

VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND RELATED ISSUES

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES ONE HUNDRED THIRD CONGRESS FIRST SESSION

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VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND RELATED ISSUES

WEDNESDAY, JUNE 23, 1993

**HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.**

The subcommittee, pursuant to call, met at 8:30 a.m., Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Waters, Kreidler, Ridge, Everett, and Quinn.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Good morning and I want to welcome everybody.

The role of women in the Armed Forces and in society is changing. Women are now being assigned to Navy combat ships and they are being assigned to fly Apache helicopters, F-15 Eagles, and F-14 Tomcats. Just this past week, a woman took command of an Air Force missile squadron, the same squadron that her father commanded a generation ago.

With almost daily news on the changing role of women in the military, the public has become much more aware of the contributions women are making to our national defense. Later this year, in November, a memorial to women veterans of the Vietnam War will be dedicated on the grounds of the Vietnam Veterans Memorial, and later a Memorial to Women in the Military Services will be constructed at the main gate of the Arlington National Cemetery.

In spite of this increased public awareness of women in the military and the fact that women comprise the fastest growing segment of our veteran population, it appears that the Department of Veterans Affairs has not improved the availability of gender-specific health care services needed by women veterans accordingly.

Information recently provided by the VA's Inspector General, who will be testifying today, reveals significant deficiencies in VA health care for women veterans. Insufficient knowledge of available women's health care services, inadequate training for individuals who coordinate those services, and a lack of gender-specific medical equipment are just some of the unacceptable findings which will be discussed today.

In some cases, deficiencies in VA health care for women veterans have been reported before, some as long as ten years ago. For women, ten years without gender-specific health care can be a long time. For some women, in fact, those ten years are the rest of their

lifetime. Frankly, this subcommittee does not understand why it should be so difficult or take so long to provide adequate health care services to women veterans. Women are not second-class citizens, they are not second-class veterans, and their health care needs are not second class either.

The chair of this subcommittee and other members of the Committee have repeatedly given the VA strong encouragement to provide the full range of medical care services needed by women veterans. Despite strong congressional support, women veterans today still cannot rely on the VA for their health care needs. There are, we know, some isolated examples of success. Minneapolis is certainly one. But pointing to one or even a few isolated successes is not good enough. The success of these few programs is due to the determination of a few local individuals, not the leadership or the VA policy-makers in Washington, DC.

Over and over, the VA has pointed with pride to Women Veterans Coordinators, as the bright and shining example of the VA's commitment to women's health care, but unfortunately coordinators have been given few, if any, specific responsibilities, they have been given little or no institutional support, they have had too little time to do the job, and in many cases they have received little, if any, training.

Under national health care reform, VA is expected to be a competitive health care provider. I want the VA to succeed. I want the VA to be part of that process. One thing is clear, however: VA must provide quality health care to women veterans today if it hopes to be the health care provider picked by women veterans tomorrow. Results, not rhetoric, are needed now.

The new Deputy Secretary of Veterans Affairs has recognized this problem. He recently said VA "has neglected women badly" and must do more in the area of women's health care. We welcome this frank and realistic assessment of this long-standing neglect. We agree VA health care for women veterans must be improved, and we look forward to making the improvements with this administration.

Legislation to improve VA services to women veterans has and will be proposed by several of our colleagues, including Congresswoman Maxine Waters, the vice chair of this subcommittee. The chair commends, welcomes, and strongly supports each of these important initiatives.

Before I call on our colleagues, Representative Pat Schroeder of Colorado and Representative Rosa DeLauro of Connecticut, for their presentations, I would be glad to yield to members of the subcommittee for their comments.

Mr. EVERETT. Thank you, Mr. Chairman.

I have the good fortune to represent Fort Rucker, AL, where those women are trained to fly Apache helicopters and where stationed is a combat veteran and POW woman who has served this country very, very well, and something we can be very, very proud of, in Desert Storm.

I am anxious to hear what our colleagues have to say. I have read through the material, and I find some things very disturbing. I know there have been some steps for the better made, and I look forward to us being able to move forward even more in this.

I also congratulate you, Mr. Chairman, and our Ranking Member, Mr. Tom Ridge, for holding these hearings, and I will submit my remarks for the record and other questions too, please.

[The statement of Congressman Everett appears at p. 66.]

Mr. EVANS. Thank you very much.

The gentleman from New York.

Mr. QUINN. Thank you, Mr. Chairman.

I am pleased to be here with you this morning and our colleagues who will testify in just a few minutes, and we are anxious to get to that testimony. I want to thank you, Mr. Chairman, for putting together the hearing.

Mr. Everett and I are doing all we can to make perfect attendance, not quite as well as Mr. Natcher yesterday, but we will do what we can during these hearings, and we are pleased to be here with you this morning.

Thank you.

Mr. EVANS. We appreciate your attendance and your remarks. Thank you very much.

Mr. EVANS. We are pleased to welcome two colleagues, Pat Schroeder and Rosa DeLauro, before the subcommittee as our first witnesses today. Pat appeared before this subcommittee last September when we examined sexual harassment in the VA workplace and women veterans' health care.

Last year, due in large part to her strong and effective leadership, Congress enacted ground-breaking legislation to provide counseling for women veterans who were sexually assaulted during their military service. In this Congress she has introduced H.R. 2285 to improve VA-provided services to women veterans.

As we will learn today, there is a clear need for marked improvement in the VA delivery of services to women veterans. We welcome you, Pat, and thank you for your continued participation.

Rosa is also a very strong supporter and good friend of all veterans. She recently joined with Congresswoman Schroeder as the principal author of letters to DOD and the VA on gender-specific health concerns and problems of Persian Gulf War veterans.

We thank you also for participating, and let me open it up to Congresswoman Schroeder.

STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mrs. SCHROEDER. Thank you very much, Mr. Chairman and members of the committee.

You are right, it is not quite a year since I was here last time, and I really want to thank this committee because we did make some progress and it wouldn't have been without all the help and without all the energy that came out of here. I think what we are saying is, okay, we have moved a little closer to the goal line, but we hope now we can move the rest of these bills and finally get equality.

I think one of the other things we forget about is, the military would have never functioned in any of these wars without the terrific nurses that we have had that have been under fire, have been taken prisoner, and every other such thing, putting out high-quality care, and to turn around and give them the shabby care in re-

turn, I think, is unconscionable, and when we hear from the Inspector General I think it is going to give everybody chills. I thought I knew how bad it was, and I found out I didn't know how bad it was, but this is a real shame on this country, and I thank you for asking for the IG report and bringing it to the attention of everyone.

I am going to ask unanimous consent to put my testimony in the record, because I know that most of you are very well aware of this. What I basically want to talk about is how we did have this terrific breakthrough by passing Public Law 102-585, which really finally addressed veterans who were carrying psychological and physical wounds from sexual trauma and established a counseling program for them.

As you know, it has been in effect and it has been going on, but it has some huge loopholes in it. It left women who had been out of the military for more than two years totally denied access to these new services. If you needed the services and were in the services, they were terminated after one year unless you got from the Secretary a special exemption, and it appears that the contract agreement covering all of these services expires on December 31, 1994.

So we made a beginning and we established that this is very serious, but there are huge loopholes.

As the chairman said, I have introduced a bill to try to fill these loopholes, H.R. 2285, which the chairman cosponsors, and I am really very pleased that the Secretary of Veterans Affairs, Jesse Brown, has said this should be done. Also, the Steering Committee on the National Women Veterans Health Training Program and the VA Task Force on Sexual Trauma all have pointed out that we really should be providing these services across the board, and that is basically what this does. It closes the time line loopholes, and, in addition, it establishes a 24-hour hotline for veterans who are survivors of this kind of sexual harassment and provides them with some comprehensive referrals.

Then what we would like to do is have the Secretary report what they are hearing from this hotline periodically to see what kind of patterns we see out there.

It also places a coordinator of veterans' services in each region and makes sure they are full-time positions with direct access to the Central Office.

I must say, I am very frustrated by how the Women Veterans Coordinators program in each region has been dealt with. It was originally instituted in 1986, and one more time we were patted on the head and told, "There, there, now; this will take care of it all," except that what we have found is that, you know, in many places it is like the third person through the door gets to be the Women Veterans Coordinator. You know, we have got librarians, we have got people with 15 other job descriptions.

The Inspector General's report, of course, is a very chilling assessment that what I am saying is not off the mark at all, that it really has not been a major concern. It is just like we have got to fill in that slot with someone's name. So what this says is, it has got to be a full-time job in each region with direct access to the Central Office, no more nonsense.

When you look at it, it is very clear that many patients were unaware of this Women Veterans Coordinator and those who were aware of it often couldn't find them, no one knew who it was. In my city of Denver, I am very sad to say, we were told that there was no Women Veterans Coordinator and that there was also no women veterans advisory committee—it is like no and no—and that is an agency with an attitude if they are going to tolerate that kind of thumbing their nose at the law.

The IG's report also indicates women's health care services at the VA are much worse than we thought. It is not just the coordinators, it trickles right out into all the services. Of the 166 facilities surveyed, 75 offered no on-site women's health care clinics, and that is really amazing. You are going to hear much more from them, but I was even appalled that some of those who said that they did have women's health clinics, when they pressed them they found out they were every other week and maybe for four hours. So if you didn't know when that window was open, you were in real trouble.

Then when you look at the services and the equipment that they had, good luck trying to find it. Much of it was out of date; we haven't had the mammography standards put in; and on and on and on. It is a parade of horrors, and it is a parade of saying that, "Women veterans just really don't count, and we don't like having you here, and we are going to do everything we can to send you away."

I think the IG's ten recommendations are excellent, and I know that the chairman and this committee will take them very seriously and move on them, talking about the in-house gender-specific services, reallocating staff in the Central Office to support women's health programs, develop quality indicators for gender-specific services, have training programs—imagine such a thing. I support them all, and we just can't implement them fast enough.

I am soon going to be also offering another piece of legislation that will provide women veterans a basic primary care and preventive care package and expand research on women's health at the VA. We need the tough quality standards for mammography, and we also need to look much more at research for women who have been in the military.

There was a GAO study in the mid-eighties that pointed out it appeared women in the military were having about twice the incidence of cancer of women who hadn't been in the military. Now we haven't got any research to look at that, how hard is that. We could learn a lot about environmental effects on that, and we will be introducing this comprehensive package that covers that whole range.

I want to say I am also so pleased that my colleague, Rosa DeLauro, who has been just a great supporter of women veterans in all issues dealing with the plight of women, has taken up the issue of women who served in Desert Storm, and I know you are later on going to hear from another constituent of mine who has been working very, very hard in this area, Doris Besikof, who is here on behalf of the National Veterans Conference and the Fund for Women Active in our National Defense their advocates and supporters called WANDAs. This is a new group of advocates and sup-

porters and attorneys that are really saying, "We've had it; enough; you know, equality is equality; and what part of 'liberty and justice for all' don't you understand?"

So I am really pleased that you have got this wonderful group of witnesses and that you are dedicated to moving, and thank you very, very much for letting us be here to kick this off, and hopefully we finish it off this year.

[The prepared statement of Congresswoman Schroeder appears at p. 69.]

Mr. EVANS. Thank you very much. We appreciate it.
Rosa.

STATEMENT OF HON. ROSA DELAURO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Ms. DELAURO. Thank you very much, Mr. Chairman and members of the subcommittee. I really am delighted to be here this morning, and thank you for the opportunity to be able to speak before the subcommittee. It is also a pleasure for me to sit alongside my colleague, Pat Schroeder, who all of you know has been a real leader on issues of women in the military and issues of women's health.

I applaud the subcommittee for holding this hearing. The issue of women's health care through the Department of Veterans Affairs is of critical importance to women veterans and for those who are currently serving in our Armed Forces.

Mr. Chairman, my desire to testify today is driven by two factors. First, I have a deep interest in women's health issues that stems from my own personal experience with cancer, my work with the Congressional Caucus for Women's Issues and on the Appropriations Subcommittee on Labor, Health and Human Services and Education.

Second, I had the opportunity to meet Carol Picou who testified before your subcommittee three weeks ago. Her description of the health problems that women and men who served in the Persian Gulf War are experiencing prompted me to speak to the chairman about what was happening regarding these reports and, more generally, what problems women veterans were encountering in receiving appropriate medical care through the VA. What I learned, quite honestly, has given me a sense of *deja vu*.

When I came to the Congress in 1991, I was impressed by the scope of the problem of the lack of adequate research into diseases that primarily affected women and the lack of women in clinical trials at the NIH. Not only were women excluded from important clinical trials, but little analysis was being done of study results based on gender, little analysis of diseases that especially affected women—those were poorly funded—and female researchers were few and far between.

The GAO issued a report that was deeply critical of the National Institutes of Health, the leading biomedical research facility in this Nation and probably in the world. The NIH, charged with involving women in clinical trials, had made precious little progress in that direction.

So in my first term in Congress I joined with the Women's Caucus, and we were able to address some of these issues. As a tiny

band of women, both Democrats and Republicans together, we really took the initiative, along with a number of groups who were concerned about women's health research, to fight and to begin to try to change some of those ossified attitudes and what has been an astonishing insensitivity toward research into women's health issues.

We worked very, very hard to provide serious resources to the National Cancer Institute for research on breast and ovarian and cervical cancer. The result of these efforts was the creation of an Office of Women's Health Research at the NIH, substantial increases in funding for women's health research, and the establishment of Federally-funded centers for research on contraception and infertility.

So it is out of my grave concern about past women's health research that has been overlooked and the importance of disease prevention that I am very disturbed about the results of the GAO studies that point to deficiencies in health care that women veterans receive through the VA. We really can't allow—and I associate myself with my colleague's comments—our women veterans, who have made so many personal sacrifices to serve all of us by helping to defend this Nation, to have their needs go wanting for appropriate health care services.

In particular, the latest report noted that cancer screening for women veterans continued to be sporadic—that the VA has not effectively implemented plans to ensure that as part of their physical examinations women veterans receive appropriate cancer screening.

It was also noted that the VA medical centers are inadequately monitoring in-house mammography programs to ensure compliance with quality standards. I strongly believe we need to make every effort to ensure that women veterans are properly screened for breast, ovarian, uterine, and cervical cancers and that greater attention be paid to the quality of those screening programs and services.

We know that part of the cure is early detection. It is very clear from the statistics. While the GAO found that progress is being made in some VA medical centers—for example, in Martinez and in San Francisco—at too many centers quality control reviews do not ensure that all women veterans are receiving the screening they should. Information about successful programs should be shared rapidly with other centers that are lagging behind. This should become a top priority for VA medical centers and regional and national VA offices. If we know that this can be done, there really is no excuse for inaction.

In addition, since the VA's 1985 survey of female veterans, we learned that almost nine percent of women veterans had cancer and that the lifetime prevalence of cancer among women veterans is nearly twice the rate of that among all adult women. It is my understanding—and Pat Schroeder mentioned this this morning—that there has been no serious effort to discover why this is so. If the information were collected and analyzed by the VA and/or by the Department of Defense, perhaps we could uncover what factors place these women veterans at greater risk for developing cancer and measures could be taken to either minimize or to eliminate

those factors. So I would encourage a joint VA/DOD study be developed to do just that.

I am also aware of the problems that veterans of the Persian Gulf War are facing, such as Carol Picou brought to your attention and to the attention of the American public. Her testimony before the subcommittee and her appearance on "Nightline" provided riveting case histories and they need to be investigated.

Women have reported chronic ovarian cysts, abdominal bloating, and birth defects. Men, too, have reported health problems, including severe weight loss, joint pain, fatigue, and mood swings.

In light of the concerns that SFC Picou and others have raised, Congresswoman Schroeder and I, along with 35 Members of the Congress, are sending a letter today to VA Secretary Brown and to DOD Secretary Aspin expressing our concern that problems faced by female Persian Gulf soldiers should be properly catalogued and that necessary health care services are provided. We really cannot miss this opportunity to clearly identify and to treat these problems early. These letters urge the VA and DOD to code the health registry of those who were in Operation Desert Shield/Desert Storm for gender-specific symptoms and to instruct the National Academy of Sciences and any prospective contractors researching the health status of our Persian Gulf veterans to do the same, and I would ask unanimous consent that these letters be placed into the record of today's hearing.

Mr. EVANS. Without objection.

[The letters appears at pp. 73 and 76.]

Ms. DELAURO. I also want to express my support for the legislation that Representative Schroeder mentioned, H.R. 2285. As a cosponsor of her bill, I urge the Veterans' Affairs Committee to favorably consider this much needed improvement in the treatment of women and men veterans who have suffered sexual trauma or harassment.

In addition, the legislation will enhance the Women Veterans Coordinator program to help women get better access to services through the VA. I know at the Westhaven VA in my own district the Women Veterans Coordinator is only a part-time position. I assure you, we need someone who is full time there, and H.R. 2285 would make sure that Women Veterans Coordinators are full-time positions and that they will be provided adequate resources.

In conjunction with this initiative, I believe that funding for VA women veterans programs, including the four comprehensive women's health centers currently being developed, should be increased so that additional centers can be established and research programs on women's health needs can be extended.

In closing, I want to again commend the subcommittee for shedding light on the issue of women's health care in the VA system. We cannot continue to ignore diseases that affect our sisters, our mothers, our daughters. We need to have that heightened awareness, and we need to make sure that diseases that affect women are understood, that they are analyzed, and that they are treated with the same care and diligence that we fight other diseases. We have to invest in research and we have to invest in prevention, if we are to have healthier children and families. We must make the commitment today so that we can save lives and precious health

care dollars tomorrow. I urge the subcommittee to continue on the path of fine work that you have done, and I look forward to continuing to work with you.

Thank you.

Mr. EVANS. Thank you, Rosa, very much. We appreciate your leadership on issues of research important to Persian Gulf veterans. One of the great things about Pat's seniority on the Armed Services Committee is that the funding that we need will be pursued through the Department of Defense authorization legislation, that we will be considering soon, which must go through Pat's subcommittee.

Mrs. SCHROEDER. We think it is wired.

Ms. DELAURO. Amen.

Mr. EVANS. As Pat indicated, there is an attitude problem. As one of our later witnesses will testify, in effect, if you build facilities with privacy concerns addressed in those facilities, if you have Women Veteran Coordinators, if you have people trained in providing health care services to women, then women veterans will come. One of the concerns is that, particularly in smaller facilities, there won't be a large number of women coming in. But once you have the programs in place, once you have the coordinators providing services, we find that women will come into the VA facilities.

So it is an attitude problem not only in the hospitals, but I believe at the very top of the VA. We do have a new administration pledging support for various initiatives. Hershel Gober has indicated that he believes women have been neglected and treated very badly. So we hope that the attitude will change and with that attitude change hopefully the funding will be there for these initiatives.

So I thank you and yield to my colleagues if there are any questions.

If not, thank you both very much for being here.

Ms. DELAURO. Thank you.

Mrs. SCHROEDER. Thank you very much, and we appreciate the working partnership.

Mr. EVANS. Our next witness today is Steve Trodden, Inspector General of the Department of Veterans Affairs. He is accompanied by Dr. Alastair M. Connell, Assistant Inspector General, Office of Health Care Inspections.

Before you present your statement, Steve, I want to thank you, Dr. Connell, Ms. Slachta and the other members of your office who have contributed to your recent report on VA health care for women veterans.

Our committee wants to commend the IG for the continuing examination of women veterans issues, and we look forward to your comments. Once you are seated and ready, you may proceed. Your entire statement will be entered into the record.

**STATEMENT OF STEPHEN A. TRODDEN, INSPECTOR GENERAL,
DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY
DR. ALASTAIR M. CONNELL, ASSISTANT INSPECTOR GEN-
ERAL, OFFICE OF HEALTHCARE INSPECTIONS; AND MARION
M. SLACHTA, PROGRAM ANALYST**

Mr. TRODDEN. Thank you, Mr. Chairman. It is indeed a pleasure to be before this committee again on a very important subject.

I have with me at the table today, as you mentioned, Dr. Alastair Connell, who is the Assistant IG for Health Care Inspections, and it is his office that issued the report that is the basis for our testimony today. To my left is Marion Slachta, who was the principal inspector that produced the report.

In the interest of the committee's time, I am going to be very brief in my summary remarks. As you mentioned, the staff has worked with your staff; you have our report; you have our prepared testimony; and, frankly, Mr. Chairman, both your statement and that of Congresswoman Schroeder fairly well summarized our position on the matter, so I am going to be very terse. I want no misunderstanding, however, that the brevity of my remarks impugn the seriousness of this subject. I am trying to preserve as much time as possible for questions and answers.

Clearly, as our report points out, female veterans do have different needs. They were recognized by the Congress in congressional legislation of both 1983 and 1992. The report that we have to talk about today is our first in a series of inspections that we intend to make into women's health care issues. This one was more in the nature of a canvas or a survey of the overall landscape. We intend to follow on with inspections that will look at the actual quality of services that the VA provides to our women veterans.

The basic study done here was what we call a random stratified sample. That is a technical word, but "stratified" means we tried to get large and small hospitals represented in our study, and "random," obviously, we tried to pick things that would be representative of the VA system, and we had agreement in advance with the Veterans Health Administration that the eight hospitals that we looked at were representative of the VA system.

We found a number of things. We found that only one of the eight had a full range of services available for our women veterans. The other seven were broadly variable from very limited capability to a more extensive capability. We found the need for strong leadership in the Central Office to, as the chair previously identified, address some of the attitudinal issues that are contained in our report. We found that Women Veterans Coordinators were not adequately trained. We found that they were not easily available, that they had time constraints put on them by their ancillary duties, or actually the coordinator position was an ancillary duty, and they had primary duties that took away from their coordinator availability. We also found that some patients and employees didn't even know that they existed or how to get in touch with them.

We found that the female patients were not always informed about the range of services which were either available in the hospital or to which they were entitled. We found that privacy was not ensured, and Women Veterans Coordinators frequently had no input into the construction activities that might have redressed

some of these privacy issues. We found that specialized equipment needed for treatment of female veterans was not always available. We found that some of the eight VA medical centers had no procedures to monitor quality and appropriateness of care and others had only limited quality assurance processes.

The VHA, at our request, did a questionnaire which was even broader than the eight hospitals that we looked at personally and physically, and the responses to the VHA questionnaire were largely consistent with the findings in our report.

As the chair has also already recognized, we are not necessarily saying that each and every VA medical center needs to have a huge slug of money plowed into it for building and facilities. There needs to be some study, there needs to be some thoughtfulness, there needs to be some look at the demographics and the number of women in a particular catchment area that are available to support a program, but clearly we need to do much, much better than we have done to date.

We made ten recommendations. I think Congresswoman Schroeder has accurately summarized the important ones there. VHA has concurred and provided us with a detailed plan of action which we agree is appropriate. The one note of caution I guess I would add is with regard to our call for increased resources at Central Office to send the signal that VA is taking the women's programs very, very seriously. There is a slight hedge in the response that says "subject to availability of resources," and I get a little nervous with that hedge.

But, other than that, that is a rough, quick summary of our report. I will conclude now, and I, Dr. Connell, and Ms. Slachta are available for the committee's questions. Thank you, sir.

[The prepared statement of Mr. Trodden appears at p. 83.]

Mr. EVANS. Thank you very much, Steve.

Only one of eight medical centers reviewed by the IG provided the full range of health care services to women veterans. Of the 166 medical centers surveyed by the VA, how many also failed to provide a full range of medical services?

Dr. CONNELL. We don't have the exact figure on that, sir, but I think it is fair to say that the majority did not provide the full range of services.

Mr. EVANS. Could you provide that information for the record?

Dr. CONNELL. We will do that, sir.

Mr. EVANS. We would appreciate it.

(Subsequently, the Department of Veterans Affairs provided the following information:)

We considered a VA medical center to have a full range of women's health services if it had all of three services; a functioning women's stress disorder treatment team, a women's veterans clinic and a gynecological clinic. Of the 166 VA medical centers or outpatient clinics responding to our survey, 159 did not meet these minimum requirements.

Mr. EVANS. Forty-three medical centers simply haven't bothered to offer gender-specific health care to women veterans according to your report. What explanations have these facilities given for not providing gender-specific health care services?

Dr. CONNELL. I think there are various explanations that were given, and we can only comment in detail on the eight which were

personally inspected. Resources have been included as an explanation, and I think that is the most common explanation.

I would add, however, sir, that our inspection indicates that all the issues are not necessarily resource issues. Some of the situations could be improved by attention to the issues, and while this has not been offered as an explanation, I think focus is a very important factor.

Mr. EVANS. Please identify the facilities which were inspected by the IG.

Dr. CONNELL. The facilities that were inspected were Newington, CT; Cincinnati, OH; Gainesville, FL; Sepulveda, CA; Lyons, NJ; Minneapolis, MN; Murfreesboro, TN; and Seattle, WA.

Mr. EVANS. In some cases women veterans have not received health care examinations or treatment because specialized medical equipment wasn't available. What can you tell us about the nature and the cost of the specialized equipment needed to provide these services?

Dr. CONNELL. Some of the equipment is standard equipment, but I think the best way I can respond to that is, I will give you what is called the wish list from one of the women's coordinators that was interviewed. Specula, which are relatively inexpensive items; cytologic brush; procto swabs; a cart to hold the gynecological equipment; textbooks; patient references; and then one or two more expensive items, a culpascope—well, breast self-examining module is not an expensive one. Many of them are relatively inexpensive with a small number of somewhat more expensive items.

Mr. EVANS. Do you think this is because they have not made this a priority, they have not given it the attention that it deserves?

Dr. CONNELL. The coordinators or the hospitals?

Mr. EVANS. The fact that they don't have this relatively inexpensive equipment.

Dr. CONNELL. I am at a loss to explain why inexpensive equipment is not available. I guess it is an attention factor.

Mr. EVANS. The Under Secretary for Health has concurred with an IG recommendation that VA policy be revised to emphasize that each VA medical center and outpatient clinic must provide outpatient GYN services by at least one mechanism in addition to fee-based care. However, this revision is not projected to be completed until September 30, 1994. Is this a timely response, in your opinion?

Dr. CONNELL. I raise my eyebrows at the year and a half or year and a bit delay. I think that is a generous time scale.

Mr. EVANS. Is it too long?

Dr. CONNELL. You might feel that is so.

Mr. EVANS. How many medical center directors transmitted through the region to the Associate Chief Medical Director for Operations by May 1, 1992, an inventory of privacy deficiencies and associated corrective actions which the director had certified as required by the VA directive?

Mr. TRODDEN. We have requested that information, Mr. Chairman, but have not received it.

Mr. EVANS. That was supposed to be done by May 1, 1992. Have you received an explanation from the VA on why they haven't submitted that to you?

Ms. SLACHTA. No. We requested it, and I was told that it was going to be produced and delivered to us, and that was three months ago, and we have not received it as yet.

Mr. EVANS. Do you know if the Associate Chief Medical Director for Operations has, in fact, established a tracking mechanism for corrective actions as required by the VA directive?

Ms. SLACHTA. No.

Mr. EVANS. I want to ask your opinion about research which was mentioned in some of the opening statements. Are women being included, adequately represented, in VA and VA-supported research, as required? Have you looked into that issue?

Mr. TRODDEN. I am not aware that we have looked into that.

Dr. Connell.

Dr. CONNELL. No, sir, that has not been examined. That is one of the issues which will be considered in our series of inspections.

Mr. EVANS. I yield to Congresswoman Waters.

Ms. WATERS. Thank you very much, Mr. Chairman.

I have a statement that I would like to submit for the record that I will not read.

Mr. EVANS. Without objection, so ordered.

Ms. WATERS. Thank you very much.

[The prepared statement of Ms. Waters appears at p. 64.]

Ms. WATERS. Mr. Chairman, I would like to thank you for paying special attention to the issues confronting women veterans. As I understand it, you and others have made some effort to have an assessment of the health care services for women as administered by VA, and I have not yet had an opportunity to evaluate those services in general, but since we have representatives here today that can help guide me through this assessment, I would like to first ask whether or not you can represent here today that the health care needs of women are indeed being met based on the mandates of Congress and your own assessment of what has happened since we mandated that VA provide more comprehensive services for women veterans.

Mr. TRODDEN. Categorically I cannot so assure the Congresswoman.

Ms. WATERS. I hope I am not being repetitive. If I am, you can advise me. Would you, in a concise way, describe to me what you think the unmet needs are.

Mr. TRODDEN. Fundamentally, Ms. Waters, what we found in this report, as Dr. Connell previously mentioned, was primarily an attitudinal sort of thing where the services, first of all, that are supposed to be available to women are not even communicated as to what is available to them. The role of the women's coordinator that was established by law has been filled in a rather variable way. They have ancillary duties. They range in grade anywhere from a grade 5 to a grade 15. The position descriptions are relatively nonexistent.

The question of authority is an important one to me, and I would urge this committee to think that through as well. I would hate to think that we have simply filled in some boxes with some names and some titles if the woman coordinator didn't have the authority, when he or she observed that there was a deficiency in the women's program, to bring that to the attention of both the director of

the hospital and Central Office, and we also think that there needs to be some staffing done at Central Office to underscore the importance of women's programs, and that currently does not exist.

Ms. WATERS. Are there any women medical center directors?

Mr. TRODDEN. Yes, Ma'am, there are.

Ms. WATERS. How many are there?

Mr. TRODDEN. I do not have that total. Following me is a representative from VHA. I suspect he could answer that question. But I do know, because we have either audited or inspected, some VA hospitals which are headed by a woman, but what the precise total is I don't know. There is one in Baltimore, there is one in New York, which are two that instantly come to mind.

Dr. Connell, are you aware of others?

Dr. CONNELL. There is one in Topeka.

Ms. WATERS. Are there any women nursing directors?

Dr. CONNELL. Yes.

Ms. WATERS. There are?

Dr. CONNELL. Yes.

Ms. WATERS. How many do you have?

Dr. CONNELL. I don't know the number of that either, Ma'am.

Ms. WATERS. Mr. Chairman, is it too early in this hearing to talk about the recommendations that are being offered?

Mr. EVANS. They are offering several recommendations, so you can go right ahead.

Mr. TRODDEN. We have ten recommendations in our report, Ms. Waters. We would be glad to talk to each, any, or all of them.

Ms. WATERS. The recommendations are in the report?

Mr. TRODDEN. Yes, Ma'am.

Ms. WATERS. And you believe that these recommendations will get at the problems of a lack of communication of available services?

Mr. TRODDEN. We do. It is like any recommendation we make. We think the recommendations are well targeted and well drawn. What remains is a wholehearted fulfillment not only of the letter of the recommendation, but the spirit, and if both of those are done we do think we will have made a very giant step in the right direction.

Ms. WATERS. Do we have any reason to believe that these recommendations will be taken any more seriously than recommendations have been taken in the past?

Mr. TRODDEN. I have some optimism on that score because I have personally heard both the new Secretary and the new Deputy Secretary confess, if you will—agree with the thrust of this report that the VA has not done right by women, to be really blunt, and that we need to do something about it, so that is the cause of my optimism.

Ms. WATERS. Mr. Chairman, I would like to reserve, if I may, the opportunity to raise another question before the close of this hearing.

Mr. EVANS. In addition, any written questions you may have as well will be included.

Ms. WATERS. Thank you very much.

Mr. EVANS. Steve, thank you very much. We appreciate your assistance this morning.

Mr. TRODDEN. Thank you, Mr. Chairman. It was nice being with you.

Mr. EVANS. We thank your staff as well.

Mr. EVANS. The members of our next panel are Frank Buxton, Dr. Terri Tamase, Jill Manske, and Bette Davis. Frank is the Deputy Director of the National Veterans Affairs and Rehabilitation Commission, the American Legion. Dr. Tamase is the Chief of Primary Medical Care at West Los Angeles VA Medical Center. She is a member of the Medical Center's Women's Veterans Advisory Committee and is an Assistant Professor of Medicine at the UCLA School of Medicine. She is presenting her own views today. Jill is the Women Veterans Coordinator for the Western Region, Veterans Health Administration. She is also presenting her own views today. Bette is a clinical nurse specialist at the Washington, DC, VA Medical Center. She is testifying today as President of the Nurses Organization of Veterans Affairs.

We will recognize Frank first because he is also testifying before the Senate Veterans' Affairs Committee this morning on the same issue, I understand.

Mr. BUXTON. That is correct.

Mr. EVANS. We will hear from you first, and you will be excused at that point to fulfill your other obligation.

STATEMENTS OF FRANK C. BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; TERRI LEE TAMASE, M.D., CHIEF, PRIMARY MEDICAL CARE, DEPARTMENT OF MEDICINE, VAMC, WEST LOS ANGELES, CA, ASSISTANT PROFESSOR OF MEDICINE, UCLA SCHOOL OF MEDICINE, AND MEMBER, WEST LOS ANGELES WOMEN VETERANS ADVISORY COMMITTEE; JILL MANSKE, ACSW, LISW, WOMEN VETERANS COORDINATOR, WESTERN REGION, VETERANS HEALTH ADMINISTRATION, SAN FRANCISCO, CA; AND BETTE L. DAVIS, M.S.N., R.N., C.S., PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS

STATEMENT OF FRANK C. BUXTON

Mr. BUXTON. Thank you, Mr. Chairman.

We have a more comprehensive statement which we ask to be in the record.

Mr. EVANS. Without objection, it is so ordered.

Mr. BUXTON. Good morning, Mr. Chairman and members of the subcommittee. The American Legion appreciates this opportunity to provide our views on women veterans health care within the Department of Veteran's Affairs.

During the Vietnam Conflict, less than two percent of uniformed personnel were women. Today, 12 percent of our military forces are women, as are about four percent of the veterans seeking care in the VA. There is no doubt that these numbers will increase over time. The VA has made some improvement in the availability and accessibility of health care for women. Four regional women's health centers have been instituted and stress disorder teams have been formed. Fifteen additional Women Veteran Coordinators and four regional coordinators have been appointed. The VA has ex-

panded its capabilities to provide counseling to victims of sexual abuse and trauma, and those services must continue.

Mr. Chairman, these activities demonstrate but a modicum of compliance with Public Law 102-585. There must be continued efforts to assure that women veterans receive all the care which is needed and for which they are eligible. VA should continue to utilize fee-based care for service-connected women veterans in areas where it is not cost-effective to provide that care at the VAMC.

Where the demand is demonstrated, full-service care for women veterans must be provided. Budgetary constraints have made care for non-service-connected veterans a problem for both male and female veterans. The Congress must move rapidly to reform eligibility for VA medical care to assure adequate care for all veterans. The American Legion plan to improve medical care for veterans offers sound advice to Congress on how to make veterans' health care available, accessible, and affordable for all veterans entitled and eligible for such care.

Setting rational eligibility and entitlement criteria will determine the populations to be served, and, following that, needs assessment will provide care and funding parameters.

Mr. Chairman, in addition to clinical care, the VA must concern itself with privacy issues affecting women veterans since most facilities were designed with an expectation of a mostly male patient population. Other amenities for women patients such as conveniently located, separate, and private lavatory and shower facilities in clinical areas must be provided. In addition, there must be adequate public rest room facilities throughout and the availability of gender-specific personal care items, cosmetic toiletries, reading materials, and that should be assured by the canteen.

Mr. Chairman, the American Legion strongly advocates the placing of special emphasis on the need for increased research efforts by the VA in the areas affecting women's health. It is also important to fund and provide education, research, clinical treatment outreach to special needs of women veterans of all ages, not just those of the child-bearing ages. Research, prevention, treatment of illnesses and disabilities such as osteoporosis for older women and, in particular, those nearly 400,000 female veterans over the age of 65 must be ongoing.

Mr. Chairman, that concludes our statement.

[The prepared statement of Mr. Buxton appears at p. 86.]

Mr. EVANS. Thank you, Frank. We appreciate your testimony, and you may be excused at this time.

Mr. BUXTON. Thank you very much, Mr. Chairman.

Mr. EVANS. Ms. Manske, we will hear from you next, if you will please pull that microphone closer to you.

STATEMENT OF JILL MANSKE, ACSW, LISW

Ms. MANSKE. Mr. Chairman and members of the subcommittee, I have been the regional Women Veterans Coordinator for the Western Region since April. I have been a Women Veterans Coordinator since 1984, serving at VA hospitals in Chicago and Minneapolis. I am a social worker with 18 years Federal employment, including four in the Air Force. I appreciate being asked to testify.

In 1984, VA medical facilities were required to appoint Women Veterans Coordinators to serve as advocates for women veterans. All coordinators had full-time primary jobs, mostly in nursing and social work. There were no formal guidelines, but national conferences were held in 1985, 1986, 1990, and 1992 to provide guidance, orientation, and peer support. In 1985, VA recommended that regional Women Veterans Coordinators be appointed.

The Midwestern Region funded a half-time position, which I filled from 1987 until 1990. When the regions were reorganized, the Central Region funded my position in full. The Central Region Women Veterans Program became a prototype. It included newsletters, conference calls, an orientation program, consultation, external review, coordinator awards, and a program guide. At the time, I was the only regional Women Veterans Coordinator, but due to the success of our program, VA required all regions to appoint regional coordinators.

A number of issues have been identified by Women Veterans Coordinators. The most often cited concern was time allocation. Coordinators report having little time to see women patients. Many use their lunch time or stay late. At facilities with full-time coordinators, services to women have been enhanced, and I welcome the decision by VA to fund 18 coordinator positions in this fiscal year.

Another concern has been adequate support from medical center management. The program guide stresses the importance of giving coordinators direct access to medical center management with regularly scheduled meetings. Clerical support, office space, and general management support are critical.

Clearly defined responsibilities are another concern. Often coordinators are appointed without clear plans for their roles. The program guide offered that guidance in Central Region. In addition, coordinator orientation and networking have been invaluable.

On-site gynecologic care is a goal of most Women Veterans Coordinators. Those without women's clinics are trying to develop them. Interest in state-of-the-art, gender-specific care for women was demonstrated by the 50 proposals that we received for comprehensive women's health centers this year.

Breast cancer screening and mammography services have not always been uniformly available to women veterans. In 1991, VA required facilities to offer screening and diagnostic mammography. Since the American Cancer Society reports that one woman in nine will develop breast cancer, it is vital for women veterans to have access to screening.

Privacy has been an ongoing concern at some of the older facilities. However, a recent directive mandated physical inspections of patient care buildings to identify privacy deficiencies and plans to correct them.

Equal access to health care was an issue when I became a coordinator. Very few women were accessing the system, and some didn't receive a very welcoming reception. With the appointment of Women Veterans Coordinators and the attention given to their programs, access to health care has become more equitable.

The access problem has shifted to awareness of eligibility for benefits. Outreach to women veterans is vital. The Lou Harris sur-

vey found that women veterans greatly underutilize VA benefits, mostly through ignorance of their availability.

The slogans that VA uses, "Women are veterans too," and, "Same service, same benefits," have been helpful in getting the word out to women veterans and in convincing them that they are true veterans.

There has been much interest in sexual assault of women in the military. I served on a VA sexual trauma task force to plan a national conference, design a pamphlet, gather statistics, plan a teleconference series, and encourage the establishment of sexual trauma treatment teams. The funding of a women's division at the PTSD Center in Boston and the opening of a PTSD treatment program for women at Menlo Park, California, have enhanced care available to women veterans.

To outside bodies such as GAO and the IG, it may appear that VA is not providing adequately for the needs of women veterans. While there may still be concerns about health care provided to women, I have seen substantial progress in the nine years that I have been involved. More women veterans are accessing our system than ever before, thanks to the efforts of the women veterans coordinators.

The majority of VA's provide gender-specific health care on site, and for the first time this year VA received money for women veterans programs, allowing the funding of comprehensive women's centers, stress trauma teams, training, and positions. This is an exciting time to be involved in women veteran programs. Coordinators are feeling empowered to improve access and quality of care. Management is realizing the importance of providing health care to women veterans.

I am not concerned with why people are suddenly interested in women veterans or what stimulated that interest. The important thing is that finally Washington is as interested in women veterans as the coordinators have been since 1985. I hope with all my heart that you continue to have an active interest in women veterans and continue to support VA initiatives to provide for their needs.

That concludes my remarks.

[The prepared statement of Ms. Manske appears at p. 97.]

Mr. EVANS. Thank you very much.

Doctor.

STATEMENT OF TERRI LEE TAMASE, M.D.

Dr. TAMASE. Good morning, Mr. Chairman and members of the subcommittee.

My name is Terri Lee Tamase. I am a full-time physician in the Department of Medicine at the West Los Angeles VA Medical Center and assistant professor at the UCLA School of Medicine. I am also a member of the Women Veterans Advisory Committee. It is indeed an honor to be invited to provide information on the important issue of medical care for women veterans.

The West L.A. VA, the largest and most complex VA medical center in the country, has a catchment area of approximately 90,000 women veterans. The women veterans of Los Angeles have female health care needs unique to their urban environment, including the

highest incidence of homelessness and the third highest incidence of AIDS.

Our history demonstrates that until recently health care and related issues for women veterans at the West L.A. VA were approached reactively rather than proactively. Predictably, our services were underutilized by female veterans who chose to receive their care elsewhere. Several aspects of the system contribute to this underutilization.

The first barrier is knowledge that there is access to health care for women at VA's. Further, those women veterans who are aware of our services are frequently unaware of their eligibility. Those who are familiar with our women's programs often seek care elsewhere to avoid the sometimes user unfriendly system.

The second barrier is that equipment, supplies, and accommodations do not exist with the needs of the female veteran in mind. For example, only recently have the canteens stocked necessary and sufficient hygiene products, toiletries, and clothing.

The third barrier is a lack of comprehensive, gender-specific services. While we fulfill acute care needs through an affiliation with the Santa Monica Rape Crisis Center, we must further develop ongoing programs which target the female-specific needs of sexual trauma victims.

The next barrier is the system's failure to recognize that many common illnesses have gender-specific presentations. To this end, it is imperative that our research efforts begin to focus on the study of gender-specific diseases. We at West L.A. have actively begun to recruit women veterans for our clinical research protocols.

A few key events catalyze the reassessment and review of health care services for women at West Los Angeles including, one, this subcommittee's hearings on the status of VA health care for women veterans held on September 17, 1992; two, the commitment of West L.A.'s woman chief of medicine, Dr. Phyllis Guze, to women's health issues; and, three, the recruitment of West L.A.'s new director and chief of staff, both interested in health care for women veterans.

To overcome these barriers, we at West Los Angeles have created the Women's Life Cycle Health and Education Center, known as Well Check, which we fully expect to be funded in fiscal year 1994. I have provided a copy of the proposal for the committee.

Well Check will serve women veterans through two interrelated core components. The first component is a multi-disciplinary primary care core focusing on prevention and one-stop medical care. The second component is a comprehensive education and development core centering around patients and health care providers. We anticipate that over time this education and development center could be a national resource to the VA for education and development in the area of women's health.

With the success of Well Check, priorities and objectives for the nineties and beyond include recurring funds for, one, outreach to advertise our product and improve our image; two, education in women's health for patients and health care providers; three, equipment and supplies; four, physical plant alteration; and, five, implementation of the Well Check model at other VA facilities.

In conclusion, we need to admit to ourselves that we are not fully comfortable or equipped to care for women veterans in our male-oriented VA system. Over the past year, VA's Central Office, with the encouragement of Congress and through the funding of programs such as Well Check, has proactively sought to improve health care for women veterans. However, upgrading health care for women requires not only state-of-the-art resources in a few specialized VA centers but also basic quality services for women at every VA facility, large and small.

Mr. Chairman and committee members, thank you for inviting me, and thank you for your time spent in listening to my presentation.

[The prepared statement of Dr. Tamase appears on p. 89.]

Mr. EVANS. Thank you, Doctor.

Bette.

STATEMENT OF BETTE L. DAVIS, M.S.N., R.N., C.S.

Ms. DAVIS. Mr. Chairman and members of the subcommittee, as president of the Nurses Organization of Veterans Affairs, NOVA, I am speaking on behalf of NOVA and all VA nurses. We appreciate the opportunity to testify before the committee today and acknowledge the chairman's long-standing commitment to quality health care for all veterans.

VA has made significant progress in less than a year since recent legislation authorized the Women Veterans Health Programs Act of 1992. Since enactment of the law, a Women Veterans Health National Training Program was established for national training of VA health care personnel in the treatment of sexual and gender-specific medical problems.

Other positive health care activities include hiring counselors in 64 veterans centers, designating four women veteran comprehensive health centers, establishing four women veteran stress disorder treatment teams, hiring four full-time regional Women Veterans Coordinators for each region—in addition to 15 full-time coordinators in VA medical centers, initiating the current network for PTSD programs, and the RC vet centers, and also establishing a new women's division within the National Center for Post-Traumatic Stress Disorder. Yet we need to readdress long-standing problems in the same real issues impeding progress. It involves time, money, and training.

Therapy is a slow recovery progress even for normal people. The time limitation of one year for counseling and, more importantly, the reporting of sexual assault for care within two years of leaving the military is too restrictive and clinically inappropriate. Research indicates that a significant amount of sexual trauma is never reported and may also be repressed for years.

Presented in NOVA's testimony is a recent case example of an unreported rape, subsequently repressed, that occurred 14 years ago while the woman veteran was on active duty in the military. It illustrates how a person who suffered from rape developed PTSD years later. This case also illustrates a need for staff education at the local level in dealing with PTSD related to rape or sexual abuse. Many of the inpatient staff at this time had difficulty deal-

ing with her PTSD symptoms, resulting in a negative and frightening hospital experience.

The law gives VA the authority to provide counseling to all women veterans for sexual trauma which occurred while serving on active duty in the Armed Forces. Not only are they to be given priority in outpatient care settings, but they will not be required to prove that they were traumatized. This is not happening.

It is difficult to connect sexual trauma to females who present vague, depressed, not-feeling-well symptoms, or are reluctant to talk directly about a deep-seated sexual trauma. Unless they are service-connected or Category A, these women veterans don't get past the screening people because of a heavy workload, lack of information, or lack of sensitivity to explore the nature of the problem.

Female veterans, along with male veterans, are screened by medical administrative services and are excluded from care unless they are service-connected or at poverty level, Category A. Many are Category C and working. They want to work, but they need help to stay healthy. So, some women veterans who were sexual assault victims do not make it through this process. They are being rejected and probably will not return to the system.

There are now, to my latest knowledge, 15 full-time Women Veterans Coordinators in the field. However, most coordinators in the VA medical centers are still assigned to this position as a collateral duty and are not given sufficient time or resources to fulfill this obligation. There is no official job description requiring evaluation of performance or that it be included on a proficiency report for those with collateral assignments.

There is still a wide variation in the number and kinds of services offered in each facility and a broad diversity in the amount of time, number of hours, available or allotted for each coordinator position. The time can range from a few hours each week to one or more days per week. Some facilities have women advisory committees to discuss needs of women veterans, some do not, unless you count two coordinators, each with two hours per week, who meet with each other once a month.

The Minneapolis VA medical center, selected as one of the four women veteran comprehensive health centers, is an exemplary model of what can be done in health care programs for women in an area serving over 20,000 women veterans. By contrast, other facilities' services vary considerably. For example, one medical center's GYN clinic is held one day per week for five hours and is staffed by two women physician assistants each for two and a half hours. Consultants and attending staff are used. The clinic backlog is 60 consults, and waiting time is six to eight months for pelvic exams and Pap smears. There is no GYN examination room. Materials are on a cart and moved from one room to another. There is a men's dysfunction clinic, but women's sexual issues may be addressed in GYN clinic only.

There is no current research data on the incidence of cancer among women veterans and their nonveteran peers. According to the American Cancer Society, no such data exists. The VA does not have a centralized tumor registry. NOVA suggests VA submit data on diagnosed cancer in female and male veterans to each State's

Centralized State Tumor Registry Program. The States, too, would need an intake data question on veteran status, whether or not used in the VA.

Thank you, Mr. Chairman, for the opportunity to testify. We look forward to working with you.

[The prepared statement of Ms. Davis appears at p. 105.]

Mr. EVANS. Thank you very much for your testimony.

I will yield at this time to the gentlewoman from California.

Ms. WATERS. Thank you very much, Mr. Chairman.

I would like to thank all of our women who are here this morning helping us to understand what the situation is in our VA centers as it relates to women.

I am particularly impressed with what appears to be your comprehensive knowledge not only about the centers where you are but about the overall system.

Dr. Tamase, I intend to visit very soon out at West L.A., and I look forward to perhaps our getting together so that you can further identify for me some of the concerns that you have raised.

What is emerging here is a picture of unevenness in the administration of services, and it appears while there may be a model program some place, most places don't have those. I would like to commend all of you for the work that you have done with making something out of women coordinator's roles despite the fact you weren't given the resources and the training early on.

But that leads me to where I think we need to go, and that is an establishment of a Women's Bureau right at the top, so that we can have not only advocacy right at the top, but the kind of oversight that would help to ensure that these services, as they are identified, are, in fact, possible in an even way throughout the system.

We have introduced legislation. I will not ask you at this point whether or not you think there is a need for a Women's Bureau. I would like to make sure that you get copies of the legislation and have my staff also disseminate further information to you about what we envision and then have you give me some feedback about what you think about that possibility.

With that, Mr. Chairman, I thank you very much for once again taking your time and emphasis to serve women, and appreciate this hearing, and appreciate the opportunity you have given me for interacting with those who have come to testify today.

Mr. EVANS. We thank you and salute you for introducing the Women's Bureau legislation, something specifically the Vietnam Veterans of America support. I think is definitely needed and your leadership on these issues is very greatly appreciated.

Ms. WATERS. I also have gone over this with a number of Members, and we think that we want to have a bill that is definite, that is strengthened by way of changing some of the wording from what it is now. I think it has been mentioned to us that we have "mays" where perhaps there should be "shalls," and I have no problems with that, Mr. Chairman.

Mr. EVANS. Unfortunately, given our experience in many other issues, sometimes more mandatory language is necessary. We appreciate your willingness to be flexible on that issue.

There are problems because the roles and responsibilities of the Women Veterans Coordinators are not clearly defined. Let me ask all of you: If that is corrected, what should the relationship be between the coordinator and the local medical center director? Should the coordinator be reporting directly to the director or to the director through the chief of staff or another official at the hospital? May I have your opinions on that?

Ms. MANSKE. Minneapolis has been cited several times as having an exemplary program, and I think one of the reasons that it has that kind of a program was because they funded a Woman Veterans Coordinator position, not just a collateral assignment, in 1986, and that coordinator reported directly to the medical center director and the chief of staff. The coordinator was perceived throughout the hospital as having some power to make some changes and make some recommendations and really kind of planted seeds and got people thinking about women early on. They started a mammography program with only 35 women, kind of a "Field of Dreams" sort of a thing—"Build it, and they will come"—and now they have got over 900 women coming there to that clinic.

So I think having a funded position is the key, and having that person report directly to medical center management is absolutely necessary. The coordinators I know who report through their service chiefs don't have as much authority or power or credibility within the medical center.

Mr. EVANS. How many report directly to the medical center director?

Ms. MANSKE. Well, since they are in collateral assignments, they report to their service chiefs. Most of them are nurses or social workers. I would say probably three-quarters of them have some contact with the director or chief of staff, oftentimes not regularly scheduled meetings, kind of catch as catch can. But it is important for them to have that direct line.

Mr. EVANS. Do you think it is something we might have to do legislatively to clarify?

Ms. MANSKE. Or at the regional level in the VA. I mean it is something that the regional directors could do—could say that you must have these positions report directly to medical center management.

Mr. EVANS. Any other comments on this?

Dr. TAMASE. Yes. Can I comment first on what I think the basic needs are for women in the VA system? Would that be okay, to digress?

Mr. EVANS. Certainly.

Dr. TAMASE. I think what we have to recognize is that the care we provide women is much different than that for men. Women seek care for the normal events in their lives, when they are going through their child-bearing years, their peri-menopausal years, and their geriatric years, and what we need to do is, we need to have basic services to address those three life cycles.

As an example, at all VA medical centers we should have the ability to perform yearly Pap smears, and the fact that speculums are not available at certain facilities is unconscionable. Fortunately, we at West Los Angeles do have speculums, although we do not have disposable ones.

So I just wanted to make that point.

With regard to the Women Veterans Coordinator, I think it is dependent upon the facility. Our facility is actually run primarily by the Department of Medicine, and we are a training facility. What we envisioned was to have a board consisting of a Department of Medicine member, a member from the chief of staff, one member from the Women Veterans Advisory Committee, to which the Women Veterans Coordinator would report.

I think that that would be a more reasonable way to approach this, because clearly there is a lot of politics involved, and having representation from each of the various portions of the facility I think is really imperative, and we may even want to place someone from the outlying centers, the vet centers, on that committee as well, because clearly outreach is significant to the Women Veteran Coordinator position.

Mr. EVANS. Thank you.

I yield to the gentlewoman from California.

Ms. WATERS. I guess you just jolted me a little bit when you said that something as basic as speculums are not available, and disposable ones, at this day and age at the VA hospital in Westwood.

Dr. TAMASE. Not in West L.A. I was commenting on what the Inspector General had stated I believe before you came in, which was that at some facilities they do not have basic things such as speculums, cyto brushes, and the like. I know that there are facilities that have nothing for women. No. At West Los Angeles we actually do have all of those state-of-the-art things on line.

Ms. WATERS. Thank you very much, Mr. Chairman, but I think that still, if it is not available throughout the system, is a problem that could be addressed yesterday.

Dr. TAMASE. Absolutely.

Ms. WATERS. And, Mr. Chairman, you can make a call and get that done.

Mr. EVANS. We will pursue that.

Thank you, Maxine.

Bette, did you have a comment?

Ms. DAVIS. I was just going to say, as one of our VA nurse coordinators said, we have no staff, no space, and no clout to get it. So I do believe we need to report to either the hospital director or the chief of staff which, in reality, may be more practical, but we certainly need that route to the power.

Mr. EVANS. Doctor, I spoke in my opening remarks about the VA being competitive and meeting community standards so that under national health care reform VA will still be a player. Would you consider West L.A. to be competitive with the UCLA Medical Center, which I know you also work with, in terms of providing for women's health care?

Dr. TAMASE. Right at this moment, if I had to choose where to go for health care, I would choose to go to UCLA.

I think what needs to be understood here is that we actually have state-of-the-art equipment on board in most areas. The problem is with the culture, the attitude of the people working at the facility, the fact that the residents are not used to examining females, the fact that the nurses are not used to females. As we know, this is a Catch-22 issue.

I actually have a quote from one of the women veterans. Would you like to hear that?

Mr. EVANS. Yes.

Dr. TAMASE. This was actually a quote taken back in 1990 before we established state-of-the-art equipment and actually got a new female gynecologist. This patient is a 64-year-old retired widow. She was a Navy clerical worker between 1951 and 1955 based in Washington, D.C. In 1990, she presented to the West L.A. Gynecology Clinic for routine pelvic examination. This is her account of the experience.

"I went to the Gynecology Clinic shortly after the regular gynecologist retired. I hadn't been to see a doctor for a pelvic exam very often in the past three years, and it was very, very painful. The doctor was having a problem, and the nurse kept shouting, 'Relax. Relax.' Perhaps it would have been painful anyway, but the doctor didn't seem to be very experienced. So I felt I didn't care to ever go back. I decided to go to a private doctor. I didn't feel I was treated with consideration. I'm sorry I don't remember all the details. It's something I try to forget."

She further stated that shortly after her experience at the West L.A. Gynecology Clinic she purchased private health insurance. Her current monthly payments of \$300 cause significant hardship, yet she chooses to pay a higher price for health care and assume a financial burden rather than utilize the health care services for women provided by the VA.

Mr. EVANS. That culture is changing at West L.A. because, you believe, of the Women's Advisory Committee and the efforts that you have made?

Dr. TAMASE. Absolutely.

Mr. EVANS. Are there other things that can be done so you can get on par with UCLA?

Dr. TAMASE. Actually, I think the funding that we have been promised for the Well Check—Women's Life Cycle Health and Education Program—is really going to get things going at our facility.

Mr. EVANS. Ms. Waters.

Ms. WATERS. What did you say about that money? You have been promised some money from where?

Dr. TAMASE. Fiscal year 1994.

Ms. WATERS. It is in the budget?

Dr. TAMASE. Apparently.

Ms. WATERS. We will inquire.

Dr. TAMASE. Thank you.

Ms. WATERS. Thank you.

Mr. EVANS. Given the concerns that women veterans have had coming into the hospital system and not being made aware of their treatment possibilities, I wonder if Women Veterans Coordinators are also needed at each of the Veterans Benefits Administration's regional offices. I don't know if you have dealt with that issue or not, but I would like to know your opinion.

Ms. MANSKE. They do have Women Veterans Coordinators at all of the benefits offices, but, again, it is a collateral assignment. Mostly they are benefits counselors who also are the women veterans outreach coordinators. When women call, they try to divert those calls with questions about benefits to the coordinator, but,

again, it is a collateral assignment, and there is only so much you can do with a collateral assignment.

Mr. EVANS. Bette, according to your statement, the requirement to report a sexual assault within two years of being discharged from the military is too restrictive. What time limit, if any, could you recommend for us?

Ms. DAVIS. Well, I can't. This one example was 14 years later. If you put a time limit on it of four, five, or six years, it still would not have applied to her. I mean that is a difficult question to answer. I suppose it would have to have a time limit. Five to ten-year range at minimum, but it would be difficult to state a time limit.

Mr. EVANS. Then there is the other limitation of one year of help.

Ms. DAVIS. Of counseling? That is far too restrictive. That takes years sometimes.

Mr. EVANS. Do you know of any cases in your own experience here in Washington where that one-year counseling limit has been extended by the discretion of the Secretary?

Ms. DAVIS. I do not know of any.

Mr. EVANS. Any other experiences?

Dr. TAMASE. The only thing I would like to comment on is, clearly, one year of counseling is not enough—a minimum of five years.

Ms. MANSKE. When I was at Minneapolis, we routinely asked women about sexual trauma. When Senator Cranston sent a survey around last July asking specifically questions about sexual trauma and treatment provided to women veterans, we surveyed the women in the women's clinic that week to find out how many of them had ever suffered sexual trauma or sexual harassment in the military. One in six said that they had, and the majority are World War II era women veterans, so they are well beyond the two years post-military discharge, and if they have had a sexual trauma experience that long ago, it is going to take more than a year to resolve some of those issues.

Mr. EVANS. Bette, you spoke about a VA facility where a woman veteran was told that only male combat veterans can file for PTSD. Can you tell us what facility that was?

Ms. DAVIS. It is all right to do that? It is American Lake VA in Takoma, WA.

Mr. EVANS. We have just been joined by the Ranking Member of the subcommittee, Congressman Tom Ridge, and recognize him for any statements or questions he might have.

Mr. RIDGE. Thank you, Mr. Chairman.

I ask unanimous consent to put my statement in the record and apologize for running late this morning and yield back to the chairman.

Thank you.

[The prepared statement of Mr. Ridge appears at p. 62.]

Mr. EVANS. We want to thank you all very much for your important testimony before us today.

Testifying on behalf of the Department of Veterans Affairs today is Wayne Hawkins, Deputy Under Secretary for Health Administration and Operations. He is accompanied by Dr. Susan Mather, Assistant Chief Medical Director for Environmental Medicine and Public Health; Dr. Jessica Wolfe, Director, Women's Health Sciences Division, VA Medical Center, Boston; and Sheila Spicer,

National Women Veterans Program coordinator, Readjustment Counseling Service, Northeast Regional Office, Providence, Rhode Island.

Wayne, when you are ready, please proceed.

STATEMENT OF C. WAYNE HAWKINS, DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATION AND OPERATIONS, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY SUSAN MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR ENVIRONMENTAL MEDICINE AND PUBLIC HEALTH; JESSICA WOLFE, M.D., DIRECTOR, WOMEN'S HEALTH SCIENCES DIVISION, VA MEDICAL CENTER, BOSTON, MA, NATIONAL CENTER FOR PTSD; AND SHEILA SPICER, R.N., M.S., C., NATIONAL WOMEN VETERANS PROGRAM COORDINATOR, READJUSTMENT COUNSELING SERVICE, NORTHEAST REGIONAL OFFICE, PROVIDENCE, RI

Mr. HAWKINS. Thank you, Mr. Chairman and members of the subcommittee, for the opportunity to report on how the Department of Veterans Affairs is addressing the health care needs of women veterans.

As you indicated, with me today are Dr. Susan Mather, the ACMD for Environmental Medicine and Public Health; Dr. Jessica Wolfe, Director of the Women's Health Sciences Division, the National Center for PTSD; and Ms. Sheila Spicer, the Readjustment Counseling Service, National Women's Coordinator.

Mr. Chairman, women veterans comprise four percent, or 1.1 million, of the total veterans population of 27.2 million. However, their numbers are increasing annually. Women veterans currently represent 11 percent of the active duty force and 13 percent of the reserve force.

In fiscal year 1992, VA health care facilities provided care to 274,498 women, an increase of 21,152, or eight percent, over fiscal year 1991. Eighteen VA facilities treated more than 3,000 women veterans in 1992. While we still need intensive outreach concerning veterans' benefits for some women veterans of earlier war eras, women Persian Gulf veterans are using VA services in numbers greater than their proportion of active services.

Secretary Brown has committed VA to assuring an equal access to health care for women veterans and to supporting women veterans health care initiatives including those designed to implement the provision of title I of Public Law 102-585 which was enacted late last year. These efforts include progress in providing gender-specific health care services for women veterans, addressing privacy concerns, complete physical examinations, and appropriate cancer screening, GYN and reproductive health care services, priority access to comprehensive sexual trauma counseling, and the coordination of related health care, improving VA reporting of VA health care services to women veterans, and developing protocols to monitor the quality of the services provided to women veterans, and planning for new research initiatives related to women veterans' health needs.

Mr. Chairman, our formal statement details extensive efforts that have been taken and that are planned to initiate special counseling and treatment programs for women veterans who have suf-

ferred sexual trauma during their military services. These efforts include the development of a five-part national training program to prepare VA health care professionals to counsel and treat women veterans, the allocation of additional staff and resources for readjustment counseling, and four special PTSD treatment programs, and creation of a Women's Health Sciences Division of the National Center for PTSD.

In addition to the specific initiative to address the health care effects of sexual trauma, a number of other initiatives have been developed specifically to address health care needs of women veterans. These include the opening of four Women's Health Care Comprehensive Centers in 1993, and an additional four are planned for 1994; funding full-time women coordinators at 22 medical centers; funding full-time regional Women Veterans Coordinators; and a full-time women veterans national education coordinator at the Birmingham Regional Education Center to implement a multi-year national training program supporting the Women Veterans Health Programs.

The VA has also taken steps to encourage research on the unique health needs of women veterans and to require the fullest possible participation of women in all VA research studies.

Mr. Chairman, the VA Inspector General, whom you heard from recently, completed his audit of the women veterans program. The Inspector General's audit identified areas for improvement, and we have developed plans to respond to those recommendations. It is obvious that while many creative and innovative programs exist at the local level, there does need to be greater standardization of information and services. This will be our major programmatic thrust in the coming year. Also, the implementation of national quality indicators and improved data gathering capabilities will be accomplished during this coming year.

You will be pleased to know that we have in the VA complied with the recommendations of the 1992 GAO report discussed before your committee last year. Significant progress has been made during the last three fiscal years in providing additional privacy for female veterans in VA health care facilities, and increased emphasis has been placed on the provision of routine preventive health services to women veterans, including routine screening examinations for breast and cervical cancer.

Mr. Chairman, although the VA has always opened its doors to the Nation's women veterans population, the enactment of Public Law 102-585 and the special funding provided by the Congress last year provided a tremendous stimulus for improving VA services to women veterans.

An increasing number of women veterans are coming to the VA for services, and thousands of our dedicated staff are prepared to provide health and counseling services to them. During this coming year, we hope to further expand services for women veterans and plan to make the program improvements suggested by the recent Inspector General's audit.

Mr. Chairman, that concludes the summary of my remarks, and we would be happy to respond to any questions you or the committee may have.

[The prepared statement of Mr. Hawkins appears at p. 113.]

Mr. EVANS. Thank you very much. We will have a number of questions that we will also submit to you in writing, and your responses to those questions will be made part of the record.

First, let me ask you if you agree with Deputy Secretary Gober's recent statement that the VA has "neglected women badly" and must do more in the area of women's health care.

Mr. HAWKINS. Well, Mr. Chairman, since he is my boss, I would not want to disagree with him. I think we certainly have some improvements to make, and we have concurred in the IG's recommendations, and I think we can do a better job in the future.

Mr. EVANS. Will you be supporting legislation then to implement the recommendations made by the IG?

Mr. HAWKINS. I don't think most of them will require legislation, but if they do, certainly we will be happy to support that. Most of the recommendations made I believe we can correct within existing funds as well as laws and regulations.

Mr. EVANS. You have heard Congresswoman Schroeder talk about VA attitude problem. You have heard some of the panelists before you talk about the culture of the VA, being male dominated. What will the VA do to address this problem of a workplace culture that discriminates against women?

Mr. HAWKINS. We have several things under way such as training programs. I know Dr. Mather has been working on that very specifically, and if I could ask her to respond to that, please.

Mr. EVANS. Doctor.

Dr. MATHER. I think as an integral part of all our training programs, attitudes will be addressed. There is a gender bias that exists in society, and the VA is not immune from that gender bias. I don't think you have to look very far to see that that is not a unique situation to the VA. But the VA culture is extremely masculine, and this is one that we have to work with, and our training programs will work with that.

I think certainly Secretary Brown's recent statements on zero tolerance for sexual harassment are a help in the workplace. His and the Deputy Secretary's statements, the Chief Medical Director statements, and the training programs will address that. I think the high visibility you have given this and the Senate is giving these issues also help send a message to everyone that sexual harassment won't be tolerated in the workplace and that women are veterans too. They gave the same service, and I think the stories of their bravery and their high performance in the recent Persian Gulf crisis help combat attitudinal problems that somehow they are only secretaries or nurses, that they are not full-fledged members of the military, because they certainly are. Even playing traditional roles within the military, they are very essential, the nurses and the clerical staff.

After all, in 1918 Josephus Daniels said, "Is there any rule that women can't serve in the Navy?" and they said, "No rule at all," and he said, "Well, give me women then, and we'll have the best clerical staff in the world." They estimated that it would take two women to replace one male clerical worker, and, in fact, when they instituted the program one woman replaced two male clerical workers.

So, actually, it is a very efficient way for the military to deal with some of their problems just to bring more women into the military.

Mr. HAWKINS. Mr. Chairman, I might also—along that same line, we have asked Dr. Mather to address all of our facilities this coming Friday on our hotline to all the directors, chiefs of staff, and key staff at our medical centers regarding that issue, and that will be done this Friday.

Dr. WOLFE. May I add something, Mr. Hawkins?

Mr. HAWKINS. Doctor.

Dr. WOLFE. I think one of the problems that VA has struggled with, as you mentioned, is the workplace culture and the fact that women veterans are currently only 4.5 percent of the veteran population, making them a substantial minority in the veteran community, and that will change, to go to about 10 or 11 percent in the next decade. Nonetheless, that leaves women veterans significantly underrepresented in the health seeking population of veterans compared to the general civilians outside, where they may be anywhere from 52 to 74 percent of health consumers.

I believe that the bill that was passed, the Women Veterans Health Care Act, as part of the Veterans Health Act of 1992, really was a significant impetus and help to us in providing specialized, designated programs—the Women Veterans Comprehensive Health Care Centers, and the Women Veterans Stress Disorder Treatment Teams—by providing specialized, discrete programs which these women veterans can not only recognize from the outside, but then feel comfortable in accessing because they know they will be dealing with professionals and support staff who are specifically interested in providing them with state-of-the-art care.

So I do believe that VA has a strong interest in this area, but I also feel that the provision of these specialized programs when you are dealing with a minority culture is probably exceedingly helpful in dealing with some of the barriers to access.

Mr. EVANS. Congresswoman Waters has proposed a Women's Bureau in the VA, and I know she would be interested in your comments on this proposal.

Mr. HAWKINS. We have not been asked to officially review that. We have seen a copy of it. The Secretary has not taken a position on that at this point.

Mr. EVANS. We would ask you to consider this and respond to it as part of the written questions that we will submit to you.

Can you save me the phone call that we talked about in terms of some of the basic equipment?

Mr. HAWKINS. Yes. Let me just say, Mr. Chairman, that I know of no reason why any facility should not have the basic supplies to provide the services that are needed at that medical center, and I will be happy to address that to all of our medical centers this coming Friday also, and if there is a problem, I certainly would like to know more about it.

Mr. EVANS. In addition to national quality indicators being implemented and data collection accuracy being improved one year from today, what specific changes and improvements in VA women veterans' health care services should this committee expect as a re-

sult of greater standardization of information and services being VA's "major programmatic thrust in the coming year"?

Dr. MATHER. I think one of the important areas that we will be addressing is the position description for Women Veteran Coordinators and the allocation of an appropriate amount of time for that. We will be implementing 18 full-time Women Veteran Coordinators and an evaluation of the program. Hopefully within a year we will have the answer to the frequently asked question, will we impact significantly on the health care of women by appointing full-time Women Veteran Coordinators? So I think you can expect to see more standardization of the time Women Veteran Coordinators spend on those duties, more full-time Women Veteran Coordinators, and an evaluation of that program, per se.

We are also having a training program at the end of July for primary care providers within VA, and I think there is sometimes a confusion about how to provide services to women. Women are more than their reproductive tracts, and women's health can be provided by other than gynecologists. I think it is important to realize that women's health care has a real role in primary care, and as primary care is expanded in our ambulatory care centers, there will be increased emphasis on the special primary care that women veterans require.

Mr. EVANS. So you will be trying in the near future then to develop the job descriptions?

Dr. MATHER. We have a job description developed. It hasn't been approved by personnel yet, but we are certainly using that as a draft, and we are working hard to get that coded.

Mr. EVANS. The next step would be a report to us. Have you figured that out? That will be done on a systematic basis?

Dr. MATHER. Right. We provided you a report in January as a sort of base line based on the requirements of Public Law 102-585, and we will be continuing to provide those reports.

Mr. EVANS. We have heard about the high rate of turnover among Women Veterans Coordinators because of a lack of time to do the job, the burn-out factor, and so forth. What is the turnover at this point, do you know?

Dr. MATHER. I don't know.

Mr. EVANS. Is it a concern you have?

Dr. MATHER. Yes, it is. For purely practical reasons, if nothing else, if we are investing in training in these people, we would like them to stay. One of the problems that occurs is that people who have been trained then leave and we have an untrained person in that position. So yes, we do want to keep them in the positions.

Mr. EVANS. Let me yield to the gentleman from Pennsylvania for any questions he may have.

Mr. RIDGE. Thank you very much, Mr. Chairman.

I would like to flesh out a little bit more, if I could, the direction that you think we should take with the Women Veterans Coordinators at these facilities to get an idea as to the responsibilities you think this position should have and to whom she should be reporting.

I have a couple of VA medical centers in my congressional district—the Erie facility, the Butler facility, and right outside the district is the Pittsburgh facility—and the incidence of use I think is

consistent with the national norm, four or five percent, Persian Gulf women veterans using it a little bit more, everything is consistent.

But as I see a coordinator, I am wondering in my own mind if she is the ombudsperson to facilitate treatment; is she to be working and reporting to the medical director and/or the advisory board? I am just trying to figure out, other than a title and an important public response, what this individual will be empowered to do to help female veterans who are having a difficult time either accessing treatment or getting some response from within the VA. Could you help me with your thought process to date as to what this woman will be able to do for female veterans?

Mr. HAWKINS. Let me comment on the reporting part, and maybe Dr. Mather or Dr. Wolfe or other members may have some ideas about the organizational responsibilities and so forth.

Having served as a medical center director for many years, I think it is important to recognize that we are dealing with two things. One is the medical application or disposition to the patient care as well as the administrative and organizational alignment.

I think what is very important is that this person have access to top management in terms of identifying their problems and being able to cut through any layers to bring problems to the attention of top management.

I think it gets into a little bit of a Catch-22 in terms of whether that is the Director or whether it is the Chief of Staff or the Associate Director. So I guess my position on it would be that the position should have access to top management because the chief of staff has responsibility for the patient care programs and probably in most cases would have the women's committee reporting through the clinical executive board to him or her, as the case may be.

So organizationally, and I think as our colleague from West L.A. said, there are a lot of innovative things going on out there that are working well, and, if it is, we should allow some flexibility for local management to get the job done, but the bottom line is, they should have access to top management.

Dr. MATHER. Absolutely essential. I think one of the decisions that has been made this past year is that the Women Veterans Coordinator should be either a nurse or a social worker and not the medical librarian or the support staff that we have heard about in the past. That person will also be directly involved in providing care to women veterans, so they will be the ombudsperson, as you pointed out, for women veterans care. They will talking to women veterans as a part of their clinical responsibilities on a regular basis, so they will hear the problems directly. They will also have access to top management.

One of the things that I suspect Women Veterans Coordinators will do is to create a women's clinic to improve access for women veterans, to take care of both their basic health requirements and also to ease women into the program. I think they will also be looking at privacy problems that can be corrected locally and those that would need a more significant approach to correction.

We feel that every medical center can provide a modicum of privacy to women in certain sections of the hospital, but there are some, particularly older medical centers where this is just impos-

sible throughout and would require a major project. But there are some local things that can be done, and the business about privacy in examining rooms is a simple matter of redirecting the table and putting up a privacy curtain so that even if somebody does open the door, there is a curtain between the person on the table and the person who is coming in the room. If someone sees that curtain pulled, they realize not to go farther.

So those things, I think—I wouldn't want to be so homey as to say the woman's touch, but I think there is a need for the woman's touch and this is a part of the attitude there.

Mr. HAWKINS. I think along that same line, Congressman Ridge, we do have patient representatives in all of our medical centers, and those people are also available to assist any patient, including women veterans, through the process of eligibility or any problems they have.

The thing we don't want to create is the fact that there is only one person who can help the woman veteran. We want the entire staff to be sensitized to meeting the needs of women veterans, and we certainly want to emphasize that to our patient representatives who in many places have two or three, one in inpatient, one in outpatient.

Mr. RIDGE. I appreciate that expression of concern because you are right, we want the system, not the Women Veterans Coordinator, but we want the system to be responsive and sensitive. I think the first year or two will be critical to the long-term goal in that this coordinator has to be given the flexibility to recommend some changes because, like any other institution, and I am not saying it is wrong, you build up certain ways of getting things done—inertia, as it were—and with, I think, heightened sensitivity to this issue, when you have this ombudsman, when you have this coordinator, maybe making specific recommendations to VA medical center directors or chiefs of staff who haven't done it that way before. It is going to take a very sensible and sensitive attitude to try to work together in harmony.

I think the first year or two will probably be the toughest, because some of the recommendations may go a little bit against the grain: "Well, that's not the way we've done it for the past 50 years." "Well, we've got news for you; that is the way you are going to start doing it now."

So I think attitudinal change—again, I am not being critical—is very much a natural by-product of big organizations; they have just been doing things a certain way for a long time; but I think this person has to be given flexibility and the access that you have talked about.

Moving along in that direction, however, might I ask if you see these coordinators as being a source, a primary source, or one of the ongoing sources of information and assessment for you to see what we need to do internally, not only a year from now, but five and ten years from now? And as part of the job description are you going to put them in some kind of formal way as part of the information and assessment process so it can get to the management, the upper management, in Washington, DC, as we go about responding to the future needs of women veterans?

Mr. HAWKINS. Definitely so, and I think what is going to be very, very important is, particularly on those full-time positions at the local level, to identify the needs, if there are supply needs, if there are equipment needs, if there are construction needs, certainly the numbers in terms of the work load, and that then with a full-time position at the regional level will give us the roll-up by facility and by region, and I know Dr. Mather has done a fantastic job with the amount of resources she has had at the national level.

When I was looking at the report this week and the IG's recommendation and looking at what she accomplishes along with her support staff and the field staff, certainly we feel at the Central Office level that we immediately have to give her some additional help, and we have just authorized this week an additional position for her to be able to coordinate this at the national level, the regional level, as well as the facility level so that information flows all the way up through a consistent pattern with information that we need to evaluate and provide oversight, too, for implementation and the changes.

Mr. RIDGE. One of the questions that ultimately we will have to address—and I think it is something that the chairman and I would be interested in getting your response to—is the earmarking of certain dollars for women's health care within the VA. I mean we are saying we want the system to be responsive, we want the system to be sensitive, we want the health care delivery system just to incorporate on an ongoing basis and respond to the needs of women veterans, but for the time being I am wondering if, as legislators and as authorizers, and hopefully as appropriators, we will be called upon by you to specifically target and earmark dollars for the medical centers for these purposes or whether or not, if we are talking about the system generally, we just increase the dollar amount and expect the VA to respond accordingly.

My sense is, to get things going, we would be a lot better off if we earmarked it, Mr. Chairman, rather than just letting it filter down and people being given the discretion to use it wherever they think is appropriate.

Do you think we are right, we need to earmark it?

Mr. HAWKINS. Well, last year I think you did earmark \$7.5 million for that purpose, and it was used very effectively.

Mr. RIDGE. I think we are going to need to earmark a lot more than that, though. That is my point.

Mr. HAWKINS. I might tell you—and the question came up earlier—the Secretary's commitment to this and the Deputy Secretary, they have asked us to earmark in the 1994 budget out of existing funds another \$5 million to expand the number of comprehensive women's centers throughout the system. We intend to do that. I know the support is there, and we certainly would be happy to carry out the wishes of Congress in either way, but I think we are giving a lot of priority out of existing resources to this. Sometimes by earmarking funds, as you know, you sort of rob Peter to pay Paul.

Mr. RIDGE. Right.

Mr. HAWKINS. Maybe additional funds might be a better way to go.

Mr. RIDGE. Well, I share that.

Dr. Wolfe, I saw you were nodding in agreement. I do want you to be able to get more than the nod on the record. Please.

Dr. WOLFE. I probably shouldn't step into the middle of this, but I think the earmarking is very useful not only in motivating the system, but in continuing to foster the impression that the health care resources are going for women veterans because women veterans deserve equitable care and that it is not being conducted or instituted at the expense of male veterans' needs. It is important, I think, that everyone in the system recognize that they have equal access and equity to care and that it is not being done preferentially or differentially, and the earmarking has helped encourage that, I think.

Mr. RIDGE. I appreciate and share your point of view, and I thank you for your testimony.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Let me follow up on one question before I yield to the gentleman from Washington State.

Earlier we received testimony about the need for coordinators to have authority. Congressman Ridge said the first few years are going to be difficult. What steps do you think need to be taken to ensure that coordinators have sufficient authority? Will this be implemented systematically in the entire VA health care system?

Dr. MATHER. Well, I think authority will be inherent in the role, and I think actually in any medical center ultimate authority rests with the director. So, since we have top management support for the coordinator having access to the director and chief of staff, I think this creates authority for the role.

Obviously, authority is also something that is earned, I think. By demonstrating the usefulness of the position to improve health care and to improve services this will then be viewed, too, by people throughout the system as being an authoritative position.

Mr. EVANS. Ensuring access then to the director throughout the entire system.

Dr. MATHER. Yes.

Mr. RIDGE. Would the gentleman yield?

Mr. EVANS. Yes.

Mr. RIDGE. Just so I understand, and correct me if I'm wrong, but I see this position as being one where she may be involved in the ombudsman kind of activity where we are trying to work out the individual health care problem of a female veteran, but that is not exclusive of also being responsible for developing an overall approach toward health care related issues and women's health care related issues for that particular medical center.

So, as I see it, this coordinator wears two hats: An individual female veteran comes in and has a problem accessing a particular kind of health care; she has the responsibility to help her do that; but on a very general basis she also has a broader responsibility to help improve the system to deliver the health care for all female veterans.

Dr. MATHER. And obviously the latter is the more important, because she can't be a case worker for all the women.

Mr. RIDGE. Correct.

Dr. MATHER. And if every single woman who comes into the hospital has a problem, there is no way that one person can handle this even in our smallest medical centers where most of them are saying, at least 300 women veterans, there is no way you can be a case worker for 300 people.

So the important thing is to improve the system so very few people have trouble accessing, and then you can both provide services and help with the policy development at the local level.

Mr. HAWKINS. Most of our medical centers also have women veterans committees, and I see this person playing a major role working with all the health care professionals and the case work element in particular—social workers, nurses, doctors—but the committee then would be certainly a key group that would also work with the coordinator to identify construction needs, equipment needs, handicapped needs, supply needs, and all those things, and certainly that is a very vital part, I think, of the role of the person.

Dr. WOLFE. I think the provision of full-time positions for these individuals, at least at the larger medical centers, is critical. It would then allow that woman to serve as a professional role model for all the other disciplines and would really enable her to conduct not only community outreach programs, but staff and educational programs that go along and in some ways are almost more critical than the individual case management issues, and we really tried to do that in Boston with someone who is terrifically capable, but it is only really a small piece of her job, and just in the few hours she has been able to dedicate she has been able to put on two large-scale community seminars, bringing in 300 women, most of whom were nonusers of the system, and I do think that the allocation of the full-time positions would greatly expedite her efficacy and her visibility in the professional as well as local community.

Mr. EVANS. Mr. Hawkins, you indicated that at the majority of the hospitals there is a Women Veterans Advisory Committee. Are you going to try to establish one at every medical center?

Mr. HAWKINS. I think the guidelines are out there now that we recommend that. It is not mandated, to my knowledge, but it is recommended that local management have those committees to advise them in many areas, including those I identified. I would be very supportive of certainly emphasizing that to our directors to do that.

Mr. EVANS. Do you know how many actually do have an advisory committee, or can you provide that information to us?

Mr. HAWKINS. I don't. Does anybody?

We would be happy to furnish that for the record, if you like.

(Subsequently, the Department of Veterans Affairs provided the following information:)

According to the Veterans Health Administration survey done in January 1993 for the Office of the Inspector General, one hundred and thirty of the one hundred and sixty-six VA medical centers surveyed have women veterans committees or councils.

Mr. EVANS. Let me yield to the gentleman from Washington State.

OPENING STATEMENT OF HON. MIKE KREIDLER

Mr. KREIDLER. Thank you, Mr. Chairman.

First off, let me say that I am very pleased that you have taken up this issue and we are holding this hearing here today. I am al-

ways reminded of the stories that I heard from my aunt. She was a nurse during World War II, stationed in England, and went on some of the first medical evacuation flights into France after the invasion at Normandy. She had some very graphic stories of the trials and tribulations and risks for women in those very hazardous situations, and the kind of help and assistance they were bringing and saving some lives.

I think, as we have heard already, there is some pretty good evidence here that, by and large, the VA system has been no different from military medicine as a whole, and both have been rather weak in identifying and working with women and meeting their medical needs. In fact, I had some legislation that was just passed in the House. It dealt with violence against women, and that is something that the medical profession as a whole has been particularly weak on and I have to believe that the VA system, as military medicine, has been very weak on.

But as we start to see this change now and recognize the importance of women's health, it seems to me that there are two parts to this as it affects the VA system. Number one is certainly correcting a wrong that has been perpetrated for way too long in recognizing the position that women's health should hold. That is true in health care in general in our society, but it is particularly true for our VA system, which has reflected a military system that has not recognized the importance of women in the military.

But there is a second part of this that I would like to ask my question about, Mr. Hawkins, and that deals with where the VA medical system goes in the future. The VA is going to have to move toward becoming a health maintenance organization, and recognize the needs of all veterans, male and female, and their spouses.

So we really have to see a tremendous upgrading of the VA system to women's health, and it appears to me that if there were motivation just to correct a wrong, now there is a double motivation for the VA to reform. How prepared do you feel the VA system is to make that quantum leap, when right now they are just trying to come up to where they should be for the existing women veterans' needs?

Mr. HAWKINS. You are exactly right, Congressman, we have got to do better in terms of being able to fit into a national health care change, whatever that maybe for VA. I think some of the things we have got to do is get away from the model of specialty care which is mirrored both on the inpatient basis and the outpatient basis. We certainly cannot be very competitive by having long waits to get into clinics, several months or several weeks, and I think our eligibility system that we have worked on with the House committee for many years has got to be changed to allow us to not only administer the appropriate care in the appropriate setting but also to provide the care based on medical needs and not the administrative entitlements in terms of what we have now.

The VA has worked on this for a couple of years now in terms of proposals or options that we could consider once the White House task force report is issued and the Secretary gets the VA guidance, and I think we are prepared to move into some changes that certainly will require eligibility changes as well as changes in terms of how we do business now.

So I would say that we are excited about doing that, and I think our health care professionals would love to be able to enter that kind of environment, and I think we can really compete very effectively if we make those changes. Some investments will be required I think, up front not only in education, but certainly in capital investments to change our facilities to allow us to deliver more patient care on an outpatient basis and more home health care.

Dr. MATHER. Certainly we have already taken a small step in that in the pilot programs for CHAMPVA. Personally, I find that very exciting, because as we bring more women into the system there is an economy of scale and it will simply be easier to provide services if we have more women in the system.

We do have to take into account workload, and I am all for anything that will bring more women into the system. I think the improvement in services will be much easier when that is the case, so I welcome the CHAMPVA pilot projects which will bring some female dependents into the system.

Mr. KREIDLER. I would say that you are really under the gun right now because I can understand the limitations on resources and putting mandates in there with existing resources, trying to make the allocation. I have some empathy with the trials of an administrator in trying to deal with that and meet your current demand for services.

But this is particularly keen because I think the estimates are as high as 40 percent of the current number of VA medical patients would probably not be there if they had access to health care in their own communities. I think that number might even be higher if you take into account women who could join it as an HMO if there was a considerable amount of publicity around the fact that the VA-HMO system, as it were to become, were not responsive to women's needs.

So there is a tremendous incentive, it would appear to me, right now, to bring women's health up to a higher level than it obviously is today and realize that that is not an easy task right now, given the constriction on resources.

Dr. WOLFE. I believe that one small piece that may be beneficial for the VA is that in addition to its interest in improving preventive and primary care across the board, that the VA really does lead the Nation in areas of certain specialty care which would apply to women veterans at the present time in both clinical and research areas. That would include work being done in Alzheimer's disease and geriatric care, post-traumatic stress disorder, prosthetics. I really do see VA as doing some of the superior work that is ongoing. So possibly that could be capitalized on further.

Mr. KREIDLER. Good point.

I think Dr. Mather's point, though, is that the big push is certainly going to be on outpatient care, and it is going to be on primary care and preventive care, and that is unfortunately the area where the VA is probably the weakest when it comes to women's health needs right now.

Thank you very much, Mr. Chairman.

Mr. EVANS. Thank you.

We appreciate your testimony. As I indicated, we have other questions we will submit to you in writing, and your responses will

be made part of the record. We know you are scheduled to testify this morning in the Senate, Dr. Mather, and wish you good luck over there.

Dr. MATHER. Thanks.

Mr. EVANS. Thank you very much.

[The questions and answers appear at p. 152.]

Mr. EVANS. Our next witnesses are Linda Schwartz, Doris Besikof, Dr. Evelyn Monahan, Marsena Mungin, and Cathy Lindsay.

Linda serves as Chair of the National Women Veterans Committee, Vietnam Veterans of America; Doris is representing the National Women Veterans Conference; Dr. Monahan is President of the National Association of Women Veterans, and Marsena and Cathy are women veterans who reside in Pennsylvania.

We will start with Linda after you are seated and ready. Your entire statements will be made part of the record, and, Linda, you may proceed.

STATEMENTS OF LINDA SCHWARTZ, R.N., M.S.N., CHAIR, NATIONAL WOMEN VETERANS COMMITTEE, VIETNAM VETERANS OF AMERICA; DORIS BESIKOF, NATIONAL WOMEN VETERANS CONFERENCE; EVELYN M. MONAHAN, Ph.D., PRESIDENT, NATIONAL ASSOCIATION OF WOMEN VETERANS, INC.; MARSENA MUNGIN, VETERAN; AND CATHY P. LINDSAY, VETERAN.

STATEMENT OF LINDA SCHWARTZ

Ms. SCHWARTZ. Good morning, Mr. Chairman. I want to thank you again for having these hearings and for your continued interest in women veterans.

There is no doubt that great strides have been made and improvements have been made in the last ten years in the care of women veterans in the VA system, and I think that is due largely to your interest, Mr. Chairman, and I think it is very important to acknowledge that the efforts and relentless pursuit of moving this agenda by Dr. Susan Mather also deserve to be commended and noted.

Again, I have been sitting here today listening to things that have been said, and I think the message is very clear for all of us. We have reached a juncture where there has been legislation, there have been regulations, there have been promises, there have been all kinds of circulars from the VA, and what we come down to is that it is not a standard expectation of care in the VA that a woman can come in and receive adequate care.

In my testimony I have talked about one of our members who is 100 percent disabled and has been taken care of in the VA hospital, had a mammogram done in the VA hospital three years ago, came back now because of her age cycle to have another one and found out that they had misread three years ago her mammogram, and she did in fact have a growth. They told her it was negative three years ago; it was positive. Can you imagine, Mr. Chairman, how she must have felt?

We were able to make arrangements for her to have that growth removed, and people told the Vietnam Veterans of America not to

worry because under the Federal tort claims law this woman would receive compensation for this, and I ask you, Mr. Chairman, what kind of compensation can you give to someone when they are faced with this prospect? No amount. But that is one of the standards.

When we talk about privacy, another issue, can you imagine yourself—I know you were recently in the hospital, but consider this. We heard here just a few minutes ago that the VA has complied with all of the GAO recommendations from last year, but I am going to tell you something that happened six weeks ago.

Think of yourself being in a room with four beds, three of them occupied by men, and they are being visited by their families, in comes off of a stretcher a woman, who is plunked down in the bed semi-conscious, and they walk off. Now I don't know who was more embarrassed, the men, their wives, or the woman when she woke up and found where she was. That woman has not gone back and will not go back to a VA hospital. But, you know, this isn't ten years ago. We are talking about all the efforts you have made, all the efforts we have made, all the efforts the people in the VA have made, and still these conditions exist.

I want to call to your attention something that I put in my testimony and I promised to you. Today we have heard a lot of discussion about the rates of cancer in women veterans, and we really don't know what is going on, but, as you know, I have been doing an additional analysis of the Research Triangle Institute study on Vietnam veterans, and I have looked at the physical health problems. You will see that in my testimony I note that we saw 9.36 percent of the women who were in this study who were both in-country women veterans and era veterans had cancers of some sort.

The other thing is, I looked at the 1989 study that was done by the VA on disabilities—women were included in that study—and the analysis showed that, for the most part, about 38 percent of the women that come to the VA use it for musculoskeletal, muscle/bone things—arthritis, and so forth.

But in the study of RTI, in which the women were not all users of the VA hospital, we found that 40 percent—40 percent, Mr. Chairman—had diseases of the ovaries, the uterus, GYN problems, which we have talked about again today as a need for the VA to pay more attention to. I think these issues are not only suggestive that we need to invest more in research, but when you talk about getting the best utilization of your dollars that you will invest in the health care of anyone in this country today, you have to look at the fact that research is an element that must be the planning point, not the thing that you do afterwards.

So we really do need to know what kinds of programs is it logical for a VA hospital to provide. Is it logical for a VA hospital which only has maybe 25, 50, 100, or 200 women in their catchment area to have a mammography? No, that is not cost-effective, Mr. Chairman. But it is cost-effective that that VA facility find an alternative for her to receive that kind of care.

I have talked before about the fact that GYN care, which we seem to be honing in on—I agree with Dr. Mather, a woman veteran is not just her reproductive organs, but the fact is that that is a very grave need, and as we heard Congresswoman DeLauro

say, this is a population at high risk, and this is something that our Surgeon General advocates for all women in this country and is not even being implemented by the administration of a Government agency.

The other thing that I would like to say is, we have heard today from the IG report about the need for someone at the Central Office to be a focus for the programs of women veterans, and I want to publicly acknowledge and thank Congresswoman Waters for taking the leadership and the initiative to bring that concept to the Congress, because over the years, and just what I have been talking to you about, I see a real need here for accountability. We can year after year have hearings and reports, but it doesn't necessarily mean that anything is going to be implemented.

You talked about, do we require legislation? As I was sitting here today, I was thinking about the last ten years and saying, well, I don't really think it matters if you legislate it, it really doesn't matter, because who knows what will be implemented and what will not?

But I say that Congresswoman Waters' concept of a person at Central Office, that person must have direct access to the Secretary. Just as we heard, they must have direct access to the chief administrator at the VA level, they must have access to the Secretary.

The other thing is, we have to have some report of some sort, because we know for a fact that for several years there has existed over at the VA the Office of Minorities and Women, and we are not quite sure how long anybody was actually in those positions or actually did that work, but we know that lately there has been no one there. So on paper you have got it, but it is not really there.

Finally, Mr. Chairman, as I have listened today, the one thing that keeps coming back to me is the fact that it does not matter what Congress legislates or regulates for the rest of the country on the health care of American citizens, because what you really fund, what you really do in the Veterans Department is a reflection of what you are willing to live with, because in fact the Congress is the board of trustees of the largest health care system in the world, and this health care system is getting a bad report today, and I know that we will be looking to you, Mr. Chairman, and to the Congress to take actions to assure that the women who are serving in the military now and the women veterans of America will receive adequate care when they come to the VA.

Thank you.

[The prepared statement of Ms. Schwartz appears at p. 120.]

Mr. EVANS. Thank you.

Doris.

STATEMENT OF DORIS BESI KOF

Ms. BESI KOF. Thank you, Mr. Chairman, members of the committee.

I am Doris Besikof, an attorney from Denver, Colorado, who has been asked to speak by the National Women Veterans Conference. I am also a board member of a group called Wanda's Fund, which has been mentioned here this morning. Representative Schroeder put it so aptly; she said we are a group of attorneys and other con-

cerned women, many of them veterans, and what we want to know is, what doesn't the VA understand about equal protection, democratic rights, and honor and respect for women?

I will try to tailor my remarks that are spoken to you this morning in a way that is responsive to some of the testimony that has already passed since my remarks and my testimony are in the record, and at lines 263 through the end we have our list of requests. I think it would be really sad to call it a wish list, but, unfortunately, the things that the Women Veterans Conference is asking and saying are important have been asked for for about ten years in most respects. The bills in the Senate and the House this year will take care of some of those things if they are passed.

It took some thought and courage, before coming here, to state into my written testimony that I felt the VA was recalcitrant, negative, and had a bad attitude. Actually, I have heard those same words many times here this morning in different ways.

What I have to say to you that may be somewhat different from others. Testimony will come from my experience as an attorney practicing with veterans for over 15 years. My first woman veteran client was in 1978. Women veterans are a subgroup, which is not equal. What is happening to them isn't just a lack of care that you are hearing about here this morning. They are being damaged by the VA.

For example, a woman who has been untreated for sexual trauma, who has post-traumatic stress, relives the horrific experience until she gets some care and gets herself back on track. She, if she is a veteran, sustained that trauma when she was in the military, where the chain of command didn't allow her to speak out when she enters the VA system, problems continue.

The Federal Tort Claims Act and the Feres Doctrine, say that if you are on active duty you cannot bring a claim because you are compensated for injuries through the Veteran Benefits Programs and also because our national defense and our national discipline must be protected.

In 1993, the Army is still telling the family of Specialist Martinez Colon that her suicide over sex harassment reports that she made that were not acted on was a service-connected incident to service event. The VA has got to do something for these women because the military is telling them they have to put up with what is essentially a human rights violation as part of what is expected of them in their service to their country. Discrimination toward these women is gender based. It is sexual in nature, and it is damaging them very badly. It goes beyond failure to provide care for their reproductive systems.

I have represented one woman for over five years who now, her physicians within the system say, in addition to the post-traumatic stress she suffered from a gang rape in the military, has additional psychological and psychiatric damage that is clinically diagnosed as a result of the abuses that she has received through the VA system. She is an intelligent, courageous woman. Her doctors advocate for her in the system, they recommend for her things that she needs, and when she gets to a certain point they say, "Well, now it's time to talk to your lawyer because we have done all we can." I write the VA. I threaten them, and again this spring, at the last

moment, before we were prepared to seek mandatory injunctive relief for this woman, they backed down and said they would provide her with fee-based health care.

On countless occasions I have seen the VA provide the fee-based care; and then, once the patient is in the private sector—the administrative branch of the hospital will start calling, trying to pull that patient back into the VA system.

The focus of VA personnel is not always appropriate. I don't think that it is strictly caused by the dollars or lack of funding. Attitude does not cost money. In my opinion this committee is tremendously important because the message needs to be sent out that it is not "cool"; and it is not acceptable behavior to abuse women and to denigrate them.

There is a carry-over from the predominately male military system; but that is not a reason to unequally apply the law. These women were pioneers, many of them, in their active duty services, and there should be respect for them which is lacking. And, you know, speculums, for goodness sake. The lack of speculums is pathetic. This is 1993! The damage that it does to the women is tragic. In my written testimony there is reference to a woman, a young woman, who had a pelvic exam facing the door when the door could open at any moment with no privacy shield. A nurse who did post-traumatic stress work with male Vietnam-era veterans, and who has affected, herself, checked out of a hospital where she didn't feel safe.

Problems about requiring women patients to wear pajamas on locked psychiatric wards. This occurs commonly. The instances I refer to in my written testimony are not gathered strictly from women who are leaders in organizations. I went out, and I canvassed, if you will, women veterans I knew about in the Colorado area who were not necessarily active and vocal. They are just ordinary people who go over there to get care. One woman described being given ill fitting pajamas and being made to wear them, with her breasts exposed, in a male psychiatric ward, where she was afraid she was refused the right to wear a jogging suit.

I gave you the NWVC list of requests; and I see the red light. If I have left any time, I welcome your questions, and I thank you for having me come here.

[The prepared statement of Ms. Besikof appears at p. 130.]

Mr. EVANS. Thank you very much.

Dr. Monahan.

STATEMENT OF EVELYN M. MONAHAN, Ph.D.

Dr. MONAHAN. Thank you, Mr. Chairman.

Those of us in this chamber today are surrounded by a great cloud of witnesses. The cloud includes not only those of our generation who will view our efforts and make judgments concerning them, but those past and future generations. We and they are part of a great army, and we have come to challenge, to confront, and hopefully to change, to make level the playing field on which women veterans must stand or fall to receive VA health care.

Past generations are here today to witness our race, having run it themselves. They cheer our beginnings, cringe at our falls, are discouraged by our mistakes, and applaud our victories. The cloud

of witnesses was present in Atlanta, Georgia, in October of 1992 when a young woman veteran who had been sexually assaulted and gang raped while serving in the Armed Forces was admitted to the psychiatric intensive care unit on the anniversary date of her assault. The woman was suffering the symptomatology of post-traumatic stress disorder connected with the vicious attack she had suffered several years earlier. The woman's husband, also a veteran, was extremely upset that his wife had been placed on a locked psychiatric unit shared by male and female veterans. The cloud of witnesses watched as the woman veteran, already in pain, experienced new psychological wounds from fear rekindled in her by placing her in a gender mixed unit despite the fact that her husband asked that she be placed in a unit without men.

The cloud of witnesses listened to VA center personnel as they explained that there were no separate accommodations for female veterans who needed acute psychiatric care because of the scars of sexual assault. The cloud of witnesses watched as the woman's husband, concerned and distraught, spoke of going to the media, to Congress, to anyone who cared to help, and they watched as the woman's family removed her from the VA medical center and sought a place "where she could be cared for without inflicting new injuries."

We, the witnesses of present and past generations, call upon Congress to mandate that VA medical centers shall provide separate accommodations on psychiatric units for women veterans who have been the victims of sexual assault. Give force to the medical dictum that says, "Do no harm." Provide adequate accommodations and psychiatric care for women who have suffered the critical psychological wounds of sexual assault.

Bi-coastal centers for the study and care of such victims are not enough. At the PTSD Center in Palo Alto, the ten-bed women's unit has treated 13 patients since July of 1992, 13 women patients in the space of one year. Several questions must be asked here.

What is the cost-effectiveness of this unit when it treated one woman veteran a month over the last year?

What, if any, outreach program is used to identify women in need of this specialized service? Would not the money be better spent if it was used to finance this service at VA medical centers in large cities and throughout our Nation?

These women are in all large cities and many small towns, and it is the local VA medical centers which must be prepared to provide them with safe and protected care. In order to make these accommodations and the protected care available, the Department of Veterans Affairs must provide more than a list of counselors supposedly trained in providing care to women suffering the residuals of sexual harassments or assault.

The Department of Veterans Affairs must care more about meeting its mission than it does about "looking as though it is meeting its mission." In many VA centers today, a list of names is all that awaits the victims of sexual assault for the special training has not yet been defined or specified or provided to most VA staff whose names are on the list which provide a smoke screen and prevent the utilization of real and needed training.

The cloud of witnesses present and past has watched as VA employees who have been victims of sexual harassment or assault are offered no counseling for the wounds inflicted in the VA workplace all too frequently by VA managers who are authority figures and the agents of the Department of Veterans Affairs. The cloud of past and present witnesses calls upon Congress to mandate that counseling by effectively trained counselors shall be provided and made available to all women who have suffered the wounds of sexual harassment or assault in the VA workplace or on duty off station. We have witnessed too many care givers and care providers neither caring nor providing the psychological health care these wounded employees need and deserve.

One of the abhorrent results of sexual harassment continuum is racial discrimination which inflicts and impacts heavily on black men and black women throughout the Department of Veterans Affairs system. Harassers who have the chance to fill positions within the Department of Veterans Affairs frequently fill those positions with people who meet a certain criterion for them as possible victims. I think that discrimination in any forum is an ugly hydra that eats away at equality and at democracy.

The cloud of witnesses past and present calls upon Congress to mandate a specifically defined training program for Women Veterans Coordinators. To date, we have watched as the Department of Veterans Affairs rushed to provide a three-day training conference for Women Veterans Coordinators who should have been trained when they were given the co-lateral positions. The same such forward looking or knee jerk reaction can be seen by the Central Office when on June 17, 1993, they requested that all Women Veterans Coordinators mail whatever pamphlets or anything else they could find so they could overwhelm this committee with what they had accomplished.

I know the red light has gone on here. However, I think there are a couple of things, if you would give me the time, that really have not been mentioned before, that are really pertinent to this committee.

Mr. EVANS. We will give you an additional amount of time to discuss those if you would like.

Dr. MONAHAN. Thank you.

The cloud of witnesses past and present and future generations ask Congress to mandate specifically defined training for Women Veterans Coordinators. It is not enough to say that a Women Veterans Coordinator will be either a nurse or a social worker, because you have left out the regional offices completely, and oftentimes it is at the regional office where the woman counseling psychologist or a counseling psychologist is the first one to meet to the discharged woman veteran and the first one who has the initial interview with that woman and the longest interview with that woman, and not to have Women Veterans Coordinators at the regional offices seems almost criminal, at least unconscionable.

Mandate that interested candidates be solicited for the position rather than the director naming someone to the position simply to fill a requirement; that Congress mandate that each VA regional office shall have a Women Veterans Coordinator.

The Women Veterans Coordinator in Atlanta, Georgia, was removed from that position after she testified here on September 17, 1992, to the sexual harassment question. The director at the regional office in Atlanta stated that he saw no reason, he was not mandated to have a VA Women Veterans Coordinator at the regional office, nor was he in a position where he had to fill that, and that it was his position to give or to take away.

The Women Veterans Coordinator—there is none right now at VA in Atlanta, and I hope that Congress will mandate that they be placed at regional offices.

The cloud of witnesses has listened many times to women veterans telling women counseling psychologists of their sexual assaults while on active duty in the military. We ask also that Congress mandate a three-hour training program on the military history of women veterans and an additional three-hour training program for all employees on the history of World War II, Korea, Vietnam, all the way through the Persian Gulf, because if we are talking about respect for women—and we are—then let each employee with the Department of Veterans Affairs know what women have done and know what has gone on and why they deserve this respect.

I think if we are going to change attitudes—and I believe attitude is the main problem here, recalcitrant attitude—then we have to help them see women differently, and just as you so wonderfully mandated—and Secretary Brown did this too—that all VA employees—and I underline “all”—were to receive sexual harassment training education, I think that teaching the history of women in the military is most important if we are to change attitudes.

The cloud of witnesses has wept at the callousness displayed by the Department of Veterans Affairs in failing to provide a board-certified gynecologist on the staff of all VA medical centers. If the woman is to be accorded state-of-the-art care, a board-certified gynecologist must be on staff or available to a family nurse practitioner who does the GYN exams.

The cloud of witnesses past and present and future calls upon Congress to mandate a halt to surgery, surgical procedures, surgery clinics, surgical procedures in the surgical intensive care units at VA's or in outpatient clinics that are provided by residents without any supervision of a board-certified surgeon. I believe if we looked into that it would also be something that would be questionable about accreditation.

Our national heroes deserve more than this. They deserve what each member of this committee would wish for him or herself or for their friends. The great cloud of witnesses past, present, and future calls upon this committee and the Department of Veterans Affairs to have the courage to care, to care enough to mandate that the attitude that reinforces the idea that “appearing to meet the mission of the Department of Veterans Affairs is good enough,” because it is not good enough.

The veterans of this country, female and male, deserve much more. They deserve a Department of Veterans Affairs that honors and meets its mission, a Department that is not willing to settle for “appearance of fairness” and the “appearance of meeting the mission,” rather insisting on the reality of justice, the reality of the

mission well done, a Department of Veterans Affairs where each employee has the courage to care.

Thank you for the extra time.

[The prepared statement of Dr. Monahan appears at p. 141.]

Mr. EVANS. Doctor, thank you, and I would just like to say on behalf of the committee that if we are overwhelmed on any side of the aisle, it is not with brochures, but with the stories that we are hearing about the horrible conditions that exist in a lot of the hospitals, and that is our primary focus here today. We appreciate your testimony.

Cathy.

STATEMENT OF CATHY P. LINDSAY

Ms. LINDSAY. Good morning, Mr. Chairman.

I have a personal testimony. While serving on active duty from 1 November, 1989, until 17 April, 1992, at Fort Monroe's health clinic, I was sexually harassed by three of my male superiors, which resulted in me being transferred to my parent unit, Fort Eustis, McDonald Army Hospital, whose commander was also Fort Monroe's health clinic commander, Colonel Charles Ellis.

Following a 15-6 sexual harassment investigation, I was transferred to this hospital where I was admitted to Portsmouth Psychiatric Hospital Unit to be discharged mentally unfit for duty. However, the Portsmouth Naval Hospital discharged me fully competent and fit for duty.

Upon returning to McDonald Army Hospital, I was allowed to see Colonel Ellis regarding my assignment because I felt that my placement at McDonald Army Hospital wouldn't be in my best interests, and he transferred me back to Fort Monroe with remarks that I was destined to fail but wouldn't allow me to be reassigned to any other unit.

While I was going through the sexual harassment, I had surgery to my right foot by Dr. Collins in May of 1990. Upon returning to Fort Monroe Health Clinic following surgery, I was not allowed to properly recover from my surgery, and complications developed. The administration didn't acknowledge my profile, but forced me to work extremely hard every day, sometimes being called in after work to paint and sweep the perimeters of the building, do physical fitness, being fully aware of my medical condition.

I continued to complain about my medical problems. I was requesting assistance from the EEO, IG, and others because my problems were being ignored, but to no avail. Dr. Collins was no longer seeing me, but I was assigned a Dr. Swartz, whom I had never met, that after five minutes of examination determined that my medical problem was neither orthopedic nor podiatric but psychological and referred me to a psychiatrist, Dr. Etzell, who prescribed me amitriptyline, an antidepressant, that, upon taking, I hallucinated.

I continued to seek medical attention for my foot, but my administration was calling doctors with which I had appointments, canceling them and reassigning me with doctors that did not treat me, but would also suggest some psychological treatment. I was recommended for a medical examination board, and upon initial determination was found unfit for duty on September of 1991 and subse-

quently determined fit for duty on November 26, 1991, although my condition hadn't improved but, in fact, had worsened.

After two and a half years of this interference, I had developed severe pain in other areas of my body, including difficulty walking and, on two occasions, inability to get out of my bed. I subsequently was allowed, after visiting the Pentagon, to be extended for the purpose of being examined at Walter Reed. Dr. Yankowicz recommended surgery and told me the only relief that I would have would be by removing the scarred nerve tissue from my foot.

Upon returning with the recommendation to my command, I had to have the endorsement of Colonel Ellis, of whom I had recently requested a congressional inquiry for harassment I was receiving under his command for the last two and a half years. He denied me the opportunity to have the treatment after two and a half years of trying to alleviate my problems with only two days notice, although he had the request three weeks prior. I was informed by my unit commander to get out of the Army, out of base housing, and clear the post within two days.

The harassment includes, but is not limited to, invasion of privacy, suspected phone tapping, harassing phone calls, breaking and entering my home, and harassment of my teenage son. I am currently seeking treatment through the VA hospital, and on March 23 I was examined by student doctors under the supervision of Dr. Sonoga, and I was given a placebo. I have received no other treatment for my medical condition.

Thank you.

[The prepared statement of Ms. Lindsay appears on p. 145.]

Mr. EVANS. Thank you.

Marsena, a vote is pending, but we will receive your testimony. It may be necessary to recess the hearing then.

Marsena.

STATEMENT OF MARSENA MUNGIN

Ms. MUNGIN. First, starting out, I would like to thank you for this opportunity. This has been something very hard for me to prepare for because now I am faced with dealing with some problems that I have tried to put in the back of my mind with sexual assault, and, you know, as time goes on, doing advocacy work and dealing with other women that have been sexually assaulted or harassed, it becomes very hard not to get emotionally involved.

There is a double standard here. Being a woman veteran is one standard, but being an African-American female veteran is another. As I look at the plight of the African-American female veteran and their role with family, comrades, and community, many women can't reach out to share their knowledge due to the pain of sexual harassment, double standards, and inadequate health care, for some perceive the cause and effect as a reaction of their personal imagination.

Many questions can be raised about the VA system and the role of women. The wheels of change must come to the VA system. I view myself as an example. A disabled single parent doesn't mean anything. I am a victim of the system that cannot understand that women are veterans too. Programs are developed, but not imple-

mented. In other words, it looks good on paper, but the reality is a nightmare.

We don't have time to waste because, as history has provided, it has always been given low priority. It is apparent that society has painted a nasty picture of the real problem. It hurts to come and be a part of what we are doing here today with no chance of hope in sight, turning to anguish that burns like a burning fire.

Many women are held hostage by fear of what they have seen or things done to them. The problem starts simple, but is compounded after no care is given, and justice has played a very harsh part in our lives. I am at a point of justifying why I am here to my children. I come up with the answer, change will come, and I view what is going on here—I started writing things down, because it is starting to get to the point where I have to justify everything that I am doing, because it is like you get out there, and you work in the community, and women come and say, "Okay, I have a problem," you address the problem to the VA system, and they are like, "This can't be happening, not here; we just can't understand why this is happening." There are some VA facilities that have good care, and then there are some VA facilities that don't.

As I wait for my life to deliver the fatal blow, my mind wonders, what will life be like in 10 to 15 years? Will I, could I, or shall I move on? The only answer that I can give is, I shall move on one more time to wait some more. This is my view of what is going on. Time will always take care of itself. Please don't take slightly because children, families, and friends have given up part of their lives to support us here today. Many words are being spoken, but what do we hear? The battle cry for help.

My mind wonders about what it would be like not to see another woman assaulted or harassed and have to live with it by herself. There are some cross-cultural differences in play. We must start to deal with all the effects within and without the system.

I tried to come up with maybe some solutions that would help, and the last time that I testified we asked that consideration be given to revamping the VA system, and every time politics always plays a role, and it is done on paper, but the veteran himself is not receiving what is being said on paper. You know, they have all these elaborate programs, but in the community where the veteran lives is where they need to know about the program. There will be money funded for programs, and then, all of a sudden, you go and ask about a program and the response is, "What program are you talking about? We got rid of that program two years ago."

Family group support is very important, because I am blessed to have a family that stands behind me and supports me, but there are many women that don't have that support of their family because their family really doesn't understand what is going on. They are like, "Well, you know, maybe you are just imagining this," and it is this role of "It's all in your mind." Now is the time that we need to start dealing with how you treat the woman, but you also need to realize that these woman have children, she has a husband, that have gone through these problems with her, and not dealing with the whole problem is not really giving a solution. A look needs to be on how females are being discharged. There are some women who are discharged honorably, but they have medical

conditions, and I don't know why it is so hard for them to say "honorable" under "medical condition."

For instance, myself, I have an honorable discharge, but they did not put under "medical condition," so when the VA rated me, it was like, "Well, you know, what's going on here?" If the military doesn't say it, the VA says, "Well, you know, we can't look at that." And transitional counseling to prepare women from going from active duty to civilian life, and more research monies need to be in the area of cancer and other related medical problems due to environmental hazards, and research on cross-cultural differences among women. There are a lot of things in play here when we talk about women veterans. You talk about women veterans of Hispanic descent, of African-American descent, of American Indian descent. We have to deal with these problems in order to be able to go to the next spectrum.

Thank you.

Mr. EVANS. Thank you. We appreciate your continued willingness to advise us and work through our system to try to make it better.

We have a vote pending right now. I note a sense of frustration here, with years of hearings that we have had and the little progress that has been made. Let me just ask you as we conclude, each one of you, what would be the single most important action? Would it be to try to establish a Women's Bureau to have at the very top of the VA the authority and ability to relate?

Dr. MONAHAN. I think that would certainly be a big step in the right direction, and perhaps the only thing that will change some of the attitudinal recalcitrance that we have, because it is the attitude, I believe, at CO and throughout the field—they seem to have the attitude that they are untouchable. I think Congress needs to show them that they are not.

Ms. SCHWARTZ. I would just like to say, and I think it is important, that Dr. Mather has been very good in her leadership, but it is not her full-time job either. We need to have someone in the Central Office, which not only shows that women veterans are given more than lip service, but shows a commitment and also shows them a way that, if they have reports such as this, that is where that can go, and having direct access to the Secretary will really be an improvement. It can't be under benefits and it can't be under health, it has to be directly to the Secretary.

Mr. EVANS. We will return because I think it would be useful to have a few more questions. We will recess for about 15 minutes pending this vote.

[Recess.]

Mr. EVANS. The subcommittee will reconvene now, and I would like to finish the question I asked, and I think Doris needs the opportunity to speak—the single most important thing we might do.

Ms. BESIKOF. Meaningful accountability is needed. I think everyone has said it one way or the other. In my experience under the Federal Tort Claims Act system as well as in reviewing these issues for the women veterans—there is something about Government's tone in the Department of Veterans Affairs that sort of says, "Make me," and I have made them respond a few times, by bringing cases to the attention of the judges concerning medical care. We have obtained findings from the court that things the VA said and

did were not believable, of poor quality, and so forth. But I think that that is not an efficient or effective long-term way of dealing with this system. I think something that really is taken seriously, that causes them to be accountable in an affirmative way, and that is enforceable, is going to be necessary; and it is going to have to come from the top.

Mr. EVANS. Anyone else?

Dr. MONAHAN. Mr. Evans, one of the other things I would suggest is that women need to be on the planning and policy-making echelons of the Department of Veterans Affairs, to have something to do with the policies that are created, and carrying them through. That is one thing.

The other thing I would like to mention because I think it speaks to the attitudinal problems within the Department of Veterans Affairs. I know that a while back, in 1989, when the National Association of Women Veterans held a National Salute to World War II Women Veterans, the Central Office actually opposed us in some of the things, actually stood in the way, because they couldn't understand why we wouldn't do this in Washington instead of Atlanta, and instead of helping out, they actually became oppositional to anything that we were doing. That is hard to believe, but it is a fact.

Another fact is that in trying to offer assistance and outreach for veterans—and I know one of you has mentioned an aunt who served in World War II as an evac nurse—well, we have got lists of over 80,000 of these people, many of them suffering from PTSD and many of them who have suffered from sexual assault in the military. I know that I have talked to Dr. Mather about that, and when the conference was going to be held in Birmingham and I was denied the privilege of attending that simply because I was going to be testifying at the harassment thing, I had even asked Dr. Mather if there was something that could be done that could get me to that conference, and in doing that I mentioned the research that we had and that we would be glad to present this or in some way make this available to the Department of Veterans Affairs so they could certainly use this as a base and reach out from there.

We have also learned some very effective outreach techniques, and we were willing to share those. Dr. Mather told me that that was not applicable and they weren't really interested in World War II women or in women with PTSD through combat or anything right now and that maybe later. I never heard back from her. That is a little hard to take. I see that again as the CO's attitude that, "Make me do it." It is not even enough to offer. It is not even enough to say, "Here it is." It is rough to figure out, but I think that they are stuck in old ways and are very resistant to change.

I think it will take Congress with "shall" terminology to get the changes across, and I think what was mentioned before about making the history of women veterans known is of vital importance, because to change a person's attitude towards people, you have to change the way they see the people, and this would be one way to get across to all VA employees that, hey, "through these doors pass the heroes of this Nation, through these doors pass the men and the women who purchased the peace you enjoy." I can assure you,

from working with people like this, they don't know the history, they really don't, and I think that would be a good start.

Ms. MUNGIN. I agree with the bureau, because it is definitely something that has got to be done, and now is the time that we are going to have to put our foot down and say, "Hey, look, you have to do it." It is not, you know, "Well, this is not comfortable for me, so I don't want to." It is going to have to be like the parent saying, "You shall do what I tell you to do," and I think the bureau would kind of make the water a little smoother.

Mr. EVANS. Doris, you mentioned in footnote 20 that there were memos by VA officials discounting the recommendations of the group that you represent. Could you supply us with those memos if you don't have them today?

Ms. BESIKOF. Yes, I would be pleased to do that.

[The memos appear at p. 140.]

Mr. EVANS. Beyond doing something at the top level and beyond helping coordinators have direct reporting responsibilities to the medical center directors, it is important then that we also have an advisory committee at each of the VA hospitals?

Ms. SCHWARTZ. One of the things I would say is that in places where they do have the advisory committees our members have reported that the service is better, because if you look at the VA system, it is a closed system, it goes out to the consumer, and there is very little opportunity for the consumer to say anything about the level of care that they receive.

So by having these advisory committees not only do you improve the flow of information back and forth, you actually empower the veteran to have some influence on what is happening to them.

The one thing that I would caution is that in several places they have women veterans advisory committees that don't have women veterans on them, they are all staff, and I think that brings up another question which, I would say, is, you know, we do have the VA Women's Advisory Committee, and VVA has had a person on that committee since its inception, but one of the things that we find is that most of them have never been in a VA hospital either. So you are having people decide what is going to happen who don't know the system either.

I would suggest that in the future maybe consideration be given to having women who actually use the VA be part of the VA Women's Advisory Committee, because just as we who have been in it can impart to you with a great deal of sincerity and knowledge about what needs to be done, people don't have to explain that to us. What we can do as people who are using the system is say, "This is how it works. How can we solve this problem?"

One other thing I wanted to say about the women coordinators—I know, Mr. Ridge, you were talking about this—Vietnam Veterans of America has always had a position that we recommend funding for a full-time or half-time position in all of the regional offices and large medical centers for a period of two years, and the reason we did that is, we firmly believe that once—and now you have more women using the VA—but once these coordinators were in place, they could actually do the job of sensitizing the employees about women veterans and doing outreach that the bulk of the work could be accomplished in a limited period of time of two years.

The part that escapes me—and I say this as someone who has used the VA for many years, and now I find myself on one of those committees that is trying to develop the sexual trauma services for the VA—how little, how really little people who work in the VA know about veterans and how very little they know about the military experiences of women. So I would echo that it is imperative that the VA, along with all of the clinical training that they do, that they have some portion of that training devoted to, what is it like to be a woman in the military; the history of women in the military.

The other part of that, too, is, we are not just talking about women today. You know, 40 percent of the women who served in Vietnam were veterans of World War II and/or Korea. So we are talking about the whole gamut of age groups that are here, and that needs to be a part of the training so the people understand us.

Dr. MONAHAN. May I say one other thing to that, too, and I will make this offer here. The National Association of Women Veterans has presented for the Atlanta Historical Society an hour and a half slide presentation on the history of women veterans, and there are programs like this.

We also have masses of material that could be made into videocassettes that could be used to train VA employees on this, and we would be happy to participate in that if the Congress chose to have that done. The script is already written. We have people that we could bring for interviews, whatever, going all the way back to POW's who were prisoners of the Japanese in World War II, to women who landed on Anzio, to people who served in Vietnam, in country, to people who served in Korea, and this is so important, because how do you get people, again, to change attitude without changing what they are seeing?

Ms. MUNGIN. I think another thing is, like in South Carolina, the women coordinator was the head of nursing. This lady, you could never catch her. It was like she was stretched like a rubber band. I think the over-taxing of these women is just not fair. And then you wonder why they don't stay women coordinators. It is because it is a job that, if it was already into play and there were standards already set up, then of course doing it as an extra job would be fine, but when you don't have any standards and there are no guidelines that, "This is the way we are going to operate," it makes it very hard, and that woman gets frustrated, and then she takes out her frustration on a female veteran that comes in there with a problem or a situation, and then she becomes not sensitized to the problem but she becomes the problem.

So I think that definitely needs to be looked into making them full-time positions and not just an extra job, you know, taxing them with all the other responsibilities that they have.

Dr. MONAHAN. I would also ask the committee to consider one of the things about women being discharged from the military. When they are discharged with service-connected disabilities, they are going to be coming sooner or later to the regional office, to the Vocational Rehabilitation and Counseling Division, and, again, that is why it is so imperative to have the Women Veterans Coordinators because, again, the counseling psychologists are often the first to

encounter and talk with them about the experience and to point them in the right direction and encourage them and tell them, "Something can be done; you don't have to live with this."

I think that oftentimes, too, in the outreach programs, what women can get in the areas of rehabilitation as a benefit that is due to them is not put out in outreach programs. I would suggest that the Department of Veterans Affairs use public announcements on television, use spot announcements, to get this word out. A lot of women today and a lot of men today who are veterans, who don't know that they might be entitled to pension or might be entitled to medical care, are out there, maybe trying to live on a meager Social Security or whatever payment, and they could be taking advantage of these things, and I think the outreach and using whatever available to us is so important to have that come about.

Mr. EVANS. What I might ask you and Cathy who is, I guess, one of our most recently discharged veterans, has she received any discharge counseling in terms of benefits?

Ms. LINDSAY. I did not.

Mr. EVANS. None at all?

Ms. LINDSAY. None at all.

Mr. EVANS. Marsena, when were you discharged?

Ms. MUNGIN. In 1985, and I didn't either because it was like one of those things where, "Let's get her out of here quick."

Mr. EVANS. One other issue we are addressing in the Armed Services Committee will be the fact that the Navy and Marine Corps at this point have stopped discharge physicals, so you are in a situation where you don't have a base of information for disability claims coming out of the military. But I think that will be addressed in the Armed Services authorization.

Ms. SCHWARTZ. I was discharged in 1986, and the way in which it was said to me is, "If you really need any help, you can always go to the VA, and they will take care of you." That was the—

Mr. EVANS. That was the extent of it.

Ms. SCHWARTZ. But also accessing the system. I mean, how do you get into the VA for care? You can go for comp and pen evaluations, but then they say goodbye and tell you how disabled you are, but they don't say, "Here's where you are going to go next and we are going to help you," and that is not just women, that is men too.

Ms. BESILOF. There is one circumstance the importance of which is apparent, as I listen to the comments of everyone here this morning. It may not have been addressed; and it could be addressed with some mandatory language. When I talked about mandatory sanctions, I realize I was very general in saying that something needs to be done that is very strong. It is my recommendation that there be mandatory, proportionate allocation of the monies available for fee-based care, for women; because they compete with men for the money that they do get for fee-based care by private providers in areas where what they are asking for isn't available through the VA.

When the women who make requests for private fee-based care are not a priority, it is so easy to say, "Well, there are other people who need this more than you; there are other people who are really sick," and all of these sorts of excuses. Meanwhile, the women don't have a very good voice to speak for themselves sometimes because

of the type of damage that they have. What they are told, in a general way, may be true—that there isn't money there for them. That is not fair, and that could be fixed. It is a question of allocation, and of priorities. If you compare urology departments with gynecology, for example, urology departments have staff, slots for employees and, equipment. Gynecology departments do not have staff or equipment, including speculums and mamography machines.

Ms. SCHWARTZ. I just wanted to add that in that 1989 study that was done by the VA of disabled veterans, they found that 20 percent of the women who had service-connected disabilities, 20 percent—one in five—did not use the VA because they did not have the care there that they needed for their service-connected disability. Another 21 percent of the women who were service-connected and eligible for service said they would not go to the VA because of the poor quality or because, as we have heard today, that there were some very bad experiences.

So you have a majority of the women who are service-connected disabled, why they are not using the VA is because the care is not there. I think that that is very telling, and you would wonder if one in five Americans who couldn't use the public transportation system or one in five Americans that couldn't get through any door—wouldn't somebody care about that?

I do agree with the fee-for-service basis, the way in which it is allocated. It is more difficult because of the nature of women's health problems for them to compete on the same basis with men, but it is not easy for the men either.

Dr. MONAHAN. Speaking to that same issue, again, I have seen over 13 years as a counseling psychologist with a regional office that women have often had to prove more than male veterans that they could make a success out of particular programs. It has gotten better because we have fought for it. But I can also speak as a service-connected disabled veteran, who has been through the system, who was never told anything when I was medically discharged from the service, who did not even know what was available to me even along the line of voc-rehab or school or anything else.

When I look—and I know the system, I know where the turns are, and where the closets are, and everything else—and I see how difficult it is for me to address the system, then how much more difficult for someone who doesn't know anything about the inside of the VA?

Mr. EVANS. I think, Linda, you wanted to make a final comment before I yield to Mr. Ridge.

Ms. SCHWARTZ. I wanted to say—and I think this is just hooking on to what I said before—when I was medically retired from the military, I had been a reservist on active duty, so I tried to go back to work. I didn't do very well, I had to leave my work, and I tried to get another job, but, because of my disability and being a nurse, it was very, very difficult. I went like this for three years, and when, finally, I couldn't get a job because people said, "Well, this is your disability and we don't hire anybody with this," that is when I, just out of pure desperation, called the VA, and I remember, I said to them, "You've got to do something to help me." For three years I didn't know that they would help.

But I think it is fair to say, when I finally did get in the care of the voc-rehab people—and they were all men—they were very, very sensitive, and they still continue to be supportive of me, and I think that that sensitivity is something that they have in voc-ed, but they need to have over there in the entire system.

Dr. MONAHAN. I was the first woman to be hired in the Atlanta office in the voc-rehab and counseling division, and they did not want me there. I am 90 percent service-connected with a Ph.D. and two master's degrees, but they figured that a woman could not possibly understand what a veteran would really go through because she wasn't really a veteran, and I think that some of that same attitude still prevails. It seems strange. It has gotten better, but it is not well yet.

Mr. EVANS. Let me yield to the gentleman from Pennsylvania.

Mr. RIDGE. Thank you, Mr. Chairman.

We just get into it again and we have to get back over and vote, but I am intrigued with the unanimous, resounding support of this panel—and I don't think it was lost on anybody here—of the need for a word that is often lost in government, and that is accountability. I think that that is a very strong, and very important, and probably the most salient message from this panel. We need somehow to set up both qualitative and quantitative standards and have the internal oversight and external—this committee—to see if the system, with a lot of well-intentioned people in it, a lot of people trying to do their best, but, who also go beyond individual efforts and make the system accountable, and I like that. I think it is very important, and it is a very strong message, but I also like, and I think Ms. Besikof, you used the word “enforceable” accountability.

Ms. BESIKOF. Yes, sir.

Mr. RIDGE. I like that as well, and I think that is something the chairman and I agree wholeheartedly on ultimately, that enforcement should have something to do with purse strings and answerability here before this subcommittee or the full committee.

One of the questions that I would like to ask—and I might have to pursue it again—relates to Ms. Lindsay and Ms. Mungin and their experience in the military. One was a victim of sexual harassment and trauma as well as a physical, medical problem, and the other experienced sexual harassment. Neither, as I understand it, had any indication on their DD214 that either of these two pre-existing conditions existed, and therefore when that form follows that person out of the Department of the Army or the Department of Defense into the VA health care system, there is no public notation that these women should be eligible for, again, some of the new services that are being offered in the VA through the good efforts of many of you here in this room.

I wanted to ask you, in your experience, I suspect this is very much the norm.

Ms. MUNGIN. Yes, it is.

Mr. RIDGE. It is probably a very rare occasion when women who have been victims of sexual assault and battery, harassment, and the like, have any of that noted on those records that would give them immediate access to the VA health system. That seems to me something that we need to take up with Armed Services, not only sensitivity within the VA, but sensitivity within the DOD to make

sure that these records publicly follow the women who leave the service so they will be eligible automatically and, won't need an ombudsman, won't need a facilitator, but say, "Look, I'm a proud veteran; here's my DD214; these are the services to which I believe I am entitled; where are they?" It is the exception rather than the rule, isn't it?

Ms. BESILOF. It is a rare thing indeed to find a service-connected sexual assault victim. The more common thing that I am aware of, is that you see women who go for years without understanding there is such a thing as a treatable injury, and then have to go through a horribly painful reconstruction period in order to prove what happened. That just doesn't exist for the men whom the law presumes are entitled to care. That is part of what I have mentioned. It is opening the door to services that is a problem. Even to get in the VA's door is a different experience for a woman than it is for a male veteran.

Ms. SCHWARTZ. I would just say it is almost like being raped a second time. I think the aftermath of what you have to go through in the military is far more prolonged. It is a betrayal of something you believed in, and that is why I think it is very difficult, I am sure, as you have heard today, for women.

Dr. MONAHAN. You know, I was so very happy, as I am sure many other people were happy, to hear Secretary Brown state that he wanted the Department of Veterans Affairs to take an advocacy position rather than an adversarial position. I think that that is so important to be able to help veterans, to be able to inform them of their possibilities and their rights, their due process in filing and helping them with their claims.

Ms. MUNGIN. I think also it was a big trauma. They said they were going to change their rating scale. I had to end up getting a hysterectomy, and they gave me a K award, and it is like, "Well, you just be happy with that," and I am like, "But I'm denied my right of whether I even wanted to think about having more children." I mean if I get married again, my next husband may be like, "Well, what's going on here?"

I think that because of just sloughing off and waiting until later has caused many women's health to deteriorate, so by the time they do get to the VA system they have got to piecemeal the woman back together again because she has gone through so much, and it is like every time she reaches out for help it is like a slap on the hand: "Well, I'm sorry, we can't do this," and I think the only reason I have been given the assistance that I have been given with the VA is because I have gone and sat on a few people's desks and said, "I'm not moving until you do something," because, you see, I look at it that, if something happens to me, I want to make sure that my children are taken care of, and just telling them, "Well, we'll just give you this," is not enough for me. I want to make sure that if I die tomorrow my children are going to be taken care of, that it wasn't because of any fault of mine, what health problems I have, being the cause of my leaving. All these things come into play, and they can't seem to realize that when you have a family and you have health problems, it affects the family too.

Mr. EVANS. I am afraid we are going to stop for a vote.

Ms. MUNGIN. Okay.

Mr. EVANS. We do appreciate your testimony and are sorry that it has been interrupted twice by votes. I think that you sense bipartisan concern about these issues on this committee. We are frustrated with the problems we continue to face even though there has been some progress and perhaps even some new attitudes at the top levels of the VA. It is an issue that I can assure you we will continue to monitor as we have had hearings before the subcommittee every session of Congress, and we will continue to do so until there is major and substantial improvement.

Thank you all very much.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]

A P P E N D I X

**Statement of
Hon. Lane Evans, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs**

**VA Provision of Health Care to Women Veterans
and Related Issues**

June 23, 1993

(59)

Good morning and welcome.

The role of women in the Armed Forces and in society is changing. Women are now being assigned to Navy combatant ships. They are also being assigned to fly Apache helicopters, F-15 Eagles, and F-14 Tomcats. Just this past week, a woman took command of an Air Force missile squadron. The same squadron, by the way, her father commanded a generation ago.

With almost daily news on the changing role of women in the military, the public has become much more aware of the contributions women have made to our national defense. Later this year, in November, a memorial to women veterans of the Vietnam War will be dedicated on the grounds of the Vietnam Veterans Memorial. Later, a memorial to Women in Military Service will be constructed at the main gate of Arlington National Cemetery.

In spite of this increased public awareness of women in the military and the fact that women comprise the fastest growing segment of our veteran population, it appears the Department of Veterans Affairs has not improved the availability of gender specific health care services needed by women veterans accordingly.

Information recently provided by the VA Inspector General, who will be testifying today, reveals significant deficiencies in VA health care for women veterans. Insufficient knowledge of available womens' health care services, inadequate training for individuals who coordinate these services, and a lack of gender-specific medical equipment are just some of the unacceptable findings which will be discussed today.

In some cases, deficiencies in VA health care for women veterans have been reported before, some as long as ten years ago. For women, ten years without gender specific health care can be a long time. For some women, in fact, those ten years are their lifetime.

Frankly, this Subcommittee doesn't understand why it should be so difficult or take so long to provide adequate health care services to women veterans. Women are not second class citizens; they are not second class veterans; and their health care needs are not second class either.

The Chair, this Subcommittee and other Members have repeatedly given VA strong encouragement to provide the full range of medical care services needed by women veterans. In spite of strong Congressional support, women veterans today still can not rely on VA for their health care needs.

There are, we know, isolated examples of success. Minneapolis is one. But pointing to one or even a few isolated successes, isn't good enough. The success of these few programs is due to the determination of a few local individuals, not the leadership of VA policy makers in Washington.

Over and over, VA has pointed with pride to the Women Veterans Coordinator; the bright and shining example of VA's commitment to women veterans health care. Unfortunately, coordinators have been given few, if any, specific responsibilities; they have been given little or no institutional support; had too little time to do the job; in many cases they received little, if any, training.

Under national health care reform, VA is expected to become a competitive health care provider. I want VA to succeed. I want VA to be the health care provider for women veterans. One thing is clear, however -- VA must become a quality provider of health care to women veterans today if it hopes to be the health care provider picked by women veterans tomorrow. Results, not rhetoric, are needed now.

The new Deputy Secretary of Veterans Affairs has recognized the problem. He recently said, VA "has neglected women badly" and must do more in the area of women's health care. We welcome this frank and realistic assessment of longstanding neglect. We agree VA health care for women veterans must be improved. We look forward to the improvements this Administration will make.

Legislation to improve VA services to women veterans has and will be proposed by several of our colleagues, including Congresswoman Maxine Waters, the Vice-Chairman of the Subcommittee. The Chair commends, welcomes and strongly supports each of these important initiatives.

Before I call on our colleagues Representative Pat Schroeder of Colorado and Representative Rosa DeLauro of Connecticut for their presentations, I am happy to recognize the Subcommittee's Ranking Minority Member, Tom Ridge, for any comments he may wish to make at this time.

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STATEMENT OF THE HONORABLE TOM RIDGE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

WOMEN VETERANS' HEALTH CARE ISSUES

JUNE 23, 1993

Thank you Mr. Chairman. I would like to commend you for scheduling this hearing today. It is very important that all those involved with veterans' health care become cognizant to the special needs of women veterans.

It is not surprising that in this changing world, the number of women in the Armed Forces has significantly grown. This change in military service composition directly impacts the number of female veterans in the population who seek medical and surgical treatment in VA medical centers. Since 1982, the number of female veterans in the United States has grown from 740,000 to about 1.2 million.

We are all aware of the different medical procedures needed by women to ensure that they are given proper health care. We also know that the Veterans' Health Administration does not have a good historical record in providing these special needs, but I think that what we need to focus on is what is being done today and in the future for this special veteran population.

The testimony that we will hear today from both Stephen A. Trodden, the VA Inspector General and Mr. Hawkins, the Deputy Under

Secretary for Health for Administration and Operations, not only encourages me that we are moving in the right general direction, but that the VA is taking serious steps to ensure that this country's women veterans receive the same quality health care that their male counterparts are currently receiving.

As anyone that has ever been involved in the legislative side of policy making knows, there is no perfect program. For this reason, I look forward to also hearing input from our witnesses on what can be done to improve the current system of providing health care for women.

Mr. Chairman, I again commend you for scheduling this hearing and would like to welcome our distinguished panel of witnesses.

Opening Statement of Congresswoman Maxine Waters

**Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs**

June 23, 1993

Good morning. Mr. Chairman I want to commend you on bringing us together to once again receive testimony and engage in dialogue regarding the health care needs and concerns of women veterans. We know that the VA has a long-standing history of neglect in this area and it has been through your leadership that many of these deficiencies are now being dealt with. Your strong support and advocacy for all veterans goes without saying. I want to thank you for your leadership and support. I look forward to our continued working together as we tackle the tough issues facing our veterans.

Women play and have played an important role in the defense of our nation. They have served honorably alongside their male counterparts. As veterans, however, they receive second-class treatment.

Women facilities in VA hospitals are still woefully inadequate. Mammography capability is limited. Private rooms for women are problematic in many VA facilities. Shortcomings within the system highlighted by women are, all too often, sloughed off by the bureaucracy.

I do recognize and support the efforts of the VA to address many of these issues. The development of well women health programs, broadening the context of service-connected

Post Traumatic Stress disorder to include sexual trauma, and authorizing a Women Veteran's Health Study are all good initiatives, but should be looked upon as initial steps and not as a final solution. As pointed out by the IG's Report and the GAO Report, improvements are still needed.

It is incumbent on those of us who serve on this very fine committee to insure the equal opportunity to serve this country is coupled with equal access to veterans' benefits. The time to start is now. The trickle of women veterans we've seen in the past will soon become a flood. As women assume ever greater responsibilities in our armed forces, our veterans' services must also change to insure that women have access to a full range of quality health services.

That is why I am introducing a bill that would establish a "Women's Bureau" within the Department of Veterans' Affairs. The duty of this bureau will be quite simple -- to foster and promote standards and policies to improve the general welfare of women veterans. The bureau will have a full participatory role in policymaking, program direction, legislative and regulatory action, research and evaluation, -- all matters pertaining to the welfare of women veterans and their dependents and beneficiaries. It is not the intent of this bill to dismantle any of the programs already in place for women. The bureau will simply serve as a focal point of coordination for these programs.

I believe we need to hold the Department of Veterans Affairs accountable to women's concerns. This Women's Bureau would provide a built-in mechanism to insure that women's input into programs and policies effecting women veterans would receive the consideration it deserves.

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OPENING REMARKS
HONORABLE TERRY EVERETT
HVAC- OVERSIGHT AND INVESTIGATIONS
6/22/93

Thank you Mr. Chairman.

I would like to thank you, Mr. Chairman, and Ranking Member Tom Ridge for holding these hearings today on health care of women within the VA system. I appreciate your leadership on this vital issue that affects our increasing population of women in the VA system.

I note that according to the VA Inspector General's testimony that there are over 1.2 million women veterans as of 1990, an increase of 61% from the 1982 figure of 740,000. This growing population of women veterans has special needs within the VA healthcare system that must be addressed, and I am glad that this Subcommittee is fulfilling its role in ensuring that these women veterans' needs are being met by VA.

The GAO report that I have before me has a very disappointing title; "VA HEALTH CARE FOR WOMEN-Despite Progress, Improvements Needed." I note that in the testimony that will be heard before this Subcommittee today, the GAO reported several areas that are lacking in fulfilling the VA's mandated mission of providing adequate healthcare to our nation's women veterans.

Among those areas cited as lacking in the GAO report are physical examinations, including cancer screening for women veterans, continue to be "sporadic". Other problems cited in the Inspector General's "Report of Inspection of Women Veteran's Health Care Programs" include the fact that Women Veterans Coordinators were not adequately

trained to function in their positions, and the VHA had not established a formal training program to address this issue. Other problems mentioned in this report include the fact that there is a need for stronger leadership in providing adequate treatment for these women veterans from the highest levels of VHA management.

That is not to say that VA has not taken steps to improve health care for women veterans since the establishment of an Advisory Committee on Women Veterans in 1983. I note in today's testimony that these actions include implementing a written plan for women's care, improving outreach by requiring its regional offices to identify and maintain rosters of veterans service organizations with mostly women members, and maintaining contact with these organizations.

Other steps mentioned by Deputy Undersecretary Hawkins include creating and implementing a protocol for monitoring the quality of health care services for women veterans, priority access to comprehensive sexual trauma counseling, planning for new research initiatives related to women veterans health needs, and the appointment of a permanent member from the Veterans' Employment and Training Office to the VA Advisory Committee on Women Veterans.

Although these are all positive steps in the right direction, these reports by the GAO and the VA Inspector General reveal that this is not enough. I hope that by having this hearing today on the status of women's health care within the VA, and by holding other hearings in the future on these and other related issues to healthcare, we

can begin to recognize and address the gender-specific problems our women veterans encounter.

Thank you Mr. Chairman, and I would ask that any additional comments or questions that I may have be added for the record.

TESTIMONY OF REP. PAT SCHROEDER (D-CO)
HOUSE VETERANS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
JUNE 23, 1993
VA PROVISION OF HEALTH CARE TO WOMEN VETERANS

Mr. Chairman, it has been nearly a year since the last time I testified before this Committee regarding women veterans. Since then, thanks to your persistence, and the support of many other members of this Committee, Congress was able to pass P.L. 102-585 which began the process of addressing the critical needs of women veterans. Yet, the Department of Veterans Affairs is still not providing adequate care to women veterans. Today, I want to talk about where we are, and where we need to be to provide our 1.2 million women veterans with comprehensive care through the Department of Veterans Affairs.

As you know, P.L. 102-585 was considered a break-through for women veterans carrying the psychological and physical wounds associated with sexual trauma by establishing a counseling program for these women. Since P.L. 102-585 was passed, the VA has hosted several conferences on sexual assault, named four women's health specialty centers, and will soon be naming four sexual trauma treatment teams. Furthermore, the Readjustment Counseling Service will soon be hiring over sixty sexual assault counselors.

Despite all this activity on behalf of the VA, P.L. 102-585 imposes a series of severe restrictions on available sexual assault services. For instance, women who left the military more than two years ago are denied access to these new services, and counseling for women in the sexual assault program will be terminated after one year, unless the Secretary grants a special exception. Furthermore, if a woman in the sexual assault counseling program is receiving care under a contract agreement, that contract authorization automatically expires on December 31, 1994.

Any professional who has worked with sexual assault survivors will say that these time limits are unreasonable and will hinder

complete recovery. Secretary of Veterans Affairs Jesse Brown agrees, and in response to a Senate Veterans Affairs confirmation question, wrote "While early identification and treatment [of sexual assault] is desirable, women who have not reported their sexual trauma or received any treatment for many years can be and should be helped. Both the Steering Committee of the National Women's Veterans' Health Training Program and the VHA Task Force on Sexual Trauma are on record as recommending that the time limitation be extended... Furthermore they recommend that the time limitation on the contracting authority for women veterans for who VA facilities are geographically inaccessible be extended or eliminated..."

On May 26, with the support of several of my colleagues on the House Veterans Committee, I introduced H.R. 2285. Sen. Jay Rockefeller (D-WV), Chairman of the Senate Veterans Affairs Committee, has offered the companion bill. These bills correct the deficiencies in P.L. 102-585 and make the VA sexual assault counseling program stronger and more responsive to the unique needs of sexually assaulted female veterans. For instance, H.R. 2285 eliminates all the restrictive time limits established under P.L. 102-585, and expands the entire counseling program through December 31, 1998, thereby making sexual assault services easier to access. It also makes the program available to any male veteran who may be experiencing similar problems associated with sexual assault.

In addition, H.R. 2285 establishes a toll-free, 24-hour, hotline exclusively for veterans who are survivors of sexual assault. This hotline will provide callers with comprehensive referrals to appropriate Department and non-Department programs available to sexual-assault survivors. The legislation also calls for a series of reports from the Secretary to assess the progress of the hotline and to identify and solve problems associated with awarding priority-care status to sexual assault survivors.

Finally, H.R. 2285 places a Coordinator of Women's Services in each region and gives these full-time positions institutional

support and direct access to Central Office. These Coordinators will be available to all the Women's Veterans Coordinators (WVC) in their regions and will help strengthen the WVC program.

The WVC program was originally instituted in 1986, and WVCs were supposedly placed at each Medical Center. Nevertheless, the program has failed to serve women veterans. Recent revelations into the program's inadequacy are illustrated in the Inspector's General's "Report of Inspection of Women Veteran's Health Care Programs". This report, which will be discussed in more detail by other witnesses, is a chilling assessment as to the inconsistencies of the WVC program throughout the country and describes how WVC's often hold multiple job titles, are untrained for their position, and, in several cases, are unclear as to exactly what their responsibilities are. In many facilities, the IG found patients unaware of the WVC program. In some cases, those knowledgeable of the positions found difficulty tracking down the actual WVC. For instance, in the case of the Denver VA Medical Center, my staff was told not only was there no WVC at the facility, there was also no specific Women Veteran Advisory Committee at the facility, despite the fact that VHA suggests that all VA Medical Centers establish such committees.

The IG's report also indicates that women's health care services at the VA are worse than we thought. For instance, of the 166 VA Facilities surveyed, 75 offered no on-site women's health care clinics and 24 indicated they had no coordinating committee or councils to address the needs of women veterans. Out of the eight facilities the IG visited, two opened their women's health clinics every other week for merely four hours, five facilities offered gynecological care on a contract basis and only two facilities had rape kits and obstetrical kits available. A VHA report on women's health care and research released April 14, 1993 indicates that 22 percent of women veterans received gynecological care at VA facilities.

The IG offers ten recommendations to enhance the WVC program and improve women's health services at the VA. These recommendations include providing in-house gender-specific services in facilities with large women veteran populations, reallocating staff and

resources in Central Office to support women's health programs, developing quality indicators for gender-specific services and furnishing WVC with training programs and specific job requirements. I emphatically support the IG's suggestions, and urge the VA to implement these recommendations quickly and efficiently.

While the VA is executing these improvements, I will continue working on legislation to bring comprehensive women's health services to the VA. For example, I will soon be introducing legislation to provide women veterans with a basic primary care and preventive health care package. My legislation will also expand research on women's health at the VA and will establish tough mammography quality standards comparable with the private sector. As the reality of health care reform approaches, veterans will be weighing the services they get at VA facilities with what is available in the private sector. Unless the VA begins providing all its patients the quality care and attention they deserve now, they will not be prepared to enter the competitive market later.

I know you have a lot of issues to cover today, but before I finish, I want to welcome my colleague, Rep. Rosa DeLauro, who has been a great supporter of women veterans, and has taken a special interest in the plight of women who served in Operation Desert Shield/Desert Storm. I also want to recognize one of my constituents, Doris Besikoff, who is here on behalf of the National Women's Veterans Conference and the fund for Women Active in our Nation's Defense, their Advocates and Supporters (the WANDAS Fund). Doris is also a private attorney who has defended veterans for over fifteen years.

Again, Mr. Chairman, your dedication to this issue is nothing short of remarkable. I look forward to continued progress on behalf of women veterans.

Congress of the United States
House of Representatives
Washington, DC 20515

June 23, 1993

Les Aspin
Secretary of Defense
The Pentagon
Washington, D.C. 20301-1155

Dear Secretary Aspin:

As you know, many Persian Gulf soldiers are reporting disturbing health problems possibly related to their service in Operation Desert Shield/Desert Storm. We support your efforts to work with the Department of Veterans Affairs to establish Health Registries, and to contract with the National Academy of Sciences to research the unique health problems of these service-members.

We are writing to you in reference to the women who were in Operation Desert Shield/Desert Storm. Some of the 32,000 brave women who served in the Persian Gulf are reporting alarming gender-specific health problems, including chronic ovarian cysts and birth defects. We are concerned that these distinctive problems are not being properly recognized, researched, or treated.

We would like to know how the Department is cataloging the problems female Persian Gulf soldiers report, and what services are presently available to these women. If gender-specific problems are not being tracked or treated, we would like to know why. We would also like to know what measures will be taken to research, and treat, any future health needs of these women and their children displaying distinctive health problems. Finally, we would like to know of any additional DoD programs specifically available to women who served in the Persian Gulf.

While the number of women who served in the Persian Gulf reporting gender-specific health problems may appear to be minimal, it is crucial that the Department of Defense not use this as an excuse to ignore the need for gender-specific research and services. Otherwise, we may miss an opportunity to clearly identify and treat these early problems. We urge you to code your Health Registry for gender specific symptoms, and to instruct the NAS and any prospective contractors researching the health status of our Persian Gulf veterans to do the same.

Sincerely,


Pat Schroeder


Rosa DeMauro

Lane Evans
Lane Evans

Don Edwards
Don Edwards

Joseph Kennedy
Joseph Kennedy

Henry Waxman
Henry Waxman

Maria Cantwell
Maria Cantwell

Lucille Roybal-Allard
Lucille Roybal-Allard

Marjorie Margolies-Mezvinsky
Marjorie Margolies-Mezvinsky

Leslie Byrne
Leslie Byrne

Pat Danner
Pat Danner

Jane Harman
Jane Harman

Barbara Kennelly
Barbara Kennelly

Cynthia McKinney
Cynthia McKinney

Carolyn Maloney
Carolyn Maloney

Carrie P. Meek
Carrie Meek

Patsy Mink
Patsy Mink

Susan Molinari
Susan Molinari

Eleanor Holmes Norton
Eleanor Holmes Norton

Barney Frank
Barney Frank

Marty Mehan
Martin Meehan

Olympia Shove
Olympia Shove

Jolene Unsöld
Jolene Unsöld

Eddie Bernice Johnson
Eddie Bernice Johnson

Karan English
Karan English

Elizabeth Furse
Elizabeth Furse

Edward J. Markey
Edward J. Markey
Jack Quinn
Jack Quinn

Karen Shepherd
Karen Shepherd

Karen Thurman
Karen Thurman

Lynn Woolsey
Lynn Woolsey

Pat Williams
Pat Williams

Nancy Pelosi
Nancy Pelosi

Louis Stokes
Louis Stokes

Anna Eshoo
Anna Eshoo

Ronald V. Dellums
Ronald V. Dellums

Marilyn Lloyd
Marilyn Lloyd

Congress of the United States
House of Representatives
Washington, DC 20515

June 23, 1993

The Honorable Jesse Brown
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Brown:

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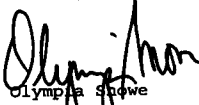
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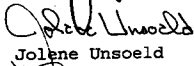
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Susan Molinari

Eleanor Holmes Norton
Eleanor Holmes Norton

Barney Frank
Barney Frank


Martin Meehan

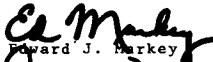

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Jolene Unsoeld

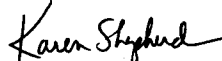

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Karan English


Elizabeth Furse


Edward J. Markey


Jack Quinn


Karen Shepherd


Karen Thurman


Lynn Woolsey

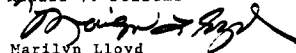

Pat Williams


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Marilyn Lloyd

TESTIMONY OF THE HON. ROSA L. DELAURO
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JUNE 23, 1993

Thank you Mr. Chairman, Rep. Ridge, and all the Members of your Subcommittee for affording me the opportunity to testify before you this morning. It is a pleasure to be here today alongside my Colleague Rep. Schroeder, who truly has been a leader on issues of women in the military and women's health. I want to applaud the Subcommittee for holding this hearing today on a subject -- women's health care through the Veterans Administration (VA) -- that is of great importance to women veterans and those currently serving in our armed forces.

Mr. Chairman, my desire to testify today is driven by two factors. First, I have a deep interest in women's health issues that stems from a very personal experience and my work with the Congressional Caucus on Women's Issues and on the Appropriations Subcommittee on Labor and Health and Human Services. Second, I had the opportunity to meet Carol Picou, who testified before your Subcommittee three weeks ago. Her description of the health problems that women and men who served in the Persian Gulf war are experiencing prompted me to speak with Chairman Evans about what was happening in regard to these reports and, more generally, what problems women veterans were encountering in receiving appropriate medical care through the VA. What I have learned has given me a sense of *deja vu*.

When I came to Congress in 1991, I was impressed by the scope of the problem of the lack of adequate research into diseases that primarily affect women, and the lack of inclusion of women in clinical trials. While I was not new to Washington, or to women's health issues, I was made aware more than ever of the deep bias that existed against adequate research into women's health issues. Not only were women excluded from important clinical trials, but little analysis was being done of study results based on gender; research on diseases that especially affected women was poorly funded; and female researchers were few and far between.

A GAO report was deeply critical of the National Institute of Health -- the leading biomedical research facility in this country, probably in the world. The NIH, charged with involving women in its clinical trial had made precious little progress in that direction.

So in my first term in Congress I joined the Women's Caucus and had the good fortune to address some of these issues. A tiny band of women -- frequently Republicans and Democrats together -- took the initiative, along with groups concerned about women's health research, to fight to change ossified attitudes and the astonishing insensitivity toward research into women's health issues. We worked to provide serious resources to the National Cancer Institute for research on breast, ovarian and cervical cancer.

I am also aware of the problems that veterans of the Persian Gulf war, such as Carol Picou, have brought to your attention, and to the attention of the American public. Her testimony before your Subcommittee as well as her appearance on Nightline provided riveting case histories that must be investigated. Questions were raised regarding the use of depleted uranium (DU) munitions and anti-nerve and biological warfare agent drugs that were administered to military personnel stationed in the Persian Gulf. Women have reported chronic ovarian cysts, abdominal bloating and birth defects. Men, too, have reported health problems including severe weight loss, joint pain, fatigue and mood swings.

In light of the concerns SFC Picou and others have raised, Congresswoman Schroeder and I, along with 32 other Members of Congress, are sending letters today to VA Secretary Brown and DOD Secretary Aspin expressing our concern that problems faced by female Persian Gulf soldiers should be properly cataloged and that necessary health care services are provided. We cannot miss this opportunity to clearly identify and treat problems early. The letter urges the VA and DOD to code the Health Registry of those who were in Operation Desert Shield/Desert Storm for gender specific symptoms, and to instruct the National Academy of Sciences and any prospective contractors researching the health status of our Persian Gulf veterans to do the same. I would ask unanimous consent that the letter be placed into the record of today's hearing.

I also want to express my support for the legislation Rep. Schroeder mentioned, H.R. 2285. As a cosponsor of her bill, I urge the Veterans Affairs Committee to favorably consider this much needed improvement in the treatment of women and men veterans who have suffered sexual trauma or harassment. In addition, the legislation will enhance the Women Veteran Coordinator program to help women better access services through the VA system. I know that at the West Haven VA in my District, the Women Veterans Coordinator is only a part-time position. I assure you the need is full-time. H.R. 2285 would make sure the Women Veterans Coordinators are full-time positions that will be provided with adequate resources.

In conjunction with this initiative, I believe funding for VA women veterans programs, including the four comprehensive women's health centers currently being developed, should be increased so that additional centers can be established and research programs on women's health needs can be extended. I know the Chairman and Rep. Schroeder have expressed their support for increased funding, as well.

The result of our efforts was the creation of an Office on Women's Health Research at the NIH; substantial increases in funding for women's health research; and the establishment of federally funded centers for research on contraception and infertility. And now that the President has signed the conference report on S. 1, the NIH reauthorization bill, women and minorities will be required, except in certain circumstances, to be included in NIH-funded research projects. This new law will put some balance into medical research, and provide millions of American women with the hope that their medical needs will be met.

It is because of my grave concern about past research that overlooked women's health and the importance of prevention that I am disturbed about the results of GAO studies that point to deficiencies in the health care women veterans receive through the VA. We cannot allow our women veterans who have made personal sacrifices to serve all of us by helping to defend our country go wanting for appropriate health care services.

In particular, the latest report noted that cancer screening for women veterans continued to be sporadic -- that the VA has not effectively implemented plans to ensure that as part of their physical examinations, women veterans receive appropriate cancer screening. It was also noted that VA medical centers are inadequately monitoring their in-house mammography programs to ensure compliance with quality standards.

I strongly believe we should make every effort to ensure that every woman veteran is properly screened for breast, ovarian, uterine and cervical cancers, and that greater attention be paid to the quality of screening programs and services. While the GAO found that progress has been made in some VA Medical Centers, for example those in Martinez and San Francisco, at too many centers quality control reviews do not ensure that all women veterans are receiving the screening they should. Information about the successful programs should be shared rapidly with other centers who are lagging behind. This should be a top priority for VA Medical Centers and regional and national VA officials. Again, if we know how this can be done, there is no excuse for inaction.

In addition, since the VA's 1985 Survey of Female Veterans, we have known that almost 9 percent of women veterans had cancer and that the lifetime prevalence of cancer among women veterans is nearly twice the rate of that among all adult women. It is my understanding that there has been no serious effort to discover why this is so. If information were collected and analyzed by the VA and/or the DOD, perhaps we could uncover what factors placed these women veterans at greater risk for developing cancer and measures could then be taken to minimize or eliminate those factors. I would encourage a joint VA-DOD study be developed to do just that.

In closing, I again want to commend this Subcommittee for shedding light on the issue of women's health care in the VA. We cannot continue to ignore the diseases that affect our daughters and mothers. We must heighten awareness that the diseases affecting women have to be understood, analyzed, and treated with the same care and diligence with which we fight all other diseases. We must invest in research and prevention if we are to have healthier children and families. We must make the commitment today so that we save lives and precious health care dollars tomorrow. I urge the Members of this Subcommittee to continue your oversight efforts, and look forward to working with you.

**STATEMENT OF THE HONORABLE STEPHEN A. TRODDEN
VA INSPECTOR GENERAL
BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
OVERSIGHT HEARING ON THE
VETERANS HEALTH ADMINISTRATION'S MANAGEMENT OF
WOMEN VETERANS' HEALTH CARE
JUNE 23, 1993**

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the Veterans Health Administration's (VHA) management of women veterans' health care. For the most part, my comments are based on a recently completed study by my Office of Healthcare Inspections. The study, published on June 17, 1993, is entitled "Report of Inspection of Women Veterans Health Care Programs," Report Number 3HI-A99-129. The study was conducted in response to requests by the House and Senate Veterans' Affairs Committees to assess the status of women veterans' health care programs in VA medical centers. VA medical centers are different from other types of hospitals because, traditionally, they have catered to a predominate male population. This situation is changing, however, because the composition of the Armed Forces has shifted in recent years to include a greater proportion of female members. This change in military service composition has contributed to a greater number of female veterans in the population who seek medical and surgical treatment in VA medical centers. For example, in 1982, there were about 740,000 female veterans in the United States. By 1990, the female veteran population had increased to about 1.2 million. The female veteran population will continue to increase at a rapid rate because the composition of the current Armed Forces is about 11 percent female.

Female patients require a different mix of services; different diagnostic and treatment tools and procedures; and greater emphasis on privacy needs than VA medical centers have been accustomed to in the past. The Congress recognized these specialized needs when it passed the "Veterans Health Care Act of 1992" which expanded eligibility of women veterans to receive a broad spectrum of health care examinations and treatments, and established more definitive requirements for women veteran services availability at VA medical centers. Congress also passed the "Veterans Health Care Amendments of 1983" which required the Veterans Health Administration to establish a VA Advisory Committee on Women Veterans, which in turn, gave the impetus to VA medical centers to begin providing health services to female veterans.

My Office addressed the issue of how effectively VA medical centers have met the needs of women veterans by visiting and evaluating the scope of women's health services as they are provided at a stratified sample of 8 VA medical centers around the country. We did not attempt to evaluate the quality of the health services being provided in these medical centers. Resources permitting, I plan to address the quality-related issues during fiscal year 1994. Veterans Health Administration officials agreed with us at the outset of the study, that the eight medical centers that we inspected could be considered to be representative of how women veterans' services are provided in VA medical centers.

At our request, VHA conducted a questionnaire survey of 166 VA hospitals to assess the status of women veterans' health care programs throughout the system. This survey was done concurrently with my inspection. The results of the VHA survey paralleled and supported my findings and conclusions that VA medical centers do not offer a consistent level of women veterans' health care support.

The results of the Healthcare inspection showed that only one of the eight medical centers that was inspected offered the full range of women veterans' health care services that VHA defines in its guidelines as constituting a comprehensive women's program. The other seven medical centers offered broadly variable women's health services that ranged from providing very limited gynecology examinations such as Papanicolaou tests (PAP smears) to conducting most gynecological examinations and treatments with supplementation by fee-basis physician services. The variability in program offerings indicated that there is a need for stronger leadership in providing adequate treatment for these patients from the highest levels of VHA management. The OIG study concluded that:

1. Women Veterans Coordinators were not adequately trained to function in their positions, and VHA had not established a formal training program to address this issue.
2. Women Veterans Coordinators were not always easily available in medical centers, and patients and some employees did not know who was available in the medical center to assist female veterans with their needs.
3. Medical center employees did not always inform female patients about the full scope of services that were available to them, or of the services to which they were entitled.
4. Medical center managers had not always ensured adequate privacy for female patients, and Women Veterans Coordinators did not have input to construction committees in order to identify and seek resolution to these problems.
5. Specialized medical equipment required for female examination and treatment was not always readily available for use when clinicians needed it, and some gynecological equipment was not always available in the type or configuration that ensured patient comfort.
6. None of the eight VA medical centers that were included in our study had established systematic procedures to monitor and evaluate the quality and appropriateness of women's health care.

The OIG study also determined that medical centers frequently did not provide some or all of the services that were needed by their female veteran patients, in-house. Rather, the services were provided by private sector or university-affiliated health care institutions on a fee-basis arrangement. We do not advocate the need for all VA medical centers to offer a broad spectrum of women's health care services, because it may not be cost effective, and safe medical practice may not be assured, if

attempts are made to provide these services in settings in which there are only small numbers of female veterans residing in medical centers' catchment areas, or if a very small number of female veterans have historically availed themselves of the services at any given medical center. Nevertheless, VA guidelines require that a base-line level of gender-specific services should be available at all VA medical centers, and that these services may be supplemented by alternative methods such as fee-basis care. This was not the case found by either the VHA survey or the OHI inspection. Forty-three VA medical centers simply did not offer women veterans health services.

These findings raise concerns as to whether or not female veterans are being accorded the level of medical, surgical, and psychiatric treatment services that they are entitled to at or through the VA health care system. Part of the reason that not all VA medical centers offer women veterans health services can be attributed to a paucity of specific guidelines from VA Central Office. VHA guidelines do not specify the skills that Women Veterans Coordinators should have in order to function effectively in their positions; nor does VHA offer training or guidance as to how Women Veterans Advisory Committees are to function. I believe that Women Veterans Advisory Committees in each medical center would be beneficial in providing the guidance and perspective that is needed to operate effective female patient treatment programs. VHA managers acknowledged that such Committees are important, but VHA leaves the development of Women Veterans Advisory Committees to the discretion of medical center managers.

The inspection resulted in 10 recommendations to strengthen the Department's women veterans' health care treatment process, the Under Secretary for Health concurred with our recommendations and provided us with planned actions that, when implemented should improve women veterans health care in VA medical centers. These actions included: clearly defining the roles of medical centers' Women Veterans Coordinators; providing adequate training and resources to WVCs; developing workload and population-based criteria upon which to base decisions as to what female-specific health services will be available in each VA medical center, and how those services will be provided; providing adequate information to female veterans as to the availability of women's treatment as well as the scope of the treatment to which they are entitled; and developing national quality of care indicators for gender-specific services. The Under Secretary of Health agreed in principle that there was a need to increase and strengthen Central Office staffing and leadership for Women Veterans health care programs. However, he believed that this need had to be balanced with the needs of other high-priority resource issues.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
JUNE 23, 1993

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to provide its views regarding women veterans health care within the Department of Veterans Affairs and other related topics. The Legion has previously testified before both the House and Senate Committees on Veterans Affairs that the provision of high quality medical care must be made available to all eligible women veterans. Recent experience suggests that VA has made some progress toward meeting the unique and routine health care needs of women veterans. Our testimony today will focus on continuing concerns.

Mr. Chairman, Public Law 102-585, 'Veterans Health Care Act of 1992', Title I - Women Veterans Health Programs, includes nine relevant sections dealing with women veterans health care matters. The first four include counseling for women veterans with sexual trauma: eligibility for counseling, training of health professionals, referral, priority for outpatient care for women requiring counseling, outreach, and reporting requirements. Other sections deal with authority to provide health care services for women, reporting requirements, coordination of services, research and a population study of women veterans. The 1992 Appropriations Act included \$7.5 million for women veterans programs.

In relation to Title I of the 'Veterans Health Care Act of 1992', VA has recently chosen four medical centers (one in each Medical Region) to establish 'Women Veterans Comprehensive Health Centers'. These programs are intended to provide VA health care initiatives for women veterans in outreach, inpatient and outpatient care, including gynecology, attention to privacy concerns, early detection and treatment of reproductive and breast cancers, and the psychological sequelae of sexual assault and PTSD.

Mr. Chairman, The American Legion recognizes that it takes time to build an acceptable level of services for women veterans. Historically, the VA medical care system has been dominated by male veterans. During the Vietnam War era, women accounted for less than two percent of all uniformed personnel. At the start of the Persian Gulf War, almost 11 percent of

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active duty personnel were women. Currently, women make up 12 percent of the active duty military force and four percent of the veteran population. VA workload totals for FY 1992 show that 14,972 women were hospitalized, comprising 2.2 percent of all hospital discharges, and 274,835 women were treated as outpatients.

Initiatives for women veterans undertaken by VA in FY 1993 include: a national training program for women veterans coordinators, establishment of four regional comprehensive health centers, four stress disorder treatment teams, hiring of fifteen full-time women veterans coordinators plus full-time coordinators in each region, and the recruitment of Vet Center counselors in 60 centers with special expertise to treat women who have experienced sexual trauma. The President's FY 1994 VA budget proposes an additional commitment of resources for women veterans health care.

With the number of women in the military increasing, the female veteran population will continue to expand over the next decade. The operation of a fully functioning women veterans health care program within the criteria established in law will require additional resources. One factor limiting VA in providing equal access to health care services for female veterans is that the women veterans workload is somewhat less evenly distributed. It may not be practical to provide full-time services in certain locations while in other locations a need may exist for a fully staffed women veterans clinic. A referral network within VA regions for certain health care services, for both male and female veterans, oftentimes is the only alternative for care. Service-connected disabled veterans have the option of receiving fee basis services, however, this option is of little use to nonservice-connected veterans. The anticipated revision of current eligibility laws will by necessity, have to examine the subject of fee basis care for scarce medical specialties.

The American Legion believes VA should be commended for its attempts to improve the delivery of health care services to women veterans. We understand that necessary modifications to accommodate greater numbers of women veterans will not happen overnight. We believe the full implementation of P.L. 102-585, with regard to further development of women veterans programs, will represent a reasonable measure of progress. The American Legion firmly believes that greater improvement in the Women Veterans Coordinator program is necessary, and that providing adequate privacy for women veterans in VA medical facilities is an ongoing objective.

Mr. Chairman, in addition to the health care provided women veterans, certain other amenities such as conveniently located separate and private lavatory and shower facilities in

clinical areas must be provided. Adequate public rest room facilities throughout the facility and the availability of gender-specific personal care items, cosmetics, toiletries and reading materials in the canteen service should be assured.

On June 8, 1993, Congresswoman Maxine Waters introduced legislation which would create a "Women's Bureau" within the Department of Veterans Affairs which would oversee "all matters pertaining to women in the VA." This legislation would create a structure from which progress of all aspects of womens services in the VA could be monitored. We commend and support this effort with the caution to avoid duplication of similar oversight provided by P.L. 102-585.

In addition, we wish to place special emphasis on the need to support and finance research efforts in VA as they relate to certain womens health problems. It is also important to point out the necessity to provide education, research and clinical treatment outreach to the special medical needs of women veterans of all ages, not just those of child-bearing age. Research, prevention and treatment of such diseases as osteoporosis, a disease which has its beginnings in young women and manifests in later years, must be pursued. Recent data reflects that today 395,000 female veterans are over 65 years old of age. This total represents 32.4 percent of the entire women veterans population. By the year 2020, the number of women veterans over 65 is projected to fall to 376,000, representing 27.8 percent of the total.

Mr. Chairman, a demographic study and medical needs assessment must be accomplished to determine those areas in which women veterans present themselves in greatest numbers for VA medical care. Once accomplished, VA can better align its resources and programs to provide full service women veterans health care clinics. For facilities with low utilization by women veterans, services which are unavailable for eligible female veterans must continue to be contracted with local providers. Until the population of veterans to be served by VA in the future is identified through comprehensive eligibility reform, a patchwork system of care and services for both male and female veterans will continue to be the norm.

Mr. Chairman, that concludes our statement.

STATEMENT OFTERRI LEE TAMASE, M.D.

CHIEF, PRIMARY CARE, WEST LOS ANGELES VA MEDICAL CENTER
 ASSISTANT PROFESSOR OF MEDICINE, UCLA SCHOOL OF MEDICINE
 MEMBER, WEST LOS ANGELES WOMEN VETERANS ADVISORY COMMITTEE

BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF
 THE UNITED STATES HOUSE OF REPRESENTATIVES

JUNE 23, 1993

Good Morning Mr. Chairman and members of the Subcommittee.

My name is Terri Lee Tamase. I am a full-time staff physician in the Department of Medicine at the West Los Angeles VA Medical Center (WLA VAMC) in Los Angeles, California and Assistant Professor of Medicine at the UCLA School of Medicine. In addition, I am a member of the Women Veterans Advisory Committee (WVAC) at WLA VAMC. It is indeed an honor to be invited to provide information on the important issue of medical care for women veterans.

OVERVIEW OF WOMEN VETERANS IN THE WEST LOS ANGELES VAMC
 CATCHMENT AREA:

WLA VAMC, located in the heart of Los Angeles, California, is the largest, most complex and ethnically diverse medical center in the entire VA system. There are approximately 90,000 women veterans in the WLA catchment area. In Fiscal Year 1993, WLA VAMC and its affiliate, Sepulveda VAMC, served over 4,500 unique female patients, with 30,724 outpatient visits and 388 inpatient admissions. Approximately 250 new outpatients are seen monthly; 7 to 12% are women. Local community-based programs (i.e., Vet Centers, Salvation Army, etc.) together serve nearly 100 women each week. With the growing number of women in the military (i.e., 11% of all active duty personnel and 13% of the ready reserves), we anticipate that we will double or triple the number of women served as they enter the ranks of women veterans in the near future.

The women veterans of Los Angeles have female health care needs unique to their urban environment. For example, Los Angeles County has the highest number of homeless veterans in the country, of these persons approximately 5% (i.e., 1200) are women. The WLA VAMC now has homeless women veterans encamped near its grounds and moving through its facilities. These homeless women, sometimes pregnant, can be found wandering through the VAMC looking for food and shelter. They sleep on couches in the lobbies, in the attics of buildings and in automobiles in the parking lots. Moreover, some women veterans eat, sleep and attend to the needs of nature under freeway embankments surrounding the VA grounds. Yet, these numbers do not account for the many "hidden" homeless female veterans that our existing programs are unable to reach. Unlike homeless male veterans who live on the streets, homeless women veterans, many with children, flee to "safe houses" for protection against the violence of the streets. As a result, they are inaccessible to our current outreach efforts.

In addition to leading the nation in the number of homeless women veterans, Los Angeles County also has the third highest number of women with AIDS. Currently, there are no reliable data regarding HIV positive (HIV+) female veterans, since the majority of these women do not seek care from the VA. However, we can extrapolate from nonveteran data on women with AIDS.

The number of women infected with HIV through heterosexual transmission is increasing at an alarming rate. Women are more likely to be infected by a male sexual partner than vice versa and are more likely to become infected after a single sexual contact.

Yet, until recently the female AIDS population has been neglected compared to more vocal and better organized groups. Only this year has the criteria for diagnosing AIDS been expanded so that more women meet CDC criteria.

The clinical presentation and needs of women with AIDS are distinct from men. Many HIV+ women present initially with gynecologic symptoms. In women with known HIV disease, more frequent cervical Pap smears are required because of their increased risk for developing carcinoma and chronic infections of the reproductive tract. Counseling needs are also quite specific and include the complex problem of HIV infection in pregnant women and mothers.

Even the prognosis of HIV disease seems to have gender-specific features. Women who are diagnosed with AIDS tend to die more quickly than men with the same diagnosis. Many will die of HIV complications without ever having been officially diagnosed as having AIDS. For those patients who do receive a timely diagnosis, therapeutic options for HIV infected women may be different and are not well understood. Clearly, each of these issues merit further attention.

The above discussion highlights some of the unique characteristics and demographics of women veterans in the West Los Angeles catchment area. I felt that it was necessary to address these important health care issues for women veterans since they are priorities for the nineties and beyond.

I would like to turn now to a detailed discussion of the seven areas of women veterans health care that are of particular interest to this Subcommittee.

1. VA PROVISION OF GENDER SPECIFIC HEALTH CARE FOR WOMEN VETERANS AND PROBLEMS ENCOUNTERED BY WOMEN VETERANS IN OBTAINING VA-PROVIDED HEALTH CARE:

In the past 5 to 10 years, the WLA VAMC has made significant improvements in its provision of gender specific health care for women veterans. To illustrate our progress, I have included quotations from two WLA VAMC female health care consumers. One woman received care in our Gynecology Clinic in 1990, the other in 1993.

Patient 1 is a 64 year old retired widow. She was a Navy "Clerical Worker" between 1951 and 1955, based in Washington, D.C. In 1990 she presented to the WLA gynecology clinic for a routine pelvic examination. This is her account of the experience:

"I went to the gynecology clinic shortly after the regular gynecologist retired. I hadn't been to a doctor (for a pelvic exam) very often in the past three years and it was very, very painful. The doctor was having a problem and the nurse kept shouting: 'Relax! Relax!' Perhaps it would have been painful anyway. But the doctor didn't seem to be very experienced. So I felt I didn't care to ever go back. I decided to go to a private doctor. I didn't feel I was treated with consideration. I'm sorry I don't remember all the details, it's something I try to forget."

She further stated that shortly after her experience at the WLA Gynecology Clinic, she purchased private health insurance. Her current monthly payments of \$300 cause significant hardship. Yet, she chooses to pay a higher price for health care, and assume a financial burden, rather than utilize the health care services for women provided by the VA.

Patient 2 is a 26 year old, unemployed female who served in the Army for 4 1/2 years as an "Electronic Intelligence Analyst." She was seen in the WLA Gynecology Clinic in 1993 for a pelvic examination to evaluate cervical dysplasia. This is her account of the experience:

"I came to the VA because I don't have any health insurance. So, this was my only option. I didn't even know women could get any services at the VA - except for teeth - let alone for anything female. But Anthonette (a VET Center counselor) told me to go on down to the gynecology clinic..."

I had a bad experience at another VA - it was sickening and depressing and it was dirty and the people were mean. When I got there and told them my problem they made

me wait outside the clinic for two hours. Then when they finally got to me they said they were closing and I'd have to go to the emergency room. When I got there one of the doctors was yelling and screaming so I said 'I'm outa here' and I finally left.

(West LA) is more under control, nicer looking, cleaner, and the personnel are nice...The resident did the best pelvic exam I ever had. I didn't feel a thing. When it was over his boss, a lady doctor (Lidia Rubenstein, M.D.), came in to check his work and answer questions right away.

When I came (to the Gynecology Clinic), everybody was nice, even the people who do the paperwork. Except (she laughs) when they went to fill out my paperwork they automatically checked male. I had to straighten them out...

If I had to summarize how I feel about the Gynecology Clinic I'd have to say - it's up and coming along."

No one could have summarized the status of health care for women at WLA VAMC more honestly and powerfully than the woman veteran quoted above: "...it's up and coming along."

HOW DID WLA VAMC REACH ITS CURRENT STATUS IN PROVIDING HEALTH CARE FOR WOMEN VETERANS?

At WLA VAMC, we have tended to care for women veterans "reactively" by addressing problems as they arise. Over time, we began to anticipate women veterans' needs. After a long and difficult journey, today we provide care for our women veterans "proactively". Highlights of our history are detailed below.

During my internal medicine residency training at WLA VAMC, between 1987 and 1990, the paucity of women seeking health care services from our system reflected the small number of women among the ranks of veterans. Since that time, this number has grown steadily. Today women constitute approximately 12% of veterans. This percentage is expected to increase to nearly 20% during the 21st Century.

As more women began to access our system, we acknowledged the need to coordinate and facilitate their services. This led to the establishment of several programs and services for women including: 1) Patient Advisory and Consultation Team (PACT) for the orientation of women veterans to their rights and responsibilities; 2) Patient Education Classes (e.g., "Breast Self Examination", "Self Esteem", and "Coping with Traumatic Situations") focusing on women; 3) the Women Veterans Coordinator Program; 4) the Homeless Veterans and Community Health Fairs targeting women; 5) the Women Veterans Lounge; and 6) the Gynecology Clinic.

The catalysts for the development of a quality assurance (QA) program for women veterans at WLA VAMC were guidelines and directives issued from the Central Office of the Department of Veteran Affairs on April 17, 1986. Our current QA Program for women features: 1) a comprehensive history and physical examination, including a pelvic and breast examination, offered to all hospitalized female veterans; and 2) a Breast Cancer Screening Protocol, including Breast Self Examination instruction and state-of-the-art mammography services.

Our Department of Medicine, recognizing the need to improve house staff care for women veterans, revised the ambulatory curriculum to include rotations at UCLA Medical Center in family planning and at Olive View Medical Center (a county hospital) in gynecology. This female-specific training has not only improved care for women veterans, but upgraded the quality of our trainees.

In the recent past, female specific personal hygiene products were either inaccessible, inadequate or completely unavailable at our facility. Largely in response to the Women Veterans Advisory Committee, our hospital and three canteens together now stock female-specific personal hygiene products, toiletries, cosmetics, and a variety of clothing.

The hard structures of our facility were designed in an era when gender-specific privacy was not a concern. As the number of women utilizing our system grew, our patients, with support from the Women Veterans Advisory Committee, brought these issues to our attention. Subsequently, formal and informal guidelines, to ensure privacy for our female veterans, were developed. In our emergency area, female veterans are evaluated in a private room. On the inpatient wards, women are accommodated in female-specific rooms equipped with private toilet and bath facilities.

Less than two years ago our gynecologic equipment, though adequate, was outdated. When our new gynecologist, Dr. Lidia Rubenstein, insisted we conform to community standards for gynecologic care, we moved quickly to meet her demands. Our Gynecology Clinic is now equipped with state-of-the-art gynecologic tables and halogen lamps.

Our history demonstrates that, until recently, health care issues for women veterans were approached "reactively". Care met minimal requirements, but did not reach community standards. Predictably, our services were under utilized by female veterans. In the emergency room, for example, we noted that women account for less than 0.05% of visits.

A few key events catalyzed the reassessment and revision of health care services for women at WLA VAMC including: 1) this Subcommittee's hearings on the status of VA health care for women veterans, conducted on September 17, 1993, and resulting in requests for proposals for Women Veterans Comprehensive Health Centers; 2) implementation of CHAMP-VA; 3) the commitment of WLA VAMC's woman Chief of Medicine, Phyllis A. Guze, M.D., to women's health issues; and 4) the recruitment, at WLA VAMC, of a new Director and Chief of Staff, both interested in health care for women veterans.

This period of reevaluation also proved to be a time of self-discovery. First, we recognized that a "new culture" had emerged at WLA VAMC. Our current staff is attuned to the needs of women and primed to proactively address those needs. Second, we learned that WLA VAMC is already a fertile resource for women's health care through existing partnerships with its affiliates, Sepulveda VAMC (SVA), the UCLA School of Medicine, and the RAND Corporation. Having made these observations, in February 1993, we established new objectives for women's health care at WLA VAMC. These goals are to:

1. Improve women veterans' access to comprehensive health care, focusing on prevention and education.
2. Provide state-of-the-art services through an integrated, cost-effective health care network.
3. Develop educational resources to serve women veterans and to educate health care professionals in women's health care delivery. The VA system is a huge national resource for the training of doctors, nurses and a variety of other ancillary personnel. These trainees go on to practice throughout the United States in non-VA settings. It is imperative that we provide the best education in women's health for our young professionals.
4. Commit to the future of women veterans' health care through the establishment of outreach programs and the development of female-specific research.

To accomplish these goals, we will combine our excellent staff and existing resources at the WLA VAMC, in partnership with our affiliates, to create WL-CHEC (known as "Well Check") - the Women's Life-Cycle Health and Education Center (to be funded in Fiscal 1994).

The WL-CHEC proposal, which I am submitting as an exhibit for the record, will provide services for women in association with the phases of their life cycles-Reproductive, Peri-Menopause, and Geriatric.

WL-CHEC will serve women veterans' needs through two interrelated Core components: 1) a multidisciplinary Primary Care Core, focusing on prevention and education; and 2) a comprehensive Education and Development Core, centering around patients and health care providers.

The WL-CHEC Primary Care Core was patterned after Sepulveda VAMC's Pilot Ambulatory Care and Education (PACE) Program. Its services and multi-disciplinary team approach were formulated on the basis of feedback from women veteran's focus groups. Key features of the Primary Care Clinics at WLA and SVA are: 1) a "One-stop" health care approach - (i.e., reorganized and combined resources will meet the comprehensive needs of women in one visit and provide more efficient health care delivery); and 2) a Multidisciplinary Team Approach - (i.e., the patient will be seen by a primary health care team consisting of a Nurse Practitioner, an Internist, and a Gynecologist).

The Education and Development Core will focus on patient education and health care provider education and development.

Building on the WLA Patient Information Resource Center (PIRC) and the SVA Patient Education Resource Center (PERC), we will expand and develop patient education modalities including classes, support groups, pamphlets, videotapes, computer interactive programs, and self-education modules. The health care provider education and development program will create educational experiences for all levels of health care providers, initially utilizing the WLA/UCLA Western Region Education Institute and UCLA Education and Development Center. Mini-residencies, seminars, videotapes, computer interactive programs, and curricula will be developed and offered. We anticipate that, over time, this Core Education and Development Center will be a national resource to the VA for education and development in the area of women's health.

The Primary Care Core and the Education and Development Core will interface with a number of specialized, interdisciplinary programs. These Programs include: 1) Mental Health; 2) Women's Outreach; 3) Surgical (Breast Diseases and Gynecology); 4) Bone Health/Osteoporosis; 5) Nutrition; 6) Geriatrics; and 7) Quality Improvement/Evaluation.

With the success of WL-CHEC, priorities and objectives for the nineties and beyond include recurring funds for: 1) Outreach - to advertise our product and improve our image; 2) WL-CHEC Patient and Health Care Provider Education in women's health; 3) equipment and supplies; 4) renovation (e.g., construction of a female-specific inpatient ward); and 5) the implementation of the WL-CHEC model at other VA facilities.

2. AVAILABILITY IN VA FACILITIES OF PERSONAL HYGIENE PRODUCTS: TOILETRIES, COSMETICS, CLOTHING AND OTHER GENDER SPECIFIC ITEMS USED BY WOMEN VETERANS:

An ongoing 1993 survey of the availability of women-specific products at WLA VAMC, conducted by Rosalie K. Jackson, Dr.P.H., Chairperson of the Women Veterans Advisory Committee who testified before this Subcommittee on September 17, 1992 on VA health care for women veterans, affords the following preliminary conclusions. The three on-campus canteens currently stock necessary and sufficient personal hygiene products and toiletries for women. While cosmetics are available, selection is limited. Two of three canteens located at WLA VAMC carry women's hosiery but not women's clothing. Although the main canteen sells a variety of women's apparel, sizes are limited. More importantly, affordable clothing for women veterans remains an issue at WLA. We continue to rely on Women Service Organizations to provide these items for indigent women veterans since the majority of our women veterans fall below the economic poverty line. We are currently exploring options such as a Women Veterans Petty Cash Fund for the purchase of essential items (e.g., shoes) when they are unaffordable.

3. VA PROVISION OF COUNSELING FOR WOMEN VETERANS WHO ARE VICTIMS OF SEXUAL TRAUMA:

At WLA VAMC we see less than 5 acute cases of sexual trauma each year. When a victim of sexual trauma does present acutely to our Emergency Room, in accordance with our Rape Protocol, she is escorted by a female social worker to the Santa Monica

Rape Crisis Center located within 5 miles of our facility. Because of the complexity of these cases, and the small number of victims seen yearly, we refer all of our sexual trauma patients to an outside state-of-the-art crisis intervention center.

For the evaluation and ongoing treatment of post traumatic sequelae and chronic sexual abuse, we offer a variety of on and off-campus services. On-campus, the multidisciplinary staff at the WLA VA medical facility has expertise in treating victims of Post Traumatic Stress, including sexual trauma. Our outpatient Mental Health Clinic is also staffed by clinicians with special skills in treating Post Traumatic Stress Disorder patients. Our homeless female population, a group particularly susceptible to sexual trauma, will be targeted through a specialized, comprehensive program which recently received funding to serve Los Angeles area homeless veterans. Off-campus, our full-time Vet Center counselors provide ongoing treatment for sexually traumatized women veterans of all eras.

In addition, two female psychiatrists, Drs. Vivian Burt and Victoria Hendrick, have identified women's mental health as their area of professional focus. They have already established a variety of women's mental health programs at UCLA Medical Center (e.g., the Women's Life Cycle Mental Health Program) and are actively seeking to bring these same services to WLA VAMC.

Despite the availability of state-of-the-art services for female victims of sexual trauma, it is difficult to locate the many "hidden" female veterans in our catchment area and "connect" them to our services. We speculate that, like non-veteran women, veteran women tend to access health care for perinatal and pediatric reasons. Since our VA offers few services for Reproductive age women, and no services for children, women veterans seek most of their health care from private facilities. We continue to search for a means to reach this "hidden" female veteran population.

Meantime, many of our outreach projects, organizations, services and programs for women veterans are highly successful including: 1) the Women Veterans Advisory Committee; 2) the Homeless and Community Health Fairs; 3) a Pilot Survey of Health and Medical Care for Female Veterans, launched in June 1993 by Dr. Arlene Bradley, in collaboration with the UCLA School of Public Health; 4) daycare services for outpatients; 5) the Women Veterans Trauma Counselor Program (the establishment of this new program at each of our VET Centers reflects the growing number of women veteran victims of sexual trauma that continue to come to the VA's attention); and 5) the VL-CHEC Program which will now enable us to streamline the entry of sexual trauma victims into our state-of-the-art system.

4. EFFECTIVENESS OF THE VA'S WOMEN VETERANS COORDINATOR PROGRAM:

The role of the Women Veterans Coordinator is critical and essential to the implementation of any program for women veterans. The complex duties and responsibilities (see VA Central Office 1991 guidelines for the duties of the WVC) require a full-time commitment. Since the hearings before this Subcommittee on September 17, 1992, WLA VAMC has been exploring the possibility of hiring a full-time WVC.

Following a lengthy process, on June 14, 1993 we were notified by the Western Region Director's Office that WLA VAMC had been allocated a full-time WVC position, at the GS-12 level, to be paid with recurring funds from VA Central Office. This breakthrough will allow WLA to hire a WVC at a level that is commensurate with the complex responsibilities of such an important position. As we speak, WLA VAMC is in the process of hiring its first full-time WVC from Social Work or Nursing, at a GS-12 or Nursing equivalent level.

Once in place, the WVC will unequivocally communicate to our women veterans that they now have an advocate. Moreover, the WVC can devote full time to the many important and complex issues of women veterans health care.

5. VA MEDICAL FACILITY ACCOMMODATIONS OF WOMEN VETERAN PATIENTS:

Currently, our Gynecology Clinic is equipped with state-of-the-art gynecologic tables, lamps and supplies. Our Emergency Room has adequate, but not state-of-the-art

gynecologic equipment. A few supplies (e.g., pajamas) are not gender-specific at the WLA VAMC. Female inpatient admissions at our facility are sometimes delayed up to four hours while medical administration procures female-specific accommodations.

If the number of female veterans utilizing the WLA VAMC increases, funding for the creation of a small female-specific ward and for the upgrade and renovation of accommodations for women veterans will be required.

6. INCLUSION OF WOMEN IN MEDICAL AND HEALTH CARE RESEARCH SUPPORTED AND/OR CONDUCTED BY THE VA:

The VA has made great strides in establishing requirements for the inclusion of women in all VA studies. However, despite this commitment, funding for women's research has not been forthcoming.

The VA is in a unique position to impact on our health care system as a whole, largely due to its ability to perform collaborative studies with both VA and non-VA patients. Why focus on women and the VA medical system? Economically, appealing to the female health care consumer is "good business." Women utilize the health care system, either for themselves or their children, spouses or aging parents, more often than do men. Women carry out most doctors' orders and treatment regimens - either as unpaid workers at home or as paid workers. Women teach about health both in the home and in the work place. At home women are usually the first to be told when someone does not feel well, and they help decide what to do next. Some health care analysts even call women the "layperson on the team" because most patient communication for and about family members flows through women. As the majority of consumers of health care, women are usually responsible for choosing health care for themselves and their families. Thus, appealing to the female health care consumer makes good business sense. If we want their business, we must change to meet their needs. Moreover, if we expect to compete with private medical centers and provide adequate services for the CHAMP-VA and CHAMP-US Programs, we must upgrade our care for women.

From a national health care standpoint, it is imperative that our research efforts begin to focus on the study of gender-specific diseases. Recently we have come to understand that many diseases (e.g., Post Traumatic Stress Disorder, diabetes, coronary artery disease, HIV/AIDS and alcoholism), which were previously thought to be generic, are unique in women. Clearly, the research of gender-specific disease in women is a priority for the nineties and beyond. All attempts by VA investigators to include women in research are currently being made.

7. INCIDENCE OF CANCER AMONG WOMEN VETERANS AND THEIR NONVETERAN PEERS:

A retrospective cohort mortality study reported in the American Journal of Epidemiology 1991, was conducted by Thomas, et al., between 1973 and 1987, at the Johns Hopkins University School of Hygiene and Public Health. They noted vietnam veterans had twofold increases in mortality from cancers of the pancreas and uterus compared with non-Vietnam veterans. In addition, compared with rates for US women, mortality from cancers of the pancreas and uterus was elevated.

Critical review of these and other studies in the available literature reveals significant design flaws. Currently, there are no conclusive data regarding the incidence of cancer among women veterans as compared with non-veterans. Clearly, additional funding for randomized cooperative clinical trials to address these important issues is a priority.

CONCLUSION:

We need to admit to ourselves that we are not fully comfortable or equipped to care for women veterans in our male-oriented VA system. Thus, most female veterans choose to seek health care from private facilities. Over the past year, VA Central Office,

with the encouragement of Congress, and through the funding of programs such as WL-CHEC, has proactively sought to improve health care for women veterans. However, upgrading health care for women requires not only state-of-the-art resources in a few specialized VA centers, but also basic, quality services for women at every VA facility, large and small. Moreover, our financial and philosophical commitment to women veterans must be ongoing and adaptable to their changing needs.

Mr. Chairman and Committee members, I sincerely commend you for your interest in seeking solutions to these difficult questions and for providing funds to begin implementation of WL-CHEC. Thank you for inviting me, and thank you for your time spent in listening to my presentation.

**Testimony of
Jill Manske, ACSW, LISW**

Introduction :

Mr. Chairman and members of the subcommittee: I am Jill Manske, Regional Women Veterans Program Coordinator for the VA Western Region. I have served in this capacity since April 1993. Prior to that date, I served as the Regional Women Veterans Coordinator for the VA Central Region and for the VA Midwestern Region. In addition, I have been a women veterans coordinator since 1984, serving at Hines VA Hospital in Chicago and Minneapolis VA Medical Center. I am a social worker by training, with a total of 18 years federal employment. This includes 4 years on active duty with the US Air Force, from 1971 to 1975. I appreciate being invited to testify before this subcommittee, as women veterans issues are very near to my heart.

I have been asked to address women veterans coordinator programs as well as how health care services are provided to women veterans at VA medical facilities. I understand that the subcommittee's interest in women veterans includes the recent preliminary report of the OIG investigation of eight VA medical facilities. In March 1993, while at the Minneapolis VA Medical Center, I participated in the OIG investigation of women veterans programs at that facility representing both the Minneapolis VA Medical Center and the Central Region.

Background :

In 1984, on the recommendation of the VA Advisory Committee on Women Veterans, VA medical facilities were required to appoint women veterans coordinators. These coordinators were to serve as ombudsmen for women veterans, advocating for them and helping them to navigate the VA system as well as ensuring women veterans received equal access to care and had sufficient privacy. VA medical center directors were given latitude in these appointments, which in all cases were collateral assignments. Women veterans coordinators had full time primary jobs, mostly in nursing and social work. While it is true that there were no formal guidelines at that time from VA Central Office as to what women veterans coordinators were to do, in August 1985, a national conference was held to provide guidance, orientation and peer support. I attended that conference, representing Hines VA Hospital. The priority the women veterans program had within the Veterans Administration was demonstrated by the address given by Administrator Harry Walters and by the ongoing presence of his staff at the conference. For the first time, women veterans coordinators had an understanding of the issues and our roles in ensuring that women veterans receive high quality, comprehensive health care. We came away energized and full of ideas for enhancing our medical center women veteran programs. We also were made aware of the General Accounting Office study on women veterans conducted in 1982 and of the national survey of women veterans conducted by Louis Harris and Associates.

Additional national women veterans coordinator conferences were provided by VA Central Office, with the planning assistance of the Birmingham Regional Medical Education Center (RMEC), in 1986 and 1990. Then in September 1992, a fourth conference was held utilizing end-of-year funding to bring together all women

veterans coordinators and 100 clinical service chiefs from nursing, psychology, psychiatry, social work and ambulatory care to Birmingham to learn about sexual trauma of women in the military. This 2.5 day conference included concurrent workshops, panel discussions, and plenary sessions on sexual assault issues as well as women veterans issues.

At the 1985 national conference, VA Central Office staff recommended that each VA region appoint a regional women veterans coordinator to oversee the health care services provided to women veterans at VA facilities. This may not have been viewed as a priority at the time, but the Midwestern Region made it a priority and funded it as a half-time position. In 1987, I was selected to be the Regional Women Veterans Coordinator for the Midwestern Region. To improve networking among women veterans coordinators, I established quarterly conference calls and edited a quarterly newsletter, both of which provided a means for getting information out to coordinators from VA Central Office and the Region. The calls and the newsletter also allowed coordinators to get to know one another, to use one another for peer support, and to publicize activities and programs they had developed at their facilities. As the Regional Coordinator, I encouraged brainstorming and sharing of ideas on enhancing health care for women veterans. I also served as a consultant for them, providing guidance and offering information to help them carry out their duties. I surveyed them about their programs and goals and in response to their needs, arranged for full Regional funding for a women veterans coordinators conference in 1989. The conference included workshops on public relations (how to be interviewed and do press releases), advocacy, improving management skills, women's health issues, how to start a women's clinic, and women Vietnam veterans. At the conference, we identified the need for a women veterans program guide to provide structure for the program and to serve as a reference manual. I pulled together a task force of interested women veterans coordinators and together we wrote the Midwestern Regional Women Veterans Program Guide, published in 1990. This program guide was used as the foundation for the VA Central Office Women Veterans Coordinators Program Guide published in 1991.

When the VA regions were reorganized, my position was continued full time by the Central Region, although I was based in the field at Minneapolis VA Medical Center. I expanded the networking and continued the newsletter and the conference calls. I was able to start a mail group on the Central Region's electronic mail system and sent weekly messages to women veterans coordinators. I revised the program guide published by the Midwestern Region to include information on sexual assault, domestic abuse, and gender-specific care and published it for the Central Region in 1992. Since women veterans coordinators were in collateral assignments, they often were not recognized for their duties during performance evaluations. I wrote a position description addendum, which could be modified and added to their primary position descriptions, so that coordinator duties could be recognized. I developed an orientation packet of materials for newly-appointed coordinators and continued serving as consultant. I helped develop a performance standard for VA medical center directors in the Central Region which addressed their support of women veterans programs, helped write criteria for a Regional external review program to assess components of women veterans health care delivery, and established an

annual Regional women veterans coordinator award program to formally recognize outstanding efforts of women veterans coordinators. At that time, I was the only Regional Women Veterans Coordinator. But due to the success of the Central Region's program, VA Central Office encouraged inclusion in the Women Veterans Health Care Act of 1992 provisions for all VA regions to have funded regional women veterans coordinators.

Issues : In analyzing responses to surveys of women veterans coordinators and anecdotal information received through phone calls, a number of issues facing women veterans coordinators surfaced.

- The most often cited concern was **time allocation** for women veterans coordinator duties, since to my knowledge only two coordinators are in full time funded positions (Northport, New York and Minneapolis). It has been very difficult for most women veterans coordinators to find time to do outreach to women veterans, to visit women patients, and to plan programs for them. Many coordinators use their lunch time or stay late to work on women veterans programs. There has also been a fair amount of turnover in these positions, as coordinators burn out trying to accomplish their primary duties as well as coordinator duties. Consequently, there has not always been continuity. Since the first national conference in 1985, women veterans coordinators have been asking for funded positions. In many cases, it has been difficult to justify funding these positions when women veteran patient populations have been so small. However, at the two VA facilities that currently have full time funded women veterans coordinators, the services available to women patients have been greatly enhanced. In the case of Minneapolis, outreach campaigns have successfully brought in over 2000 women veteran patients, out of a total State women veteran population of 15,000. The coordinator there has been able to provide staff inservice training on the special needs of women patients, to survey clinical staff on awareness of the women veterans program and attitudes toward treating women patients, and to develop brochures about the Medical Center for women veterans. Someone serving in a collateral assignment would have difficulty in finding sufficient time to accomplish these tasks. And having a funded position has helped Minneapolis attain status system-wide as a center of excellence in women veterans health care. Staff at Minneapolis receive calls from around the country requesting assistance in setting up similar programs. I welcomed the decision made by VA Central Office to use part of the money appropriated by Congress for women veterans health care in FY 93 to fund 15 full time women veteran coordinator positions.

- Another concern of women veterans coordinators has been **adequate support** from medical center management for their programs. Since medical center directors have been given latitude in appointing coordinators, it has been possible for disinterested staff members to be selected for these positions. Additionally, directors who have not felt women veterans programs are a priority have been able to appoint coordinators as window dressing to satisfy the mandate from VA Central Office. VA Central Office and the VA Advisory Committee on Women Veterans have encouraged medical centers to provide support for these programs and for the coordinators. Additionally, the Midwestern and Central Region Women Veterans

Programs Guides have offered guidance in whom to select as coordinators, the amount of time recommended to allocate to their duties, and suggested reporting policies. In the program guides as well as in briefings given to Regional boards and committees, I have stressed the importance of allowing women veterans coordinators direct access to medical center management, with regularly scheduled meetings. And again, both the directors' performance standards and the Regional external review program in the Central Region have required directors to support women veterans programs.

- **Clearly defined responsibilities** has been another concern of women veterans coordinators. Often coordinators are appointed and not given any indication of what they should be doing. The Midwestern and Central Region Women Veterans Program Guides fulfilled that function for women veterans coordinators in those regions, and the VA Central Office program guide offered similar guidance. New coordinator orientation has also been extremely helpful in the Central Region, as well as the on-going networking through conference calls, newsletters and electronic mail. With all four VA regions soon to have full time regional women veterans coordinators, the need for structure and guidance should be better met.

- **On-site gender-specific care** for women veterans turns up again and again in plans and goals of women veterans coordinators. Those without women's clinics or gynecology clinics have been industriously working to develop such clinics. Many have been very creative in the design of these clinics. For example, at the VA Medical Center in Sioux Falls, South Dakota, they do not have a sufficiently large number of women veterans to have weekly women's clinics, so they have designed a clinic that meets monthly, but which also provides time for patient education on women's health issues, information about VA benefits and accessing them, and discussions with dietitians about nutrition and dietary needs. Another principle that seems to apply to women's clinics is, "Build It and they will come". Minneapolis VA Medical Center received the first mammography unit in the VA in 1985. At that time, they only had 35 women veterans on their rolls. By 1990, the number enrolled in the Women's Preventive Medicine Clinic that supported the mammography program had grown to over 600 women veterans. Although active outreach had been conducted, word of mouth from satisfied women veterans had also played a part in expansion. The interest in state-of-the-art gender-specific care for women veterans has been demonstrated by the number of VA facilities that submitted proposals for comprehensive women's health centers in response to a VA Central office request for such proposals. Fifty proposals were received, and the quality of the proposals was so high, additional sites will be funded in FY 94.

- **Breast cancer screening and mammography** services have, until recently, not been uniformly available to women veterans at all VA medical facilities. In 1991, VHA took the initiative of publishing a circular that required all VA facilities to offer both screening and diagnostic mammography. This was to be accomplished through contracting out for mammography, utilizing sharing agreements, or through fee basis if the facility did not have on-site mammography equipment. Since the incidence of breast cancer is increasing (the American Cancer Society now reports that one woman in 9 will develop breast cancer), it was vital for women veterans to have access to screening. This year, the VA Preventive Medicine

Department has issued a directive requiring all VA facilities to establish mammography action groups to assess how breast cancer screening and mammography services are being provided to women veterans. They require that quality indicators be developed to ensure that mammography services are of the highest caliber and that both positive and negative mammography results are relayed to physicians and women veteran patients.

- Women veterans coordinators have been instrumental in ensuring that their facilities stock women's **pajamas, sanitary supplies, and appropriate pharmaceuticals**. In the Central Region, coordinators made use of newsletters and conference calls to share their successes in obtaining these items and to strategize. Coordinators have worked closely with Canteen Service, presenting the need for appropriate night wear, toiletry items, and cosmetics. They have also worked with Voluntary Service to obtain donations to purchase additional toiletries and hair dryers. In many cases, VA facilities have locally purchases women's pajamas and nightgowns when those available through normal VA channels have not been of the correct size.

- **Privacy** has been an on-going concern at some of the older VA facilities. However, the 1992 VHA directive that mandated facilities to conduct physical inspections of their patient care buildings for the purpose of identifying privacy deficiencies has been successful. In reviewing the facilities' plans to correct identified privacy deficiencies, the Central Region's Women Veterans Technical Advisory Group recommended assigning additional points to requests for minor construction projects which correct these deficiencies. This recommendation was adopted and is being used in allocating construction funds to VA facilities. Many facilities have made changes to afford women patients sufficient privacy and have policies of placing women inpatients in private or semi-private rooms. Adequate bathroom facilities may still be a problem, in that in some locations, women patients must use communal or women staff bathrooms. It will take more construction dollars to build additional bathrooms for women patients or to convert space into sleeping rooms for women veterans.

- **Equal access** to health care was very much of an issue when I first became a women veterans coordinator in 1984. Very few women veterans were accessing the system at that time and they did not always get a welcoming reception in VA facilities. However, with the appointment of women veterans coordinators and the attention given to women veterans programs on the Central Office and Regional levels, access to health care has become more equitable. VA medical facility staff have been educated that women coming in to the Admissions area are not necessarily wives of male veterans. Coordinators have publicized their names and office locations so that women veterans may contact them for advocacy. Attention has been paid to making patient care settings comfortable for women veterans.

- The access problem now seems to have shifted to awareness of eligibility for VA benefits. **Outreach** to women veterans is vital, as many are unaware they may be eligible for health care from VA. The 1985 Louis Harris Survey found that women veterans greatly under-utilize VA benefits, mostly through ignorance of their availability. While sitting at a display booth during National Women Veterans Recognition Week a few years ago, I noticed a woman picking up pamphlets and

women's health materials and asked her if she was a veteran. She replied, "I used to be." She had never used any of her VA benefits and was in the hospital accompanying her veteran husband to his medical appointment. It had never occurred to her, since she had not served in a combat theater, that she would be eligible for the same benefits as her husband. The slogans VA Central Office has used ("Women Are Veterans, Too" and "Same Service, Same Benefits") have been helpful in getting the word out to women veterans and also in bolstering their image of themselves as true veterans. Public service announcements, press releases, and articles in local newspapers have been successful in identifying women veterans. Many coordinators plan annual luncheons, teas, or workshops during National Women Veterans Recognition Week in November, which draw women veterans into VA medical facilities. Others publish newsletters for women veterans to publicize programs and to provide women's health care information to them. Again, if sufficient time is provided for women veterans coordinators, they can do aggressive and creative outreach programs to locate women veterans and advise them of their eligibility for VA benefits.

- In the last year, there has been much interest in **sexual assault and sexual harassment of women in the military**. In response to Congress, VA appointed a task force chaired by Dr. Susan Mather, of which I have been a member, to investigate the provision of sexual trauma counseling to women veterans. We planned a national conference for women veterans coordinators and clinical service chiefs (Birmingham, 9/92), designed a pamphlet for women veterans about sexual trauma, gathered data from VA facilities on numbers of women being seen for sexual trauma and staff trained in providing treatment, planned a national VA satellite teleconference series on sexual trauma, and encouraged VA facilities to establish multi-disciplinary sexual trauma treatment teams. The funding of a Women's Division in the National VA PTSD Center in Boston, the opening of a PTSD treatment program for women veterans at the National PTSD Center in Menlo Park, the funding of four women veteran stress treatment teams, and the planning of a national VA training conference for clinicians providing sexual trauma counseling have all been successful in heightening staff awareness of the issue of sexual trauma. In many VA facilities, women veterans are now being routinely asked whether they have been sexually assaulted or harassed while in the military, as we have found that women often will not volunteer this information unless asked. The National PTSD Center in Boston, in collaboration with the Center in Menlo Park, is conducting research into sexual trauma of women veterans. The concern which remains is that of eligibility for services. Was it the intent of Title I, Section 102 to PL 102-585 that all women veterans suffering sexual trauma from events that occurred while they were in the military be provided with sexual trauma counseling? The question has arisen, given the mandate to means test all veterans and to restrict access to health care to low income and service connected veterans, of whether only women veterans who meet eligibility criteria would be offered sexual trauma counseling. The VA Western Regional Director has mandated that all women veterans reporting sexual trauma resulting from military service be offered sexual trauma counseling, regardless of income eligibility. However, VA medical facilities in other regions may be interpreting the law more narrowly.

- A final issue I wanted to raise is that of **gender bias**. The literature suggests that in the private community, women's health complaints are often not taken as seriously as men's, and that women often are not worked-up as aggressively by physicians as men with the same medical complaints. Given the relatively small number of women veterans seen at VA medical facilities, one wonders whether gender bias might not in fact be more prevalent than in the community. I have been told by VA medical facility staff that women patients don't have needs that differ from men's, that some staff prefer working with men, and that women patients are more difficult to manage. I have helped women veterans coordinators in the Central Region look at possible gender bias issues and provide sensitivity training to staff. Gender bias was also addressed at the September 1992 national women veterans coordinators conference.

Conclusion :

I recognize that to an outside body, such as the General Accounting Office (GAO) or the Office of Inspector General, VHA appears to be not providing adequately for all the needs of women veterans seeking care at VA medical facilities. The 1992 GAO report title, "Despite Progress, Improvement Needed" demonstrates this very well. And while I cannot disagree that there are still some legitimate concerns about the health care services provided to women veterans, as someone who has been involved in the women veterans coordinator program for 9 years, I think substantial progress has been made. More women veterans are accessing our system than ever before, thanks largely to the outreach efforts made by women veterans coordinators. The majority of VA medical facilities have women's clinics, gynecology clinics, or gynecology consultants to provide gender-specific health care to women veterans. For the first time this fiscal year, we have actually received funding for women veterans programs, which has allowed VA to enhance care to women veterans through the funding of comprehensive women's centers, stress trauma teams, training initiatives, and funded coordinator positions.

This is an exciting time to be involved in women veterans programs. When I was offered the opportunity to develop a brand new Regional Women Veterans Program for the VA Western Region, I could not resist the challenge. Women veterans coordinators are feeling empowered to make changes to improve access and quality of care. VA medical facility management, who had in the past been only mildly interested in women veterans, are perking up now that funding is available. I'm not concerned with why people are suddenly interested in women veterans, whether because it's politically correct or because they sincerely care. Or what stimulated the interest. If it hadn't been for Desert Storm and Tailhook, would these hearings even be taking place? For me, the important thing is that finally Washington is as interested in women veterans as the women veterans coordinators have been since the 1985 national conference. And in my opinion, only good can result from this interest and attention.

I hope with all my heart that this sub-committee continues to have an active interest in women veterans and that you continue to support initiatives to both highlight and provide for the needs of women veterans.

Mr. Chairman, this concludes my remarks. Thank you again for the opportunity to provide testimony and to address this sub-committee. I will be happy to answer any questions you may have.

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Statement of

Nurses Organization of Veterans Affairs

NOVA

By

Bette L. Davis, MSN, RN, CS
President

Before the

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
United States House of Representatives

On

VA Provision of Health Care
to Women Veterans and Related Issues

June 23, 1993

Mr. Chairman and members of the subcommittee, I am Bette L. Davis, MSN, RN, CS, a Clinical Nurse Specialist at the Washington, DC Veterans Affairs Medical Center. As President of the Nurses Organization of Veterans Affairs (NOVA), I am speaking on behalf of NOVA and for all VA nurses.

NOVA appreciates the opportunity to testify before this subcommittee and acknowledges the Chairman's longstanding commitment to quality health care for all veterans. Today's testimony on the provision of gender-specific VA health care to women veterans and problems encountered by them in obtaining VA provided health care is, again, an indication of the dedicated effort by NOVA and others to ensure that steady progress is made in the delivery of comprehensive health care for women veterans.

The VA has made significant progress in the past decade since the establishment of the Advisory Committee on Women Veterans in 1983, to the recent legislation of P.L. 102-585, the Veterans Health Care Act of 1992, authorizing the Women Veterans Health Programs Act of 1992. In less than one year, major plans and action are underway, but in the process, underlying and longstanding problems continue to exist. We need to re-address the same real issues impeding progress: time, money and training.

COUNSELING OF WOMEN VETERANS FOR SEXUAL TRAINING

Training of Health Professionals

Since enactment of the law, a Woman Veterans Health National Training Program was established for national training of VA health care personnel in the treatment of sexual and gender-specific medical problems. The first in a series of national teleconferences on the Treatment of Sexual Trauma in Women was launched on May 12, 1993. The second teleconference is scheduled for September. Another educational endeavor includes a two day training conference in July on Women Veterans Health and Issues of Sexual Trauma. The national training program's aim is to ensure that each medical center will have two people clinically competent to treat women's issues, particularly sexual trauma.

Other positive health care activities are the hiring of counselors in 64 Veterans Centers to provide outreach and treatment to sexually traumatized women veterans, designating four Women Veterans Comprehensive Health Centers (San Francisco, Tampa, Minneapolis and Southeast Pennsylvania VAMC Network -- Coatesville, Lebanon, Philadelphia and Wilmington, Delaware),

establishing four Women Veterans Stress Disorder Treatment Teams, and hiring four full-time Regional Women Veterans Coordinators -- one for each region, in addition to fifteen full-time coordinators in VA medical centers. Initiating the current network for PTSD Programs and the RCS Vet Centers provide programs or referral services to assist veterans who are not eligible to obtain those from sources outside the DVA.

Case Example

NOVA testified before this committee in September of 1992 that victims of sexual assault often are in need of long term counseling, as indicated by the support therapy group discussed at that time. Therapy for that group of low functioning women, also coping with major mental disorders is still ongoing, with signs of improvement over the past year.

Therapy is a slow recovery process even for normal people. The time limitation of one year for counseling, and more importantly, the reporting of sexual assault for care within two years of leaving the military, is too restrictive and clinically inappropriate. Research indicates that a significant amount of sexual trauma is never reported. It may also be repressed for years.

The following case is a recent example of an unreported rape, subsequently repressed, that occurred fourteen years ago while the woman veteran was on active duty in the military. It illustrates how a person who suffered from rape developed PTSD years later.

Since her discharge from the Army fourteen years ago, the veteran had been a normally functioning female whose anxieties had gradually increased throughout the years, and she was seeing a VA counselor as an outpatient. She is 30% service connected for a back and arm injury. At the time of her hospitalization in May 1993, she was experiencing nightmares, severe headaches, nausea, diarrhea, feelings of being out of control emotionally to the point of being unable to breathe and experiencing a compulsion to harm herself or anyone else who might approach her.

The rape occurred when her new and immediate supervisor ordered her to report for emergency duty, on her day off, to an isolated duty post several miles from the main post, where she was violently raped by him. Because he appeared to be a friend of the Post Commanding General, she did not report it, fearful of further retaliation. Eventually, she blocked all memory of the

actual incident from her conscious and was unable to recall anything about the sexual assault until this hospital admission. Twice in the past year, she had worked with two separate counselors to help stop feelings of total fear and anxiety without provocation, and to prevent the continual nightmares that left her in a state of panic. The nightmares consisted of a body without a head in a separate room of sounds and laughter.

During this hospitalization, her anxieties, fears and rage without provocation increased, and she was given a diagnosis of PTSD, instead of Bipolar Disorder. Especially frightening to her during this admission was being the only female, left alone in a unlocked room down a hall on a ward of thirty men. In time, she was moved to a room which locked from the outside with a key, but one from which she could exit. Within a week, the memory of the rape returned. Because she felt able to handle it better outside the hospital, she left.

This case also illustrates a need for staff education in dealing with PTSD related to rape or sexual abuse. Many of the inpatient staff had difficulty dealing with her PTSD symptoms. According to the veteran patient and her social worker, her symptoms were misunderstood, minimalized, discounted, or invalidated. Again, she felt victimized.

Programs on sexual counseling should be geared to other areas of services. When this same veteran in the above case went to file for adjustments from the VA for PTSD; she was told that only male combat vets can file for PTSD, but that she could file for Social Security since she was never going to work again and might as well not fight it, as it wasn't welfare. She left the office with stamped envelopes.

Because of her negative experience, she wrote it up for her treatment team on her unit. This example shows that despite national efforts to improve care, we haven't made much progress at the local level in educating staff.

Eligibility for Care

P.L. 102-585 gives VA the authority to provide counseling to all women veterans for sexual trauma which occurred while serving on active duty in the Armed Forces. Not only are they to be given priority in outpatient care settings, but they will not be required to prove that they were traumatized.

It isn't happening. It is difficult to connect sexual trauma to

females who present vague, depressed, not-feeling-well symptoms, or are reluctant to talk directly about a deep-seated sexual trauma. Unless they are SC or Category A, these women veterans don't get past the screening people because of a heavy workload, lack of information, or lack of sensitivity to explore the nature of the problem. Female veterans, along with male veterans, are screened by Medical Administrative Services (MAS) and are excluded from care unless they are SC or at poverty level, Category A. Many are Category C and working. They want to work, but they need help to stay healthy. So, some women veterans who were sexual assault victims do not make it through this process. They are being rejected and probably will not return to the system.

NOVA advocates an extension of the current time allowed the VA to provide sexual trauma counselling at both VA health care facilities and through contracts with providers outside of the VA system. NOVA believes that the elimination of the current time limitations on eligibility for sexual trauma counseling, and elimination of the current one-year limit for sexual trauma counseling, are realistic and necessary expectations if the VA is to adequately serve those in need of treatment. Equally significant, sexual trauma reporting and counseling should be authorized for male veterans as they, too, may be suffering from similar unreported incidents of sexual assaults.

WOMEN VETERANS COORDINATORS PROGRAM

Women Veterans Coordinators (WVCs) oversee the women veterans programs at each VA facility. Until this past year, none were employed full-time. Now, there are fifteen WVCs in the field and four regional full-time WVCs. This is progress. However, it is not enough. Most WVCs in VA medical centers are still assigned to this position as a collateral duty and are not given sufficient time or resources to fulfill this obligation. There is no official job description requiring evaluation of performance, or that it be included in a proficiency report.

Overall, there is some improvement in staffing, educating and marketing of programs and services at facilities. But there is still a wide variation in the number and kind of services offered in each facility, and a broad diversity in the amount of time (number of hours) available or allocated for each WVC position. The time can range from a few hours each week to one or more days per week. Some facilities have women's advisory committees to discuss needs of women veterans, some do not; unless you count two coordinators, each with two hours per week, who meet once a month.

WVCs are instrumental in enhancing services and programs, such as developing groups for clinicians or therapists, an additional duty without additional resources. One coordinator said that marketing programs terrorize her because of the current workload. At her facility, all non-SC veterans are being turned down in the Outpatient Department because of the heavy caseload. They are told to go elsewhere.

The Minneapolis VAMC, selected as one of the four Women Veteran Comprehensive Health Centers, is an exemplary model of what can be done in health care programs for women in an area serving over 20,471 women veterans.

By contrast, other facilities' services vary considerably. For example one VAMC's GYN clinic is held one day per week for five hours and is staffed by two women physician assistants, each for 2.5 hours. Consultants and attending staff are used. The clinic backlog is 60 consults and waiting time is six to eight months for pelvic exams and pap smears. There is no GYN examination room. Materials are on a cart and moved from one room to another. There is a men's sexual dysfunction clinic, but women's sexual issues may be addressed in GYN clinic only.

Mammographies are scheduled on a fee basis. There is a VA Department of Defense (DoD) sharing for GYN hospitalizations and contract hospitalizations for medical, surgical or psychiatric care of women veterans. At this same facility, 571 women veterans were seen, but only 150 were enrolled in the GYN clinic. Where are the others getting GYN health care, if at all?

Another facility is still using inexperienced staff for pelvic exams, but an RN is now assigned for total management of breast health. This RN will coordinate mammography service shared with the DoD, for appointments, reports and follow-up discussions on results and plans with patients and physicians.

Overall, GYN service remains a system-wide problem, even with some sporadic improvements. Many facilities are still lacking the basics of time and equipment. Fees for health care services do not assure quality and are not cost-effective, unless the population sample is very small. As one VA nurse stated, "We have no staff, no space and no clout to get it."

The effectiveness of the Women Veterans Coordinators Program is dependent upon ensuring that the coordinators are provided

sufficient resources, including sufficient allotted time, clerical and communications support, administrative support, and training to carry out their responsibilities as outlined in The Women Veterans Coordinators Program Guide, (G-5, M-2 Part I) October 7, 1991. In addition, a national program of this scope cannot continue to function optimally without a full-time National Director directly responsible to the Secretary, who can be held accountable for its effectiveness. Until this is accomplished, it is difficult to monitor its effectiveness throughout the system. It is certain, however, that women veterans coordinators are essential if VA is to provide quality health care to women veterans in a timely manner.

MEDICAL FACILITY ACCOMMODATION AND AVAILABILITY OF PERSONAL ARTICLES

Most facilities report an improvement in the accommodations of women, even with increased numbers utilizing them. It is not universal throughout the VA system -- extremes exist. The Minneapolis VAMC is admitting more female inpatients to its new facilities. They are assigned a private room with a bathroom in each room. They are given new pajamas and robes. Volunteers work with the women veterans coordinators and supply ditty bags containing dental hygiene articles, hand lotion, shampoo, hair spray, hand mirror and perfume. They distribute arts and crafts such as needlework, puzzles, etc. In the GYN clinic, heavy and light peri-pads with adhesive strip are available.

At another facility, it is a different story. On a psychiatric inpatient unit, females have one bathroom with one shower stall and one toilet in the same room. Privacy is an issue. If one woman is taking a shower, a staff person must be with a second woman if she is using a toilet. Women's needs such as tampons, Kotex, etc. are not stocked in supply. Women are directed to the canteen retail store to purchase them. What do they do on weekends and evenings when the canteen is closed? Female pajamas are not supplied. Women veterans bring their own or use the smallest men's pajamas. The laundry facilities were in the men's bathroom, but are now being moved to a laundry room.

In general, the canteen stores have an increased supply and range of female articles and clothing in most facilities. Volunteers may supply separate ditty bags for females, but are not pushed to do so.

VA RESEARCH RELATING TO WOMEN VETERANS HEALTH

It is very discouraging to note that the Population Study of Women Veterans, mandated by law to determine the needs of women veterans for health care services, was not funded. VA research appropriations for FY 1993 and FY 1994 are not available for new proposals relating to the health of women veterans.

VA policy to include women in study populations and all research proposals, if gender-appropriate, is limiting. Almost all research, 90% or more, includes female veterans in medical and health care research supported or conducted in VA. But no specific research is being conducted on women. The standard answer is, "too small a sample."

There is no research data on the incidence of cancer among women veterans and their non-veteran peers. According to the American Cancer Society, no such data exist. The VA does not have a centralized tumor registry. A proposal for one has been submitted this year by Dr. Neologian with Marsaleen Fowler as the proposal writer.

NOVA recommends that Congress request the American Association of Cancer Center Registries to include a question regarding veteran status. Another suggestion is to have VA submit data on diagnosed cancer in female and male patients to each state's Centralized State Tumor Registry Program. The states too, would need an intake data question on veteran status, whether or not using the VA.

It is encouraging to end on good news. NOVA is very pleased that the VA established a new women's division within the National Center for Post-Traumatic Stress disorder (PTSD). The Women's Health Science Division is the first of its kind and will study the effects of traumatic stress on woman veterans' mental health and physical well-being, including problems caused by sexual harassment and sexual assault. Studies will be designed to improve the assessment, diagnosis and treatment of PTSD in women, as well as PTSD training.

In summary, NOVA's first priority is that veterans health care be based on research applicable to all veterans. VA nursing practice depends upon it.

Thank you, Mr. Chairman, for the opportunity to testify here today. NOVA looks forward to working on women veterans' health care services. I am now available for questions.

STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE COMMITTEE ON VETERANS' AFFAIRS

VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND RELATED ISSUES
JUNE 23, 1993

Mr. Chairman,

Thank you for the opportunity to report on how the Department of Veterans Affairs (VA) is addressing the health care needs of women veterans.

According to the 1990 census, women veterans comprise 4 percent (1.1 million) of the total veteran population (27.2 million). Today, women veterans represent 11 percent of the active duty force and 13 percent of the reserve force. Among women veterans, the largest group served in peacetime (45 percent), followed by women who served in World War II (26 percent) and during the Vietnam Era (21 percent).

VA is responding to the health concerns of women veterans by expanding existing services and instituting new programs. In FY 1992, VA health care facilities provided care to 274,498 women - an increase of 21,152 (8 percent) over FY 1991. Of that number, there were 14,972 women hospitalized, representing a 6 percent increase over FY 1991. The distribution of workload is not uniform throughout VA. VA medical centers show a significant range in women veterans served from the fewest - Miles City, Montana, where 223 women veterans were treated, to the most - Albuquerque, New Mexico, where 5,595 women veterans were treated in FY 1992. Eighteen facilities treated more than 3,000 women veterans in 1992. While we still need intensive outreach concerning veterans benefits for some women veterans of earlier eras, the word that VA is here for them is certainly getting out to the newest women veterans. Among Persian Gulf veterans, where women accounted for approximately 6 percent of the forces in country, 9 percent of the outpatients and 7.6 percent of the inpatients seen in VA facilities have been women. The proportion is even higher among Persian Gulf era patients, where 14 percent of the outpatients and 13.8 percent of the inpatients are women.

Secretary Brown has committed VA to assuring equal access to health care for

women veterans and to supporting women veterans' health care initiatives, including those designed to implement the provisions of Title I of Public Law 102-585, Women Veterans Health Programs, enacted November 4, 1992.

These efforts include progress in (1) providing gender-specific health care services for women veterans, addressing privacy concerns, complete physical examinations and appropriate cancer screening, gynecological and reproductive health care; (2) priority access to comprehensive sexual trauma counseling and the coordination of related health care; (3) improving VA reporting of health care services to women veterans; (4) developing protocols to monitor the quality of the services provided to women veterans; and (5) planning for new research initiatives related to women veterans health needs.

In 1992, when VA began receiving increasing numbers of women veterans seeking treatment for the effects of sexual trauma, a task force was established to address the most immediate needs: diagnosis and treatment. The task force met in July 1992 and was active in planning and carrying out a major training program for VA staff held in Birmingham, Alabama, in September. At least one person from each VA medical center received training there on the needs of women veterans who suffered sexual assault and other sexual trauma. In addition, selected Chiefs of Ambulatory Care, Nursing, Psychiatry, Psychology and Social Work, and the membership of the Readjustment Counseling Service Women Veterans Working Group attended.

Caring for victims of sexual trauma is a major area of emphasis in the multi-year National Training Program (NTP) on women veterans' health. We have developed a series of five Women Veterans Health National Training Program modules designed for VA mental health and readjustment counseling clinicians, including psychiatrists, psychologists, social workers, nurse clinicians, vet center counselors, women veterans coordinators and other clinical staff. A nationwide satellite broadcast conference, "Treatment of Sexual Trauma" was held on May 12, 1993. It was designed to provide VA mental health clinicians with an understanding of the factors influencing the assessment, diagnosis, and treatment of women veterans who have been victims of sexual assault while on active duty. The second satellite broadcast in this series is scheduled for September 23, 1993. It is designed to provide VA mental health clinicians with an understanding of the multiple factors influencing a victim's response to sexual assault and how they can be addressed in the therapeutic process.

While war-zone related experiences originally served as the primary backdrop for framing a PTSD diagnosis, later discoveries have shown that sexual abuse or sexual harassment of female veterans while they were in the military can be the precipitant factor in later stress disorder symptomatology.

To respond to these findings and to the increasing numbers of women veterans seeking care for stress symptomatology, in 1992, the National Center for PTSD created and funded a Women's Health Science Division (WHSD) headed by Dr. Jessica Wolfe. The WHSD is devoted exclusively to research and education on the psychological impact of military service including traumatic stress on women veterans. These efforts will permit collaboration with the Menlo Park Division of the National Center for PTSD in offering a broad range of educational and training programs for clinicians.

In addition to existing programs and treatment resources, the VA has committed to creating four Women Veterans Post Traumatic Stress Disorder Treatment Teams. These teams will provide evaluation, diagnosis and direct patient care and treatment. Also, provisions will be made to obtain consultation and liaison to other inpatient and outpatient medical/surgical services when needed. Selection of the four locations for these teams will be announced in the near future.

Readjustment Counseling Service officials began reporting an increased number of cases of women veterans coming to Vet Centers with psychological difficulties related to sexual trauma in late 1991. In early 1992, Readjustment Counseling Service responded to this emerging problem by initiating specialized in-service training on sexual trauma counseling for Vet Center staff and for management officials of the Readjustment Counseling Service at the Regional and VACO levels. In November 1992, Readjustment Counseling Service conducted a survey of all Vet Centers and found that 26 percent (or 159 out of 620 cases) of all women veterans they were counseling had reported sexual assault in the military. As part of VA's extension of services to women veterans the Readjustment Counseling Service was provided with an additional \$1.5 million in FY 1993 for 34 FTEE to augment the staff at Vet Centers in 69 cities. These new staff members will be specifically used to provide counseling services to women veterans experiencing the psychological aftermath of sexual trauma incurred while on active duty in the military. Readjustment Counseling Service has also established systematic

criteria for evaluating the training and clinical experience necessary for existing staff to provide sexual trauma counseling. To the extent that existing Vet Center counselors have the necessary credentials and training, women veterans are already receiving these services at the Vet Centers. In other locations, women veterans with problems related to sexual trauma are provided with an assessment and appropriate referral. We anticipate that designated Vet Centers in 69 cities will have their additional staff in place by the end of August 1993. The new hires, as well as other Vet Center staff, will also provide significant new-outreach activities for women veterans.

In addition to the specific initiatives to address the health effects of sexual trauma, a number of other initiatives have been developed specifically to address health care needs of women veterans. These include the opening of four Women Veterans Comprehensive Health Centers in FY 1993 and an additional four planned for FY 1994; full-time women veterans coordinators at selected VA Medical Centers; full-time regional women veterans coordinators; and a full-time women veterans national education coordinator and staff at the Birmingham Regional Medical Education Center to implement a multi-year National Training Program fully supporting the Women Veterans Health Programs. All of these initiatives have been supported by an allocation of \$7.5 million from the VA's FY 1993 Budget.

On May 21, 1993, VHA announced the designation of four Women Veterans Comprehensive Health Care Centers. Each center will serve as a resource, providing a full range of services for women veterans in a specific geographic area, and each center will support a specified group of VA facilities with these services. Each center will also represent a "pilot" program for duplication throughout VA. Sites were selected competitively from a nationwide request for proposals. The four proposals chosen for funding are from the VA Medical Centers in Minneapolis, Tampa, San Francisco and the Southeast Pennsylvania VAMC Network, comprised of Coatesville, Lebanon, Philadelphia and Wilmington, Delaware.

The Advisory Committee on Women Veterans has consistently recommended funding of full-time Women Veterans Coordinator positions. VHA has designated a full-time Women Veterans Coordinator position at each of the four VHA Regional field offices. Full-time regional coordinators will provide, among other activities, the provision of innovative local programs to meet specific needs,

liaison with VA Central Office, consultation to the Regional Director on matters relating to health care for women veterans, and provide regional program coordination and evaluation. In addition, on June 18, VA notified the following 22 facilities that they are receiving a full-time coordinator position: Bronx, Boston, East Orange, Philadelphia, Allen Park, Cleveland, Chicago (WS), Minneapolis, Bay Pines, Dallas, Houston, Miami, San Antonio, San Francisco, Tampa, Albuquerque, Long Beach, Palo Alto, Phoenix, San Diego, Portland and West Los Angeles. The full-time Women Veterans Coordinators we are seeking will be either social workers or nurses. They will be responsible for planning, organizing and coordinating services to women veterans at the medical center. For VA medical centers without full-time positions, we are providing the requirements for the specific time commitments for the administration of the local Women Veterans Program.

A Women Veterans Health Program National Steering Committee has been established and strategic plans developed to help implement a variety of educational and informational methodologies relating to women veterans health. The first issue of a national newsletter devoted to the Women Veterans Health Program is underway and we now have a brochure concerning Women Veterans Health Programs, including Sexual Trauma Counseling Services which will be distributed by the end of July 1993.

In August 1992, the Office of Research and Development and the Health Services Research and Development Service sponsored a national conference for researchers, clinicians, and policy makers to discuss VA's research agenda related to women. Research involving women veterans is a long-term commitment with anticipated long-term pay-offs. As of October 1, 1992, the Research and Development Program had expended in the previous year approximately \$6.1 million on research related to the unique health care needs of women veterans. Also, since May 1991, it has been VA policy that all applicants for VA research must consider (and document) the inclusion of women in their proposed study. This policy should contribute significantly to the achievement of the intent of Section 107 of P.L. 102-585.

Mr. Chairman, the VA Inspector General recently completed an audit of the Women Veterans Program. The Inspector General's audit has identified areas for improvement and we have developed action plans to respond to the recommendations. It is obvious that while many creative and innovative

programs exist at the local level, there does need to be greater standardization of information and services. This will be our major programmatic thrust in the coming year. Also, the implementation of national quality indicators and improved data gathering capabilities will be accomplished during the coming year.

You will be pleased to know that VA is in compliance with the recommendations of the 1992 GAO Report, discussed before your committee last year. Significant progress has been made during the last three fiscal years in providing additional privacy for female veterans in VA health care facilities. Correction of existing privacy deficiencies is an ongoing process and current VHA directives require quarterly reporting of the status of all planned and funded projects to make these corrections.¹ Special considerations have been incorporated into the methodologies used in scoring and prioritizing Nonrecurring Maintenance and Minor Construction projects that correct privacy deficiencies. In addition, space and planning criteria for new construction have been carefully reviewed to assure that these criteria fully support the need for patient privacy. During the last three fiscal years over 280 projects have included correction of privacy deficiencies.

Increased emphasis has been placed on the provision of routine preventive health services to women veterans. In March 1992, VHA Directive 10-92-030 was published establishing the policy that women in VA facilities will be offered a Pap smear if they have not had one in the preceding year. Routine screening examinations for breast and cervical cancer will be offered according to pre-approved schedules. In FY 1992, 20,247 women veterans received Pap smears through VA. Our policy on screening for breast disease including the routine use of mammography according to pre-approved schedules was established in September 1991 (Circular 10-91-101). Thirty-seven VA facilities have in-house screening capability, while all other VAMC's use contract services or refer patients to other VA medical centers for mammograms. In FY 1992, 15,964 women veterans received mammograms through the VA. The number of Pap smears and mammograms reported probably represents under-reporting because of the methodology used to extract the data. Steps are being taken to improve the reporting situation. The FY 1992 information was obtained by a survey done in January 1993. This survey also established that 27,586 women received general reproductive health care through VA Gynecology clinics.

Mr. Chairman, although VA has always opened its door to the Nation's women Veteran population the enactment of Public Law 102-585 and the special funding provided by the Congress last year for improving Women Veterans Health Programs provided a tremendous stimulus for improving VA services to women veterans. Increasing numbers of women veterans are coming to the VA for services and thousands of dedicated VA staff are prepared to provide health and counseling services to them. During this coming year we hope to further expand services for women veterans and plan to make the program improvements suggested by the recent Inspector General audit.

* * *



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STATEMENT OF
VIETNAM VETERANS OF AMERICA

Presented By

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Chair, VVA National Women Veterans Committee

Before The
House Veterans' Affairs Subcommittee On
Oversight and Investigations

On
VA Health Care for Women Veterans

June 23, 1993



★ A non-profit national veterans' service organization ★

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Mr. Chairman and members of the Subcommittee, my name is Linda Schwartz and I am medically retired from the United States Air Force Nurse Corps and a Doctoral Candidate at Yale University School of Medicine, Department of Epidemiology and Public Health. I also have the honor to serve as Chair of Vietnam Veterans of America's Legal Affairs and the Women Veterans Committees. In addition, I am a Trustee of the Connecticut State Department of Veterans Affairs, and as a disabled veteran, I have used VA services for several years. I would like to express my appreciation for your interest and support for America's women veterans.

Since our inception, Vietnam Veterans of America (VVA) has recognized the contributions of women who served in the Armed Forces. Because women are an integral part of our organization, VVA has a special interest in the status of programs which are specific to their needs. Our members and our legislative agenda have been both vocal and active in seeking enhancements and reforms in the VA system that will be more responsive to the growing numbers of women who are eligible for VA services. Because approximately 40% of the women who served in Vietnam are also veterans of World War II and/or Korea, our concerns and advocacy are not limited to a single age group or generation but are much broader and encompass the entire population of women veterans.

As a Congressionally chartered veterans service organization, we also have a national network of service representatives which provides a grassroots view of the current needs of veterans and the Department of Veterans Affairs' (VA) efficacy in addressing these problems. There is no question that great strides have been made in increasing the awareness of the public, veterans organizations and the VA about the unique contributions that women veterans have made to the nation. The 1992 GAO Report on VA Health Care For Women noted that significant progress has been made in the ten year interim from their first report.

Improvements in health care services, emphasis on outreach and attention to the gender specific needs of women is due in large part to the interest of this Subcommittee and the very valuable work of the VA Advisory Committee on Women Veterans. The appointment of Women Veteran Coordinators at each Medical Center has also been vital to local outreach and identifying the problems encountered by women veterans. Many of the blatant inequities noted in the 1982 GAO Report are being improved and in some instances resolved. However we have noted with great dismay that major problems which reflect systematic deficiencies still have not been adequately addressed in all VA facilities.

OUTREACH TO WOMEN VETERANS

Our members still report that outreach to women veterans is an area of need. We find that a major problem continues to be identifying women veterans and informing them of their benefits, and the education and sensitizing of VA health care providers to the special needs of women veterans. Because no accurate records exist on the actual numbers of women who served in Vietnam, government researchers have maintained that they are unable to identify a large enough cohort to study. At first glance, the task of identifying these women appears to be a complicated process with insurmountable roadblocks.

However if you trace the development of the National Vietnam Veterans Readjustment Study (NVVRS), which was the first and only research of that generation to include women, you will find that "a special list reported to contain the names of all female veterans who served in Vietnam was compiled for the VA by the Department of Defense's Environmental Support Group (ESG)." It is puzzling that this list which was compiled by a review of military records of every woman on active duty during the Vietnam era has either disappeared or is not being shared within the Department.

I want to be quite clear about which list I believe should be shared. I am referring to the master list of women veterans used to draw the sample used in the NVVRS. My need to emphasize this point comes from the fact that it is rumored in the veteran and research communities that the VA is presently in the process of attempting to identify the women who actually participated in the study by matching responses in the NVVRS to military records. I was an interviewer for the NVVRS and in that capacity learned first-hand how secretive and

guarded some of these women veterans are about their military service.

The promise of anonymity which is a universally accepted and fundamental research precept was essential to their participation in the study. Irrespective of the VA's rationale for such an effort, I raise my voice about this issue because the anonymity promised to the women when they participated in the study will be violated if this reported activity succeeds. However, a larger list with the names of over 5,000 women who served in Vietnam should be shared with the Women Veterans Working Group and other structural service elements of the VA.

ADEQUATE PHYSICAL EXAMINATIONS

The 1992 GAO Report also found that cancer screening for women veterans continues to be sporadic. VA has not effectively implemented its plans to ensure that women veterans receive appropriate cancer screening as part of their physical examinations. It is troubling that although there is a requirement for each woman inpatient to receive pelvic and breast exams and Pap tests and mammograms, the VA's own Medical District Initiated Peer Review Organization found that in some places as few as 10% of the women received mammograms and only 20% received Pap tests when they were indicated. The highest rates of compliance anywhere in the VA for these tests was 80% for breast exams. All of the others were 55-65%.

The Report noted that Medical Centers are not consistently monitoring women's health care through their quality assurance programs. The GAO attributed the lack of adequate physicals to:

1. Frequent rotation of medical residents expected to perform the examinations, thus limiting the knowledge of the requirement.
2. Reluctance on the part of physicians to conduct breast and pelvic exams when their specialty was in some other field.
3. Limited efforts by Medical Centers to monitor the thoroughness of women veterans examinations.

All of these reasons suggest that physicians are not required to practice good medicine in the VA. No facilities in the private sector would send a patient to a physician who would not be mindful of the need for adequate cancer screening, or to a physician who would not perform a complete physical. We are talking about a population at risk for gynecological cancers.

The 1985 Lou Harris Survey of Female Veterans commissioned by the VA found that women veterans have twice the rates of cancer of the general adult female population. Subsequent studies by LeDonne and Grant have provided additional evidence to suggest that these rates of cancers should be of concern to women veterans and of interest to the VA. In 1992, the VA's Chief Medical Director raised the issue of the reported high incidence of cancers and noted that "women veterans have reason to be interested in early detection of these malignancies."

What is especially striking about these reports is the high rates of ovarian, cervical and uterine cancers, which is 43% in women veterans compared to 9% (American Cancer Society, 1987) in the general adult female population. Early detection and diagnostic screening procedures for these types of cancer have been available and have been included in routine physical exams for years.

Since the GAO Report and in each succeeding year, VVA has brought the issues of high rates of cancers and incomplete physicals to the attention of the Congress and the VA. We believe that it is imperative that every woman veteran treated by the VA will be provided with complete exams.

In noting VA's response last year to the pending legislation that would require complete physicals, I was intrigued by the suggestion that providing health care screening and examinations which fall within the accepted standard of care and are endorsed by the Surgeon General are construed to create inequitable provisions based on gender and to be discriminatory

to men.

The attitude portrayed by this VA statement is an example of the years and years of struggle women veterans have had to endure to receive even basic care. Recently, one of our members learned of a slight error in the reading of her mammogram taken in the VA three years ago. At that time, she was told the test was negative, when in fact it was positive. Because of her age, year after year she was told she did not need to repeat the exam. Suddenly, she was faced with the possibility that a cancer had been growing inside her for three years--three years of regular health care by the VA. Arrangements were quickly made for surgery and a removal of the growth.

VVA raised the issue in the Senate that the omission of complete physicals constitutes negligence. At the same time we questioned whether the provisions of the Federal Tort Claims Act would allow any woman being cared for by the VA who did not receive complete physicals and later developed cancer, to be eligible to file a disability claim and receive compensation. While this may sound adequate, in reality there is no amount of money that could compensate for cancer allowed to develop through negligence. When our member realized the possibility of cancer, no compensation could calm the terror she felt.

The inequity and discrimination in adequate health screening is quite clear. Men do not have cancer of the cervix. Men do not have cancer of the ovaries. Rarely do men have cancer of the breast. If they were at risk for these cancers, I would be at this table advocating for them as well, because we need to provide every opportunity we can to beat the odds on cancer.

PROVISIONS FOR PRIVACY

VVA continues to voice our concern for the inadequate accommodations to insure privacy and access to treatment programs to eligible women veterans. Our members have related experiences of being hospitalized in VAMCs with inadequate provisions for privacy. In some of these instances the women felt demeaned and embarrassed by the kinds of care and facilities they were expected to use. While there has been great attention played to the expanded roles of women in the military during the recent Operation Desert Storm, we see that such attention has not translated into provisions for the care of them as veterans.

The 1982 GAO Report recommended that the VA revise its privacy standards and ensure that future construction plans be made to accommodate women. Interestingly, the 1992 GAO Report noted that surveys conducted in response to the 1982 recommendation provided little guidance on what constitutes facility inability to accommodate women veterans. Since the definition of capacity to provide privacy was left to the facilities, many Medical Centers responded that they could accommodate women when in fact they could not. For example, even the North Chicago VAMC reported that it could take women, when in actuality they could not accept women into all of the psychiatric programs.

The most recent report concluded that the VA has not instituted adequate procedures to ensure basic privacy for women. In fact, there was speculation that because there was really no definition of privacy or follow-up to the original survey, no one could say for certain how many facilities could or could not accept women. Does a woman recovering from a minor procedure in a room with three men and their visitors have adequate or inadequate privacy? Is a sign on a door with no lock in communal showers and toilets acceptable to ensure privacy? Perhaps the most important first step in this process would be to develop a standard that guaranteed every patient's privacy.

SUPPORT FOR GAO RECOMMENDATIONS

VVA supports the recommendations made in the 1992 GAO Report. The utilization of Nurse Practitioners and Certified Nurse Midwives for gynecological screening is both cost-effective and has been known to dramatically improve preventive health services. The suggested education and training of medical staff about being sensitive to women veterans needs will be beneficial to all veterans regardless of gender. Emphasis on Quality Assurance Monitoring of women veteran's health records will assist in identifying problem areas and problem physicians.

This will serve as a stimulus for increased compliance with existing VA directives. More importantly, such monitoring will stress to VA health care providers the need for adequate screening. As previously mentioned, precise standards of privacy in VA facilities are not gender specific. The somewhat military style of the VA may not be as foreign to men as it often is to women. However that does not mean that basic attention to privacy will not be welcomed by all patients.

S. 1030 AND H.R. 2285

While last year's Veterans Health Care Act of 1992 authorized counseling services for victims of sexual assaults and trauma associated with their military service, limitations to these services were quickly identified by those within the VA tasked with implementing the program. The introduction of S. 1030 by Senator Rockefeller and the companion H.R. 2285 introduced by Congresswoman Schroeder to improve the sexual trauma counseling for veterans and to improve the Women Veterans Coordinator positions within the VA are pragmatic and humane proposals which strengthen both programs and further affirm the intentions of Congress that America's veterans will receive the care they need.

By broadening the language to the inclusive "veteran" rather than suggesting that sexual trauma is only experienced by women, these bills allow for compassionate and sensitive treatment for any veteran—man or woman—who experiences these extremely violent and personal assaults. Lifting the time requirement on when a veteran can seek assistance from the VA, and extending the time constraints for care, are in keeping with the accepted therapeutic approaches to treatment. The aftermath of sexual trauma does not conform to anyone's time schedule, nor does therapy for victims follow a specific trajectory or time limit. Because Congress has taken the initial steps to investigate and provide treatment for the casualties of sexual trauma, support for S. 1030 and H.R. 2285 will provide realistic expectations for outreach, treatment and assessment of the needs of this program.

Equally important are the provisions in the legislation for funding and support for the Women Veterans Coordinators program. Since 1982, VVA has expressed concern for the status of this very vital service to women veterans. We still hear that there are problems with the present system of assigning this important responsibility as an additional duty. Many Women Veterans Coordinators have to stretch the limits of their time to attempt to provide adequate outreach and education programs. Particularly disturbing were their reports of trying to obtain even the most basic feminine hygienic supplies for hospitalized women veterans.

There was the distinct impression that these Coordinators exist with little to no clout or access to administrators to solve the identified problems and needs specific of women veterans. The appointment of Women Veteran Coordinators with little or no time allocated for this responsibility is a cruel hoax, both to those assigned the duty, and to those they are assigned to serve. The efforts of these Coordinators reflect individual accomplishments rather than a system-wide level of service or commitment.

We believe that any serious efforts to apprise women of their rights as veterans will only come when there is a more structured approach. VVA continues to advocate for half or full time Women Veterans Coordinators in each Regional Office for a period not to exceed two years, to conduct more formalized outreach and educational initiatives. We believe that this pending legislation is an important step in providing a more formalized network which will ultimately better serve women veterans now and in the future.

WOMEN VETERANS' HEALTH STATUS

The 1989 VA Study of Disabled Veterans found that 28% of Service-Connected Disabled (SCD) women veterans do not use the VA. Equally impressive was the fact that a 1992 VA statistic indicated that 55% of the women who use the VA are Non-Service Connected. When asked why they did not use the VA, 20% of the SCD women veterans reported that the VA did not provide the care they needed, 21% said that the quality of care in the VA was too poor. Women have also reported that they will not use the VA because of unfavorable and frightening experiences they had in the system. Many view the VA as a continuation of the discrimination

and humiliation they endured in the military. Despite efforts on the part of the VA to address these problems, women veterans feel like outsiders.

The response that 20% of SCD women could not find the services they needed in the VA raised the questions about just what kinds of problems they have. What is known about the health problems of women veterans is based on small studies and findings? The often quoted Lou Harris study did have some basic questions on health which suggested that there are some problems that should be investigated more thoroughly.

The National Vietnam Veterans Readjustment Study (NVVRS) was the first time that women were included in any study of the Vietnam generation. The strength of the design of the NVVRS is that there are three cohorts for comparisons. Women who served in Vietnam (THR) were compared with military women who did not serve in Vietnam (ERA) and women who never served in the military (CIV). This study found that 19.8% of the THR women had service connected disabilities at the time of the study in 1985. The greater portion of these 12.8% were rated 30% or more.

This was a highly significant difference from the 13% seen in men who served in Vietnam. Perhaps the most important finding of the study was the difference or lack of difference found in the comparison of In-Country women veterans with ERA women.

There was not significant difference seen in THR versus ERA women in chronic health problems. Life time prevalence of PTSD symptoms were not significantly different for THR women exposed to low or moderate stressors and ERA women. Military women who did not serve in Vietnam reported a 2.3% prevalence of PTSD. Given the fact that 265,000 women served during Vietnam, it is conceivable that ERA women have suffered or may be currently suffering symptoms of PTSD which could benefit from professional treatment.

When comparing specific diseases in civilian women, THR women had significantly higher rates of the following diseases:

<u>DIAGNOSIS</u>	<u>CASES</u>	<u>UNWEIGHTED RATE/100</u>
Tuberculosis	5	1.17
Dyspnea	33	7.80
Arthritis	9	2.09
Circulatory	52	12.09
Liver	28	6.68
Ulcers	35	8.25
Spine and Back	108	26.15
Multiple Sclerosis	6	1.39
Respiratory	63	14.62
Gyn (Diseases of the Ovaries and Uterus)	168	40.00

Additionally, THR women reported significant health problems so severe they could not work (18.52/100).

Data from the study also supports earlier findings that women who served in Vietnam do have significantly more negative reproductive outcomes (miscarriages, stillbirths and children who die before their first birthday) than do other military or civilian women. Of particular interest is the high rates of multiple sclerosis which was 6/432 in THR women. Reports from the National Multiple Sclerosis agency indicate that more than four cases found in any population is significant. The reported rates of tuberculosis (5/426) are also of concern because at the time the data for the NVVRS was collected, the national average was 6/100,000. Although rates of cancer were not significantly different in THR women (40/428) when compared with other military women (19/304) and civilian women (13/218), the higher incidence suggests that this is an area in need of further study.

RESEARCH ON WOMEN VETERANS

Although there have been gestures by the VA and the Congress to initiate research with regard to women veterans' health problems, little has actually been done. For instance, in 1983 the VA mandated that all future studies of veterans conducted or contracted by VA must include women veterans. While this was the mandate, in truth it has not been the practice. Women were not included in the 18,581 sample used for the 1987 Health Status of Vietnam Veterans Study. Additionally, the 1986 Public Law 99-272, sponsored by Senator Cranston, which authorized an epidemiologic study of any long term adverse health effects, particularly gender specific health effects experienced by women who served in Vietnam, has been languishing on the drawing board for years because researchers can't agree on a design.

Last year the Veterans Health Care Act of 1992 had provisions authorizing the VA to initiate and expand research on diseases specific to women, but was not funded. A comprehensive study of the health problems of women veterans would be a modest investment in accurately assessing the status of this population. Such assessments are a realistic strategy for planning and implementing health care policies and procedures that will insure the maximum utilization of resources while promoting quality health care.

Our members are dismayed that year after year they have been forgotten. Instead, segmented proxy measures have been planned to meet the requirements of what was hoped to be a thorough scientific inquiry. The recently published Mortality Study of Women Vietnam Veterans was insufficient to provide answers or drive any policy or planning decisions. Given the fact that the majority of women who served in Vietnam never married or had children, the planned Reproductive Outcomes Study on Women Vietnam Veterans will not give us the information we need to answer the health concerns of most of the women who served there.

I would like to share with you one of the most compelling reasons Congress needs to not only authorize but fund research for women veterans. Recently, I received a phone call from a woman from Indiana who served in Pleiku from 1967-1968. She called to ask me if any studies had been done on the effects of Agent Orange on women veterans. I told her there had not been because of differences of opinion on how the study would be done. She then told me why she had called.

She said that she had 13 miscarriages, 1 hydatiform mole which she called a baby and 3 live children, two with birth defects. She went on to say that she has cancer of the stomach and thyroid, non-hodgkin lymphoma, kidney tumors, mitral valve collapse with a replacement. She has chloracne, diabetes and several cancerous growths had been found on her legs. She wanted to know if any of this had to do with her Vietnam service. I asked her what the VA was doing to help her. She told me she doesn't go to the VA because they turned her away when she went for help in the past. I wish I could say this is an isolated incident, but it is not. I wish there was a better answer for her, but there is none. I think she deserves some kind of answer.

When I remember her, I think of all the mothers who lost babies or had children born with cancer or deformities--mothers with children slow to learn or play. I know that there are days when they wonder if these problems are related to their service in Vietnam or in the military. I tell you there is no greater heartache than to watch these children struggling, because you wonder over and over again if the price of your service to this nation is being paid by the child who struggles every day to overcome those disabilities.

WOMEN VETERANS' HEALTH CARE

Section I of the Veterans Health Care Act of 1992 was a landmark victory in the long struggle by women veterans to assure continued recognition and support for their specific health care needs. VVA is proud of the leadership role we have taken in the last ten years to spearhead these efforts. However, the legislation which calls for the development of well women health care programs, broadening the context of service-connected Post Traumatic Stress Disorder to include the aftermath of sexual trauma and authorization of funding for a Women Veteran's Health Study are only initial steps in adequately addressing the needs expressed by women eligible for VA health care.

We have noted at hearings in Congress, in the media and within our own membership that women veterans consistently voice the same problems year after year, with no real, hard evidence of a concerted effort at the VA to address these issues. More often than not, complaints or reports of inadequacies in the system are treated as if they were anecdotal rather than the symptoms of system-wide deficiencies. Increased numbers of women serving in the armed forces are becoming eligible for VA programs. If we are to really address the needs of these veterans, there has to be a more conscious effort on the part of the VA to assure that women receive quality care.

With the new authorizations for health care programs, funding for women veteran coordinators and research for women veterans, there is need for more accountability than can be assured by the present staff and their access to the Secretary. VVA has suggested that the time has come to establish a more formalized process to assist women veterans by developing a department within the VA much like the Department of Labor's Women's Bureau. We believe the recurring problems of outreach, privacy, adequate physicals and any other gender-related issues would be best addressed if there was some structured oversight within the VA.

Not only could this unit serve as a clearinghouse for present programs designed specifically for women veterans, there is the additional potential for program evaluation and planning based on research and hard facts instead of relying on the traditional tools of rhetoric and conjecture. The establishment of a structural unit dedicated to women would reflect the Department's interest and commitment to rectifying the mistakes of the past and its resolve to maintain the standard of care these veterans deserve. More importantly, it would be a major step in instituting a method to assure the maximum utilization of resources designated to assist women veterans.

We would like to thank Congresswoman Maxine Waters for her leadership in introducing legislation which would create such an office in VA. It was 45 years ago this month that President Truman signed the law making women a permanent part of America's Armed Forces. The struggle for women veterans' rights preceded that law and continues with the same determination and dedication to women now and in the future. The passage of the legislation proposed by Congresswoman Waters sends a clear message to women in today's military and to all of America's women veterans, that there will now be a permanent place for them at the Department of Veterans Affairs. This legislation is a commitment from Congress that the needs of women veterans will receive timely, responsive and thoughtful attention.

SUMMARY

There is no question that the VA has greatly improved services to women veterans since the problems were first identified ten years ago. Many of those improvements have come as a result of the VA Women Veterans Advisory Committee and the Department's willingness and capacity to be responsive to the perceived needs of women veterans. Ten years ago, no one could have foreseen a need to make arrangements for homeless women veterans and their children, the need to broaden the context of care for women with PTSD, or the troubling reports of cancers in women veterans.

It is most ironic that an agency so well known for its research projects and accomplishments has not found the physical health problems of women veterans to be of any interest. When I think of the excuses that have been given to delay the study that was authorized in 1986, I remember someone from the CDC saying that there was too small of a group of women to study. As I look back over the years since then, I see that more and more of the cohort has disappeared—we buried them.

While it is disappointing that the original study has not been done, the reality of time and the greater need to accurately assess the needs of the entire population suggest that the research would be more beneficial if it called for a comprehensive Women Veteran Health Study. Such a study would accurately answer the questions about rates of cancer, need for the specific types of health services and how the VA can best serve the needs of women veterans.

It is important to say that Vietnam Veterans of America realizes that there are many

caring, compassionate and competent individuals working in the VA system. Dr. Susan Mather and Barbara Brandau at VA Central Office have juggled their own responsibilities while also being the prime and relentless movers of change and improvements in the health care services for women. Dr. Jessica Wolfe and Joan Furey of the National Center for PTSD have been special friends who through their research and clinical work, have increased our knowledge and understanding of the different dynamics experienced by women veterans with PTSD.

I used to think of the quality of VA services as being a question of how the country honors its veterans, but I have come to see it in another way. I think it is more a question of the honor of the Congress than the country. Because it does not presently matter how much Congress legislates or regulates health care for the private sector, the effectiveness of the VA system is an actual reflection of what Congress is willing to live with. In essence, Congress is the Board of Trustees of the largest health care system in the world. We talk about adequate health care. Is that the floor or the ceiling? Is that acknowledging that cancer may be a problem for women veterans but doing nothing about it? Is that conceding that "Women are Veterans Too" but only giving lip service to helping them access the system? Is it saying that we will care for our military veterans, but we will not provide the same standard of health care enjoyed by Americans who never served their country?

Thank you Mr. Chairman. This concludes our statement.

**TESTIMONY CONCERNING HEALTH CONCERNS OF WOMEN VETERANS
HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE**

JUNE 23, 1993

BY: DORIS BESIKOF

ON BEHALF OF: NATIONAL WOMENS VETERANS CONFERENCE (NWVC)

**WANDAS FUND, (WOMEN ACTIVE IN OUR NATIONS DEFENSE,
THEIR ADVOCATES AND SUPPORTERS)**

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1 **MR. CHAIRMAN, Members of the Committee:** Thank you for
2 inviting the National Women Veterans Conference (NWVC) to submit
3 testimony on the subject of women veterans' health care in the VA
4 medical system. The NWVC has requested me to speak for them. I
5 am a Colorado attorney, who has worked with male and female
6 veterans, regarding health care issues, for approximately fifteen
7 years. I am a board member of WANDAS FUND, which also supports
8 women veterans and endorses this testimony. The basis for my
9 testimony on this subject is knowledge and experience gained
10 through my law practice, information provided to me by women
11 veterans, veterans service officers, and documentation provided by
12 the National Women Veterans Conference.

13 **I. THE CLIMATE IN WHICH WOMEN VETERANS' HEALTH CARE ISSUES ARISE**

14 Upon discharge from active duty, veterans, particularly those
15 with service connected disabilities, move into the VA health care
16 system. It is certainly true that male, as well as female veterans

17 often have to advocate vigorously in order to obtain the health
 18 care that is their legal entitlement.¹ Some have pointed out that
 19 men are also treated poorly, but this is no defense. In my
 20 experience, and in the experiences of the women veterans which you
 21 will hear, the plight of women in the VA system is abysmal; and it
 22 is far worse than that of men. Fundamental democratic principles
 23 are violated; and equal protection of the law is denied by the VA
 24 medical system's current handling of women veterans health care.

25 When a woman veteran seeks VA medical care, she finds that
 26 negative attitudes and practices toward women, which she
 27 encountered in the military have been carried over into the VA
 28 system.² Often she literally, and figuratively speaking, cannot
 29 get inside the door to obtain the care she needs and is entitled
 30 to by law. Women currently report that they are still being met
 31 with disbelief that they are veterans. They are required by VA
 32 personnel to show papers proving their veterans' status, while men
 33 who tell the same personnel that they are veterans are taken at
 34 their word, no further proof required.

35 In the military, under the Feres doctrine, someone on active
 36 duty has no right to compensation for injuries they receive, except
 37 through service connection of their disability and military and

38 ¹ Lack of funding is often raised as justification for availability and quality problems within the
 39 VA system. In my experience, funding alone will not cure problems of recalcitrance and insensitivity in this
 40 bureaucracy, which traditionally has not been accountable for its conduct. Judicial review of the VA actions
 41 concerning veterans was only established recently by the Veterans' Judicial Review Act of 1988.

42 ² The VA employs many veterans, most of whom are male. 1980 and 1987 U.S. Merit Systems Protection Board
 43 (MSPB) studies indicate that the VA has the second highest incidence of workplace sexual harassment of 24
 44 government agencies surveyed.

45 veterans pensions.³ However, the laws determining pensions and
46 disability benefits do not treat women equally.⁴

47 Over the years, the military has plainly told women that
48 sexual assault was a risk of service.⁵ Instead of removing the
49 risk of harm to women by enforcing powerful military discipline;
50 commanders have handled the problem by placing the burden on the
51 women. They have warned women not to venture out alone on military
52 bases, such as Fort Gordon, Georgia and Fort Hood, Texas. As
53 recently as March 16, 1993, Army Lieutenant Colonel William C. Kirk
54 informed the family of Army Spec. Alexis Martinez Colon that the
55 sexual harassment and failure of her superiors to take corrective
56 action, when the harassment was reported, were all, "incident to
57 Specialist Colon's service," when he issued a denial of the
58 family's federal tort claims on account of her suicide. As long
59 as this shameful circumstance exists, the VA medical system must

60 ³ United States v. Brown, 348 U.S. 110, 175 S.Ct. 141, 99 L.Ed. 139 (1954); Brooks v. U.S., 337 U.S.
61 49, 69 S.Ct. 918, 93 L.Ed. 1200 (1949) and Feres v. U.S., 340 U.S. 135, 71 S.Ct. 153, 95 L.Ed. 152 (1950) are
62 the cases which deny a private right of action to active duty military personnel, based upon the need to
63 maintain military discipline; and based upon the belief that the claimant, who is already entitled to veterans
64 benefits and pensions would receive a double recovery. In actual practice this rule of law leaves the veteran
65 with no recovery at all, when the VA system does not provide what is needed.

66 ⁴ Women veterans are required to meet greater burdens than men in qualifying for benefits.
67 Discrimination is first seen in the availability of counseling. While the Secretary SHALL provide counseling
68 for readjustment and post traumatic stress syndrome; the Secretary MAY provide counseling for sexual trauma.
69 To qualify for counseling, radiation survivors, agent orange victims and veterans suffering post traumatic
70 stress syndrome must prove that they were in an area where exposure could have occurred, or is presumed to
71 have occurred, that they subsequently developed a disease, and are GENERALLY suffering psychological problems.
72 For women to qualify, they must show that they are suffering sexual trauma as a result of sexual assault,
73 battery or harassment. Harassment is narrowly defined to include only repeated, unsolicited and threatening
74 contacts. While the predominantly male groups can seek counseling at any time, and have unlimited access to
75 counseling; women must seek counseling within two years after discharge or release, and counseling may not
76 exceed one year, unless authorized by the Secretary. Readjustment counseling, 38 U.S.C. 1712A, Congressional
77 Record S-17871 October 8, 1992, Title I, Section 102; 38 U.S.C. 1712A (a)(1); Women Veterans Health Care
78 Program, Congressional Record S-17871 October 8, 1992 Title I, Section 102; Radiation claims CFR 3.31b(a)(4);
79 Agent Orange claims, CFR 3.311a(b); Presumption of exposure and qualification for benefits, 38 U.S.C. 1116.
80

81 ⁵ Statement of Veteran Barbara Franco, re Fort Hood and statement of Veteran Diana Danis re Fort
82 Gordon, among others.

83 be prepared to provide care and treatment for women veterans who
84 are victims of sexual assault.

85 II. WOMEN VETERANS FACE RECALCITRANT, NEGATIVE ATTITUDES WHEN
86 THEY EXERCISE THEIR RIGHT TO VA MEDICAL CARE.

87 Since 1978, when I represented my first woman veteran, it has
88 been clear that women veterans are a separate, less than equal,
89 subclass of the veteran patient population.⁶ The VA has
90 historically treated women as a group which is too small, too
91 costly and too inconvenient to treat. Women veterans who seek care
92 are regarded as if they are asking for special treatment. Their
93 smaller numbers are no justification for the way that women are
94 ignored and mistreated. There are small percentages of blind and
95 paralyzed veterans; but they are not denied care because of their
96 numbers. Such thinking is neither humane, nor sensible. Women who
97 served their country, with dedication to its ideals, are now being
98 denied protection of the very laws they sought to uphold.

99 In 1982, the lack of care for women veterans was recognized
100 and all VA facilities were ordered to appoint Women Veterans
101 Service Coordinators.⁷ This would have been the beginning of a
102 solution to the women veterans problems; if there had also been a
103 change in the priority given to women within the VA system.
104 However, funding for these hopeful sounding positions was not
105 authorized by Congress, or requested by the VA.⁸ The coordinator's
106 duties were often assigned to busy nurses, who were not veterans,

107 ⁶ According to the 1990 Census, women veterans make up 4% of the total number of veterans.

108 ⁷ P.L. 98-160, November 1983, establishing Women Veterans Coordinators; in response to a 1982 GAO report
109 documenting deficiencies in women veterans care.

110 in addition to their regular responsibilities.

111 The VA does not provide equal quality of care to men and women
 112 suffering from mental and emotional illnesses arising out of
 113 military service. Male veterans have traditionally been cared for
 114 when they suffered "battle fatigue"⁹, post traumatic stress
 115 disorder and dependency problems. The VA has routinely treated
 116 problems related to the male reproductive system; but has
 117 structured its care programs as if the female reproductive system
 118 does not exist! For example, Denver's VA has a urology staff
 119 member on its roster, but no one for gynecology. Men routinely
 120 receive prostate care, vasectomies and full exams; while gynecology
 121 services are available only 1/2 day per week and analogous
 122 procedures for women are often only obtained after board review.^{10 11}

123 One female, service connected veteran who needed a
 124 hysterectomy, had letters recommending and prescribing the
 125 procedure from her VA physicians and from other physicians, but
 126 still required the assistance of an attorney; and had to go
 127 through a medical board review process to have the medically
 128 indicated procedure performed. At the same time, in the same
 129 facility, her male counterparts received vasectomies as routine

130 ⁹ A term commonly used to describe emotional problems suffered by veterans after the first and second
 131 World Wars.

132 ¹⁰ It should be remembered that the VA hospitals around the country are adjuncts to medical schools
 133 and are often staffed by physicians in training; and researchers. Little or no research is being done on women
 134 veterans who are believed to suffer from cancer of their reproductive organs at twice the rate of female
 135 civilians.

136 ¹¹ The Denver VAMC, for example, has a urology service with twelve staff urologists who are board
 137 certified and 3 resident slots. As of January 1, 1993, the ob/gyn clinic is only open 2 days per month. 3
 138 ob/gyn physicians from the University of Colorado visit the clinic on a rotating basis. The pap smear clinic
 139 is conducted by a nurse practitioner; and women report that nurse practitioners, not doctors, examine them.
 140 No data is believed to be kept on numbers of women seen, procedures performed, etc.

141 care.

142 Of all women veterans, the most damaged, needy and least able
143 to advocate for themselves in obtaining care are the women who were
144 subjected to rape and sexual harassment in the military. These
145 women are also the ones who most often receive no care, or such
146 backward and primitive care, that it damages them; and drives them
147 deeper into the cycle of problems suffered by untreated victims of
148 sexual trauma.¹²

149 Post traumatic stress results when human beings are subjected
150 to trauma, or experiences which are beyond the realm of what they
151 can endure. Rape and sexual assault are recognized traumas of this
152 sort. The symptoms include a reliving of the horrific experience;
153 and other mental and emotional problems.¹³

154 Women who have been raped or harassed in the military have
155 additional special factors to deal with, which rarely affect
156 civilian rape victims. The military chain of command, and military
157 discipline require them to give up their civil rights and their
158 ability to protest, except through prescribed channels. Women
159 often find those "channels" to be hostile, and retaliatory when
160 reporting rape or sexual harassment.¹⁴ The losses of confidence,
161 sense of self worth and trust in others which are normally

162 ¹² "It is hard to imagine a worse recovery milieu than the military." Sen. Alan Cranston, letter to
163 Chairman Sam Nunn, Senate Armed Services Committee, July 31, 1992, quoting Dr. Mary Koss.

164 ¹³ Noted and described in further detail, in the Diagnostic and Statistics Manual III, Rev.

165 ¹⁴ Reports are discounted, never written up, women who resist and bruise their attackers are told their
166 sex was consensual, just a little rough, gynecological services are not provided, civilian authorities refuse
167 to take reports if both the attacker and victim are military. Women who file complaints are frequently
168 transferred; or are told they are mentally ill for imagining such things as physical attacks; or are threatened
169 with less than honorable discharges, for failure to adjust to the military, or for being unstable. See, also
170 letter of Senator Cranston note 10, above.
171

172 experienced following sexual trauma, are exacerbated by their
 173 military experience. Their cases are further complicated, when as
 174 damaged, dysfunctional, physically and mentally ill veterans, they
 175 enter the VA system which tells them they are equal; but denies
 176 them what they need and insults them. Effective therapy for post
 177 traumatic stress sufferers requires the skill and expertise of
 178 someone trained in working with victims of a particular stressor.
 179 Thus, it does not work to place a rape victim into a combat-
 180 related stress group, or group dealing with any other trauma,
 181 including rape in a civilian setting.

182 Women patients, who are military rape victims commonly report
 183 that they feel unsafe in VA hospitals, which make no allowances for
 184 gender differences; and require them to be hospitalized on
 185 predominantly male wards.¹⁵ They often report that there are no
 186 pajamas for them, or only pajamas which do not fit; but they are
 187 not allowed to wear other clothing.¹⁶ One woman decompensated
 188 severely when told that she would be required to wear pajamas on
 189 a locked psychiatric ward. Another reported being required to wear
 190 pajamas too small for her, which left her breasts exposed, when
 191 hospitalized on a predominantly male psychiatric ward. Another
 192 woman complained of fear for her safety when hospitalized in
 193 psychiatric wards; and received little or no reassurance from the
 194 staff. She discharged herself and went without care, in order to

195 ¹⁵ The Menlo Park, California facility for women veterans, including those suffering from PTSD after
 196 serving in Viet Nam, was only opened within the last five years, although similar services for male Viet Nam
 197 combat veterans have been provided for many years.

198 ¹⁶ Women referred to in this statement are not named. Complaints frequently are not seen as information
 199 which gives opportunity for corrections and improvement. Instead, over the years, I have witnessed retaliation
 200 toward those who complain in the form of cutting off of benefits, ridicule and hostility.

201 feel safe.

202 Reason and common sense, without medical degrees or
203 federal law, should cause humane administrators to take steps, many
204 of which would cost very little, to spare women the additional harm
205 and indignity which goes along with the psychiatric ward
206 experiences noted here.

207 The lack of courtesy, privacy and common sense is appalling.
208 When women do receive care; they report crudeness and
209 insensitivity: pelvic exams performed in rooms where their feet
210 are positioned facing a door, which can be opened at any time; no
211 pajamas, or ill fitting pajamas, or gowns, designed for men;
212 uncertified mammography machines and examiners who comment that
213 they have never performed the exam in question on anyone with
214 breasts before. There is an ignorant, snickering attitude that
215 gynecology relates to the sexual act. It is especially
216 heartbreaking for young women, who have bladder and female problems
217 related to paralysis, or service connected loss of the ability to
218 bear children; when they encounter these attitudes as part of the
219 care they cannot do without out; and cannot go elsewhere to obtain.

220 Medical research for women has been neglected.¹⁷ Data on
221 services to women is poorly kept. The VA acknowledges that figures
222 in its reports do not add up.¹⁸ While VA research may include some

223 ¹⁷ On more than one occasion Congress and the VA have failed to request funding for women veterans
224 programs: "Section 109 of P.L. 102-585 authorized \$1.5 million to foster and encourage the initiation and
225 expansion of research relating to the health of women veterans, however, these funds have not been appropriated;
226 and as a result no new initiatives have been implemented with respect to this section." April 14, 1993 Report
227 on Health Care Services and Research Relating to Women Veterans to the House of Representatives Committee on
228 Veterans' Affairs as required by P.L. 102-585.

229 ¹⁸ April 14, 1993, report on Health Care Services and Research Relating to Women Veterans to the House
230 of Representatives Committee on Veterans' Affairs as required by P.L. 102-585.

231 care that is received by men as well as women, the VA is passing
 232 up the opportunity to conduct research which would benefit all
 233 women; and which is needed by female veterans who suffer twice the
 234 rate of some types of cancer as civilian women.¹⁹

235 In 1992, recommendations by NWVC which would have helped to
 236 make appropriate care available were discounted by VA officials,
 237 who also took no action in-house to address the need for better
 238 care.²⁰

239 The facts related in this testimony are the stuff of class
 240 action litigation. However litigation is not the first choice for
 241 solving these problems. The woman veteran is often poor and ill.
 242 For her, litigation is not an attractive avenue by which to seek
 243 fair treatment. It would be another overwhelming burden.
 244 Nevertheless, when one looks at reports which have point out that
 245 the same problems discussed today have been documented as existing
 246 for more than ten years; it is time to note the potential for legal
 247 actions by veterans who can wait no more; and who are not as
 248 patient as many of the women who provided the facts contained in
 249 this statement.

250 A positive resolution for the veterans and for our country,
 251 would be steps to honor and respect these women, measures of which
 252 we could all be proud. Affirmative words and actions are needed
 253 that show from the highest levels in our government, that it has

254 ¹⁹ Cancer statistics, 1982 GAO/HRD-82-98, Actions Needed to Insure that Female Veterans Have Equal
 255 Access to VA Benefits, September 24, 1982, among others.

256 ²⁰ Memos discounting the recommendations of NWVC: 10/30/92, Larry Layman, Director of Mental Health
 257 and Behavioral Science, VA Central Office; and Art Blank, National Director of VA Readjustment Counseling
 258 Program, undated.

259 become out outmoded and unacceptable to continue with the current,
 260 deplorable state of affairs. The changes listed below have been
 261 requested many times in the past; but they are still desperately
 262 needed:

263 Funding needs to be appropriated for programs in place;
 264 WWII women veterans need to be included in geriatric care;
 265 VA personnel should have mandatory sensitivity training;
 266 Fee basis services, including mental health services should
 267 be available where there is no care; or only irregular care;
 268 Medical and Administrative Directors should be accountable for
 269 implementing mandatory women veterans programs;
 270 Women Veterans Coordinator positions should be funded and
 271 staffed by women veterans with authority and access to
 272 the VAMC Director and Central Office.
 273 An Assistant Secretary for Women Veterans Issues should
 274 be appointed; and women veterans should have an 800 line
 275 dedicated to fielding complaints and providing referrals.
 276 Medical research for women, including cancer research should
 277 be required, and given the same emphasis and funding as
 278 predominantly male programs.
 279 Board certified physicians should see, or supervise physicians
 280 on site, who see patients; and nurse practitioners should
 281 not be used instead of doctors.
 282 The time restrictions and proof requirements for
 283 application for psychological treatment for sexual trauma
 284 should be removed; and funding for appropriate treatment
 285 and fee based treatment should be appropriated. (P.L.
 286 102-585).
 287 Legislation this year includes HR2285 and companion SB1030,
 288 which eliminate the unfair time window for women veterans seeking
 289 PTSD therapy; changes the discretionary word "may" to a mandatory
 290 "shall"; and also creates an 800 number for women veterans. Your
 291 affirmative support for women will improve their lot; and will give
 292 them the honor and respect, which they deserve. Thank you.

WRITTEN by Art BLANK, NATIONAL DIR. READJUSTMENT Cslng Pr.

Comments on NMVC paper on training of counselors on sexual trauma

Page 1

1. Two years experience in counseling for women veterans is excessive. Quantitative requirement should be by number of cases seen, and not by length of time. Also, experience with civilian victims is relatively easily translatable to veterans--with some additional training on military specific issues.

Disagree that civilian experience is not significant; with a small amount of additional training on military specific issues, it may be sufficient.

Item 3) on page 2 includes relevant criteria, but is not all-inclusive.

Item 4) is somewhat overstated: Advanced degree in and of itself is not qualifying, but may make a contribution to qualifications.

Reference to Certified Trauma Counselor: It is my understanding that this is an organization created by some practitioners in the last few years, and that it has no standing, validation by any professional society, recognition by any state licensing board, etc. It would be interesting to see what the requirements are for this certification.

pp 3-4: The suggested curriculum content is standard, would be agreed to by most in this field, and also is similar to what is being used in the RCS staff training on this topic.

It is my understanding that the writers of this document are putting themselves forward as trainers, in this area, have contacted at least one RCS official offering their services, and have quoted prices far above what VA is currently paying for expert trainers in this field.

The reference to International Association of Trauma Counselors raises questions as indicated above.

Target Report



NAWW

National Association of Women Veterans, Inc.

Evelyn M. Monahan, Ph.D.
President

Rosemary Greenlee, M.N., R.N.
Vice President

TESTIMONY SUBMITTED

BY: Evelyn M. Monahan, Ph.D.
President

National Association of Women Veterans, Inc.

TO: The House Committee on Veterans Affairs
Subcommittee on Oversight and Investigations
23 June 1993

Congressman Evans; members of the committee; ladies and gentlemen; my name is Evelyn Monahan, I am a retired Vietnam Era veteran, and I reside in Atlanta, Georgia.

Those of us in this chamber today, are surrounded by a Great Cloud of Witnesses. That Cloud includes not only those of our generation who will view our efforts and make judgments concerning them, but also those past and future generations. We and they are part of a great army, and we have come to challenge; to confront, and to change; to make level the playing field on which women veterans must stand or fall, in order to receive VA Health Care.

Past generations are here today to witness our race; having run it themselves, they cheer our beginnings, cringe at our falls, are disappointed by our mistakes, and applaud our victories.

This Cloud of Witnesses was present in Atlanta, Georgia in October of 1992 when a young woman veteran, who had been sexually assaulted and gang raped while serving in the Armed Forces, was admitted to the Psychiatric Intensive Care Unit, on the anniversary date of her assault. The woman was suffering the symptomatology of Post Traumatic Stress Disorder connected with the vicious attack she had suffered several years earlier. The woman's husband, also a veteran, was extremely upset because his wife had been placed on a locked psychiatric unit, shared by male and female veterans. The Cloud of Witnesses watched as this woman veteran, already in pain, experienced new psychological wounds from fear rekindled in her by placing her in a gender mixed unit, despite the fact that her husband asked that she not be placed on a unit with men.

The Cloud of Witnesses listened as VA Medical Center personnel explained that there were no separate accommodations for female veterans who needed acute psychiatric care because of the scars of sexual assault and rape.

The Cloud of Witnesses watched as the woman's husband, concerned and distraught, spoke of going to the media; to Congress; "to anyone who cared enough to help"; and they watched as the woman's family removed her from the VA Medical Center and sought a place "where she could be cared for without inflicting new injuries."

We, the Witnesses of Present and Past Generations, challenge the Congress to mandate that VA Medical Centers shall provide separate accommodations on psychiatric units, for women veterans who have been the victims of sexual assault and rape. Give force to the medical dictum that says "Do no harm!" Provide adequate accommodations and psychiatric care for women who have suffered the critical psychological wounds of sexual assault and rape. Bi-coastal centers for the study and care of such victims are not enough. These women are in all large cities and many small towns, and it is the local VA Medical Centers which must be prepared to provide them "safe" and "protected" care.

In order to make these accommodations and this "protected" care available, the Department of Veterans Affairs must provide more than a list of counselors supposedly trained in providing care to women suffering the

residuals of sexual harassment/assault, and or rape. The Department of Veterans Affairs must care more about meeting its mission than it does about "looking as though it is meeting its mission". In many VA Medical Centers today, a list of names is all that awaits the victims of sexual assault-for the "special training" has yet to be "defined", "specified" and provided to most VA staff whose names on a list, provide a smoke screen, and prevent the mobilization for real and needed training.

The Cloud of Witnesses Present and Past has watched as VA employees who have been victims of the sexual harassment/assault/rape continuum, are offered no counseling for the wounds inflicted in the VA workplace, all too frequently by VA managers who were authority figures and agents of the Department of Veterans Affairs. The Cloud of Past and Present Witnesses calls upon Congress to mandate that counseling by effectively trained counselors, shall be made available to all women who have suffered the wounds of the sexual harassment/ assault/rape continuum in the VA workplace or while on duty off station. We have witnessed too many care givers and care providers-neither caring nor providing the psychological health care these wounded employees need.

One of the abhorrent results of the sexual harassment/assault continuum is racial discrimination which impacts heavily on black men and black women, since selections for placement and promotions are frequently made by a harasser with a particular type person in mind for the available job, and the un-advertised position for the harassment victims who have paid for promotions with sexual favors or the promises of sexual favors. Discrimination no matter which mask it wears, is an ugly hydra that eats away at the underpinnings of equality and democracy.

The Cloud of Witnesses Past and Present calls upon Congress to mandate a specifically defined training program for Women Veteran Coordinators. To date, we have watched as the Department of Veterans Affairs rushed to provide a three day training conference for Women Veterans Coordinators who should have been trained before they were given the co-lateral responsibility of that position.

Too frequently we have seen people appointed to the positions of Women Veteran Coordinator without the slightest idea what their duties were, and how they were to carry them out. Past and Present Witnesses have seen a vast disparity in the knowledge, perceived mission, and the training provided to Women Veterans Coordinators. In some VA Medical Centers, Women Veterans Coordinators confine their efforts to having teas for women veterans; while others become involved in limited efforts to reach out to women veterans in their states through a "publish as you can" newsletter.

We, the Cloud of Witnesses of Past, Present, and Future Generations, call upon Congress to:

1. Mandate specifically defined training for Women Veterans Coordinators,
2. Mandate that "interested" candidates be solicited for the position, rather than the director naming someone to the position simply to fill a requirement.
3. That Congress mandate that each VA Regional Office shall have a Women Veterans Coordinator who will work in concert with the Women Veterans Coordinator at the VA Medical Center. Recently, in Atlanta, Georgia, the Cloud of Witnesses, Past and Present, watched as the Director of the Regional Office, Charles Wickes, removed the Women Veterans Coordinator who testified before this committee on 17 September 1992; and wrote a memo stating that a Women Veterans Coordinator was not needed as there were "plenty of women veterans on station".

The Cloud of Witnesses Past and Present has listened many times to women veterans telling women counseling psychologists of their sexual assault/rape while on active duty in the military. Women veterans who have come to VA Regional Offices seeking rehabilitation, need and deserve a Women Veterans Coordinator to act as an advocate for them with the Regional Office, and as an advocate and liaison with the VA Medical Centers. It is frequently the counseling psychologists in the VA Regional Offices who have the first and longest in depth interview with women veterans following their discharge from the military.

4. Congress to mandate that 3 hours of training in women's military history shall be provided to all VA employees.
5. Congress mandate that an additional 3 hours of training in the military history of WWII, Korea, Vietnam, through the Persian Gulf War shall be provided to all VA employees in order to foster greater knowledge, respect, and concern for all veterans and the sacrifices they have made to purchase the peace our country enjoys.

The Cloud of Witnesses Past and Present have wept at the callousness displayed by the Department of Veterans Affairs, in failing to provide a

board certified gynecologist on the staff of each VA Medical Center. If women are to be accorded state of the art health care, a board certified gynecologist must be on staff or available to a family nurse practitioner who conducts GYN exams, and consults as necessary with a board certified gynecologist.

The Cloud of Witnesses Past, Present, and Future calls upon Congress to mandate a halt to all surgery and/or surgical procedures performed by residents without the supervision of a board certified surgeon present. How can the Department of Veterans Affairs win or maintain the trust of veterans who seek the watchful eyes of Congress, and the protected care of VA Medical Centers, when they are most vulnerable to the practices of what can in truth, only be called the malpractice of medicine?

Our national heroes deserve more than this -they deserve what each member of this committee would wish for him or herself or for their friends and loved ones. It has been said that individuals or a committee, which does not have the courage of their convictions-have no convictions.

The Great Cloud of Witnesses, Past, Present and Future, calls upon Congress, this committee, and the Department of Veterans Affairs to have the courage to care! To care enough to mandate that the attitude that enforces the idea that appearing to meet the mission of the Department of Veterans Affairs is good enough; is not good enough! That the veterans of this country, female and male, deserve much more-they deserve a department which honors and meets its mission- a Department of Veterans Affairs with the courage to care!

**TESTIMONY OF MARSENA MUNGIN
PA. STATE NATIONAL WOMEN VETERANS COORDINATOR**

As we look at the plight of the African-American Female veterans, and their role to family, comrades, and community. Many women can't reach out to share their knowledge due to the pain of sexual harassment, double standards and inadequate health care. For some perceive the causes and effect, a reaction of one persons' imagination. Many questions can be raised about the Veterans Administration system, and the role of women. The wheels of change must come or the VA system to myself as example: Disabled single parent doesn't mean anything. I am a victim of this system that can't understand that "Women are veterans too."

Programs are developed, but not implemented; in other words, it looks good on paper but in reality is a nightmare. We don't have the time to waste because there has always historically been low priority given. It's apparent that society has painted a nasty picture of the real problem. It hurts to come and be a part of what we're doing here today. With no chance of hope in sight, turns to anguish that burns like a burning fire. Many women are held hostage by fear of what they have seen, or things done to them. The problem starts simple, but is compounded after no care is given.

Injustice has played a very harsh part in our lives. I'm at a point justifying why I'm here to my children. I come up with the same answer, "Change will come." I view myself as in this poem.

As I wait for me to deliver it's fatal blow, my mind wonders what will life be in ten to fifteen years from now. Will I, could, shall I ever move from this time or will by hair become gray with the wisdom or my body become stiff and brittle. The only answer that can be given is I shall move on one more time to wait some more.

This is my view on what's going on, time will always take care of its self. Please don't take slightly because our children, family and friends have given up some part of their life to support us to be here today. Many words are being spoken, but do you hear the battle cry for help.

My mind wonders about what it would be like to not see another woman assaulted, or harassed and have to live with it by herself.

There are so many cross-cultural differences into play that we must start to deal with all the effects within and out of the system.

We are proud, beautiful women that God has made for this special call.

TESTIMONY OF CATHY P. LINDSAY
SSS 199-46-5449

While serving on active duty, from 1 Nov. 89 until Apr. 92 at Ft. Monroe I was sexually harassed by three of my male superiors, which resulted in me being transferred to our parent unit, Ft. Eustis' McDonald Army Community Hospital who's commander was also Ft. Monroe's Health Clinic Commander, Col. Charles Ellis.

Following a 15-6, sexual harassment investigation I was transferred to MACH, where I was admitted to Portsmouth Psychiatric Hospital Unit, to be discharged mentally unfit for duty. However the Portsmouth hospital discharged me fully competent and fit for duty.

Upon returning to MACH I was allowed to see Col. Ellis regarding my assignment because I felt that my placement at MACH wouldn't be in my best interest and he transferred me back to Ft. Monroe with remarks that I was destined to fail, but wouldn't allow me to be reassigned to any other unit.

While I was going through the sexual harassment I had surgery to my right foot by Dr. Collin May 1990. Upon returning to Ft. Monroe Health Clinic, following surgery I was not allowed to properly recover from my surgery and complications developed. The administration didn't acknowledge my profile, forced me to work extremely hard every day sometimes being called in after work to paint and sweep the perimeters of the building, do P.T., fully aware of my medical condition.

I continued to complain of the medical problem. I was requesting assistance from EEO, IG and others because my problems were being ignored. Dr. Collins was no longer seeing me, but I was assigned a Dr. Swartz whom I'd never met, that after 5 minutes of examination determined that my medical problem was neither orthopedic nor podiatric, but psychological and referred me to a psychiatrist, Dr. Etzell who prescribed me amitriptyline an anti-depressant that upon taken I hallucinated. I continued to seek medical attention for my foot, but my administration was calling Drs. in which I'd appointments with, canceling them and reassignment me with Drs. that did not treat me but also would suggest some psychological treatment. *(falsification of Medical records)*

I was recommended for MEB, and upon initial determination was found unfit for duty on 4 Sept. 91, and subsequently determined fit for duty on 26 Nov. 91. Although my condition hadn't improved but in fact had worsened.

After 2 1/2 years of this interference I had developed severe pain in other areas of my body including, difficulty walking, two occasions inability to get out of bed.

I subsequently was allowed after visiting the Pentagon, to be extended for the purpose of being examined at Walter Reed AMC. Dr. Yankowicz, whom recommended surgery and told me the only relief that I would have would be by removing the scarred nerves from my foot. Upon

returning with the recommendation to my command I had to have the endorsement of Col. Charles Ellis of whom I had recently requested a congressional inquiry for harassment I was receiving under his command for the last 2 1/2 years. He denied me the opportunity to have treatment after 2 1/2 years of trying to alleviate my problems with only 2 days notice although he'd had the request three weeks prior.

I was informed by my unit commander Col. Alvarez to be out of the Army, base housing, cleared post within 2 days.

The harassment includes but is not limited to invasion of privacy, suspected phone tapping, harassing phone calls, breaking and entering my home, harassment of my teenage son. Also enclosed are letters from family members that witnessed the suffering I endured.

I am currently seeking treatment through the Phila. VA Hospital, and on 23 March examined by student Drs. under the supervision of Dr. Sonoga when I was given a placebo. I have received no other treatment for my medical problem.

Request that the committee investigate my charges of sexual harassment. Proper treatment for physical condition and mental anguish, correction of discharge. (Medical discharge). Also request compensation of military finances and personal property.



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AMVETS

Statement for the Record

before the

**House Veterans Affairs Subcommittee
on
Oversight and Investigations**

regarding

VA Health Care Services for Women

and

Related Issues

June 23, 1993

Mr. Chairman, thank you for soliciting AMVETS' views on VA health care for women.

It is time for VA to move aggressively towards accommodating more women within its treatment facilities. In the past, women have formed a very small percentage of the active duty forces and thus a small percentage of all veterans. But in the 1970's, that began to change as the services shifted to the all-volunteer force. Women now comprise about 12% of the U.S. armed forces and VA is now faced with a rapidly growing segment of the veteran population that must no longer be ignored as non cost-effective use of resources. That is especially important as VA moves to compete in the coming national health plan, but it is even more important as a measure of fairness and good faith.

The recently-released VA Office of the Inspector General report on women's health care in the VA is perhaps the best example of how far the VA has to go to provide access to gender-specific care within the VA.

The study had six major conclusions:

- a. Women Veteran Coordinators (WVC) were not trained for their duties and VHA had no training program;
- b. WVC were not available or known to the women patients;
- c. Female patients were not told about the range of services available at facilities or services to which they were entitled;
- d. Privacy continues to be a problem and WVC were seldom involved in construction planning;
- e. Proper medical equipment was not available; and
- f. Quality Assurance procedures were inadequate or non-existent.

AMVETS finds it difficult to understand why over ten years has elapsed since a 1982 GAO study produced similar results, yet little has been actually accomplished. The study's conclusions point to a single cause for the inertia: a lack of management attention that cannot be attributed to VA funding.

Mr. Chairman, AMVETS supports eligibility reform that will entitle all service-connected veterans, the medically indigent veterans, uninsurable and catastrophically injured veterans to a full continuum of VA medical services including long-term care. Naturally, it follows that we support a full range of services for our sister veterans, including routine gynecological treatment. But there is a grave danger facing VA in defining the range of services.

However, AMVETS is very concerned that VA may be dragged into the national

debate on abortion while trying to provide treatment to its women veterans. It is obvious that with the significant changes about to take place in national health care policy, it is important that VA adapt quickly to the new realities of competition. It will be a tragedy if the debate on abortion is allowed to slow or stop VA health care reform. It is predictable that the forces on both sides of the issue will seek to hold VA hostage over inclusion or exclusion of abortion services. AMVETS respects the opinions of those on both sides of the issue and we neither oppose nor endorse abortions. AMVETS position is simple - that VA should conform to the laws of the land concerning abortion - no more, no less.

Mr. Chairman, AMVETS is deeply disappointed at the lack of priority given to the Women Veterans Coordinators (WVC) programs. Instituted in the mid-1980's, it is long past time when position descriptions should have been standardized, a grade structure established and full administrative and training support provided by the central office. Until care for women becomes routine, it is vital that these positions be filled, preferably on a full time basis, by women who are dedicated to enhancing the level of service provided to women veterans.

We are also concerned about the lack of facilities to provide the privacy and security needed by women veterans. Stories about bathrooms that are shared with male patients, makeshift screening to block line of sight, open access to women patients' quarters, lack of feminine hygiene products, lack of grooming products, reading materials and a generally less-than-welcoming atmosphere continue to be the norm.

These are simply more examples of a lack of management attention. It is important that WVC's and other female staff members be full participants in functions like construction planning to begin to address the special concerns of women patients. It is ludicrous that routine medical equipment needed for female exams is not available. And it borders on criminal that VA's Quality Assurance program has not included women's programs as a matter of routine.

Mr. Chairman, in short, it is time for VA to make women veterans full participants in the VA medical system, both as management and patient. that concludes our testimony.

To: Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
United States House of Representatives

From: Shirley W. Menard, R.N., M.S.N.
Chairperson, Advisory Committee on Women Veterans
Department of Veterans Affairs

Date: 15 June, 1993

Subject: Testimony regarding women veterans

I want to thank the Subcommittee for providing this opportunity to provide written testimony regarding the provision of services to women veterans within the Department of Veterans Affairs facilities. It is only through open hearings such as this that there is a true exchange of information and ideas.

I would like to discuss each of the issues suggested, but would first take the opportunity to talk about the Advisory Committee on Women Veterans. As you know, the Advisory Committee was established by Congressional Charter in 1983. In the decade that has passed since its inception, the Advisory Committee has brought forth many issues with solutions to the Secretary of Veterans Affairs. There has been continual involvement of the Advisory Committee to insure that the needs of women veterans are identified and met. The Advisory Committee has been directly responsible, through its advice to the Secretary, for many of the changes seen in VA facilities over the past 10 years. One of the duties of the Advisory Committee has been to submit a written report to the Secretary, and hence to the Congress, every two years on the status of women veterans. The last such report was in July, 1992. Members of Congress should have received a copy of this report and it is available from Department of Veterans Affairs.

Because the Advisory Committee is directly responsible to the Secretary, Veterans Affairs, I believe that it has been able to accomplish things that might otherwise have become bogged down in bureaucracy. I understand that there is pending legislation in the House to establish a Womens Bureau within VA. I would respectfully suggest that the Advisory Committee is much more able to advance the needs of women veterans because it is an advisory committee rather than a part of the VA bureaucracy. Additionally, in this time of fiscal constraints, I believe that less money will be spent by keeping the Committee than would be spent by creating another department. The Committee has suggested, and the Congress has agreed (Women Veterans Health Equity Act of 1992) that the Committee should meet more frequently and should visit VA facilities more frequently. For the work that it has accomplished, the Committee has been woefully under funded, but adding to the funds allocated for the work of the Advisory Committee will still be more cost effective than the establishment of an additional department. The Committee believes that because it is "civilian" and reports directly to the Secretary, it has been able to function in such a way as to encourage change within VA. I do not believe that another department within VA would be able to do what the Committee has done.

VA has really improved in the area of gender specific care. In the early 1980's, it was difficult for a woman veteran to receive care related to gender. Today, most VA facilities offer gender specific care (mammography and pap smears). They do this by having it available at their facility, working with other VA facilities, or by contracting it out. Routine preventive care for women is available. Due in part to the Women Veterans Health Equity Act of 1992, Womens Health Clinics will be part of some VA facilities. Not all facilities will have these clinics, but not all facilities treat large numbers of women veterans. It is appropriate for facilities with smaller numbers of women veterans to continue to work with larger VA facilities or to contract out the gender specific care of those women.

In the site visits that I have made to VA facilities, I have found that privacy issues for women veterans continues to be a challenge. In the older facilities there are many structural and fiscal difficulties to having private rooms, etc. In the newer facilities, privacy is not really a problem since they are built

with private and semi-private rooms which have bathrooms attached. It would be unfair to assume that only women veterans need privacy. It is the contention of the Advisory Committee that all veterans should have privacy. Most of the facilities really do try to accommodate their women veterans in a variety of ways. The important thing is that VA continue to be aware of and work on privacy issues. I have also found that the canteen does offer a selection of toiletries and clothing for women. I would recommend that VA continue to work on this area as more women veterans come to VA for care.

Sexual abuse and trauma of women who served in the military has recently been the focus of many investigations. It is true that VA had not been as well equipped to handle these issues as they might have been, but that is changing. Money has been allocated for training professionals to counsel these women and the VET centers have become particularly effective. I suspect that as we find more women veterans coming forward many years after the trauma, that more money will need to be allocated. Since Post Traumatic Stress Disorder is associated with many different traumatic events, the PTSD centers at Palo Alto and in Boston which have women's units may need to be expanded.

One of the most effective programs VA has for women has been the Women Veterans Coordinators program which has been advocated for by the Advisory Committee on Women Veterans. More women have become aware of their veteran status through the outreach of women veteran coordinators. One problem which is being corrected is that in most facilities, the women veteran coordinator job is "added on" to that person's other duties. To be an advocate for women veterans, the women veteran coordinator needs to have specific set aside time to work with women veterans. In some facilities this is being done, but not in all. Additionally, VA is adding regional women veteran coordinators to help local women veteran coordinators in their efforts. VA has also instituted a newsletter for women veteran coordinators and has held national workshops for women veteran coordinators. The Advisory Committee on Women Veterans strongly supports the newsletter and the continuance of annual meetings for women veteran coordinators.

The final issue listed in your letter was research and the inclusion of women veterans in VA research. Additionally, there is a concern that women veterans have a higher cancer risk than non-veteran women as noted in two separate research studies. It is true that in the past, there was not much research that included women veterans. Part of the reason was that it was male gender specific research and part of the reason was that there was not much research nationally in NIH which included women. This is changing and there is more research in VA on women veterans and their problems. One example is in the area of breast cancer, where VA has several research projects ongoing, including the research at Durham, NC. Recently, VA sponsored a workshop on research aimed at women veterans. There was a wonderful exchange of ideas and an openness of VA to spend more money on research that will benefit women veterans. In order to do this, VA will need money to be allocated. For example, the Women Veterans Health Equity Act of 1992 requested that VA do a population study of women veterans. Without money appropriated for this study, it will not be done.

Several years ago, two research studies showed that women veteran generally, and women Vietnam veterans specifically, had a cancer rate much higher than non-veteran women. Cancer of the reproductive organs among women Vietnam veterans was very high and so Congress mandated a study of reproductive outcomes among women Vietnam veterans. The contract for that study has been awarded and the study is set to begin as soon as possible. I have been appointed to chair the oversight committee on this very important research.

In conclusion, I believe that VA has been striving to meet the needs of women veterans. There is still much to be done. Secretary Brown has been most receptive to women veterans and the Advisory Committee. His actions have shown that he will continue to be responsive to all veterans, including women veterans. I want to thank you for your kind consideration of my remarks and stand ready to assist Congress in any way that I can.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES
CHAIRMAN EVANS TO DEPARTMENT OF VETERANS AFFAIRS

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VA PROVISIONS OF HEALTH CARE TO WOMEN VETERANS AND
RELATED ISSUES

JUNE 23, 1993

Question 1: Why does VA believe the number of mammograms and Pap smears provided by VA facilities during 1992 have been seriously underreported? What actions has VA taken to improve the accuracy of the number of mammograms and pap smears reported as provided by VA facilities? What additional actions will VA take to improve the accuracy of the number of mammograms and Pap smears reported as provided by VA facilities?

Answer: The belief that the reported number of mammograms and Pap smears provided by VA facilities during 1992 represents under reporting is based on anecdotal evidence of chart reviews by VA medical centers showing good compliance with the policy on breast and cervical cancer screening plus the well recognized difficulties involved in tracking the actual numbers because of a lack of automated data bases. The statistics we reported were gathered through surveys. This type of data is felt to be unreliable. To improve the accuracy of reported Pap smears and mammograms, the requirement for proper reporting will be publicized through newsletters, conference calls and training programs. Monitoring these reports will be one of the duties of the newly appointed Regional Women Veterans Coordinators. The use of existing DHCP software will likewise be encouraged in an attempt to improve reporting.

Question 2: Why are some VA facilities not providing complete physical examinations, including pelvic and breast exams, to all women inpatients as provided in VA policy? Have these facilities been identified?

Answer: It is the policy that all VA medical facilities offer annual breast and pelvic exams to women veteran inpatients and this has been extended to women veteran outpatients as well. All VA medical centers have approved medical center policies requiring complete physical examinations for women inpatients.

Consequently, each woman veteran who is admitted to a VA facility generally should be offered a breast and pelvic exam as part of her admitting physical examination. However, there are times when performing a pelvic exam on a woman veteran is not advisable at the time of her admission; for example, if she is too ill to be examined or if she is admitted with acute psychiatric problems. In these cases, the medical records of these women veterans should be annotated that the pelvic and/or breast exam has been deferred to a later date.

In addition, a number of women veterans are followed for gynecologic care at VA women's clinics/gynecology clinics and receive annual breast and pelvic exams in these clinics. Were such a woman to be admitted, it would not be clinically indicated to perform another exam unless the exam were part of the diagnostic process for her presenting complaint. In the medical records of these women veterans, notations during the admitting history and physical should reflect the date that the patient had received such exams.

(Page 2)

HONORABLE LANE EVANS

Many health professionals feel that unless a woman veteran inpatient requires an immediate pelvic or breast exam for diagnostic purposes, it is better to refer her to the facility's women's clinic/GYN clinic where she will not only receive these exams by specialists in women's health care, but also will be provided patient education and additional gender-specific health care screening.

Question: At which VA facilities are all women inpatients not receiving Pap smears as provided by VA policy?

Answer: The policy is that women who have not had a Pap smear in the previous year will be provided one, unless contraindicated. Some women have had Pap smears through other providers and some refuse the service. However, it is anticipated that most women under VA care would be receiving Pap smears. In a survey of women veterans program activities in FY 1992, 15 medical centers reported no Pap smears done. However, a recent survey indicates that all are now providing Pap smears.

Question: Who is responsible for determining which VA facilities have complied or failed to comply with VA policies concerning the provision of gender specific health care to women veterans?

Answer: Compliance is a local responsibility. In addition, VHA Directive 10-92-030 provides that follow-up responsibility for compliance with such VA policies rests with the ACMD for Environmental Medicine and Public Health.

Question 3: Identify the accomplishments of the August, 1992 conference on VA's research agenda related to women.

Answer: In September 1992, the VA Office of Research and Development sponsored a one-day conference to address an agenda for research on women's health care issues. Participants included staff, researchers, policymakers and clinicians from the Veterans Affairs Central Office and Veterans Affairs Field Programs, and representatives from the Office of the Secretary of Veterans Affairs and the Department of Defense.

The VA Health Services Research and Development Service has begun work on three initiatives discussed at the September conference. These include development of a research project to study breast cancer among women veterans, development of plans for a research consortium with a special focus on women's health care, and liaison with the VA Office of Environmental Medicine and Public Health to plan an evaluation of new clinical initiatives in women's health.

Question 4: Since the 1985 "Survey of Women Veterans" reported that the lifetime prevalence of cancer among women veterans is nearly twice the rate for American women in general, what additional studies on the incidence of women veterans cancer have been conducted? Please summarize the results of each study.

Answer: Since the publication of the "Survey of Women Veterans" in 1985, no additional studies of the incidence of women veterans cancer have been conducted. However, VA investigators in the Environmental Epidemiology Service (116E) have completed and published (in the American Journal of Epidemiology) a study

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entitled "Mortality Among Women Vietnam Veterans, 1973-1987." This study included data on deaths due to cancer. Women Vietnam veterans had lower-than-expected mortality from all causes of deaths combined. However, compared with death rates for U.S. women, mortality from cancer of the pancreas and uterine corpus was significantly elevated among Vietnam veteran nurses. Although this study is substantially different in design and focus from the 1985 study, it is an important epidemiological effort to understanding the health problems of women veterans. Further, since 1985 approximately 200 studies have been conducted by VA investigators on breast cancer.

The HSR&D Service has just approved a pilot study with several objectives, including the construction of sample frames and survey instruments to be used for a national survey of women veterans to assess prevention practices, barriers to early detection, women's preferences related to early cancer detection and chemo-prevention strategies.

Question 5: How many VA medical facilities included education and training on services specific to women in their inservice and continuing education programs, as required by VA policy?

Answer: In a survey conducted in August 1989, 107 facilities indicated that they have had staff education regarding women veteran issues as part of the in-service education programs.

Currently no one has been assigned a monitoring responsibility. The issue of monitoring compliance with guidelines will be considered as a part of the comprehensive review that is being undertaken for all policies and guidelines related to the women veterans program.

Question 6: Which VA facilities do not have written plans for providing breast screening services which includes physical examination, education and mammography, as required by VA policy?

Answer: All VA facilities have written plans for the provision of health care services to women veterans, which include plans for offering breast and pelvic exams, Pap smears and mammograms. Copies of these plans were forwarded to the ACMD for Environmental Medicine and Public Health per VHA Directive 10-92-030. In the VA Central Region, facilities were asked to review and update their policies by August 1993. As regional women veterans coordinators are appointed in all VA regions, review of facility policies will be conducted and requests for revisions made.

Question: Who is responsible for monitoring facility compliance with this VA policy?

Answer: Follow-up responsibility, per VHA Directive 10-92-030, was assigned to the ACMD for Environmental Medicine and Public Health. However, in VA regions with regional women veterans coordinators, oversight of the provision of health care services to women veterans has become part of the regional coordinators' responsibility.

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- Question 7: How many examinations are generally required per year to establish in-house VA facility mammography?
- Answer: Current VA policy requires a minimum of 300 mammography exams per year to establish an in-house mammography program. This is the minimum number of exams considered generally necessary for cost effective utilization compared with contracting for the services outside the facility. Interpreting radiologists are required to read a minimum of 480 mammograms per year as promulgated in the American College of Radiology Mammography Accreditation Program requirements to maintain clinical competence. This is possible since workloads of 300 exams per year would not require a full-time radiologist and the radiologist may be reading mammograms elsewhere in the community.
- Question 8: Since May 1991, have all applicants for VA research documented the planned inclusion of women in the proposed study, as required by VA policy?
- Answer: VA policy requires the inclusion of minorities and women, in clinical research studies, particularly in population-based studies. Applicants routinely document their plans regarding the inclusion of subjects (in clinical research) according to gender. The primary mechanisms for oversight of investigator compliance are local review of proposals by the Research and Development Committees and the review by the Merit Review Boards in Central Office. We have instructed both review groups to attend to the inclusion of women and minorities, and, they have sought to deal with the requirement.
- Question: Under what conditions are women not required to be included or adequately represented in VA supported research?
- Answer: Women must be included in clinical research studies whenever possible and scientifically desirable. There are times when, because of the largely male population, sufficient women to provide statistical significance are not included. When this occurs, the investigator is required to document that every reasonable effort was made to recruit women patients. Further, there are also instances when the inclusion of women in a clinical study is not meaningful, as in studies of prostate disease.
- Question: How many times has VA waived this requirement?
- Answer: We have no record of having been asked to waive the policy stated in our internal manual (M-3, Part I, chapter 14).
- Question 9: Why haven't written job descriptions, including duties and responsibilities, been established for all Women Veterans Coordinators?
- Answer: Since no special funding was provided for hiring women veterans coordinators when the position was first established, most were collateral assignments and inclusion of these duties was left up to the individual VA medical centers. Recently, the Central Region published an addendum to a position description for facilities within that region. With the funding of full-time

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women veterans coordinators at eighteen VA medical centers, a written job description has been drafted and will be in place for those coordinators. An addendum to the job description of part time coordinators is being drafted as a part of guidelines for women veterans programs.

Question: Have written job descriptions, including duties and responsibilities been provided to each Regional Women Veteran Coordinator? Please submit this information for the record.

Answer: Job descriptions have been developed for each Regional Women Veteran Coordinator. A copy of each job description is attached.

Question 10: Will the next Survey of Veterans provide comprehensive information on the awareness and use of veterans benefits by women veterans?

Answer: Interviewing for the National Survey of Veterans began in July 1993. This survey includes comprehensive questions on the awareness and use of veterans benefits, and the sample of veterans chosen for the study does include women veterans. Some analyses of this group may be feasible; however, because of the small proportion of women in the veteran population, detailed analyses will not be possible. Public Law 102-585 does direct the Secretary to conduct a study to determine health care service needs of women veterans, but only if funds are provided for this purpose in an Appropriation Act. Should funds be provided, a study specifically designed to address women veteran health care needs would allow for more detailed analyses.

Question 11: Should VA submit data on diagnosed cancer in female and male patients to each state's centralized state tumor registry program, as has been recommended by Ms. Bette Davis?

Answer: States cannot order VA medical centers to provide data to centralized state tumor registries, but the VA encourages submission of cancer data to such state tumor registry programs to the extent possible, consistent with laws and regulations governing disclosure of patient information.

Currently, about 70 VA medical centers are reporting to some 36 state tumor registries.

VA laws and regulations restrict the types of information that may be provided without patient consent. The nature of the state laws in individual states is a factor in what information may be released.

Also, there are additional restrictions on release of patient information relating to such conditions as HIV/AIDS, alcohol and drug abuse, and sickle cell anemia disease.

Question 12: When is it appropriate to place a woman veteran exhibiting PTSD symptomology on a locked psychiatric unit?

Answer: A general response to this question is that the criteria for appropriateness of admission of any veteran to a locked unit is based on the severity of illness of that patient at that time.

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Most VA general psychiatry units are "lockable." In other words, they are preferably kept unlocked, to provide the least restrictive treatment environment, but they can be locked if there is a clinical situation that warrants increased security. There are some special units (e.g., Psychiatric Intensive Care Units) that are anticipated to be locked because they are designed to treat patients whose behavior presents a severe risk to themselves or others. It is possible that a veteran, male or female, suffering from an acute and/or severe episode of PTSD, might be so much at risk of harming themselves or others as to warrant care on a locked unit.

Question 13: Has VA responded to the recommendations made by the Advisory Committee on Women Veterans in their July, 1992 report?

Please submit a copy of VA's response to each of these recommendations.

Answer: The Report has been sent to the appropriate offices in VA for response. A copy of that response will be provided when the review has been completed.

Question 14: How will each of the four Women Veterans Comprehensive Health Care Centers serve as a resource for providing a full range of services for women veterans in a specific geographic area?

Answer: The four centers were selected, in part, based on the capability to establish "pilot" or "model" programs for duplication throughout VA. The selection criteria included: ability to support a primary service area having a large number of women veterans; having staff with the specialized clinical expertise required; and having expert interdisciplinary teams to provide care, monitor the evolving needs of women veterans at various age groups and demonstrate outreach efforts. Centers were then also judged on the extent that these "pilot" or "model" programs could be established in localities lacking a sufficient quantity or range of community services for women veterans (i.e., hopefully establish the first four centers where VA could demonstrate a significant impact on services). Centers were also judged on their capacity to participate in the research and population survey components of Public Law 102-585. It is the goal of VHA to implement additional Women Veteran Comprehensive Health Care Centers - duplicating these four "pilot" or "model" programs. It is unlikely that women veterans will be willing to travel a greater distance, i.e., outside their primary service area, for their routine preventive care. Therefore, the major concept for the centers was not that of a larger geographic referral center, but rather the smaller primary service area.

Question: How will each Center support the VA facilities located in its geographic service area?

Answer: This will, of course, fully develop over time. However, as stated above, it is the goal of VA that each "model" center will offer the specialized services developed from their added programs to the other VA facilities within their primary service area. The centers will serve to complement existing programs within the primary service area, through the establishment of new or expanded services. In addition, each

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HONORABLE LANE EVANS

center will share consultation, teaching, research, data collection, and monitoring techniques concerning women veterans health care with staff at VA medical centers within their primary service area, as well as the entire VA system.

Question: What minimum services will each Center make available to each facility located in its geographic service area?

Answer: The uniqueness of each primary service area (i.e., its unique demographics, staff clinical expertise, and existing women veterans health care programs) generated four "model" centers each having a slightly different focus. However, as a minimum, within its primary service area, each center will (1) foster outreach and improve access to comprehensive medical and psychological care for women veterans (both preventive and routine); (2) provide state-of-the-art diagnostic, treatment, consultation and referral; (3) coordinate medical/surgical health care services and psychological care for the detection and coordination of specialty mental health needs; (4) collect, develop and analyze data derived from the experiences of the "pilot" program to assist in planning for women veterans services throughout the larger VA system; and (5) utilize and share appropriate clinical indicators and monitoring activities to assure quality of care.

Question 15: Please provide the criteria used by VA to select the 22 facilities which were notified on July 18, 1993, they were receiving a full-time Women Veterans Coordinator position.

Answer: The decision on the locations of the funded WVCs was made on the basis of workload, interest as demonstrated by submitting a proposal for a comprehensive center, and demographics (women in the PSA or Primary Service Area). Finally, some effort was made to equalize geographic distribution, even though there is a very uneven population density of women veterans, the most densely populated states being California (146,210), Florida (85,436), Texas (72,759), and New York (56,266).

Question 16: Identify the members of VA's Women Veterans Health Program National Steering Committee and provide the criteria used to select the members of the Committee.

Answer: Members:

Joan W. Lightfoot, M.B.A. (Chairman)
Women Veterans Health National Education Coordinator
Birmingham Regional Medical Education Center
Department of Veterans Affairs
Birmingham, Alabama

Susan H. Mather, M.D., M.P.H. (Co-Chairman)
Office of Environmental Medicine and Public Health
Veterans Administration Central Office
Washington, DC

Barbara Bartman, M.D.
VA Medical Center
Baltimore, Maryland

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Members (continued):

Joan Furey, RN, M.A.
National Center for PTSD
VA Medical Center (Menlo Park)
Palo Alto, California

Marie Gilbert, Ph.D.
Vet Center
St. Petersburg, Florida

Susan Laing
Learning Resources Center
VA Medical Center
Birmingham, Alabama

Susan K. Sverha, RN, M.S.N.
Office of Academic Affairs
Veterans Administration Central Office
Washington, DC

Cathy Wright, RN
Women Veterans Coordinator
VA Medical Center
Lincoln, Nebraska

Barbara Brandau
Women Veterans Program Chief
Veterans Administration Central Office
Washington, DC

Andrea Love
Acting Special Assistant for Women Veterans Programs
Office of Environmental Medicine and Public Health
Veterans Administration Central Office
Washington, DC

Josephine Schuda
Office of Public Affairs
Veterans Administration Central Office
Washington, DC

Paul Smith
Learning Resource Center
VA Medical Center
Salt Lake City, Utah

Sandra Marshall, M.D.
VA Medical Center
Washington, DC

Selection was based on their knowledge of women's health issues, women veterans issues, and educational strategies. The members represent expertise in ambulatory and primary care, psychology and sexual trauma, nursing, women veterans coordinators programs, outreach and readjustment counseling.

Question 17: How many medical center directors transmitted through the Region to the Associate Chief Medical Director for Operations by May 1, 1992, an inventory of privacy deficiencies and associated corrective actions which the director had certified, as was required by VA directive?

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- Answer:** All VA facilities transmitted inventories of privacy deficiencies identified by teams of facility staff through their regions to the Associate Chief Medical Director for Operations, per VHA Directive 10-92-038. However, not all facilities had privacy deficiencies to report. The regions have resolved and/or funded solutions for a number of these problems and others have plans for resolution in FY 94 or later. Tracking of these issues is completed on a quarterly basis in all regions.
- Question:** When was a tracking mechanism for corrective actions, as required by VA directive, established?
- Answer:** Tracking mechanisms for corrective actions were developed as follows: Eastern Region, June 1992; Central Region, April 1992; Southern Region, April 1992; and Western Region, March 1992.
- Question:** How many privacy deficiencies were certified by medical center directors? How many of these privacy deficiencies have been completely corrected?
- Answer:** In Western Region, 115 deficiencies were cited, 9 of which have been corrected. An additional 8 projects are ongoing, with completion scheduled in FY 94 and FY 95. Of the 115, 24 were major construction, 31 were minor construction, 33 were minor miscellaneous construction, 23 were non-recurring maintenance projects and 4 were facility-level projects. In the Central Region, 57 deficiencies were noted, 31 of which were approved for funding. And, 36 deficiencies were corrected prior to submission of the final report and another project has since been completed. A total of 25 projects was unfunded. In the Eastern Region, 100 deficiencies were noted, 37 of which have been corrected.
- Question:** What is the maximum amount of time which could elapse before a recognized privacy deficiency was corrected?
- Answer:** There are no VA facilities that cannot accommodate women patients, including domiciliaries and nursing homes. Even in facilities with major privacy deficiencies, there are still areas of the facility appropriate for housing and caring for women patients. Many corrective actions required the purchase of privacy screens and curtains. However, several of the deficiencies identified required major construction to correct, such as remodeling of inpatient ward space to provide more private rooms and bathrooms or more conveniently located bathrooms. As these are expensive projects and as no additional construction monies were allocated to specifically address privacy deficiency projects, the correction of some deficiencies may take years. Of the projects funded, the longest time to elapse would be 2 years.
- Question 18:** When a VA medical center does not offer required gender specific health care to women veterans, which medical center official(s) should be held accountable by VA for that facility's failure to provide gender specific care to women veterans?

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HONORABLE LANE EVANS

Identify each VA medical facility at which a facility official has been held accountable during the last year for the failure of that facility to provide required gender specific health care to women veterans. Describe the methods of accountability which have been used.

Answer: Accountability for provision of health care services, for both men and women within a VA facility, is a performance requirement for facility top management officials. However, VA has not found it necessary to take corrective action against responsible management officials for not providing sufficient health care services to women veterans. In cases where the full range of gender specific health care services has not been provided to women veterans, the causes have been found to be lack of resources and lack of qualified staff to provide such services. VA has chosen to take a more proactive approach to the problem of inadequate provision of gender specific health care services. This approach has included staff education, program guides, committees and task forces, conferences, and the appointment of facility women veterans coordinators and regional women veterans coordinators. The Western Region has ensured that appropriate services are available to women veterans through communication of the importance of the women veterans program to facility management, through provision of program guides and consultation, and through the development of a Women's Committee of the Regional Planning Board and a Regional Director's Women Veterans Advisory Group. The Central Region has included review of facility women veterans programs in regional review programs and site visits, the publication of a regional program guide, the sponsoring of clinical staff training programs in women's health care issues, and the planning of conferences and teleconferences. All VA regions ensured that the funded women veterans coordinator positions were given to facilities located in geographic areas with the largest women veteran patient populations. Through the funding of 4 comprehensive women's health care centers in FY 93, VA has begun a process of developing centers of excellence in women's health care. These centers will offer training and consultation to staff throughout each region as well as opportunities for research. VA is also looking at incentives and ways to encourage facilities to enhance the gender specific health care services they currently offer to women veterans. Incentives could include awards and funding for special equipment requests. In the spirit of total quality improvement, it is better to educate and encourage facility staff and management than to reprimand them for not providing adequately for all health care needs in the past.

In addition, the appropriate provision of care for any veteran, male or female, is not limited to on-site VA services. VA management is responsible for ensuring that veterans have access to needed health care on-site as well as through contract or sharing agreement services. In some cases, it is more appropriate to provide highly-specialized services in a university medical center setting by specialists. For example, gynecologic oncology (cancer) surgeries require a great deal of expertise and experience to maximize successful outcomes for patients. It is far better to contract out for these services when such specialists are not available within VA facilities. Therefore, it should not be considered a deficiency if a VA facility does not provide all aspects of gender-specific services to women or men so long as that facility provides timely access to needed services through non-VA sources.

REGIONAL WOMEN VETERANS COORDINATOR
CENTRAL REGION

I. Principal Duties and Responsibilities

DRAFT

The Incumbent is the Regional Women Veterans Coordinator for the Central Region. The incumbent is responsible for overseeing the performance of duties by women veterans coordinators at 42 medical centers and 9 outpatient clinics in the Region. The purpose of these functions is to assure the provision of comprehensive, high quality health care to women veterans in the Region.

As Regional Women Veterans Coordinator, the incumbent has the following responsibilities:

A. Program Coordination:

1. Education and Training The Regional Women Veterans Coordinator will provide orientation and training to women veterans coordinators at medical centers in the Central Region. This will include instruction on the role of the women veterans coordinator, recommended duties, reporting requirements, and time allocation. The Regional Coordinator will provide each women veterans coordinator with information pertinent to her duties, including the Regional Women Veterans Program Guide; copies of VHA directives and manual chapters regarding women veterans; and samples of brochures, hospital policies, and forms for use in their work with women veteran patients. The Regional Coordinator will keep the women veterans coordinators informed about national and Regional programs, policies, and initiatives regarding women veterans. The Regional Coordinator will disseminate information on pending legislation, research, and resources to women veterans coordinators. The Regional Coordinator will organize Regional training for women veterans coordinators and will assist in the planning for national VA conferences for women veterans coordinators.

2. Networking The Regional Coordinator will develop a network of women veterans coordinators at medical centers in the Central Region. Networking activities will include publication of quarterly women veterans coordinators newsletters, moderation of quarterly women veterans coordinators conference calls, and use of the Region's electronic mail system FOURWORD for dissemination of information to women veterans coordinators.

REGIONAL WOMEN VETERANS COORDINATOR
CENTRAL REGION

DRAFT

I. Principal Duties and Responsibilities (continued)

3. Consultation The Regional Coordinator will serve as a consultant to women veterans coordinators at medical centers in the Central Region. The Regional Coordinator will assist women veterans coordinators in the resolution of problems in the delivery of services to women veterans and in the development and enhancement of women veterans programs. This will include assistance in writing hospital policies on health care for women, responding to VHA directives and circulars, responding to congressional inquiries and surveys, and overseeing medical center women veterans programs.

B. Program Liaison:

1. Coordinator Liaison The Regional Coordinator will serve as liaison between women veterans coordinators and Central Region staff. The Regional Coordinator will represent the needs of women veterans coordinators to Central Region staff and will advocate for enhancement of support for medical center women veterans programs.

2. Director's Collateral Assignment The Regional Coordinator will work closely with the medical center director with the Region's Women Veterans Program as his/her collateral assignment. The Regional Coordinator will assist with preparation of quarterly collateral assignment status reports and will keep the director informed about current activities within the Region's Women Veterans Program.

3. Central Region Staff The Regional Coordinator will assist Central Region staff and task forces, including technical advisory groups, with issues pertaining to women veterans. The Regional Coordinator will make presentations and give briefings on the Regional Women Veterans Program as directed. The Regional Coordinator will compile responses from medical centers in the Region to VHA directives and requests for information and will prepare summaries of responses.

II. Supervisory Controls Over the Position

The incumbent is under the supervision of the Regional Nurse, Central Region for program direction and guidance. Administrative responsibility for the position.....

Reg. 0113

POSITION DESCRIPTION (Please Refer Instructions on the Back)

1 Reason for Submission: ☐ Redescription ☒ New ☐ Hours ☒ Field ☐ Other

2 Reason for Submission: ☐ Reestablishment ☐ Other

3 Location of Position: Jackson, MS

4 Location of Position: Jackson, MS

5 Agency Position No.

6 UFM Certification No.

7 Fair Labor Standards Act: ☒ Exempt ☐ Nonexempt

8 Financial Statements Required: ☐ Executive Personnel ☐ Financial Statement ☐ Employment and Financial Interests

9 Subject to Action: ☐ Yes ☒ No

10 Position Status: ☒ Competitive ☐ Excepted (Specify in Remarks)

11 Position Is: ☒ Supervisory ☐ Managerial ☐ Neither

12 Sensitivity: ☒ 1-Non Sensitive ☐ 2-Moderate Sensitive ☐ 3-Critical Sensitive ☐ 4-Special Sensitive

13 Competitive Level Code

14 Agency Use

15 Classified/Graded by: ☐ U.S. Office of Personnel Management ☐ Department, Agency or Establishment ☐ Second Level Review ☐ First Level Review

16 Organizational Title of Position (if different from official title): Program Analyst

17 Name of Employee (if vacant, specify): GM 343 13

18 Department, Agency or Establishment: Department of Veterans Affairs

19 Third Subdivision: Office of the Regional Chief of Staff

20 First Subdivision: Veterans Health Administration

21 Second Subdivision: Southern Region

22 Fifth Subdivision

Employee Review—This is an accurate description of the major duties and responsibilities of my position.

23 Supervisory Certification: I certify that this is an accurate statement of the major duties and responsibilities of this position and its organizational relationships, and that the position is necessary to carry out Government functions for which I am responsible. This certification is made with the knowledge that this information is to be used for statutory purposes relating to appointment and payment of public funds, and that false or misleading statements may constitute violations of such statutes or their implementing regulations.

a. Typed Name and Title of Immediate Supervisor: Robert E. Lynch, MD
Associate Regional Chief of Staff

b. Typed Name and Title of Higher-Level Supervisor or Manager (optional): John R. Higgins, MD
Regional Chief of Staff

24 Classification/Job Grading Certification: I certify that this position has been classified/graded as required by Title 5, U.S. Code, in conformance with standards published by the U.S. Office of Personnel Management or, if no published standards apply directly, consistently with the most applicable published standards.

25 Position Classification/Standards Used in Classifying/Grading Position

Information for Employees: The standards, and information on their application are available in the personnel office. The classification of the position may be reviewed and corrected by the agency or the U.S. Office of Personnel Management. Information on classification/job grading appeals, and complaints on exemption from FLSA, is available from the personnel office or the U.S. Office of Personnel Management.

26 Position Review: Initials Date Initials Date Initials Date Initials Date Initials Date

a. Employee (optional)

b. Supervisor

Classifier

Remarks: In the performance of official duties, the employee has regular access to printed & electronic files, containing sensitive data which must be protected under the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, VA statutes and policy and VHA policy. The employee is responsible for 1) protecting that data from unauthorized release from loss, alteration, or unauthorized deletion and 2) following applicable regulations and structures regarding access to computer files, release of access codes, etc., as set out

REGIONAL WOMEN VETERANS COORDINATOR

Background Information:

The Southern Region, 1 of 4 within the VA's Veterans Health Administration (VHA), includes 43 VA medical centers, 1 independent outpatient clinic, 32 nursing homes, 9 domiciliaries, and 39 satellite outpatient and community health clinics. Facilities include on the average, 20,000 operating hospital beds, 3,231 nursing home care beds, and 2,166 domiciliary beds. Region 3 supports the operations of 51 Readjustment Counseling Centers, 13 DVB Regional Offices and 30 National Cemeteries. Additionally, the Region supports the operation of 49 Vietnam Veteran Outreach Centers. The Region provides health care to the 7.3 million veterans who reside in 11 states plus the Commonwealth of Puerto Rico and the Virgin Islands. This area spans approximately 1.2 million square miles.

The Region employs more than 57,000 individuals and has a budget in excess of \$3 billion. Annually, the Region treats more than 350,000 inpatients and provides 6 million outpatient visits. The medical facilities vary in complexity and include highly affiliated institutions which serve an important role in this country's medical education and research.

The Office of the Regional Director is located in Jackson, Mississippi, and has three decentralized RDO support sites in Atlanta, Georgia; Grand Prairie, Texas; and Bay Pines, Florida.

I. Principal Duties and Responsibilities

In conjunction with the Department's emphasis on women veterans' health care issues, the incumbent provides program management; plans, designs and executes activities to ensure the effectiveness of health care delivery for women veterans in the Region. The incumbent will help formulate, effect, execute, evaluate, and assure compliance of all VHA policies and regulations and other relevant requirements concerning the Women Veterans Program. Maintains liaison with Regional and Central Office planning and construction programs aiding in the development of program feasibility criteria for all Southern Region programs affecting female veterans.

Assures through program management that women veterans receive the full compliment of health care services. In addition to general medical, surgical, psychiatric, intermediate and extended care services the program manager fosters development of programs to meet the specific needs of women veterans by providing for example:

2.

- Preventive health care including mammography, and gynecological examinations
- Counseling services addressing the special needs of women veterans
- Patient room and bath privacy

Incumbent provides support and advice to the Regional Director in the area of significant public and consumer affairs issues concerning women veterans' health care. Incumbent ensures appropriate responses are provided to all inquiries received in the Region pertaining to women veterans' health care issues: These inquiries include contacts from patients, their families, service organizations, Congressional offices, the Secretary's office, VHA and VBA officials and other interested parties; includes controlled correspondence received from VACO, I.G. Hotline reports, and all other third party referrals. Develop or assist medical centers with promotional events and media coverage of activities designed to enhance public perception of women veterans' health care in the VA, coordinating with public affairs specialists in the Region and Central Office.

The incumbent will be responsible for establishing methodology to evaluate facility programs through Regional review programs, including site visits, and development of tracking trending process. Submits reports and recommendations to the Regional Director through the Regional Chief of Staff. This includes evaluation of medical center project proposals, problems and program developments. The incumbent formulates recommendations, provides guidance and makes decisions based on an in-depth knowledge of women veterans' health care delivery management systems. Recommendations and proposed solutions are made to organizational policy decision makers, and often result in changes in management policies and practices having Region or agency wide impact.

Works closely with Quality Assurance staff in developing criteria for appropriate monitoring of the adequacy, quality and access to health care for women veterans. Develops and maintains a centralized data base of indicator factors.

The Regional Coordinator is responsible for providing training to newly appointed women veterans coordinators, and provides continuing information and education for coordinators. Plans and conducts Regional training conferences. Serves as technical advisor and consultant to facility programs; assists field coordinators in developing and improving their women veterans programs. Serve as liaison between field coordinators, Regional Office and Central Office staff; trouble-shooting and problem-solving issues brought by the coordinators media and other interested parties. Plays a vital role in program oversight; the direction and formulation of

new initiatives for female veterans, and assuring the best interest of both patients and the Development are served.

May be asked to serve on national, regional, local task force, committees, and represent the Regional Director on all issues related to the Women Veterans Program.

The incumbent develops and maintains effective working relationships with women veterans' organizations and auxiliaries. Presents information to and about women veterans to community organizations. Develops marketing strategies to meet the needs of all female veterans in the Southern Region catchment areas.

The Regional Coordinator publishes a quarterly newsletter and disseminates information from VACO and the Region. Develops or evaluates proposed policy issuances and provides assistance to both management and program officials on policy guidance.

In the performance of official duties, the employee has regular access to printed and electronic files containing sensitive data which must be protected under the provisions of the Privacy Act of 1974, and other applicable laws, federal regulations, VA statutes and policy, and VHA policy. The employee is responsible for (1) protecting data from unauthorized release or from loss, alteration, or unauthorized deletion, and (2) following applicable regulations and instructions regarding access to computerized files, release of access codes, etc., as set out in a computer access agreement which the employee signs.

The Regional Coordinator may also be assigned other health care administration duties such as responsibilities for national coordinating activities for the bone-marrow transplant board.

Coordinates with the planners in the RDOs for women veterans initiatives; assists with training on women veterans' health care for the facility planners and serves on the Regional Planning Board.

Assists with activities related to the community nursing home program and pilots for adult care, homemaker, and home health aid services.

II. Supervisory Controls

The Regional Associate Chief of Staff provides general administrative guidance with assignments in terms of broadly defined policy objectives. The Women

Veterans Coordinator is the region-wide program manager and independently formulates

plans, directs and implements program objectives, and processes for achieving a successful Regional Women Veterans Program. Accomplishments are considered technically authoritative, and are usually accepted without change.

III. Other Significant Facts

The incumbent possesses in-depth knowledge of women's health care issues and other broad, related issues specific to women veterans with the ability to apply managerial, statistical, and technical interpretations of broad based information for analysis, evaluation, and presentation for persuasive value. In addition, this knowledge is especially required in advising the Regional Director, Regional Chief of Staff, Regional Planner, and Construction Manager, providing guidance to medical center directors. The scope and impact of recommendations are of such magnitude that they present significant management demands on the program manager in providing effective program leadership in the decision making process of the Regional Director and Medical Center Directors. Decisions directly affect the success of the program. The incumbent has authority to expand and extend the VACO policies in adopting them to the peculiarities of the Southern Region, and those of the individual medical centers. The incumbent must possess teaching ability, effective presentation skills, and the willingness to make public address on the issues of the VA Women Veterans Program both within the agency and to interested veterans groups and other external bodies. The incumbent must possess the ability to interact effectively with all levels of personnel in the private and public sectors. Knowledge of laws and regulations concerning eligibility requirements and benefits for veterans will also be required.

V. A. WESTERN REGION (134)

301 HOWARD STREET, SUITE 700
 SAN FRANCISCO, CALIFORNIA 94105

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FAX 415-744-7504

FAX 415-744-7513



DATE: 2-22-93
 TO: Daniel Given
 FAX #: 700-523-1618
 FACILITY: DFS (134)
 FROM: Sharon Daugherty
 SUBJECT: Women Vet Coor P.D. as per
your request.
 COMMENTS: _____

TOTAL PAGES 4 (INCLUDING THIS COVER SHEET)

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Keeps abreast of current literature, research and legislation related to female veterans and incorporates this knowledge into program and policy development.

II. Supervisory Controls over the Position:

The incumbent is responsible to the Regional Chief of Staff for coordination of the Women Veterans Program for the Western Region. Program direction and guidance are received from the Regional Chief of Staff or designee.

III. Other Significant Data:

The incumbent must be knowledgeable of women's health care issues and other issues specific to women veterans. Teaching ability and the willingness to speak in public is required. The incumbent must demonstrate an ability to interact effectively with all levels of personnel in the private and public sectors. The incumbent will be required to represent the Western Region in the community at large. Must have knowledge of eligibility requirements and benefits for veterans.

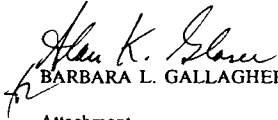
ATTACHMENT TO QUESTION NO. 9
(HONORABLE LANE EVANS)

DEPARTMENT OF
VETERANS AFFAIRS

Memorandum

Date MAR 16 1993
From Regional Director (131/RN)
Subject Position Description for Women Veterans Coordinator
To Director, Field Support (131/DFS)

1. Attached is a position description for the Eastern Region's Women Veterans Coordinator position.
2. If you have any questions, please call either of the Regional Nurses, Ms. Anna Mae Fowler or Ms. Pamela Jackson-Malik, at FTS 410-687-8986.


BARBARA L. GALLAGHER

Attachment

**REGIONAL WOMEN VETERANS COORDINATOR
EASTERN REGION**

I. Principal Duties and Responsibilities

The purpose of these functions is to assure the provision of comprehensive, high quality health care to women veterans in the Region. The Eastern Region Women Veterans Coordinator is responsible for overseeing the performance of duties by women veteran coordinators at 45 Medical Centers.

As RWV (Regional Women Veterans) Coordinator the incumbent has the following responsibilities:

A. Program Coordination:

1. Education and Training: The RWV Coordinator will provide orientation and training to women veterans coordinators at Medical Centers in the Eastern Region. This will include instruction on the role of the women veterans coordinator, recommended duties, reporting requirements, and time allocation. The Regional Coordinator will provide each women veterans coordinator with information pertinent to her duties, including the RWV Program Guide; copies of VHA directives and manual chapters regarding women veterans; and sample of brochures, hospital policies, and forms for use in their work with women veteran patients. The RWV Coordinator will keep the women veterans coordinators informed about national and Regional programs, policies, and initiatives regarding women veterans. The RWV Coordinator will organize Regional training for women veterans coordinators and will assist in the planning for national VA conferences for women veterans coordinators.

2. Networking: The RWV Coordinator will develop a network of women veterans coordinators at Medical Centers in the Eastern Region. Networking activities will include publication of quarterly newsletters, moderation of conference calls, and use of the Region's electronic mail system FORUM/TROY for dissemination of information to women veterans coordinators.

3. Consultation: The RWV Coordinator will: serve as a consultant to women veterans coordinator at each Medical Center in the Eastern Region; assist women veterans coordinators in the resolution of problems in the delivery of services to women veterans; and in the development and enhancement of women veterans programs. This will include assistance in writing hospital policies on health care for women, responding to VHA directives and circulars, responding to congressional inquiries and surveys, and overseeing Medical Center women veterans programs.

B. Program Liaison:

1. Coordinator Liaison: The RWV Coordinator will serve as liaison between women veterans coordinators and Eastern Region staff and represent the needs of women veterans.

2. Eastern Region staff: The RWV Coordinator will assist Eastern Region staff and task forces, including technical advisory groups, with issues pertaining to women veterans. The RWV Coordinator will make presentations and give briefings on the RWV Program as directed. The RWV Coordinator will compile responses from Medical Centers in the Region to VHA directives and requests for information and will prepare summaries of responses.

II. Supervisory Controls Over the Position

The incumbent is under the supervision of the Regional Nurse, Eastern Region, for program direction and guidance. Administrative responsibility for the position include data collection, annual reports, and other duties as assigned.

ATTACHMENT TO QUESTION NO. 9
(HONORABLE LANE EVANS)

**DEPARTMENT OF VETERANS AFFAIRS
VHA SOUTHERN REGION
REGIONAL WOMEN VETERANS COORDINATOR
FUNCTIONAL STATEMENT**

Incumbent serves as the Southern Region's Women Veterans Coordinator providing direct support to Women Veterans Coordinators throughout the Southern Region in a variety of issues affecting the delivery of health care to women at 44 VA health care facilities. The Region provides health care to the 7.3 million veterans who reside in the 11 states of Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas.

The Regional Coordinator is responsible for providing training to newly-appointed women veterans coordinators, assists medical centers in developing women veterans programs, serves as consultant to the coordinators, and advises the Regional Director's staff on issues pertaining to the provision of services to women.

The Regional Coordinator publishes a quarterly newsletter and disseminates information from VA Central Office and the Region. Presents briefings to the Regional Director, Regional Chief of Staff, and Regional Nurses on pertinent issues.

The Coordinator assures the compliance of the Women Veterans Program with all existing VHA policies and regulations and other relevant requirements. Provides assistance and guidance to the medical center coordinators and/or staff. Maintains liaison with regional and central planning and construction programs aiding in the development of program feasibility criteria for all Southern Region programs affecting female veterans. Recommends building modifications to reflect the needs of women patients.

Maintains listing of women veterans coordinators in the Region and communicates changes to Region and VACO.

Provides continuing education for coordinators (e.g., regional training conferences). Coordinates quarterly conference calls for all Southern Region Coordinators and actively participates in conference calls with the four Regional Coordinators.

Assist field coordinators in developing and improving their women veterans programs.

Serves as liaison between coordinators and Regional Director's staff and VA Central Office, trouble-shooting and problem-solving issues brought by the Coordinators. Plays a vital role in program oversight and the direction and formulation of new initiatives for female veterans.

Presents information to and about women veterans to the community. Develops and maintains effective working relationships with women veterans organizations and auxiliaries. Develops marketing strategies to meet needs of all female veterans in Southern Region catchment areas.

Works closely with the quality management staff in developing criteria for monitoring the adequacy, quality and access to health care for women veterans and maintains centralized data base of indicator factors and outcomes of quality improvement initiatives.

Coordinates field input and prepares reports and responses for information from VA Central Office and other public and private agencies.

Serves as a member on various national, regional and local committees, acts as a spokesperson and represents the entire Southern Region on all issues related to the Women Veterans Program.

Performs annual program evaluation and assessment of female veteran program (s) in Southern Regional/VA medical centers.

Keeps abreast of current literature, research and legislation related to female veterans and incorporates this knowledge into program and policy development.

Collateral duties:

Assumes responsibilities for national coordinating activities for the bone marrow transplant board.

Coordinates with the planners in the regional division office (RDO) for women veterans initiatives; assists with training on women veterans

health care for the facility planners; serves on the Regional Planning Board.

Assists with activities related to the community nursing home program and pilots for adult care, homemaker and home health aid services.

II Supervisory Controls over the Position:

The incumbent is responsible to the Regional Chief of Staff for coordination of the Women Veterans Program for the Southern Region. Program direction and guidance are received from the Regional Chief of Staff or designee.

III Other Significant Data:

The incumbent must be knowledgeable of women's health care issues and other issues specific to women veterans. Teaching ability and the willingness to speak in public is required. The incumbent must demonstrate an ability to interact effectively with all levels of personnel in the private and public sectors. The incumbent will be required to represent the Southern Region in the community at large. Must have knowledge of eligibility requirements and benefits for veterans.

ATTACHMENT TO QUESTION NO. 9
(HONORABLE LANE EVANS)

Incumbent serves as the Western Region's Women Veterans Coordinator providing direct support to Women Veterans Coordinators throughout the Western Region in a variety of issues affecting the delivery of medical care to women veterans at 36 medical facilities, 5 independent outpatient clinics, 24 nursing homes and 1 independent domiciliary, and 4 Regional District Offices. The Region provides health care to the 5.3 million veterans who reside in the 13 states of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming. In addition, Western Region jurisdiction includes VA services provided to veterans in the Philippines and the territories of the Pacific Basin, including Guam, American Samoa and the Trust Territory of the Pacific.

The Regional Coordinator is responsible for providing training to newly-appointed women veterans coordinators, assists medical centers in developing women veterans programs, serves as consultant to the coordinators, and advises the Regional Director's staff on issues pertaining to the provision of services to women.

The Regional Coordinator publishes a quarterly newsletter and disseminates information from VA Central Office and the Region. The Regional Coordinator briefs the Regional Director and Regional Chief of Staff on pertinent issues.

The Coordinator assures the compliance of the Women Veterans Program with all existing VA policies and regulations and other relevant requirements. Provides assistance and guidance to the medical center coordinators and/or staff. Maintains liaison with regional and central planning and construction programs aiding in the development of program feasibility criteria for all Western Region programs affecting female veterans. Recommends building modifications to reflect the needs of women patients.

Maintains listing of women veterans coordinators in the Region and communicates changes to Region and VACO.

Provides continuing education for coordinators (e.g., regional training conferences). Coordinates quarterly conference calls for all Western Region Coordinators and actively participates in conference calls with the four Regional Coordinators.

Assist field coordinators in developing and improving their women veterans programs.

Serves as liaison between coordinators and Regional Director's staff and VA Central Office, trouble-shooting and problem-solving issues brought by the Coordinators. Plays a vital role in program oversight and the direction and formulation of new initiatives for female veterans.

Presents information to and about women veterans in the community. Develops and maintains effective working relationships with women veterans organizations and auxiliaries. Develops marketing strategies to meet needs of all female veterans in Western Region catchment areas.

Works closely with the quality assurance staff in developing criteria for monitoring the adequacy, quality and access to health care for women veterans and maintains centralized data base of indicator factors.

Coordinates field input and prepares reports and responses for information from VA Central Office and other public and private agencies.

Serves as a member on various national, regional and local committees, acts as a spokesperson and represents the entire Western Region on all issues related to the Women Veterans Program.

Performs annual program evaluation and assessment of female veteran program(s) in Western Regional/VA medical centers.

Keeps abreast of current literature, research and legislation related to female veterans and incorporate this knowledge into program and policy development.

II. Supervisory Controls over the Position:

The incumbent is responsible to the Regional Chief of Staff for coordination of the Women Veterans Program for the Western Region. Program direction and guidance are received from the Regional Chief of Staff or designee.

III. Other Significant Data:

The incumbent must be knowledgeable of women's health care issues and other issues specific to women veterans. Teaching ability and the willingness to speak in public is required. The incumbent must demonstrate an ability to interact effectively with all levels of personnel in the private and public sectors. The incumbent will be required to represent the Western Region in the community at large. Must have knowledge of eligibility requirements and benefits for veterans.

QUESTIONS SUBMITTED BY
HONORABLE TERRY EVERETT
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VA PROVISIONS OF HEALTH CARE TO WOMEN VETERANS AND
RELATED ISSUES

JUNE 23, 1993

Question 1: On page 2 of your statement you say that VA's efforts include progress in planning for new research initiatives related to women veterans' health needs. What kind of research do you plan to conduct.

Answer: A research proposal has been developed for a Health Services Research and Development (HSR&D) Service Directed Research project to study the special needs or problems faced by women veterans seeking breast cancer care in the VA health care system. Principal Investigators for this study will be Dr. John Feussner and Dr. Denise Hynes at the Durham VA Medical Center. This study will serve as the pilot phase for a subsequent study to evaluate current primary and secondary prevention practices and rehabilitation therapy for breast cancer among women veterans in the United States, especially women veterans who are eligible for VA health care services. The research proposal has undergone a rigorous peer review and has been approved for scientific merit. The HSR&D Service plans to initiate this research if funds are available in FY 1994.

Plans have begun for establishment of a consortium of HSR&D Field Programs to specifically develop a program of research on women's health care issues. The proposed mission of the consortium will be to improve women veterans' health care through a coordinated effort of research and information dissemination. Although the primary objective of the consortium will be to conduct and coordinate health services research to address the needs of women veterans, the consortium will also provide information and expertise to other researchers, managers and policymakers both within Veterans Affairs and within other federal and non-federal agencies and institutions. The HSR&D Field Programs in Durham, North Carolina; Houston, Texas; Chicago (Hines), Illinois, and Bedford, Massachusetts, will participate in this consortium. Full development of these plans also depends on availability of funding in Fiscal Year 1994.

Coordinated through the HSR&D Management Decision and Research Center, the HSR&D Service is working closely with the ACMD for Environmental Medicine and Public Health to design and implement a series of evaluation studies to be conducted in conjunction with clinical initiatives in women's health care. This effort will be led by Dr. Nelda Wray at the Houston VA Medical Center.

In addition to the health services research planned, VA was mandated by the "Veterans Health Care Act of 1992" to conduct a population survey of women veterans and women on active duty to determine their needs for health care services. The VA Office of Policy and Planning has been tasked with this responsibility. Implementation of this survey is dependent on specific funding for this purpose in our Appropriations Act.

In Fiscal Year 1992 Medical Research Service spent approximately \$2 million to support research initiatives related to the health needs of women veterans. VA

{Page 2}

HONORABLE TERRY EVERETT

investigators received an additional \$6 million from extra-VA sources to conduct research on this topic. Altogether, 90 research projects were supported relevant to women's health issues. As an example of VA research accomplishments in this area, one investigator found that the absence of the female hormone estrogen leads to excessive production of bone scavenger cells (osteoclasts), which literally bore holes into the bones of women, leaving them with a weakened skeletal frame. The identification of this hormonal imbalance paves the way for pharmacologic therapies that can reduce and, quite possibly, someday eliminate this disease.

Medical Research Service plans to increase its emphasis on research relevant to women, especially on breast cancer in Fiscal Years 1994 and 1995, providing the research appropriations permit such initiatives. Since 1985, approximately 200 studies have been conducted in breast cancer.

In summary, VA has made progress in developing plans for enhancing and expanding current research efforts in the area of women's health care. These include HSR&D Service Directed Research, and HSR&D consortium for research on women's health care, systematic evaluation of clinical initiatives in women's health care, and a needs assessment study of women veterans and active military. Full implementation of these plans is contingent on availability of funds in upcoming fiscal years.

Question 2: On page 6 of your testimony, you say full-time Women Veterans Coordinators at selected VA Medical Centers are planned for FY 1994. On what basis will these selections be made?

Answer: The decision on the locations of the funded WVCs was made on the basis of workload, interest in submitting a proposal for a comprehensive center, and demographics (women in the PSA or Primary Service Area). Finally, some effort was made to equalize geographic distribution, even though there is a very uneven population density of women veterans, the most densely populated states being California (146,210), Florida (85,436), Texas (72,759) and New York (56,266).

Question 3: The Inspector General testified that "part of the reason that not all VA Medical Centers offer women veterans health services can be attributed to a lack of specific guidelines from VA Central Office." Would you comment?

Answer: All VA medical centers offer some women veterans health services. However, not all medical centers offer in-house gynecology. It is unclear exactly how the Inspector General defined "women veterans health services," but he appeared to feel that all medical centers should offer the full range of gender-specific services. This is unrealistic when you look at the missions of some VA medical centers. Large tertiary care centers should be able to have a fully developed Women Veterans Health Program with the full array of gender-specific care while small primary care centers may only offer primary care with referrals for more complex services. While directives outlining policy on breast screening, complete physical examinations and privacy have been issued within the past 18 months to supplement the existing policy manual, there are no "specific guidelines from Central Office" describing a women veterans program. Guidelines are currently in the concurrence process with a projected publication date of September 1993.

(Page 3)

HONORABLE TERRY EVERETT

Question 4: The American Legion feels that a demographic study and medical needs assessment must be accomplished to determine those areas in which women veterans present themselves in greatest numbers so that VA can better align its resources and programs to provide full service women veterans health care clinics. Would you comment on this?

Answer: We agree with the principle that demographics and workload should be used in the placement of health care facilities. Program staff and planners do study available demographics and clinical inventories when determining needs. In most locations, services are being added incrementally until "full service" status is achieved. We would welcome the survey of women veterans authorized, but not funded, by Public Law 102-585, as it would give us the first complete picture of the demographics of the women veterans population since 1985.

Question 5: Can you tell us, on a nationwide basis, what percentage of medical services such as gynecological care for women veterans are contracted out? Are there any cost estimates available?

Answer: There is no national data base from which VA could retrieve this information. VACO would have to request that each medical facility develop and generate computer reports with requested information. The data would then have to be forwarded to VACO to be summarized into one total report. This process would take six to eight weeks.

RESPONSES TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND RELATED ISSUES
June 23, 1993 Hearing

Prepared by: Jill Manske, Regional Women Veterans Program
Coordinator, VA Western Region, August 5, 1993

1. Should all VA medical facilities have a full-time Women Veterans Coordinator? If not, which VA medical facilities should have a full-time Women Veterans Coordinator?

- I do not believe that each VA medical facility needs a full-time women veterans coordinator. In states with small numbers of veterans, such as North Dakota and Montana, having a full-time staff member devoted to women veterans does not seem cost effective.
- However, I firmly believe that each facility should have a funded women veterans coordinator and that the amount of time allocated should be correlated with workload and with the women veteran population in that catchment area. In medical facilities where there are large numbers of women veterans both in the catchment area and accessing health care at the facility, a full time coordinator would be appropriate (e.g., Minneapolis, West Los Angeles, Tampa, San Antonio, Phoenix, and San Francisco). VA used 3000 unique women veterans as the cut-off in their determination of where to place 22 full-time funded coordinator positions. On the basis of the previous year's workload and workload projections as well as the potential women veteran patients in the catchment area, decisions can be made on whether the position should be full-time.
- Those facilities without sufficient numbers could fund half-time women veterans coordinators. (Appointing someone to a less than half-time position almost assures that the duties of the primary assignment will have first priority.)
- The present system of appointing women veterans coordinators as collateral assignments places a heavy burden on coordinators, who must find time in their busy work schedules to oversee women veterans programs. The rate of turnover among coordinators in collateral assignments is high due to burnout. If we truly believe that women veterans are important clients and that we must provide for their unique needs, then we must give the program credibility through funding coordinator positions.
- As I have not seen the workload data for all VA medical facilities, I cannot accurately determine which facilities should qualify for full-time coordinator positions. However, the regional planners in each region could make recommendations based on their workload statistics and demographics.

2. Identify the possible action(s) VA should take to improve facility directors' support for the Women Veterans Coordinator.

- Facility directors have many priorities, all of which demand and compete for their attention. Forcing them to give special priority to women veterans' health care may lead to resistance in some cases.
- I think the best course of action is for VA leadership (including the Secretary, deputy secretaries, under secretaries, and regional directors) to educate VA medical facility management about women veterans health care issues and to encourage them to provide state-of-the-art gender-specific services. This can be accomplished through presentations at senior management conferences, special components of training for associate directors and chiefs of staff, and training conferences for service chiefs.
- Incentives could be used; the new VA Committee on Health Care of Women Veterans has discussed presentation of awards in a variety of categories to recognize efforts to develop and enhance programs for women veterans. Certainly the competition for funding for comprehensive women's centers and women's stress disorder treatment teams has generated interest in women veterans in management which had never been interested before. Many facilities would want to compete for the reputation of providing high quality care for women veterans.
- I believe that facility directors and chiefs of staff want to provide health care for all veterans and that they do not intentionally neglect women. Given guidelines and resources, most will provide the support necessary.

- Support, however, needs to be clearly delineated. It includes:
 - the resources the women veterans coordinators require, such as clerical help, office space, and time allocated to perform their duties.
 - support of clinical programs, such as women's clinics and mammography programs, with funding to support these services and adequate staffing for them.
 - emotional support, demonstrated by appointing a suitable person as women veterans coordinator; giving her direct access on a regular, scheduled basis to the director; management's attending events to honor and recognize women veterans; allowing the women veterans coordinator access to facility management committees; and including the needs and interests of women veterans in all future program planning and facility construction.

3. From both a facility and a systems perspective, what actions can VA take to improve outreach to women veterans?

- It's vital that all women veterans be advised of their entitlement and eligibility for VA benefits, including medical care. Unfortunately, the military does not always provide this information to those separating from the service. VA could work more closely with the Department of Defense to improve the out-briefings active duty military personnel receive about VA benefits. For women, this could include distribution of a revised "Women Are Veterans, Too" pamphlet as they attend separation briefings.
- VA could also collaborate with National Guard and reserve units on outreach, as many of their members have served on active duty.
- The women veterans coordinators at VA medical facilities could network with the women veterans coordinators appointed at the Veterans Benefits Administration and Vet Centers to actively outreach to women veterans who have applied for other VA benefits, such as GI bill and home loans.
- Coordinators could also network with their state departments of veterans affairs, some of which have women veterans advisory groups or task forces, to coordinate outreach campaigns within the states.
- VA could collaborate with veterans organizations and auxiliaries; the traditional veterans organizations are predominantly male and could benefit from the recruitment of women members. Many women veterans joined the auxiliaries when told they were not eligible for veterans organization membership.
- A media campaign is necessary, complete with public service announcements, articles in local newspapers, and interviews on TV and radio talk shows. Women veterans coordinators could be called upon to give interviews, do press releases and advise local media of events at their facilities for women veterans.
- Coordinators can also do public speaking, talking to community groups, networking with women's organizations, and serving on community committees.
- Coordinators can develop contacts with health care organizations, clinics and hospitals in the community to encourage the referral of low income women veterans and those without health insurance. (Often, community hospitals do not think to ask uninsured women patients if they are veterans.)
- It's important, though, that outreach to women veterans be preceded by enhancement of services to women veterans. It would be catastrophic to outreach to women veterans and have them come to VA medical facilities inadequately prepared to treat them.
- Finally, there is the question of eligibility for services. Since women comprise less than 3% of VA patient populations, it is difficult for staff to remain proficient in their care. In states with small numbers of women veterans, there may not be enough eligible women veterans to maintain a viable women's clinic. Despite some of the testimony heard June 23rd, it was my experience that when VA facilities were required to discharge category C women veterans, many of those women pleaded to be seen and were willing to make co-payments or have their insurance billed in order to continue receiving care at VA medical facilities. If we could allow all women veterans to be seen, there would be sufficient numbers to justify staffing women's clinics, hiring gynecologists, and purchasing state-of-the-art equipment.

From both a facility and a system perspective, what actions can VA take to become more user friendly to women veterans?

- In my opinion, each facility should invite a consultant, possibly the regional women veterans coordinator, to visit and to examine services from a patient's perspective. It may be difficult for facility staff to view their hospital objectively or to see what visitors might find obvious.
- The most attention needs to be paid to the gatekeepers, the VA staff working in Medical Administration Service (MAS), who are the first people women veterans meet when visiting a VA medical facility. If the MAS clerk is insensitive or uninformed about women's programs, a patient could become alienated and not return. Even the most well conceived women's program with comprehensive gender-specific care can be undermined by a thoughtless clerk. MAS staff need to be briefed on which services are available for women veterans, the eligibility for those services, and needs women veteran patients might have.
- The visitor coming to the facility should view the waiting areas and the admissions areas. Would a woman patient coming alone feel safe and comfortable? Are the only magazines "Field and Stream"?
- Next, look at privacy. Are there curtains in the exam area and are the exam tables placed away from doorways? Are appropriate gowns available for women patients? Are supplies necessary for examining women patients readily available, such as specula, tables with stirrups, and personal hygiene products? Are there women's bathrooms placed near exam areas and in lab areas?
- If the woman needs to be admitted, are there sufficient private or 2-bed rooms to accommodate women and do they have complete baths? Are women's pajamas and robes available?
- The first few minutes a woman veteran spends in a VA facility will determine whether she returns for care in the future. If she feels the staff are prepared to treat women patients, that they are knowledgeable and sensitive to her needs, she will likely view the experience positively. You don't need mauve walls and lace curtains.
- Finally, the prominently-displayed photo of the women veterans coordinator along with her name and office number will send an important message to a woman veteran about how she is viewed by the facility.

4. Should each VA medical center attempt to establish a Women Veterans Advisory Committee for that facility?

- I have mixed feelings about this issue. On the one hand, having a women veterans advisory committee can benefit the women veterans coordinator in that she has a group of interested staff to assist her in overseeing services provided to women veterans. Committee members can share the burden of planning activities, writing policy memoranda, and assessing the needs of women patients, with members bringing viewpoints from their respective services. The committee can also provide credibility for the facility's women veterans program, particularly if it reports to medical center management and management boards. Minutes of the committee meetings can be reviewed and distributed to other medical center committees. Committee members can serve as a sounding board for the coordinator and can advise management where women's health care issues are concerned.
- However, the danger in mandating that all facilities have women veterans advisory committees is that in some cases, everything having to do with women patients will be referred to this group, letting other committees and groups off the hook. For example, if the facility determines that the women veterans committee will do chart reviews and monitor quality of care provided to women patients, the quality improvement committee does not need to think about women patients. It would seem better for all committees to take into consideration the needs of women patients when appropriate.
- I believe establishing women veterans advisory committees should be strongly encouraged, but perhaps not required.

Should women veterans who receive health care from VA be included as members of each facility level Women Veterans Advisory Committees?

- If VA is serious about total quality improvement, it does not seem possible to have a women veterans advisory committee and not include customers (women veterans) as members. Again, it's the different perspective that's so helpful, the viewpoint of a consumer of services. I've attended women veterans committee meetings where members plan programs and workshops for women veterans, guessing at what will draw them and what sort of program they would like. How much better to ask them?
- One reason given for not including women veterans on these committees is that discussion of sensitive issues (problems in providing care, etc.) would need to be curtailed. VA staff are not eager to air dirty laundry in front of patients who may be likely to report what they've learned to veterans groups or congressional representatives.
- In my opinion, this is a needless concern. If there are problems, we can enlist the suggestions of women veterans in how best to address the problems. And confidentiality of committee agenda items can be a committee norm.
- However, despite what I've said about women veteran representation, I don't think it's wise to require that women veterans advisory committees include women veterans. Again, proscribing membership can be seen as manipulative and controlling. Making recommendations for committee composition and establishing guidelines for committee reporting might be more useful.

If I can be of any further assistance in your study of the issues of providing health care to women veterans in VA medical facilities, please do not hesitate to contact me. Thank you for your interest and support.

**AMERICAN LEGION RESPONSE TO POST-HEARING QUESTIONS OF
6/23/93**

1. Should all VA medical facilities have a full-time Women Veterans Coordinator? If not, which VA medical facilities should have a full-time Women Veterans Coordinator?

Reply

No. VA needs to establish workload criteria and a position description which helps to define the answer to this question. Clearly, a Women Veterans Coordinator's job is to help facilitate the care and treatment of women veterans. This responsibility should ensure that medical staff are sensitive to the issue of providing care to women veterans and that all local level concerns surrounding this subject are considered at the medical center director's level. In turn, any issues which remain unresolved at the local level should be communicated to the Regional Women Veterans Coordinator and then to VA Central Office. In particular, The American Legion is concerned that VA has not had sufficient construction dollars to correct female patient privacy issues on both an inpatient and outpatient basis.

2. Identify the possible action(s) VA could take to improve the facility director's support for the Women Veteran Coordinator.

Reply

VA can develop a directive detailing the specific duties, responsibilities, organizational alignment and the authority invested in Women Veterans Coordinators, and hold director's accountable for the conduct of a system-wide policy.

3. From both a facility and a system perspective, what actions can VA take to improve outreach to women veterans?

Reply

It will take time to manifest behavioral changes in women veterans' user patterns. Under national health care reform, VA has a unique opportunity to outreach to women veterans and provide an inducement for them to use the VA health care system. Obviously, VA must be able to offer all gender related health care services to women veterans, through either in-house or contract providers. Public service announcements, media advertising, utilizing veteran service organizations effectively, and other outreach efforts are all necessary. Improved access to care, cost, quality of care, and availability of services are all

important prerequisite conditions before effective outreach can be provided to women veterans.

4. Should each VA medical center attempt to establish a Women Veterans Advisory Committee for that facility?

Reply

Yes. The local level Women Veterans Advisory Committee's efforts, however, should be guided by national level policy and monitored by regional office personnel. By all means, women veterans who have utilized the services of VA should be sought out for their input and suggestions. We suggest that effective occurrence screening and discharge planning techniques be implemented with regard to care provided to women veterans so that each VA facility can develop a database on issues of concern. A VA national user survey of women veterans could be conducted to obtain a national database of general information, while the facility information would have more specific benefit.

TESTIMONY CONCERNING HEALTH CONCERNS OF WOMEN VETERANS
HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

OCTOBER 5, 1993

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FAX: 303-455-6737

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THEIR ADVOCATES AND SUPPORTERS)
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1 MR. CHAIRMAN, Members of the Committee: Thank you for
2 inviting an additional written submission answering questions sent
3 to myself and the National Women Veterans Conference, following my
4 testimony in person, before you, on June 23, 1993.

5 The questions and my responses are as follows:

6 QUESTION NO. 1: Should all VA medical facilities have a full-
7 time Women Veterans Coordinator? If not, which VA medical
8 facilities should have a full-time Women Veterans Coordinator?

9 It is my recommendation that there be full time Women Veterans
10 Coordinators at all VA medical facilities for a specified period
11 of time, such as one to three years. During this time, the job
12 description for the Coordinators would include outreach to women
13 veterans, identification of the number of women veterans in the

14 area served by the facility; programs to educate the women
15 veterans concerning services available to them; and promotion of
16 the use of those services by women veterans. Even in areas where
17 there is currently little or no utilization of VA medical care by
18 women veterans, this effort should be made, through an established
19 VA program.

20 Unless there is an affirmative outreach program, women
21 veterans' feelings of alienation and lack of trust in the VA, will
22 continue. In the past, from anecdotal information I have heard
23 and from the studies which I have seen, it is fair to say that many
24 women have not felt that the VA was available for them; and they
25 have been assumed to be dependents, or otherwise ineligible, when
26 they have approached the VA for care. World War II and Korean
27 female veterans are now in the age group which has geriatric care
28 needs. Yet many of these women's experiences do not even cause
29 them to realize that they indeed, are veterans.

30 The mandatory sensitivity training for VA personnel,
31 recommended at page 10 of my June 23 written testimony is needed
32 in order to enable other medical center staff to complement the
33 efforts of the Womens Coordinators, rather than to work at cross
34 purposes with them.

35 After the recommended initial period when all VA facilities
36 have had full time Women Veterans Coordinators; the number of women
37 veterans in the area served by the facility and their needs would
38 be sufficiently known to permit a determination as to whether or
39 not the position at each individual facility should continue as
40 a full time position.

41 It is my impression from the women veterans I have worked with
42 and with whom I have spoken, that their alienation from the VA is
43 deep and long standing; and there will be a bit of an uphill battle
44 at first, to persuade women to feel at home enough in the VA system
45 to utilize it.

46 Nevertheless, it is important to make the VA outreach to women
47 meaningful. They are a special population, with unique needs as
48 a result of their military service; and they will be well served
49 by medical facilities with expertise in treating veterans.
50 Additionally, these women are an identified population with common
51 health problems, such as their documented frequency of certain
52 types of cancer. Medical research related to their health problems
53 will be of benefit to our entire population.

54 QUESTION 2. Identify the possible action(s) VA could take to
55 improve the facility director's support for the Women Veteran
56 Coordinator.

57 Facility directors must give status and support to the Women
58 Veterans Coordinators at their facilities. The endorsement of the
59 director, in status and backing for the Coordinators is necessary
60 in order to empower the coordinators.

61 In the past, when the Coordinators duties were added on to the
62 other workloads of some women VA personnel, there was no
63 opportunity for the woman assigned to do a thorough job; and once
64 again, the message to the women veterans was that their needs were
65 of lesser importance than the needs of men.

66 The Coordinators must have the ability to do what is needed
67 for the women they serve. The VA would vastly improve the
68 utilization and the availability of women's health care by

69 allocating a portion of the funds for its patient services and its
70 funds for fee based, or private paid services to women veterans.
71 Then the Women Coordinators will have resources to offer the women
72 they work with. Also, availability of funds for care for women
73 will have an immediate impact on the problems of outdated,
74 uncertified equipment such as mammography machines and speculums,
75 inappropriate male hospital garb and confinement of women in too
76 close a proximity with men when they are hospitalized.

77 QUESTION NO. 3: From both a facility and a system
78 perspective, what actions can VA take to improve outreach to women
79 veterans?

80 Outreach will be improved by responsiveness. Women veterans
81 throughout the country should be able to dial an "800" number to
82 obtain assistance in accessing services they need; and also to
83 obtain appropriate PTSD counselling resources, in the event they
84 are suffering from PTSD, as a result of military experiences; or
85 as a result of sexual harassment in the military. The higher
86 thresholds imposed on women attempting to qualify for service
87 connected PTSD, as compared to male veterans should be removed.

88 In the facilities themselves, and throughout the system,
89 qualified women veterans should be in meaningful, visible roles for
90 all veterans to see. This will validate the existence of women as
91 part of the broader veteran population; and will encourage women
92 veterans to come forward for needed help.

93 From both a facility and a system perspective, what actions
94 can VA take to become more user friendly to women veterans?

95 "User friendliness" will be enhanced for women veterans when
96 they are not treated as oddities by medical center personnel.
97 Sensitivity training mentioned above, improvement of equipment and
98

99 available care, which is appropriate to women's needs and
100 willingness to spend money to provide help for women will all make
101 the system; and the facilities more user friendly.

102 Brochures, mailings and pamphlets on site at each center,
103 which are circulated to veterans in general, should plainly depict
104 women veterans of all ages and eras in photographs and drawings,
105 as well as text. Publicity concerning the addition of facilities
106 and services for women will need to be done frequently in order to
107 build recognition of the VA centers as places where women are
108 welcome; and as places where they can obtain help.

109 All women veterans should be asked routinely for their
110 opinions of the outreach efforts; and of the services they receive.
111 This type of communication will foster participation; and will
112 provide an ongoing assessment of the effectiveness of the VA
113 efforts concerning women. The VA needs to be perceived by women,
114 as well as by other veterans, as an advocate for them. All too
115 often, it is still seen as an adversary.

116 QUESTION NO. 4: Should each medical center attempt to
117 establish a Women Veterans Advisory Committee for that facility?

118 Yes, for all of the reasons noted above; and in my earlier
119 written and in my oral testimony. A committee familiar with the
120 facility and with the community it serves, composed of medical
121 staff, employees, and women veterans could provide valuable,
122 balanced insights to be used in putting women's programs in place;
123 and in addressing problems related to women veterans' outreach and
124 health care, as they arise.

125 Should women veterans who receive health care from VA be
126 included as members of each facility level Women Veteran Advisory
127 Committees?

128 Yes. Women who are brought into the VA medical system in
129 meaningful ways, such as on a Women Veterans Advisory Committee,
130 will give valuable input. They will raise the level of trust in
131 prospective women patients. They are likely to be of great
132 assistance in encouraging other women veterans to come to the
133 facility; and they will advocate constructively for women's needs
134 in a cooperative fashion.

135 At this time, women who do utilize VA health care are often
136 overburdened by the extent to which they must advocate for
137 themselves in order to obtain the care they need. Service on a
138 committee with the goal of improving services for women veterans
139 would be a highly desirable alternative to the individual struggles
140 they experience surrounding their VA health care.

141 Women veterans are an invaluable source of information for VA
142 personnel who wish to find out: how well their programs are
143 functioning; how their personnel are communicating with the women
144 patients; and what their women veterans needs are. Veterans,
145 including women veterans, with whom I have worked over the past
146 fifteen years have proven to be respectful of their government, and
147 able to work appropriately and cooperatively around issues related
148 to their health care. A Women Veterans Advisory Committee, which
149 did not include women veterans would be incomplete; and would not
150 be taken seriously by the very group they were formed to help. For
151 these same reasons, the Women Veterans Coordinators should be women
152 veterans. Thank you for your consideration.



DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 3 1993

The Honorable Lane Evans
Chairman, Subcommittee on
Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in reference to your recent letter requesting answers to follow-up questions concerning the Office of Inspector General's "Report of Inspection of Women Veterans Health Care Programs."

Enclosed, please find our response to your inquiry. In certain instances, we are not prepared to provide an indepth answer based on the information we have developed thus far. As indicated in our testimony, the Office of Healthcare Inspections has identified specific areas to evaluate and, as appropriate, recommend improvements in major quality assurance and medical treatment programs administered by Veterans Health Administration, and specifically for Women Veterans.

Sincerely,

William + Mervin
STEPHEN A. TRODDEN

Enclosure

**QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS**

**VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND
RELATED ISSUES**

JUNE 23, 1993

**QUESTIONS FOR MR. STEPHEN A. TRODDEN
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS**

1. **Identify all Office of Inspector General recommended changes, if any, in the base-line services that VA facilities are required to provide to women veterans.**

The Inspector General's Office of Audit was able to retrieve the following two audits that involved women issues.

**Audit of VA Medical Center Boston
(Report Date: February 9, 1990)**

Finding: Less than one-half of women veterans admitted to the medical center during Fiscal Year 1989 received tests and examinations required by VA Policy.

Pap smears and mammograms were not performed as required, even though clinical service chiefs were apprised of the problem in January 1989.

OIG follow-up reported that the Chief of Staff's office instituted concurrent review of documented care of women veterans in January 1990. Criteria used in the evaluation of the documentation includes complete admission history and physical examination; annual breast examinations; mammogram as indicated; and PAP smear as indicated. Results have been closely monitored by their Quality Management

Program, which is under the direction of a full-time physician, the Assistant Chief of Staff. A significant improvement has been demonstrated in each criterion over the last 9 months (October 2, 1990). The Office of Policy, Planning and Resources closed this report on the information provided by the facility on August 26, 1991.

Audit of VA Medical and Regional Office Center, Togus
(Report Date: January 25, 1991)

Finding: Seventy-eight percent of women veterans had not received pelvic and breast examinations as part of the physical examination as required by VA policy.

Specifically that:

2a. The VAMROC Director increase emphasis on women's health services by requiring the Chief of Staff (COS) to take action to ensure physicians comply with VA policies regarding care for women veterans.

2b. The VAMROC Director increase emphasis on women's health services by conducting focused reviews for treatment provided to women veterans to ensure that appropriate gender-related tests and examinations are offered.

OIG follow-up reported that on or about April 12, 1991, results of the facilities' first quarter reviews were sent to the appropriate Service Chiefs for corrective action, as well as to the Clinical Executive Board through the Medical Records Committee. Changes will be made to the History and Physical format to include breast and pelvic exam findings for female veterans.

A copy of the directive establishing quarterly reviews of compliance with agency policies on care for Women Veterans and a copy of the first quarter results as submitted through Medical Records Committee to the Clinical Executive Board was submitted. The Medical Records Committee recommended a Task Force, consisting of Women's Veterans Coordinator and representatives from at least Medical, Surgical, Psychiatry, Ambulatory Care, Nursing, and Medical

Administration be formed to consider the recommendations made as a result of the first quarter focused review and perceived lack of proper equipment, "Qualifications" and proposed change in History and Physical format. The Office of Policy, Planning and Resources closed this report on the information provided by the facility on February 7, 1992.

OFFICE OF HEALTHCARE INSPECTIONS - received and substantiated two hotline allegations that involved base-line services. Three additional cases were inspected, but the allegations were not substantiated.

Inspection - VAMC Fresno
(Date of Report: July 14, 1993)

Allegation: A woman veteran was not properly diagnosed and treated for vaginal bleeding. Further, she had to go to a private hospital for treatment and incurred about \$900 in medical bills.

Findings:

OHI concurred with the complainant's allegation that she was not properly assessed, and she should have been examined every time she presented herself to the clinic. Further, failure to properly examine the patient caused her to seek medical care at a private medical center.

Although the Medical Center officials did not receive a request for reimbursement from the complainant, the medical center reviewed the request submitted through the OIG for reimbursement. Medical Center managers decided that the VA would refund the veteran's expenses at the private hospital.

Inspection VA Medical Center Gainesville
(Report Date: July 26, 1993)

Allegation: The admitting nurse wanted to place a female patient in a room with a male patient. When the female patient objected to

having a male roommate, the nurse told her that, "the other patient was catatonic." The female patient continued to object, and the nurse ultimately relocated another female patient in the room with the male patient. The nurse then assigned the complainant to a private room which had been formerly occupied by the other female patient.

Findings:

OHI concluded that the practice of co-locating male and female patients in one room was not appropriate. The Under Secretary for Health agreed and reaffirmed VHA's Policy Directive 10-92-038, dated March 31, 1992, "Identifying and Correcting Privacy Deficiencies Adversely Affecting Women Veterans." Further, on July 16, 1993, during a nationwide conference call, the Assistant Chief Medical Director for Environmental Medicine and Public Health (including Women Veterans Program) announced, "It has come to our attention that at least one episode has occurred in which a female patient in a VA Medical Center [was] co-located in a semi-private room with a male patient. This is inappropriate. When women are admitted to VA facilities they must be housed in single rooms or multi-bed rooms with other women."

2. From both a facility and a system perspective, what actions can VA take to improve outreach to women veterans?

A broadly based recommendation in a recent OHI report (3HI-A99-129) on the Inspections of Women Veteran's Health Care Programs was "Ensure that women veterans are informed about available services and their eligibility for VA health care."

We agree with the VA Advisory Committee on Women Veterans - July 1992 Report which outlines seven specific recommendations for outreach to women veterans.

1. VA should continue to portray women veterans in all media productions (print and video) including audiovisuals used in training and readjustment programs.
2. VA should work with all national veterans' organizations to encourage full acceptance of women veterans as members.
3. VA should have Public Affairs monitor and respond to media portrayals of negative image of VA which may discourage veterans, including women, from utilizing available services.

4. VA should continue to work with social and welfare agencies in the Federal Government to identify disadvantaged women veterans and utilize these agencies to distribute VA information brochures.

5. VA should continue to utilize the existing network of individual State Directors of Veterans Affairs to disseminate information and raise awareness that "Women are Veterans, Too!"

6. VA should attempt to work with state agencies to sensitize employment counselor to ask women about their veteran status and service experience.

7. VA should mail directly to all state employment offices publicity regarding "Women Are Veterans, too!"

From both a facility and a system perspective, what actions can VA take to become user friendly to women veterans?

We believe that the existence in each VA medical center of a Women Veterans Advisory Committee with adequate influence could impact VA staff behaviors making the system more user friendly to women veterans.

3. Should each VA medical center attempt to establish a Women Veterans Advisory Committee for that facility?

In the findings of the Audit of VAMROC Togus, in order to resolve and establish quality care for women veterans, a Task Force was established from the primary areas within the Medical Center. When this Task Force reviewed and made recommendations, the concern, quality, and visibility of care for women veterans were raised. These types of Task Forces, or Advisory Committees, play an integral role in the quality of care that women veterans would and should receive.

The addition of a Women Veterans Advisory Committee could and would supplement and support the Women Veterans Coordinator, and enhance the overall women veterans program.

Should women veterans who receive health care from VA be included as members of each facility level Women Veterans Advisory Committees?

The involvement of women veterans on the local Women Veterans Advisory Committee could enhance these committees. The national VA Advisory Committee on Women Veterans Advisory is comprised

of veterans and/or individuals actively involved in veterans affairs. The Advisory Committee has contributed to the increased recognition of women veterans and, by their recommendations to the VA, have played an important role in the improvement of services furnished by the VA. The members of this committee are mostly women veterans; through their experience within the military and care received at various VA facilities, the members can and do provide a different perspective on the type of care given and on the attitudes towards women veterans.

4. **When a VA medical center does not offer required gender specific health care to women veterans, which medical center official(s) should be held accountable by VA for that facility's failure to provide gender specific care to women veterans?**

The station Director is ultimately responsible for the quality and type of care and services that our veterans receive.

5. **Should all VA medical facilities have a full-time Women Veterans Coordinator? If not, which VA medical facilities should have a full-time Women Veterans Coordinator?**

Our report indicated that we do not believe that all VA medical facilities necessarily should have a full-time Women Veterans Coordinator. However, their time and position responsibilities should be commensurate with the number of women veterans in the facilities catchment area, size of the facility, services available, and overall work responsibilities to determine if a full-time Coordinator is warranted.

A review of each facility that has elected to have a less than full-time Coordinator should be performed every 2 years to determine if the position has grown into a full-time position.

6. **Identify the possible action(s) VA could take to improve the facility director's support for the Women Veterans Coordinator.**

A recommendation of OHI Report Number 3HI-A99-129 was to "Reallocate staff and resources in VA Central Office necessary to ensure that the women's health program can properly function within the criteria established in law." Strong leadership and coordination is needed in Central Office to give direction, establish policy, and give guidance to the field directors in support of this program.

RESPONSES TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND RELATED ISSUES

JUNE 23, 1993

BY
TERRI LEE TAMASE, M.D.
CHIEF, PRIMARY CARE
WEST LOS ANGELES VAMC, LOS ANGELES, CA
ASSISTANT PROFESSOR OF MEDICINE, UCLA SCHOOL OF MEDICINE

1. SHOULD ALL VA MEDICAL FACILITIES HAVE A FULL-TIME WOMEN VETERANS COORDINATOR? IF NOT, WHICH VA MEDICAL FACILITIES SHOULD HAVE A FULL-TIME WOMEN VETERANS COORDINATOR?

The role of the Women Veterans Coordinator, precisely defined by VA Central Office, is enormous in scope. Our experience at West Los Angeles VAMC, the largest and most complex facility in the VA system, demonstrates that the Women Veterans Coordinator position requires a full-time commitment to effectively meet the needs of female veterans in our urban setting.

Should all VA medical facilities have a full-time Women Veterans Coordinator? Currently, VA facilities providing services to smaller numbers of women may not warrant full-time Women Veterans Coordinators. However, it is important to note that the number of women served is only one of many criteria to determine a facility's need for a full-time Women Veterans Coordinator. At centers where the required time commitment of this position is in question, a site visit by the Regional Women Veterans Coordinator could provide a solution.

It is also important to emphasize that, given the VA's commitment to improving health care for women, an influx of female patients is anticipated in the near future. As the number of women served rises, full-time Women Veterans Coordinators at all VA facilities will become a necessity.

2. IDENTIFY THE POSSIBLE ACTION(S) VA COULD TAKE TO IMPROVE THE FACILITY DIRECTOR'S SUPPORT FOR THE WOMEN VETERANS COORDINATOR.

The degree to which the Women Veterans Coordinator is supported by the director is site specific. At the West Los Angeles VAMC our Director, Kenneth Clark, is committed to women's issues. Thus, our Women Veterans Coordinator enjoys both an encouraging climate and easy access to the Director's office.

-2-

One action to improve support for the Women Veterans Coordinator is to establish the director or the Chief of Staff as the Women Veterans Coordinator's immediate supervisor.

However, this solution has limitations. Due to time constraints, the director or the Chief of Staff may inadequately address the special needs of the Women Veterans Coordinator. Thus, designating assistants within the offices of the director or the Chief of Staff to oversee the Women Veterans Coordinator is a more effective approach.

Another action to ensure easy access to the director's office is to require the director to respond to all line items in the monthly Women Veterans Advisory Committee minutes.

3. FROM BOTH A FACILITY AND A SYSTEM PERSPECTIVE, WHAT ACTIONS CAN VA TAKE TO IMPROVE OUTREACH TO WOMEN VETERANS?

FROM BOTH A FACILITY AND A SYSTEM PERSPECTIVE, WHAT ACTIONS CAN VA TAKE TO BECOME MORE USER FRIENDLY TO WOMEN VETERANS?

From both a facility and a system perspective, these are the actions the VA could take to become more user friendly to women veterans:

I. CLARIFY AND SIMPLIFY ELIGIBILITY REQUIREMENTS Many female veterans are unaware of, or unclear about, their eligibility status. Thus, they fail to utilize the VA health care system. While this problem is not unique to women, men have greater access to organized outreach groups which provide eligibility information. Female veterans are much more isolated. Thus, a well publicized program to answer women's eligibility questions is required.

II. PROVIDE WOMEN'S HEALTH CARE EDUCATION AND SENSITIVITY TRAINING Women's health care providers should be competent in providing acute, chronic, and preventive female-specific care. All hospital personnel should receive sensitivity training regarding the care of women.

III. MEET THE BASIC HEALTH CARE NEEDS OF WOMEN AT ALL VA FACILITIES Basic health care components should be available at all VA facilities. These include female-specific:

- A. Human Resources.
- B. Procedures (e.g., breast biopsy).
- C. Equipment and supplies.
- D. Laboratory tests (e.g., pregnancy tests).
- E. Medications (e.g., oral contraceptives).
- F. Environment (e.g., female bathrooms and showers).

-3-

Once the above components are in place, the VA could then launch a public relations campaign to advertise its product and improve outreach to women veterans. Marketing strategies could include the use of media, networking, lectures and community outreach.

4. SHOULD EACH VA MEDICAL CENTER ATTEMPT TO ESTABLISH A WOMEN VETERANS ADVISORY COMMITTEE FOR THAT FACILITY?

SHOULD WOMEN VETERANS WHO RECEIVE HEALTH CARE FROM VA BE INCLUDED AS MEMBERS OF EACH FACILITY LEVEL WOMEN VETERANS ADVISORY COMMITTEE?

Each VA medical center should establish a Women Veterans Advisory Committee which includes women veteran consumers (i.e., women veterans who receive health care from the VA) and the Women Veterans Coordinator as members. Ideally, the chairperson of the committee would be a female veteran. Additionally, the group should include a few male members to offer a male perspective and help make committee recommendations easier to "sell" to male decision-makers.

The Women Veterans Advisory Committee would monitor women's issues, steer the facility in future directions for women, and empower female veterans through easy access to the director.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND
RELATED ISSUES

JUNE 23, 1993

QUESTIONS FOR MS. CATHY LINDSAY

1. Should all VA medical facilities have a full-time Women Veterans Coordinator? If not, which VA medical facilities should have a full-time Women Veterans Coordinator?

ANS. Yes.

2. Identify the possible action(s) VA could take to improve the facility director's support for the Women Veteran Coordinator.

ANS. First and most importantly, is to apprise the facilities' directors of all possible situations that would be presented by women veterans. I would also recommend that person be someone with sufficient knowledge and compassion; first hand and/or with personal experience relating to these issues, which are kept abreast of the ever-changing rules and regulations to include the military medical board processing to aid in the elimination of the many problems which are developed prior to discharge.

3. From both a facility and a system perspective, what actions can VA take to improve outreach to women veterans?

ANS. From a facility perspective, to improve outreach to women veterans, the VA must acknowledge their specific needs and develop a program for that purpose, specifically.

From a system perspective, to improve outreach to women veterans, the VA ensure that whatever programs are developed, are in fact, fully represented and women veterans made fully aware of all resources available to them.

From a facility and a system perspective, what actions can VA take to become more user friendly to women veterans.

ANS. From a facility perspective, realizing females specific needs for privacy and accomodating their special needs as an other that male in all areas regarding treatment at VA.

From a system perspective, by assuring that staff and males, respectively, acknowledge and respect the privacy and special needs of females and by allowing when necessary, females the right to express her concerns when she feels she's been violated, knowing her concerns will be addressed and dealt with accordingly.

4. Should each VA medical center attempt to establish a Women Veterans Advisory Committee for that facility.

ANS. No.

Should women veterans who receive health care from VA be included as members of each facility level Women Veteran Advisory Committee.

ANS. A centralized Women Veterans Advisory Committee, whether on a local, state or national level should be established so that all Women Veterans Coordinators may have a systematic program to be recognized and utilized by all which will ensure that all women veterans are receiving equal, quality care to include women veterans that receive health care for VA.

NOVA

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QUESTION SUBMITTED BY
 HONORABLE LANE EVANS, CHAIRMAN
 COMMITTEE ON OVERSIGHT & INVESTIGATIONS
 COMMITTEE ON VETERANS' AFFAIRS

VA PROVISION OF HEALTH CARE TO WOMEN VETERANS AND
 RELATED ISSUES

JUNE 23, 1993

QUESTIONS FOR MS. BETTE L. DAVIS, MSN, RN, CS
 PRESIDENT
 NURSES ORGANIZATION OF VETERANS AFFAIRS

1. Should all VA medical facilities have a full-time Women Veterans Coordinator? If not, which VA medical facilities should have a full-time Women Veterans Coordinator?

Not all VA medical facilities need full-time Women Veterans Coordinators. It would depend upon the women veterans' population in the particular geographical area and on available resources, whether the facilities or resources are VA or non-VA. Most VA facilities could benefit by requiring a 0.5 FTE position for this assignment, as a minimum, and require an official job description and written proficiency in order to recognize the importance of this job.

2. Identify the possible action(s) VA could take to improve the facility director's support for the Women Veteran Coordinator.

Congress could request that Women Veteran Coordinator report directly to the facility director. This direct line lends credence to the notion that the head of the facility can do something -- be accountable, since the ultimate responsibility would be shared, not left unattended on the coordinator. Problem areas, as well as resources, are more likely to be identified and addressed at a level responsible for change and correction.

3. From both a facility and a system perspective, what actions can VA take to improve outreach to women veterans?
 From both a facility and a system perspective, what action can VA take to become more user friendly to women veterans?

Continuing programs or plans that are underway since the enactment of P.L. 102 - 585 are absolutely essential for improving outreach to women veterans. Congress needs to ensure that appropriate amounts of time, money, and training are utilized by the VA to support its goals of improved health care for women veterans. Reaching eligible women veterans begins in-house, at each VA facility, through continual educational efforts directed at professional and administrative staff responsible for recognizing and treating all aspects of women's health care. National advertisements via various media can bring women veterans to VA medical centers, but without sufficient resources of time; clerical and administrative support; and training for specific responsibilities, any efforts of outreach stop at the entry level into the medical center, defeating the purpose of outreach.

To continue actions that are user-friendly to women veterans, the VA should pursue further to: enhance physical facilities for privacy, security and convenience; educate staff (professional and administrative) to women veterans' health care eligibilities and resources for treatment, particularly for sexual trauma; ensure available resources whether in-hospital or out-of-hospital; publicize or marketing information material via national media (radio, T.V., newspaper, magazines) and at the community level in places like churches, private hospitals and community clinics, etc.; and increase the time of women veterans coordinators with allotted FTE positions.

4. Should each VA medical center attempt to establish a Women Veterans Advisory Committee for that facility?

Should women veterans who receive health care from VA be included as members of each facility level Women Veteran Advisory Committee?

Each VA medical center should have its own Women Veterans Advisory Committee which functions for the specific needs of the individual medical center, yet is capable of networking with other medical centers at the national level.

A women veterans representative for women veterans receiving health care from VA should be included as a member of each facility's Women Veterans Advisory Committee. A person using the system has much to offer the Committee in identifying problem areas and in resolving them.

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
JUNE 23, 1993
QUESTIONS SUBMITTED FOR THE RECORD BY
CHAIRMAN LANE EVANS
TO
LINDA SCHWARTZ
VIETNAM VETERANS OF AMERICA

1. *Should all VA medical facilities have a full-time Women Veterans Coordinator? If not, which VA medical facilities should have a full-time Women Veterans Coordinator?*

Although I wish each VA facility could have a full-time Women Veterans Coordinator, in this day and age we must be pragmatic about the relationship of utilization and the needs of all veterans. Utilization of a facility should be the guiding light for the assignment of full-time staff. There are areas like Los Angeles that have a very high utilization rate by women veterans which substantiate the need for a full-time Women Veterans Coordinator. At the same time, utilization by women veterans at Togus, Maine is most probably so low that it would be a waste of resources to employ a full-time Coordinator there. Another factor which should be considered when making these assignments is the potential population of women veterans that are eligible for care in the VA system. If there are women veterans in the catchment areas entitled to health care services, then full-time efforts to conduct outreach and staff education would be beneficial. Similarly, eligible women veterans residing in an area where women's health care services are not available within the local VA facilities should be able to get assistance from Women Veteran Coordinators in obtaining care at VA expense from contract providers, or fee-for-service arrangements.

2. *Identify the possible action(s) VA could take to improve the facility director's support for the Women Veteran Coordinator.*

I am a firm believer in consumer participation in governance in VA facilities. If you consider that the VA is a closed system in which information and directives flow to the consumer with no opportunity for the veteran to have any say in what happens to him or her, advisory groups empower both the veterans and the staff to have some influence in the process of evaluating and improving the delivery of services. If there was more dialogue between these two groups there would be less frustration and maybe even fewer Congressional hearings about problems in the system.

3. *From both a facility and a system perspective, what actions can VA take to improve outreach to women veterans?*

From both a facility and a system perspective, what actions can VA take to become more user friendly to women veterans?

I have talked about the need for greater outreach to women veterans for years, and this problem was identified far prior to when my advocacy began in 1982. I am surprised that over ten years later we are still trying to solve this puzzle. Within the VA system there is no specific office or person devoted full-time to women veterans. Because of this, there has been no accountability within the system to develop needs assessment. VA has to demonstrate a concern for women veterans by dedicating personnel to the program. Thus far it has been mostly lip service to "Women Veterans". The progress that has been made is a testament to the tenacity of Dr. Susan Mather and Barbara Brandau and the creativity and determination of the VA Advisory Committee on Women Veterans. Present and future women veterans, however, necessitate that more time and resources are committed to do this job adequately. Likewise, greater utilization of facility Women Veteran Advisory Groups which include women veteran VA health care consumers, would assist with local outreach and make the system more user friendly.

4. *Should each VA Medical Center attempt to establish a Women Veterans Advisory Committee for that facility?*

Should women veterans who receive health care from VA be included as members of each facility level Women Veteran Advisory Committee?

Every VAMC should have a Women Veterans Advisory Committee. This committee should have women veterans who utilize the facility as well as women veteran advocates and experts from the community. These advisory groups bring a great deal of legitimacy and support to VA programs and positions. Some of these groups have been in existence for years and are valued by facility directors and staff for their input into program development and assessment of services. It is surprising that even the VA Advisory Committee on Women Veterans does not have disabled women veterans represented in its roster. I have never been able to understand how women who do not use the VA would know what it is like to be cared for in the system. Perhaps that is why so many of their deliberations and recommendations do not actually address the service needs that women veterans experience on a day to day basis. In many ways the membership of the national committee and facility advisory groups sends a message that women veterans who use the VA cannot speak for themselves or that what they have to say is not important.

To: The Honorable Lane Evans
 From: Evelyn M. Monahan, Ph.D.
 President, National Association of Women Veterans, Inc.
 Subject: Response to Questions Regarding Women Veterans Health
 Care
 Date: August 20, 1993

Preamble

Many centuries ago a wise woman philosopher said: "God save me from wise old men who sit in ivory towers and dream our lives away." Surely this philosopher had the Department of Veterans Affairs Central Office in mind, our "Twentieth Century Jurassic Park" with life-like dinosaurs, inhabiting the executive offices in a place where poverty of ideas, lack of motivation, lack of caring, and an almost maniacal interest in preserving one's own position at any cost, reigns supreme. In truth the old guard of the status quo is the largest obstacle to any real change being introduced and nurtured throughout the VA system. The "Old Guard of the Intellectually Impoverished", and the "Old Guard of Preserving Ones Own Position at Any Cost", are like the plaque and cholesterol which block arteries, and prevent needed life-giving ideas and changes from having a chance to effect real change on a systemic level.

1. Should all VA medical facilities have a full-time Women Veterans Coordinator? If not, which VA medical facilities should have a full-time Women Veterans Coordinator?

1. It is doubtful that all VA Medical Centers (VAMCs) would need a full-time Women Veterans Coordinator (WVC). VAMCs vary in size, complexity, patient load, patient turn over rates, number of services, etc. WVC until most recently have assumed the WVC role as a collateral responsibility. In large, urban, and affiliated VAMCs, fulfilling the WVC role creates an unrealistic work load on the WVC, and lose-lose situation is created; the conscientious WVC may spend numerous hours beyond the normal duty hours, which eventually will create physical/emotional/family crises; "burn-out" will occur; quality of work of the primary workload and the WVC workload will suffer.

The Department of Veterans Affairs (DVA) would determine the placement of full-time WVC in specific VAMCs, by basing the decision on traditional criteria such as the following:

- A. Bed capacity of 250 or more,
- B. Out-patient visits per year greater than 80,000,
- C. Medical, nursing, social work, theology etc.
school affiliations,
- D. Locations in large metropolitan areas,
- E. Multiple patient services offered such as open heart surgery, acute psychiatry, substance abuse, day treatment programs for psychiatry, elderly,
- F. Catchment area for the facility has over 8,000 women veterans, service connected and non-service connected,

G. Catchment are has over 2000 service connected women veterans, etc.

However criteria such as these, are inadequate to truly addressing the problem of making such a decision. A health care program for women veterans should be based on the health care needs of the population it purports to serve, and, until that population is defined, efforts will continue to be ineffective.

Past random surveys by various pollsters contracted by the DVA have only produced figures from which the DVA has projected the **supposed** number of women veterans in this country. The surveys have done nothing to uncover the hidden 360,000 approximately, who served in WWII alone. These surveys have not addressed the whereabouts or the health needs of the hidden women veterans population, especially the 360,000 women who served in WWII. The DVA does not have the criteria necessary for use by those within the DVA who are setting the policy for outreaching to women veterans and providing care to women veterans; nor are they even aware that their policies are like a spot light focused on the visible part of an iceberg. The policy makers shout proudly that they have identified the women veterans population without even realizing that perhaps as high as 90 per cent of this nation's women veterans population, lies hidden, unaddressed, and outside the awareness of policy makers at the DVA. Even if those policy makers miraculously concede the truth of this analogy, they would still be faced with the momentous task of identifying women veterans who have not been counted or tracked by the DOD or the DVA up to the present date.

Women veterans' health care is so sorely lacking in the vast majority of VAMCs, that one is hard pressed to arbitrarily "draw the line". A facility by facility needs assessment would be necessary. (A detailed, concise method for the consignment of full-time WVC, taking into account numerous and weighted variables, could be made available to the DVA on a consultation basis, upon request. The intricacies of the method include, specific outreach avenues that have proven extremely successful in the past, and would be a relatively negligible financial cost to the DVA.) The appointment of full-time WVCs must be seen in the context, and against the background, of specifics such as the age groups of the women veterans who may be in most need of services from a particular facility. A large population of elderly female veterans who have had little contact with the DVA in the past, might well be expected to be more confused concerning available services and the avenues by which those services are accessed. The role of a full-time WVC in such a situation might well mean the difference of whether women veterans receive the services to which they are entitled, and which the law mandates the DVA to deliver, and the failure of the DVA in meeting its mission, and fulfilling the laws by which it is directed.) Without an overall vision of the problems confronting the DVA in fulfilling this particular part of its mission, it is doubtful that any efforts, no matter how well intentioned, will be successful.

2. Identify the possible actions VA could take to improve the facility director's support for the Women Veterans Coordinator.

All employees including the Director, need consciousness raising:

A. Training courses on the history of American military women.

B. By addressing the importance of, and passing legislation that will state that the VA "shall" rather than "ought to" have WVCs.

C. Mandate that there be a WVC, even if a collateral position, at each VA Regional Office (VARO); often a woman veterans' first contact is at the VARO, when she is seeking some form of veterans benefits, such as vocational rehabilitation training, VA loan, counseling for Chapter 30, etc.;

D. A WVC at VARO would provide a bridge, a liaison, with the VAMC and VA Vet Center in the area; these facilities frequently function in isolation of each other. The WVC could share information regarding the services for the women veterans, coordinating the services, and could provide follow-up for each woman veteran, i.e. managed care by the team which is made up of VA staff from several VA facilities.

E. A survey of the attitudes of VA facility Directors including VAMC, VARO, and Vet Centers should be conducted to ascertain the basic philosophy of each Director regarding the benefits and care that should be provided for women veterans within their geographic bounds of responsibility. It might well be that some Directors are harboring philosophies which are adversarial to the establishment of the WVC position, and detrimental to the care and benefits provided to women veterans. These individuals could be provided with additional mandatory sensitivity training.

F. There is a definite connection between the recalcitrant philosophy and attitudes entrenched in VACO and behaviors found to be acceptable at VA field facilities. It would appear that many high level employees at VACO have been isolated from the reality of field work for so long that they have either lost the ability to see problems in the field, or have lost the sensitivity and caring to address problems in the field. If these recalcitrant attitudes are not amenable to mandatory sensitivity training for all levels of employees within VACO, Congress should consider whether the DVA has created its own "Jurassic Park" where dinosaur-like philosophy, roam the halls, and armor plating wards off any suggestions of change, as a necessary means of providing better care to veterans, and fulfilling the VA mission.

It is time that Congress and the DVA realize that some people's attitudes, even in the face of convincing facts, will never change and, given such situations, Congress must have the courage to remove those people and replace them with employees who neither fear change or new ideas.

Dr. Evelyn M. Monahan

3A. From both a facility and a system perspective, what actions can VA take to improve outreach to women veterans?

The DVA has missed a crucial element in outreach to women veterans, and without a totally new philosophy and vision in this area, singular suggestions would be merely band-aides placed on a gangrenous wound.

Outreach is certainly a key element in fulfilling the mission of the VA, yet many divisions within the VA that could work together in performing this vital service are not even aware of what other divisions might offer an outreach package.

It would take many pages to analyze the reasons why DVA has failed in outreach to women veterans; and the solution that can turn this failure into a success would take many pages to outline a strategic plan to accomplish outreach at a level that would meet the VA mission.

A large part of the VA's outreach problem is the fact that it has never seen the problem as a whole, and has responded only with "knee jerk" reactions to criticisms from outside, regarding the almost total failure of the VA in this element of its mission.

3B. From both a facility and a system perspective, what actions can VA take to become more user friendly to women veterans?

1. The first step the VA would have to take in becoming user friendly to women veterans, is to see women veterans in a totally different light than they have been by DVA to date. A crucial element in changing the DVA view of women veterans, is to educate every Department of VA employee concerning the military history of women in our armed forces; and, to carry this process one step further, this education should be promoted to all DoD employees, so that ex-military and retired military individuals hired by VA would bring this new attitude and perspective with them.

2. Women veterans must be appointed to the higher echelons of policy making and training within the DVA. It is difficult to take the DVA seriously concerning their "high regard" for women veterans when women veterans have not been admitted to the higher echelons of policy making within the DVA. A female chief council for DVA is one small step in a very long journey to the place where the DVA will be seen as, and hopefully will be, user friendly to women veterans.

3. The key is education, education, and education; if people are to treat women veterans differently, they must first see them differently.

4B. Should each VA medical center attempt to establish a Women Veterans Advisory Committee for that facility?

Yes, absolutely; since the VACO has little real contact with VA facilities in the field, a Women Veterans Advisory Committee might be the first real steps provided for women, in having in-put into changing a system which has been historically male oriented, male dominated, and male friendly to the exclusion and detriment of women veterans. The Advisory Committee should consist of representatives from each type of VA facility in the area i.e. the Vet Center, the VARO, VA Domiciliary, nursing home, medical center; and active duty, women veterans who receive services through VA. (women veterans consumers)

4B. Should women veterans who receive health care from VA be included as members of each facility level Women Veteran Advisory Committees?

Absolutely; who better to pin point the places where care and communication are breaking down, than those who have tried to use the system and found it wanting.

Placing people with different perspectives, i.e. active duty personnel, VARO personnel, VAMC personnel on the advisory committee, a new vision has the chance to be born and produce new solutions to old and recalcitrant problems.

Again, the key words are education, change, education, change, and education again.

MARSENA MUNGIN

June 23, 1993
Health Care to Women Veterans

1. *Should all Va medical facilities have a full-time Women Veterans Coordinator?*

This process of choosing full-time Women Veterans Coordinator should be based upon demographics, of veteran population. Also by region around VA medical facilities, were their are more than one in a area (example Texas VAMC)

2. *Identify the possible action(s) VA could take to improve the facility director's support for the Women Veteran Coordinator.*

There are a number of things that could be done:

- a) a working relation with all staff
- b) promote the coordinator to vet groups, and other community organizations
- c) make sure that she receive training possible to perform a effective job
- d) moral support at all times

3. *From both a facility and a system perspective, what actions can VA take to improve outreach to women veterans?*

- a) Involve outside resources to teach technical assistance in designing a outreach plan
- b) Provide over all services nation wide using a survey to fine out what has been effective

From both a facility and a system perspective, what actions can VA take to become more user friendly to women veterans?

- a) Evaluate the programs that are in place
- b) Provide volunteer day care for outpatient status
Which can be managed by service organization
(to include all veterans)
Which would lower missed appointments rate
This will help promote healthier veterans
- c) Positive roll modeling within the veteran community
- d) Offer new services to become competitive with private sector
- e) Incentive programs to employees that are veterans to share ideas on outreach
- f) Community awareness of cause and effect of women vets with a special exception for disabled women vets
- g) Involve the staff in major changes as relate to their perception of women veterans

4. *Should each VA medical center attempt to establish a Women Veterans Advisory Committee for that facility?*

Yes, A effective program depend on input from all parties

Should women veterans who receive health care from VA be include as member of each facility level Women Veteran Advisory Committees?

Yes, Those receiving health care should be number one on the list for Advisory Committees
The over all based upon concern for change and attitude of compassionate human being