanding Innovative Technology

In the area of innovative technologies, VA is expanding its efforts to dramatically transform and improve care for women Veterans by enhancing its electronic health records system to provide more functionality related to women's health, including clinical reminders, pharmacy alerts for teratogenic drugs, improved decision support, gender-specific health history and screening questionnaires, e-videos and other tools for shared decisionmaking, particularly with regard to preference-sensitive health care choices (e.g., breast cancer surgery and treatments).

CONCLUSION

Mr. Chairman, VA's commitment to women Veterans is unwavering. We stand now at a unique moment in time where our actions and plans today will build the system that will provide care equal to the health care needs of all of America's Veterans, regardless of gender. Thank you once again for the opportunity to testify. My colleagues and I are prepared to address any additional questions you might have.

Chairman AKAKA. Thank you very much, Dr. Hayes.

Mr. Williamson, we will now begin with your testimony.

STATEMENT OF RANDALL B. WILLIAMSON, DIRECTOR OF HEALTH CARE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. WILLIAMSON. Good morning, Mr. Chairman and Members of the Committee. I am pleased to be here today as the Committee considers issues related to VA's health delivery of service to women veterans.

VA provided health services to over 281,000 women veterans in fiscal year 2008, an increase of 12 percent in just 2 years. Looking ahead, VA estimates that, while a total number of veterans will decline by 37 percent by the year 2033, the number of women veterans will increase by more than 17 percent over that period; thereby putting greater demands on VA's health care system to meet the physical and mental health care needs of women veterans.

Women veterans seeking care at VA medical facilities need access to a full range of physical health care services including: basic gender-specific services, such as cervical cancer screening and clinical breast examinations; specialized gender-specific services such as obstetric care and treatment of reproductive cancers; and mental health care services, such as care for depression and anxiety.

In addition, women veterans from conflicts in Iraq and Afghanistan present new challenges for VA's health care system. These women have experienced a greater exposure to combat than women participating in previous conflicts. VA data showed that as many as 20 percent of women veterans of Iraq and Afghanistan have been diagnosed with Post Traumatic Stress Disorder. An alarming number have also experienced sexual trauma while in the military. As a result, many have complex physical and mental health care needs.

In my testimony today, which is based on ongoing work for the Committee, I will discuss three aspects based largely on the work we did at 19 VA medical facilities.

First, the onsite availability of health care services for women veterans at VA facilities. Second, the extent to which VA facilities are following VA policies for delivering health care service for women veterans. And, third, some key challenges that VA facilities face in providing women's health care.

Dr. Hayes has outlined a number of steps VA is undertaking to fulfill its commitment to provide high-quality health care services for women veterans. VA has taken some bold steps in this regard. However, much remains to be done in some areas to fully implement the new initiatives.

Regarding the availability of services, we found that basic gender-specific services, including pelvic and clinic breast examinations, were available onsite at all 9 VAMCs and 8 of the 10 CBOCs we visited. All of the VAMCs that we visited offered at least some other specialized gender-specific services, such as treatment for abnormal cervical screening test and breast cancer.

Among the CBOCs, the two largest facilities we visited offered an array of specialized, gender-specific care onsite. The other eight referred women to other VA and non-VA facilities for most of these services. Outpatient mental health care services for women varied

widely among the VAMCs and the eight Vet Centers we visits, but were more limited at some of the CBOCs.

Four CBOCs offered women-only counseling groups, and only the two larger CBOCs offered specific programs for women who had experienced sexual trauma in the military. Also, only two VAMCs offered residential treatment programs for women who experienced sexual trauma. None had dedicated inpatient psychiatric units for women.

Regarding the extent to which VA facilities are following VA policies for delivering health care services for women veterans, we found that none of the VAMCs and CBOCs we visited was fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings where those requirements applied.

For example, many of the outpatient clinics we visited did not have adequate visual and auditory privacy in their check-in areas. Further, the facilities we visited were in various stages of implementing VA's new initiative to provide comprehensive primary care for women veterans.

Finally, officials at facilities that we visited identified challenges they face in providing health care services to the increasing numbers of women seeking VA health care. One challenge involves space constraints.

For example, the number, size, and configuration of exam rooms, as well as limited space for women's bathrooms, sometimes made it difficult for facilities to comply with VA's privacy requirements.

Officials also reported challenges in hiring providers with specific training and experience in women's health care issues, including treatment for women veterans with Post Traumatic Stress Disorder and those who had experienced military sexual trauma.

So, overall, Mr. Chairman, while VA has taken important steps in many areas to improve health care services for women veterans, some areas still require attention.

Mr. Chairman, that concludes my remarks.

[The prepared statement of Mr. Williamson follows:]

United States Government Accountability Office

GAO

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

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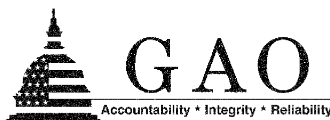
VA HEALTH CARE

Preliminary Findings on VA's Provision of Health Care Services to Women Veterans

Statement of Randall B. Williamson
Director, Health Care



GAO-09-884T

Highlights

Highlights of GAO-09-884T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

Historically, the vast majority of VA patients have been men, but that is changing. VA provided health care to over 281,000 women veterans in 2008—an increase of about 12 percent since 2006—and the number of women veterans in the United States is projected to increase by 17 percent between 2008 and 2033. Women veterans seeking care at VA medical facilities need access to a full range of health care services, including basic gender-specific services—such as cervical cancer screening—and specialized gender-specific services—such as treatment of reproductive cancers.

This testimony, based on ongoing work, discusses GAO's preliminary findings on (1) the on-site availability of health care services for women veterans at VA facilities, (2) the extent to which VA facilities are following VA policies that apply to the delivery of health care services for women veterans, and (3) key challenges that VA facilities are experiencing in providing health care services for women veterans. GAO reviewed applicable VA policies, interviewed officials, and visited 19 medical facilities—9 VA medical centers (VAMC) and 10 community-based outpatient clinics (CBOC)—and 8 Vet Centers. These facilities were chosen based in part on the number of women using services and whether facilities offered specific programs for women. The results from these site visits cannot be generalized to all VA facilities. GAO shared this statement with VA officials, and they generally agreed with the information presented.

View GAO-09-884T or key components. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

July 14, 2009

VA HEALTH CARE

Preliminary Findings on VA's Provision of Health Care Services to Women Veterans

What GAO Found

The VA facilities GAO visited provided basic gender-specific and outpatient mental health services to women veterans on site, and some facilities also provided specialized gender-specific or mental health services specifically designed for women on site. Basic gender-specific services, including pelvic examinations, were available on site at all nine VAMCs and 8 of the 10 CBOCs GAO visited. Almost all of the medical facilities GAO visited offered women veterans access to one or more female providers for their gender-specific care. The availability of specialized gender-specific services for women, including treatments after abnormal cervical cancer screenings and breast cancer, varied by service and facility. All VA medical facilities refer female patients to non-VA providers for obstetric care. Some of the VAMCs GAO visited offered a broad array of other specialized gender-specific services on site, but all contracted or fee-based at least some services. Among CBOCs, the two largest facilities GAO visited offered an array of specialized gender-specific care on site; the other eight referred women to other VA or non-VA facilities for most of these services. Outpatient mental health services for women were widely available at the VAMCs and most Vet Centers GAO visited, but were more limited at some CBOCs. While the two larger CBOCs offered group counseling for women and services specifically for women who have experienced sexual trauma in the military, the smaller CBOCs tended to rely on VAMC staff, often through videoconferencing, to provide mental health services.

The extent to which the VA medical facilities GAO visited were following VA policies that apply to the delivery of health care services for women veterans varied, but none of the facilities had fully implemented these policies. None of the VAMCs and CBOCs GAO visited were fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings where those requirements applied. For example, many of the medical facilities GAO visited did not have adequate visual and auditory privacy in their check-in areas. Further, the facilities GAO visited were in various stages of implementing VA's new initiative to provide comprehensive primary care for women veterans, but officials at some VAMCs and CBOCs reported that they were unclear about the specific steps they would need to take to meet the goals of the new policy.

Officials at facilities that GAO visited identified a number of challenges they face in providing health care services to the increasing numbers of women veterans seeking VA health care. One challenge was that space constraints have raised issues affecting the provision of health care services. For example, the number, size, or configuration of exam rooms or bathrooms sometimes made it difficult for facilities to comply with VA requirements related to privacy for women veterans. Officials also reported challenges hiring providers with specific training and experience in women's health care and in mental health care, such as treatment for women veterans with post-traumatic stress disorder or who had experienced military sexual trauma.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as the Committee considers issues related to the Department of Veterans Affairs' (VA) delivery of health care services to women veterans. Historically, the vast majority of VA patients have been men, but that is changing. As of October 2008, there were more than 1.8 million women veterans in the United States (representing approximately 7.7 percent of the total veteran population), and more than 102,000 of these women were veterans of the military operations in Afghanistan and Iraq, known as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). According to VA data, in fiscal year 2008, over 281,000 women veterans received health care services from VA—an increase of about 12 percent since 2006. Looking ahead, VA estimates that while the total number of veterans will decline by 37 percent between 2008 and 2033, the number of women veterans will increase by more than 17 percent over the same period.

The health care services needed by women veterans are significantly different from those required by their male counterparts. Women veterans are younger, in the aggregate, than their male counterparts. Based on an analysis conducted by the VA in 2007, the estimated median age of women veterans was 47, whereas the estimated median age of male veterans was 61. Women veterans seeking care at VA medical facilities need access to a full range of physical health care services, including basic gender-specific services—such as breast examinations, cervical cancer screening, and menopause management—and specialized gender-specific services such as obstetric care (which includes prenatal, labor and delivery, and postpartum care) and treatment of reproductive cancers. Women veterans also need access to a range of mental health care services, such as care for depression.

In addition, women veterans of OEF/OIF present new challenges for VA's health care system. Almost all of these women are under the age of 40—58 percent are between the ages of 20 and 29. VA data show that almost 20 percent of women veterans of OEF/OIF have been diagnosed with post-

traumatic stress disorder (PTSD).[1] Additionally, an alarming number of them have experienced sexual trauma while in the military.[2] As a result, many women veterans of OEF/OIF have complex physical and mental health care needs.

Congress and others have raised concerns about how well VA is prepared to meet the physical and mental health care needs of the growing number of women veterans, particularly veterans of OEF/OIF. Traditionally, women veterans have utilized VA's health care services less frequently than their male counterparts. In fiscal year 2007, 15 percent of women veterans used VA's health care services, compared to 22 percent of male veterans. VA believes that part of this difference may be attributable to barriers that the current care models at many VA medical facilities present to women veterans. For example, women veterans have often been required to make multiple visits to a VA facility in order to receive the full spectrum of primary care services, which includes such basic gender-specific care as cervical cancer screenings and breast examinations. Because many of these women work or have child care responsibilities, multiple visits can be problematic, especially when services are not available in the evenings or on weekends.

VA has taken some steps to improve the availability of services for women veterans, including requiring that all VA medical facilities make the Women Veterans Program Manager (WVPM)—an advocate for the needs of women veterans—a full-time position and providing funding for equipment to help VA medical facilities improve health care services for women veterans. Additionally, in November 2008, VA began a systemwide initiative to make comprehensive primary care for women veterans available at every VA medical facility—VA medical centers (VAMC) and community-based outpatient clinics (CBOC). In announcing this initiative,

[1]PTSD may develop following exposure to combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who experience stressful events often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can occur within the first few days after exposure to the stressful event but may also be delayed for months or years. If symptoms continue for more than 30 days and significantly disrupt an individual's daily activities, a diagnosis of PTSD is made.

[2]VA defines military sexual trauma (MST) as "psychological trauma, which in the judgment of a VA mental health professional resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training." VA reported that in fiscal year 2008, 21 percent of women screened for MST, screened positive for having experienced MST.

VA established a policy defining comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, gender-specific care, and mental health care—from one primary care provider at one site.

You asked us to examine VA's health care services for women veterans. In my testimony today, I will discuss our preliminary findings, based on visits to selected VA facilities, regarding (1) the on-site availability of health care services at VA facilities for women veterans, (2) the extent to which VA facilities are following VA policies that apply to the delivery of health care services for women veterans, and (3) some key challenges that VA facilities are experiencing in providing health care services for women veterans.

To examine the availability of health care services at VA facilities for women veterans and to determine the extent to which VA facilities are following VA policies that apply to the delivery of health care services for women veterans, we reviewed applicable VA policies[3] and available VA data, and interviewed officials from VA headquarters, Veterans Integrated Service Networks (VISN),[4] and VA facilities. In addition, we conducted site visits to a judgmental sample of nine VAMCs located in Atlanta and Dublin, Georgia; San Diego and Long Beach, California; Minneapolis and St. Cloud, Minnesota; Sioux Falls, South Dakota; and Temple and Waco, Texas. We also visited 10 VA CBOCs affiliated with these nine VAMCs, and eight Vet Centers, which are counseling centers that help combat veterans readjust from wartime military service to civilian life. We used VA data to select these sites based on several factors, including the number of women veterans using health care services at each VAMC and whether facilities offered specific programs for women veterans, such as outpatient or residential treatment programs for women who have PTSD or have experienced military sexual trauma (MST). See appendix I for additional details on the selection criteria we used and information on the number of women veterans using health care services at each VAMC and CBOC we

[3]The scope of services VA requires to be provided to women veterans, including requirements for ensuring the privacy of women veterans, are outlined in Veterans Health Administration (VHA) Handbook 1330.1, and the requirements for WVPM are outlined in VHA Handbook 1330.02 and in a July 2008 VA directive titled "Women Veteran Program Managers Full-Time FTEE Positions."

[4]The management of VAMCs and CBOCs is decentralized to 21 regional networks referred to as VISNs.

visited. To further examine the availability of services for women veterans, we obtained information from each VAMC and CBOC regarding the organization and availability of primary care services, basic gender-specific services, specialized gender-specific services, and mental health services in outpatient, residential, and inpatient settings; and the availability of specific clinical services such as prenatal care, osteoporosis treatment, mammography, and counseling for MST. When services were not available on site, we determined whether they were available through fee-for-service arrangements (fee basis), contracts, or sharing agreements with non-VA facilities. During our site visits we also toured each facility and documented observations of the physical space in each care setting. We examined how facilities were implementing VA policies pertaining to ensuring the privacy of women veterans in outpatient, residential, and inpatient care settings; and VA's model of comprehensive primary care for women veterans. Finally, to identify key challenges that VA facilities are experiencing in providing health care services for women veterans, we reviewed relevant literature; interviewed VA officials in headquarters, medical facilities, and Vet Centers; interviewed VA experts in the area of women veterans' health; and documented challenges observed during our site visits. The findings of our site visits to VA facilities cannot be generalized to other VA facilities. We shared the information contained in this statement with VA officials, and they generally agreed with the information we presented.

We conducted our performance audit from July 2008 through July 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA Health Care System

VA's integrated health care delivery system is one of the largest in the United States and provides enrolled veterans, including women veterans, with a range of services including primary and preventive health care services, mental health services, inpatient hospital services, long-term

care, and prescription drugs.[5] VA's health care system is organized into 21 VISNs that include VAMCs and CBOCs. VAMCs offer outpatient, residential, and inpatient services. These services range from primary care to complex specialty care, such as cardiac and spinal cord injury care. VAMCs also offer a range of mental health services, including outpatient counseling services, residential programs—which provide intensive treatment and rehabilitation services, with supported housing, for treatment, for example, of PTSD, MST, or substance use disorders—and inpatient psychiatric treatment. CBOCs are an extension of VAMCs and provide outpatient primary care and general mental health services on site. VA also operates 232 Vet Centers, which offer readjustment and family counseling, employment services, bereavement counseling, and a range of social services to assist combat veterans in readjusting from wartime military service to civilian life.[6]

When VA facilities are unable to efficiently provide certain health care services on site, they are authorized to enter into agreements with non-VA providers to ensure veterans have access to medically necessary services.[7] Specifically, VA facilities can make services available through

- referral of patients to other VA facilities or use of telehealth services,[8]
- sharing agreements with university affiliates or Department of Defense medical facilities,
- contracts with providers in the local community, or

[5]See 38 U.S.C. § 1710(a), 38 C.F.R. § 17.38 (2008). Any veteran who has served in a combat theater after November 11, 1998, including OEF/OIF veterans, and who was discharged or released from active service on or after January 28, 2003, has up to 5 years from the date of the veteran's most recent discharge or release from active duty service to enroll in VA's health care system and receive VA health care services. See 38 U.S.C. § 1710(e)(1)(D), (e)(3)(C). Veterans who were discharged or released before January 28, 2003, and who did not enroll in VA's health care system are eligible for these VA health care services for 3 years after January 28, 2008.

[6]All veterans who have served in a combat theater, including OEF/OIF veterans, are eligible for Vet Center services. See 38 U.S.C. § 1712A(a).

[7]See 38 U.S.C. § 1703.

[8]Telehealth is the provision of health services from a distance using telecommunications technologies, such as videoconferencing.

- allowing veterans to receive care from providers in the community who will accept VA payment (commonly referred to as fee-basis care).

VA Policies Pertaining to Women's Health

Federal law authorizes VA to provide medically necessary health care services to eligible veterans, including women veterans.[9] Federal law also specifically requires VA to provide mental health screening, counseling, and treatment for eligible veterans who have experienced MST.[10] Although the MST law applies to all veterans, it is of particular relevance to women veterans because among women veterans screened by VA for MST, 21 percent screened positive for experiencing MST. VA provides health care services to veterans through its medical benefits package—health care services required to be provided are broadly stated in a regulation and further specified in VA policies. Through policies, VA requires its health care facilities to make certain services, including gender-specific services and primary care services, available to eligible women veterans.[11] Gender-specific services that are included in the VA medical benefits package[12] include, for example, cervical cancer screening, breast examination, management of menopause, mammography, obstetric care, and infertility evaluation. See table 1 for a list of selected basic and specialized gender-specific services that VA is required to make available and others that VA may make available to women veterans.

[9]38 U.S.C. § 1710.

[10]38 U.S.C. § 1720D.

[11]These services are defined in VHA Handbook 1330.1, *VHA Services for Women Veterans* (revised July 16, 2004) and VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008).

[12]See 38 C.F.R. § 17.38 (2008).

Table 1: Selected Clinical Services That VA Is Required to Make Available and Others That VA May Make Available to Women Veterans, by Category

	Services that VA medical facilities may make available to women veterans
Primary care/basic gender-specific services[a]	• Intake and initial assessment, including screening for military sexual trauma (MST)[b] • Routine physical exams • Intimate partner violence screening • Smoking cessation counseling • Smoking cessation treatment • Nutrition counseling • Weight management and fitness • Urgent/emergent gender-related care—normal hours • Urgent/emergent gender-related care—evenings, weekends, and holidays • Pelvic examination[b] • Clinical breast examination[b] • Education on performing breast self-examination[b] • Cervical cancer screening[b] • Menopause management[b] • Uncomplicated vulvovaginitis treatment[b] • Osteoporosis screening[b] • Osteoporosis treatment[b] • Hormone replacement therapy[b] • Prescription of oral contraceptives[b]
Specialized gender-specific services[a]	• Treatment after abnormal cervical cancer screening[b] • Surgical sterilization—evaluation[b] • Surgical sterilization • Sexually transmitted disease (STD) screening • STD counseling • STD treatment • Intrauterine device (IUD) placement • Pregnancy test—urine • Pregnancy test—serum • Prenatal care • Labor and delivery • Postpartum care • Infertility evaluation[b] • Endometriosis treatment • Evaluation of polycystic ovarian syndrome[b] • Treatment of polycystic ovarian syndrome[b]

Services that VA medical facilities may make available to women veterans
• Screening mammography[b]
• Diagnostic mammography
• Surgical treatment of breast cancer[b]
• Surgical treatment of reproductive cancer[b]
• Medical treatment of breast cancer[b]
• Medical treatment of reproductive cancer[b]

Source: GAO review of VA data.

Notes: The data are from a review of VHA Handbook 1330.1 and VA's annual Plan of Care and Clinical Inventory Survey.

[a]The distinction between "basic" and "specialized" gender-specific services is based on the definitions included in VHA Handbook 1330.1 and the 2003 article by Yano and Washington. Elizabeth Yano and Donna Washington, "Availability of Comprehensive Women's Health Care Through Department of Veterans Affairs Medical Center." Published by Donna Washington, et al., in *Women's Health Issues*, v. 13 (2003).

[b]Denotes a service that VA medical facilities are required to make available to women veterans, based on VHA Handbook 1330.1.

In November 2008, VA established a policy that requires all VAMCs and CBOCs to move toward making comprehensive primary care available for women veterans. VA defines comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, basic gender-specific care, and basic mental health care—from one primary care provider at one site. VA did not establish a deadline by which VAMCs and CBOCs must meet this requirement.

VA policies also outline a number of requirements specific to ensuring the privacy of women veterans in all settings of care at VAMCs and CBOCs.[13] These include requirements related to ensuring auditory and visual privacy at check-in and in interview areas; the location of exam rooms, presence of privacy curtains, and the orientation of exam tables; access to private restrooms in outpatient, inpatient, and residential settings of care; and the availability of sanitary products in public restrooms at VA facilities.

1n 1991, VA established the position of Women Veteran Coordinator—now the WVPM—to ensure that each VAMC had an individual responsible for assessing the needs of women veterans and assisting in the planning and delivery of services and programs to meet those needs. Begun as a part-time collateral position, the WVPM is now a full-time position at all

[13]VHA Handbook 1160.01 and VHA Handbook 1330.1.

VAMCs. In July 2008, VA required VAMCs to establish the WVPM as a full-time position (no longer a collateral duty) no later than December 1, 2008. Clinicians in the role of WVPM would be allowed to perform clinical duties to maintain their professional certification, licensure, or privileges, but must limit the time to the minimum required, typically no more than 5 hours per week.

VA Mental Health Services

In September 2008, VA issued the *Uniform Mental Health Services in VA Medical Centers and Clinics*,[14] a policy that specifies the mental health services that must be provided at each VAMC and CBOC.[15] The purpose of this policy is to ensure that all veterans, wherever they obtain care in VA's health care system, have access to needed mental health services. The policy lists the mental health care services that must be delivered on site or made available by each facility. To help ensure that mental health staff can provide these services, VA has developed and rolled out evidence-based[16] psychotherapy training programs for VA staff that treat patients with PTSD, depression, and serious mental illness. VA's training programs cover five evidence-based psychotherapies: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE), which are recommended for PTSD; Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT), which are recommended for depression; and Social Skills Training (SST), which is recommended for serious mental illness. The training programs involve two components: (1) attendance at an in-person, experientially-based, workshop (usually 3-4 days long), and (2) ongoing telephone-based small-group consultation on actual therapy cases with a consultant who is an expert in the psychotherapy.

[14]VHA Handbook 1160.01.

[15]The mental health services that must be provided in CBOCs differ according to the size of the clinics.

[16]Psychotherapies that have consistently been shown in controlled research to be effective for a particular condition or conditions are referred to as "evidence-based."

VA Facilities Provided Basic and Specialized Gender-Specific Services and Mental Health Services to Women Veterans, though Not All Services Were Provided On Site at Each VA Facility

The VA facilities we visited provided basic gender-specific and outpatient mental health services to women veterans on site, and some facilities also provided specialized gender-specific or mental health services specifically designed for women on site. All of the VAMCs we visited offered at least some specialized gender-specific services on site, and six offered a broad array of these services. Among CBOCs, other than the two largest facilities we visited, most offered limited specialized gender-specific care on site. Women needing obstetric care were always referred to non-VA providers. Regarding mental health care, we found that outpatient services for women were widely available at the VAMCs and most Vet Centers we visited, but were more limited at some CBOCs. Eight of the VAMCs we visited offered mixed-gender inpatient or residential mental health services, and two VAMCs offered residential treatment programs specifically designed for women veterans.

Basic Gender-Specific Care Services Were Generally Available On site at VA Medical Facilities

Basic gender-specific care services were available on site at all nine of the VAMCs and 8 of the 10 CBOCs that we visited. (See table 2.) These facilities offered a full array of basic gender-specific services for women—such as pelvic examinations, and osteoporosis treatment—on site. One of the CBOCs we visited did not offer any basic gender-specific services on site and another offered a limited selection of these services. These CBOCs that provided limited basic gender-specific services referred patients to other VA facilities for this care, but had plans underway to offer these services on site once providers received needed training. In general, women veterans had access to female providers for their gender-specific care: of the 19 medical facilities we visited, all but 4 had one or more female providers available to deliver basic gender-specific care.

Table 2: On-site Availability of Selected Basic Gender-Specific Services for Women Veterans at Selected VA Facilities

	VAMC, by number									CBOC, by number									
Service	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Pelvic exam and cervical cancer screening	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿	⦿[a]	●	●	●
Prescription of oral contraceptives	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿[a]	●	●	●
Osteoporosis treatment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿[a]	●	●	●
Menopause management	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⦿[a]	●	●	●

Source: GAO.

Key:

● Service available on site

⦿ Refer to another VA facility

Note: We collected this information using a data collection instrument during site visits to VA medical facilities from October 2008 through April 2009. Some VA facilities reported that serious or complicated cases may be referred to other VA medical facilities.

[a]This facility may also fee-base this service to an outside provider on a case-by-case basis.

The facilities we visited delivered basic gender-specific services in a variety of ways. Seven of the nine VAMCs and the two large CBOCs we visited had women's clinics. The physical setup of these clinics ranged from a physically separate dedicated clinical space (at five facilities) to one or more designated women's health providers with designated exam rooms within a mixed-gender primary care clinic. Generally, when women's clinics were available, most female patients received their basic gender-specific care in those clinics. When women's clinics were not available, female patients either received their gender-specific care through their primary care provider or were referred to another VA or non-VA facility for these services.

Basic gender-specific services were typically available between 8:00 a.m. and 4:30 p.m. on weekdays. At one CBOC and one VAMC, however, basic gender-specific care was only available during limited time frames. At the CBOC, a provider from the affiliated VAMC traveled to the CBOC 2 days each month to perform cervical cancer screenings and pelvic examinations for the clinic's female patients. In general, medical facilities did not offer evening or weekend hours for basic gender-specific services.

While All VAMCs Offered at Least Some Specialized Gender-Specific Services On site, CBOCs Typically Referred Patients Needing These Services to Other VA or Non-VA Medical Facilities

The provision of specialized gender-specific services for women, including treatment after abnormal cervical cancer screenings and breast cancer treatment, varied by service and by facility. (See table 3.) All VA medical facilities referred female patients to outside providers for obstetric care. Some of the VAMCs we visited offered a broad array of other specialized gender-specific services on site, but all contracted or fee-based at least some services. In particular, most VAMCs provided screening and diagnostic mammography through contracts with local providers or fee-based these services. In addition, less than half of the VAMCs provided reconstructive surgery after mastectomy on site, although six of the nine VAMCs we visited provided medical treatment for breast cancers and reproductive cancers on site. In general, the CBOCs we visited offered more limited specialized gender-specific services on site. For example, while most CBOCs offered pregnancy testing and sexually transmitted disease (STD) screening, counseling, and treatment, only the largest CBOCs offered IUD placement on site. Most CBOCs referred patients to VA medical facilities—sometimes as far as 130 miles away—for some specialized gender-specific services. Because the travel distance can be a barrier to treatment for some veterans, officials at some CBOCs said that they will fee-base services to local providers on a case-by-case basis. At both VAMCs and CBOCs, specialized gender-specific services were usually offered on site only during certain hours: for example, four medical facilities only offered these services 2 days per week or less.

Table 3: On-site Availability of Selected Specialized Gender-Specific Services for Women Veterans at Selected VA Facilities

	VAMC, by number									CBOC, by number									
Service	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9	10
Treatment of sexually transmitted diseases (STD)	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●[a]	◉	●	●	●
Treatment after abnormal cervical cancer screening	●	●	◉[b]	●	●	●[c]	●[a]	●[a,c]	●[a]	●	●	◉	◉	◉[c]	◉	◉[c]	◉	◉	◉
Intrauterine device (IUD) placement	●	●	◉[b]	●	●	●	●[a]	●	●	●	●	◉	◉	◉[c]	◉	◉[c]	◉	◉	◉
Screening mammography	●	⊙[d]	●	⊙	●	○	◉	⊙	⊙[d]	◉	○	⊙	◉	⊙	◉	◉[c]	⊙	⊙	⊙
Obstetric care	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Medical treatment of breast and reproductive cancers	●[c]	●[c,e]	●[c]	●[c]	●	◉[c]	◉	●[e]	◉	[Data about the availability of this service were not collected at CBOCs.]									
Reconstructive surgery after mastectomy	○	●	●[c]	●	●	○	○	⊙	◉	[Data about the availability of this service were not collected at CBOCs.]									

Source: GAO.

● Service available on site

◉ Refer to another VA facility

⊙ Refer to a contract provider

○ Refer to a fee-basis provider

Notes: We collected this information using data collection instruments during site visits to VA medical facilities from October 2008 through April 2009.

[a]This facility may refer this service to another VAMC.

[b]This facility refers this service to a large CBOC located approximately 13 miles from this facility.

[c]This facility may also fee-base this service to a non-VA provider on a case-by-case basis.

[d]This facility provided screening mammography services through a contract provider. That contract provider has a mobile unit that offers screening mammography services on site at the VAMC a few days a month.

[e]This facility contracts for associated stereotactic biopsies.

Outpatient Mental Health Services Were Widely Available at Most VAMCs and Vet Centers, but More Limited at Smaller CBOCs

A range of outpatient mental health services was readily available at the VAMCs we visited. The types of outpatient mental health services available at most VAMCs included, for example, diagnosis and treatment of depression, substance use disorders, PTSD, and serious mental illness. All of the VAMCs we visited had one or more providers with training in evidence-based therapies for the treatment of PTSD and depression. All but one of the VAMCs we visited offered at least one women-only counseling group. Two VAMCs offered outpatient treatment programs specifically for women who have experienced MST or other traumas. In addition, several VAMCs offered services during evening hours at least 1 day a week. While most outpatient mental health services were available

on site, facilities typically fee-based treatment for a veteran with an active eating disorder to non-VA providers.

Similarly, the eight Vet Centers we visited offered a variety of outpatient mental health services, including counseling services for PTSD and depression, as well as individual or group counseling for victims of sexual trauma. Five of the eight Vet Centers we visited offered women-only groups, and six had counselors with training or experience in treating patients who have suffered sexual trauma. Vet Centers generally offered some counseling services in the evenings.

The outpatient mental health services available in CBOCs were, in some cases, more limited. The two larger CBOCs offered women-only group counseling as well as intensive treatment programs specifically for women who had experienced MST or other traumas, and two other CBOCs offered women-only group counseling. The smaller CBOCs, however, tended to rely on staff from the affiliated VAMC, often through telehealth, to provide mental health services. Five CBOCs provided some mental health services through telehealth or using mental health providers from the VAMC that traveled to the CBOCs on specific days.

While Most VAMCs Offer Mixed-Gender Residential or Inpatient Mental Health Services, Few Have Specialized Programs for Women Veterans

While most VAMCs offer mixed-gender residential mental health treatment programs or inpatient psychiatric services, few have specialized programs for women veterans. Eight of the nine VAMCs we visited served women veterans in mixed-gender inpatient psychiatric units, mixed-gender residential treatment programs, or both. Two VAMCs had residential treatment programs specifically for women who have experienced MST and other traumas. (VA has ten of these programs nationally.) None of the VAMCs had dedicated inpatient psychiatric units for women. VA providers at some facilities expressed concerns about the privacy and safety of women veterans in mixed-gender inpatient and residential environments. For example, in the residential treatment programs, beds for women veterans were separated from other areas of the building by keyless entry systems. However, female residents in some of these programs shared common areas, such as the dinning room, with male residents, and providers expressed concerns that women who were victims of sexual trauma might not feel comfortable in such an environment.

Medical Facilities Had Not Fully Implemented VA Policies Pertaining to the Delivery of Health Care Services for Women Veterans

The extent to which VA medical facilities we visited were following VA policies that apply to the delivery of health care services for women veterans varied, but none of the facilities had fully implemented VA policies pertaining to women veterans' health care. In particular, none of the VAMCs or CBOCs we visited were fully compliant with VA policy requirements related to privacy for women veterans. In addition, the facilities we visited were in various stages of implementing VA's new initiative on comprehensive primary care: most medical facilities had at least one provider that could deliver comprehensive primary care services to women veterans, although not all of these facilities were routinely assigning women veterans to these providers. Officials at some VA facilities reported that they were unclear about the specific steps they would need to take to meet VA's definition of comprehensive primary care for women veterans.

None of the Facilities Were Fully Compliant with VA Policies Related to Ensuring the Privacy of Women Veterans

None of the VAMCs and CBOCs we visited were fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings where those requirements applied. Table 4 summarizes the extent to which the facilities we visited complied with VA policy requirements related to privacy for women veterans.

Table 4: VA Facilities' Compliance with VA Privacy Requirements

	Compliance with requirement																		
	VAMC, by number									CBOC, by number									
Privacy requirement	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Adequate visual and auditory privacy at check-in	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	◒	○	◒	○	◒	○
Adequate visual and auditory privacy in the interview area	●	◒	◒	●	●	◒	●	◒	●	◒	●	●	◒	●	●	●	●	●	●
Exam rooms located so they do not open into a public waiting room or a high-traffic public corridor	●	●	◒	◒	◒	◒	◒	●	◒	●	●	●	●	●	●	●	●	●	●
Privacy curtains present in exam rooms	●	●	●	◒	●	●	●	●	●	●	●	○	●	●	●	●	○	○	●
Exam tables placed with the foot facing away from the door (if not possible, placed so they are fully shielded by privacy curtains)[a]	◒	◒	○	○	◒	○	●	○	◒	○	●	○	○	○	N/A	N/A	○	●	○
Changing area provided behind privacy curtain	●	●	●	◒	●	●	●	●	●	●	●	○	●	●	●	●	○	○	●
Toilet facilities immediately adjacent to examination rooms where gynecological exams and procedures are performed	◒	●	○	●	◒	◒	○	○	◒	○	○	○	○	●	N/A	N/A	○	○	○
Sanitary napkin and/or tampon dispensers and disposal bins in at least one women's public restroom	●[b]	○	○	○	○	○	○	○	●[b]	○	○	○	○	○	○	○	○	○	○
Privacy curtains in inpatient rooms (exception: psychiatry and mental health units)	◒	●	●	●	●	●	N/A	●	○	[This requirement does not apply to CBOCs.]									
Access to a private bathroom facility (with toilet and shower) in close proximity to the patient's room (inpatient and residential units)	●	◒	●	●	●	◒	◒	◒	●	[This requirement does not apply to CBOCs.]									

Source: GAO.

● Facility was compliant with requirement in all clinical settings

◒ Facility was compliant with requirement in at least one—but not all—clinical settings

○ Facility was not compliant with requirement in any clinical settings

N/A We did not tour any clinical settings at this facility where this requirement must be applied

Notes: We collected this information using data collection instruments during site visits to VA medical facilities from October 2008 through April 2009.

[a] We did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the doorway.

[b] At this facility, sanitary napkins, tampons, or both were available free of charge in baskets that had been placed in public restrooms.

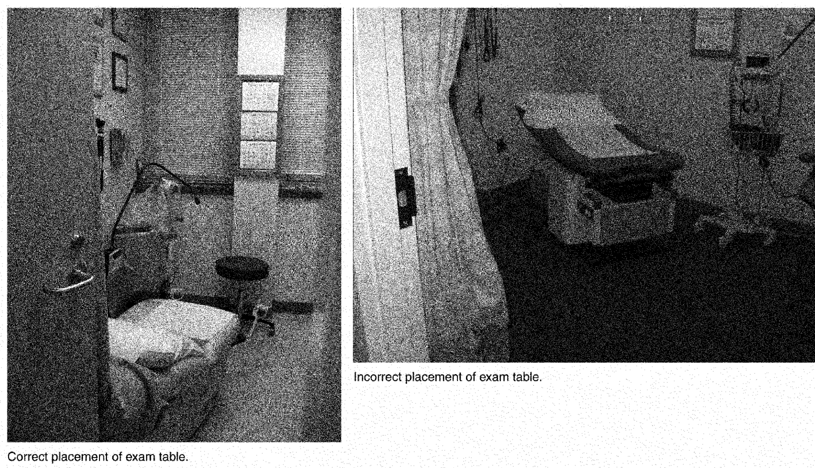
All facilities were fully compliant with at least some of VA's privacy requirements; however, we documented observations in many clinical settings where facilities were not following one or more requirements. Some common areas of noncompliance included the following:

- **Visual and auditory privacy at check-in**. None of the VAMCs or CBOCs we visited ensured adequate visual and auditory privacy at check-in in all clinical settings that are accessed by women veterans. In most clinical settings, check-in desks or windows were located in a mixed-gender waiting room or on a high-traffic public corridor. In some locations, the check-in area was located far enough away from the waiting room chairs that patients checking in for appointments could not easily be overheard. In a total of 12 outpatient clinical settings at six VAMCs and five CBOCs, however, check-in desks were located in close proximity to chairs where other patients waited for their appointments. At one CBOC, we observed a line forming at the check-in window, with several people waiting directly behind the patient checking in, demonstrating how privacy can be easily violated at check-in.
- **Orientation of exam tables**. In exam rooms where gynecological exams are conducted, only one of the nine VAMCs and two of the eight CBOCs[17] we visited were fully compliant with VA's policy requiring exam tables to face away from the door.[18] In many clinical settings that were not fully compliant at the remaining facilities, we observed that exam tables were oriented with the foot of the table facing the door, and in two CBOCs where exam tables were not properly oriented, there was no privacy curtain to help assure visual privacy during women veterans' exams. At one of these CBOCs, a noncompliant exam room was also located within view of a mixed-gender waiting room. Figure 1 shows the correct and incorrect orientation of exam tables in two gynecological exam rooms at two VA medical facilities.

[17]We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams.

[18]According to VA policy, if it is not possible for exam tables to be placed with the foot facing away from the door, they may be placed so that they are fully shielded by privacy curtains. However, we did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the door.

Figure 1: Correct and Incorrect Placement of Exam Tables in Gynecological Exam Rooms at VA Medical Facilities



Correct placement of exam table.

Incorrect placement of exam table.

Source: GAO.

- **Restrooms adjacent to exam rooms**. Only two of the nine VAMCs and one of the eight CBOCs we visited were fully compliant with VA's requirement that exam rooms where gynecological exams are conducted have immediately adjacent restrooms.[19] In most of the outpatient clinics we toured, a woman veteran would have to walk down the hall to access a restroom, in some cases passing through a high-traffic public corridor or a mixed-gender waiting room.

- **Access to private restrooms in inpatient and residential units**. At four of the nine VAMCs we visited, proximity of private restrooms to women's rooms on inpatient or residential units was a concern. In one

[19]We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams, so this requirement was not applicable at those 2 CBOCs.

mixed-gender inpatient medical/surgical unit, two mixed-gender residential units, and one all-female residential unit, women veterans were not guaranteed access to a private bathing facility and may have had to use a shared or congregate facility. In two of these four settings, access to the shared restroom was not restricted by a lock or a keycard system, raising concerns about the possibility of intrusion by male patients or staff while a woman veteran is showering or using the restroom.

- **Availability of sanitary products in public restrooms**. At seven of the nine VAMCs and all 10 of the CBOCs we visited, we did not find sanitary napkins or tampons available in dispensers in any of the public restrooms.

Medical Facilities Were in Various Stages of Implementing VA's Initiative on Comprehensive Primary Care for Women Veterans, but Officials at Some Facilities Were Unclear about the Steps Needed to Implement VA's New Initiative

VA has not set a deadline by which all VAMCs and CBOCs are required to implement VA's new comprehensive primary care initiative for women veterans, which would allow women veterans to obtain both primary care and basic gender-specific services from one provider at one site. Officials at the VA medical facilities we visited since the comprehensive primary care for women veterans initiative was introduced reported that they were at various stages of implementing the new initiative. Officials at 6 of the 7 VAMCs and 6 of the 8 CBOCs we visited since November 2008—when VA adopted this initiative—reported that they had at least one provider who could deliver comprehensive primary care services to women veterans. However, some of the medical facilities we visited reported that they were not routinely assigning women veterans to comprehensive primary care providers.

Officials at some medical facilities we visited were unclear about the steps needed to implement VA's new policy on comprehensive primary care for women veterans. For example, at one VAMC, primary care was offered in a mixed-gender primary care clinic and basic gender-specific services were offered by a separate appointment in the gynecology clinic, sometimes on the same day. The new comprehensive primary care initiative would require both primary care and basic gender specific services to be available on the same day, during the same appointment. Officials at this facility said that they were in the process of determining whether they can adapt their current model to meet VA's comprehensive primary care standard by placing additional primary care providers in the gynecology clinic so that both primary care services and basic gender-specific services could be offered during the same appointment, in one location. Facility officials were uncertain about whether it would meet VA's comprehensive primary care standard if primary care and basic gender-specific services were still delivered by two different providers.

However, VA's comprehensive primary care policy is clear that the care is to be delivered by the same provider. Another area of uncertainty is the breadth of experience a provider would need to meet VA's comprehensive primary care standard. Officials from VA headquarters have made it clear that it is their expectation that comprehensive primary care providers have a broad understanding of basic women's health issues—including initial evaluation and treatment of pelvic and abdominal pain, menopause management, and the risks associated with prescribing certain drugs to pregnant or lactating women. However, in one location, we found that the only provider who was available to deliver comprehensive primary care may not have had the proficiency to deliver the broad array of services that are included in VA's definition, because the facility serves a very low volume of women veterans and opportunities to practice delivering some basic gender-specific services are limited.

VA Officials Identified Key Challenges Related to Space, Hiring Staff with Specific Experience and Training, and Establishing the WVPM as a Full-time Position

VA officials at medical facilities we visited identified a number of key challenges in providing health care services to women veterans. These challenges include physical space constraints that affect the provision of care, including problems complying with patient privacy requirements, and difficulties hiring providers that have specific experience and training in women's health, as well as hiring mental health providers with expertise in treating veterans with PTSD and who have experienced MST. Officials at some VA medical facilities also reported implementation issues in establishing the WVPM as a full-time position.

VA Facility Officials Identified Space Constraints as a Challenge Affecting the Provision of Health Care Services to Women Veterans

Officials at VA medical facilities we visited reported that space constraints have raised issues affecting the provision of health care services to women veterans. In particular, officials at 7 of 9 VAMCs and 5 of 10 CBOCs we visited said that space issues, such as the number, size, or configuration of exam rooms or bathrooms at their facilities sometimes made it difficult for them to comply with some VA requirements related to privacy for women veterans. At some of the medical facilities we visited, officials raised concerns about busy waiting rooms and the limited space available to provide separate waiting rooms for patients who may not feel comfortable in a mixed-gender waiting room, particularly women veterans who have experienced MST. Officials at one CBOC said they received complaints from women veterans who preferred a separate waiting room. At this

facility, space challenges that affected privacy were among the factors that led to the relocation of mental health services to a separate off-site clinic. VA facility officials told us that some of the patient bedrooms at two VAMC mixed-gender inpatient psychiatric units that were usually designated for female patients were located in space that could not be adequately monitored from the nursing station. VA policy requires that all inpatient care facilities provide separate and secured sleeping accommodations for women and that mixed-gender units must ensure safe and secure sleeping arrangements, including, but not limited to, the ability to monitor the patient bedrooms from the nursing station.

VA facility officials also told us they have struggled with space constraints as they work to comply with VA's new policy on comprehensive primary care for women and the requirements in the September 2008 *Uniform Mental Health Services in VA Medical Centers and Clinics*, as well as the increasing numbers of women veterans requesting these services. For example, officials at a VAMC said that limitations in the number of primary care exam rooms at their facilities made it difficult for providers to deliver comprehensive primary care services in an efficient and timely manner. Providers explained that having only one exam room per primary care provider prevents them from "multitasking," or moving back and forth between exam rooms while patients are changing or completing intake interviews with nursing staff. Similarly, mental health providers at a medical facility said that they often shared offices, which limits the number of counseling appointments they could schedule, and primary care providers sometimes have two patients in a room at the same time separated by a curtain during the intake or screening process. In addition, at one VAMC, officials reported that the facility needed to be two to three times its current size to accommodate increasing patient demand.

VA officials are aware of these challenges and VA is taking steps to address them, such as funding construction projects, moving to larger buildings, and opening additional CBOCs. However, some of these projects will not be finished for a few years. In the interim, officials said, some facilities are leasing additional space or contracting some services to community providers.

VA Facility Officials Identified Difficulties Hiring Primary Care Providers with the Specific Training and Experience Needed to Provide Services to Women Veterans

VA facility officials reported difficulties hiring primary care providers with specific training and experience in women's health. VA's comprehensive primary care initiative requires that women veterans have access to a designated women's health primary care provider that is "proficient, interested, and engaged" in delivering services to women veterans. The new policy requires that this primary care provider fulfill a broad array of health care services including, but not limited to

- detection and management of acute and chronic illness, such as osteoporosis, thyroid disease, and cancer of the breast, cervix, and lung;
- gender-specific primary care such as sexuality, pharmacologic issues related to pregnancy and lactation, and vaginal infections;
- preventive care, such as cancer screening and weight management;
- mental health services such as screening and referrals for MST, as well as evaluation and treatment of uncomplicated mental health disorders and substance use disorders; and
- coordination of specialty care.

Officials at some facilities we visited told us that they would like to hire more providers with the required knowledge and experience in women's health, but struggle to do so. For example, at one VAMC, officials reported that they had difficulty filling three vacancies for primary care providers, which they needed to meet the increasing demand for services and to replace staff who had retired. They said it took them a long time to find providers with the skills required to serve the needs of women veterans. Similarly, at one CBOC, officials reported that it takes them about 8 to 9 months to hire interested primary care physicians. Further, officials at some facilities we visited said that they rely on just one or two providers to deliver comprehensive primary care to women veterans. This is a concern to the officials because, should the provider retire or leave VA, the facility might not be able to replace them relatively quickly in order to continue to provide comprehensive primary care services to women veterans on site.

VA officials have acknowledged some of the challenges involved in training additional primary care providers to meet their vision of delivering comprehensive primary care to women veterans. A November 2008 report on the provision of primary care to women veterans cites insufficient numbers of clinicians with specific training and experience in

women's health issues among the challenges VA faces in implementing comprehensive primary care.[20] To help address the knowledge gap, VA is using "mini-residency" training sessions on women's health. These training sessions—which VA designed to enhance the knowledge and skills of primary care providers—consist of two and one-half days of case-based learning and hands-on training in gender-specific health care for women. During the mini-residency, providers receive specific training in performing pelvic examinations, cervical cancer screenings, clinical breast examinations, and other relevant skills.

VA Medical Facility and Vet Center Officials Identified Challenges Hiring Mental Health Providers with Training and Experience in Treating PTSD and MST

VA medical facility and Vet Center officials reported challenges hiring psychiatrists, psychologists, and other mental health staff with specialized training or experience in treating PTSD and MST. Medical facility officials often noted that there is a limited pool of qualified psychiatrists and psychologists, and a high demand for these professionals both in the private sector and within VA. In addition, two officials reported that because it is difficult to attract and hire mental health professionals with experience in treating the veteran population, some medical facilities have hired younger, less experienced providers. These officials noted that while younger providers may have the appropriate education and training in some evidence-based psychotherapy treatment methods that are recommended for treating PTSD and MST, they often lack practical experience treating a challenging patient population.

Some officials reported that staffing and training challenges limit the types of group or individual mental health treatment services that VA medical facilities and Vet Centers can offer. For example, officials at one VAMC said that they had problems attracting qualified mental health providers to work at its affiliated CBOCs. The facility posted announcements for psychiatrist and psychologist positions, but sometimes received no applications. Because the facility has not been able to recruit mental health providers, it relies on contract providers and fee-basing to deliver mental health services to veterans in its service area. At one Vet Center, officials told us that because none of their counselors have been trained to counsel veterans who have experienced MST, patients seeking counseling for MST are usually referred to the nearby CBOC or VAMC. At one CBOC,

[20]Department of Veterans Affairs, *Report of the Under Secretary for Health Workgroup, Provision of Primary Care to Women Veterans*, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group (Washington, D.C.: November 2008).

a licensed social worker reported that he provides individual counseling for about seven women who have experienced MST, even though he has limited training in this area. He said that this situation was not ideal, but said that he consults with mental health providers at the associated VAMC on some of these cases, and that without his services some of these women might not receive any counseling.

VA officials told us that they are aware of the challenges involved in finding clinical staff with specialized training and experience in working with veterans who have PTSD or have experienced MST. A VA official told us that as part of a national effort to enhance mental health providers' knowledge of clinically effective treatment methods and make these methods available to veterans, VA has developed evidenced-based psychotherapy training for VA mental health staff. In particular, CPT, PE, and ACT are evidence-based treatment therapies for PTSD and also commonly used by providers who work with patients who have experienced MST.[21] A VA headquarters official who is responsible for these training programs told us that as of May 4, 2009, 1,670 VA clinicians had completed VA-provided training in evidence-based therapies. Although VA is providing training in these evidence-based therapies, VA officials stated that this training is not mandatory for VA mental health providers who work with patients who have PTSD or have experienced MST.

Some VAMC Officials Reported That Establishing the WVPM as a Full-time Position Has Raised Implementation Issues

Some VA officials expressed concerns that certain aspects of the new policy making the WVPM a full-time position may have the unintended consequence of discouraging clinicians from applying for or staying in the position, potentially leading to the loss of experienced WVPMs. One concern that some WVPMs raised during our interviews was that they were interested in performing clinical duties beyond the minimum required to maintain their professional certification, but would not be able to do so under the new policy. The new policy limits a WVPM's clinical duties to the minimum required to maintain professional certification, licensure, or privileges, typically no more than 5 hours per week. Another concern was that the change to full-time status could result in a reduction in salary for some clinicians because the position could be classified as an administrative position, depending on how the policy is implemented at

[21]According to VA officials, these therapies address the PTSD diagnosis commonly associated with sexual trauma. Other diagnoses commonly associated with MST are depression and generalized anxiety.

the VAMC. At two VAMCs we visited, such concerns had discouraged the incumbent WVPM from accepting the full-time position.

VA headquarters officials told us that they are aware of and have expressed their concerns to VA senior headquarters officials about unintended consequences of the new policy. VA headquarters officials provided VISN and VAMC leadership with some options that they could use to help avoid or minimize the potential loss of experienced WVPMs. For example, one option that could be approved on a case-by-case basis is to use a job-sharing arrangement that would allow the incumbent WVPM and another person to each dedicate 50 percent of their time to the WVPM position, performing clinical duties the other 50 percent, in order to transition staff into the full-time position or as a succession planning effort. VA headquarters officials said that action on this issue was important because VA does not have the time or resources to train new staff to replace experienced WVPMs who may leave their positions.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other Members of the committee have at this time.

For further information about this testimony, please contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made major contributions to this testimony are listed in appendix II.

Appendix I: Information on the Selection of VA Facilities Examined in This Report

We selected locations for our site visits using VA data on each VA medical center (VAMC) in the United States. Our goal was to identify a geographically diverse mix of facilities, including some facilities that provide services to a high volume of women veterans, particularly women veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF); some facilities that serve a high proportion of National Guard or Reserve veterans; and some facilities that serve rural veterans. We also considered whether VAMCs had programs specifically for women veterans, particularly treatment programs for post-traumatic stress disorder (PTSD) and for women who have experienced military sexual trauma (MST). For each of the factors listed below, we examined available facility- or market-level data to identify facilities of interest:

- total number of unique women veteran patients using the VAMC;
- total number of unique OEF/OIF women veteran patients using the VAMC;
- proportion of unique women veterans using the VAMC who are OEF/OIF veterans;
- proportion of unique OEF/OIF women veterans using the VAMC who were discharged from the National Guard or Reserves;
- within the VA-defined market area for the VAMC, the proportion of women veterans who use VA health care and live in rural or highly rural areas; and
- availability of on-site programs specific to women veterans, such as inpatient or residential treatment programs that offer specialized treatment for women veterans with PTSD or who have experienced MST, including programs that are for women only or have an admission cycle that includes only women; and outpatient treatment teams with a specialized focus on MST.

We selected a judgmental sample of the VAMCs that fell into the top 25 facilities for at least two of these factors. Once we had selected these VAMCs, we also selected at least one community-based outpatient clinic (CBOC) affiliated with each of the VAMCs and one nearby Vet Center, which we also visited during our site visits. In selecting these CBOCs and Vet Centers, we focused on selecting facilities that represented a range of sizes, in terms of the number of women veterans they served.

Tables 5 and 6 provide information on the unique number of women veterans served by each of the VAMCs and CBOCs we selected for site visits.

Table 5: Women Veterans' Health Care Utilization at Selected VA Medical Centers (VAMC)

VAMC, by number	Number of unique women veterans served in fiscal year 2008	Percentage increase between fiscal year 2006 and fiscal year 2008 in the number of women veterans served	Percentage increase between fiscal year 2006 and fiscal year 2008 in the total number of veterans served (both men and women)
VAMC 1	6,464	19.5	8.5
VAMC 2	6,360	22.4	12.8
VAMC 3	4,497	8.2	7.3
VAMC 4	3,588	19.4	10.2
VAMC 5	2,324	11.7	4.8
VAMC 6	1,846	20.2	3.9
VAMC 7	1,841[a]	19.8	5.1[a]
VAMC 8	999	12.5	1.0
VAMC 9	995	22.5	6.9

Source: VA data and GAO analysis.

[a]This VAMC is part of the same health care system as VAMC 1. Some of these veterans may also have received services at VAMC 1.

Table 6: Women Veterans' Health Care Utilization at Selected Community-Based Outpatient Clinics (CBOC)

CBOC, by number	Number of unique women veterans served in fiscal year 2008	Percentage increase between fiscal year 2006 and fiscal year 2008 in the number of unique women veterans served
CBOC 1	2,926	12.5
CBOC 2	1,750	27.0
CBOC 3	599	90.2
CBOC 4	554	51.0
CBOC 5	224	13.1
CBOC 6	115	8.5
CBOC 7	103	21.2
CBOC 8	88	54.4
CBOC 9	48	9.1
CBOC 10[a]	42	not applicable[a]

Source: VA data and GAO analysis.

[a]This facility opened in 2007, so percentage increase since fiscal year 2006 does not apply.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann, Assistant Director; Susannah Bloch; Chad Davenport; Alexis MacDonald; and Carmen Rivera-Lowitt made key contributions to this testimony.

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Chairman AKAKA. Thank you very much, Mr. Williamson.

Dr. Hayes, thank you for your testimony.

VA is poised to make some important changes to how care is delivered to women, but, in fairness, we seem to have a bit of a disconnect between mandates and what is actually happening. I am going to ask you a series of questions about this.

First, VA has mandated that all VA medical centers appoint a full-time Women Veterans Program Manager.

Does every VA medical center have one in place?

Ms. HAYES. VA has reported, as you know, that there are 144 out of the 144 sites that have a full-time Women Veterans Program Manager. I am actively now in the process of verifying that.

What we do know is that my office, over the last 3 months, has held three different trainings. We trained 142 Women Veterans Program Managers over the last 3 months. We think it is very important to train folks—to take these brand-new folks and make sure that they know what they are doing—in terms of this plan to develop health care for women.

Chairman AKAKA. Dr. Hayes, hopefully, you have read the testimony of the second panel.

Jennifer Olds details her battle with PTSD and specifically makes a case for cognitive therapy. Congress passed a law last year requiring that these state-of-the-art therapies be available to all veterans.

I suppose this is something you need to take for the record, but are all veterans with PTSD able to receive this kind of treatment?

Ms. HAYES. You're right, Mr. Chairman, I will have to take that specifically for the record in terms of the issues about access to PTSD treatment. But I think that one of the things that was pointed out in the GAO report about where there is access, it is very important that we first ask veterans what they need, and that is why it is important to hear from veterans about what their struggles are and, I think, to make sure that we are addressing what that veteran needs in terms of her care.

So, for example, there has been a lot of question about residential treatment. I think when we look at women veterans, we have to be aware that, for example, women with children are not necessarily interested in going off, leaving their children, and going to

a residential site. So that every time we look at what we have available, we have to make sure we have available for each veteran what she might need, whether it is intensive outpatient, residential, or telehealth-telemedicine. Some of our veterans have rated that as very highly successful for them to be in that type of treatment.

So, we will take the question for the record in terms of the exact issue of where PTSD treatment is available, but I think that it needs to be a constant issue of asking the veteran what they need, and that particular issue for Ms. Olds, I think, is very important.

Chairman AKAKA. Thank you.

[The response to additional information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP, U.S. DEPARTMENT OF VETERANS AFFAIRS

The Department of Veterans Affairs (VA) is strongly committed to making evidence-based psychotherapies for Post Traumatic Stress Disorder (PTSD) widely available to Veterans. VA is in the process of actively disseminating Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE), two specialized forms of Cognitive-Behavioral Therapy for PTSD. CPT and PE are recommended in the VA/Department of Defense (DOD) Clinical Practice Guidelines for PTSD stating that the intervention is always indicated and acceptable. Moreover, in 2008, the Institute of Medicine conducted a review of the literature of pharmacological and psychological treatments for PTSD and concluded in its report, *Treatment of Post Traumatic Stress Disorder: An Assessment of the Evidence*, that the evidence was greater for these treatments than for all other currently available treatments for PTSD.

To date, 1,908 Veterans Health Administration staff have received training in CPT. The majority of these clinicians were trained as part of the national CPT rollout, with some staff also receiving training through similar, locally arranged training. In addition, 722 DOD clinicians have received CPT training through the national rollout or locally arranged VA training. Seven hundred and twenty-eight VHA providers have received training in PE, with the majority of staff being trained as part of the national PE rollout. One hundred and twenty-nine DOD clinicians have received PE training through the national rollout or other similar VA training. Additionally, VA is planning training in CPT and PE for the remainder of this Fiscal Year and beyond. Currently, 94 percent of VA medical centers provide CPT or PE; remaining sites are implementing plans to provide at least one of these therapies. Moreover, to promote the implementation and ongoing delivery of evidence-based psychotherapies for PTSD and other mental disorders, VA has designated a Local Evidence-Based Psychotherapy Coordinator at each medical center.

Chairman AKAKA. Mr. Williamson, your testimony lays out that none of the facilities reviewed fully implemented VA's policies for women's health care.

Could you determine the reasons behind this noncompliance? Was it funding, lack of training, or anything else?

Mr. WILLIAMSON. Thank you, Mr. Chairman.

It is very difficult sometimes to understand the reason.

The area you referred, for example, in assuring privacy of women veterans, part of it is due to facilities in terms of the layout that currently exists and is trying to convert and modify that. But, also, I think part of it comes down to commitment at the local level.

There is no doubt that the Secretary, Dr. Hayes, and others at the top are very committed to implementing VA policies and improving overall health care for women. Yet, as we visited the facilities, simple things that are easy to do like placing exam tables so the foot is away from the door, putting sanitary products in bathrooms for women—those things are easy—and if they're not being

done, part of that reason may come back to is there a commitment at the local level to make sure these policies are done?

Chairman AKAKA. Several witnesses on the second panel are quite critical of VA care for women. Let us take these one by one.

DAV is most concerned that some service-connected women veterans are without access to VA health care.

Ms. Williams detailed a lack of understanding on the part of VA providers.

Ms. Christopher found that community care is easier to access than VA care.

And Ms. Chase finds that, generally, VA is playing catch-up to meet the needs of women veterans.

Dr. Hayes, what is at the root of all these issues, and how can we rectify them?

Ms. HAYES. I think that what is at the root of these issues really is a system that has not been responsive to the needs of women veterans.

I came a year ago and launched an initiative specifically to make VA more inclusive of women veterans: to establish primary care that meets their needs so they do not have to come for multiple visits; and to make sure that we reach out to those who do not have health care.

One of the things that research has shown us over and over again is that women do not know that they have VA services available. And it is not good enough if we reach them yet we do not have the right care when they get in our front door.

And, so, we have a very intensive effort going on, which started, as you saw last year, but is rolling up August 1 with every facility giving us an implementation plan for: how to fix primary care for women veterans; how to make the facilities respond to the environment of care issues; and to develop services going forward that will meet women veterans' needs. I think that until we do that—until we make sure that it is right—then we should begin to reach out to our women veterans and welcome them back. We will have a specific initiative which we identified the need for service-connected women veterans to get their health care, and that is the first on our list. When we can be assured that there is primary care available for them when they walk in the door.

Chairman AKAKA. Thank you.

Senator Burr, your questions?

Senator BURR. Thank you, Mr. Chairman.

Dr. Hayes, I want to give you an opportunity to clarify something for me from a statement.

In your testimony on page 7, you state, "As of June 2009, each of the VA's 144 health care systems has appointed a full-time Women Veterans Program Manager," but I thought I heard you say in the response to Senator Akaka that you were in the process of confirming if you had 144 Women Veterans Program Managers. Which one is accurate? Do we have them or are you in the process of verifying that we——

Ms. HAYES. I am personally in the process of verifying, and because I want to make sure that I can tell you that is accurate when we say that we have 144 in place.

Senator BURR. How long does that take?

Ms. HAYES. We have a list out now. It is really a question sometimes of are they in place or not. The 144 was——

Senator BURR. But your testimony says, "As of June 2009, each of the VA's 144 health care systems has appointed a full-time Women Veterans Program Manager."

Is that a correct statement or an incorrect statement?

Ms. HAYES. That is a correct statement in terms of a person appointed to be in that job. We want to make sure that person is full-time, they are able to do the job, they have been trained, and they are the person in place to do the work that we need them to do to advance this program.

Senator BURR. But what——

Ms. HAYES. Some of them had just been hired——

Senator BURR. This is under an architecture put out by VA leadership that you are going to have 144 individuals in 144 facilities, and I would take for granted that listed in the dictate is permanent and full-time. It spells out exactly what these program managers are going to do.

Ms. HAYES. That is correct.

Senator BURR. So, I guess what I am having difficulty clarifying is if you say they are "in place," but you have to verify they are in place because you want to make sure that they are full-time folks, et cetera. Does that mean that you have had individual facility managers who have hired somebody different than what the leaderships dictate was?

Ms. HAYES. No, sir. I do not want to indicate that.

For example, we had sites where a Women Veteran Program Manager was half-time, and——

Senator BURR. But is that allowable under——

Ms. HAYES. No, excuse me. I do not mean new, I meant that she was doing it half-time. She was performing duties serving women veterans in a clinic setting, and she has been appointed as a full-time person. We want to make sure that veterans have been transferred appropriately to other people so that her full-time can be devoted to the Women Veteran Program Manager job.

We are still in a transition phase. I'm making sure that we are fulfilling what we said we're fulfilling, which is making sure those folks are available to do this work for us.

Senator BURR. OK. You said on page 9, "The VA plans to have gynecologists available at each of the VA's 144 health care systems by 2012."

Why is it 2012 and not 2009?

Ms. HAYES. Maybe I should explain. We have gynecologists onsite in approximately 70 locations. And, again, I do not have an exact number for the record on that. At the other sites, we have gynecology services available largely by fee-basis.

As we develop and the number of women veterans increases, we anticipate that we will need to bring those services in-house; and we want to move toward that by fiscal year 2012.

Senator BURR. Well, do you agree with the statement that I made that we've actually had a decrease in the number of women seeking gender-specific health care services at the VA from last year to this year?

Ms. HAYES. I do not actually think that we have had a decrease. I think that the way that we were accounting for the numbers for gender-specific health care has changed, and that, in fact, masked some of the gender-specific care. We've changed from having women go just to pap clinics to having women go to comprehensive primary care clinics, and the costs of that were all rolled in together so that we actually, on paper, look like we decreased our gender-specific care, when, in fact, we believe that it has increased.

Senator BURR. What percentage of gender-specific care does the VA purchase in the community? Has it increased or decreased?

Ms. HAYES. I do not know the answer to that.

Senator BURR. OK. In your testimony, you mentioned the disparity in quality between male and female veterans in the VA System. You specifically noted the disparity in prevention measures such as colon cancer screening, depression screening, and the immunizations.

What are you doing to address these issues?

Ms. HAYES. We are quite aware that there have been quality differences for women. The quality for performance measures for women has been significantly lower than that for men, and we have data now consistently showing that trend from 2006 forward.

We have launched, with the Office of Quality and Performance, efforts which are identifying the quality measures at each site. That data was not available to facility directors until very recently, so, we knew there was a national problem, but we did not know exactly how people were doing. So, we have asked the facilities now—as we rolled out this data just this last week—to address specific areas at their facility where the gender performance scores are lower for women than men; and we are helping them as we develop mechanisms to look at patient factors, provider factors, and system factors.

And, again, it goes back to the issues about are we providing care that women can access in a way that once we say, for example, come back for your fasting lipid test, that that is even possible for a woman to conveniently do. So, we need to look at all of it. We need to look at it from a facility-specific level, and we need to address these gender disparities very actively, and we are doing that.

Senator BURR. You noted the recently-released report "Provisions of Primary Care to Women Veterans," and you point to it as a roadmap for improving service to women veterans. The report's recommendations, I think, have been well-received throughout the veterans' community.

Let me ask you, does the VA have a timetable for implementing the report's recommendations?

Ms. HAYES. We have a timetable for implementing comprehensive primary care to women veterans. The first part—the comprehensive plans—are due by the facilities in August, and that is a 5-year plan. Not to say they have 5 years to get it done, but they must take immediate actions, interim actions, and mid-term actions.

Senator BURR. Does that plan encompass all of the recommendations in that report?

Ms. HAYES. That plan does not encompass all the recommendations in the report. There are many recommendations that are still being developed in terms of a timeline.

Senator BURR. Whose responsibility will it be for implementing the recommendations in the report?

Ms. HAYES. It is ultimately the responsibility of the Under Secretary for Health. The workgroup was set up by the Under Secretary for Health, but I consider the responsibility largely on my shoulders and my office.

Senator BURR. Great. I thank you and thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Burr.

Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman.

Let me follow-up on Senator Burr's question on the report called "Provision of Primary Care for Women Veterans."

I thought it was a good report, and it did a good job of detailing some of the most pressing challenges, but it was sent out as not mandatory. It was just sent out to the VA facilities.

If it did not include any mandatory requirements or any accountability, how do we expect it to be implemented?

Ms. HAYES. There are two factors that actually help us move forward immediately with the recommendations of the report. As I mentioned, there were these mandatory implementation plans which started in January; and there was a gap analysis that was mandatory and required in March; and a resource request that was submitted in May, which was also required.

The other part of the policy, though, is that we have the policy for Women Veterans Program Health Services Handbook, formally known as handbook 1330.01, which has been revised and is now in the concurrence process. It details mandated policy changes, including the one-stop type model for Provision of Women's Health Care and Primary Care. It also continues to mandate the privacy standards and the other environment issues that are required.

Senator MURRAY. OK. Well, sometimes when things are sent out, it is informational; they're not implemented. So, I am concerned that there is not any mandatory requirements, but we will continue to follow that.

Dr. Hayes, as you know, the military currently bars women from serving in combat. We all know, however, in today's wars that there is no frontline on the battlefield. We know that women are serving right alongside their male colleagues and they are engaging in combat with the enemy. Unfortunately, the new reality of this modern warfare is not well understood here at home, including by some in the VA. This knowledge gap obviously impacts the ability of women veterans to receive health care and disability benefits from the VA.

What are you doing, Dr. Hayes, to ensure that all VA staff—both in the VHA and in the VBA—are aware that women are serving in combat and that they are getting the health care and benefits that they have earned?

Ms. HAYES. We have initiated a number of efforts. In addition to training providers—we know that it is not enough just to train the providers in terms of women's health—we need to train all of the staff. We have a staff module—a sensitivity module, which is under

development—in order to get across and make sure that everyone who comes into contact with women veterans appreciates the extensiveness of her service and some of the complex issues that she may face.

As you know and are well aware that many of our women veterans have the effects of combat and are serving—there is not, I do not think, anyone who is serving today who is not under significant stress.

Senator MURRAY. Right. But we have people who say well, you were not in combat. You are a woman.

Ms. HAYES. I am distressed that those reports have come forward, and we are educating our mental health people and our other staff about the significance of women's service.

Senator MURRAY. Are you working with the Defense Department to make sure that the experience of women veterans is properly documented in their DD–214s?

Ms. HAYES. Dr. Trowell-Harris?

Ms. TROWELL-HARRIS. I serve as an ex-officio on the Defense Advisory Committee on Women in the Services, and the director for that committee also is an ex-officio on the VA Advisory Committee on Women Veterans.

This issue does come up frequently, and we are attempting to educate everybody within DOD and VA; and currently we are exploring an option of working with DOD and VA through the White House Project called the Interagency Council on Women and Girls. But, in this case, we are looking at women veterans and servicemembers.

We are interested in an outreach communications model for exploring that and which could help educate because the education is not just to women veterans, the women servicemembers——

Senator MURRAY. But you are talking about outreach in general. I am talking about the problem which women are finding on their DD–214s. It's not that nobody wrote "combat" because nobody wanted to say they are in combat, but they come home and then they cannot get service.

And Mr. Chairman and Members of the Committee should know that we do have the Defense Bill on the floor right now. I am going to be offering an amendment to make sure that the Defense Department properly notes the combat experience on the DD–214s so that when women come home, they are not fighting somebody when saying "but I was in combat." And they reply, "Well, you can't be."

Ms. TROWELL-HARRIS. Right.

Senator MURRAY. So, I hope that I get the support of this Committee to do that.

Ms. TROWELL-HARRIS. And that issue was raised in a roundtable we had recently, which we were told during that session that the military documents the location and they do not use the word of combat. So, we did take that back to the DACOWITS Committee, and they had somebody who is going to be looking at that.

But this is probably an area where you all could really help us with that, because the documentation needs to be there. That would make it really easy for VA to deal with those particular cases.

Senator MURRAY. OK. Well, I plan on offering that. I will have more on the second round, but, for this round, I hear so often from women veterans that you can provide all the service you want, but I have got to take care of my kids. There is no childcare available.

Are we looking at the issue of making sure women have childcare so that is not the obstacle to them getting the treatment they need?

Ms. HAYES. As you mentioned, we are very much aware that women and men with children and grandparents with children need childcare in order to access VA services. The Secretary has us actively examining the issues, and we also are looking at the opinion of General Counsel.

We may need Congress's support on this in terms of authority to provide childcare, but we are actively exploring it with the task force. We do have some pilots——

Senator MURRAY. You need authority from Congress to be able to provide childcare? Did I hear——

Ms. HAYES. General Counsel may advise us. We will have to get back with you for the record because there is concern about the authority to provide childcare by VA.

Senator MURRAY. Well, do you expect to have that soon?

Ms. HAYES. Yes. Yes, ma'am, we do.

[The response to additional information requested during the hearing follows:]

RESPONSE TO QUESTION ARISING DURING THE HEARING BY HON. PATTY MURRAY TO PATRICIA M. HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP, U.S. DEPARTMENT OF VETERANS AFFAIRS

Department of Veterans Affairs

Memorandum

Date: September 10, 2009 **VAOPGCADV 7-2009**

From: General Counsel (023)

Subj: Response to Request for Legal Opinion on Authority to Provide Child-Care for VHA Patients; EDMS 436483/ GCL 29031

To: Chief Public Health and Environmental Hazards Officer (13)

QUESTION PRESENTED:

What are the legal barriers that prevent VA from providing child-care for VHA patients when the patients have appointments at a VHA facility?

HELD:

VA is not authorized to operate child-care facilities for VHA patients.

DISCUSSION:

1. Congress created the Veterans Health Administration ("VHA") and described the scope of VHA's authority in 38 U.S.C. § 7301, which states that the "primary function of [VHA] is to provide a complete medical and hospital service for the medical care and treatment of veterans, as provided in this title and in regulations prescribed by the Secretary pursuant to this title."

2. Because VA is an administrative agency, it is "a creature of statute, having only those powers expressly granted to it by Congress or included by necessary implication from the Congressional grant." *Soriano v. U.S.*, 494 F.2d 681, 683 (9th Cir. 1974). The U.S. Supreme Court referred to the limit of agency authority in a more absolute manner, stating that "an agency literally has no power to act . . . unless and until Congress confers power upon it." *Louisiana Public Service Comm'n v. F.C.C.*, 476 U.S. 355, 374 (1986). The Federal Circuit has noted that agencies must "refrain from the temptation to stretch their jurisdiction to decide questions of competing public priorities whose resolution properly lies with Congress." *Killip v. Office of Personnel Mgmt.*, 991 F.2d 1564, 1570 (Fed. Cir. 1993) (citing *Office of Consumers' Counsel v. Fed. Energy Regulatory Comm'n*, 655 F.2d 1132, 1152 (D.C. Cir. 1980)). Accordingly, VA may provide child-care services in VHA facilities only if Congress expressly granted that authority to VA or if child-care is "included by necessary implication" in the authority granted VA.

2.

Chief Public Health and Environmental Hazards Officer (13)

3. No statute expressly authorizes VHA—or VA in general—to provide child-care for VHA patients who are being treated at VHA facilities, so Congress has not expressly granted VA the authority to provide child-care to patients. Moreover, Congress has authorized VA to operate child-care centers for the benefit of VA employees and other Federal government employees. 38 U.S.C. § 7809. Congress has also granted authority to the Department of Defense (DoD) to provide child-care to service members and their families. 10 U.S.C. §§ 1791-1800 (granting to DoD the authority to operate "military child development centers and programs"). Additionally, section 630 of Pub. L. No. 107-67 authorizes Federal agencies, in accordance with OPM regulations, to use appropriated funds to improve the affordability of child-care for lower income employees. *See* 5 C.F.R. § 792.200-231. The absence of similar statutory authority to provide child-care for children of Veteran patients stands in stark contrast, underscoring that it has been withheld.

4. Nor can we conclude that Congress has implicitly granted that authority. Congress has authorized VA to provide medical services and hospital care to eligible Veterans. An implicit grant of the authority to provide child-care would exist if these terms could reasonably be read to include the provision of child-care. "Medical services," which is defined in 38 U.S.C. § 1701(6), includes, *inter alia*, examination, treatment, rehabilitative services, and other services such as surgical, dental, optometric, and preventive health services. "Hospital care" is defined, in general, as "medical services rendered in the course of the hospitalization of any veteran." *Id.* § 1701(5). We note that the definition of "medical services" also includes "such other supplies or services as the Secretary determines to be reasonable and necessary." *Id.* § 1701(6)(F)(iii). However, all of the "medical services" listed in section 1701(6)(F) are directly related to the medical care of the Veteran (e.g., provision of wheelchairs, artificial limbs, and clothing made to accommodate prostheses). Thus, it would be unreasonable to conclude that child-care may constitute a "service" that the Secretary could make available.[1]

5. We also note that generally to the extent services or benefits provided as part of VA hospital care or medical services do not involve direct medical care of the patient, they are expressly authorized by statute. This is especially true for services or benefits that are provided for those other than the patient, even if the patient indirectly benefits. For example, Congress authorized VA to provide

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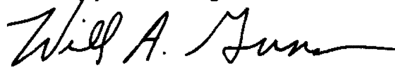
[1] As a matter of statutory interpretation, where general words follow specific words, "the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words." 2A Norman J. Singer, Statutes and Statutory Construction § 47.17 (West 2000). In this case, the general word is "services" and the specific words that precede "services" are words such as "wheelchairs," "artificial limbs," and "special clothing." 38 U.S.C. § 1701(6)(F). Accordingly, the word "services" is "construed to embrace only objects similar" to "wheelchairs," "artificial limbs," and "special clothing"—objects that, contrary to child-care, are clearly related to a Veteran's medical care.

3.

Chief Public Health and Environmental Hazards Officer (13)

temporary lodging to certain Veterans who travel a "significant distance" for medical care and to family members who accompany Veterans. 38 U.S.C. § 1708. Congress also authorized VA to provide counseling services for family members of Veterans receiving treatment. *Id.* § 1782. Child-care is similar to these VA benefits because, while child-care would help facilitate the provision of medical care, it does not constitute either "medical services" or "hospital care." Accordingly, VA could provide child-care to patients—in the same way that VA provides lodging and counseling to Veterans and family members—only if Congress were to grant VA the authority to do so.

6. As a Federal agency, VA possesses "only those powers granted to it by Congress or included by necessary implication from the Congressional grant." *Soriano*, 494 F.2d at 683. Federal law cannot reasonably be read to provide VA the authority—either explicitly or implicitly—to provide child-care for patients. Accordingly, VA could provide child-care to VHA patients only through a grant of authority from Congress.



Will A. Gunn

Senator MURRAY. OK.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you, Senator Murray.

Senator Begich?

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you, Mr. Chairman. Thank you very much for your testimony.

I apologize I was not here when you gave your verbal testimony, but I have a few questions. I do want to follow-up on several of the questions by the Chairman and the Ranking Member in regards to the Women Veterans Program Managers.

I have a friend in Alaska, Joelle Hall, who's a female veteran with two kids and a husband in the Guard. She has given me kind of a shopping list the minute I told her that you all were coming in front of me. She quickly gave me a list of questions to ask and this is one of them.

I know there is a lot of discussion of what the 144 is or is not, and I am going to ask you this question, then ask for a timeline.

Can you provide the list of the positions that will be occupied and by whome full-time, part-time, and when they will actually be working full-time?

Ms. HAYES. We can provide that for the record.

Senator BEGICH. And your timetable to do that?

Ms. HAYES. We can provide that very soon for the record.

[The response to additional information requested during the hearing follows:]

Status of Filling Full-Time Women Veteran Program Manager Positions, 10-6-09

VISN	Facility	Start Date
1	Togus	8/20/96
1	White River Junction	1/13/09
1	Providence	2/2/09
1	Northampton	5/4/09
1	Bedford	5/10/09
1	Boston	7/16/09
1	Connecticut HCS	7/17/09
1	Manchester	7/19/09
2	Bath VAMC	10/1/07
2	WNY (Buffalo/Batavia)	12/7/08
2	Syracuse VA	1/4/09
2	Albany VAMC	1/5/09
2	Canandaigua VA	2/2/09
3	NY Harbor (Brooklyn)	10/1/93
3	Northport	3/1/98
3	Hudson Valley	5/8/09
3	Bronx	8/6/09
3	New Jersey	12/9/07
3	NY Harbor (Manhattan)	12/7/08
4	Butler VAMC	6/30/08
4	Lebanon VAMC	7/15/08
4	VA Healthcare VISN 4	10/13/08
4	Erie VAMC	10/14/08
4	Philadelphia VAMC	4/1/09
4	Altoona VAMC	11/15/08
4	Clarksburg VAMC	12/1/08
4	Pittsburgh VAMC	12/1/08
4	Coatesville VAMC	2/22/09
4	Wilkes-Barre VAMC	3/2/09
4	Wilmington VAMC	5/1/09
5	Washington DCVAMC	9/30/03
5	Maryland VAHCS	9/1/08
5	Martinsburg VAMC	3/2/09
6	Asheville	3/28/99
6	Salisbury	9/30/05
6	Hampton	10/3/08
6	Richmond	12/7/08
6	Beckley	1/18/09
6	Durham	5/11/09
6	Fayetteville, NC	5/11/09
6	Salem	12/7/08
7	Central Alabama HCS	11/26/06
7	Charleston	7/20/08
7	Birmingham	12/9/08
7	Columbia	12/21/08

VISN	Facility	Start Date
7	Augusta	4/12/09
7	Dublin	5/24/09
7	Atlanta	7/20/09
7	Tuscaloosa	Acting in place - currently recruiting
8	Bay Pines	3/6/05
8	Caribbean	10/1/06
8	North Florida/South Georgia	11/1/06
8	Tampa	11/1/08
8	VISN 8 WVPM	11/1/08
8	Orlando	2/1/09
8	West Palm Beach	7/8/09
8	Miami	8/1/2008
9	Tennessee Valley (Nashville)	Acting in place - currently recruiting
9	Tennessee Valley (Murfreesboro)	Acting in place - currently recruiting
9	Louisville	12/10/06
9	Huntington	9/2/08
9	Lexington	2/17/09
9	Memphis VAMC	7/19/09
9	Mountain Home	Acting in place - currently recruiting
10	Dayton	11/9/08
10	Columbus	12/1/08
10	Cincinnati	2/1/09
10	Cleveland	7/17/09
10	Chillicothe	4/31/08
11	Detroit VAMC	5/28/94
11	VA Ann Arbor HCS	10/22/08
11	Indianapolis VAMC	12/7/08
11	Saginaw VAMC	1/26/09
11	VA Northern Indiana HCS	2/1/09
11	VA Illiana HCS	2/2/09
11	Battle Creek VAMC	12/7/08
12	Milwaukee	3/30/08
12	Madison	11/23/08
12	North Chicago	11/23/08
12	Hines	12/1/08
12	Tomah	12/15/08
12	Iron Mountain	1/18/09
12	Jesse Brown	8/2/09
15	Wichita	8/18/08
15	Eastern Kansas HCS	11/23/08
15	Marion	3/29/09
15	St. Louis	3/29/09
15	Kansas City	4/2/09

VISN	Facility	Start Date
15	Columbia, MO	5/24/09
15	Poplar Bluff	6/7/09
16	Alexandria, LA VAMC	6/26/05
16	Biloxi, MS VAMC	1/1/08
16	Muskogee, OK VAMC	11/23/08
16	Shreveport, LA VAMC	12/1/08
16	New Orleans, LA VAMC	3/23/09
16	Jackson, MS VAMC	6/30/09
16	Fayetteville, AR VAMC	7/1/09
16	Houston, TX VAMC	7/9/09
16	Oklahoma City, OK VAMC	Acting in place - currently recruiting
16	Little Rock, AR VAMC	9/21/09
17	Central Texas HCS	4/4/04
17	North Texas HCS	12/15/08
17	South Texas HCS	6/21/09
18	West Texas HCS	1/1/00
18	Phoenix HCS	4/1/06
18	Northern Arizona HCS	1/4/09
18	Southern Arizona HCS	1/4/09
18	VISN 18	1/4/09
18	Amarillo HCS	2/1/09
18	El Paso HCS	2/1/09
18	New Mexico HCS	5/1/09
19	VA Eastern Colorado HCS	3/30/08
19	VA Salt Lake City HCS	12/15/08
19	Sheridan VAMC	2/17/09
19	Grand Junction VAMC	3/1/09
19	Cheyenne VAMC	5/12/09
19	VA Montana HCS	9/14/08
20	VA Puget Sound HCS	10/1/03
20	Portand VAMC	7/1/08
20	Walla Walla VAMC	8/31/08
20	VA Roseburg HCS	11/23/08
20	Spokane VAMC	12/21/08
20	VA Alaska HCS	7/19/09
20	Boise VAMC	7/19/09
20	Southern Oregon Rehabilitation Center and Clinics	Acting in place - currently recruiting
21	VA Northern California HCS	10/1/06
21	VA Pacific Islands HCS	12/15/08
21	San Francisco VSMC	3/2/09
21	VA Central California HCS	3/29/09
21	VA Palo Alto HCS	Acting in place - currently recruiting
21	VA Sierra Nevada HCS	8/3/09
22	Long Beach	10/1/08

VISN	Facility	Start Date
22	Las Vegas	12/1/08
22	Loma Linda	12/1/08
22	San Diego	12/1/08
22	Greater Los Angeles	12/1/08
23	VISN 23 POC/Minneapolis VAMC	1/1/00
23	Fargo VAMC	6/1/06
23	Sioux Falls VAMC	3/15/09
23	Iowa City VAMC	10/15/07
23	St. Cloud VAMC	10/28/07
23	VA Black Hills HCS	10/12/08
23	VA Central Iowa HCS	12/7/08
23	Nebraska Western Iowa HCS	2/1/09

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Senator BEGICH. OK, I think that will specifically answer the questions that we are all asking around this topic and, in that process, make sure that we know where they are going to be assigned, which would help us understand the 144, and what they mean, and what they are going to be doing.

Also, in regards to the Women Veterans Program Manager, is there discussion of expanding this requirement to the CBOCs?

Ms. HAYES. We currently require that there be a liaison named at each CBOC—a VA employee who is the liaison to the Women Veterans Program Manager. We are not requiring that at the CBOCs. They are facilities that we are looking at, particularly at the very large CBOCs, as to whether that would be an appropriate placement. But, no, we do not have a requirement for that at the CBOCs.

Senator BEGICH. Let me ask you personally. Do you think that is something that we should strive to do? I mean, it is easy to have a task force and a group, but what do you think? You are running the program.

Ms. HAYES. I think that if the person is full-time at the facility and they are doing their job to involve everyone in taking care of women veterans, then we do not necessarily need one at a CBOC. I think the person has the ability to go out to that CBOC, to make sure what is going there, and to provide active coordination through other means—telephone and other means—with that site.

So, I think if we make it so they are able to do their job, then the CBOCs do not necessarily have to have one onsite.

Senator BEGICH. OK. Let me ask, and I do not know who would answer this—Dr. Hayes or Dr. Harris. In regards to the design of the facilities, we know—based on some of the other facilities—the design is not there really to take into account women veterans.

What is the process now to expand the facilities for that purpose? And then I have a couple of additional questions.

Ms. HAYES. In part of the implementation plan, which, as I said, could expand as far as 5 years, we have asked facilities to name where they need space, where they need construction monies to be

able to fix the situation in terms of women veterans. And, so, they are able to submit those longer-term requests right now.

Also, my office is working with the Office of Construction and Design so that new construction appropriately has designs for women veterans' exam rooms, appropriately has requirements for bathrooms, et cetera, in the new design process.

Senator BEGICH. In the Office of Construction Design, other than your office, do they actually have clients that sit down with them on a regular basis reviewing the designs? Do people actually use the facilities?

Ms. HAYES. I do not know. We would have to get back with you on that.

[The response to additional information requested during the hearing follows:]

WOMEN VETERANS FACILITY DESIGN GUIDANCE

VA's Office of Construction & Facilities Management's (CFM) guiding principles for the development of design and construction standards for state-of-the-art 21st century VA facilities include a variety of approaches to ensure they address the needs of Veterans, their families, and VA health care providers in the most efficient and cost-effective manner.

- Advocating evidence-based design, with involvement and awareness of latest issues in healing environment forums including Planetree, Greenhouse, AIA Academy of Architecture for Health, American Society of Healthcare Engineers, Center for Health Environments Research, and others. Example: VAMC Martinsburg '07 Patient Single Rooms Mock-up Study with results published in Health Environments Research and Design (HERD) Journal, a leading peer reviewed evidence-based design publication.
- Basing Space Planning Criteria and Design Guide programs on applicable evidence-based design research, active participation of VA healthcare providers, administrators, and staff. Surveying best-practice in private sector and other agencies, with Veterans' input. All CFM efforts are focused on providing Veteran- and family-centric healing environments supporting world class health care. Design Guides depict functional relationships and design considerations in addition to space planning criteria for heath care functions. They include comprehensive information including an overview of design principles and concepts, narrative text descriptions, and guide plates for reference.
- Extensively involving state-of-the-art experienced national health care consultants together with field input in regular VA Design and Construction Standards upgrades. CFM also follows the principles in 2010 Guidelines for the Design and Construction of Healthcare Facilities used by HHS, most state and local Authorities Having Jurisdiction, and the Joint Commission for Accreditation of Health Care Facilities as codes, regulations, or guidelines for design and inspection. This process provides the experience of a wide range of technical consultants and users.
- Coordinating with over 70 VA advisory groups who collaborate in the development and updating of VA Design Guides, Space Planning Criteria, and Construction Standards and Specifications for life-cycle operations. Examples: VA Community Living Centers; VA Mental Health Facilities; Polytrauma Rehabilitation Centers; etc.

Many of the Veteran- and family-centric environments included in our updated criteria reflect women's needs; these include the privacy afforded by single bedrooms with bathrooms in hospitals and VA's patient-centered design for Community Living Centers, replacing older design concepts of traditional nursing home care facilities, again with single bedrooms with bathrooms, organized in small community family-like living units.

The Space Planning Criteria and Design Guides, completed in the recent past, have addressed numerous specific changes reflecting women's issues. These include Design Guides for Ambulatory Care, Outpatient Clinic, and Leased-Based Clinic Design Guide, MRI, Radiology, Nuclear Medicine, Radiation Therapy, etc. Changes include increased importance of Mammography spaces, adjustment of workload criteria to ensure the appropriate generation of women's health spaces, larger more private dressing rooms areas, women's specialty exam/procedure rooms larger than standard spaces, more bathrooms in targeted treatment and diagnostic areas, sepa-

rate male and female bathrooms in small pubic areas and waiting rooms where one unisex bathroom would technically suffice. On going recent efforts include:

- February 5, 2010 finalization of interim space criteria for Women's clinic, working with CFM staff and the Chief, Consultant Women's Health Office. This interim space criteria will be utilized either as part of a larger ambulatory care clinic or a stand alone women's clinic.
- Chief, Consultant Women's Health Office and members of her staff have been regular members of advisory committee reviewing CFM Standard updates.
- 00CFM has been meeting regularly with Women's Health Office since early 2009 to review standards and discuss comments
- Ongoing updates of Mental Health Design Guide, Community Living Center Design Guide, Inpatient Units—Medical, Surgical Patient Care Units Design Guide, and Procedure Suites Design Guides will include updated criteria specifically addressing women's issues, related to waiting rooms, privacy, check in areas, bathroom facilities etc. These will be completed later this year.
- Current IDQA/E task order is complete and soon to be contracted for the updating or development of 6 priority Design Guides, one of which is the Women's Clinic Design Guide which will include the interim space criteria for women's clinic noted above and additional guidance, to be completed later this year.

Project Examples:

- VAMC Las Vegas New Hospital—Under Construction:

  Women's Ambulatory Care Clinic located at the 3rd floor level of the tower. The clinic area is 5600 sq. ft. and includes 9 exams rooms, 2 procedure rooms, a reception/waiting area, a nurse station, utility rooms (clean and soiled), patient toilet, staff lounge, staff toilet and offices.
- VAMC Walla Walla OPC:

  Women's Exam Rooms and physician offices grouped in a "mini" pod type arrangement (800 sq. ft.) along a dedicated clinic corridor affording privacy, two dedicated exam rooms with dedicated women's toilet provided between the exam rooms, private dressing cubicle within the room and exam table out of the line-of-sight from the door, and separate family waiting and toilet rooms room to accommodate women and families.

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Senator BEGICH. I would suggest, as a former mayor who dealt with many designs of buildings, that the users need to be part of the equation. If they are not involved, they should be, to be very frank with you, because—no offense to your office and anyone else—but I know construction people; I used to be in the business. They build to facilitate, they work off of budget, and then they are done. I highly recommend that you establish your work with the Office of Construction including an advisory of actual clients who utilize those facilities currently or have utilized their facilities to give advice on how those should be constructed.

Some of the issues that you brought up, Mr. Williamson, are small, yet they are significant. And design is part of it because I can tell you if you do not design the bathroom the right size, those extra items that you want in there are not going to fit. Just if you would take that under at least some advisement, I would appreciate that.

Mr. WILLIAMSON. If I may add also——

Senator BEGICH. Sure.

Mr. WILLIAMSON. We have heard the same thing in terms of needing to have good communication between Dr. Hayes' office and others with the construction people because, again, we are dealing with a cultural change here. And it is really important that the design people and the people who do specifications have incorporated the needs of women veterans in terms of the facilities.

Senator BEGICH. Well, thank you very much for echoing that. Again, if you could report back to the Committee what your plans are. I cannot stress enough, I have seen projects turn from good projects to excellent projects because of the client involvement. It does not matter if it is health care facilities or anything, but, in this case, health care.

I will just end on this one question.

To follow-up on Senator Murray's comments in regards to how women veterans understand what care is available, you had mentioned there were veterans that are not necessarily aware of the benefits.

How big would you say that universe is if you could measure it in volume of people? Is it a few thousand? Is it tens of thousands?

Ms. HAYES. I think it might be on the level of about 1 million women veterans.

Senator BEGICH. One million women.

Ms. HAYES. We have an active plan now to utilize the VA call centers to reach out to women veterans and advise women veterans about the benefits and the access. Again, that is going to be phased in. We will start with the service-connected women veterans, but we want to make sure that that does not start until at least this fall because we want to make sure the clinics are available.

Senator BEGICH. OK.

Ms. HAYES. And we have been told that there may be in the neighborhood of 1.5 million women veterans altogether, including those who use us.

There are about 450,000 enrolled women veterans right now. So, there are about 1 million women veterans who have not enrolled in VA. To the extent that they do not know about us, we can only hope that we can reach out and tell them.

Senator BEGICH. And where do you think they get health care coverage now?

Ms. HAYES. We don't know that.

Senator BEGICH. Or do they?

Ms. HAYES. We do have a study underway by Dr. Donna Washington, and the results of that study will be available approximately September. She has done research on this for us—a stratified random sample of women—women who use VA, women who do not use VA who are veterans, and those who use this and don't come back. That study is going to help us understand how women veterans who do not use VA access health care.

Senator BEGICH. Great. If you could share that with us, that would be great.

[Note: This study was not completed in the anticipated timeframe and the target for completion and release is spring of 2010.]

Senator BEGICH. Mr. Chairman, I apologize for going over, and thank you very much.

Chairman AKAKA. Thank you very much, Senator Begich.

I have one remaining question for you, Dr. Hayes.

As part of my oversight responsibility, I learned that some veterans at the Austin, Texas, clinic were inappropriately being charged for services related to military sexual trauma. As you well know, such care is provided at no charge. It is quite difficult for women to seek such care to begin with, let alone to be presented

with a bill for it. One woman told me she found this emotionally draining and an insult to all women who served.

Is it your belief that this situation at Austin is an isolated incident or are veterans nationwide being charged for care for military sexual trauma?

Ms. HAYES. I can only let you know that personally having been in the field for 25 years, I was actually involved in the initial attempts to roll out the eligibility for military sexual trauma for free counseling. It should not be "free;" it is without-charge counseling for veterans who have undergone such trauma. So, it is personally distressing when I see all these years later that there are veterans who have, I think, inadvertently been charged, but, nevertheless, been charged for their counseling services.

After the incident in Austin, a mental health group that oversees the Military Sexual Trauma Program not only educated the persons there at Austin regarding eligibility, but have done a nationwide search and should have a report very soon about any other cases that were uncovered. But we believe it is an isolated type of occurrence.

They made an effort to retrain the eligibility clerks through some online information that has gone out, and they will have a report as to whether they discovered any other sites where veterans were being charged for these services.

Chairman AKAKA. Thank you very much.

Let me call on Senator Murray for any second round questions.

Senator MURRAY. Thank you, Senator Akaka. I just have two additional questions.

One is about homeless female veterans. The number of women veterans who are ending up homeless has nearly doubled over the last decade. One out of every 10 homeless veterans under the age of 45 is now a woman. Many of these homeless female veterans have kids.

According to Pete Dougherty, who is the Director of VA's Homeless Veteran Programs, he said, "While the overall numbers of homeless vets have been going down, the number of women veterans who are homeless is going up."

I have introduced legislation to expand and improve the services and care for homeless female veterans and their children through the VA Grant and Per Diem Program in the Labor Department's Homeless Veteran's Reintegration Program.

Dr. Hayes, tell me what else you think we should be doing currently; and are you aware of this challenge that we have?

Ms. HAYES. Yes, I am very aware of the challenge. And I think it is in part an unfortunate side effect of what is going on in terms of the number of new women veterans, but it is a particular challenge in a system that we have not done what I think we need to do with screening for the things that underlie the problems of homelessness.

I think—again, women veterans are largely invisible, so we need to do more to screen for risks of homelessness in our primary care setting. We need to do a better job of screening women for substance use, asking women about whether they have enough to get by, and having earlier interventions to avoid the final decline into homelessness.

So, that is what I think we need to do in our system; and, again, when we organize the primary care better to comprehensively serve women and not just say, well, we will take care of your pap smear and we will take care of your mammogram, but to say instead, we will take care of you as a whole person. Part of our goal is to make sure that we have adequate mental health and social work in our primary care setting for women.

I applaud and thank you for your efforts to put more into the Grant and Per Diem Program. As you know, there have been barriers because of the issues of children, and women with children have been the most difficult group to place—whether they are veterans or non-veterans—and, so, I certainly applaud that effort because that is clearly what we need in expanding the services that are available to women.

And I think it is another area where we have to continue to provide education to our homeless outreach workers and our homeless placement folks in areas where we may underserve the women homeless so that they clearly ask a homeless person whether they are a veteran and ask a homeless women whether she is a veteran to make sure she gets in the VA services.

Senator MURRAY. Which goes to my last question. When a man tells you they are a veteran, folks immediately say yes. Women do not perceive themselves to be veterans. The general public does not perceive women to be veterans, even if the woman says she served in the military.

How are we going to overcome that sentiment and make the VA and the general public really respect the service of women and for women to perceive themselves as veterans? I mean, may we should not call them "veterans." I do not know. It is just a real problem.

Have you thought about that? Do you have any advice for us? What can we do to change that?

Ms. HAYES. I may turn to Dr. Trowell-Harris. A major effort of her office is to tackle this problem.

I, myself, believe that the kind of effort that you are putting in to raise the awareness goes very far in helping to identify that women proudly served, and women have always served as volunteers. I think we have to continue to get that message out in the media, in the Internet, any way that we can, and turn to our partners who are here—the veterans who are here—to help us with that message.

But Dr. Trowell-Harris' office is dedicated also to this outreach effort.

Ms. TROWELL-HARRIS. We participate in all of the major women's policy groups, the Veteran Service Organizations Convention, minority groups, roundtable groups, hearings, and we work with DOD. So, we try to get the education out there. But my opinion is it is a matter of changing the culture, getting everybody to understand that women are veterans.

So, you may recall that, years ago, the census used to ask women are you a veteran? They would say, "no." But the census question changed to ask, "Have they ever served in the Armed Forces?" Then women would say, "yes."

But, still, the education is needed for everybody, as Dr. Hayes, said: the media, the women veterans, VA staff, and Congressional

members. It takes all of us. And, again, this is one way that you can help us.

We are doing extensive outreach with the State Departments of Veterans Affairs. Each State Department of Veterans Affairs has a designated female assigned to work with women veterans, and we do have conferences and send them tons of educational material. Again, we work with various committees, such as the Homeless Committee, the Minorities Affairs Committee, and the Research Committee.

I have a report which some of you have seen. I had 20 recommendations for women veterans, and, as part of that, the program managers who were part of that committee got Dr. Hayes' office raised on the VA organizational chart, which was one of the recommendations, and that has been done.

So, all of these things we are trying to do to improve outreach. We are also working with the Honorable Tammy Duckworth, who was just employed with VA. She heads a major outreach effort, so we are meeting with her staff, looking at some creative ways of getting the message out—not just to the women veterans, but to everybody.

Senator MURRAY. I appreciate that. I think we really have to focus on that as communities, as the media, as everybody so that we, as a country, recognize that women who serve in the military are veterans, deserve the benefits that they have earned, and the respect of this country.

Ms. TROWELL-HARRIS. Thank you.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Begich?

Senator BEGICH. Mr. Chairman, if I can just ask a couple more quick questions. I know I went over time last time.

Can you give me a sense of—making people aware as women who are getting into the military—what kind of relationship does the VA have with the DOD in ensuring that knowledge of what is available specifically for women is available once they become a veteran?

Who could answer that? Just what kind of relationship is there?

Ms. TROWELL-HARRIS. Our Secretary works with the Secretary of Defense, and, also, there is a designated person at DOD that works on benefit issues and also on health care issues. And I did mention before about being on the DACOWITS Committee.

We do have some printed material that we use at all major conventions and forums for women veterans. We have open forums. Women do site visits to the field with our Advisory Committee. So, we're trying multiple ways of getting the word out.

We have numerous media interviews, also; and we really appreciate those because they help us get the word out to the veterans nationally.

Senator BEGICH. And recruitment centers? Is there information available at the recruitment centers?

Ms. TROWELL-HARRIS. You mean military?

Senator BEGICH. Yes.

Ms. TROWELL-HARRIS. I am not sure about that. We can get back to you on that.

Senator BEGICH. I mean, the recruitment centers are the first opportunity to educate on what the benefits are on the back-end. So, if you could let me know how the recruitment centers are operating and people are doing the recruitment, what is there also? Is there any special effort, especially for women on what is available and what could be available to them?

So, whichever of you could answer that, that would be great.

Ms. TROWELL-HARRIS. Sure, we will get back to you on that.

Senator BEGICH. And please, whoever would be the right person to answer this, please do so.

From a funding level, is there enough resources for what you need in some of the leasing of the space that is occurring as well as future construction, and what will be necessary to expand these facilities to meet the women veterans' needs? And, if not, is that part of the 5-year plan, and tell me how that all works.

Ms. HAYES. We have been working very closely with the Office of Budget and with the Secretary's office to help define the resource needs for this infusion of infrastructure, and we understand that with the support of the Secretary, VA will have the resources needed to enhance the care to women veterans.

Senator BEGICH. That is good. Very good.

At what point will you have kind of the strategic plan of expansion of facilities that this Committee could at least see? In other words, a plan that would kind of say, here is our game plan for the next five or so years and here are the highest priorities based on demand, based on facility structure, and so forth.

Ms. HAYES. OK, that will not be my office specifically, although, the plans are coming back through the VISN level office and the Offices of Construction, but we can get back to you regarding the Secretary's response on how the Secretary's office would see these priorities.

[The response to additional information requested during the hearing follows:]

RESPONSES TO QUESTIONS ARISING DURING THE HEARING BY HON. MARK BEGICH TO THE DEPARTMENT OF VETERANS AFFAIRS

Question. Please provide a priority list of VA's plans to have the facilities identified in the GAO's preliminary findings on VA's Provision of Health Care Services to Women Veterans.

Response. VHA has identified the following as top privacy and security priorities based on the preliminary findings of the GAO's Report on VA's Provision of Health Care Services to Women Veterans:

- Adequate visual and auditory privacy at check-in;
- Adequate visual and auditory privacy in the interview area;
- Exam rooms located so they do not open into a public waiting room or a high-traffic public corridor;
- Privacy curtains present in exam rooms;
- Exam tables placed with the foot facing away from the door (if not possible, placed so they are fully shielded by privacy curtains);
- Changing area provided behind privacy curtain;
- Toilet facilities immediately adjacent to examination rooms where gynecological exams and procedures are performed;
- Sanitary napkin and/or tampon dispensers and disposal bins in at least one women's public restroom;
- Privacy curtains in inpatient rooms (with exception of psychiatry and/or mental health units);
- Access to a private bathroom facility (with toilet and shower) in close proximity to the patient's room (inpatient and residential units).

Senator BEGICH. That would be great. And that is just so I can get a sense of where and what in preparation priorities. You see, when I sat on the Armed Services Committee we sometimes focused just on the year. The problem with that is one year will have ramifications for the next and following years. So, it just kind of helps.

Ms. HAYES. Yes.

Senator BEGICH. I know there is a big commitment from the president in regards to dollars for the Veterans Administration, which is great. I just want to make sure we are in the right tow here.

Ms. HAYES. I also want to clarify, a lot of the issues, as Mr. Williamson said, are really issues of being able to put some renovation costs and would be on the priority list for construction, but rather needing the ability to plan and put together a space that would really involve renovation costs and local costs.

Senator BEGICH. If I can ask, so, will the renovation costs then not be in the long-term capital improvement?

Ms. HAYES. Oh, no, I did not mean to confuse that.

Senator BEGICH. Oh, OK.

Ms. HAYES. I am just telling you that the process is one in which we are looking at both short-terms in terms of some renovation where places are putting in new projects. That is already part of other processes that you would be aware of.

Senator BEGICH. OK. Very good.

Mr. Chairman, I am going to end there. I do have some additional questions, but I know I exceeded my time the last time and I have a feeling with about 30 seconds left, I'll burn that up very quickly. So, let me end here.

Thank you.

Chairman AKAKA. Thank you very much, Senator Begich.

I want to thank the first panel for your testimony and your responses.

As we know, we are facing a huge surge of an issue here that has been important to our country, and some of the problems have been noted. We want to work together as closely as we can to move it and provide the health care services that our women veterans expect and will have.

So, we look forward to working with you. Thank you very much.

Ms. TROWELL-HARRIS. Thank you.

Ms. HAYES. Thank you.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. VA's written testimony discusses how the "women's comprehensive health implementation planning (WCHIP) tool" is used to "assist facilities in analyzing its own current health care deliver for women veterans." After the initial analysis is completed by each facility, is there a process to repeat the analysis periodically to account for the expected growth in the women veteran population and how that may affect the model a facility uses to provide care for its women veterans?

Response. The Veterans Health Administration (VHA) continues to incorporate WCHIP to assess the current status of primary care delivery to women Veterans across VHA, and recommend enhancements as required.

For every VA health care facility, VHA will create a benchmarking tool to evaluate WCHIP. The tool will help define and develop recommendations regarding the

essential components and critical capabilities of comprehensive primary care delivery models. In addition, metrics will be developed that evaluate the implementation of comprehensive care for women Veterans. The tool is currently being developed with an expected completion of February 2010. A plan to pilot the tool is expected in March 2010, and validation is expected May-August 2010. Once the tool has been validated, an annual reporting process will be established for ongoing evaluation and resource monitoring and tracking so that facilities can plan for the expected growth in the women Veteran population in their areas.

Question 2. During the hearing, there was discussion regarding VA's plans for expanding and remodeling clinical areas that provide women's health care and the need to maintain close coordination with VA's Office of Construction and Facilities Management when implementing these plans. In addition to evaluating the space used to provide women's health care, is VA evaluating the equipment, such as exam tables, used in these spaces to ensure it is appropriate for all women veterans, particularly those with catastrophic disabilities?

Response. VA's design criteria moved aggressively to improve space and logistics issues related to women's health this past year. The design criteria incorporated many women-specific requirements, such as ensuring adequate space for women specific equipment, ensuring 100% private patient rooms and ensuring adequate space for dependents accompanying the women Veterans. These design criteria have been incorporated into both, our existing facilities, as well as new Women's Centers.

More specifically for high-tech/high-cost equipment, equipment needs are assessed and evaluated for performance continually. Prior to a new acquisition, an intensive review occurs to optimize the selection to best suit VA's needs. This new equipment then becomes the basis for designing the room to ensure adequate space and privacy.

Regarding the space designs for women's areas in general, VA's standards development efforts have increased addressing the physical and mental health care needs of the growing number of women Veterans. Most efforts related to updating VA's Space Planning Criteria and Design Guides for specific functional areas. Space Planning Criteria provides space requirements and guidance for development of space programs for specific VA Facility Project development and leasing agreements. It contains functional relationships and design considerations in addition to space planning criteria for heath care functions. Design Guides provide comprehensive information, including an overview of design principles and concepts, narrative text descriptions, and guide plates for reference.

These Space Planning Criteria and Design Guides, particularly over the recent past, have addressed numerous specific changes reflecting women's issues. In the most recent Design Guides for Ambulatory Care, Outpatient Clinic, MRI, Radiology, Nuclear Medicine, Radiation Therapy, etc., changes include increased importance of Mammography spaces, adjustment of workload criteria to ensure the appropriate generation of women's health spaces, larger more private dressing room areas, women's specialty exam/procedure rooms (10% larger than standard spaces), more bathrooms in targeted treatment and diagnostic areas, separate male and female bathrooms in small public areas, and waiting rooms where one unisex bathroom would technically suffice.

The Office of Construction and Facility Management (CFM) is partnering with and including the Chief Consultant Women's Health Office, on the Advisory Teams established to update Space Planning Criteria and Design Guides along with consultants and other VHA health care providers. Design Guide and Space Planning Criteria recently completed or major updates are underway: *Mental Health; Inpatient Units—Medical, Surgical, and Neurological Patient Care Units; Intensive Care Units; Procedure Suites; and Leased-Based Clinic Design Guide.*

Question 3. Much attention is given to providing gender-specific care to women Veterans from OIF/OEF. Besides the research mentioned in written testimony regarding hormonal effects on diseases in post-menopausal women, what is VA doing to ensure there are adequate gender-specific services for our older generations of women veterans?

Response. The gender-specific services VA provides takes into account the changing needs of women at each stage of their lives. VA's comprehensive health services for older women Veterans include:

- Continued access to gender-specific screening for breast and cervical cancer to detect early malignancies and improve survival. VA also notes that postmenopausal women are at increased risk of having cardiovascular disease, the number one killer of women. Thus our comprehensive primary care initiatives take into account the needs of our aging women Veterans and focus on breast health and heart health, diabetes and weight management, and smoking and lung cancer.

• Education initiatives for women's health providers include modules on prevention and management of osteoporosis in addition to evaluation and basic assessment of reproductive issues in older women. In addition to hormonal replacement therapy, these issues include urinary incontinence, pelvic floor disorders, and reproductive cancers. Women Veterans with are appropriately and expeditiously referred to subspecialty care services as needed.

Question 4. VA's testimony referred to the mini-residency training in women's health which is taught by national women's health experts. During the hearing it was suggested numerous times that it would be beneficial for someone to learn about women veterans' experiences in the military from actual women veterans. What is your view about having women veterans provide education and insight to VA health care providers in order to help them understand their patients better?

Response. VA understands and agrees that it is essential to have women Veterans participate in providing insight to VA health care providers. In September 2009, VA held a conference entitled, "OEF/OIF Evolving Paradigms II: The Journey Home," that was aimed at preparing approximately 3,000 VA providers of care to Veterans returning from the current conflicts. This conference included several plenary sessions featuring men and women Veteran patients sharing their stories.

VHA also created a staff training CD-Rom which includes numerous images of women Veterans, aimed at increasing awareness and sensitivity about women Veterans. This presentation also includes a video of a woman Veteran describing her military experiences, and her perspectives on care in a VA primary care women's clinic. VA will include women Veterans in person and videos when possible in future educational events. In addition, future educational programs will include techniques and tools for providers such as the military service history pocket card (http://vaww.va.gov/oaa/pocketcard/default.asp) to help providers discuss a better military history and to begin to engage their own patients in the dialog to better understand the experiences of their patients.

All of these things are essential as VA moves toward providing health care that is more patient-centered.

Question 5. What can this Committee do to assist the CWV in its efforts to increase awareness about the women veterans' programs?

Response. The Center for Women Veterans continues to encounter women Veterans who do not self-identify as Veterans, or who are unsure of their entitlement to VA benefits and services. The Senate Committee on Veterans' Affairs could complement the Center's efforts to educate women Veterans about VA's programs for women Veterans as it interacts with constituents, especially those who are women Veterans. Examples of actions the Committee and its members can consider include:

• Including information about women Veterans programs in outreach literature targeting Veterans in general.

• Noting the contributions of women in the military and women Veterans in remarks and speeches, as appropriate.

• Establishing forums for women Veterans in their respective states that would provide opportunities to learn about these programs and how to access them.

• Sharing initiatives and ideas with non-Committee lawmakers regarding VA's programs and efforts for women Veterans in order to expand opportunities for outreach.

Question 6. What happens if a female veteran asks for a female provider and one is not available?

Response. It is VHA's goal that women Veterans be given the option to designate their preference for a female provider. Overall, 62% of VHA providers are female. More than 80% of all nurse practitioners are women and up to one third of all VA physicians are women. Facilities are strongly encouraged to make the necessary accommodations for a female provider (if one is requested) so that services are provided in-house to the greatest extent possible. If a female provider is not available in-house, services are to be provided through fee-basis arrangements or sharing contracts to the extent the Veteran is eligible.

Question 7. When will the new handbook for VHA services for women veterans be issued?

Response. The revised handbook for VHA services for women Veterans incorporates the new standard requirements and delineates the essential components necessary to ensure that all enrolled women Veterans have access to appropriate services, regardless of their VHA site of care. The handbook has recently been revised to reflect comments made in the review process and is going back through internal concurrence. The handbook is expected to be issued during the second quarter of FY 2010.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY SENATOR BURR TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1.a. As we discussed at the hearing, on page 7 of your written testimony there is a statement that "As of June 2009, each of VA's 144 health care systems has appointed a full-time Women Veterans Program Manager." On page 9 of GAO's testimony there is a statement that "In July 2008, VA required VAMCs to establish the WVPM as a full-time position (no longer a collateral duty) no later than December 1, 2008. So, it appears that according to both VA's internal directives and your own testimony that each health care system should have appointed a full-time WVPM long ago.

In response to questions from the Chairman, however, you stated that you were "actively in the process of verifying" whether that is, in fact, the case. In response to my questions you stated, in essence, that just because each system has appointed a full time WVPM that it doesn't necessarily mean that it's happening, and that you wanted to make sure it was because VA was in a "transition phase" on this matter. For the record:

Please clarify these statements. Is there a distinction between the "appointment" of a WVPM and the actual placement of an individual to fill that job?

Response. Occasionally during the hiring process, when bringing on board a new person to fill a vacant slot, there may be a lag from appointment to actual on-site placement. In those cases, the Department of Veterans Affairs (VA) names an acting women Veterans program manager (WVPM) until the appointed individual is officially on board. Additionally, many of the WVPMs who held the position prior to its becoming a full-time position have had to greatly reduce their clinical time to fill the role of a full-time WVPM. For some, the transition from clinical duties had taken longer than expected. This process is still underway. VA currently employs 137 full-time WVPMs; 7 sites have individuals acting in these roles with recruitment for full-time employees underway.

Question 1.b. Is it typical for VA to appoint someone to a position who is unable to perform the job to which they are appointed?

Response. VA does not appoint anyone to a position who is unable to perform that position. Mandatory training of new hires does not suggest they are unqualified or unable to perform the job to which they are appointed. The role of the WVPM is quite complex with regard to understanding the population of women Veteran and their unique needs. Therefore, significant training of new WVPMs and ongoing training for all existing WVPMs is required.

Every new WVPM is required to complete a Web-based, 40-hour certificate training course, which is monitored through the employee education system. In addition, VA women Veterans health strategic health care group (SHG) has provided training for all WVPMs. The eastern region 1 training was held in Baltimore, MD, in April 2009; the mid-western/south region 2 in Chicago, IL, in May 2009l and the western region 3 in San Francisco, CA, in June 2009. Through the course of these three sessions, VA trained all existing, acting and new WVPMs in additional program-specific skills areas. A follow-on training meeting for all current WVPMs was held on September 20, 2009. This training focused on a variety of relevant topics including:

- Follow-up on the Women's Comprehensive Health Care Implementation Plan (WCHIP)
- Issues related to the newly developing Veteran-centered patient care model
- Building a successful women's health center with full backing of leadership
- Writing successful request for proposal responses
- Issues associated with military sexual trauma

Question 1.c. How long before you have verified that each of the 144 WVPMs is in place, trained, and performing the duties for which they were appointed? Please report that to me as soon as possible.

Response. Attached is a comprehensive list of the 144 WVPMs, where they are posted and when they began working full time in that position; 2 WVPMs are currently part-time, and 3 sites have acting WVPMs, while recruitment for the 5 permanent positions are being advertised. All have received the WVPM training referred to in response to question 1b.

Question 2.a. At the hearing I noted that VA budget submissions show a decline, from 2007 to 2008, in the number of unique users seeking gender-specific care at VA. In response you stated that "on paper it looks like we've decreased our gender specific care when, in fact, we believe that it's increased." Please clarify this for me If from one year to the next the number of unique users seeking gender-specific care

has declined, doesn't that indicate that those who were once users of the system for gender-specific purposes are seeking that care elsewhere?

Response. In the fiscal year (FY) 2010 President's Budget submission the reported number of the female Veterans being treated for gender specific conditions (FY 2008 actual) was lower than the number that was reported in the FY 2009 President's Budget (FY 2007 actual). The reason the FY 2007 (actual) number was higher is because non- Veteran women were mistakenly counted in the FY 2007 number; that cohort should have been deleted from the equation before the budget submission was finalized.

In addition to identifying the non-Veteran inconsistency, the VA review process produced insight on what is identified as gender-specific care for women. In that review, 172 additional diagnosis codes that represent gender specific were added to the former list of 441 codes to more accurately identify care that is gender-specific. These additional codes were applied to historical data for use in the FY 2011 budget process.

Question 2.b. If you believe that the number of women seeking gender-specific care has actually gone up instead of down, then, what are the true numbers? What do the numbers look like for 2009 and do they track what was estimated for 2009?

Response. The table below shows the revised historical data for female Veterans who come to VA for gender-specific care using the expanded list of diagnosis and clinics.

In FY 2008, actual data through mid-year reflected 61 percent of the annual total unique female Veteran patients in FY 2008 had already received care and 43 percent of the annual total costs had been expended by mid-year FY 2008. At mid-year FY 2009, actual unique patients are 68 percent of the estimated annual total and actual costs are 50 percent of the estimated annual total, so actual experience thus far indicates that the estimate may have been low if second half expenditures occur at the same pace as happened in FY 2008. As compared to mid-year FY 2008, FY 2009 actual data shows a 14 percent increase in female Veteran patients and a 26 percent increase in cost.

The following table shows historical data for female Veterans who come to VA for gender-specific care using the expanded list of diagnosis and clinics. The response to question 2a discusses the expansion of the scope of gender-specific care.

	FY 2008 Actual	FY 2009 Budget	FY 2008 Mid-Year	FY 2009 Mid-Year
Female Veteran Patients	141,698	145,647	87,128	99,500
Obligations (000s)	$153,315	$167,330	$65,758	$82,860

Question 3. What percentage of the gender-specific care (as a percentage of obligations) VA provides was purchased from a non-VA provider? Has this number increased or decreased in the last decade?

Response. The data below shows the percentage spent in VA and the percentage spent on non-VA providers. Data are not available prior to FY 2005. Since FY 2005 the percent spent on gender-specific care increased between 12.18 percent in FY 2005 to 14.2 percent in FY 2009. The data over this short period is narrow in variance and does not allow for reliable trending.

Fiscal Year	VA	Non-VA
2009, 2nd quarter	85.80 percent	14.20 percent
2008	86.90 percent	13.10 percent
2007	87.92 percent	12.08 percent
2006	88.49 percent	11.51 percent
2005	87.82 percent	12.18 percent

Chairman AKAKA. I welcome now a second panel this morning. Members of this panel are five women veterans, each working in the field of advocacy in its various forms.

First, I welcome Joy Ilem, Deputy National Legislative Director for Disabled American Veterans.

Next, we have Tia Christopher, who is an Iraq Veteran and Project Associate and Women Veteran Coordinator for Swords to Plowshares.

Next, welcome to Genevieve Chase, Executive Director for American Women Veterans.

We will hear testimony also from Kayla Williams, a veteran of the U.S. Army.

And, finally, we have Jennifer Olds, also a U.S. Army veteran. I am grateful to VFW for making it possible for Ms. Olds to join us today.

Ms. Ilem, we will begin with you and then move down the table in order.

Ms. Ilem?

STATEMENT OF JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Ms. ILEM. Thank you, Mr. Chairman and Ranking Member Burr. Thank you for inviting the Disabled American Veterans to participate in this timely hearing on women veterans.

The changing roles of women in the military, increasing numbers of women coming to VA for care, and the impact of war on women's health present a number of new challenges for VA in meeting the unique needs of women veterans today.

Ensuring equal access to benefits and high-quality health care services for women veterans is a top priority for DAV. We have a longstanding resolution that calls for review of VA's health program for women to ensure they have access to the same high-quality health care and specialized services that male veterans receive.

It is apparent from the recently-released Report of the Under Secretary for Health Workgroup on Women Veterans that VA is aware of the shortcomings in its women's health program and is making a concerted effort to systematically address the significant challenges it faces to bring care provided to women veterans on par with male veterans.

The report outlines the most critical challenges VA faces in caring for women veterans, and, more importantly, provides a roadmap for change. Some of the most critical issues identified in the report include: significantly increasing utilization rates of younger women accessing VA care; the systemic fragmentation of primary care delivery for women; too few proficient, knowledgeable providers with expertise in women's health; and a number of identified outpatient quality disparities for women veterans.

Additionally, VA researchers report a number of access barriers for women veterans, including lack of childcare services, privacy, safety, and comfort concerns, and unique post-deployment mental health reintegration issues for newly-discharged women veterans who have served in Operations Iraqi and Enduring Freedom.

The workgroup states its primary objective is to ensure every woman veteran has access to a qualified health care provider who can deliver coordinated, comprehensive, primary, women's health care inclusive of gender-specific care, preventive, and mental health services.

It plans to achieve these goals through a number of key policy recommendations to reform and enhance women's health delivery in VA. These recommendations thoroughly address quality, efficiency, access, and equity of care for women who use VA services.

And we congratulate the Women Veterans Health Strategic Health Care Group for an extraordinarily forthcoming report in a highly-detailed series of goal-orientated recommendations and action items. These recommendations are fully consistent with a series of recommendations that have been made in recent years by VA researchers, experts in women health, VA's Advisory Committee on Women Veterans, and the *Independent Budget*.

If implemented, these reforms will change the face of health care delivery for women veterans in the VA health care system, and, in turn, improve the health of women veterans.

Without question, VA has a lot of hard work ahead to achieve these goals it has set out for itself, but we are hopeful with the attention, oversight, and collaboration of this Committee, that an implementation plan can be expeditiously carried out.

A number of events focused on women veterans have been held in recent months and all are essential to process of change. However, nothing is more important than taking action. For these reasons, DAV urges the Committee to carefully consider the recommendations outlined in the report on women's health and to support VA's efforts for change.

Although this groundbreaking report represents progress, we question if the women's health program directors have the resources to build adequate infrastructure and program capacity and the internal support necessary at the very highest levels to make the reforms it says are necessary.

One final concern we bring to the Committee's attention, although it appears VA has been making a good faith effort to move forward on its plans for improving women's health care services and implement the principles outlined in the report, it does not appear VA has issued a formal policy or directive to the field to address the gaps identified in the report. Therefore, we seek assurance from VA that its implementation will be, in fact, faithfully executed.

Mr. Chairman, again, we thank you and other Members of the Committee for your leadership and continued support on women veteran's issues, and we appreciate the opportunity to participate in this important hearing.

Thank you.

[The prepared statement of Ms. Ilem follows:]

PREPARED STATEMENT OF JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: Thank you for inviting the Disabled American Veterans (DAV) to testify at this hearing that is focused on women veterans, entitled "Bridging the Gaps in Care." This hearing is extremely timely given the changing roles of women serving in our Armed Forces today, the 1.7 million women veterans who served previously, and the dramatically growing number of women seeking health care and other benefits from the Department of Veterans Affairs (VA).

Ensuring equal access to benefits and high quality health care services for women veterans is a top priority for DAV. We have a long-standing resolution from our membership of 1.2 million disabled war veterans that seeks to ensure VA health care services for women veterans, including gender-specific care, are provided to the same degree and extent that services are provided to male veterans. Also, given the undoubted greater exposure of servicewomen to combat, we believe they should have equal access to supportive counseling and psychological services incident to combat exposure. Military sexual trauma, while not exclusively a women's issue, is also of

special concern to DAV. Additionally, we urge VA to strictly adhere to their stated policies regarding privacy and safety issues related to the treatment of women veterans and to proactively conduct research and health studies as appropriate, periodically review its women's health programs, and seek innovative methods to address women's barriers to VA health care and services, thereby better ensuring women veterans receive the treatment and specialized services they rightly earned through military service to America.

Likewise, for many years, the organizations that make up the *Independent Budget* (*IB*)—AMVETS, DAV, Paralyzed Veterans of America (PVA) and Veterans of Foreign Wars of the United States (VFW)—have included a special section in the *IB* emphasizing women veterans, in an effort to call attention to the need to address many of the challenges VA faces in providing high quality health services to women veterans in a predominantly male-oriented health care system. We are pleased to see that many of the recommendations made in this section of the fiscal year 2010 *IB* have been addressed by VA in a recent ground-breaking publication—*Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans* (Report), published in November 2008 but released only very recently. Additionally, DAV included a special focus on women veterans as part of our ongoing Stand Up For Veterans campaign—focusing public attention on the unique needs of women veterans—with a special emphasis on women who became disabled during their wartime service.

VA's 2008 Report [1] reflects the most pressing challenges VA faces: specifically, developing the appropriate health care model for women in a system that is disproportionately male focused, the increasing numbers of women coming to VA for care, the impact of changing demographics in the women veteran population, and impact on VA health care delivery as well as the already-identified gender disparities in quality of care for women veterans.

Women veterans are the fastest growing segment of the veteran population—and according to the Veterans Health Administration (VHA), women are projected to account for one in every seven enrollees within the next fifteen years, compared to the one in every sixteen enrollees today. Because of the large and growing number of women serving in the military today, the percentage of women veterans is projected to rise proportionately from 7.7 percent of the total veteran population in 2008, to 10 percent in 2018. Additionally, VA notes that women who served in Operations Iraqi and Enduring Freedom (OIF/OEF) utilize VA services at a higher rate than other veterans, including other women veterans and male OIF/OEF veterans—with 42.5 percent of the 102,000 OIF/OEF women veterans having enrolled in VA, and nearly 43.8 percent who are consuming between two and ten VHA visits per year on average. Earlier generations of women veterans enrolled in VA health care at a 15 percent average rate.[2]

As reported by VA, historically, women have underutilized VA health in comparison to male veterans. In the past five years, on average, 22 percent of men versus 15 percent of women have accessed VA health care. Women veterans using VA health care are also younger—with an average age of 48 compared to male veterans' average age of 61. Among women users from OIF/OEF, more than 85 percent are under age 40 and of child-bearing age, and nearly 60 percent are between the ages of 20–29.[3] In addition, women veterans have been shown to have unique and more complex health needs with a higher rate of comorbid physical health and mental health conditions, i.e., 31 percent of women have such comorbidities versus 24 percent of men. Even with this high rate of comorbidity, women veterans receive their primary and mental health care in a fragmented model of VA health care delivery that complicates continuity of care. In fact, according to the VHA Plan of Care Survey for fiscal year 2007, 67 percent of sites provide primary care in a multi-site/multi-provider model (i.e., with primary care at one visit and gender-specific primary care at another visit), with only 33 percent of facilities offering care to women in a one-visit model. The Under Secretary's workgroup concluded given these facts that there are now sufficient numbers of women veterans to support coordinated models of service delivery to meet their needs, and that while women will always comprise a minority of veterans in the VA system, they represent a critical mass

[1] U.S. Dept of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*. Washington, DC: November 2008.

[2] Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 1. June 2009. www.amsus.org/sm/presentations/Jun09-B.ppt

[3] Ibid.

as a group and should therefore be factored into plans for focused service delivery and improved quality of care.

As indicated above, we have read with great interest a recently released VA publication titled: *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, dated November 2008. We are impressed with the thoroughness of the review of women's care in VHA, and also with the optimism of its recommendations to improve women's health. If implemented nationally its recommendations could assure that women veterans receive coordinated, comprehensive, primary care at every VA facility from clinical providers who are trained to meet their needs; an integration of women's mental health with primary care in each clinic treating women veterans; the promotion of innovation in women's health delivery; enhanced capabilities of all staff interacting with women veterans in VA health care facilities; and an achievement of gender equity in the provision of clinical care within VA facilities.

As directed by the VA Under Secretary for Health, the workgroup was charged with defining the actions necessary to ensure that every woman veteran has access to a VA primary care provider who can meet all her primary care needs. The workgroup reviewed the current organizational structure of VHA's women's health care delivery system, addressed impediments to delivering their care in VHA, identified current and projected future needs, and proposed a series of recommendations and actions for the most appropriate organizational initiatives to achieve the Under Secretary's goals.

CURRENT CHALLENGES

VA noted in its Report that only recently had it begun to address development of the most appropriate health care services for women veterans at each VA facility. The workgroup identified seven challenges that VA must overcome in order to deliver quality, comprehensive primary care to women veterans.

Challenge 1: VA recognizes that women have been under-served in the veterans health care system. Utilization rates for men have held at approximately 22 percent for many years—while utilization rates for women range between 11–19 percent. Research shows that women veterans do not self-identify as bona fide veterans, and are more unlikely to be unaware of their enrollment eligibility. Of special note to DAV—and greatest concern is that among women veterans in this study who had not had access to health care in the past 12 months, 18.7 percent of this group is service-connected for disability incurred in the line of duty.[4] This finding—that service-connected women veterans are without access to health care, are not enrolled in nor using VHA services—is especially distressing to DAV.

Challenge 2: VA acknowledged there is a clear and growing need for improved service delivery to women veterans in VHA. Given the significantly higher VA utilization rates among women returning from OIF/OEF as indicated above, VA expects the number of women veterans coming to VA for care will likely double within the next four years. The workgroup noted there are now sufficient numbers of women to justify a VA effort to produce coordinated models of service delivery to meet their needs—and that as a group women veterans should be factored in as a special population cohort in any new strategic plans for service delivery.[5]

Challenge 3: In recent years, VA reports have shown a significant demographic shift related to women VA-users and notes the impact of age-related health concerns. Given the fact that almost all new users of the system are under age 40—and of child-bearing age—there is a need for a focused shift in the provision of health care services. The Under Secretary's workgroup also noted VA must continue to be sensitive to the needs of older women veterans as well, since women over 55 years of age face high risks for cardiac disease, cancers and the consequences of obesity (such as Type 2 diabetes).

Challenge 4: The workgroup identified and acknowledged gender disparities in quality of care in VHA. Despite positive results on gender-specific measures such as screening for cervical and breast cancer, significant differences are recorded in VHA performance scores between men and women on certain outpatient quality measures that are common to both men and women. Specifically, depression and PTSD screening, colorectal cancer screening and vaccinations were reported as less favorable for women.

[4] Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 15. June 2009. www.amsus.org/sm/presentations/Jun09-B.ppt

[5] Ibid.

Challenge 5: The workgroup identified routine fragmentation of health care delivery to women veterans that poses possible negative health outcomes. According to the report, to a large extent, health care services offered to women veterans have evolved in a patchwork fashion. Some facilities have strong champions with expertise in women's health and offer comprehensive services in one location; other facilities, however, require women to see several providers for basic primary care services, and some VA facilities rely heavily on fee-basis providers to care for enrolled women veterans.

Challenge 6: One of the most significant challenges VHA faces according to this workgroup report is an insufficient number of clinicians with specific training and experience in women's health. The report acknowledges that the historical predominance of male veterans in the VA setting has resulted in many providers lacking or having limited exposure to women patients.[6] According to the workgroup, women veterans' numerical minority in VHA has created logistical challenges in creating and sustaining delivery systems that assure VA's goal of equitable access to high quality comprehensive services that include gender-specific care.

Challenge 7: Finally, the workgroup identified that there is inconsistent policy in place for women's health in VHA. The group noted that, in previous directives issued by VA Central Office, VA clinical staff were required to provide gender-specific care on-site in VA facilities, but, that more recent versions of the directives shifted the emphasis to "preferred" rather than "required." As a result, a decline in on-site gynecological services occurred with an increase in fee-basis referral for those key women's health care services. The workgroup noted that in contrast, gender-related care always has been recognized as an integral part of primary care delivery for men in VA health care.

To aid in the implementation of comprehensive health care for women veterans at every VA facility, the Women Veterans Health Strategic Health Care Group developed a Women's Comprehensive Health Implementation Planning (WCHIP) tool. The tool, which outlines a care gap analysis, market analysis and needs assessment, was designed to help VA facilities and VISNs assess and make decisions about which services need to be developed and what resources were necessary to carry out those plans. The stated goal was to then have Women Veterans Program Managers (WVPM) work directly with strategic planners at their VA facilities to incorporate the results of the WCHIP into the health care planning model for those facilities. We are pleased the WVPM position was made full time in July 2008, since these managers are clearly integral to providing increased outreach to women veterans, improving quality of care and developing best practices in the delivery of care to women veterans throughout the VA health care system.

WORKGROUP REPORT RECOMMENDATIONS

The workgroup made a series of key recommendations with accompanying action items, as follows:

> Recommendation 1 focuses on the delivery of coordinated, comprehensive primary women's health care at all VA facilities, including the development of systems and structures for care delivery that ensure every woman veteran has access to a qualified primary care physician who can provide care for acute and chronic illnesses, gender specific care, and preventative and mental health services.
>
> Actions items necessary to achieve this goal include using the WCHIP tool to provide an assessment of the current status of care delivery and resources at each facility; identify steps needed to achieve coordinated comprehensive primary women's health care and implement a practice plan for each facility and women's population in a particular catchment area; provide appropriate funding to build adequate infrastructure and program capacity; increase utilization rates for women and provide staff and resources to conduct outreach and education to women veterans; collect, analyze and report on data related to access, staffing flexibility, and cost to carry out plan; and, coordinate with VA academic affiliates for delivery of comprehensive primary care services to women.
>
> The workgroup noted that current research evidence, clinical data and the adoption of models of patient-centered care support the advancement of comprehensive primary women's health care and are further supported by existing policies in VHA Handbook 1330.1 and Standards of Primary Care Directive

[6] Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 16. June 2009. www.amsus.org/sm/presentations/Jun09-B.ppt

2006–031. These directives state that primary care includes gender-specific care services.

Recommendation 2 seeks to ensure integration of women's mental health care as a part of primary care. The workgroup identified that women veterans using the VA health care system carry a heavy burden of mental illness diagnosis—with depression being the most frequent condition in women seeking care in 2007. PTSD was the fourth most frequent diagnosis reported, above diabetes and hypertension. (page 52 Rec. 2) The workgroup concluded the adoption of the combined provision of primary and mental health care services would help women veterans overcome barriers to access needed mental health care.

Action items for Recommendation 2 include: assignment of mental health providers in primary care clinics who can provide assessment and psychosocial treatment for a variety of mental health problems, including depression and problem drinking with associated sexual behavior risk factors; facilitating collaboration of behavioral health with primary care to provide ancillary services such as pain management, weight management, and smoking cessation programs designed to meet the needs of women veterans.

Recommendation 3 focuses on promoting new ways of providing care delivery for women through support of best practices fitted to a particular facility or VISN configuration and the women veteran population in that location or region. The workgroup opined that individual VA facilities are best positioned to develop innovative programs to meet the needs of women veterans, especially sub-populations of minority groups and women veterans from rural areas. We concur with VA that best practices can help address variation in geographic and demographic challenges across the system, and that innovative technologies should be utilized to enhance delivery of care for this population.

Action items to achieve this goal include: sharing best practice models for comprehensive women's health care through an improved web portal, conferences and other appropriate information transfer methods; developing requests for proposals from VA field facilities for pilot project initiatives using new technology; collaboration between the Offices of Care Coordination and Information to explore new opportunities in telehealth, inclusive of women veterans; recognize and promote local achievements in creating environments of care that support privacy, safety and comfort for women veterans who seek VA care.

Recognizing that VHA has a longstanding history and focus on male patients, Recommendation 4 addresses the need to cultivate and enhance the capabilities of all VHA staff—including medical providers, clinical support, non-clinical, and administrative staff, to meet the comprehensive health care needs of women veterans. The workgroup acknowledged that despite increasing numbers of women enrolling for VA care, women users of the system continue to be relatively "invisible." We fully concur that a paradigm shift is necessary and that a coordinated training and cultural sensitivity program will be essential to creating an atmosphere of equity and welcome for women veterans in VA health care facilities.

According to the workgroup, many VA clinical providers have acquired skills during health professions internships or residencies but have subsequently lost those proficiencies in their intervening years working in VA facilities therefore, a concerted effort must be made to cultivate and enhance the capabilities of all VA staff to meet the needs of women veterans. Action items to achieve this goal include: recruitment and training of practitioners to be proficient, knowledgeable, and engaged providers in women's health; funding mini-residency programs in women's primary care programs for current VA providers; continue to strengthen VA-based women's health fellowships; develop recruitment and retention strategies to increase the number of trained staff in women's health; train and sensitize all VA staff on issues specific to women's health care.

Recommendation 5 seeks to achieve parity in clinical performance measures and gender equity in clinical quality of care issues by addressing the systemic reasons for the identified disparities in outcomes for women using VA in order to effect change in clinical practice.

Although overall quality of care is high compared to the private sector and despite positive results on gender-specific measures such as screening for cervical and breast cancer, VA acknowledges that clinical quality performance disparities exist in the provision of care to women for certain prevention measures. We are pleased the workgroup states its goal is to be a "national model for women's health care" and challenges VA to stand by its principles of providing the highest quality of care—the best care anywhere—and to ensure gender parity in the delivery of VA health care.

> Actions necessary to achieve this goal include: assuring continual measurement of women veterans' health outcomes for gender-specific and gender-neutral care; continuing research that addresses best practice models for delivery of care to women veterans; working closely with the VA Office of Research and Development to better understand the unique health concerns of post-deployed women veterans; developing and implementing a validated tool for routine clinical assessment of sexual activity, risk behaviors, and anticipation of pregnancy.

These recommendations thoroughly address quality, efficiency, access and equity of VA care for women who use VA services. The workgroup found the need to improve all these areas in today's VA health care programs for women veterans, and to better prepare these programs for tomorrow's women veterans. We commend the members of the workgroup who contributed so much to what appears to us to be a comprehensive roadmap that could lead VA to make great strides in improving health programs and services for women veterans.

RESEARCH

Research plays an integral role in developing the most appropriate health care delivery model for women veterans and providing access to high quality health care services.

Over the years, VA researchers have brought to light a number of important facts that, if acted upon, would greatly improve the care that women veterans receive at VA health care facilities. Among these facts, it was shown that access and waiting time scores were better at sites where primary care and gender-specific services were available in a one-stop setting. VA facilities that have established this type of primary care delivery, whether in women's clinics or in general primary care, have better patient satisfaction scores on care coordination for contraception, sexually transmitted disease screening and menopausal management than facilities that separate these services across multiple clinics.

DAV is pleased that VA's Office of Research and Development (ORD) supports a comprehensive women's health research agenda, and VA has intensified its research on women's health in the last decade. The first comprehensive VA women's health research agenda, which covered biomedical, clinical, rehabilitative and health services research, was directed by ORD in 2004 with the goal of positioning VA as a national leader in women's health research. ORD successfully mapped research priorities based on the needs of women veterans and capitalized on VA's significant and productive research enterprise while using evidence-based data on the health status and health care needs of women veterans to include a systemic literature review on health care research related to women veterans and women in the military. Within ORD, VA's Health Services Research and Development Service (HSR&D) is at the forefront of research focused on understanding and improving the health and health care of women veterans.

ORD currently supports a broad research portfolio that includes: studies on diseases prevalent solely or primarily in women; hormonal effects on diseases in postmenopausal women; PTSD and other post-deployment mental health concerns among women; and, osteoporosis and multiple sclerosis in women. Gender disparities have also been analyzed and highlighted in addition to the disparities in some types of preventative care among spinal cord injured women veterans that include the need of special equipment and body adjustments required to perform care. HSR&D is also currently funding 27 research projects that examine the health and health care of women veterans; the consequences of military sexual trauma and other military traumas; PTSD treatment in women; screening and utilization as well as post-deployment access and reintegration issues; utilization; outcomes and quality of care for women veterans related to ambulatory care; chronic mental and physical illness, alcohol misuse, breast cancer and pregnancy outcomes. HSR&D is also in Phase II of a study examining VA's approaches for delivering care to women veterans while another is assessing the implementation and sustainability of VA women's mental health clinics. These studies include OIF/OEF populations.

We look forward to the results of these 27 research projects, and applaud VA for standing in the forefront and leading the way in assuring our women veterans that they will secure the same access to and quality of care that their male counterparts receive in the VA health care system.

SUMMARY

We congratulate the Women Veterans Health Strategic Health Care Group for an extraordinarily forthcoming report and highly relevant series of goal-oriented recommendations and action items. These recommendations are fully consistent with a series of recommendations that have been made in recent years by VA research-

ers, experts in women's health, VA's Advisory Committee on Women Veterans, the *Independent Budget*, and DAV. DAV Resolution 238 seeks to ensure high quality comprehensive VA health services for all women veterans, with a special focus on the unique post-deployment needs of women veterans returning from OIF/OEF. DAV's resolution notes that VA needs to undertake a comprehensive review of its women's health programs, and to seek innovative methods to address barriers to care for women veterans to ensure they receive the treatment and specialized services they need and deserve. Therefore, we fully support the recommendations made in the Report and urge their speedy implementation.

We are pleased that VA Secretary Shinseki has testified previously that the delivery of enhanced primary care for women veterans is one of VA's top priorities. Likewise, the Women Veterans Health Strategic Health Care Group's commitment to assuring all eligible women veterans will receive gender-specific primary care by proficient and interested primary care providers; privacy, dignity, and sensitivity to gender-specific needs; state-of-the-art health equipment and technology; gender parity in performance measures; and, the right care in the right place and time are all laudable goals. We fully concur with the workgroup's conclusion that "the debt owed to all our veterans and to women in particular demands nothing less than our full attention."

However, making these goals a reality will require VA's building the proper resources and adequate infrastructure and program capacity and developing the internal support necessary at the highest levels to make the changes it says are needed. Without question, this is a significant undertaking by VA and there is a lot of hard work ahead to achieve the goals it has set out for itself, but we are hopeful with the attention, oversight and collaboration of this Committee that VA can achieve implementation of the recommendations in this report.

Mr. Chairman, a number of public events focused on women veterans have been held in recent months. All are essential to the process of change; however, nothing is more important than taking action. For these reasons DAV urges the Committee to carefully consider the recommendations outlined in the *Provision of Primary Care to Women Veterans* Report and to support VA's efforts to achieve these reforms.

We would like to point out, Mr. Chairman, that as of March 11, 2009, this landmark report on women veterans was distributed to VA field facilities and to regional network management offices within VHA. However, its transmittal to the field by VA Central Office did not take the form of a VHA directive; nor did it convey any mandatory implementation requirements or accountability on the part of local or regional officials. It was simply transmitted to VA field elements as an informational device, apparently for their discretionary use in planning. We recognize that VA has been making a good faith effort to move forward on its plans for improving women veterans' health services, and it is clear from VA correspondence included at the end of the workgroup report that at multiple levels work is underway to assess and implement principles outlined in the report. However, we note there is no formal expression of policy or directive to fill the gaps that this report identified.

For these reasons we ask the Committee to oversee and seek VA's commitment to issue instructions to all VA health care personnel who will be held accountable for implementation of this comprehensive policy. The implementation phase should include establishing performance measures for facility and network executive staffs, submission of appropriate reports and provision of other oversight to ensure these reforms are implemented and sustained at every VA facility caring for women veterans. Additionally, we ask that Congress ensure VA is provided sufficient resources to accomplish these essential reforms.

As you know, women are a growing population within the ranks of the active, Guard and Reserve forces of our Armed Services, and women veterans are streaming into VA health care by the thousands. Soon women veterans will share ranks nearly two million strong and will constitute one of every seven veterans enrolled in VA health care. Expectations for VA to step up to this challenge are high, and this report by VHA's own workgroup clearly reveals the necessity for VA to make significant changes in the short term to begin better addressing women's needs in the long term. This workgroup report is an excellent beacon to show them the way, but we must have, and seek assurance that its implementation will be faithfully executed.

Mr. Chairman, again we thank you for the opportunity to share our views at this important hearing focused on women veterans—and bridging the gaps in their care. We will appreciate your consideration of our views on this pressing and important matter to America's women veterans. I would be pleased to address your questions, or those of other Committee Members.

Chairman AKAKA. Thank you very much for your testimony. I want you to know that your prepared remarks will be, of course, made part of the hearing record.

So, now, let me call on Ms. Christopher.

STATEMENT OF TIA CHRISTOPHER, U.S. NAVY VETERAN; IRAQ VETERAN PROJECT PROGRAM ASSOCIATE, WOMEN VETERAN COORDINATOR FOR SWORDS TO PLOWSHARES

Ms. CHRISTOPHER. Thank you, Mr. Chairman and Members of the Committee for allowing me to speak.

My name is Tia Christopher. I'm a U.S. Navy veteran, and Woman Veterans Coordinator for the veteran non-profit Swords to Plowshares. I speak before you today both in my professional capacity and from my personal experience as a woman veteran.

I am 70 percent VA-rated disabled veteran for PTSD and military sexual trauma. My experiences have given me the passion and perseverance to do advocacy work on behalf of Swords to Plowshares. I mention this to illustrate that I am a VA consumer, as well as a community avenue for my peers to seek and access care.

The VA has made notable strides in the care of our Nation's women veterans. I would not be the person I am today without the young woman veteran PTSD groups established at some VA medical centers.

Even as we acknowledge the amazing strides that have been made, it must be noted that services and support for women remain insufficient both in quality and accessibility. More women are serving in the military than ever before.

No one entity should be expected to provide the breadth of services and support needed for female veterans. There needs to be a coordination and collaboration between the DOD, VA, and community providers in order to delivery adequate care.

Community providers, such as Swords to Plowshares, are on the frontlines everyday serving veterans from all our Nation's conflicts. Because of the historical lack of gender-appropriate services, it is critical that no door be the wrong door to accessing care.

Resources are stretched—we all know that—both for the government and non-profits. Women veterans may seek assistance in the community, which do not address their underlying health issues, but address their pragmatic needs in the moment.

For example, I had a young woman Air Force veteran come in initially asking for help finding a job, but, at the end of our conversation, it became evident she was homeless. This young women who honorably served her country divulged that she was now selling her body just to get by. It broke my heart that this sister veteran of mine had been reduced to this.

Because of the specific employment and training services that Swords provides and the fact that she was able to speak with a fellow female veteran, she felt comfortable asking for help. In this case, she needed mental health attention, as well. Services need to reflect the myriad, co-occurring issues surrounding our female veterans and care providers need to be versed in how to appropriately and comprehensively address these issues.

This veteran is not unique in her experience. Female veterans frequently access community care rather than VA care, which is

often times less of a hurdle to navigate, as well as less intimidating. Swords to Plowshares conducted focus groups of female veterans in San Francisco, during which many participants noted barriers to VA services.

One stated, “If you do have benefits available through the VA, you have to be very persistent, you have to want to get your benefits, and you have to fight for them. If the benefits are there, you're entitled to them, and you just have to find the right person in the office that's going to help you fight for them.”

Women need not only more gender-specific care, but also care that is appropriate for their needs. The gender of a mental health provider does not necessarily qualify them to treat that woman veteran. It is essential that women who do need inpatient treatment for PTSD, whether combat or sexual assault-related, receive care in a safe treatment space. A coed environment can truly be the worst thing for a woman suffering from military sexual trauma and PTSD. We need more woman-veteran-only inpatient VA programs.

Just having the resources is not enough. Again, the quality, quantity, and accessibility of that care is vital. For those who are uncomfortable receiving treatment at a VA facility for whatever reason, funding needs to be allotted for culturally-competent care within the community.

Both government and community entities need to be educated on the specific needs of women veterans. I regularly speak during the community panel portion of the National Center for PTSD's Clinical Training Program. Sharing my story and experience navigating the VA system and receiving treatment has helped these clinicians better understand their patients.

The Iraq Veteran Project of Swords to Plowshares is primarily composed of staff who are veterans. We provide foundation-funded free panel representations for VA clinicians and community behavioral health providers on issues such as prevalence of PTSD, TBI, MST, military terminology clarification, triggers, cultural obstacles to care, and effective outreach approaches. This has led to greater dialog and collaboration among community and government entities treating veterans, as well as help the veterans themselves feel that they are understood by their caregivers.

Thank you very much for your time.

[The prepared statement of Ms. Christopher follows:]

PREPARED STATEMENT OF TIA CHRISTOPHER, U.S. NAVY VETERAN AND WOMEN VETERAN COORDINATOR—IRAQ VETERAN PROJECT, SWORDS TO PLOWSHARES

Good morning. Thank you, Senators, for allowing me to speak. My name is Tia Christopher. I am a U.S. Navy veteran and Women Veterans Coordinator for the veteran nonprofit Swords to Plowshares. Our organization has been helping veterans since 1974.

In response to the wars in Iraq and Afghanistan, we established the Iraq Veteran Project to specifically address the needs of the newest generation of veterans. Following the formation of the Iraq Veteran Project, Swords created my position to respond to the specific needs of the fastest growing cohort of the U.S. veteran population: Women. I speak before you today both in my professional capacity and from my personal experience as a woman veteran. I am a 70% VA-rated, disabled veteran for PTSD and Military Sexual Trauma. My experiences have given me the passion and perseverance to do advocacy work on behalf of Swords to Plowshares. I mention this to illustrate that I am a VA consumer as well as a community avenue for my peers to seek and access care.

The Department of Defense has made considerable progress in the eight years since I served. Significant steps have been made in the area of sexual assault prevention; (i.e.: the establishment of the SAPR program). In the same spirit, the VA has made notable strides in the care of our Nation's women veterans. I would not be the person I am today without the young women veteran PTSD groups established at some VA medical centers. Even as we acknowledge the amazing strides that have been made, it must be acknowledged that services and support for women remain insufficient both in quality and accessibility. More women are serving in the military than ever before. No one entity should be expected to provide the breadth of services and support needed for female veterans. There needs to be coordination and collaboration between the DOD, VA, and community providers in order to deliver adequate care.

Community providers such as Swords to Plowshares are on the front lines every day serving veterans from all our Nation's conflicts. Because of the historical lack of gender appropriate services it is critical that no door be the wrong door to accessing care. Resources are stretched; we all know that, both for the government and nonprofits. I am scrambling every day to find resources for the women veterans who come through our door.

Whether it is housing, inpatient programs, or resources for their families, services are insufficient for women veterans. Women veterans may seek out services in the community which don't address their underlying health needs but address their pragmatic needs in the moment. For example, I had a young woman Air Force veteran come in initially asking for help finding a job, but at the end of our conversation it became evident she was homeless. This young woman who honorably served her country divulged that she was now selling her body just to get by. It broke my heart that this sister veteran of mine had been reduced to this.

Because of the specific employment and training services that Swords provides, and the fact that she was able to speak with a fellow woman veteran, she felt comfortable asking for help. In this case, she needed mental health attention as well. Services need to reflect the myriad co-occurring issues surrounding our female veterans; and care providers need to be versed in how to appropriately and comprehensively address these issues.

This veteran is not unique in her experience; female veterans frequently access community care rather than VA care, which is oftentimes less of a hurdle to navigate, as well as less intimidating. Swords to Plowshares conducted focus groups with female veterans in San Francisco, during which many participants noted barriers to VA services. One participant stated, "If you do have benefits available through the VA, you have to be very persistent. You have to want to get your benefits, and you have to fight them for it. The benefits are there, you're entitled to them, and you just have to find the right person in the office that's going to help you fight for them."

Women need not only more gender specific care, but also care that is appropriate for their needs. It is essential that women who do need inpatient treatment for PTSD, whether combat or sexual assault related, receive care in a safe treatment space. A coed environment can truly be the worst thing for a woman suffering from Military Sexual Trauma (MST) and PTSD. Just having the resources is not enough, again, the quality, quantity, and accessibility of that care is vital. For those who are uncomfortable receiving treatment at a VA facility, for whatever reason, funding needs to be allotted for culturally competent care within the community.

Both government and community entities need to be educated on the specific needs of women veterans. I regularly speak during the community panel portion of the National Center for PTSD's clinical training program. Sharing my story and experience navigating the VA system and receiving treatment has helped these clinicians better understand their patients. The Iraq Veteran Project is primarily composed of staff who are veterans. We provide free panel presentations for clinicians and community behavioral health providers on issues such as prevalence of PTSD, TBI and MST, military terminology clarification, triggers, language, cultural obstacles to care, and effective outreach and treatment approaches. Sessions such as these are a foundation-funded free service provided by our nonprofit to government and community entities. This has led to greater dialog and collaboration among the various entities treating veterans, as well as helping the veterans themselves feel that they are understood by their caregivers.

Another area of great concern is an understanding of the resources available to them, and an understanding of what to expect during transition. I encountered dry, outdated materials that were difficult to digest and did not speak to me as a young veteran. As a result, Swords to Plowshares published our OIF/OEF transition manual written in familiar language from one veteran to another. The concept behind this manual is not profound- however- it is unique in its approach and has been

met with extremely positive feedback from DOD, VA, and community entities, as well as from the veterans themselves. Materials such as this could considerably augment and aid accessibility to VA services on a nationwide scale. This is one example of how the community and the VA can work together. Based on the success of this manual written for both genders, it is my dream to write one specifically for women veterans, working in partnership with the DOD and VA.

Finally, women veterans have expressed their need for resources strictly for them. During the focus groups with Swords to Plowshares many expressed the need for peer-based emotional support. One participant stated, "Getting support from other military veterans definitely helps. We have something in common." One answer to this has been weekend retreats. In October 2008 several veteran nonprofits came together with the support of several VAs, Vet Centers, and active duty bases. This retreat was attended by OIF/OEF women veterans, reservists, and active duty. The overwhelming response from the 25 participants was how important it was for them to have a space to call their own. Being surrounded by their peers was integral for their healing; they heard and saw that they were not alone. This experience not only aided in their healing and transition process into the civilian world, but also functioned as a successful augmentation to the post-deployment process. In the words of one participant, "Thank you for recognizing this aching need for women veterans to meet and bond with other women veterans. Military service as a female . . . has been a very lonely and isolated experience, and I wish that I had been able to attend a workshop/retreat like this much earlier in my military career. Perhaps if such a support group/network had been established for me early on, I would not have struggled so much (or at least, not alone) through the dark valleys of depression and self-doubt that I traversed as a young female in the military."

The following are a list of recommendations for greater access to care for women veterans:

- Mandatory and routine training for VA clinicians on the specific issues facing women veterans.
- Resources available for VA providers to include: issues facing female combat veterans; military era specific information (i.e., OIF/OEF versus the Vietnam era); military terminology; the differences between Military Sexual Trauma and sexual trauma in a civilian setting; co-occurring combat and sexual trauma based PTSD, sometimes referred to as "The Double Whammy;" etc.
- Escorts at VA facilities for women veterans not comfortable going alone. This "battle buddy" system could be implemented at no cost to the VA through use of volunteers, the Chaplain Service, and veteran peers. This simple gesture could eliminate a huge barrier to care.
- Development of permanent women-only clinics at VA facilities, and improved signage at all VA facilities designating where the women's clinic is.
- Separate entrances or waiting areas that are safe and monitored.
- Childcare and extended clinic hours, at least for mental health. Some VA facilities do have extended hours, however this option needs to be universal regardless which community women veterans return to.
- More female only inpatient PTSD and MST programs. For veteran nonprofits providing these programs, greater collaboration between the VA and these entities needs to occur.
- Greater outreach concerning the eligibility for veterans with MST.
- Utilization of peer based approaches and the retreat model to supplement care received at the VA.
- More collaboration with community entities and the DOD to truly make transition seamless.
- VA to track rates of MST and subsequent early discharge from military service to provide evidence that rates of MST are a retention issue for the DOD.

ABOUT SWORDS TO PLOWSHARES

War causes wounds and suffering that last beyond the battlefield. Swords to Plowshares mission is to heal the wounds, to restore dignity, hope and self-sufficiency to all veterans in need, and to significantly reduce homelessness and poverty among veterans.

Founded in 1974, Swords to Plowshares is a community-based not-for-profit organization that provides counseling and case management, employment and training, housing and legal assistance to homeless and low-income veterans in the San Francisco Bay Area.

We promote and protect the rights of veterans through advocacy, public education, and partnerships with local, state and national entities. Over the years the name Swords to Plowshares has become synonymous with excellence in serving veterans

in need, a highly visible yet dramatically underserved population. We developed a model of coordinated care based on the philosophy that the many obstacles veterans face-including homelessness, unemployment and disability-are interrelated and require an integrated network of support.

Frontline Drop-In Center

Provides mental health services, including counseling for drug and alcohol problems and PTSD, as well as case management, income advocacy and referrals.

Supportive Housing

We offer permanent supportive housing combined with options for counseling, academic instruction and vocational training for 102 formerly homeless disabled veterans. Additionally, we provide transitional housing for 75 veterans at a time for intensive individual, group and peer counseling and a variety of recreational, cultural and community-building activities. Both housing programs provide daily hot meals to residents.

Employment Support

Swords to Plowshares helps veterans make the transition to gainful employment by offering vocational counseling, life-skills training, resume preparation and job referrals.

Legal Services

Many of our country's veterans never apply for or receive the benefits they deserve. Swords to Plowshares is one of the few organizations in the country that provides free attorney representation, case management and advocacy to indigent veterans seeking benefits.

The Iraq Veteran Project

Launched in 2005 to make sure systems of care are appropriate, sufficient and accessible to meet the needs of veterans returning from the wars in Iraq and Afghanistan, and the needs of their families as well.

Chairman AKAKA. Thank you, Ms. Christopher.

Now Ms. Chase.

STATEMENT OF GENEVIEVE CHASE, U.S. ARMY RESERVE VETERAN; EXECUTIVE DIRECTOR, AMERICAN WOMEN VETERANS

Ms. CHASE. Mr. Chairman and Members of the Subcommittee, thank you for inviting us to testify today.

My name is Genevieve Chase, and I am a Founder and Executive Director of American Women Veterans. On behalf of my peers, I would like to thank you for your commitment and dedication to serving the growing number of women veterans.

I am a veteran of combat operations in Afghanistan. While serving in the Army Reserve, I volunteered for a 32-month active-duty tour, which included deployment in support of Operation Enduring Freedom.

On April 7, 2006, our vehicle was attacked by a suicide vehicle-borne, improvised explosive device. The car that hit our truck nearly disintegrated. Although I suffered minor external injuries, the impact of that explosion has continued to this day, and I now know that we were not adequately informed of the services available to us after our service.

The Reserve soldiers I served with were discharged from active service with a 5-minute out-briefing. A single sheet of paper listing Web sites to access for VA health care and services. What I recall from that time was that being focused on overwhelming issues, like finding a job and figuring out how I was going to make it in a civilian world that had become somewhat foreign to me, not on service-related health issues I would face in the months to come or how

I would seek care for those issues. I was not and am not alone in this.

Weeks after returning home, I began to experience additional symptoms that I now know to be characteristic of Post Traumatic Stress and mild Traumatic Brain Injury, such as extreme guilt, anxiety, panic attacks, memory loss, hyperactivity, and bouts of deep depression, in addition to periods of consecutive days where I suffered exhaustion from insomnia and lacked the energy to leave my apartment or speak to anyone.

During the past 2 years, I have gone to the VA Web site repeatedly and called the VA to pursue an assessment and screening for TBI and other related issues. After attempting to navigate through the bureaucracy, I gave up, frustrated by an unclear Web site and unfriendly service on the other end of the phone.

I looked to the VA for help when I most needed it, but never succeeded in completing my enrollment, let alone actually receiving the care that I needed. In communicating with other veterans, I have found that I am hardly alone in this, as well.

While the VA struggles to catch up and provide adequate, gender-specific care to previous generations of women veterans, the total number of women veterans is projected to double in the next 10 years. It is vital that this Nation proactively and immediately address the broad spectrum of treatment needs for this significant increase in the women veteran population.

VA resources for women must expand to meet the growing number of combat-experienced women; and women dealing with PTS, military sexual trauma, and TBI must be able to find easily-accessible and concise information and guidance about these vital services when needed. Veterans should not need a third party to help them navigate the VA system.

AWV believes that women veterans of all generations are entitled to VA services that include women-only clinics, women providers, holistic care, extended service hours, offsite care, PTSD and MST peer support groups, and the availability of childcare during clinic visits. But even with all of these services, women must know they are eligible, they must be enrolled, and they must have access to the VA.

Despite the VA's efforts and claims of educating and reaching out to today's veterans, the message is not getting through. Even minor changes in the delivery of this message can have a huge impact.

As just one example, women veterans from all eras have expressed to me that they would prefer to receive immediate e-mail updates on VA benefits and services rather than periodic, automatic mailings, which do not always get forwarded through the postal system. AWV believes the best way to improve access to the VA is for servicemembers to be educated and enrolled into VA services while they are still on active-duty.

Briefings, workshops, and enrollment for VA benefits must be mandatory and should be conducted by knowledgeable representatives from the VA. Reaching out to all veterans prior to their discharge from active-duty would address several issues to include raising awareness and knowledge of eligibility for benefits and care; allowing continuity of care and eligibility from hospital to hospital; and offering immediate availability of physical and mental

health care when needed rather than after lengthy and unknown waiting periods.

Veterans getting the care they need when they need it can help prevent a number of extended issues which includes extreme depression, which contributes significantly to the risk of homelessness, substance abuse, and suicide.

In closing, our Nation's veterans from all eras answer this country's call to service, and the VA has the unique and rapidly-growing challenge of ensuring easily-accessible, quality services for women veterans across the spectrum from childbearing years to well beyond retirement.

On behalf of American Women Veterans, thank you for working to honor and repay the service of all veterans through this inclusive dialog, and we thank you for your commitment to ensure the quality and scope of physical and mental health care that today's American women veterans have earned by their service.

Ladies, gentlemen, and Mr. Chairman, I thank you for your time and consideration and welcome your questions.

[The prepared statement of Ms. Chase follows:]

PREPARED STATEMENT OF GENEVIEVE CHASE, U.S. ARMY RESERVE VETERAN, OPERATION ENDURING FREEDOM; FOUNDER AND EXECUTIVE DIRECTOR, AMERICAN WOMEN VETERANS

Mr. Chairman and members of the Subcommittee, Thank you for inviting us to testify today. My name is Genevieve Chase and I am the Founder and Executive Director of American Women Veterans (AWV). On behalf of my peers, I would like to thank you for your commitment and dedication to serving the growing number of women veterans.

I am a veteran of combat operations in Afghanistan. While serving in the Army Reserve, I volunteered for a 32-month active duty tour, which included a deployment in support of Operation Enduring Freedom. On April 7, 2006, our vehicle was attacked by a suicide vehicle-borne, improvised explosive device. The car that hit our truck nearly disintegrated. Although I suffered minor external injuries, the impact of that explosion has continued to this day and I now know that we were not adequately informed of the services available to us.

The reserve soldiers I served with were discharged from active service with a five-minute out-briefing and a single sheet of paper listing Web sites to access for VA services. What I recall from that time was being focused on overwhelming issues like finding a job and figuring out how I was going to make it in a civilian world that had become somewhat foreign to me—not on the service related health issues I would face in the months to come or how I would seek care for those issues.

Weeks after returning home, I began to experience additional symptoms that I now know to be characteristic of Post Traumatic Stress (PTS) and mild Traumatic Brain Injury (TBI), such as: extreme guilt, anxiety, panic attacks, and bouts of deep depression—in addition to periods of consecutive days where I suffered exhaustion from insomnia and lacked the energy to leave my apartment or speak to anyone.

During the past two years, I have gone to the VA Web site repeatedly and called the VA to pursue an assessment and screening for TBI and other related issues. After attempting to navigate through the bureaucracy, I gave up, frustrated by an unclear Web site and unfriendly service on the other end of the phone. I looked to the VA for help when I most needed it, but never succeeded in completing my enrollment, let alone actually receiving the care I needed. In communicating with other veterans, I have found that I am hardly alone in this.

While the VA struggles to catch up and provide adequate, gender specific care to previous generations of women veterans, the total number of women veterans is projected to double in the next 10 years. It is vital that this Nation proactively address—immediately—the broad spectrum of treatment needs for this significant increase in the women veterans population. VA resources for women must expand to meet the growing number of combat-experienced women; and women dealing with PTS, Military Sexual Trauma (MST) and TBI must be able to find easily-accessible and concise information and guidance about these vital services when needed. Veterans should not need a third party to help them navigate the VA system.

AWV believes that women veterans of all generations are entitled to VA services that include women-only clinics, women providers, holistic care, extended service hours, offsite care, PTSD and MST peer support groups, and availability of childcare during clinic visits. But even with all of these services; women must know they are eligible, must be enrolled and must have access to the VA.

Despite the VA's efforts and claims of educating and reaching out to today's new veterans, the message is not getting through. Even minor changes in the delivery of this message can have a huge impact. As just one example, many women veterans have expressed to me that they would prefer to receive immediate email updates on VA benefits and services rather than periodic automatic mailings which don't always get forwarded through the postal system.

AWV beleives the best way to improve access to the VA is for servicemembers to be educated and enrolled into VA services while they are still on active duty.

Briefings, workshops and enrollment for VA benefits must be mandatory, and should be conducted by knowledgeable representatives from the VA. Reaching out to all veterans prior to their discharge would address several issues to include:

- Raising awareness and knowledge of eligibility of benefits and care,
- Allowing continuity of care and eligibility from hospital to hospital, and
- Offering immediate availability of physical and mental health care when needed, rather than after lengthy and unknown waiting periods.

Veterans getting the care they need, when they need it, can help to prevent a number of extended issues to include extreme depression which contributes significantly to the risk of homelessness, substance abuse and suicide.

In closing, our Nation's veterans from all eras answered this country's call to service and the VA has the unique and rapidly growing challenge of ensuring easily accessible, quality services for women veterans across the spectrum, from child-bearing years to those well beyond retirement. On behalf of American Women Veterans, thank you for working to honor and repay the service of all veterans through this inclusive dialog, and we thank you for your commitment to ensure the quality and scope of physical and mental healthcare that today's women veterans have earned by their service.

Ladies, gentlemen and Mr. Chairman, I thank you for your time and consideration and welcome your questions.

Chairman AKAKA. Thank you very much, Ms. Chase.

Now we'll hear from Ms. Williams.

STATEMENT OF KAYLA M. WILLIAMS, U.S. ARMY VETERAN; BOARD MEMBER, GRACE AFTER FIRE

Ms. WILLIAMS. Mr. Chairman and Members of the Committee, thank you for hearing me speak today. On behalf of women veterans, I would like to thank you all for your commitment to meeting the changing needs of our Nation's veterans.

My name is Kayla Williams. I sit on the Board of Directors of Grace After Fire, a non-profit dedicated to helping women veterans.

As a soldier with the 101st Airborne Division, Air Assault, I took part in the initial invasion of Iraq in 2003, and was there for approximately 1 year. As an Arabic linguist, I went out on combat foot patrols with the infantry in Baghdad.

During the initial invasion, my team came under small arms fire. Later, in Mosul, we were mortared regularly. I served right alongside my male peers. With our flak vests on during missions, we were all truly Soldiers first.

However, it became clear upon our return that, as Senator Murray noted, most people do not understand what women in today's military experience. I was asked whether, as a woman, I was even allowed to carry a gun; and I was also asked whether I was in the infantry. This confusion about what role women play in war today extends beyond the general public. Even VA employees are still sometimes unclear on the nature of modern warfare, which presents challenges for women seeking care.

For example, since women are supposedly barred from combat, they may face challenges proving that their PTSD is service-connected. It is vital that all VA employees, particularly health care providers, fully understand that women do see combat in Operations Iraqi Freedom and Enduring Freedom, so that they can better serve women veterans.

Many of the other problems that women face when seeking health care through the VA are by no means exclusive to women. The transition from DOD to VA remains imperfect, despite efforts to improve the process—lost records and missing paperwork are frequent complaints. Despite a growing number of community clinics and Vet Centers, many veterans face lengthy travel times to reach a VA facility, which is a particular burden during these tough, economic times. Often, other barriers may disproportionately affect women.

For example, since women are more likely to be the primary caregivers of small children, they may require help in getting childcare to attend appointments at the VA. Currently, many VA facilities are not prepared to accommodate the presence of small children. Several friends have described having to change babies' diapers on the floors of VA facilities because the restrooms lacked even the most basic changing tables.

Another friend, whose babysitter canceled at the last minute, brought her infant and toddler to a VA appointment. The provider told her that it was not appropriate, and that if she could not find childcare, she should not even bother to come in.

Facilities in which to nurse and change babies, increased availability of telehealth or telemedicine, and/or childcare assistance, or at least patience with the presence of small children, would ease the burdens on all veterans with small children, especially women.

Women in the military are also far more likely to be married to other servicemembers. These women veterans must worry not only about their own readjustments to civilian life, but also the challenges their husbands may be facing. The VA must consider the dual role that women veterans may be balancing as both givers and seekers of care.

My husband, for example, sustained a penetrating Traumatic Brain Injury in Iraq, and was medically retired from the military. This impacted my decision not to reenlist because he needed assistance that he simply was not getting. It was years before I realized that, as both a caregiver and a veteran, I needed to not simply suck it up and drive on as the military taught, but rather had to reach out for help and support.

When struggling to cope with invisible wounds of war, such as PTSD or in simply facing challenges readjusting post-combat, peer support can be vital. However, there are things about women's experiences in war zones that our male peers simply do not understand.

They cannot truly know what it is like to fear not only the enemy, but also sexual assault from your brothers in arms. They may be aware of, but not fully able to empathize with the challenges of facing regular sexual harassment, and they certainly do not understand what it is like to feel invisible as a veteran, as many women veterans do. It is, therefore, vital that the VA provide

times and/or places where women veterans—especially those who may have experienced military sexual trauma—can feel safe and comfortable in seeking help in a community of their peers. These are all challenges that I am confident every VA hospital can meet and overcome.

In 2006, I went to the VA Medical Center in Washington, DC. My visit was uncoordinated, stressful, and confusing. The facility did not smell clean and was crowded with veterans who seemed to have poorly-managed mental health concerns. I was not given clear information about what services were available to me.

My husband also went to that VA in 2006. He was regularly told that he was at the wrong clinic and sent from one office to the other. Doctors gave him the impression that he and his issues were an inconvenience at best. My husband's inability to schedule timely, well-coordinated appointments eventually made him give up on getting care from the VA at all.

We both began relying exclusively on TRICARE for all of our medical and mental health needs, even though civilian providers we see are less familiar with combat injuries and Post Traumatic Stress.

My visit to the VA Medical Center in Martinsburg, West Virginia, last month, however, was a stark contrast to both my previous experience and the experiences that I have heard about from other women veterans at some facilities.

There was a women's restroom clearly visible in the lobby. It was clean. There was a changing table available. I was treated as a veteran at all times, asked about my combat experiences, and sensitively asked if I had experienced sexual harassment or assault in the military. Providers carefully coordinated my visit, ensured that I was aware of all available resources, and followed-up promptly and thoroughly.

Their OEF/OIF integrated care clinic and newly-opened women's clinic are models worthy of emulation, and I truly believe that with continued advocacy and oversight, all VA facilities can provide that same standard of care.

In order to best meet the needs of all veterans, I also urge the development of enhanced relationships not only between the DOD and VA, but also with those community organizations that are ready and willing to fill gaps in services. Public-private partnerships can allow all of us to come together to meet the needs of our veterans in innovative and exciting ways. I strongly urge that all legislators support S. 597, which will help better meet the needs of women veterans.

Thank you all so much for working to assess VA's health care services for women veterans and for your efforts to improve care for all of our Nation's veterans.

[The prepared statement of Ms. Williams follows:]

PREPARED STATEMENT OF KAYLA M. WILLIAMS, AUTHOR: LOVE MY RIFLE MORE THAN YOU: YOUNG AND FEMALE IN THE U.S. ARMY; BOARD OF DIRECTORS, GRACE AFTER FIRE; SENIOR ADVISER, VOTEVETS.ORG

Mr. Chairman and Members of the Committee, thank you for hearing me speak today. On behalf of women veterans, I would like to thank you all for your commitment to meeting the changing needs of our Nation's veterans.

My name is Kayla Williams. As a Soldier with the 101st Airborne Division (Air Assault), I took part in the initial invasion of Iraq in 2003, and was there for approximately one year. As an Arabic linguist, I went on combat foot patrols with the Infantry in Baghdad. During the initial invasion, my team came under small arms fire. Later, in Mosul, we were mortared regularly. I served right alongside my male peers: with our flak vests on during missions, we were all truly Soldiers first.

However, it became was clear upon our return that most people did not understand what women in today's military experience. I was asked whether as a woman I was allowed to carry a gun, and was also asked if I was in the Infantry. This confusion about what role women play in war today extends beyond the general public; even Veterans Affairs (VA) employees are still sometimes unclear on the nature of modern warfare, which presents challenges for women seeking care. For example, being in combat is linked to Post Traumatic Stress Disorder (PTSD), but since women are supposedly barred from combat, they may face challenges proving that their PTSD is service-connected. One of my closest friends was told by a VA doctor that she could not possibly have PTSD for just this reason: he did not believe that she, as a woman, could have been in combat. It is vital that all VA employees, particularly health care providers, fully understand that women do see combat in Operations Iraqi Freedom and Enduring Freedom so that they can better serve women veterans.

Many of the other problems that women face when seeking to get health care through the VA are by no means exclusive to women: the transition from DOD to VA remains imperfect, despite efforts to improve the process. Lost records and missing paperwork are frequent complaints. A woman I know who spent over twenty years in the Army Reserves was turned away from her local VA hospital because she never deployed to a combat zone; her paperwork was never even examined to determine if she is indeed eligible for care. Despite a growing number of community clinics and Vet Centers, many veterans face lengthy travel times to reach a VA facility—a particular burden during tough economic times.

Other barriers may disproportionately affect women. For example, since women are more likely to be the primary caregivers of small children, they may require help getting childcare in order to attend appointments at the VA. Currently, many VA facilities are not prepared to accommodate the presence of children; several friends have described having to change babies' diapers on the floors of VA hospitals because the restrooms lacked changing facilities. Another friend, whose babysitter canceled at the last minute, brought her infant and toddler to a VA appointment; the provider told her that was "not appropriate" and that she should not come in if she could not find childcare. Facilities in which to nurse and change babies, as well as childcare assistance or at least patience with the presence of small children, would ease burdens on all veterans with small children.

Women in the military are also far more likely to be married to other servicemembers; throughout the Department of Defense (DOD), 51.3% of married female enlisted active duty personnel reported being in dual-service marriages, compared to only 8.1% of their male counterparts.[1] These women veterans must worry not only about their own readjustments, but also their husbands' challenges. The VA must consider the dual role women veterans may be balancing as both givers and seekers of care. My husband sustained a penetrating Traumatic Brain Injury (TBI) in Iraq and was medically retired from the military. This impacted my decision not to reenlist, because he needed assistance that he simply was not getting. In addition, I was so focused on his recovery that I barely considered my own needs. It was years before I realized that as both a caregiver and a veteran I needed to not simply "suck it up and drive on," as the Army taught, but rather had to reach out for help and support.

When struggling to cope with invisible wounds of war such as PTSD, or when simply facing challenges readjusting post-combat, peer support can be vital. However, there are things about my experience as a woman in a war zone that my male peers do not understand. They cannot truly know what it is like to fear not only the enemy, but also sexual assault from your brothers in arms. They may be aware of, but not be able to fully empathize with, the challenges of facing regular sexual harassment. And they certainly do not understand what it is like to feel invisible as a veteran, as many women veterans do. It is therefore vital that the VA provide times or places where women veterans, especially those who may have experienced military sexual trauma, can feel safe and comfortable seeking help in a community of their peers.

[1] "Population Representation in the Military Services," Table 3.7, FY2004, available at: http://www.defenselink.mil/prhome/poprep2004/enlisted—force/marital—status.html

These are all challenges that I am confident every VA hospital can meet and overcome. In 2006, I went to the VA Medical Center in Washington, DC. My visit was uncoordinated, stressful, and confusing. The facility did not smell clean and was crowded with veterans who seemed to have poorly managed mental health concerns. I was not given clear information about what services were available to me. My husband also went to that VA in 2006; he was regularly told that he was in the "wrong clinic" and sent back and forth between multiple offices. Doctors gave him the impression that he and his issues were an inconvenience at best. My husband's inability to schedule timely appointments that fit in with his schedule eventually made him give up on getting care from the VA at all. We both began relying exclusively on TRICARE for all our medical and mental health needs, even though the civilian providers we saw were less familiar with combat injuries and post-traumatic stress.

My visit to the VA medical center in Martinsburg, West Virginia in June 2008, however, was a stark contrast to my own previous experience and the stories I have heard from veterans about some other facilities. There was a women's restroom clearly visible in the lobby; it had a changing table. I was treated as a veteran at all times, asked about my combat experiences, and sensitively asked if I had experienced sexual harassment or assault in the military. Providers carefully coordinated my visit, ensured that I was aware of all available resources, and followed up both promptly and thoroughly. Their OEF/OIF Integrated Care Clinic and newly-opened Women's Clinic are models worthy of emulation, and I truly believe that with continued advocacy and oversight, all facilities can provide the same standard of care.

In order to best meet the needs of all veterans, I also urge the development of enhanced relationships not only between the DOD and VA but also with those community organizations that are ready and willing to fill gaps in services. Public-private partnerships can allow all of us to come together to meet the needs of our veterans in innovative and exciting ways.

Thank you for working to assess the VA's health care services for women veterans, and for your efforts to improve care for all our Nation's veterans.

Chairman AKAKA. Thank you very much, Ms. Williams.

Ms. Olds?

STATEMENT OF JENNIFER OLDS, U.S. ARMY VETERAN ON BEHALF OF VETERANS OF FOREIGN WARS

Ms. OLDS. Mr. Chairman and Members of the Committee, I would like to thank you and the VFW for the opportunity to testify today.

My name is Jennifer Olds, and I served in the U.S. Army during the first Gulf War from 1990 to 1992.

During my time in the military, I experienced multiple incidences of military sexual trauma. As a result of my experiences in the military, I suffer from severe and chronic PTSD.

Some of the health conditions that resulted from that severe and chronic PTSD involved both physiological and psychological effects. Some common psychological effects that have been stated before are flashbacks, nightmares, insomnia, distrust of society, constant fear, depression, and becoming suicidal. I also suffered from physical ailments because of the PTSD, which include things like nervous issues, anxiety attacks, panic disorders, dizzy spells, ulcers, and I had shingles twice in my 20s.

As I look back over the treatment that I have received from the VA, I find a list of things that I think has comprehensively helped me to recover to the place that I am today, which is significantly much better than I was 15 years ago. Among this list include the availability of counseling from the Vet Centers in the Portland, Oregon, VA; and, also, being assigned a psychiatric nurse practitioner who tried to provide medications to help me with sleeping because getting sleep can help improve your ability to handle all the other effects of PTSD.

Eventually, about 10 years after my initial start in the VA system, I finally allowed them to provide anti-anxiety medications, which, in combination with other things, seemed to help me improve quite a bit.

One of the things I believe that had a severe impact on turning my life around was my admittance into the vocational rehabilitation program. That gave me a reason to stop being suicidal or at least to start fighting my suicidal ideations and allowed me to look forward to my future.

Not long after, a few years later, I was given the opportunity to participate in some PTSD research. It was a research study at the VA comparing cognitive studies—cognitive therapy—against exposure therapy. I was randomized into the exposure therapy program and participated in it. It was a 10-week, intense, grueling program that asked me to recollect and discuss a traumatic event.

So, it is not a program that is easy for people to get through, but, if you can, and you are like me, you benefit significantly.

As I also look back, I realize the importance of having holistic care. Because I suffered not only psychological issues, but physical issues, being able to get the support from both sides of the coin was very helpful, as well.

Finally, and I think most importantly, as we look at providing care for vets or women vets in particular—with the kinds of backgrounds that we tend to have, I think with PTSD and military sexual trauma—having very patient, understanding, good-fit providers is key. If we have someone that we are unhappy with or we feel does not understand us, we are not going to go. So, finding people that have the patience and endurance to stick with us until we are able to sort of work for ourselves, I think, is very important.

As I look forward to the future for things that I think would be helpful for the VA system to implement, the first thing that comes to my mind is location.

I spent an hour-and-one-half driving each way to my counseling appointments, not to mention the amount of time I spent in my counseling appointments, and those combined ended up being at least 4 hours per day, 3–5 days per week. That does not bode well for working.

Also, as I think back on my original discharge, I, again, was not given any information. I had no idea that there was stuff available for me; and really, there was not, as I look back for PTSD and women specifically.

But I had gotten so suicidal that I sought my own care from a private institution where I utilized my own private insurance. That only covered 2 weeks at the most. It only covers a portion of that amount, so, my family had to take on the burden of the additional costs. So, my point of this is: getting acceptance right into the VA system immediately is important.

I also think that we need to think about women veterans as individuals. I do not think there is a one-size-fits-all. I have listed a number of things that I felt were extremely beneficial to me, but there were other options that came up that were available to me that I did not take advantage of because they were not good fits for me.

An example of this is a counselor that tried to provide EMDR, another type of therapy for PTSD. While it has been proven to be very effective, it was not a type of therapy that I felt was fitting for me at the time.

So, being able to look at the individual and examine what they themself need, then providing a variety of options to pick from, I think, is important, as well.

One of the other things I think that we need to provide is education for everyone—for providers, for women vets, and for the public—on what the VA can offer and how the VA provides care for the women, sort of an around the world picture for everyone.

As I have looked at the care that has been offered for women vets, I have come up with a conclusion like what some of the other people have said. I believe that if we have some of what I call "information sessions" for women or "for vets by vets" sessions in helping them understand how to navigate the system and to move forward with the different kinds of options, which is important, as well. If I had had that, I may have started some things earlier in my treatment plan. And I would be one to volunteer to do that for other vets because I feel it is important to help others get their life back sooner than some of us have.

And, finally, I think we need to reduce the stigma that the VA has in the system in general. While I go out and speak positively about my experiences from the VA—because I have had numerous, wonderful experiences from the Portland, Oregon, VA—there are other people who do not, and we need to reduce the amount of incidences like this that prevent the VA system from getting the good reputation that it can deserve.

I understand there are differences from VA to VA, but, in general, reducing that stigma, I think, will help encourage vets to use the system.

So, Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or the other Members of the Committee may have. Thank you for your time.

[The prepared statement of Ms. Olds follows:]

PREPARED STATEMENT OF JENNIFER OLDS, B.S., M.B.A., U.S. ARMY VETERAN ON BEHALF OF VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee: I would like to thank you and the Veterans of Foreign Wars of the United States (VFW) for the opportunity to testify today.

My name is Jennifer Olds, B.S., M.B.A., and I am from Forest Grove, Oregon. When I enlisted at 18 years old, I was voraciously positive about what life could offer and had much to look forward to. I was college oriented in high school taking college prep classes like physics, chemistry, college writing, etc., as well as athletic, engaged to be married and strong in my faith. I served on active duty in the U.S. Army during the first Gulf War, from 1990–1992. While in the Army I was exposed to Military Sexual Assault situations numerous times, either trying to protect myself, or the other female soldiers around me. This was my own "battle field." Once discharged, I became increasingly aware of my new symptoms of PTSD.

Some examples of my PTSD involved the following:

1) While I was driving, I was constantly in belief that someone was out to harm me, constantly watching to see who was following me home, driving out of the way to make sure no one was following me, thus experienced intense fear and anxiety attacks while driving,

2) While at restaurants I needed to sit in the corner, or against the wall and would be on constant guard evaluating who was out to harm me or my family. If one of them needed to run to the bathroom I would be extremely on edge until their

return. If anyone asked me what was discussed during dinner at the restaurant, I couldn't tell you since I was so busy paying attention to the potential bad guys around us.

3) I was no longer engaged upon my return from the military and had not dated for over 10-years since my discharge. Finally, When in my home I had to have every curtain closed, window and door locked, and was constantly freaked out about who was driving by or walking by because I truly believed they were scouting me out and would eventually be back to harm me.

After a year of continued daily battles with insomnia, nightmares, flashbacks, anxiety attacks, depression, with situations described in the previous paragraph, it became clear to me that this way of living was something I no longer wished to deal with. I no longer felt that life would be worth living if that is all I had to look forward to. I became extremely depressed and suicidal, and had no knowledge of how to help myself.

When I became suicidal I met with my family and asked them for help, since I had no idea what needed to be done and frankly was in no position to help myself. They suggested I enter a program at a hospital facility where I was admitted but the insurance coverage ran out within two weeks and I was discharged owing thousands of dollars to them, which my family had to take on. Within a week or so, I was desperate for help, as I knew I was still suicidal and finally was admitted to the Portland VAMC where again I was discharged within two weeks. I was told I didn't belong there and that staying any longer would force them to send me to the Salem "crazy ward," a place I was sure would ruin my future. Again I was sent home with nowhere to go or seemingly any help.

Fortunately I was assigned a psychiatric NP who patiently saw me over the next several years with little improvement from me. You see, our visits went something like this, I would be unable to continue a stream of thought, as the anxiety increased and I would become blank and unable to figure out my thoughts or feelings. This made the process very difficult, but so did making the appointments given the stigma. I didn't want others to know about, or me to actually realize about myself.

I met with a representative of Paralyzed Veterans of America (PVA) who asked the right questions and helped me realize and seek help from the VA for the treatment of PTSD. Initially, I was sent to the Vet Center that was located over an hour drive away from my home. Eventually that therapist moved on, and I was assigned a new one who wanted to do EMDR. I was in no position to do EMDR and told the new therapist this many times and it seemed an endless conversation so I stopped going altogether. At this point I only maintained a working relationship with my Psychiatric NP who had the strength of a horse with enduring patience with my slow progress.

Over the course of my treatment with the VA, I was given the opportunity to go to college under the VOC REHAB program, which was a turning point for me. This opportunity inspired me to want to live, and to fight the constant suicidal ideations. Getting over this hurdle took time, but college was certainly one of the many steps that have eventually given me some solace on life. By the time I was finishing up my undergraduate degree, a serious life event forced me to begin looking at old trauma wounds and I began to focus efforts with my NP. Eventually, after a few more years in treatment, my fabulous NP suggested I participate in the research study comparing cognitive therapy with exposure-based therapy. I said I would, because I wanted my life back, that is, the voracity and charge to live life and be happy.

I participated in this grueling 10-week program that asked me to repeatedly discuss one of my traumatic events. I had intense anxiety attacks, dizzy spells, nausea, etc., while I was undergoing this therapy. It was not long after the completion of this treatment, that my family and friends became aware of the changes I was making, little known to me at the time. Eventually I came to see that I now could partake in conversations with others and actually hear what they were talking about and know what was going on in their lives. Within a few years I was dating again after quite some time. I have decreased nightmares, no longer watch who's following or walking by my house, and even enjoy a night full of sleep more often. I am extremely delighted with the caregivers at the Portland VA and think if not for them, I would not be where I am today.

To say I had PTSD should not be summarized by mental capacities only. I made several visits to the doctors for dizzy spells, chest pains, skin issues, nervous ticks, ulcers, stomach/bowel issues and the shingles x2, all while in my 20's. Most of the time these things were "undiagnosable," but I have come to realize over the last 15 years that much of these were stress related. That is, I believe PTSD caused not only mental issues, but numerous physical issues as well. A person, like me, can

become overwhelmed with the array of issues one can experience simply from PTSD, and become quite discouraged on how to tackle it all.

I have a few suggestions on how I think we can encourage others to get help and improve their PTSD symptoms:

1) encourage support groups and speakers from others like themselves who have actually improved from PTSD.

2) Provide them with names of providers who have enormous patience.

3) Provide holistic approaches, and specific focused treatment: I truly believe that one size does not fit all.

For example, Eye Movement Desensitization and Reprocessing Therapy (EMDR) is a comprehensive, integrative psychotherapy approach often used for MST. Although I did not feel comfortable with this type of treatment, it may work for some and exposure-based therapy may work for others, or perhaps medications in addition or on their own may also be the best way.

Today I am able to do things that I have not been able to do in a long time, and I also find myself void of other previous behaviors, which were not positively affecting my life. All these changes are not only very encouraging, but seem to continue to yield way to yet more and more "platforms" on which to continue with more positive changes. I have seen these abilities and actions of change as extremely exciting and very positive, and so have my family and friends who have known the struggles I have had to deal with since my time in the Army. My life is continuing to improve.

I have watched PVA make significant changes that have improved the care to all veterans and am extremely pleased with my care. This process of dealing with PTSD has been a learning experience for me as well as many at the VA.

Mr. Chairman this concludes my statement, I would be happy to answer any questions you or the other Members of the Committee may have.

Chairman AKAKA. Thank you very much, Ms. Olds, for your testimony, and all of you here.

Several of you mentioned the importance of VA providers to understand and acknowledge that women can experience combat while serving in the military.

How would you recommend VA and women veterans educate their providers about this in order to help them provide better care for women veterans?

Ms. CHASE. Senator, I think——

Chairman AKAKA. Ms. Chase?

Ms. CHASE [continuing]. In terms of recognizing combat and raising awareness about that, there are several military occupational specialties within the Army and across the services that have women who are engaging in activities outside of the wire. Some of these include our intelligence teams, our medics, our truck drivers, our civil affair soldiers, our military police, and even sometimes our finance and supply sergeants and NCOs, and officers.

I think the best way to get people to understand and to pay attention is to connect the two. I think if we could provide or somehow get together statements and maybe even personal testimony or a team of people that address the Veterans Affairs directly—to some of these service providers and some of these clinics in their local areas—and say, "I am a real person and I am standing in front of you to tell you that I served in combat, and I need you to hear me." I think that would be more impactful than anything else that we could give them on a memo or an e-mail.

Chairman AKAKA. Yes, Ms. Williams?

Ms. WILLIAMS. Another option that may help people understand a little more viscerally would be to have viewings of the Lioness documentary about women serving in combat available at VA facilities perhaps over lunch hour or in some way that providers would have a chance to watch it.

Chairman AKAKA. Ms. Ilem?

Ms. ILEM. I would just note that I think the Lioness documentary probably most exemplifies a great opportunity for them to really see and hear female veterans in their own voices. Either that or other short videos that VA has done on a number of issues related to TBI and OEF/OIF population and mental heath issues—reintegration issues. A video on women veterans specifically would be an excellent opportunity for providers to see something short, and told in women veterans' own words for them to be able to connect.

Ms. CHASE. And, Senator, I would like——

Chairman AKAKA. Ms. Chase?

Ms. CHASE [continuing]. To caveat that. Sorry.

The Lioness documentary is a phenomenal and fantastic documentary. However, it is specifically about a particular team of women called the Lionesses who were embedded with combat teams and infantry teams. We also need to recognize and make sure that they are aware that there are very many jobs out there—there are a lot of women every day on different jobs in different capacities, in different branches of service—that are serving outside the wire in combat every day, and not just that one specific team specific to that movie or documentary.

Ms. CHRISTOPHER. Mr. Chairman?

Chairman AKAKA. Ms. Christopher?

Ms. CHRISTOPHER. I agree with the fellow panelists on what they're suggesting. The one thing that I would like to note though, to be quite frank, is trainings can be very boring. I mean, whether you are watching a PowerPoint or a video or listening to someone talk, I mean, I think that in order for it to be truly effective, there needs to be dialog, and it needs to be interactive.

And I think there should be a Q and A portion. When we do our trainings through Swords to Plowshares, we open ourselves up for questions. We actually refer to it as "an uncomfortable questions panel," and we encourage the clinicians to ask us—to clarify MOSs and military terminology—and to ask us our opinion on treatment that has worked for us and that has not; and we make it extremely candid, and I think that it has helped immensely. The feedback has been so positive.

So, I just definitely stress the interactive component for a successful training.

Chairman AKAKA. Thank you.

We will have a second round of questions. So, let me call on Senator Murray for her questions.

Senator MURRAY. Thank you very much, Mr. Chairman.

First of all, thank you all for your service to the country. I really appreciate what all of you have done, and going beyond the service now to come and talk with us about the important issue that we are discussing today. I just want to reiterate that I really do appreciate that.

While it is the official policy of the military that women can not serve in combat, many of you talked about your experiences, whether it is Traumatic Stress Syndrome, being close to IED explosions, or being injured.

Given the fact that women are serving in combat roles, have you found that this combat experience is reflected in DD–214ss?

Ms. WILLIAMS. My own certainly was reflected on my DD–214s. It shows that I was awarded the service medal for my time in Operation Iraqi Freedom; and, also, if it ever were to become a question, I also received Army medals and the paperwork that support those details of what experiences they were earned for, which is another way people can show their experience. But I know that is not universally the case. I was just lucky enough that that was true for me.

Senator MURRAY. How about others of you?

Ms. Chase?

Ms. CHASE. When we get our DD–214ss, it states in there whether or not you served and in what theater, and it also states your job. I was also awarded the combat action badge. However, that is not an automatic award. It's not an automatic entitlement. It is something that is submitted by your chain of command, and if it is not submitted or the paperwork gets lost or it does not go through, then you do not have that, as well.

And it also is not a qualifier. A lot of people do not perceive it to mean that you were actually in combat or directly engaging the enemy. So, that policy needs to be changed or reworded to reflect that women are, in fact, serving in combat and they are, in fact, on missions outside of the wire. Regardless of whether or not they are going outside the wire and they are inside an FOB or a PRT, when you have mortars that are incoming daily and you have no idea where they are coming from, that is combat; and the perception, I think, needs to be changed. I think the perception would be helped if the wording in the policy was changed, as well.

Senator MURRAY. Ms. Williams, you mentioned that you were both a caregiver and a care seeker. Your husband was in the military. I assume that it is fairly common for a woman to be married to a fellow military officer and be in the same position.

What can be done to help us better care for women veterans who are not only dealing with their own readjustment issues, but are dealing with spouse or children, as well?

Ms. WILLIAMS. You are right, the percentages are very high. I think that it is important that care be more comprehensive. Among active-duty, enlisted, married, female servicemembers, over 50 percent are married to other servicemembers, compared to only 8 percent of their male peers. My husband and I were both enlisted.

I know the VA is trying very hard to do outreach. I once got a call, for example, asking if I had sustained a Traumatic Brain Injury as part of their outreach effort to make sure that they are catching everybody. And I said, no, I did not; but I am glad you called because my husband did and our family is in shambles right now. I do not know how to hold myself together and my family together and keep my job, and I am struggling really hard here. And he said, well, I cannot really help you with that; I am calling to ask if you have suffered a brain injury.

And that is the way that I think we can try to make sure that we are addressing entire family needs. If you have a servicemember who has sustained an injury making sure that their family is being taken care of both while they are in the DOD and once they have transitioned to VA care, is an important step.

I know the VA does not cover care for family members, but if they learn that the spouse is also a veteran, it is important that they take an extra step, reach out and contact them proactively, and ask if they need help as a caregiver. Of course, this does apply to both male and female spouses; its just that the number of female spouses giving care is much higher.

Senator MURRAY. I hear a lot from women about the access of childcare being a barrier to go to the VA. Several of you mentioned this in your testimony, and I do not think a lot of people realize that if you tell a woman that there is no childcare, they just simply do not go. That is it. They do not get their health care.

For all of the panelists, do you think that the VA providing childcare services would increase the number of women who go to the VA and get the care that they need?

Ms. ILEM. I would say definitely. I think researchers have repeatedly shown this as a barrier for women veterans, and that is the frustration. How many research surveys do you have to do when women keep repeatedly saying this is a barrier for them to access care? And I think it was Kayla who mentioned an experience of someone who was told it is inappropriate for them to bring their child with them. At some of these very personalized appointments for mental health or other things, it may be very difficult, but they have no other choice.

So, I think it would definitely be a benefit and we would see an increase in the number of women veterans who would probably come to VA.

Senator MURRAY. Ms. Williams?

Ms. WILLIAMS. I definitely think that user traits of the VA would increase if women knew that they had childcare available. There are a variety of innovative ways that we could try to address the problem of women having to balance their needs for childcare with their needs to get services. Among them would be increasing the availability of telehealth or telemedicine, where women do not have to necessarily go all the way to a remote facility, spending 4 hours trying to get to and from and then be in care.

There are also opportunities for innovative programs.

For example, the VA has small business loans available. If they could provide loans to women veterans who want to provide childcare at facilities near VA facilities, that would be a great way to try to marry these two needs.

There are also a lot of community organizations that stand ready and waiting to help that would be happy just given a small office to staff it with volunteers and be able to help provide that care for the time that a women has to be in an appointment.

And I think as many others have said, the specific solutions may vary by location, but there are a lot of innovative ways that we could forge public-private partnerships to try to meet these needs.

Senator MURRAY. OK. Excellent.

Mr. Chairman, I have gone way over my time. I need to get to another committee for mark-up, but I love the video idea of showing the Lioness documentary at VA facilities. I think it, at the very least, opens peoples' eyes to the fact that women have served in very important roles and will maybe open that little door in their head to think oh, wow, women really have served our country in

amazing ways and they do need the care and the respect and the services that they have earned.

I would love to see another documentary about all the other things that women have done and start helping people everywhere really recognize the important service that women are providing.

So, I thank all of you. And, Mr. Chairman, thank you so much for having this hearing today.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator Begich?

Senator BEGICH. Thank you very much, Mr. Chairman.

Like Senator Murray, at around 11:30, I am going to have to depart for a meeting. This is a very interesting panel, and I want to thank you for your service, and also for your insight in the day-to-day utilization of the VA services and what can be done. I have a couple of questions.

I am going to look through my notes here and try to reread my handwriting, as each one of you were speaking, and I am going to make a couple of comments. It is not necessary for you to respond.

I am kind of looking to Dr. Hayes. If you could follow-up with at least me and if the Committee so desires on a couple of things—one being the childcare issue.

I remember a circumstance in Anchorage, Alaska. My wife and I had our first child, who was 1 year old when I got elected. In my office we had at least a crib in there at any given time and there were probably toys scattered throughout. I can remember a colonel from the Army coming over and introducing himself to me with his spouse and their 2-year-old, who also came into my office; and I think because I created an environment that showed it was OK, it made a big difference. I would not ever imagine that 5 years ago a colonel from the Army would bring his 2-year-old to the mayor of the city where they were being stationed. That would never probably have happened, but we created an environment for that.

So, you had mentioned the childcare, each one of you, as critical.

The question I would have, Dr. Hayes, you had mentioned legal counsel may have some issues with this. I would like to get whatever they write up, if they do, on childcare. I would like to see that because the one thing I know about attorneys—and, no offense, I am not one—but they will always tell you why something cannot happen versus why something should happen. And, so, if you approach them in a way that when they give you the answer why it cannot happen, which is probably the likelihood, can you ask them what can change to make it happen?

That is what I think many of us are talking about or are going to be interested in because I agree with you, if the facility does not have childcare—facilities for both women and men—it is a problem. And, so, if you could do that, that would be fantastic.

A couple of you mentioned training and successful training, and I agree with you, it is "boring." The trainings I have had to go to when they are not interactive are boring.

I'll look to you first, Ms. Christopher.

In your interactions, how do the clinic folks come to you? In other words, do they volunteer to come to your training? What happens? How does that work? Does the VA require it? I would say no to

that, but it is a set up question. But how does it work? How do you get folks to participate from the clinical side, the professionals?

Ms. CHRISTOPHER. Honestly, we have been very lucky. Actually, the DOD liaison to the Palo Alto Polytrauma Center actually invited me and my colleagues to join the National Center PTSD Clinical Training Program. He actually cut his time in half to develop a community panel because he thought it was important. And, honestly, I found that the DOD liaisons have been extremely instrumental in bridging the gap between the VA and the community, which I think is fantastic.

When it comes to the VA clinician trainings that we have done, honestly, we have approached them and we have gotten really good feedback, and I think in the Bay Area, there is some really good dialog. But, no, we——

Senator BEGICH. No outcome yet?

Ms. CHRISTOPHER. To suggest it.

Senator BEGICH. OK. Do you have something, again, you could share at least with me in any written document that is specifying what you would like to propose to the VA?

For example, we did this with community police training in Anchorage when we saw an opportunity because we had a lack of understanding within our police department in regards to the cultural diversity of our city. We have 90-plus languages spoken in our school district—a very diverse community—so, we integrated that into our training. We kind of forced it at first because it was a structure, and police are paramilitary, so they have similar structures, procedures, and processes; and change is not necessarily high on the list.

I would be interested in, Ms. Christopher—and I think it was Ms. Williams who also talked about training—any of you that have some suggestions of how to then have a discussion with the VA on how they can make that a little better. I would be very interested in that, if you could.

Ms. CHRISTOPHER. Yes, Senator.

Senator BEGICH. And whoever else would be willing to do that.

In connection to that, again, I am going to kind of veer through you to Dr. Hayes.

I would be very interested if the VA actually surveys their clients for results of VA clinics because—I am just guessing—even though in theory they are all same, they operate differently.

The example you gave, Ms. Williams, was your positive experience in the last clinic you had gone to. It was very positive and there are some good things that occurred there. But that varies clinic to clinic. I would be curious if, Dr. Hayes, you could provide that. Ms. Williams, if you could tell me again where that was. I did not write it down quick enough. The one you had a very good experience in.

Ms. WILLIAMS. Yes, sir. I have had negative experiences at the DC VA. And, just on my way here this morning, I shared with a woman in uniform that I was coming here, and she said she is in the process of retiring. She just went to the DC VA, and had the same experience that I did. She said that it seemed unclean to her and very disorganized, and there were people there clearly struggling to cope. It can be nerve-racking when you are seeking care

to worry that that is your future. So I said, go to the one in Martinsburg, West Virginia.

We live out near Dulles airport, and from there, it takes just as long to get into D.C. as it does to go all the way out to West Virginia based on the lovely traffic we all face. And the Martinsburg facility is doing great.

There are obviously areas that they could improve on, as well. They are undergoing construction. So, currently, the OEF/OIF clinic is collocated with the mental health outpatient clinic, which at first I found a little off-putting, but when they said that was because of the ongoing construction to improve the facility, I thought that was great and it is really a wonderful model.

Senator BEGICH. That is great. Thanks for telling me which clinic that was which helps me get a little better understanding.

The last think I will just mention, triggered by the discussion of telemedicine, that Alaska, because of our ruralness and remoteness, telemedicine is a very powerful tool, and it is very valuable in a lot of ways. So, I know we have had very positive comments and conversations with the VA about telemedicine and their interest in expanding that.

I know from my State, it is a critical path to delivery because we do not have a VA hospital, for one. We have clinics. And then, in remote areas, we have nothing. And it is very difficult because there are no roads to get from one place to the next. So, I appreciate your comments on telemedicine from another perspective. You know, I see it from a rural perspective. I appreciate your comments from women veterans' perspective, is another access point that is a positive one. So thank you for that.

Mr. Chairman, I will end there. It is a very enlightening panel in a lot of ways because of your direct contact, utilization, and work with other folks. So, thank you very much for this insight.

Chairman AKAKA. Thank you very much, Senator Begich.

Hearing what has gone on here, I just want to inform everyone that the Committee's legislation S. 252 has provisions making childcare more available by using an existing childcare program and providing reimbursement to those getting care. So, that is in that bill and this is something, of course, as we have discussed, that certainly can be used here with helping all women.

One of my major goals is to create a seamless transition for servicemembers as they leave the military and become veterans.

As women veterans, what do you perceive as a major gap in this transition process, and how would you recommend we fix it?

Ms. Williams?

Ms. WILLIAMS. Sir, I think one thing that will go a long way toward fixing some of the problems—and it is my understanding it is at least in the trial process now in some locations—would be electronic medical records.

Having to hand-carry your own medical records when you leave the DOD system and take them to the VA system, and the fear that some piece of paper will get lost—a vital piece of paper proving what has happened to you in the past—is very difficult and stressful, and may be even more of a challenge for veterans who may have sustained a Traumatic Brain Injury or be struggling with mental health concerns. So, I think that the implementation of uni-

versal electronic medical records will go a long way toward fixing that problem.

Also, there can be big challenges in terms of benefits.

When my husband was medically retired from the military, there was a gap between that time and when he started getting his VA benefits. During that time, we were so financially insecure that both of us ended up going on unemployment, which was a deeply humiliating experience for two proud and honorable combat veterans—to be reduced to that while we were waiting for his VA benefits to start coming in, and I was waiting for my job to get started.

So, trying anything that can help smooth and ease that transition would help. I think efforts to get VA exams done for those servicemembers who have been injured in the military so that they can have a more seamless transition in terms of benefits is another step in the right direction.

Chairman AKAKA. Thank you.

Ms. Chase?

Ms. CHASE. Senator, as a Reservist, when you come off of active-duty, which can be multiple times during your military career—especially if you have been activated several times—one of the biggest issues is that we are handed our records, and then it comes on you to keep and maintain those records throughout the duration for however long you will need them.

Once you are handed your medical records, that is it. That documentation does not flow from what is or may have been put into a computer system at a care facility that you were at even to another care facility while on active-duty orders from base to base, much less from when you are on DOD and then into the VA System.

So, that enrollment period where the records directly transfer from your active military service and they follow you throughout your VA service or throughout your VA eligibility time, it is important, it is significant, and I cannot stress and say enough about how vital it is to have that to also prove combat service. If a woman or any veteran has served in combat and has been seen or treated by a physician or a physician's assistant while on active-duty, then it would flow right into their VA eligibility and into the computer system. So, it will alleviate so many of the other issues that we are seeing.

Chairman AKAKA. Thank you very much.

Are there any other—Ms. Olds?

Ms. OLDS. Mr. Chairman, thank you.

I want to follow-up with the medical records topic.

That was one of the biggest problems with me getting care when I first got out back in 1992. To this day, no one has found my records, and, of course, that caused a significant delay in getting benefits from the VA. It took almost 3 years and Councilwoman Furse to get involved. So, having access to our medical records, having them transferred without anyone having an opportunity to lose them, I think, is significantly important.

And, also, giving information to people about what benefits they can get, I was not given any. I had no idea I had benefits coming until I met with someone at the PVA and they asked the right questions.

So, information and medical record availability, I think, are probably the two big ones as far as us getting our access into the VA system when we get out.

So, thank you.

Chairman AKAKA. Thank you.

Ms. Christopher?

Ms. CHRISTOPHER. Mr. Chairman, when I got out of the military, I did not think that I had any benefits. It was due to a volunteer writing an op-ed in the *Seattle Times* that I found out about the Military Sexual Trauma Program, and that I might be eligible.

Needless to say, when I arrived, I had to fight for my eligibility. I have an honorable discharge, but the circumstances are a bit more complicated, so, it was the clerks that I really had to fight with to get seen to get treatment.

Once I did finally prove that I was a veteran and that I was entitled to treatment for MST, I got great care by the doctors that I got there. But it was an uphill battle, and having to prove again and again my trauma and that I am a veteran has definitely affected me. And, let me tell you, it was very validating to finally be rated by the VA.

I have witnessed having OEF/OIF advocates and case managers nowadays since the process is so much easier for new veterans, and I am so glad that the VA has those. However, most veterans—newly-separated servicemembers—are not always aware that these positions exist.

So, again, referring back to the community: when veterans come into my clinic or when we are doing briefings, I ask them, hey, do you know about this office in the VA; or I hand out a business card and personally introduce them to my VA counterparts. So, my point is that the community is still a really integral tool in accessing VA health care.

Chairman AKAKA. Ms. Ilem?

Ms. ILEM. I would say that things have changed a lot since I got out of the military in the mid-80s when there was little-to-know information. I definitely did not recognize myself as a veteran; did not know that I had access to the VA; and did not even recognize that I was entitled to service-connected benefits for disabilities incurred during service until I met DAV folks.

So, I think VA is on the right track now in terms of a number of outreach efforts when people are coming back from deployments—trying to outreach with them then, get them enrolled in VA care at that point, and giving them information—but also then doing follow-up letters and follow-up phone calls.

The unfortunate thing is, as we heard from Ms. Williams, when somebody from VA does call, if they would have the ability to just adapt a little bit and take into account that, yes, they were calling on this particular veteran, but others need help—to be able to refer them and simply go ahead and take care of these people. That is going to be key in terms of continued follow-up until the time when that veteran is ready; and maybe catch them at a point when they realize they have access to these benefits and are in need of them.

Chairman AKAKA. Thank you very much, Ms. Ilem.

First, I want to thank you for the sacrifice you have made for our country; and for the kind of help you are giving us in trying to sup-

port our women veterans, I want to thank all of you for being here today.

We have heard about a lot of good initiatives VA is undertaking to increase the quality and access to care for women veterans. However, we also heard that there is much more that could be done, especially in the areas of outreach and education about these services; and you mentioned medical records and also the electronic shift that needs to come.

All our Nation's veterans, both men and women, deserve the best quality of health care, and I will continue to work to make sure that they receive it.

I look forward to working with VA and others to find solutions to the gaps in care for our women veterans.

Thank you all, again, for being here today. You have been very helpful.

This hearing is now adjourned.

[Whereupon, at 11:10 a.m., the hearing was adjourned.]

A P P E N D I X

PATIENT SATISFACTION SCORES BY GENDER USING CAHPS REPORT PROVIDED BY VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Patient Satisfaction Scores by Gender Using CAHPS

In FY09 Survey of Healthcare Experiences of Patients (SHEPS) transitioned to full implementation of a standardized core set of questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS surveys were developed by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) and are widely used in public and private healthcare settings. The CAHPS items in the SHEP survey allow VHA to measure, report, and externally benchmark patient satisfaction metrics as part of VA strategic initiative to improve the quality of healthcare from the patient's perspective.

This preliminary analysis of FY09 data show that, after adjustment for demographic factors, women report similar scores as men for most of the CAHPS composites and reported measures. Unadjusted results indicated that women were significantly less satisfied on most CAHPS measures for both inpatient and outpatient care. However, after adjustment for age, health status, and education (factors known to affect patient satisfaction), most of the gender-related differences disappear or diminish. Exceptions in the outpatient care where women were slightly less satisfied include How Well Doctors/Nurses Communicate and Getting Care Quickly. Exceptions in the inpatient setting where women were less satisfied include Communication about Medication and Pain Control.

Inpatient	**Overall**	**Females**	**Males**
Overall Rating of Hospital	62.1	57.5	58.4
Communication with Nurses	92.4	89.1	91.1
Communication with Doctors	92.0	88.1	90.6
Communication about Medication	77.0	71.6	75.6*
Nursing Services	82.1	79.2	79.5
Discharge Information	80.9	76.4	79.8
Pain Control	87.7	83.1	85.4*
Cleanliness of the Hospital Environment	90.8	88.1	90.6
Quietness of the Hospital Environment	84.8	85.8	84.4
Willingness to Recommend Hospital	65.6	58.8	62.1
Outpatient			
Outpatient Overall Quality	55.6	50.1	50.8
Getting Needed Care	81.6	77.8	78.8*
Getting Care Quickly	78.0	71.7	75.3
How Well Doctors/Nurses Communicate	91.9	89.2	90.4*
Rating of Personal Doctor/Nurse	66.2	64.0	63.2

NOTE: Results reported are "positive" scores for each dimension of care. Results for Females and Males are adjusted to account for differences in age, self-reported health status, and self reported education; factors known to influence CAHPS scores. Overall results are unadjusted. All scores are weighted to reflect population results. Data are from the FY09 Inpatient and Outpatient SHEP survey, and are cumulative through March. "*" Indicates statistically significant difference at $p<0.01$ level.

Definitions of Inpatient Reporting Measures

Reporting measure	Survey items	Method of calculation
Communication with Nurses	**Question 1.** During this hospital stay, how often did nurses treat you with courtesy and respect? **Question 2.** During this hospital stay, how often did nurses listen carefully to you? **Question 3.** During this hospital stay, how often did nurses explain things in a way you could understand?	**Questions 1, 2, and 3** have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Communication with Nurses is then calculated as the average of the site's scores on the three items.
Communication with Doctors	**Question 5.** During this hospital stay, how often did doctors treat you with courtesy and respect? **Question 6.** During this hospital stay, how often did doctors listen carefully to you? **Question 7.** During this hospital stay, how often did doctors explain things in a way you could understand?	**Questions 5, 6, and 7** have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Communication with Doctors is then calculated as the average of the site's scores on the three items.
Communication about Medication	**Question 16.** Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? **Question 17.** Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? *Filter:* *Question 15. During this hospital stay, were you given any medicine that you had not taken before?* *[Response options: Yes, No]* *Responses to Questions 16 and 17 were used only if response to Question 15 was 'Yes' or blank.*	**Questions 16 and 17** have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Communication about Medication is then calculated as the average of the site's scores on the two items.

Definitions of Inpatient Reporting Measures

Reporting measure	Survey items	Method of calculation
Nursing Services	**Question 4.** During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it? **Question 11.** How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? *Filter:* *Question 10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?* *[Response options: Yes, No]* *Responses to Question 11 were used only if response to Question 10 was 'Yes' or blank.*	**Question 4** has the following response scale: Never, Sometimes, Usually, Always, I never pressed the call button. The score on Question 4 is calculated as the percentage of responses that fall in the top two categories (Usually, Always); responses of 'I never pressed the call button' are excluded from the denominator in the calculation of this percentage. **Question 11** has the following response scale: Never, Sometimes, Usually, Always. The score on Question 11 is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Nursing Services is then calculated as the average of the site's scores on the two items.
Discharge Information	**Question 19.** During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? **Question 20.** During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? *Filter:* *Question 18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?* *[Response options: Own home, Someone else's home, Another health facility]* *Responses to Questions 19 and 20 were used only if response to Question 18 was 'Own home,' 'Someone else's home,' or blank.*	**Questions 19 and 20** have the following response scale: Yes, No. The score on each item is calculated as the percentage of 'Yes' responses. Discharge Information is then calculated as the average of the site's scores on the two items.
Pain Control	**Question 13.** During this hospital stay, how often was your pain well controlled? **Question 14.** During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? *Filter: Question 12. During this hospital stay, did you need medicine for pain?* *[Response options: Yes, No]* *Responses to Questions 13 and 14 were used only if response to Question 12 was 'Yes' or blank.*	**Questions 13 and 14** have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Pain Control is then calculated as the average of the site's scores on the two items.

Definitions of Inpatient Reporting Measures

Reporting measure	Survey items	Method of calculation
Cleanliness of the Hospital Environment	**Question 8.** During this hospital stay, how often were your room and bathroom kept clean?	**Question 8** has the following response scale: Never, Sometimes, Usually, Always. The reporting measure is calculated as the percentage of responses that fall in the top two categories (Usually, Always).
Quietness of the Hospital Environment	**Question 9.** During this hospital stay, how often was the area around your room quiet at night?	**Question 9** has the following response scale: Never, Sometimes, Usually, Always. The reporting measure is calculated as the percentage of responses that fall in the top two categories (Usually, Always).
Overall Rating of Hospital	Please answer the following questions about your stay at the hospital named on the cover. Do not include any other hospital stays in your answer. **Question 21.** Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?	**Question 21** has the following response scale: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).
Willingness to Recommend Hospital	**Question 22.** Would you recommend this hospital to your friends and family?	**Question 22** has the following response scale: Definitely no, Probably no, Probably yes, Definitely yes. The reporting measure is calculated as the percentage of responses in the top category (Definitely yes).

Definitions of Outpatient Reporting Measures

Reporting measure	Survey items	Method of calculation
Getting Needed Care	**Question 47.** In the past 12 months, how often was it easy to get the care, tests or treatment you thought you needed through VA? *Filter: Question 46. In the past 12 months, did you try to get any care, tests or treatment through VA? [Response options: Yes, No]* *Response to Question 47 was used only if response to Question 46 was 'yes' or blank.* **Question 49.** In the last 12 months, how often was it easy to get appointments with specialists? *Filter: Question 48. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of healthcare. In the last 12 months, did you try to make any appointments to see a specialist? [Response options: Yes, No]* *Response to Question 49 was used only if response to Question 48 was 'yes' or blank.*	**Questions 47 and 49** have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Getting Needed Care is then calculated as the average of the site's scores on the two items.
Getting Care Quickly	**Question 31.** In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed? *Filter: Question 30. In the last 12 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office? [Response options: Yes, No]* *Response to Question 31 was used only if response to Question 30 was 'yes' or blank.* **Question 35.** In the past 12 months, not counting the times you needed care right away, how often did you get an appointment as soon as you thought you needed? *Filter: Question 34. In the last 12 months, not counting the times you needed care right away, did you make any appointments for your healthcare at a doctor's office or clinic? [Response options: Yes, No]* *Response to Question 35 was used only if response to Question 34 was 'yes' or blank.*	**Questions 31 and 35** have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Getting Care Quickly is then calculated as the average of the site's scores on the two items.
How Well Doctors/Nurses Communicate	**Question 11.** In the last 12 months, how often did your personal doctor or nurse explain things in a way that was easy to understand? **Question 12.** In the last 12 months, how often did your personal doctor or nurse listen carefully to you? **Question 13.** In the last 12 months, how often did your personal doctor or nurse show respect for what you had to say? **Question 14.** In the last 12 months, how often did your personal doctor or nurse spend enough time with you? *Filters:* *Question 9. A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. Do you have one person you think of as your personal doctor or nurse? [Response options: Yes, No]* *Question 10. In the last 12 months, how many times did you visit your personal doctor or nurse to get care for yourself? [Response options: None, 1, 2, 3, 4, 5 to 9, 10 or more]* *Responses to Questions 11, 12, 13, and 14 were used only if response to Question 9 was 'yes' or blank and response to Question 10 was not 'None.'*	**Questions 11, 12, 13, and 14** have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). How Well Doctors/Nurses Communicate is then calculated as the average of the site's scores on the four items.

Definitions of Outpatient Reporting Measures

Reporting measure	Survey items	Method of calculation
Rating of Personal Doctor/Nurse	**Question 18.** Using any number from 0 to 10, where 0 is the worst personal doctor/nurse possible and 10 is the best personal doctor/nurse possible, what number would you use to rate your personal doctor/nurse? *Filters:* *Question 9. A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. Do you have one person you think of as your personal doctor or nurse? [Response options: Yes, No]* *Question 10. In the last 12 months, how many times did you visit your personal doctor or nurse to get care for yourself? [Response options: None, 1, 2, 3, 4, 5 to 9, 10 or more]* *Responses to Question 18 were used only if response to Question 9 was 'yes' or blank and response to Question 10 was not 'None.'*	**Question 18** has the following response scale: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).
Outpatient Overall Quality	**Question 45.** Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last 12 months? *Filter: Question 33. In the last 12 months, not counting the times you went to an emergency room, how many times did you go to a clinic to get healthcare for yourself? [Response options: None, 1, 2, 3, 4, 5 to 9, 10 or more]* *Response to Question 45 was used only if response to Question 33 was not 'None.'*	**Question 45** has the following response scale: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).

PREPARED STATEMENT OF MARSHA (TANSEY) FOUR, RN, CHAIR, WOMAN VETERANS COMMITTEE, VIETNAM VETERANS OF AMERICA

Good morning Mr. Chairman, Ranking Member Burr, and distinguished Members of the Senate Veterans' Affairs Committee. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to submit our statement for the record regarding VA Health Care Services for Woman Veterans. VVA supports swift passage of S. 252, "The Veterans Health Care Authorization Act of 2009;" however, we would like for additional language to be included in Section III, regarding woman veterans health care which was missing from H.R. 1211, the Women Veterans Health Care Improvement Act that was passed by the House.

It is indisputable that the number of women in the military has risen consistently since the 2 percent cap on their enlistment in the Armed Forces was removed in the early 1970s. This has resulted in an increased number of women we can now call "veterans", and most assuredly, will have a direct bearing on the number of women who will be knocking on the door of the VA in the very near future. A focus on the capacity and capability of the VA to equitably and effectively provide care and services must be a priority today. Planning and readiness is essential for the future. These responsibilities also require oversight and accountability in order to meet VA and veteran goals, objectives, requirements, standards, and satisfaction, along with agency advancement.

While much has been done over the past few years to advance and ensure greater equity, safety, and provision of services for the growing number of women veterans in the VA system, these changes and improvements have not been completely implemented throughout the entire VA system. In some locations, women veterans still experience significant barriers to adequate health care. Thus, VVA asks Secretary Shinseki to ensure senior leadership at all VA facilities and in each VISN to be held accountable for ensuring that women veterans receive appropriate care in an appropriate environment by appropriate staff.

There is much to learn about women veterans as a separate patient cohort within the VA. Women's Health is now studied as a specialty in every medical school in the country. It has moved far beyond that of obstetrics and gynecology. Gender has an impact on nearly every system of the body and mind. This has great significance in the ability of any health care system to provide the most appropriate, comprehensive, and evidence-based scientific treatment and care. This also has a direct effect on the delivery system along with staff requirements to meet the needs of women now utilizing the VA health care system, as well as for those new women veterans who will soon be accessing the system in the days and years to come.

The VA has already identified that our country's new women veterans are younger and that they expect to use the system more consistently. For example, in December 2008, the VA reported that of the total 102,126 female OIF-OEF veterans, 42.2 percent of them have already enrolled in the VA system, with 43.8 percent using the system for 2–10 visits. Among these returning veterans, 85.9 percent are below the age of 40 and 58.9 percent are between 20 and 29. In fact, the average age of female veterans using the VA system is 48 compared with 61 for men. The needs of women veterans have yet to be fully identified or recognized * * * these needs are growing and already taxing the VA system, which historically has focused on an older male population.

As time, social environments, and veterans' population demographics change, there are also cultural expectations based on scientific advancements in health care that elicit a re-definition of women veterans' needs in the VA system. Knowing the needs is vital to understanding and meeting them. The VA has recognized many of the needs of women veterans by actually creating interest groups comprised of not only VA staff, but veterans as well. For example, there is recognition that younger women veterans are also working women who need flexible clinic and appointment hours in order to also meet their employment and child-care obligations. They also need to have sexual health and family planning issues addressed, along with the needs of infertility and pre-natal maternity. And there are unanswered questions and concerns about the role of exposures to toxic substances and women's reproductive health.

VVA requests that this Committee continue to focus on treating women veterans who are homeless with children, victims of sexual trauma, and provide funding for additional caseworkers and mental health counselors, a women's mental health treatment program, and a comprehensive mental health study of returning female soldiers.

Studies and Assessments of Department of Veterans Affairs Health Services for Women Veterans

VVA believes that this study is vital to understanding today's women veterans and that building on the "National Survey of Women Veterans in Fiscal Year 2007–2008" is a referenced starting point and this study should be included as language in the bill as similar to H.R. 1211 to expand a survey of sufficient size and diversity to be statistically significant for women of all ethnic groups and service periods.

VVA believes that this study should identify the "best practices" that facilities utilize to overcome identified barriers.

VVA believes that with the fragmentation of women's health care services there needs to be consideration for driving time/transportation to medical facilities that offer specialty care as well as primary care.

While VVA holds great respect for and recognizes the important work of both the Office of the Center for Women Veterans and that of the Advisory Committee on Women Veterans, this section as written would limit the initial review, creating unnecessary delays. Rather, VVA believes that this study should also go immediately to these two entities, plus the VA Undersecretary for Health, the Deputy Undersecretary for Quality and Performance, the Deputy Undersecretary for Operations, the Office of Patient Care Services, and the Chief Consultant for the Women Veterans Health Program for review and recommendations, which in turn are then forwarded to the Deputy Undersecretary for action to remove or ameliorate the identified barriers.

VVA recognizes that this requires 30 months after the VA publishes the 2007–08 National Survey of Women Veterans that the VA Secretary in turn is required to report to Congress on the barriers study and what actions the VA is planning. However, in reality, this means that the information/directions contained in the 1907–08 report is/are put "on hold" for two and a half years. Therefore VVA believes that the Secretary's report to Congress should also include what actions—if any—have transpired both during the survey and the 30 month hiatus.

Independent Study on Health Consequences of Women Veterans of Military Service in Operation Iraqi Freedom and Operation Enduring Freedom

VVA believes this section should include appropriate language directing the study format to include the use of evidence-based "best practices in care delivery."

During the 110th Congress, VVA was heartened to see that the S. 2799 legislation included a "Long Term Study of Health of Women Veterans of the Armed Forces Serving Operation Iraq Freedom and Operation Enduring Freedom." However, VVA is extremely disappointed to see that while calling for "a study on health consequences for women veterans of service on active duty in the Armed Forces in deployment in Operation Iraqi Freedom and Operation Enduring Freedom;" it eliminates the longitudinal aspect contained in S. 2799 of the 110th Congress.

As you know, the second round of the National Vietnam Veterans Readjustment Study was never completed by the VA, even though it was mandated by Congress to do so. VVA urges you not to let this opportunity be lost again on a statistically significant and diverse population of veterans. It is an important element to a study that will bring long term identification and understanding and of the long term implication of military service during this period of history when the role and duties of women veterans has far expanding the service of women in the past.

Report on Full-Time Program Managers for Women Veterans Programs at Medical Centers

VVA applauds the VA for recognizing the need and importance of the requirement for a full time Woman Veteran Program Manager at all VA medical center. However, VVA feels this action falls short of providing these managers with the reporting process that is commensurate with their full duties and responsibilities. Consistency is vital in recognizing the true tracking of the work they perform and in evaluating the issues of their mission. VVA believes this position is most significant and demands that this position's reporting line should also be significant and not determined by individual medical centers. It is known that reporting lines are varied from medical center to medical center. In some instances the reporting of identified items of the Woman Veteran Program Manager is moved forward through the medical center hierarchy based, not on the desire of the Woman Veteran Program Manager, but of other staff who are selective on what is actually "moved up the chain of command" at the medical centers. VVA calls for the Undersecretary of Health to define the reporting line for the Woman Veteran Program Managers as that of the Chief of Staff at each medical center. This action backs up the initial significance that the VA recognized when elevating the position to full time. It brings significant investment in the importance of meting the needs of women veterans in its vast

health system. If not, a true reporting of the work of the Woman Veteran Program Managers and the issues of women veterans could fall into the vast dark pit of the unknown. The work of the Woman Veteran Program Managers is vital to recognizing not only the needs but also providing clear information for program and process formation but also on establishing even possible research opportunities.

Improvement of Health Care Programs of the Department of Veterans Affairs for Women Veterans

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 from 14 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 solely 14 days. 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.

Training and Certification for Mental Health Care Providers on Care for Veterans Suffering from Sexual Trauma

VVA has concerns about the VA establishing a "certification" program. In order to be valid, VVA believes that such a certification program be based upon and modeled after those already utilized by many professional organizations. Such a certification program would lend itself well to oversight and accountability. Too many VA certification programs now consist of only a 1-hour training class or reading materials.

Although this section calls for reporting the number of women veterans who have received counseling, care and services under subsection (a) from "professionals and providers who received training under subsection (4)", VVA asks "Who in the VA is already trained and holds professional qualifications under these subsections"?

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 premature births. Prenatal and neonatal birthrate demographics (including miscarriage and stillborn data) would seem to be an important element herein.

Delivery of Services

Considering the ever increasing percentage of women veterans in the homeless veteran population and the extraordinary occurrence of this in the OEF/OIF homeless veteran population, one can see that their presence in the VA system will affect all levels of service, delivery, treatment, and care. Advocacy for them within the VA will be paramount.

Vietnam Veterans of America believes women's health care is not evenly distributed or available throughout the VA system. Although women veterans are the fastest growing population within the VA, there seems to remain a need for increased focus on women health and its delivery. It seems clear that although VACO may interpret women's health as preventative, primary and gender specific care, this comprehensive concept remains ambiguous and splintered in its delivery throughout all the VA medical centers. Many view women's health as only a GYN clinic. As you are aware, throughout medical schools across the country and in the current health

care environment, women's health is viewed as a specialty onto itself and involves more that gender specific GYN care.

The new woman veterans also need increased mental health services related to re-adjustment, depression, and re-integration, along with recognition of differences among active duty, Guard, and reserve women. The VA already acknowledges the issue of fragmented primary care, noting that in 67 percent of VA sites, primary care is delivered separately from gender specific health care—in other words, two different services at two different times, and in some cases, two different services, two different times, and two different delivery sites. The VA also notes that there are too few primary care physicians trained in women's health, and at a time when medicine recognizes the link between mental and medical health, most mental health is separate from primary care. VVA seeks to ensure that every woman veteran has access to a primary care provider who meets all her primary care needs, including gender specific and mental health care in the context of an on-going patient-clinician relationship; and that general mental health providers are located within the women's and primary care clinics in order to facilitate the delivery of mental health services.

Providing care and treatment to women veterans by professional staff that have a proven level of expertise is vital in delivering appropriate and competent gender-specific care. It is not sufficient to simply have training in internal medicine. Women's health care is a specialty recognized by medical schools throughout the country. Providers who have both a knowledge base and training in women's health are able to keep current on health care and its delivery as it relates to gender. In order to maintain proficiency in delivering care and performing procedures, these providers must meet experience standards and maintain an appropriate panel size. This cannot occur if women veterans are lost in the general primary care setting. It is critical that women receive care from a professional who is experienced in women's health. If attention is not given to defining qualified providers, it will be a detriment to the quality of care provided to women veterans.

VVA does, however, feel comprehensive women's health care clinics are most desirable where the medical center populations indicate because comprehensive consolidated delivery systems present increased advantage to the patients they serve.

Research

Vietnam Veterans of America applauds the VA for elevating its Office of Women's Health to the Strategic Health Care Group level. With this action, the VA has "pumped up" the volume on the attention and direction of the VA regarding woman veterans. But there remains much to be learned about women veterans as a health care cohort. Data collection and analytical studies will provide increased opportunities for research and health care advancement in the field of women's health, as well as offer evidence-based "best practices" models and innovative treatments.

As discussed by Phyllis Greenberger, President and CEO of the Society for Women's Health Research, at a recent Roundtable on Women Veterans before the House Committee on Veterans' Affairs, Ms. Greenberger stated that the focus of The Society clearly demonstrated that sex and gender differences exist throughout all conditions that affect women differently, disproportionately or exclusively and research needs to be done to identify those differences and understand their implications for diagnosis and treatment. She discussed the unknown in regard to the influence of hormones on not only the bodily process of the women's medical and mental care but also its influence on the regime of medication prescribed by the care providers and utilized by women veterans. This is especially true with medications in the mental health arena.

It is well recognized that biological differences related to hormones affect mental health risks, rates of disorders and course of those disorders. Research had indicated that estrogen and progesterone influence brain function and stress response. Some women experience increased vulnerability to depression during times of reproductive endocrine changes such as premenstrual, postpartum and perimenopausal periods. VVA believes more funding needs to be available for research into sex differences and better coordination is needed among VA centers throughout the country to increase the number of women in clinical trials to understand the differences and their implication for treatment.

Suicide Risk

Last, but just as important, VVA is deeply concerned about the high suicide risk among women veterans as reported at the American Psychiatric Association's May 2009 meetings in San Francisco. A 2007 longitudinal study of women veterans, which followed individuals for a period of 12 years, suggests that women who have been in the military have a 3fold increased risk for suicide compared with non-

military women. Furthermore, female veterans are more likely to be young and use firearms to commit suicide compared with their civilian counterparts, who tend to choose other methods—commonly drug overdose. Data for this study came from the National Health Interview Study and was then linked with data from the National Death Index. It is important to note that this study was population-based and therefore, the findings are applicable to all military personnel and not just those in the Veterans Affairs (VA) health system.

The VA is a massive health care system that possesses challenges for woman veterans, who are encouraged to seek treatment at VA facilities; but not many do. Treatment of women veterans at various facilities throughout the country are not "women" friendly. We are hopeful that any shortfalls can be turned into positive action for our so woman veterans who deserve the same care and treatment because of their service and sacrifice to this country.

In closing, VVA would like to personally thank Senator Patty Murray, for her hard work and dedication to our woman veterans, for without Senator Murray, VVA believes that this hearing today would not be possible. We thank this Committee for the opportunity to submit testimony for the record.

PREPARED STATEMENT FROM ANURADHA K. BHAGWATI, MPP, EXECUTIVE DIRECTOR, SERVICE WOMEN'S ACTION NETWORK (SWAN)

My name is Anuradha Bhagwati. I am a former Captain in the U.S. Marine Corps. I currently serve as Executive Director of the Service Women's Action Network (SWAN), a non-partisan, non-profit organization founded by female veterans, based out of New York City. SWAN specializes in policy analysis, advocacy, and legal services for all servicewomen, women veterans, and their families.

Despite the progress the Veterans' Health Administration has made in addressing the recent influx of women veterans into the VA system, the challenges in delivering adequate health care services to women veterans remain numerous and daunting.

Every day, SWAN receives calls from frustrated, disappointed, and traumatized women veterans looking for legal assistance or personal support due to inadequate health care, or mistreatment and harassment by staff or male patients at VA hospitals. Many women justifiably give up on the VA, as their traumas and conditions rapidly deteriorate into drug and alcohol abuse, homelessness, or suicide.

The epidemic of Military Sexual Trauma (MST)—sexual harassment, assault and rape—which has yet to be fully recognized by the Armed Forces, has also yet to be adequately integrated into the daily operations of VA hospitals.

MST screening at hospitals around the Nation appears to be inconsistent, at best. A shortage of female physicians and counselors, a rapid turn-over of inexperienced residents, a preponderance of culturally conservative administrative staff, and poorly trained or unprofessional medical staff contributes to a lack of understanding about how to treat veterans who suffer from symptoms related to MST.

However, I must emphasize that regardless of medical condition, women veterans, when compared to their male counterparts, are largely subjected to unequal treatment at VA facilities nationwide. The following anecdotes illustrate just a few of the VA's institutional failures to deliver proper health care to women veterans:

- One Iraq veteran who checked herself into inpatient psychiatric care during a particularly bad PTSD episode, was forced to share a bathroom with male veterans, including a peeping tom. When she told her nurse she felt uncomfortable eating her meals with male veterans, the nurse threatened that she would not be fed at all.
- An Afghanistan veteran—a single mother—who was raped in theater by a fellow servicemember, cannot bear to enter a VA facility out of sheer terror of re-triggering the trauma from her assault. Like many other women veterans, she pays for counseling out of pocket so as not to subject herself to further trauma.
- One veteran recently received her annual pap smear with a male gynecologist who did not enforce the requirement to have a female staff member present during the examination. When this veteran mentioned to the gynecologist that she had experienced MST, he left the room and barked down the hall, "We've got another one!"

Many of these examples illustrate a larger point: that the VA requires an enormous cultural shift recognizing the sacrifices and specific needs of women veterans.

RECOMMENDATIONS TO BRIDGE THE GAPS IN CARE FOR WOMEN VETERANS

1. Require that the VA remedy the shortage of female physicians, female mental health providers and MST counselors at VA hospitals nationwide. Also require that the VA provide the option of female-only counseling groups for female combat vet-

erans, and female- as well as male-only counseling groups for female and male survivors of MST.

2. Require the VA to implement a program to train, educate, and certify all staff, including administrative and medical, in Federal Equal Opportunity regulations and MST, to reduce a discriminatory and unwelcoming atmosphere toward women veterans.

3. Require the VA to increase accessibility of fee-based care for veterans (both male and female) who have been diagnosed with Military Sexual Trauma.

4. Require day-care facilities for veterans who are parents, as well as more flexible evening hours for working veterans, at every VA hospital.