ISSUES FACING WOMEN AND MINORITY VETERANS

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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ISSUES FACING WOMEN AND MINORITY VETERANS

THURSDAY, JULY 12, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee on Health] presiding.

Present from the Subcommittee on Health: Representatives Michaud and Hare.

Present from the Subcommittee on Disability Assistance and Memorial Affairs: Representatives Hall, Hare, Lamborn, Turner, and Bilirakis.

OPENING STATEMENT OF CHAIRMAN MICHAUD, SUBCOMMITTEE ON HEALTH

Mr. MICHAUD. The Subcommittee on Health will come to order. I'd like to thank everyone for coming today. This is a joint hearing with the Subcommittee on Disability Assistance and Memorial Affairs as well.

Today we will examine the U.S. Department of Veterans Affairs (VA) programs regarding women and minority veterans. The face of the military is changing and so is the face of the veterans' population. According to the 2000 census, minorities make up over 14 percent of the existing veterans' population. The population of women veterans is projected to continue to rise from 6 percent in 2000 to 8 percent in 2010 and to 10 percent in 2020.

VA needs to consistently evaluate existing programs to address the needs of special groups and make changes when needed. I further believe that VA should implement new and innovative programs to help close the many gaps that exist today in delivering high-quality, safe health care and other benefits and services VA provides.

Service in Operating Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) has created growing challenges for the VA in meeting the needs of women and minority veterans as they separate from service. We know that an unprecedented number of female servicemembers have been routinely exposed to combat or combat-like conditions. VA reports that the prevalence of potential

post traumatic stress disorder (PTSD) among new OEF/OIF women veterans treated at VA has grown from 1 percent in 2002 to nearly 19 percent in 2006. Issues such as cultural differences, effective outreach, education, research and delivery of care should be carefully examined in an effort to provide the best possible service to these veterans.

I hope that we will learn how the VA is meeting the needs of these populations, what challenges are on the horizon, and what we can do to provide veterans the best possible care available.

At this time, I would yield to Mr. Lamborn who is the Ranking Member of the Disability Assistance and Memorial Affairs Subcommittee for an opening statement.

[The prepared statement of Chairman Michaud appears on p. 31.]

OPENING STATEMENT OF HON. DOUG LAMBORN, RANKING REPUBLICAN MEMBER, SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

Mr. LAMBORN. Thank you, Mr. Chairman, for recognizing me and I look forward to this hearing with you, with Mr. Hall from New York, with Mr. Turner and everyone else who can join us as we go through this hearing.

I'm glad that we are having this hearing on the challenges facing minority and women veterans. I welcome our witnesses including my colleague from New Mexico Representative Heather Wilson. And I thank you all for your contributions to the Veterans' Affairs system.

America's minorities and women of our great Nation are integral to the quality of our national security. Women make up nearly 10 percent of our Nation's 24 million living veterans. Women on active duty represent more than 15 percent of our armed forces. According to a 2005 Heritage Foundation study, about 25 percent of military recruits identify themselves as other than Caucasian. Further, military women are more likely to identify themselves as members of a racial or ethnic group than men.

Our military has a higher percentage of some minorities such as African Americans, American Indians, Native Alaskans and Hawaiians and Pacific Islanders than the percentage of these minorities in the general population. These men and women are patriots. In more than 2 centuries of service to our country, women and minority servicemembers have created a rich legacy. This legacy has only been enriched by the intrepid and resolute accomplishments of their decedents in the global war on terror.

Our challenge is to ensure that women and minority veterans indeed all veterans receive equal treatment for their qualifying service to our Nation. The VA Centers for Women and Minority Veterans and the Department's associated Advisory Committees are charged with increasing awareness of VA programs, with identifying barriers and inadequacies in VA programs, and with influencing improvement.

We do not look to these VA programs to merely identify and report, we want them to influence policy and accept a measure of accountability for departmental results. In that regard, I will, of

course, be very interested in hearing today about challenges facing women and minority veterans such as gender specific health care.

I want to learn about disabilities more likely to effect minority veterans. I want to hear about the challenges facing veterans who wish to take advantage of economic opportunities in the public and private sectors. I will, however, especially want to learn today how the VA and it's component organizations are effectively rising to meet these challenges.

Mr. Chairman, I yield back.

[The prepared statement of Congressman Lamborn appears on p. 32.]

Mr. MICHAUD. Thank you very much, Mr. Lamborn. And now I would like to yield to a gentleman who feels strongly about veterans' issues as well, Mr. Hall who is the Chairman for the Subcommittee on Disability Assistance and Memorial Affairs for an opening statement.

Mr. Hall.

OPENING STATEMENT OF CHAIRMAN HALL, SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

Mr. HALL. Thank you, Chairman Michaud and Mr. Lamborn. I always enjoy serving with you on our Disability Assistance Subcommittee. Good morning, all.

I would first like to say that I am honored to join Mr. Michaud in cochairing this hearing and I applaud the leadership he exercises on behalf of our veterans, especially on veterans health care issues. I would also like to thank the witnesses for joining the 2 Subcommittees this morning for a hearing to examine issues facing women and minority veterans.

This rare joint hearing speaks volumes about how important these issues are to the Committee as a whole. I look forward to hearing from all of today's witnesses. I also want to apologize in advance for the fact that I am double booked in another Committee meeting and will have to leave and then come back in a little while so that I can hear as much testimony as possible. I will read the written testimony that I may miss in person.

Women veterans are the fastest growing segment of the veteran population comprising 7 percent of the total veteran population and 5 percent of those using VA services. Over 14 percent of veterans are from a racial or ethnic minority group with African Americans comprising the bulk at 9.7 percent according to 2000 U.S. Census figures. I am certain that the VA does its best to ensure that all veterans encounter no barriers to access and the receipt of veterans' benefits, treatment and services. However, the fact remains that the barriers in society at large that women and minorities often face might very likely translate into barriers in the smaller VA system.

As such, Congress, in its wisdom, developed both the Center for Minority Veterans and the Center for Women Veterans in 1994 to ensure that these veterans are fully integrated into the VA system. I look forward to hearing from both Centers as well as their separate Advisory Committees, which developed detailed reports to help inform the policies of the VA for women and minority veterans. I especially would like to learn the VA's and the Advisory Committee

on Minority Veterans' views on the sunsetting provisions that would end the Advisory Committee in 2009 and what, if any, plans it has to replace this vital organization.

I know that Representative Gutierrez has introduced a bill, H.R. 674, that would prevent this from occurring. Getting rid of the Minority Veterans Advisory Committee would be a seriously troubling result in light of the recent findings by VA researchers that health disparities appear to exist in all clinical arenas and have a direct impact on the health outcomes for minority veterans.

And last, but certainly not least, I welcome my colleague Congresswoman Heather Wilson, the only woman veteran in Congress. I am sure that all of our witnesses, including our experts and the veterans service organizations will provide critical insight on issues facing women and minority veterans, especially in light of returning OIF and OEF veterans.

Thank you very much and I yield back, Mr. Chairman.

[The prepared statement of Chairman Hall appears on p. 31.]

Mr. MICHAUD. Thank you very much, Chairman Hall. Mr. Turner, do you have an opening statement?

OPENING STATEMENT OF HON. MICHAEL R. TURNER

Mr. TURNER. Mr. Chairman, I want to thank both of the Chairmen for our proceeding with this hearing. This is very important and I want to congratulate and thank Heather Wilson for all of her efforts in Congress, not only to be a strong advocate for veterans in our military, but also to bring her experience to assist us so that we can also better serve. Thank you.

Mr. MICHAUD. Thank you. Mr. Bilirakis, do you have an opening statement?

Mr. BILIRAKIS. I'll submit my opening statement for the record, but I wanted to thank you for having this hearing. I also want to thank Congresswoman Heather Wilson for her great insight. And it is just a great subject and we need to concentrate more on minority veterans and women veterans. Thank you very much. I appreciate it.

[The prepared statement of Congressman Bilirakis appears on p. 32.]

Mr. MICHAUD. Thank you very much. It is my pleasure now to introduce our first panelist, Congresswoman Heather Wilson of New Mexico. I want to thank you very much for your willingness to come here and give us your expertise and your insight on these very important issues. Thank you for your leadership as well on these issues.

So without further ado, Congresswoman Wilson.

STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Ms. WILSON. Mr. Chairman, thank you. And thank you very much for having this hearing today and bringing some focus on an issue very important to me.

Now all of us are concerned about whether the VA health care system is meeting the needs of our current generation of veterans, but there is a special subcategory that sometimes I think gets overlooked. And the fact that you are having this hearing today says

that the Congress and this Committee in particular cares about women veterans and whether they are getting the services that they need.

In 1978, I got a one way ticket to Colorado Springs, Colorado, to attend the United States Air Force Academy in the third class with women. They opened the Air Force Academy to women when I was a junior in high school. And I got on the bus and went to the base of that big ramp at the front edge of the ramp part range in Colorado and walked up a ramp with huge letters over the top of it that said, "Bring me men."

It took over 25 years to get that sign taken down. It is gone now, but some of us as women veterans think that maybe the VA health care system is now only experiencing the kind of integration that the military saw 20 years ago because my classmates and the women who went into the military in the seventies are now starting to retire. And, we also have women returning from combat zones with health care needs that we haven't seen in previous generations. So it creates a new challenge for the VA and I appreciate your willingness to look at this.

Currently deployed in Iraq, 1 in 7 Americans deployed in Iraq and Afghanistan are women. They are doing jobs that in previous generations no women undertook in the military. And we need to orient our health care system toward the needs of both women and men. Women, frankly, face different obstacles when trying to get care from the VA, their needs are often different. Whether it is long term, whether the VA is going to be able to deal with the problems, whether it is osteoporosis or obstetrics/gynecology (OB/GYN) care or cancer screening and treatment or mental health issues and how they manifest themselves, they are often different needs. And we need to make sure that the VA is responsive to those needs.

For example, if you are a veteran and you go to one of the clinics for a problem with PTSD at the VA hospital and they have a support group that is a bunch of guys, is that really where a woman feels particularly comfortable talking about her experiences? I am not sure I would. And I am not sure I would turn to the VA for the kind of care. Likewise, many women veterans do not even call themselves veterans. It is an interesting phenomena. But it is only now that women who have served in the military even use that term to describe themselves. And it is very different from men who have served. Someone, a fellow woman veteran gave me a tee shirt which I still have and wear from time to time around the house that says on the back of it, "I am a veteran too."

Getting women to that point where they feel like they are veterans and they feel comfortable calling on the VA health care system, that the door is open to them, is a hurdle that we have to get over and the VA has to reach out to women veterans, I believe. In addition to those kinds of social or psycho-social issues, there is a question of appropriate care. And while I haven't seen too many specifics incidences of problems in the VA health care system, I certainly had my share of them going through the U.S. Department of Defense (DoD) health care system and I can't imagine that the VA has magically addressed all of these problems without having to kind of go through their own learning curve.

You know, for example, when I was on active duty and they had opened up flight school to women, you had to have a flight physical. Well a flight physical for women included an OB/GYN exam. The rules said that a flight physical had to be done by a flight surgeon, but the flight surgeons often times had only done their, you know, their last OB/GYN exam was in medical school and they didn't like it much when they did it the first time. So there were rules about how health care was to be provided for active duty women that weren't—there wasn't a most appropriate way to provide care. And I believe that those kinds of things probably exist in the VA health care system, but were only on the upward curve now with respect to the women that are getting care from the VA because their numbers have been so small, particularly the numbers of women veterans who are also combat veterans.

In the 110th Congress, I have introduced a piece of legislation. It is a bipartisan commission on wounded women warriors. We focused a lot in the last year about the VA health care system and it's responsiveness to veterans overall. And all of us are keenly aware of the problems at Walter Reed and elsewhere on the care of our returning soldiers and veterans, but I think there is a subgroup we also need to look at. And I introduced this legislation to establish a 12 member bipartisan commission to bring some focus and expertise on this issue, to identify major problems and surface them at senior levels. The military did this in the seventies and eighties and it was very effective at identifying policies that needed to be changed, capabilities and services that needed to be expanded and provided and to better support our women in the military. And now I need to—I think we need to do a similar kind of thing for women veterans.

Last month during debate on the military construction and VA Appropriations bill for fiscal year 2008, I offered an amendment that was accepted by voice that would devote $2 million from the Administration's general operations expenses account to the Advisory Committee on Women Veterans. The intent of that amendment was to provide the funding for a bipartisan commission on wounded women warriors to look at these issues and identify problems and plans to make sure health care for women veterans is what it needs to be so that we can adequately meet their needs.

We can't address the needs of women veterans unless we fully understand the problems. And I don't think we are yet fully at the point of fully understanding the problems within the VA health care system. And I think this Congress needs to make sure that we put ourselves on a path to do so.

I thank you very much for holding this hearing today. And to the extent I can, I would be very happy to answer any questions you may have of me.

Mr. MICHAUD. Thank you very much, Congresswoman Wilson. Just a quick question, do you get a lot of communication between women veterans that might not go to a male Member of Congress that know your experience? And what has been some of their concerns, if there is anything different than what you have already given in your testimony?

Ms. WILSON. Sure. I think women sometimes feel more comfortable coming to me and it is I am sure it is—all of us come here

with our own stories. And sometimes people will come where they feel more comfortable or feel somebody will get it. And so, yes, women veterans do come to me, both New Mexicans and some of the groups nationally or leaders nationally both veterans and active-duty servicemembers.

Some of the kinds of issues is women's health care clinics at VA hospitals. We have had a problem in some VA hospitals including our hospital in New Mexico where several years ago they wanted to close the women's health care clinic. For some women being able to walk in and they are, you know, that they have a women's clinic is kind of important. Now there are a lot of ways and different models to provide that, but that was an issue. And it wasn't just an issue on the appropriateness of health care, it was the VA sending a message as to whether we are welcome here, or not, or do they want us to go somewhere else?

And so that is an issue. I dealt with academy issues with respect to sexual assault, discrimination, those kinds of things come up. I was very active with Mr. Langevin of Rhode Island when women in Saudi Arabia were being asked to wear the abaya with the Muslim cloak while they were fighting to free the Afghan women from having to wear the burka. And they were required to wear by DoD policy, and we were able to change that by law. So, yes, women do come to me.

Mr. MICHAUD. My last question, since there is not a large number of women veterans using VA facilities, trying to look on the fiscal side of the issue, do you think that VA should hire more women staff, or would it be more fiscally responsible to contract out the type of services a woman might need to help women veterans?

Ms. WILSON. I think it is going to depend on the population served and, you know, we have clinics in all over New Mexico that are really quite small. And it so that a veteran can get primary care and in Truth or Consequences, New Mexico, without having to come all the way to Albuquerque. At the same time, the availability of services, particularly OB/GYN services in our major VA hospitals, I think is probably an issue. And the appropriateness of that care, whether it is by a contract doctor or an agreement with one of the universities or direct on-staff hire, and as you all know, the VA has had difficulty filling positions for a variety of reasons over time, but it is an issue of the appropriateness of care. And frankly, some women prefer to have a women doctor as an OB/GYN. And even the policy that says for most hospitals now you are a primary provider. If your health care is from a health maintenance organization, I can go to my primary care doctor. I can also get direct access to my OB/GYN. I believe that is currently VA policy, but making clear that you can go. You don't have to go through another gatekeeper. You can go directly. Those kinds of things I think are important to women.

Mr. MICHAUD. Great. Thank you very much. Mr. Lamborn?

Mr. LAMBORN. I thank you, Mr. Chairman. In counting back the years, I think you were leaving Colorado Springs just as I was arriving there, because I moved there in 1987.

Ms. WILSON. I graduated in 1982.

Mr. LAMBORN. Okay. How prevalent is the problem of women veterans being unaware that their military service qualifies them

for VA health care? We are finding that male veterans are many times unaware of the benefits that they are entitled to.

Ms. WILSON. I think you were right, Mr. Lamborn, that there is a problem of awareness of what benefits you are eligible for across the board. When I left the service, I didn't retire from the service, I left after 7 years as an officer. I had no clue, you know, that I left without any disability or any problems or anything. But I think most folks are pretty clueless. They, you know, we sign off on the forms and go on with our lives and things.

So I think there does need to be outreach, but there really is a difference and it is starting to change, but women do not think of themselves. In my generation of women, we don't call ourselves veterans. I mean it doesn't, it didn't feel comfortable. It is starting to more, but if you don't even think of yourself as a veteran, it is unlikely that you are going to walk into the VA and say, "I am a veteran and I want to see if I can get help."

Mr. LAMBORN. Representative Wilson, you have made reference to that a couple of times now. Why do you think that is the case?

Ms. WILSON. Because guys are veterans. You know, it is. And I don't, I think, probably for younger women, that is not the case. I think for our generation of women there is also an association that you are only a veteran if you were in combat. It is the veterans of foreign wars kind of standard. I even remember I had an uncle, a World War II veteran, and I was serving in the military. He is a loveable person and I thought the world of him. And he arranged for me to be a member of the American Legion Auxiliary, because I thought I should.

Mr. LAMBORN. Okay.

Ms. WILSON. And I was on active duty in the military. And I thanked him so much and I was a member. But we didn't think of ourselves as being necessarily part of the group.

Mr. LAMBORN. Okay. Thank you. Now, the VA has brought authority to contract for care of women's veterans to contract out these services for care. Do you think non-VA professionals understand the unique needs of women who have served in the military, or are they subject to the same possible issues that the VA is?

Ms. WILSON. The difficulty in the VA is that you are still dealing with a fairly small percentage of the clientele who are women. So they are not dealing with these issues in large numbers. I think that one of the areas we do need to look at is combat disabled veterans, and particularly some of the mental health issues that can manifest themselves differently among men and women. How do women approach mental health issues? How do they present themselves? What kinds of therapies are effective? And I having worked with children, mentally ill children, there are some differences among teens and young adults, men and women and what is affective? And I think we're going to need to take a look at that issue.

And we know that there are large numbers of veterans returning with PTSD, acute PTSD as opposed to chronic PTSD, which we saw in the Vietnam cohort or we had been used to dealing with it in the Vietnam cohort. Do these 2 populations of women and men respond different, present differently, and what does that mean for the best kind of treatment, whether that is contract or whether that is within the actual VA system.

Mr. LAMBORN. Thank you. And my last question, to accomplish these goals that we are talking about today, should the VA have women's clinics? Should it better integrate women's health care into existing VA clinics or should it enhance the contracting out of care in community settings?

Ms. WILSON. I like the idea of at least some point of presence. A women's clinic is a way of reaching out to women in a place particularly for OB/GYN care, cancer screenings, those kind of things, preventative health care. But this was one of the reasons why I think we need a high level commission to focus on things for a while to identify major issues and give us advice as legislators as opposed to all of us taking a wag based on personal experience or what we are seeing in our communities. Lets get some smart people together to really focus on this. Call in a lot of women veterans. It is amazing what they will tell when you turn off the microphones and close the doors and say, "What is really happening? What works? What doesn't work? What regulations are you facing that are barriers to you?"

And when we did that with women in the Defense Department, it was amazing. Some of the stupid rules and regulations that were barriers to women getting care.

Mr. LAMBORN. Well thank you for your answers. Thank you for your testimony today. And thank you for all the work that you are doing in this area. And most of all, thank you for your service to our country.

Ms. WILSON. Thank you very much.

Mr. MICHAUD. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. And thank you so much for coming this morning, Representative Wilson. I just had a comment, maybe a question. Well, actually, I was just thinking about what you said about a new generation of women veterans and perhaps that is because we see currently in Iraq, when causalities come, we are seeing a lot of women who are injured and who are losing their lives. I think it is very unfair to your generation, to our generation of veterans that preceded them that they are somehow forgotten. In other words, if they haven't served recently are they really veterans? I think that is sad.

I guess what I would like to know from your perspective is what can we, and the VA do, to really bring the attention back to the people like yourself who have served honorably? We have a responsibility, I think, to and I have said this many times to this Committee to all of our veterans irregardless of what branch, irregardless of what their gender is. What can we do, do you think, to get the VA and to promote the type of benefits for veterans so that they—you know you just said you get women behind a door and you shut off the microphones and they will talk a lot. What could we do to enhance that and to be able to get more women to be able to understand that there are benefits available, and how to get them? Because I think it is terribly important that we do this.

Ms. WILSON. A couple of things. First of all, I think it is important for the Congress as a Congress to establish a commission and say, "Let's get some smart people and get some recommendations on what legislation and programs we need to support. I think that is important and it allows us to provide some leadership.

One of the things that is important, and I heard someone slip recently in a position of public prominence, I don't want to identify them in a speech talking about our men in military. Our men overseas.

Mr. HARE. Uh huh.

Ms. WILSON. It was the first Persian gulf war when the lexicon of American public life changed for the first time. When you heard at that time, General Colin Powell, Brent Scowcroft, the first President Bush, the Members of Congress, for the first time they talked about our men and women in the Persian Gulf. The military had gone co-ed. And that was the first Cable News Network (CNN) war really where, you know, America was surprised that we had women helicopter pilots flying into harms way in front of the infantry forces. It was a major social change. But we can't go back, as I and that was just a slip, but I heard it. And when someone said, "Our men in the military. Our men in Iraq and Afghanistan." Language matters, and people like me will hear that if you say it.

I would also encourage, you there are now, there is at least in New Mexico and I think it is growing national movement. I look at all the flags behind you and all of us have the Jewish War veterans and the Purple Heart veterans and the American Legion and the VFW that all come to see us and see all of you annually. There is now a group starting and I think it is nationwide, but a chapter has started in New Mexico of a national Association of Women Veterans. We have to stand up first for ourselves. And I would encourage you to reach out to women veterans and ask them to come in and talk to you about what is going on with the VA in your community.

And I am a member of some of those organizations of women veterans and there is an Association of Women Aviators that I am an honorary—well I am an associate member of I guess. I am not an aviator by profession. But those kinds of things I think help women to bring our issues to the floor just like the Reserve Officers Association does and make people aware of problems.

So a commission, meet with people, and as leaders be careful to include us.

Mr. HARE. Absolutely. I am sorry I came in late and I don't know if you mentioned this in your testimony or not, but do you have any idea of how many women veterans we are talking about think are being underserved or not being served?

Ms. WILSON. In Afghanistan and Iraq, 1 in 7 Americans serving there is a woman. There have been over 2 million American women who have served this country in uniform in our history. Over 2 million and every single one of them was a volunteer.

Mr. HARE. That is amazing. Thank you very much.

Mr. MICHAUD. Thank you, Mr. Hare. Mr. Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman. I have one question. First of all, thank you for your testimony and enlightening us on this issue. Do you think it would be helpful if we had a program within the VA where women veterans can talk to women veterans and identify with them whether it is outreach, any kind of an issue. Would you think that would be helpful?

Ms. WILSON. The VA does have an office for women's veterans that does outreach and so forth, but I actually think it is helpful

to facilitate women coming together. At one time in my deep dark past, I served on the Defense Advisory Committee on Women in the Service after I had left the military but came back. And one of the great things about those conferences and meetings that we had was women in the military got together and there was cross talk.

If you are in any group and you were talking about there is what 6 percent now? Between 6 and 8 percent of our veterans are women. That means in any room with 100 people there are only 6 women. You are feeling a little isolated in any group. If you make the effort to pull women together so that you can get cross talk about what is going on in my State, in your State, and the health care system and so on, you get good ideas that come out of that and you help to identify problems.

The VA does have an office for women veterans. I am not sure how much they really bring together in a working group kind of way, those kinds of colloquy to pull together women veterans in a circumstance where they are not out numbered. And to be able to take our shoes off and say, "So what is going on in your State, because this one is a mess," or whatever it is. I think it would be helpful.

Mr. BILIRAKIS. And maybe making sure that we mandate that there is one, at least one person at an out-patient clinic or the VA where the veteran can go to that individual, making sure that that is a women so they feel comfortable talking to them.

Ms. WILSON. There are up sides and down sides to that, which is why I get back to lets pull some people together and make sure the system of care is responsible. If you created it at one VA hospital the women's office or the women's advocate in some ways that says to the rest of the system, "Well, I don't have to deal with that. Go down to the women's office. Now that is not my job," as opposed to if you are a cancer specialist or the oncology department has to be taking into account possible screenings for breast cancer and cervical cancer, so integrating into the way the VA does it's business.

But I do think that there is advantage, particularly in OB/GYN, care to having systems set up so that women feel as though they are welcome here. There is a place for——

Mr. BILIRAKIS. Sure.

Ms. WILSON [continuing]. And they are not separate but equal or pushed out somewhere else.

Mr. BILIRAKIS. Make sure that there is a women's counselor there available for them. Would you agree with that?

Ms. WILSON. Yeah, I would. But I don't want to say, "All right, we are going to create a space within the VA for women and this is the women's office and that is where we deal with that problem because we are the VA, and you know just stay over there. We have got a little office for you in the closet."

Mr. BILIRAKIS. Okay. Thank you very much. I appreciate it Mr. Chairman. Thank you.

Mr. MICHAUD. Thank you very much. And once again, thank you very much, Congresswoman Wilson. We really appreciate you enlightening us on this particular area. And thank you for your serv-

ice not only to your constituents back in your district, but also to your country. So thank you very much.

Ms. WILSON. Thank you, Mr. Chairman. I appreciate it.

Mr. MICHAUD. We will now move to our second panel. And I would ask that the members of the second panel to please come forward.

I would like to thank the second panel. We have for the second panel Shirley Ann Quarles who is Chairwomen of the Advisory Committee on Women Veterans; Colonel Reginald Malebranche who is a member of the Advisory Committee on Minority Veterans; Saul Rosenberg, who is Clinical Psychologist at the University of California, San Francisco; and Maureen Murdoch who is a VA Medical Center doctor in Minneapolis.

So I want to thank the panelists for coming today. I look forward to hearing your testimony. Why don't we start with Dr. Quarles and work our way down?

Thank you once again for coming here this morning. Dr. Quarles?

STATEMENT OF SHIRLEY A. QUARLES, R.N., ED.D., CHAIR, ADVISORY COMMITTEE ON WOMEN VETERANS, U.S. DEPARTMENT OF VETERANS; COLONEL REGINALD MALEBRANCHE, USA (RET.), MEMBER, ADVISORY COMMITTEE ON MINORITY VETERANS, U.S. DEPARTMENT OF VETERANS AFFAIRS; SAUL ROSENBERG, PH.D., ASSOCIATE CLINICAL PROFESSOR OF MEDICAL PSYCHOLOGY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, CA; AND MAUREEN MURDOCH, M.D., MPH, CENTER FOR CHRONIC DISEASE OUTCOMES RESEARCH, MINNEAPOLIS VETERANS AFFAIRS MEDICAL CENTER, MINNEAPOLIS, MN, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS (ON BEHALF OF HERSELF AND NOT VA)

STATEMENT OF SHIRLEY A. QUARLES, R.N., ED.D.

Dr. QUARLES. Thank you. Chairman Michaud, Chairman Hall and Members of the Subcommittees. I am Chair of the Department of Veterans Affairs Advisory Committee on Women Veterans and also a Colonel in the United States Army Reserve. I am pleased to testify today on behalf of the Department of Veterans Affairs Advisory Committee on Women Veterans regarding our views on: The Department of Veterans Affairs and how they serve women veterans through it's current programs; the present and future needs of women veterans, which is a growing population; VA strategies to meet those needs; and outreach efforts that are being conducted on women veterans.

The Advisory Committee was established in 1983 by Public Law 98–160 and charged with advising the Secretary of Veterans Affairs on VA benefits and services for women veterans. The Committee submits a biennial report to the Secretary about findings and recommendations.

The Advisory Committee on Women Veterans consists of 14 members, men and women who are mostly veterans. As a means to obtain information regarding women veterans' services, and programs provided by the VA, the Committee conducts site visits to

VA facilities throughout the U.S. During the site visits, the Committee tours the facilities, meets with senior leaders, and hosts an open forum for the local women veterans community. The forum provides an opportunity for open dialog to learn more about women veterans' experiences within the VA, to discuss issues, and for women veterans to raise questions regarding gender specific VA benefits and services.

Another means for the Advisory Committee on Women Veterans to obtain information regarding services provided by the VA is by meeting twice a year at VA Central Office in Washington, DC. During these meetings the Committee has briefs from various program leaders. The Committee also submitted recommendations to the Secretary in their 2006 Report. The Committee made 23 recommendations that addressed mental health, outreach, research, strategic planning, training, women veterans health program, and women veterans health program managers and coordinators and homeless women veterans.

One recommendation that has already been implemented is the organizational realignment of the Women Veterans Health Program Office to Strategic Healthcare Group. This recent realignment elevated the Women's Health Program Office and provided it an opportunity to gain more expertise in the area of women's health.

To address a strategy as it relates to VA meeting the present and future needs of women veterans, the Committee was able to witness first hand the need to provide mental health care during a site visit at Palo Alto VA Women's Center for Mental Health. Another strategy that the Committee recommends for future needs is through research studies. Research studies were recommended in both the 2004 and 2006 Advisory Committee on Women Veterans Reports.

Also there is a current national survey that is being conducted to address the knowledge gap we have regarding women veterans. The final findings for this national survey will be submitted December of 2008. As it relates to outreach, the Advisory Committee on Women Veterans 2004 Report recommended that materials such as brochures, pamphlets, booklets, and fact sheets be published in both English and Spanish languages.

The Committee also encourages increased partnership with the Federal, State, county agencies, and national veterans service organizations. Additionally, the Committee plans to participate in the upcoming 2008 National Summit for Women Veterans.

The Advisory Committee on Women Veterans is grateful to the VA and to the Center for Women Veterans for taking care of our women veterans of yesterday, today, and the future.

This concludes my formal testimony. I will be pleased to answer any questions.

[The prepared statement of Dr. Quarles appears on p. 33.]

Mr. MICHAUD. Thank you very much. Colonel.

Dr. QUARLES. Thank you.

STATEMENT OF COLONEL REGINALD MALEBRANCHE, USA (RET.)

Colonel MALEBRANCHE. Chairman Michaud, Chairman Hall, and Members of the Subcommittee, I am indeed honored to represent the Chairman of the Advisory Committee on Minority Veterans and give you our views on the services provided by the Department of Veteran Affairs.

Pursuant to Public Law 103–146, the Committee is tasked with assessing the needs of the minority veteran population and reporting back to the Secretary on the effectiveness of the programs and services at meeting those needs. The Committee works in close coordination and collaboration with the Center for Minority Veterans and relies on the expertise of the Center for current information about VA programs, policies, and services.

In it's 2006 report on the Greater Los Angeles Healthcare System, the Committee made 11 recommendations with the key issues being outreach, research, staff diversity, and seamless transition. During its visit to the Los Angeles Ambulatory Care Center, the Committee was dismayed by the staggering number of homeless veterans. Twenty-three percent of the 90,000 homeless population in Los Angeles were reported to be veterans. The Committee was encouraged though by the range of programs identified by VA for homeless veterans, yet the Committee was concerned that these programs may not reach the targeted audience.

Outreach is a major challenge for the VA. At the townhall meeting, the Committee learned that the major issue was that minority veterans were unaware of their VA benefits and other VA services available. Transportation to VA Centers in major metropolitan, rural and isolated areas is an impediment for minority veterans. Accessibility, affordability, and distances to VA Centers are major problems affecting minority veterans.

Much remained to be accomplished in the area of outreach. The Committee recognize that is not simply a VA issue. Several of its members have taken the mantle to assist the VA in its quest to reach out to minority veterans.

Access to care is another challenge for VA. The plight of Alaskan natives and other minority veterans living in rural and isolated areas cannot be ignored. The challenge for VA is to develop and implement innovative programs which target those minority veteran populations. Rural and remote areas in Alaska and the Navajo Nation may be good targets to test rural health initiatives. VA could enter into a reimbursable agreement with Alaska natives organizations, Health and Human Services, and the Indian Health Service to reach out to minority veterans and provide all the services which fall within the realm of VA.

The Committee applauds the strides made by VA in expanding its telehealth and telemedicine programs and its ability to reach a significant number of the minority veteran population.

Mental health is and will become a major challenge. The Committee recognizes the efforts and the programs put forth by VA to support, identify, and care for service personnel who serve and are serving in OEF and OIF. The early identification of post traumatic stress disorder will certainly help in the observation and treatment of veterans who served in those areas. Yet, the Committee is con-

cerned that the same level of services might not be readily available to minority veterans who have served in prior conflicts.

Electronic health records are another part that we need to develop and embrace all services personnel with VA. The processing and adjudication of benefits seem to affect all veterans and to make them aware of their entitlements. The Veterans Claim Assistant Act of 2000 puts the onus on VA to maximize its assistance to all veterans.

Senior staff diversity remains an issue at VA. The absence of minorities at the senior staff level has been, and continues to be, noticeable during site visits. Data presented and subscribed by VA suggest that VA's problems is limited to recruiting white females and Hispanic females, yet all the data maintained at VA suggested that minorities were not well represented at senior staff levels.

The professionalism, the expertise shown by VA personnel was striking. There was a perception that most staff would endeavor to do anything or everything for a veteran. The challenge is to include minority veterans in that equation and that philosophy.

Sir, I thank you for this opportunity to address the Subcommittee. And I would be happy to answer any questions. Thank you very much.

[The prepared statement of Colonel Malebranche appears on p. 35.]

Mr. MICHAUD. Thank you very much, Colonel. Dr. Rosenberg.

STATEMENT OF SAUL ROSENBERG, PH.D.

Dr. ROSENBERG. Thank you both Chairmen and the Committee for inviting me this morning. I am Dr. Saul Rosenberg. I am a clinical psychologist. I did my very first clinical training at the Ann Arbor VA and it has stuck with me ever since. I currently teach and supervise interns in residence at the San Francisco VA, which is associated with University of California, San Francisco (UCSF) where I am on the faculty. I am not currently on the faculty or receive salary from the VA. So I am, I would say, independent of the VA and a friend of the VA.

My interest is in mental health and what the needs are for screening returning troops, when troops screen positive what kind of diagnostic assessments are conducted, and what kinds of treatment recommendations are made, and how can we follow up treatments to make sure that the veterans are getting the most affective treatments.

So we can start with screening. The DoD, and with the VA and the Deployment Center, have started the use of pre- and post-deployment questionnaires, which is a wonderful innovation. Soldiers coming back are filling out brief questionnaires regarding exposure to combat, regarding symptoms of PTSD, regarding possible exposure to roadside bombs and improvised explosive devices (IEDs). The returning soldier then has an interview with a primary care physician who goes over the form, and from that interview a determination is made whether they need to go on to more intensive evaluation and treatment.

My colleagues at UCSF and the San Francisco VA recently completed a nationwide epidemiological study of veterans returning from Iraq. They studied over 100,000 veterans in VA health care

facilities all across the country. They found a high prevalence of mental disorders. Mental disorders that fit the criteria of the diagnostic and statistical manual of the American Psychiatric Association were about 25 percent and about 5 percent had psycho-social and social relational problems.

So almost a third of this sample had diagnosed mental disorders. Now these disorders were not based on just the screening form, they were based on the actual diagnosis. There have been reports about the prevalence of PTSD based on the screening form and so it is important to note the difference. This was an actual diagnosis.

The sample, I think, was pretty representative of women and racial groups. And one of the positive things about the study is that they did break their results down by racial groups. A simple recommendation that I would make that would help us understand better the needs and the treatment outcomes of women and minorities is to ask researchers to include gender and a description of race, education, and marital status, all of those variables, when they are doing research so that we have an opportunity to look and see if in fact there are differences. Oftentimes you will see reports in the literature in which there is no comment at all about race or gender as if everyone is the same. Researchers should be aware of that.

A related point is that the assessment of mental disorders requires a clinician to do an interview and often benefits from psychological test, which is my area of expertise. Now psychological tests have often been developed on a white middle-class population. And so psychologist know, and the American Psychological Association has put out papers on this topic, that there needs to be more what is called culturally sensitive and culturally competent assessment. Having an individual of this same race interview and test a veteran is a proxy in a way for that cultural sensitivity. What we care about is does the interviewer or the doctor, the evaluator is that person capable of empathizing with the experience of the person that they are evaluating? And more particularly, do they know anything about the values and preferences of that person? Particularly if that person comes from another culture. So there has been a move within the American Psychological Association to do culturally sensitive training and the result has been more satisfaction of individuals of a different race than the treating doctor when the treating doctor has gone through a training program that helped him be more culturally sensitive.

In this sample of 100,000, women comprised 13 percent; 69 percent were white; 18 percent were black; 11 percent Hispanic; and 2 percent came from other racial groups. The most striking finding in the study wasn't about race or gender, it was about the different risk of developing PTSD and mental disorders in our youngest veterans. Veterans between the ages of 18 and 24 had dramatically higher risk of developing PTSD or mental disorder than veterans 40 years and over, irrespective of race.

That is an important finding. And we have to think about, well how can we use this information? I have, like many of my academic colleagues, written papers and they get published in peer review journals and they are mostly read by other doctors and psychologists and clinical investigators. The serving the needs of the vet-

erans returning from Iraq requires a different kind of research. At UCSF, we call it clinical and translational research, which means we need research on real patients, clinical research, but we have to translate that research into actual services that benefit patients and then study whether the treatments we are doing actually work.

We can't expect providers to be going into the academic literature to find information they need about treating an individual. So, for example, this fact that young veterans are at much higher risk, that information belongs in a clinical practice guideline that comes up on the doctor's screen automatically as the doctor is seeing the patient in that age group. You are about to interview a patient between the ages of 18 and 24 and a little alert or reminder comes up. A little pop-up comes up on the screen, "This group, younger veterans, may be at more risk. Consider asking a few additional questions."

Mr. MICHAUD. Doctor, I was wondering, since your time has expired, could you please summarize? I am sorry to interrupt you.

Dr. ROSENBERG. The main point I want to make is the VA has conducted wonderful research and National Institute of Mental Health (NIMH) has conducted wonderful research. We need to bring that research into the clinical situation. The VA is an ideal place to do that because of its excellent electronic health record, VistA. What I am talking about is taking the next step, which is developing clinical practice guidelines within VistA and then the next step beyond that is developing clinical decision support systems. These are systems that can integrate biomedical and psychosocial data and suggest diagnosis or treatment plans and offer ways to evaluate how effective a treatment is.

Clinical decision support has been used in medicine for decades. It has been relatively rare in mental health. And there is a possibility of a great contribution that could be made in mental health from clinical decision support systems.

[The prepared statement of Dr. Rosenberg appears on p. 37.]

Mr. MICHAUD. Thank you, Doctor. Dr. Murdoch.

STATEMENT OF MAUREEN MURDOCH, M.D., MPH

Dr. MURDOCH. Thank you. Mr. Chairman and Members of the Subcommittees, thank you for the opportunity to appear before you today. Today I will present some findings from my team's research on possible disparities in PTSD disability awards among race and gender groups. I must note that the views presented here today are mine and do not necessarily represent the views of the Department of Veterans' Affairs. And they reflect the results of my studies and not necessarily the findings of others. And I also need to point out that unfortunately after this panel is done I am on service at Minneapolis and so I have to leave and catch a plane and go back to the hospital. So, I apologize for that.

PTSD as you may know is the most common psychiatric condition for which veterans seek VA disability benefits. And long-term health studies indicate that women have a higher prevalence of PTSD than men and may be more susceptible to PTSD. Conversely, African American or black persons appear to have similar risk for PTSD compared to persons of other race or ethnic groups.

In 2000, my colleagues and I began investigating if there were race and gender disparities in VA disability awards for PTSD. We assembled a representative sample of almost 5,000 men and women veterans who applied for disability benefits on the basis of PTSD between 1994 and 1998. We tested 4 hypotheses examining the relationships between PTSD symptoms severity, the level of disability, combat experience, and a race or gender differences as they impact the determination about service connection.

Overall, the 3,337 respondents were highly symptomatic. About 80 percent met our definition for PTSD and 62 percent were service connected for PTSD. Concerning the relationship between PTSD and gender: PTSD service connection and gender, once we controlled for combat exposure, the effect of gender and service connection for PTSD became insignificant. However, because men had notably greater combat exposure they likewise had a higher rate of service connection.

In our investigation of racial disparities we found that in our sample African Americans were just as likely to be service connected for disorders other than PTSD as the rest of the respondents. However, they were substantially and significantly less likely to be service connected for PTSD compared to the other respondents.

The negative association between African American race and service connection for PTSD was not found for any other racial or ethnic group. Now among the veterans who actually got service connection PTSD the service connected rating or the degree of service connection awarded was similar regardless of race. So African American respondents had an average service connected rating of 43 percent—if they were service connected—and other veterans had an average service connected rating of 45 percent, if they were service connected.

However, after fully adjusting for everything that we could think of, the estimated probability of being service connected for PTSD was 43 percent for African American veterans compared to 56 percent for other respondents; a 13 percent difference. Examining clinicians were about seven-tenths as likely to diagnose PTSD in African Americans as they were to diagnose PTSD in other veterans.

When thinking about these results, there are several issues that need to be considered. First, the pool of respondents was selected based on their submitted claims for PTSD service connection. But our questions focused on their current health and adjustment status. It is distinctly possible that those with the greatest need at the time of their application have been receiving treatment and now may actually report better health outcomes then their peers.

Second, the study relied on veterans' self-reports of their PTSD symptoms severity, the degree of disability and trauma history, which may not have been clinically accurate or universally consistent.

So, I have a few recommendations. In order to strengthen and expand this research, I would suggest that future studies identify and evaluate veterans shortly after applying for PTSD disability benefits, instead of 2 years later as we did. And in addition, we need to collect and assemble more data from the claims file to supplement survey data. And finally, I would recommend that future

studies investigate for possible disparities in disorders other than PTSD, when we think about service connection awards.

Mr. Chairman and Committee Members, this concludes my statement. And I am pleased to respond to any questions that you may have. Thank you.

[The prepared statement of Dr. Murdoch appears on p. 40.]

Mr. HARE. Thank you, Doctor. And let me thank all the panelist for being here. I have a number of questions and I know, Doctor, you have to leave fairly soon. We will try to brief on this. I don't want you to be late getting back to work and getting in trouble on my account.

So Ms. Quarles, I was pleased to see that the National Survey of Women Veterans is being implemented with results expected in December of 2008. In your estimation, what do you think are the 3 most prevalent or urgent issues facing women veterans today?

Dr. QUARLES. I think that, or the Committee feels that, issues that are facing women veterans today certainly access to care. And these are women veterans who live in the rural areas.

Another concern that we feel the Advisory Committee has observed through briefings and visits is that primary care in the Community Based Outpatient Centers (CBOCs), in the clinics is the same as the services provided at the facilities.

And also another concern that we are hearing through our open dialog from women veterans is that women veterans want to know that they can receive the same equal health care as their male veteran counterparts.

Mr. HARE. To my knowledge, the VA has not yet held any type of summit or conference on OEF or OIF female veterans and the unique needs that are arising with women being in combat. Has the Advisory Committee looked into this and if so what have you found, if anything?

Dr. QUARLES. Well the Advisory Committee is learning through our briefs and through our visits that mental health care is certainly continuing to be an issue and that there is a need for mental health care to be enhanced throughout. One of the concerns we have is the training. Training for personnel with the VA as well as training for affiliated professionals who come to the VA to understand the women veterans population regarding unique needs they will have. And it is very important that we look at the continue monitoring of training for our professionals and the VA.

Mr. HARE. Thank you. Colonel, I was just wondering in your testimony you stressed the absence of diversity at the senior staff level. When the Committee presented their concerns to the VA about this issue, how did they respond to you?

Colonel MALEBRANCHE. They will look at it, sir, and then, however, though when we look at the data, the data that VA utilizes seems to suggest that their major problems is in the recruitment of white females and Hispanic females. However, all the data at VA suggests otherwise. So it appears to be an aspect of using the data that is available in terms of what it shows and then presenting that to—if you tell me that I can only recruit white female and Hispanic female that is all I am going to try to recruit.

Mr. HARE. A big concern regarding the provisions of care to the minority veteran population is sensitivity to the cultural dif-

ferences of minority veterans. For example, the differences in how to approach an Alaskan Native veteran community as opposed to Hispanic veteran community. Does the VA provide education to many of it's employees on cultural competencies and sensitivities, particularly to the frontline medical personnel, to your knowledge?

Colonel MALEBRANCHE. Sir, I think there is an attempt at doing that for the staff. Alaska is a particular issue because, one, the location of really the population at risk and the ability to get to that population. The diverse dialects that they are spoken in Alaska. So it presents some different challenges. I think the challenge is basically to find means to use the Alaskan Native organization that already exist possibly even the U.S. Department of Health and Human Services or the Indian Health Service and enter into an agreement, reimbursable agreement or cooperative agreement that is going to target those population.

Recently, Alaska probably had the largest deployment of Alaskan Natives to OEF and OIF. And those units are slowly coming back.

Mr. HARE. Thank you. I guess this is both for Dr. Rosenberg and Dr. Murdoch or whoever would like to take a stab at this. You mentioned, and I know my time is running out, but I was interested in the testimony and your comments on the fact that African American veterans were about half as likely as other veterans to receive service-connected disability for post traumatic stress disorder. I am wondering from your perspective why this is happening. Do you have any thoughts on, why it is happening and what we can do to improve this? Because it seems to me to be grossly unfair here.

Dr. MURDOCH. That is an excellent question. I think that, first of all, keeping in mind the limitations of the study it would be extremely helpful to replicate it collecting better data. And second of all, to expand upon it to try and understand why those differences exist.

Mr. HARE. Dr. Rosenberg.

Dr. ROSENBERG. That would cover it for me, but I would like the opportunity to add something of that——

Mr. HARE. Sure.

Dr. ROSENBERG [continuing]. Unique needs of women veterans. The Institute of Medicine was asked to do a report on PTSD disability in veterans. It is an excellent report. And they expressed a concern that women are victims of sexual assault called military sexual assault. That those women victims are not getting sufficient treatment, identification, or disability determination. It is a lot harder to prove sexual assault than you were in combat. And the Institute of Medicine recommended much more attention be paid to understanding this phenomena of military sexual assault, doing everything we can to prevent it. And making sure that those individuals who are injured in that way do receive treatment, rehabilitation, and disability.

Mr. HARE. Thank you, Doctor. Mr. Lamborn.

Mr. LAMBORN. Thank you Representative Hare. Dr. Murdoch, just to clarify something, I think you eluded to this, but I just wanted to make sure I understand. Did you document and verify the combat history disability status or PTSD diagnosis of the individuals in your study or did they self report those factors?

Dr. MURDOCH. We got the disability status from VBA records. They self-reported their PTSD, their combat exposure, and I forget the last one that you asked about.

Mr. LAMBORN. Combat history, disability status, and PTSD diagnosis.

Dr. MURDOCH. Yeah. So PTSD diagnosis and their disability status in terms of how disabled they reported themselves to be, those were self-report.

And then we did take a small sample, 11 percent, where we also audited their claims file and tried to verify what they reported in the survey. And it seems that the—that their reports of PTSD matched up with the clinical diagnosis that they were being given in the claims file.

Mr. LAMBORN. And, Doctor, what was that percentage again?

Dr. MURDOCH. About 80 percent.

Mr. LAMBORN. That you audited their——

Dr. MURDOCH. Right. So about 80 percent met survey criteria for PTSD and then when we did the claims audit and looked for a clinical diagnosis by a qualified examiner in their claims file, 80 percent of them had a diagnosis of PTSD.

Mr. LAMBORN. Okay. Thank you. And I yield back to the Chairman.

Mr. HALL. Mr. Bilirakis.

Mr. BILIRAKIS. I don't have any questions.

Mr. HALL. Okay. Thanks so much. Let me thank the panel and wish you a safe trip back to all of you. Thank you for taking the time to be here for this morning. Thanks so much.

Dr. MURDOCH. Thank you.

Dr. QUARLES. Thank you.

Mr. HALL. Our next panelist is Joy Ilem who is the Assistant National Legislative Director for the Disabled American Veterans.

Thank you, Ms. Ilem. Sorry for disappearing and then reappearing. You are now recognized for 5 minutes. Your written remarks will be submitted for the record.

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

Ms. ILEM. Thank you very much. Mr. Chairman and Members of the Subcommittees, thank you for inviting DAV to provide testimony on the present and future needs of women and minority veterans seeking services from the Department of Veterans Affairs.

In June 2007 the VA Health Services Research and Development Service completed a systematic review of racial and ethnic disparities in the VA health care system. Researchers concluded that disparities appear to exist in all clinical arenas. According to the researchers, one key finding was especially troubling since it may indicate that disparities in health care delivery are contributing to real disparities in health outcomes.

It is clear from the findings of this recent study that much more needs to be done in this area, therefore, we urge VA to continue it's research, to adjust policies, and to provide appropriate resources to eliminate racial disparities in VA health care.

In preparing for this hearing, we also reviewed the most recent annual report available from the VA Advisory Committee on Mi-

nority Veterans. The Committee made a number of recommendations, but of special concern was the issue of outreach to minority veteran populations. We agree with the Advisory Committee that the VA should clarify it's policy with regard to outreach to ensure minority veterans are aware about their VA benefits.

We support the recommendations made by the Advisory Committee and applaud it's continued efforts to increase awareness about minority veteran issues and advance the quality of services minority veterans currently receive.

With increasing numbers of women serving in the military and with more women veterans seeking VA health care following military service, it is essential that VA be responsive to the unique demographics of this population. In addition, VA must ensure that it's special disability programs are tailored to meet the unique health care concerns of women who have served in combat theaters and those who have suffered catastrophic disabilities as a result of military service.

Researchers report that VA care for women veterans is fragmented. Researchers also found a number of barriers to delivering high quality health care to women veterans. Specifically, field reports of insufficient funding for women's health programs, competing local or network priorities, limited resources for outreach, inability to recruit specialists and an insufficient number of clinicians skilled in women's health. We urge VA to implement recommendations by researchers to address these barriers.

Several years ago VA established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. We strongly encourage VA as it takes steps to advance this agenda to focus on research and programs that enhance VA's understanding of women veteran health issues and discover new ways to optimize health care delivery and improve health outcomes for this patient population.

The challenge of addressing the unique health care needs of the newest generation of women veterans returning from combat theaters in Iraq and Afghanistan is daunting. In reviewing VA's health care utilization data we see increasing numbers of women veterans accessing VA health care and increasing rates of PTSD and other medical conditions among women who served in combat theaters.

DoD and VA need to coordinate and improve sharing of data and women's health information. We also need to learn more about what barriers exist for women veterans trying to access VA care following deployments.

In closing, VA needs to ensure priority is given to women veterans programs so quality health care and specialized services are available equally for women and men. VA must continue to work to provide an appropriate clinical environment for treatment even where there is a disparity in numbers. Given the changing in roles of women in the military, VA must also be prepared to anticipate the specialized needs of women who were sexually assaulted in the military or catastrophically wounded in combat theaters.

Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA must address the health issues that pose special challenges for women.

DAV has recommended that VA focus its women health research on finding the health care delivery model that demonstrates the best clinical outcomes for women veterans. Likewise, VA should develop a strategic plan along with DoD to collect critical information about the health status and care needs of women veterans, with a focus on evidence based practices to identify other strategic priorities for its women health research agenda.

Mr. Chairman, that concludes my testimony and I will be happy to answer any questions that you or Members of the Subcommittees may have. Thank you.

[The prepared statement of Ms. Ilem appears on p. 41.]

Mr. HALL. I thank you Director Ilem and thank all DAV members for their work and to their service.

I first of all wanted to ask regarding your statement that it is unlikely that the past experiences of women veterans in the VA will serve as an accurate guide because of the unique experiences of women who served in OIF/OEF, particularly because of this ongoing exposure to combat conditions. Could you elaborate further, please, on why this is true and offer your opinion on a few things that the VA can do to prepare for the impending influx of women veterans of OIF/OEF?

Ms. ILEM. Sure. Thank you for the question. I think that, you know, and this is—that came about as from talking to different mental health providers within the VA. And I think, you know, the equal access to health care for specialized programs for men and women is extremely important. And this newest generation of veterans returning are looking like there is some unique health concerns and mental health, perhaps mental health issues as well that need special attention.

One of the things that I think would be important is to really talk to these women in terms of looking at the barriers for care that they perceive or have had and exist, you know, trying to access VA care. So just by doing the patient satisfaction report, I don't think you are going to see that within VA. Those are people that are using the VA system, but what about those that have met up with a barrier and aren't feeling that they, you know, can use VA health care or have had some problem getting that care.

So I think it would be important to talk to them directly, for VA to hold focus groups with these women veterans. And people that have expressed a barrier to getting care for those services.

Mr. HALL. You mentioned in your testimony that one of the Advisory Committee's recommendations was to expand outreach to all veterans, including minorities. Can you elaborate on what you believe would be useful and adequate measure to improve those outreach programs?

Ms. ILEM. I think that, you know, just outreach in general is extremely important I mean to all veterans, obviously. And then with special attention, I think, as has been mentioned by the previous panel to looking at unique concerns of either minority populations or women veteran population. Things that you need to do specifically to outreach to them that they have found, you know, seems where there is a barrier. And make sure that things are culturally sensitive to some, you know, to their needs.

And I think you know VA I think is trying to do a very good job in terms of the transitioning veterans that are coming out of the military, but I don't know how much focus in terms of outreach has been put on specifically minority veterans and women veterans. I think that, you know, we would like to see more being done in that area as well in terms of working with DoD to get on those bases to make sure the people as they are transitioning out are aware of their benefits.

And then I know that VA is providing doing a letter to all veterans coming back from OEF/OIF, but you know probably continued follow up needs to be done. There are reports from the Women Veterans Advisory Committee that often these veterans go back to their communities and then just disappear or their work, you know, they have children, they have other things that they are trying to accomplish in their lives and they just don't get that message that there is great benefits out there in terms of VA health care and services that could help them.

Mr. HALL. Thank you. You also mentioned that some women will suffer from severe PTSD, which will require more intensive evidence-based treatment. I am curious if you have noticed any difference between PTSD issues that women face compared to men? It is the old Mars and Venus thing. I have known that in the educational and psychological communities there is quite a lot awareness about the difference in how women perceive the world and react to it and how men do.

Also with regard to women with children, the stress that they feel because of fear for their children or the stress that the children are feeling, that the women and mothers feed off of in some instances. In particular, is child care at VA facilities something that we should focus on more so that we remove that barrier to mothers who have no other option to seek treatment themselves when they have children at home?

Ms. ILEM. Right. Right. Thank you for that question, those series of questions. I just spoke with a former VA mental health provider that for many years, that I really look to, that has been involved in this issue and participating on the Dole Shalala Commission as well. And you know, in talking to him about these evidence based treatments and how important they are and how case intensive they are. I asked him, you know, that very question, "What are you seeing? What are women reporting or what are the doctors reporting that are seeing them, you know, that have had combat PTSD related and males? Are you putting males and females together? What are, you know, what is happening out there?"

And it was interesting he noted that women are reporting and he is hearing from clinicians that they are—when women have combat related PTSD that they prefer to be with their fellow soldiers, so male and female. That seems to be appropriate. They feel that connection. They have been through the same thing, they have had similar experiences. And although there is some evidence-based treatment, I understand in current research of evidence-based treatment and that is specific to women, you know, that it is still the clinical move for putting them together in that environment appears to work best for them so far from what they are seeing.

The difference is if it is the dual burden of sexual trauma and combat related, certainly women veteran may not feel comfortable being in an environment, you know, with male colleagues talking about something as personal as sexual assault. I am sure either a male or a female probably would have similar feelings.

So you know that is more of a unique consideration in terms of being able to have the number of providers that are needed for this very intensive resource-based evidence-based treatments for PTSD. And making sure that clinicians not only are trained in it, but then have the time to work with these patients where it is, you know, on an outpatient basis but it may be very over a number of days a week, many hours a day.

On the child care issue thinking long and hard on that. I mean certainly women often are the primary caretaker of women either if they are married or single parent. And attending the Evolving Paradigms seminar that VA put on conference out in Las Vegas, there was a panel on women veterans talking about their experiences. They were all from OEF or OIF. And I mean that was a real eye opener, but listening to women talk about sometimes having trouble re-connecting with their children because of the emotional distress that they are going through based on their experience in the military and exposure to combat.

And if they are the primary caretaker that is obviously, you know, a real concern in the family to be able to have that re-connection and get them the help that they need in terms of re-connecting with their family and their children, but also if there are these evidence based treatments available, if they have child care as a responsibility and they can't afford child care then, you know, what is the option for them?

So I am hoping that VA will their Women Veterans Program managers are excellent group of people that, you know, are very innovative and can think of ways to maybe connect with the community or to see what the need is out there. What they are hearing and seeing from women veterans and if that is something that they can do to either work with the community or a voucher. Do something to make sure they can also participate in those programs.

Mr. HALL. Thank you very much for your generous and detailed response. My time has expired. I will now recognize Mr. Bilirakis.

Mr. BILIRAKIS. Thank you Mr. Chairman, I appreciate it. Thank you Ms. Ilem. You did an outstanding job. Thanks for your testimony.

In your written testimony you state that, "Although the VA has improved health care services for women veterans . . . privacy issues for women veterans still exist at some VA facilities." That really concerns me. Are these deficiencies concentrated in a particular region of the country or are the spread out throughout the health care system? That is my first question.

Ms. ILEM. I think in general, I mean, I would say first of all that VA has done a really good job in the last several years really trying to deal with this, especially the Center for Women Veterans and the Women's Health Program, to make sure that those deficiencies don't exist. However, from being a member of that Advisory Committee and traveling around the country and just as my position

now I had the opportunity to visit many VA facilities and that is something that I am always on the look out for.

And I think it is more of an issue that, you know, women's clinics where they have, you know, had to make room for them and they try to make a very nice area in most places, but sometimes it is a space issue in the VA health care system in general of where those clinics are located and what space they were provided.

And occasionally we see that there is an issue when you come in with regard to privacy one thing comes to mind is just being a user of the VA health care system myself and being in the clinic, coming in. Great people. Everybody is very friendly, wants to make my visit go well and I hear the person speaking on the phone to a veteran with being very, very nice to them, but in the conversation they have named their name. They have talked about a particular medical issue that they have had. And that was information that, you know, that clinic is very small, it is very confined space. And everyone in that clinic can overhear that information. And to me that is a privacy issue, you know, that gives me concern.

And I know that sometimes there is just not, you know, there needs to be more, maybe more awareness. If the space is not available where that receptionist can have a private conversation with a person on the phone they need to be made aware then about the, you know, what they are saying and knowing that other people in the waiting room can hear that.

Mr. BILIRAKIS. Thank you very much. What role do the Advisory Committees on Minority and Women Veterans and the Center for Women and Minority Veterans planning and influencing VA policy.

Ms. ILEM. What role do they play? I——

Mr. BILIRAKIS. Yeah. No. Are they effective?

Ms. ILEM. Yes. I think they are. It is really a committed group of veterans that have been willing to serve on those Committees. They are very active. They are usually in their other roles outside of the VA, active in women's issues. People take it upon themselves to do extra visits, to really, I think, they really take on these issues. And I think that they try very hard in their reports to report that information to the Secretary and to Congress. And I think it was great that there was an opportunity for them to testify today.

And I just hope that, you know, people pay attention to those reports and that, you know, their energies are not wasted. That those recommendations are taken to heart and things are made better for these populations.

Mr. BILIRAKIS. Okay. Thank you very much. Thank you, Mr. Chairman, appreciate it.

Mr. HALL. Thank you, Mr. Bilirakis. And Ms. Ilem, thank you for your testimony and your answers to our questions. You are now excused. Give us a minute for our changing of the guard. Welcome to our panel 4 witnesses, Betty Moseley Brown, Associate Director of the Center for Women Veterans of the U.S. Department of Veterans Affairs; and Lucretia McClenney, Director of the Center for Minority Veterans of the U.S. Department of Veterans Affairs. Welcome.

It is my understanding that we are going to have a vote called soon on the House floor, but we will begin and hope we can get through your testimony before they do that.

Dr. Moseley Brown, you are recognized for 5 minutes. And your written statement is in the record.

STATEMENT OF BETTY MOSELEY BROWN, ED.D., ASSOCIATE DIRECTOR, CENTER FOR WOMEN VETERANS, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND LUCRETIA MCCLENNEY, DIRECTOR, CENTER FOR MINORITY VETERANS, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF BETTY MOSELEY BROWN, ED.D.

Dr. MOSELEY BROWN. Chairman Hall and Members of the Subcommittees, I am pleased to testify today on behalf of the Department of Veterans Affairs and the Center for Women Veterans. The Center was established by Public Law 103–446 in November 1994 to oversee VA programs for women veterans. The Center's mission is to ensure that women veterans receive benefits and services on par with male veterans; and that VA programs are responsive to gender specific needs of women veterans; and that outreach is performed to improve women veterans awareness of services, benefits, and eligibility criteria. And, finally, that women veterans are treated with dignity and respect.

The Center monitors these changes in services through briefings by the 3 VA administrations and assesses the impact these changes have on the delivery of care of our 1.75 million women veterans. As stated earlier, there are women veterans that still don't believe that they are women veterans, so part of our charge is to make sure that every woman who served knows that she too is a veteran.

Regarding health care, in fiscal year 2006, the Veterans Health Administration served over 235,000 women veterans in our health system. This is a 5-year relative increase of 37.8 percent. At each VA Medical Center there is a women veterans program manager and each regional office a women veterans coordinator to help our women to maneuver through the system of VA. We know that it can be difficult and those employees are there to help our women veterans coordinate for their benefits and services.

Of the total number of women who have been discharged from active duty after deployment of Operation Iraqi Freedom and Operation Enduring Freedom, 37.5 percent have been to a VHA health care facility at least once.

I would like to also state that there is a 2006 study cosponsored by Dr. Yano from Los Angeles that actually clarified which model of care women prefer. There was earlier discussion regarding if women wanted to go to a primary care facility or a gender specific type environment and VA is currently looking at that to see what women really want, what their needs are, and then to make changes regarding that.

In the area of mental health, there are specialized women's mental health services. There are in-patient and residential programs for women veterans where the length of stay ranges from 28 days to 18 months. At every VA facility there is a designated military

sexual trauma coordinator who serves as a point of contact for military sexual trauma issues.

In fiscal year 2007, VA's Office of Mental Health Services established a military sexual trauma support team that is designed to help ensure that VA is in compliance with legally mandated monitoring of military sexual trauma screening and treatment.

Currently, the VHA Office of Research and Development is supporting a broad portfolio focused on women's health issues. In 2001, this Office created a Center of Excellence for Research aimed at identifying factors which cause disparities in health outcomes across racial, ethnic, and gender lines, as well as promoting equity in health and health care.

These Centers are co-located in 2 sites in Pittsburgh and Philadelphia; has 29 core investigators and have contributed over 128 peer reviewed scientific articles over the past 2 years.

We have been talking about health care, but I do want to add some things about benefits, because our women veterans are also concerned about benefits. In fiscal year 2006, Vocational Rehabilitation and Employment Program received 57,856 applications of which almost 10,000 were female veterans. Also during fiscal year 2006, there was an increase in the percent of guaranteed home loans for our women veterans. The average loan amount was $173,923 and it went to over 17,000 women veterans.

Also in fiscal year 2006, 8,442 women veterans used their education benefits under the Montgomery GI Bill. Part of our mission in the Center for Women Veterans is to attend some of the transition assistance program briefings that are held nationally. And we listen to what is stated and last year 8,541 VA benefit briefings were given to both male and female servicemembers, including Guard and Reserve who were transitioning.

I also wanted to state that to promote accuracy and consistency in the claims review process, VBA has taken a number of actions. For example, in the last 4 years, VBA has published guidance and conducted training for employees on a full range of issues related to PTSD claims adjudication—from development of the claim to proper application of the rating schedule. VBA and VHA are also working very closely regarding PTSD in modifying the examination request worksheet and template when a veteran applies for PTSD.

In closing, I would like to say that the Center has developed a 25 most frequently asked questions booklet that I believe you have received. We created this booklet from thousands of inquiries from women veterans. It has been published in both English and Spanish and is on our website as well as VA's website.

Next year, June 20 through the 22nd, we are going to hold a national Women Veterans Summit here in Washington, DC. We are planning to outreach to our military services, particularly our Reserves and National Guard. We are going to have workshops including "Readjustment Counseling Service: Outreach and Transition Services for Veterans Families," "Gender Differences: What the Data Shows," and workshops on mental health issues.

Our Nation is proud of our women veterans and I am proud to be a women veteran and to serve our women veterans. This concludes my formal testimony, but I am pleased to take any questions.

[The prepared statement of Dr. Moseley Brown appears on p. 47.]

Mr. HALL. Thank you very much for your testimony and for your service to our veterans and to our country. Ms. McClenney, I will now recognize you for a 5-minute statement. There is a vote that has just been called, but we are going to stay here and listen to you and then we may ask you to answer our questions in writing so that you don't have to sit here and wait for an hour or more while we are across the street voting.

Ms. McClenney, your statement is in the record and you are recognized for 5 minutes.

STATEMENT OF LUCRETIA MCCLENNEY

Ms. MCCLENNEY. Thank you Chairman Hall and Members of the Subcommittee. I appreciate the opportunity to come before you today to discuss the mission of the Center for Minority Veterans and address your specific questions on the Department of Veterans Affairs service to minority veterans through its current programs, present and future strategies addressing the needs of this growing population, and out reach efforts being conducted by VA to minority veterans.

Like the Center for Women Veterans, the Center was created by Public Law 103–446 in November 1994. The Director of the Center serves as primary advisor to the Secretary and Deputy Secretary of Veterans Affairs on all matters related to minority veterans.

The role of the Center is primarily one of advocacy for minority veterans. Pursuant to Public Law, the Center's primary emphasis is on veterans who are African Americans, Asian Americans, Pacific Islanders, Hispanics and Native Americans including American Indians, Alaska Natives, and Native Hawaiians.

To establish a national presence and to ensure issues are addressed at the local level, the Secretary directed the appointment of Minority Veterans Program Coordinators (MVPCs) at each VA health care facility, Regional Benefits Office, and National Cemetery. There are approximately 300 MVPCs serving across the Nation.

The Center provides training to the MVPCs in cultural competency and outreach strategies. These coordinators educate their facility personnel to the needs of the minority veterans in their local communities and promote the use of VA benefits and services by minority veterans. In addition, the 3 administrations each have a designated central office MVPC Liaison. The Center's staff meets monthly with these liaisons and quarterly with the senior leadership of each administration to discuss outreach activities and to benchmark best practices.

The Advisory Committee on Minority Veterans advises the Secretary and Congress on VA's administration of benefits and services and makes recommendations in an annual report to address unmet needs of the minority veteran population. The Center facilitates the Committee's outreach to minority veterans by ensuring they are kept abreast of VA's policies and programs that may impact minority veterans and coordinates the logistics and travel for all site visits and business meetings for the Committee. In addition, the Center tracks the Department's action taken on the Committee's recommendations.

The needs of our Nation's 4.7 million minority veterans are not unlike the needs of minorities throughout our Nation. Some of these may include access to medical facilities, especially for veterans living in rural, remote, or urban areas. Disparities in health care centered on diseases that disproportionately affect minorities, homelessness, unemployment, limited medical research and limited statistical data related to minority veterans. VAs strategies to meet the needs of minority veterans include but are not limited to the following: VA is improving access to care as evidenced by the significant increase in outpatient clinics. For example, in 1995, VA had only 102 community based outpatient clinics and by 2007, 872 ambulatory care and outpatient clinics were in operation.

VA is addressing homelessness in the minority population by partnering with community stakeholders and expanding VA's grant and per diem program. The Center is working with VHA's Office of Health Services Research and Development Service to target minority groups and encourage minority veterans participation in research programs.

The Center has staff who serves as veteran liaisons for each of the 5 minority groups that we are mandated to oversee. They establish active partnerships with veterans service organizations as well as internal and other external stakeholders to increase awareness of minority veterans issues and develop collaborative strategies to address unmet needs.

Mr. Chairman, this concludes my prepared statement.

[The prepared statement of Ms. McClenney appears on p. 51.]

Mr. HALL. Thank you, Ms. McClenney.

Ms. MCCLENNEY. I would be happy to answer any questions.

Mr. HALL. Thank you so much for your work, for your statement, for the service that you give to our veterans and to our country. If Mr. Bilirakis would agree, which I think he does, neither of us have the power to control the schedule on the floor of the House. But some day, maybe we will.

We appreciate your patience and we are sorry we can't ask you questions now. We do have a number of them, but we will submit them to you in writing. If you would be so kind as to respond in writing, we would appreciate that.

Ms. MCCLENNEY. It will be an honor, sir.

Dr. MOSELEY BROWN. Yes.

Mr. HALL. Once again, thank you very much. This hearing is adjourned.

[Whereupon, at 11:45 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will come to order. I would like to thank everyone for coming today.

This is a joint hearing with the Subcommittee on Disability Assistance and Memorial Affairs.

Today, we will examine the Department of Veterans Affairs programs regarding women and minority veterans.

The face of the military is changing and so is the face of the veteran population. According to the 2000 Census minorities make up over 14 percent of the existing veteran population. The population of women veterans is projected to continue to rise, from 6 percent in 2000, to 8 percent in 2010 and to 10 percent by 2020.

VA needs to constantly evaluate existing programs to address the needs of these special groups, and make changes when needed.

I further believe that VA should implement new and innovative programs to help close the many gaps that exist today in delivering high quality, safe health care and the other benefits and services VA provides.

Service in Operations Enduring Freedom and Iraqi Freedom has created growing challenges for VA in meeting the needs of the women and minority veterans as they separate from service.

We know that an unprecedented number of female servicemembers have been routinely exposed to combat or combat like conditions.

VA reports that the prevalence of potential PTSD among new OEF/OIF women veterans treated at VA has grown from 1 percent in 2002 to nearly 19 percent in 2006. This represents a considerable and disturbing increase.

Issues such as cultural differences, effective outreach, education, research and delivery of care should be carefully examined in an effort to provide the best possible service to these veterans.

I hope that we will learn how VA is meeting the needs of these populations, what challenges are on the horizon and what we can do to provide these veterans with the best possible care available.

Prepared Statement of Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs

Good morning.

I would first like to say that I am honored to join Mr. Michaud in cochairing this hearing and I applaud the leadership he exercises on behalf of our veterans, particularly on veteran health care issues.

I would also like to thank the witnesses for joining the 2 Subcommittees this morning for a hearing to examine issues facing women and minority veterans. I think this rare joint hearing speaks volumes about how important these issues are to the Committee as whole and I look forward to hearing from all of today's witnesses.

Women veterans are the fastest growing segment of the veteran population, comprising 7% of the total veteran population and 5% of those using VA health services.

Over 14% of veterans are from a racial or ethnic minority group with Blacks comprising the bulk at 9.7% (2000 U.S. Census figures).

I am certain that the VA does its best to ensure that all veterans encounter no barriers to access in the receipt of VA benefits, treatment and services.

However, the fact remains that the barriers in the society at large that women and minorities often face, might very likely translate into barriers in the smaller VA system.

As such, Congress in its wisdom developed both the Center for Minority Veterans and the Center for Women Veterans in 1994 to ensure that these veterans are fully integrated in the VA system.

I look forward to hearing from both Centers, as well as their separate Advisory Committees, which develop detailed reports which help to inform the policies of the VA for women and Minority veterans.

I especially would like to learn the VA's and the Advisory Committee on Minority Veterans' views on the sunsetting provisions that would end the Advisory Committee in 2009 and what if any plans it has to replace this vital organization. I know representative Gutierrez has introduced a bill, H.R. 674 that would prevent this from occurring. Getting rid of the Minority veterans' Advisory Committee would be a seriously troubling result in light of recent findings by VA researchers that health disparities appear to exist in all clinical arenas and have a direct impact on the health outcomes for minority veterans.

Last, but certainly not least, I welcome my colleague Congresswoman Heather Wilson, the only woman veteran in Congress.

I am sure all of our witnesses, including our experts and the VSOs, will provide critical insight on issues facing women and Minority veterans, especially in light of returning OIF/OEF veterans.

Thank you.

Prepared Statement of Hon. Doug Lamborn, Ranking Republican Member, Subcommittee on Disability Assistance and Memorial Affairs

Thank you Mr. Chairman for recognizing me. I thank you for holding this hearing on the Challenges Facing Minority and Women Veterans.

I welcome our witnesses, and thank you all for your contributions to the veterans' affairs system.

America's minorities and the women of our great Nation are integral to the quality of our National security. Women make up nearly 10 percent of our Nation's 24 million living veterans. Women on active duty represent more than 15 percent of our armed forces.

According to a 2005 Heritage Foundation study, about 25 percent of military recruits identify themselves as other than Caucasian; further, military women are more likely to identify themselves as members of a racial or ethnic group than men.

Our military has a higher percentage of some minorities—such as African Americans, American Indians, Native Alaskans and Hawaiians, and Pacific Islanders—than the percentage of these minorities in the general population. These men and women are patriots.

In more than 2 centuries of service to country, women and minority servicemembers have formed a glorious legacy. That legacy has only been enriched by the intrepid and resolute accomplishments of their descendents in the global war on terror.

Our challenge is to ensure that women and minority veterans—indeed all veterans—receive equal treatment for their qualifying service to our Nation.

The VA centers for women and minority veterans and the department's associated advisory Committees are charged with increasing awareness of VA programs, identifying barriers and inadequacies in VA programs, and influencing improvement.

We do not look to these VA programs to merely identify and report. We want them to influence policy and accept a measure of accountability for departmental results.

In that regard, I will of course be very interested in hearing today about the challenges facing women and minority veterans, such as gender-specific health care.

I want to learn about disabilities more likely to affect minority veterans. I want to hear about the challenges facing veterans who wish to take advantage of economic opportunities in the public and private sectors.

I will also, however, especially want to learn today how VA and its component organizations are effectively rising to meet those challenges.

Mr. Chairman, I yield back.

Prepared Statement of Hon. Gus M. Bilirakis, a Representative in Congress from the State of Florida

I want to thank Chairman Hall and Chairman Michaud for scheduling today's joint hearing on the issues facing women and minority veterans. As a new Member

of the Veterans' Affairs Committee, I am glad that we will be examining how women and minority veterans are being treated within the Department of Veterans' Affairs.

The numbers of women and minorities serving in our military continues to grow, and consequently, their ranks among our Nation's veterans' population is also rising. As a result of the changing demographics of our military personnel, I believe it is important for our Committee to examine the challenges that face women and minority veterans as they transition back into civilian life.

We must also ensure that they have access to the services and benefits that they have earned through their service to our country. I am anxious to hear from our witnesses to learn more about how we improve the services provided to women and minority veterans.

Thank you, Mr. Chairman. I look forward to working with you and our colleagues on the VA Committee on these important issues.

Prepared Statement of Shirley A. Quarles, R.N., Ed.D., Chair, Advisory Committee on Women Veterans, U.S. Department of Veterans Affairs

Chairman Hall, Chairman Michaud, and Members of the Subcommittees, I am pleased to testify today on behalf of the Department of Veterans Affairs Advisory Committee for Women Veterans regarding our views on: how the Department of Veterans Affairs (VA) serves women veterans through its current programs; the present and future needs of a growing women veterans population; the strategies VA has for meeting these needs; and outreach efforts that are being conducted by VA for women veterans.

The Advisory Committee on Women Veterans (ACWV) was established by Public Law 98–160 in 1983. The Advisory Committee is charged with advising the Secretary of Veterans Affairs on VA benefits and services for women veterans, assessing the needs of women veterans, reviewing VA programs and activities designed to meet the needs of women veterans, and developing recommendations that address unmet needs of women veterans. The Advisory Committee submits a biennial report to the Secretary of Veterans Affairs that delineates the Committee's findings and recommendations.

The Advisory Committee on Women Veterans consist of 14 members (women and men) most are veterans; who have served across all services of the Armed Forces. This Committee is supported by the Center for Women Veterans with advisors and ex-officio members from the Department of Defense (DoD), Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), National Cemetery Administration (NCA), Department of Labor (DoL), and the Department of Health and Human Services (HHS).

How is the Department of Veterans Affairs (VA) serving women through its current programs?

As a means to obtain information regarding women veterans' services and programs provided by VA on health care and benefits, the Advisory Committee on Women Veterans (ACWV) conducts site visits to VA facilities throughout the U.S. Additionally, the ACWV tours the facilities and meets with senior leaders to discuss services and programs available to women veterans. During the site visits, the ACWV also hosts open forums with the local women veterans' community to encourage open dialog from women veterans to share their experiences within VA, to discuss issues, and to raise questions related to gender specific VA benefits and services.

As another means to obtain information regarding women veterans' services and programs provided by VA, the ACWV meets twice a year at VA Central Office (VACO) and receives briefings from the Veterans Health Administration (VHA), Veterans Benefits Administration, (VBA), National Cemetery Administration (NCA), Office of Research and Development (ORD), and other staff offices. These briefings update the Committee on the status of VA programs and how these programs address the needs of women veterans. During these meetings, members have the opportunity to question presenters about services in their area of concentration and share their observations and concerns from site visits. The Advisory Committee uses information gathered from the site visits and briefings to formulate recommendations to the Secretary of Veterans Affairs in the biennial reports. The Center for Women Veterans provides support to the ACWV during their site visits and meetings at VACO.

In the 2006 Report of the Advisory Committee on Women Veterans, the Committee made 23 recommendations that addressed behavioral and mental health care, health care, military sexual trauma (MST), outreach, research studies, strategic planning, training, women veterans health program, women veterans program managers and women veterans coordinators, and homeless women veterans.

One recommendation that has already been implemented was to organizationally realign the Women Veterans Health Program Office to the status of a Strategic Healthcare Group. With the recent elevation of the Women Veterans Health Program to the Women Veterans Health Strategic Healthcare Group, it has positioned the office to gain expertise in the population of women veterans, strategically plan for health care delivery and provide leadership in clinical knowledge of this unique group of women and to catalyze optimal integration of women veterans health issues across all VHA programs and offices. VA strives to be the lifetime provider of health care services to women veterans and exceed their expectations for care during each phase of their lifecycle. Additionally, VA aims to be a world leader in innovative and high quality for women veterans.

In the area of women veterans health program, the Advisory Committee on Women Veterans 2006 Report recommended that VA ensure that the Center for Women Veterans is provided an annual update on the effectiveness of the responsibilities of the VHA Women Veterans Program Managers. VHA leaders and the Acting Chief Consultant, Women Veterans Health Strategic Healthcare Group (formerly known as Women Veterans Health Program), briefed the Committee on this issue at the February–March 2007 Advisory Committee for Women Veterans meeting. Additionally, the Acting Chief Consultant and the Women Veterans Health Strategic Healthcare Group work closely with the Center for Women Veterans on issues that are frequently referred to Women Veterans Program Managers in field facilities.

The submission of the 2006 Report to Congress was at the discretion of the Secretary for Veterans Affairs; a strong supporter of the Advisory Committee on Women Veterans. As a courtesy to this Committee, the Secretary agreed to forward the report to Congress during May 2007.

What are the present and future needs of these growing populations and what strategies does VA have for meeting them?

One area the Advisory Committee for Women Veterans was able to witness first hand the present needs of women veterans' mental health care was at our site visit in June 2007 to the Women's Mental Health Center in Palo Alto, CA. The Women's Trauma Recovery Program (WTRP) is a 60-day residential post-traumatic stress disorder (PTSD) and military sexual trauma (MST) treatment program.

The future needs can be met through research and studies specifically on women veterans. In the 2004 and 2006 Advisory Committee on Women Veterans Reports, research and studies have been recommended. The last national survey of female veterans was conducted in 1985, leaving VHA policy makers and managers with limited information with which to adequately plan for future health care services for women veterans. To address this knowledge gap, the WVHSHG commissioned Donna Washington, MD, MPH, VA Greater Los Angeles HSR&D Center of Excellence, to conduct a national Survey of Women Veterans. The objectives of the National Survey of Women Veterans are: (1) identify the current demographics, health care needs, and VA experiences of women veterans; (2) determine how health care needs and barriers to VA health care use differ among women veterans of different periods of military service, e.g., OEF/OIF versus earlier periods; and (3) assess women veterans preference for and perceived value of different types of VA interventions to improve access and quality. The survey will enroll from 2,500 to 3,200 women veterans across the Nation, including equal numbers of VA users and nonusers. The final report will be submitted by December 31, 2008. The initial funding award was for $870,400.

What outreach efforts are being conducted by VA to women veterans?

We continue to outreach to the women veterans' community with increased emphasis with our partnerships with federal, state, and country agencies, national veterans service organizations and community organizations. To enhance collaboration and better serve our women veterans, appointed advisors and ex-officio representatives from HHS, DoL, DoD, and VA Administrations (VHA, VBA and NCA) serve on the Advisory Committee on Women Veterans. The Center's Director, Dr. Irene Trowell-Harris serves as an ex-officio member of the Defense Advisory Committee on Women in the Services (DACOWITS). In this role, she ensures that DoD and VA, as a team, address military and women veterans' health and benefits issues.

The 2004 Advisory for Women Veterans Report recommended that brochures and outreach materials that are currently only available in English be translated in Spanish. VA has distributed brochures, pamphlets, fact sheets, and booklets in Spanish from VHA, VBA and NCA. Numerous benefit fact sheets and other informational materials, printed in Spanish, are available on VA's Internet web site at www.va.gov.

The Advisory Committee on Women Veterans plans to participate in the 2008 National Summit on Women Veterans Issues to be held in Washington, DC during June 2008 and to facilitate a townhall meeting to better serve our women veterans.

The Advisory Committee on Women Veterans is grateful to the VA and the Center for Women Veterans on their vision and professional efforts to take care of our women veterans of yesterday, today, and the future.

This concludes my formal testimony. I will be pleased to answer any questions.

Prepared Statement of Colonel Reginald Malebranche, USA (Ret.), Member, Advisory Committee on Minority Veterans, U.S. Department of Veterans Affairs

Chairman Michaud, Chairman Hall, and Members of the Subcommittees, I am indeed pleased to represent the Chairman of the Advisory Committee on Minority Veterans, give you our views on the services provided by the Department of Veterans Affairs (VA) to Minority Veterans; on VA's present and future strategies addressing the needs of this growing population; and VA's outreach efforts toward Minority Veterans.

The Advisory Committee on Minority Veterans (Committee) was established in November 1994, pursuant to Public Law 103–146. The Committee is tasked with assessing the needs of minority veteran populations, and reporting back to the Secretary on the effectiveness of VA programs and services at meeting those needs. The Committee works in close coordination and collaboration with the Center for Minority Veterans (Center) and relies on the expertise of Center staff for current information about VA programs, policies and services.

The Advisory Committee on Minority Veterans members are appointed by the Secretary, and serve at his/her discretion. The majority of the Committee members are veterans and are representative of the 5 minority groups—African American, Asian American, Hispanic, Pacific Islander, Native American (including Alaskan Native, American Indian, and Native Hawaiian).

As a means of obtaining information regarding the delivery of health care and services to minority veterans, the Committee conducts an annual site visit to a selected VA facility with a high density of minority veterans. During these visits, the Committee tours the facilities and meets with senior VA officials to discuss services and programs available to minority veterans. The Committee also hosts open forums with Veteran Services Organizations with the local veterans, to encourage them to discuss issues, problem areas, and seek information related to VA benefits and services.

The Committee meets once a year at VA Central Office and receives briefings from the VA Senior leadership, the Center for Minority Veterans, Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA) and other staff offices. These briefings update the Advisory Committee on the status of VA programs and address issues and concerns raised during the site visits.

In its 2006 Report on the Greater Los Angeles Health Care System, April 3–7, 2006, the Advisory Committee made eleven recommendations, with the key issues being Outreach, Research, Staff Diversity, Seamless Transition, and the Native American Veteran Housing Loan Program.

During its visit to the Los Angeles Ambulatory Care Center, The Committee was dismayed by the staggering number of homeless veterans. Twenty-three percent (23% or 21,424) of the 90,000 homeless populations in Los Angeles were reported to be veterans. The Committee was encouraged by the range of programs identified by VA for homeless veterans. Yet, the Committee was concerned that those programs may not reach the targeted audience. There was insufficient evidence that outreach programs had been designed and publicized to a level to ensure that homeless minority veterans were aware of their existence. The Committee believed that similar situations may affect the homeless veteran population throughout the Continental United States and its Territories.

What outreach efforts are being conducted by VA to minority veterans?

Outreach is a major challenge for the VA. During its sessions with Veteran Services Organizations, and with minority veterans, at its townhall meeting, the Committee learned that the major issue was that minority veterans were unaware of their VA benefits, and other VA services available. The Committee recognized that VA made strides to reach out to minority veterans and inform them of their benefits and the services available. The Committee noted that VA had developed and distributed comprehensive and illustrative pamphlets. However, the Committee believes that additional resources such as publishing and distributing a veterans' magazine similar to the VA employee magazine Vanguard, could be utilized to inform veterans of their entitlements.

Transportation to VA centers, in major metropolitan, rural and isolated areas, is a major impediment for minority veterans. Accessibility, affordability, and distances to VA centers are major problems affecting minority veterans. Although Veterans Services organizations and many non-profit organizations provide some forms of relief, the Committee noted that a major segment of the minority veterans were not within easy or affordable reach to VA centers.

Much remained to be accomplished in the area of outreach. The Committee recognized that it is not simply a VA challenge. Several of its members have taken the mantle to assist VA in its quest to reach out to minority veterans. Committee members head Veterans Services Organizations and insure that the VA's efforts are well publicized and supported. Others visit medical centers and hold informal meetings with minority veterans to ensure that those veterans, and/or their family members/friends/acquaintances are aware of their entitlements and benefits.

The challenge to reach all minority veterans will require a concerted effort of VA, other Federal and state agencies, Veterans Services Organizations, Members of the Committee, and the public to make sure that all veterans are keenly aware of their entitlements.

What are the present and future needs of those growing populations and what strategies does VA have for meeting them?

Access to Care

Minority veterans' access to care is a major challenge for VA, particularly for minority veterans in large metropolitan areas, in rural and isolated areas. For example the plight of Alaska Natives, living in rural and isolated areas of the state, cannot be ignored; and neither can the plight of minority veterans living in rural and isolated areas within the Continental United States. The challenge for VA is to continue to develop and implement innovative programs which target those minority veteran populations.

Rural and remote areas such as Alaska and the Navajo Nation may be good areas to test rural health initiatives. VA could enter in a reimbursable agreement with all Alaska Natives' organizations, the Health and Human Services and Indian Health Service to reach out to all minority veterans and provide all the services, which fall within the realm of the VA.

The Committee applauds the strides made by VA in expanding its telehealth and telemedicine programs, and its ability to reach a significant number of the minority veteran population. Yet, those programs are not stand alone, and will require significant investment and training.

Mental Health

Mental health is and will become a major challenge. The Committee recognizes the efforts and the programs put forth by VA to support, identify, and care for soldiers, sailors and airmen, who have served in Operation Enduring Freedom and Operation Iraqi Freedom theaters of operations. The early identification of Post Traumatic Stress Disorder will certainly help in the observation and treatment of all veterans who served in those areas. Yet, the Advisory Committee is concerned that the same level of services might not be readily available to minority veterans who have served in prior conflicts.

The Committee is also concerned that an interoperable electronic health record has not been developed to embrace all Uniformed Services personnel.

Benefits

The processing and adjudication of benefits seem to affect all veterans. The Committee recognized the initiatives approved by the Congress to improve the processing and adjudication of benefits by VA. The Veterans Claims Assistance Act of 2000—Public Law 106–475—puts the onus on VA to maximize its assistance to all veterans and to make them aware of their entitlements.

Staff Diversity

Senior staff diversity remains an issue at VA. The absence of minorities at the senior staff level has been and continues to be noticeable during site visits. Data presented and subscribed by VA suggests that VA's problem is limited to recruiting white females, and Hispanics. Yet, other data maintained at VA suggested that minorities were not well represented at senior staff levels. The Committee was concerned at the inconsistency of the data, and its implications for minority veterans and the minority population at VA.

How is the U.S. Department of Veterans Affairs (VA) serving minorities through its current programs?

The professionalism, the expertise shown by VA personnel was striking. The Committee noted in several instances that VA's efforts in most areas were only limited by personnel and time. There was a perception that most staff would endeavor to do all possible for a veteran. The challenge is to include minority veterans in that equation and philosophy.

VA's strides in supporting veterans are especially noteworthy. Thank you for this opportunity to address the Subcommittees. I would be happy to address any questions you may have.

Prepared Statement of Saul Rosenberg, Ph.D.,
Associate Clinical Professor of Medical Psychology,
University of California, San Francisco, CA

Mr. Chairman, thank you for inviting me to this joint hearing of the Subcommittees on Health and Disability Assistance and Memorial Affairs to discuss the needs of women and minority veterans. My name is Dr. Saul Rosenberg. I have been engaged in assessing and treating veterans and civilians with Posttraumatic Stress Disorder (PTSD) for many years. As a clinical psychology intern at the Ann Arbor VAMC I learned that to be an effective therapist I had to understand the cultural experiences, preferences and values of the individual I was trying to help. The lessons I learned as a trainee I have taught to interns and psychiatry residents at the San Francisco VAMC. I am not employed by the VA nor do I represent the VA.

With my colleagues in the Dept. of Psychiatry at the University of California, San Francisco and the San Francisco VAMC I have participated in the development of diagnostic interviews and psychological tests to help counselors and therapists better understand the psychological problems that contribute to social isolation. Social support from families, friends, Vet Centers and veterans' service organizations play a huge role in healing the body, mind and spirit.

My current professional interest is in the development of public-private partnerships, between University of California campuses, affiliated military hospitals and VAs, governmental agencies, foundations and the private sector to improve access to evidence-based, cost-effective mental health diagnostic and treatment services. I believe that public-private partnerships are essential to reduce the disparities in access to mental health services for racial and ethnic minorities, native Americans, rural populations, women, children, the elderly and all underserved and vulnerable populations.

My colleagues at UCSF and the SFVAMC recently published the first detailed report on the prevalence of mental health and psychosocial problems, with a breakdown by gender and race, for over 100,000 veterans first seen at VA health care facilities. The prevalence of mental disorders was high: over 30% had a diagnosed mental disorder or psychosocial problem. Posttraumatic Stress Disorder (PTSD) was the most common diagnosis, and more than half of those diagnosed with a mental disorder had 2 or more mental health diagnoses.

Women comprised 13% of the sample; 69% were White, 18% were Black, 11% were Hispanic and 2% came from other racial groups. The likelihood of receiving a diagnosis for PTSD or another mental disorder was the same for women and men and across all racial groups. The most striking finding in the study had to do with age and not with race or gender. The youngest veterans, between 18 and 24 years of age, had a significantly higher likelihood of being diagnosed with PTSD or another mental disorder, compared to veterans 40 years and older. The youngest men and women, Whites, Blacks and Hispanics, were more vulnerable to stress than those who were over 40 years of age. The results of this study point to the impor-

tance of funding programs that target the early identification and treatment of PTSD in the youngest servicemen and women.[1]

In this study, most mental disorders were identified in primary care and non-mental health settings within a few days of the first visit to a VA clinic. The detection of PTSD, depression and substance abuse in primary care settings is crucial in order to initiate treatment which can prevent chronic mental disorders and disability. This study shows that the emphasis the VA is placing on the early detection of mental disorders in primary care settings has been effective.

Clinical research on the screening and psychological assessment of mental and substance abuse disorders and suicide risk in primary care deserves continued funding. Evidence-based clinical guidelines for the detection of PTSD, substance abuse and suicide risk should be continuously evaluated. The most effective protocols should be disseminated to all settings where veterans receive care, including the private sector.

For many years, The VA, DoD, National Institute of Health (NIH) and the National Institute of Mental Health (NIMH) have supported research on evidence-based diagnostic tools and treatments for PTSD, depression and substance abuse. I have been grateful to the NIMH for supporting my own research. Like most academics, I have published my research in peer reviewed journals. However I now believe that research that benefits patients needs to be delivered to health care providers when they need it—at the point of care.

The VA—more than any other public or private institution—is in the best position to implement computer-aided decision support for mental disorders at the point of care. The VA is the largest integrated delivery system that provides mental and behavioral health care. In addition, the VA has VistA, the oldest and most robust Electronic Health Record (EHR). The delivery of clinical practice guidelines matched to a patient's diagnosis and delivered directly into to a patient's EHR at the point of care deserves the highest priority. In addition, efforts now underway to develop portable longitudinal Personal Health Records that injured veterans can take with them wherever they seek care deserve continued support.

Too much excellent research that could benefit veterans is buried in professional journals; we need one place to accumulate all the data from all the studies so that health care providers can learn from past experience and share knowledge about the best ways to treat and rehabilitate injured veterans. All researchers and contractors who receive Federal funding for health related projects should be encouraged to deposit their data in a secure, private and confidential data base. Investigators and contractors should be encouraged to report results by gender and race to insure that treatments are available that are attuned to the experiences, culture, values and preferences of injured veterans and their families.

Many servicemen and women returning from Iraq have been exposed to roadside bombs and improvised explosive devices. Never before have so many soldiers received simultaneous injuries to their brain and mind. There is much that we have to learn about the diagnosis and cognitive rehabilitation of Traumatic Brain Injuries (TBI) from powerful bombs. These blast injuries are not the same as concussions resulting from a car accident or a sports injury. Thorough screening and comprehensive neurological and neuropsychological assessment is essential to characterize these injuries and to maximize the prospects for recovery, a good quality of life and the ability to work, contribute and participate in a community.

Most veterans receive their health care outside the VA system. I am especially concerned about the lack of coverage provided by private health insurance plans for neuropsychological assessment. Many private insurance companies will pay over $1,000 for neuroimaging studies but refuse to pay for the costs of comprehensive neuropsychological testing. Proper neuroimaging studies are essential but they cannot measure cognitive functioning, like the ability to sustain and focus attention or short-term memory—only neuropsychological tests can do that. Congressional hearings that investigate the treatment of veterans with TBI should invite neuropsychologists and representatives of professional neuropsychological associations to provide testimony on this issue. Before the DoD and VA outsource the treatment of military personnel and veterans with brain injuries to private facilities they should have the assurance that unwarranted restrictions on neuropsychological assessment are the exception rather than the rule.

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[1] Karen H. Seal, MD, MPH; Daniel Bertenthal, MPH; Christian R. Miner, PhD; Saunak Sen, PhD; Charles Marmar, MD, "Bringing the Ware Back Home: Mental Health Disorders Among 103 788 U.S. Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities" Arch Intern Med. 1007, 167, 476–482.

The VBA has acknowledged a backlog of over 400,000 disability claims awaiting disability determination. The VBA has acknowledged that the waiting time to complete disability examinations is unacceptably long.

According to a 2007 Institute of Medicine (IOM) report regarding disability determination for veterans, the methodology the VBA uses for determining disability is outmoded and does not reflect current knowledge about the assessment of functional impairments. The IOM recommended development of pilot programs to immediately award partial disability to veterans who meet presumptive criteria for a disabling mental disorder. Implementing the IOM's recommendations would assure that injured veterans received immediate help and financial support while waiting—sometimes for years—for their claims to be adjudicated.

The IOM also recommended funding demonstration projects to implement the International Classification of Functioning, Health and Disability published by the World Health Organization. The IOM pointed out that we need better description and quantification of functional capacities that promote involvement. Projects should be encouraged that map the full range of impairments and also the full range of functional capacities. A major goal of rehabilitation is to reengage the disabled veteran and promote social connections. Injured veterans need to be engaged in their communities, working, volunteering and connecting with friends and veterans.

Wide variability exists between military and VA disability ratings and across different regions of the U.S. I am especially concerned about the possibility of racial disparities in disability ratings for PTSD. In a presentation to the Institute of Medicine, Dr. Charles Engel, the Director of the Deployment Health Clinical Center, reported that African American veterans were about half as likely as other veterans to receive service connected disability for PTSD (Medical Care 2003;41(4):536–549). This issue deserves urgent attention. Culturally sensitive assessment tools need to be developed to insure that consistent and equitable procedures are implemented and that any racial disparities that exist are eliminated.

A 2007 Institute of Medicine (IOM) report, PTSD Compensation and Military Service, recommended that new methods should be developed to identify women who are victims of military sexual assault. Because PTSD from sexual assault is more difficult to prove than PTSD resulting from combat, the IOM recommended that more attention should be focused on the prompt identification and treatment of women who are victims of sexual assault and that better procedures be established for awarding disability compensation.

A 2007 report form the DoD Task Force on Mental Health has called for more attention to the prevention of mental disorders and the building of resilience and coping strategies to deal with the stress of deployment. The report stated:

> "The mission of caring for the psychological health of the military has fundamentally changed—new programs are needed—to meet current and future demands for a full spectrum of services including: resilience-building, assessment, prevention, early intervention, and provision of an easily accessible continuum of treatment for psychological health of service members and their families in both the Active and Reserve Components. There are not sufficient mechanisms in place to assure the use of evidence-based treatments or the monitoring of treatment effectiveness"[2]

Currently, health information technology contracts and clinical research are conducted along parallel separate tracks. I recommend that contracts and research be funded for joint projects that integrate health services research and health information technology. Programs like the VA Special Fellowship Program in Medical Informatics provide a bridge for connecting patients, providers and researchers to health information technologies. The next generation of providers will be increasingly sophisticated in utilizing cutting edge technologies for telemedicine such as those being developed by the Telemedicine and Advanced Technology Research Center (TATRC).

A recent study by Dr. Charles Marmar at the San Francisco VAMC and UCSF and his colleagues across the country, found predictors of PTSD for police and other first responders following a disaster or critical incident.[3] This study measured per-

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[2] Defense Health Board Task Force on Mental Health (2007). An achievable vision: Report of the Department of Defense Task Force on Mental Health. Falls Church, VA; Defense Health Board; ES 2–3

[3] Charles R. Marmar; Shannon E. McCaslin; Thomas J. Metzler; Suzanne Best; Daniel S. Weiss; Jeffery Fagan; Akiva Liberman; Nnamdi Pole; Christian Otte; Rachel Yehuda; David

Continued

sonal characteristics prospectively—prior to exposure to a stressful event. Factors that predicted chronic and severe PTSD symptoms and greater functional impairments included the use of maladaptive coping strategies, especially self-medication with alcohol. In contrast, police officers who had a strong social support network after exposure to a critical stressful incident, exhibited less symptoms and impairments in functioning and were more likely to return to duty. The National Institute of Mental Health has generously funded research on vulnerabilities and protective factors related to the development of PTSD; congress should continue to support these promising initiatives.

The Mental Illness Research, Education and Clinical Centers (MIRECC) were established by Congress to translate clinical research and best practices in mental health care into tangible benefits for patients of the VA. The MIRECCs are conducting research on post-deployment mental disorders, PTSD, substance abuse and suicide prevention. In addition, the MIRECCs produce clinical educational programs. These excellent programs deserve continued support and new programs should be funded, such as centers of excellence for the study of resilience—an idea promoted by the DoD Task Force on Mental Health.

The Telemedicine and Advanced Technology Research Center (TATRC) was established by congress to implement innovative telemedicine and technology projects to deliver medical expertise anywhere it is needed. Technologies developed by TATRC to help injured servicemen and women on the battlefield, and in remote rural communities, can be transferred to the private sector. Like many technology projects sponsored by the VA, the benefits accrue not only to veterans and their families but to the whole community. VistA, the VA's EHR is being installed around the world; countries that cannot afford to spend millions of dollars to develop an EHR can install VistA for a tiny fraction of the cost of commercial EHR.

Thank you for your support for research and for the education and training of the clinicians who provide health care to injured veterans. I will be happy to answer any questions.

Prepared Statement of Maureen Murdoch, M.D., MPH,
Center for Chronic Disease Outcomes Research,
Minneapolis Veterans Affairs Medical Center, Minneapolis, MN
Veterans Health Administration, U.S. Department of Veterans Affairs
(on behalf of herself)

Mr. Chairman and Members of the Subcommittees, thank you for the opportunity to appear before you today to present findings from my team's research on possible disparities in PTSD disability awards among race and gender groups. I must note the views presented today are mine and do not necessarily represent the views of the Department of Veterans Affairs (VA) and reflect the results of my studies and not necessarily the findings of other research.

Background

PTSD is the most common psychiatric condition for which veterans seek VA disability benefits. Long-term health studies indicate women have a higher prevalence of PTSD than men, and may be more susceptible to PTSD. Conversely, African American or blacks appear to have similar risks for PTSD compared to whites.

In 2000, my colleagues and I began investigating if there were race and gender disparities in VA disability awards for post-traumatic stress disorder (PTSD). We assembled a representative sample of almost 5,000 men and women veterans who applied for PTSD disability benefits between 1994 and 1998.

We developed and tested 4 hypotheses:

1. Veterans reporting more severe PTSD symptoms would be more likely to be Service-Connected for PTSD than veterans reporting less severe PTSD symptoms.
2. Veterans reporting more severe disablement would be more likely to be Service-Connected for PTSD than veterans reporting less disablement.
3. Veterans with combat experience would be more likely to be rated Service-Connected for PTSD than veterans not in combat.
4. These 3 covariates (PTSD symptom severity, degree of disability, and combat exposure) would explain any race or gender differences in VA PTSD disability awards.

Mohr; and Thomas Neylan, "Predictors of Posttraumatic Stress in Police and Other First Responders" Ann. N.Y. Acad. Sci. 1071: 1–18 (2006).

Results of the Studies

Overall, the 3,337 respondents were highly symptomatic. About 80 percent met our definition for PTSD and 62 percent were service connected for PTSD. Our results yielded several interesting findings. Concerning the relationship between PTSD service connection and gender, despite fewer major medical complications and superior physical functioning, women's overall role functioning was similar to men's. Almost 94 percent of men and 29 percent of women reported at least some combat exposure. Most importantly, once combat exposure was controlled, the effect of gender on service connection for PTSD became insignificant. Specifically, more than 90 percent of combat-injured veterans, regardless of gender, became service-connected for PTSD. Those with higher levels of combat exposure were substantially more likely than those with lower levels to be service connected for PTSD. Since men had notably greater exposure to combat, they likewise had higher rates of service connection. In sum, instead of a gender bias in awards for PTSD service connection, we found evidence of a combat advantage that disproportionately favored men and adversely affected women.

We also compared PTSD symptom severity and Social Adjustment scores of veterans reporting sexual assault and combat exposure. We found, on average, veterans reporting combat alone had marginally less severe PTSD symptoms than those reporting sexual assault. Veterans reporting only combat exposure also reported significantly better Social Adjustment Scores than those reporting sexual assault. Men and women who reported sexual assault were equally unlikely to be service connected for PTSD.

In our investigation of racial disparities, we found that the African Americans in our sample were just as likely to be service connected for other disorders, but were substantially and significantly less likely than other respondents to be service connected for PTSD. The negative association between African Americans and service connection for PTSD was not found for any other racial or ethnic group. Among veterans receiving service connection for PTSD, the service-connected rating was almost identical, regardless of race—an average rating of 43 percent for African Americans versus 45 percent for all other veterans. Controlling for gender, African Americans' modified combat exposure scores were similar to other veterans, but African Americans were significantly less likely to have a documented combat injury. With full adjustment, the estimated probability of being awarded service connection for PTSD was 43 percent for African American veterans compared with 56 percent for other respondents. Examining clinicians were about seven-tenths as likely to diagnose PTSD in African Americans as they were for other veterans, although this difference was not statistically significant.

Discussion About the Studies

There are several issues warranting consideration when evaluating this research. First, the pool of respondents was selected based upon their submitted claims for PTSD service connection, while our questions focused on their current health and adjustment status. It is distinctly possible that those with the greatest need at the time of their application have been receiving treatment and may now actually report better health outcomes than their peers. Second, the study relied on veterans' self-reports of their PTSD symptom severity, degree of disability, and trauma history, which may not have been clinically accurate or universally consistent.

Recommendations

In order to strengthen and expand this research, future studies should identify and evaluate veterans shortly after applying for PTSD disability benefits. In addition, we need to collect and assemble more data from the claims files. Finally, future studies should investigate claims for disorders other than PTSD.

Mr. Chairman, this concludes my statement. I am pleased to respond to any questions you or the Subcommittee members may have. Thank you.

Prepared Statement of Joy J. Ilem,
Assistant National Legislative Director, Disabled American Veterans

Messrs. Chairmen and Members of the Subcommittees:

Thank you for inviting the Disabled American Veterans (DAV) to provide testimony at this joint hearing on the present and future needs of women and minority veterans seeking services from the Department of Veterans Affairs (VA). You have called a hearing on important topics that demand attention by the Committee, the VA, and the Department of Defense (DoD).

MINORITY VETERANS

In June 2007 the VA Health Services Research & Development Service (HSR&D) released a new report, Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review.

For many years, the VA has expressed its commitment to eliminating ethnic disparities in health care to ensure equal access and quality health care for all veterans using VA services. Researchers systematically reviewed the existing evidence on disparities to determine which clinical areas racial and ethnic disparities are prevalent within VA, described what is known about the sources of those disparities and qualitatively synthesized that knowledge to determine the most promising avenues for future research aimed at improving equity in VA health care.

Researchers looked at a number of clinical areas including: arthritis and pain management; cancer; cardiovascular diseases; diabetes; HIV and Hepatitis C; mental health and substance abuse; preventative and ambulatory care; and rehabilitative and palliative care. The findings of the study concluded that disparities appear to exist in all clinical arenas and a number of reasons were offered as to why disparities exist. More notably, researchers commented in nearly each case that the underlying causes of these disparities were not explored or remain unclear. One key finding was that in studies examining quality indicators representing immediate health outcomes—such as control of blood sugar, blood pressure, or cholesterol—non-white veterans generally fared worse than whites. The researchers noted that this finding was especially troubling since it may indicate that disparities in health care delivery are contributing to real disparities in health outcomes. It was also noted that fewer studies examined Hispanics, American Indians, and Asians and that in general, disparities in the VA appear to affect African American and Hispanic veterans most significantly.

The study relates specific sources of disparities and offers a number of future research recommendations to further elucidate and reduce/eliminate racial disparities in VA health care including:

- Designing decision aids and information tools for minority veterans with a focus on literacy, language and cultural issues.
- Interventions to make patients more active participants in their health care decisions.
- Improved communication strategies for patients and clinicians to help strengthen patient-provider relationships.
- Additional studies to determine sources of variation in clinical judgment by patient race.
- Interventions to promote evidence-based decisionmaking by providers.
- Interventions to provide support to veterans to improve adherence to medication and treatment plans.

It is clear from the findings of this recent study that much more needs to done in this area. We urge VA to continue its research and provide appropriate resources and policies to eliminate racial disparities in VA health care.

In preparing for this hearing we also reviewed the most recent annual report (July 1, 2006) available from the VA Advisory Committee on Minority Veterans. The Advisory Committee made a number of recommendations including: improved outreach to all veterans including minority veterans; expansion of Internet based access to VA benefits and health care with particular attention given to cultural and linguistic diversity; continued research to help eliminate barriers for minority veterans to access health care and other benefits; increased attention to minority veterans living in rural areas, increase staff diversity; hire minority veterans from Operation's Enduring and Iraqi Freedom (OEF/OIF) to ensure sensitivity to a new generation of minority veterans seeking benefits and health care services from VA; improve coordination between VA and DoD to ensure basic information about VA benefits and services is made available to newly returning minority veterans from OEF/OIF. Of special concern to the Advisory Committee was the issue of outreach versus marketing. The Committee reported that field facilities may be under the impression that they are prohibited from marketing including conducting outreach to minority veteran populations. We agree with the Advisory Committee that this interpretation of policy is a serious impediment to minority veterans' knowledge of their VA benefits.

We support and applaud the Advisory Committee for its continued efforts to increase awareness about minority veteran issues and advance the quality of the services minority veterans currently receive.

WOMEN VETERANS

With increasing numbers of women serving in the military, and with more women veterans seeking VA health care following military service, it is essential that the VA be responsive to the unique demographics of this veteran population cohort. In addition, VA must ensure that its special disability programs are tailored to meet the unique health concerns of women who have served in combat theaters and those who have suffered catastrophic disabilities as a result of military service.

Although VA has markedly improved health care services for women veterans over the past 10 years, privacy issues at some facilities and other deficiencies still exist. VA needs to monitor and enforce, at the network and local levels, the legislation, regulations, and policies specific to health care services for women veterans. Only then will women veterans receive high quality primary and gender-specific care, continuity of care, and the privacy they expect and need at all VA facilities.

Messrs. Chairmen, there has been a trend in the Veterans Health Administration (VHA) to move away from comprehensive or full-service women's health clinics for the purpose of providing both primary and gender-specific health care to women veterans. According to VA, less than half of its facilities surveyed provide care to women through mixed gender primary care teams and refer women to specialized women's health clinics for gender-specific care. As you are aware, in the mid-nineties VA reorganized from a predominantly hospital-based delivery care model to an outpatient health care delivery model focused on preventative and health maintenance care. While we supported that shift, we are concerned about the incidental impact of the primary care model on the quality of health care delivered to women. VA's 2000 conference report "The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services" noted that with the advent of primary care in VA, many women's clinics were being dismantled and that women veterans were assigned to primary care teams on a rotating basis, essentially without regard to gender. Findings from the report indicated that this practice further reduced the ratio of women to men in any one practitioner's caseload, making it even more unlikely that the clinician would gain the clinical exposure necessary to develop and maintain expertise in women veterans' health. We understand that a follow on study is currently being conducted and we look forward to those findings.

VA acknowledges that full-service women's primary care clinics that provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care to women veterans. Or, in cases where there are relatively low numbers of women being treated at a given facility it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of provider clinical skills in women's health. VA also notes that the health care environment directly affects the quality of care provided to women veterans and has a significant impact on the patient's comfort, privacy, feeling of safety, and sense of welcome.

According to VA researchers, although women veterans surveyed reported that they prefer receiving primary and gender-specific health care from the same provider or clinic, in actuality, their care is fragmented, with different components of care being provided by different clinicians with variable degrees of coordination and expertise of caring for women. Additionally, researchers found a number of barriers to delivering high quality health care to women veterans. Specifically, insufficient funding for women's health programs, competing local or network priorities, limited resources for outreach, inability to recruit specialists, lower numbers of women veterans' caseloads, limited availability of afterhours emergency health services, and an insufficient number of clinicians skilled in women's health.

VA Researchers made several recommendations to address these barriers, including concentrating women's primary care delivery to designated providers with women's health expertise within primary care or women's health clinics; enhancing provider skills in women's health; providing telemedicine access to experts to aid in emergency health care decisionmaking; and, increasing communication and coordination of care for women veterans using fee-basis or contract care services. We are pleased that funding has been approved for VA researchers to study the impact of the practice structure on the quality of care for women veterans and fragmentation of care for women veterans including unmet health care needs for women with chronic physical and mental health conditions.

Messrs. Chairmen, VA previously established women's health as a research priority to develop new knowledge about how to best provide for the health and care of women veterans. In 2004, VHA's Office of Research and Development held a groundbreaking conference, "Toward a VA's Women's Health Research Agenda: Setting Evidence-Based Research Priorities for Improving the Health and Care of Women Veterans." The participants of the conference were tasked with identifying gaps in understanding women veterans' health and health care and with identifying

the research priorities and infrastructure required to fill these gaps. In April 2005, a special solicitation was issued for research proposals to assess health care needs of women veterans and demands on the VA health care system in targeted areas, such as mental health and combat stress, military sexual trauma (MST), post-traumatic stress disorder (PTSD), homeless women veterans, and differences in era of service (e.g., Iraq vs. Gulf war). An entire issue of the Journal of General Internal Medicine was dedicated to VA research and women's health in March 2006. Published findings included articles on why women veterans choose VA health care; barriers to VA health care for women veterans; health status of women veterans; PTSD and increased use in certain VA medical care services; and, MST.

We have strongly encouraged VA, as it takes steps to advance this agenda, to focus on research and programs that enhance VA's understanding of women veterans' health issues and discover new ways to optimize health care delivery and improve health outcomes for this patient population.

Addressing the Needs of Women Veterans Who Served in Operations Enduring and Iraqi Freedom (OEF/OIF)

According to the VA Women Veterans Health Program Office, as of August 31, 2006, approximately 70,000 women have served and separated from military service in OEF/OIF. Among this group nearly 37.2 percent, or 25,960, have sought and received health care from VA since separation from military service (up from 32.9 percent, or 15,903, in the previous year). According to VAthe prevalence of potential PTSD among new OEF/OIF women veterans treated at VA from fiscal year 2002–2006 has grown dramatically from approximately 1 percent in 2002 to nearly 19 percent in 2006.

The challenge of addressing the health care needs of the growing number of women veterans exposed to combat with and without obvious injury is daunting. In the future, the needs will likely be significantly greater with more women seeking access to care, increased health care utilization, and a more diverse range of medical conditions. It is unlikely the past experience of women veterans in the VA will serve as an accurate guide because of the unique experiences of women who have served in OEF/OIF.

Equal access to quality mental health services is critical for women veterans, especially women veterans who have readjustment problems associated with serving in a combat theater or those who have suffered sexual or other trauma during military service. The VA Women's Health Project, a study designed to assess the health status of women veterans who use VA ambulatory services, found that active duty military personnel reported rates of sexual assault higher than comparable civilian samples, and there is a high prevalence of sexual assault and harassment reported among women veterans accessing VA services. The study noted and we agree, that it is "essential that VA staff recognizes the importance of the environment in which care is delivered to women veterans, and that VA clinicians possess the knowledge, skill, and sensitivity that allows them to assess the spectrum of physical and mental conditions that can be seen even years after assault."

According to VA, approximately 19 percent of the women screened between fiscal years 2002 and 2006 responded "yes" to experiencing MST, compared to 1 percent of men screened. In response to these reports, VA established a Committee to explore ways to address the mental health needs of women veterans and to improve mental health services to women who have experienced MST. In 2006, VA developed an MST support team under its mental health service to specifically work with MST coordinators in the field to better monitor tracking, screening, treatment, and training programs for MST. VA is yet to implement earlier recommendations made by the Mental Health Strategic Health Care Group Subcommittee on Women's Mental Health, including development of an MST provider certification program, providing separate sub-units for inpatient psychiatry and other residential services, and improved coordination with DoD on transition of women veterans. We encourage VA revisit these recommendations.

Given the increasing role of women in combat deployments and with more than 70,000 women now having served in OEF/OIF combat theaters, we are pleased that VA's Women's Health Science Division of VA's National Center for PTSD is evaluating the health impact of combat service on women veterans, including the dual burden of exposure to traumatic events in the war zone and MST. According to the center, although there is no current empirical data to verify MST is occurring in Iraq there have been numerous reports in the popular press citing cases of sexual misconduct. In the center's Women's Stress Disorder Treatment Team, of 49 returning female veterans, 20 (41 percent) reported MST.

The Center notes that anecdotal reports from OEF/OIF veterans suggest a number of unique concerns that have a more direct impact on women than their male

counterparts returning from combat theaters, including lack of privacy in living, sleeping, and shower areas; lack of gynecological health care; health care impact of women choosing to stop their menstrual cycle; health consequences of dehydration and chronic urinary tract infection. There are also reported findings that suggest distinct differences in homecoming, including that women may be less likely to have their military service recognized or appreciated; possible differential access to treatment services; and possible increased parenting and financial stress. Additionally, women may be more likely to seek help for psychological difficulties.

We are pleased the Center is looking at gender differences in mental health, MST in the war zone, and gender differences in other stressors associated with OEF/OIF service and homecoming. We understand a number of research initiatives/projects are focused on treatment of PTSD in women, enhancing sensitivity toward and knowledge of women veterans and their health care needs among VA staff, and MST among Reserve components of the armed forces.

Some women will suffer from severe PTSD which will require more intensive evidence based treatment. VA has conducted ground breaking research on evidence based treatment for PTSD, including a recent study that established the efficacy for women. The most effective approaches often require intensive outpatient or residential care. Lack of adequate child care is a significant problem for women requiring such care, as is transportation to treatments which require frequent, even daily attendance. Furthermore, while the establishment of the efficacy of these approaches is an important first step, they will only have an impact on the thousands of women veteran affected when they are fully deployed throughout the VA system and easily accessible to patients. This is not currently the case, as acknowledged by the National Center representative in recent testimony before the President's Wounded Warriors Commission.

We recognize that VA is attempting to address the needs of women veterans returning from combat theaters in a variety of ways and has provided guidance for medical facilities to evaluate the adequacy of programs and services for returning OEF/OIF women veterans in anticipation of gender-specific health issues. We understand that the Women Veterans Health Program Office and the local women veterans' program managers (WVPMs) have partnered with the VA Seamless Transition Office to provide information during National Guard, Reserves, and family member demobilization briefings on VA services and programs for women veterans. VA should continue to strengthen its partnership with the DoD to ensure a seamless transition for women from military service to veteran status. An improvement in sharing data and health information between the Departments is essential to understanding and best addressing the health concerns of women veterans. Unlike female veterans from previous conflicts, this new cohort of female veterans has been routinely exposed to combat in Iraq. It is imperative to acknowledge that we do not fully understand the barriers that may prevent OEF/OIF women from accessing VA care. We do know from recent studies of OEF/OIF active duty and reserve component personnel that stigma is a major in accessing mental health services; with over 40% reporting that stigma would impact their access. Furthermore, we must acknowledge that we will never adequately understand the barriers to seeking VA care by only studying the minority of female veterans who actually receive care, as is the case with VA patient satisfaction surveys.

Therefore, DAV makes the following recommendations to better serve women veterans returning from combat theaters.

- VA and DoD should collaborate to conduct surveys of recently discharged active duty women and recently demobilized female reserve component members that fully assess the barriers that they perceive or have experienced to seeking health care through VA. These surveys should include assessments of the effect of sigma, driving distance, absence of child care, understanding of VA eligibility and services, user friendliness of VA services for those who have attempted to access care, cultural sensitivities that differentially affect women, and other key potential barriers.
- VA should quickly disseminate and deploy resources to make evidence based PTSD treatment easy accessible for women veterans across the country, and explore options for providing child care for those needing it to attend treatment.
- DoD should fund a prospective, population-based health study of women who served in OEF/OIF. An epidemiologic study with at least a 10 year follow-up is needed. This study should be carried out by DoD, VA and University researchers collaboratively.
- VA should conduct a comprehensive assessment of its Women Veterans' Health Programs, including specialized programs for women who are homeless or have substance-use and/or mental health issues, and develop an action plan to im-

prove services for this population and projected future needs of OEF/OIF women veterans.
- VA's sexual trauma programs should be enhanced.
- Family counseling programs should be expanded and enhanced to meet the needs of the spouses and children of veterans who have served in combat theaters. These mental health programs are critical to veterans and their families after military deployments.
- Each VA Medical Center should establish a consumer council that includes veterans' service organizations, family members, and veterans including OEF/OIF veterans to ensure that care is veteran centered.
- VA's Women Veterans and Minority Advisory Committees should include representative(s) who served in Iraq and Afghanistan.

At a recent VA National Conference: Evolving Paradigms—Providing Health Care to Transitioning Combat Veterans—one track focused on women veterans who served in Iraq. A panel discussion by those women was very revealing about their unique experiences in the military and the impact of that service on their physical and mental health, as well as their existing impressions of access to VA services post-deployment. The women who participated in this panel, as well as other women who have served in combat theaters, could offer valuable insight on the impact of military experience on this new generation of women veterans. We understand that VA had planned to convene a focus group of approximately 50 women veterans of the wars in Iraq and Afghanistan to examine gaps in service and how VA could better meet the needs of this group. It is not clear whether VA still plans to convene such a group, but DAV believes this could stimulate an effective policy debate within VA and greatly benefit this new generation of women veterans.

Finally, some women serving in the military may suffer the dual burden of combat exposure and MST. While the DoD has established an office to deal with the incidence of sexual trauma, the conditions of a combat theater, quartering and lack of personal security offer special threats to women. VA and DoD need to better coordinate policies and treatment for transitioning women veterans who suffer readjustment issues related to combat exposure and/or have suffered MST. With increasing pressure to address MST, DoD established a Sexual Assault Prevention & Response Office (SAPRO). Veterans now have the option to file either a "restricted" or "unrestricted" report of sexual assault in the military. In the case of a "restricted" report there is no investigation or legal action sought on behalf of the veteran but he or she will have access to medical treatment, counseling and advocacy support. Records detailing the assault and medical findings are kept for 1 year following the incident. It is our understanding that after the 1 year period if the veteran has not filed an unrestricted report any evidence collected including records of the incident will be destroyed. It is our hope that VA will collaborate with the SAPRO to ensure these records are either provided to the veteran or put in safe keeping. If a veteran is diagnosed with a mental health or physical disorder related to the assault during military service the records at the time of the assault would be essential in supporting the veterans claim for service-connection.

As we see growth in the number of women veterans using VA health care services, we also expect to see increased VA health care expenditures for women's health programs. Unfortunately, VA medical center administrators are under continued pressure to streamline programs and impose every efficiency practicable. Often, smaller programs, such as programs for women veterans, are at risk of discontinuation. The loss of a key staff member responsible for delivering specialized health care services or developing outreach strategies and programs to serve the needs of women veterans, can threaten the overall success of a program.

Women veterans program managers (WVPM) and benefits coordinators are another key component to addressing the specialized needs of women veterans. These program directors and benefits coordinators are instrumental to the development, management, and coordination of women's health and benefits services at all VA facilities. Given the importance of this position, DAV is concerned about the actual amount of time WVPMs are able to dedicate to women veterans issues and if they have appropriate administrative support to carry out their duties. According to VA, 71 percent of all WVPMs serve in a collateral role. Only 20 percent reported they were allocated more than 20 administrative hours per week to fulfill their program responsibilities during the fiscal year. With increasing numbers of women veterans, VA WVPMs must have appropriate support staff and adequate time allocated to successfully perform their program duties and to conduct outreach to women veterans in their communities. Increased focus on outreach to these veterans is especially important because they tend to be less aware of their veteran status and eligibility for benefits than male veterans.

In closing, VA needs to ensure priority is given to women veterans' programs so quality health care and specialized services are available equally for women and men. VA must continue to work to provide an appropriate clinical environment for treatment, even where there is a disparity in numbers. Given the changing roles of women in the military, VA must also be prepared to anticipate the specialized needs of women veterans who were sexually assaulted in military service or catastrophically wounded in combat theaters, suffering amputations, blindness, spinal cord injury, or traumatic brain injury. Although it is anticipated that many of the medical problems of male and female veterans returning from combat operations will be the same, VA facilities must address the health issues that pose special challenges for women. DAV has recommended that VA focus its women's health research on finding the health care delivery model that demonstrates the best clinical outcomes for women veterans. Likewise, VA should develop a strategic plan along with DoD to collect critical information about the health status and care needs of women veterans with a focus on evidence-based practices to identify other strategic priorities for women's health research agenda.

Messrs. Chairman, this concludes my testimony and I will be happy to address questions from you or other Members of the Subcommittees.

Prepared Statement of Betty Moseley Brown, Ed.D., Associate Director, Center for Women Veterans, U.S. Department of Veterans Affairs

Chairman Hall, Chairman Michaud, and Members of the Subcommittees, I am pleased to testify today on behalf of the Department of Veterans Affairs (VA) about services in VA for women veterans. Particularly, I will address how VA serves women veterans through its current programs, how present and future strategies will address the needs of this growing population, and what outreach efforts are being conducted by VA to women veterans. The Center for Women Veterans was established by Public Law No. 103–446 in November 1994 to oversee VA programs for women veterans. The Center's mission is to ensure that women veterans receive benefits and services on par with male veterans; that VA programs are responsive to gender-specific needs of women veterans; that outreach is performed to improve women veterans' awareness of services, benefits and eligibility criteria; and that women veterans are treated with dignity and respect. The Director, Center for Women Veterans, acts as the primary advisor to the Secretary and Deputy Secretary on all matters related to policies, legislation, programs, issues, and initiatives affecting women veterans.

How is the Department of Veterans Affairs (VA) serving women through its current programs?

The Center for Women Veterans monitors changes in services through briefings by the 3 VA administrations and assesses the impact these changes may have on the delivery of services for the Nation's 1.75 million women veterans—from programs for homeless women veterans with children, elderly women veterans, women veterans living in rural areas, and for those women still unaware they, too, are veterans, since many do not identify themselves as such. The Center regularly monitors VA briefings during Transition Assistance Programs to ensure that active duty women are provided access to information on the benefits and services available to them as veterans prior to their release from active duty.

The Advisory Committee on Women Veterans was established by Public Law 98–160 in 1983. The Advisory Committee is charged with advising the Secretary of Veterans Affairs on VA benefits and services for women veterans, assessing the needs of women veterans, reviewing VA programs and activities designed to meet those needs, and developing recommendations addressing unmet needs. The Advisory Committee submits a biennial report to the Secretary incorporating the Committee's findings and recommendations.

As a means of obtaining information regarding the delivery of health care and services to women veterans, the Advisory Committee conducts site visits to VA facilities throughout the country. In addition, the Advisory Committee tours the facilities and meets with senior officials to discuss services and programs available to women veterans. During site visits, the Advisory Committee also hosts open forums with the women veterans' community, encouraging women veterans to discuss issues and ask questions related to VA benefits and services. The Advisory Committee meets twice a year at VA Central Office (VACO) and receives briefings from the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration (NCA) and other staff offices. These brief-

ings update the Committee on the status of VA programs and respond to concerns raised during the site visits. The Advisory Committee uses information from these site visits and briefings in its biennial reports to the Secretary.

In the 2006 Report of the Advisory Committee on Women Veterans, the Advisory Committee made 23 recommendations. Some of the key report issues included outreach, behavioral and mental health care, military sexual trauma, health care, research and studies, strategic planning, training, and women veterans who are homeless. The 2006 Report has been provided to Congress.

Regarding women veterans health program, the Advisory Committee, in its 2006 Report, recommended VA ensure the Center is provided an annual update on the effectiveness of the VHA Women Veterans Program Managers Program. VHA officials, including the Women Veterans Health Strategic Healthcare Group (formerly known as Women Veterans Health Program), briefed the Center and Advisory Committee members on this issue at the February– March 2007 meeting of the Advisory Committee. In addition, the Women Veterans Health Strategic Healthcare Group works closely with the Center on issues that are frequently referred to Women Veterans Program Managers in field facilities.

- In FY 2006, the VHA served 235,901 women veterans in our health system. By comparison, in FY 2001 VHA served 171,161 women veterans. This is a 5 year relative increase of 37.8 percent.
- In FY 2006, 14 percent of the census-projected number of all women veterans utilized VHA services. This compares to 22 percent of all male veterans utilization.
- Of the total number of women who have been discharged from active duty after deployment in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF), 37.5 percent, or 25,960 women veterans, have been to a VHA health care facility at least once. This compares to a male utilization rate of 32 percent for OIF/OEF veterans.
- There are 22 VA health care facilities that have dedicated, comprehensive women's center space.

VHA's Women Veterans Health Strategic Healthcare Group (WVHSHG) studies the continuum of care available to women veterans through an annual Plan of Care-Clinical Inventory Report. This Report surveys availability of all related types of physical and mental health services for women at each medical facility. Every facility has a designated Women Veterans Program Manager to serve as program administrator, veteran advocate and referral source to appropriate care; this report also tracks their time allotment.

In addition, in 2006 WVHSHG cosponsored Elizabeth Yano, PhD, MSPH, Deputy Director VA Greater Los Angeles HSR&D Center of Excellence and Associate Professor at UCLA, to survey VISN Leadership, facility and program directors regarding provision of care models in women's health in VHA. We expect delivery of this report in late 2007, informing VHA of the provision of primary care to women veterans through models of specialized women's health clinics and in models of mixed-gender primary care sites, including community based outpatient sites. This study will clarify which models of care for women provide the best performance outcomes and higher patient ratings of care.

Realizing the current influx of returning women veterans will increase the number of women seen by VHA in the next several years, VHA has initiated programs to identify interested primary care providers and provide them with intensive training in women's health. The needs assessment for this program will be implemented in September 2007 through VA's Employee Education Service efforts. This program will be especially important in addressing the health care needs of rural women. We also recognize that the majority of women veterans new to VHA are of childbearing age and could be at risk for birth defects from some prescription medications. This presents new challenges which we are addressing through initiatives in pharmacy management and provider education.

VHA is committed to expanding the focus of women veterans' health care beyond the issues of gender specific screening for breast and cervical cancer. In the United States, heart disease is the number one cause of death in women, and WVHSHG has proposed initiatives in improved management and prevention for heart disease risk including cholesterol, weight management and smoking cessation. On June 22, 2007, VHA's Office of Public Health and Environmental Hazards awarded 2 clinical demonstration grants specific to smoking cessation programs for women veterans.

Another focus area for women veterans' health is prevention and detection of cancers, particularly colorectal cancers, through improved screening of women veterans. We are evaluating factors related to the fact that fewer women than men receive colorectal cancer screening, both within VA and in community samples.

Mental Health

There are specialized women's mental health services in VHA:

- *Specialized inpatient and residential programs for women veterans*—these programs are for women who need more intensive treatment and support. While in these programs, women live either in the hospital or in a residence with other women. Length of stay for these programs ranges from 28 days to 18 months.
- *Inpatient and residential programs with cohort treatment for women or separate women's wings*—these are programs for women who need more intensive treatment and support, like the specialized inpatient and residential programs discussed above. However, these programs accept both men and women and accept women in groups at specific start dates or have separate space for women.
- *Women's Stress Disorder Treatment Teams (WSDTTs)*—these are specialized outpatient mental health programs that focus on the treatment of Post Traumatic Stress Disorder and other problems related to trauma.
- *Women's Homelessness Programs*—although many VA homelessness programs serve women, there are also programs specific for women veterans that provide services for those who are homeless or at risk of becoming homeless.
- *Military Sexual Trauma (MST) Coordinators*—every VA facility has a designated MST Coordinator who serves as a point of contact for MST-related issues. Vet Centers also have specially trained sexual trauma counselors.
- *Sexual Trauma Treatment Provided in Residential or Inpatient Settings*—there are programs that offer sexual trauma-specific treatment in a residential or inpatient setting. Programs range from those solely dedicated to the treatment of sexual trauma; to those with a special track emphasizing the treatment of sexual trauma; to those with 2 or more staff members with expertise in sexual trauma who, in the context of a larger program not focused on sexual trauma, provide treatment targeting this issue.
- *MST Support Team*—In FY07, VA's Office of Mental Health Services (OMHS) established a Military Sexual Trauma (MST) Support Team that is designed to help ensure that VA is in compliance with legally mandated monitoring of MST screening and treatment. The team also helps to coordinate and expand legally mandated education and training efforts related to MST, and to promote best practices in the field.
- *National Training Initiatives in Evidence-Based Practices for PTSD*—there are currently 2 national initiatives to train therapists in evidence-based practice for PTSD being funded by VA's Office of Mental Health. The first one is to train and support therapists to conduct cognitive processing therapy (CPT), a highly effective treatment for PTSD and related symptoms. The second therapy is an exposure therapy for PTSD called prolonged exposure. There have been a number of studies supporting the use of exposure treatment for PTSD.
- In addition, there is a wide range of services for women available through VA's Readjustment Counseling Services and Vet Center Programs. Female veterans who served in combat theaters are eligible for the full range of readjustment services as provided by VA's Vet Center Program. Since the onset of the Vet Center program, women veterans have been provided outreach services to promote early intervention and access to VA care, preventive educational services, counseling for substantive readjustment problems (including war-related PTSD services), family counseling and employment related services. Since 1993, female veterans of any era have also been able to access military related sexual trauma counseling at Vet Centers. Vet Centers promote the hiring of female veteran service providers at equal to or higher than the representation of women in the military. Access to care for women veterans is also promoted through the Vet Center program's working group. The working group is composed of female staff members who assist management by educating their fellow Vet Center staff on the contributions made by women in the military and exploring gender-related issues to promote gender-sensitive services to women veterans.

Research

Currently, the VHA Office of Research and Development (ORD) is supporting a broad portfolio focused on women's health issues, including studies on diseases prevalent solely or predominantly in women [e.g., certain types of cancer (breast, cervical, ovarian), lupus, human papillomavirus (HPV) and hormonal effects on diseases in post-menopausal women], research focusing on women subjects (e.g., PTSD in women, osteoporosis in women, multiple sclerosis in women) and research on the health care of women veterans.

ORD's efforts to support research that will improve the health care of the growing number of women veterans can be categorized in 3 areas:

- Research assessing VA's organization of care for women veterans and the implications for improved quality of care.
- Research on the unique experiences of women veterans regarding risks, treatment and health care outcomes related to sexual and other military traumas.
- Research examining the general health care needs and service utilization of women veterans.
- In 2001, VA's Office of Research and Development created a Center of Excellence for Research aimed at identifying factors which cause disparities in health outcomes across racial, ethnic, and gender lines, as well as ways for promoting equity in health and health care. This center, co-located at 2 sites (Pittsburgh and Philadelphia), has 29 core investigators who have contributed over 128 peer-reviewed scientific articles over the past 2 years.

Veterans Benefits Administration

- In fiscal year 2006, Vocational Rehabilitation and Employment Program (VR&E) received 57,856 applications of which 9,895 were female veterans. During the entire fiscal year, VR&E had 52,982 active participants of which 12,627 were female veterans.
- In fiscal year 2006, 193,112 female veterans received compensation for a service-connected disability.
- In fiscal year 2006, the percent of guaranteed loans was increased for women veterans with 12.2 percent in FY06 with 17,355 loans to women veterans at an average loan amount of $173,923.
- In fiscal year 2006, 8,442 women separating from service used their education benefits under the Montgomery GI Bill (MGIB). Since the inception of the MGIB, 214,369 female veterans have used their benefits under Chapter 30 of the program. This represents a 72.7-percent rate of usage.
- There are 58,086 female veterans covered under the Veterans Group Life Insurance (VGLI) program. The total amount of coverage in force for female veterans is $17.6 billion for an average coverage of $123,300.
- Presented and participated in 8,541 VA benefits briefings attended by 393,345 active duty military service members including Guard and Reserve members.
- To promote accuracy and consistency in the claims review process, VBA has taken a number of actions. For example, in the past 4 years, VBA has published guidance and conducted training for employees on the full range of issues related to PTSD claims adjudication—from development of the claim to proper application of the rating schedule.
- VBA and VHA have worked collaboratively to modifying the examination request worksheets and the examination templates related to PTSD. This ensures that the information gathered during the exam is uniform and sufficient to make the determinations concerning entitlement and degree of impairment.

What are the present and future needs of these growing populations and what strategies does VA have for meeting them?

The last national survey of female veterans was conducted in 1985, leaving VHA policy makers and managers with limited information with which to adequately plan for future health care services for women veterans. To address this knowledge gap, the WVHSHG commissioned Donna Washington, MD, MPH, VA Greater Los Angeles HSR&D Center of Excellence, to conduct a national Survey of Women Veterans. The objectives of the National Survey of Women Veterans are: (1) identify the current demographics, health care needs, and VA experiences of women veterans; (2) determine how health care needs and barriers to VA health care use differ among women veterans of different periods of military service, e.g., OEF/OIF versus earlier periods; and (3) assess women veterans preference for and perceived value of different types of VA interventions to improve access and quality. VA will survey between 2,500 and 3,200 women veterans across the Nation, including equal numbers of VA users and nonusers. The survey began in April of 2007 and the final report will be submitted by December 31, 2008.

The recent elevation of the Women Veterans Health Program to the Women Veterans Health Strategic Healthcare Group has positioned the office to gain expertise in the population of women veterans, strategically plan for health care delivery and provide leadership in clinical knowledge of this unique group of women and to catalyze optimal integration of women veterans health issues across all VHA programs

and offices. We aim to be a world leader in innovative and high quality care to women veterans.

What outreach efforts are being conducted by VA to women veterans?

We continue to outreach to the women veterans' community with increased emphasis on our partnerships with Federal, state, and county agencies, national Veterans Service Organizations and community organizations. To enhance collaboration and better serve our women veterans, representatives from the Department of Health and Human Services (HHS), the Department of Labor (DoL), the Department of Defense (DoD), and VA Administrations (VHA, VBA and NCA) serve on the Advisory Committee on Women Veterans as appointed ex officio members. The Center's Director serves as an *ex officio* member on the Defense Advisory Committee on Women in the Services (DACOWITS). In this role, she ensures that DoD and VA collaboratively address military and women veterans' health and benefits issues.

The Center published the 25 most Frequently Asked Questions from women veterans in English and Spanish based on thousands of inquiries from women veterans. These questions are posted on the Center's website and the VA website.

The next National Summit on Women Veterans Issues will be June 20–22, 2008. We are planning to outreach to the military services, particularly the Reserves and National Guard. We are planning various workshops, including "Readjustment Counseling Service: Outreach and Transition Services for Veterans Families," "Gender Differences: What the Data Shows," and "Mental Health Issues." Our previous summit was attended by over 300 women veterans, Federal, state and veteran advocates and developed recommendations for how to better serve women veterans.

Since October 2001, the Center staff has completed nearly 100media interviews and hundreds of keynote speeches, participated in veterans forums, and monitored Transition Assistance (TAP) sessions and veterans briefings. To ensure veterans' issues are addressed quickly during forums, VA has assigned local women veterans program managers from VA Medical Centers and women veteran coordinators from Regional Offices to accompany Center staff to answer general questions and see that health care and benefit issues raised regarding individual cases receive immediate attention. In addition, Center staff works closely with numerous other VA advisory Committees and councils, DoD, DoL, HHS, Women's Policy, Inc., state and local agencies, and VSO's to address and resolve women veterans issues.

VA is grateful for the work of the Advisory Committee because its activities and reports play a vital role in helping VA assess and address the needs of women veterans.

This concludes my formal testimony. I will be pleased to answer any questions.

Prepared Statement of Lucretia M. McClenney, Director, Center for Minority Veterans, U.S. Department of Veterans Affairs

Chairman Hall, Chairman Michaud, and Members of the Subcommittees, I appreciate the opportunity to come before you today to discuss the mission of the Center for Minority Veterans and address your specific questions on the Department of Veterans Affairs (VA) service to minority veterans through its current programs; present and future strategies addressing the needs of this growing population; and outreach efforts being conducted by VA to minority veterans.

Center for Minority Veterans

The Center for Minority Veterans was created by Public Law 103–446, in November 1994. The Director of the Center serves as primary advisor to the Secretary and Deputy Secretary of Veterans Affairs on all issues related to minority veterans.

Our Mission

The mission of the Center for Minority Veterans includes serving in an advisory role to the Secretary and Deputy Secretary on the adoption and implementation of policies and programs affecting veterans who are minorities; making recommendations to senior VA officials for the establishment or improvement of programs; promoting minority veterans' use of benefits; analyzing and evaluating complaints made by or on behalf of minority veterans; and consulting with, and providing assistance and information to external local, state and Federal stakeholders.

Who We Serve

The Center serves all veterans regardless of race or ethnicity, but pursuant to Public Law 103–446, the Center's primary emphasis is on minority veterans. Specifically, veterans who are: African Americans, Asian Americans, Pacific Islanders,

Hispanics, or Native Americans, including American Indians, Alaska Natives, and Native Hawaiians.

How is the Department of Veterans Affairs (VA) serving minority veterans through its current programs?

Minority Veterans Program Coordinators (MVPC)

To establish a national presence and to ensure issues are addressed at the local level, the Secretary of Veterans Affairs in 1995 directed the appointment of Minority Veterans Program Coordinators (MVPCs) at each VA Health Care Facility, Regional Benefits Office and National Cemetery. There are approximately 300 MVPCs across the Nation. The Center provides training to MVPCs in cultural competency and outreach strategies. These coordinators educate and sensitize facility personnel to the needs of minority veterans in the community and promote the use of VA benefits, programs and services by minority veterans. In addition, the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA) and National Cemeteries Administration (NCA) each have designated a Central Office MVPC Liaison. The Center staff meets monthly with these liaisons and quarterly with the senior leadership of each Administration to discuss outreach activities, issues and concerns that impact minority veterans.

The Center has converted the coordinators' annual written report to a quarterly web based report to provide greater visibility on their outreach efforts, identify opportunities for improvement, benchmark best practices and recognize the Minority Veterans Program Coordinator of the Quarter and Year for each Administration.

Advisory Committee on Minority Veterans (ACMV)

The Advisory Committee on Minority Veterans (ACMV) was also established under Public Law 103–446. The Committee is composed of veterans of all ranks and services appointed by the Secretary. Members represent the 5 minority groups the Center is mandated to oversee. The Committee advises the Secretary and Congress on VA's administration of benefits and provision of health care to minority veterans; assessing the needs of minority veterans, reviewing VA programs and activities designed to meet those needs and developing recommendations to address unmet needs.

The Committee submits an annual report to the Secretary incorporating its findings and recommendations. In order to assess the delivery of health care services and benefits, the Committee conducts 2 meetings annually (one site visit and 1 business meeting). During the site visits the Committee tours VA facilities (of all 3 Administrations), meets with senior officials to discuss services and programs available for minority veterans, and conducts Town Hall meetings for local veterans and the community to hear firsthand their concerns and/or issues. The Committee meets once annually at VA Central Office (VACO) and receives briefings from VHA, VBA and NCA and other staff offices. These briefings provide the Advisory Committee an update on current VA policies and programs and afford them the opportunity to discuss their findings and concerns impacting minority veterans.

What are the present and future needs of this growing population and what strategies does VA have for meeting them?

Needs of Minority Veterans:

In many instances, any challenges that minority veterans encounter as they seek services from VA are magnified by the adverse conditions in their local communities. These challenges may include access to VA medical facilities (especially for American Indians, Alaska Natives, and Pacific Islanders, and other veterans residing in rural, remote or urban areas), disparities in health care centered on diseases and illnesses that disproportionately effect minorities, homelessness, unemployment, lack of clear understanding of VA claims processing and benefit programs, limited medical research and limited statistical data related to minority veterans.

Cultural competency and diversity training assist VA employees when serving our very diverse minority veteran population.

VA Strategies to Meet the Needs of Minority Veterans include but are not limited to the following:

- Access to VA medical care has been addressed by dramatically increasing the number of Community Based Outpatient Clinics (CBOC). In 1995, VA had 102 Community Based Outpatient Clinics and by 2000, VA had 600 Community Based Outpatient Clinics. In the second quarter of 2007, 872 Ambulatory Care and Outpatient Clinics were in operation. One hundred Operation Enduring

Freedom and Operation Iraqi Freedom Patient Advocates have recently been assigned to assist our newest veterans as they seek care from VA.

- VA is addressing homelessness in the minority veteran population by partnering with community stakeholders; enhancing outreach activities; and expanding VA's Grant and Per Diem Program.
- In 2001, VA's Office of Research and Development created a Center of Excellence for Research aimed at identifying factors which cause disparities in health outcomes across racial, ethnic, and gender lines, as well as ways for promoting equity in health and health care. This center, co-located at 2 sites (Pittsburgh and Philadelphia), has 29 core investigators who have contributed over 128 peer-reviewed scientific articles over the past 2 years.
- The Center is working with VHA's Office of Health Services Research and Development and the Center for Health Equity Research Program to target minority groups such as the Tuskegee Airmen, Buffalo Soldiers, Montford Point Marines, and National Congress for American Indians by actively encouraging minority veteran's participation in research programs.
- Since 2003, VHA has encouraged minority veterans to voluntarily self identify by racial and ethnic groups to assist in data retrieval of minority veteran demographics and utilization of VA services and benefits.
- VA's Office of Patient Care Services is developing a 3 year phased educational cultural competency curriculum for clinicians and administrative leadership.
- Native American traditional healing has been recognized as an additional avenue to pursue to enhance clinical outcomes. Several VA medical centers have sweat lodges, and some VA facilities utilize the fee basis program to secure the services of Native American healers.
- To promote accuracy and consistency in the claims review process, VBA has taken a number of actions. For example, in the past 4 years, VBA has published guidance and conducted training for employees on the full range of issues related to PTSD claims adjudication—from development of the claim to proper application of the rating schedule.
- VBA and VHA have worked collaboratively to modifying the examination request worksheets and the examination templates related to PTSD. This ensures that the information gathered during the exam is uniform and sufficient to make the determinations concerning entitlement and degree of impairment.
- VBA's Native American Veteran Direct Loan Program (NADL) enables a Native American veteran or a veteran who is married to a Native American veteran to use their VA home loan guaranty benefit on Federal trust land. The program began as a pilot in 1992 and was made permanent by Public Law 109–233, The Veterans Housing Opportunity and Benefits Act of 2006. Nearly 550 loans have been made to eligible veterans in 14 states and 3 U.S. territories. 71 tribal governments and 3 territorial governments have participated in the program.
- With enactment of Public Law 109–461, *The Veterans Benefits, Health Care, and Technology Information Act of 2006*, on December 22, 2006, the National Cemetery Administration (NCA) may now award grants to Tribal Organizations for the establishment, expansion and improvement of veteran cemeteries on trust lands.
- NCA strives to accommodate the special needs of Native American veterans. This includes active participation in meetings with tribal nations, the encouragement of participation in new VA national cemetery dedications, and accommodating the religious customs during committal services at VA national cemeteries.

What outreach efforts are being conducted by VA to minorities?

The Center for Minority Veterans has staff who serve as veteran liaisons for each of the 5 minority groups: African Americans, Asian Americans, Pacific Islanders, Hispanics and American Indians and serve as consultants to the Minority Veterans Program Coordinators. They establish partnerships with Veterans Service Organizations as well as internal and external stakeholders to increase awareness of minority veteran issues and develop collaborative strategies to address unmet needs. The Center has active partnerships with VA's Center for Veterans Enterprise, National Veterans Employment Program, Women Veterans Health Program, and Health and Human Services' Center for Medicare and Medicaid Services who are active participants in our community outreach efforts and presenters in our biennial training conferences.

Other active partnerships with minority organizations include, but are not limited to:

African Americans—Congressional Black Caucus, NAACP and The National Urban League

Hispanics/Latinos—American GI Forum and League of United Latin American Citizens (LULAC)

Native American—National Congress of American Indians, United South and Eastern Tribes, Navajo Nation Washington Office, and the White House Indian Affairs Working Group

Asian/Pacific Islanders—Japanese American Veterans Association and Federal Asian Pacific Americans Council

VA is most appreciative of the outstanding accomplishments of the Advisory Committee on Minority Veterans and the Minority Veterans Program Coordinators because their outreach activities and reports are critical in helping VA assess and address the needs of minority veterans.

This concludes my prepared statement. I would be happy to answer any questions you may have.

Statement of Shannon L. Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Division, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's views on VA's programs addressing women and minority veterans. The American Legion commends the Subcommittees for holding a hearing to discuss these very important issues.

Programs Serving Women and Minority Veterans

The Center for Women Veterans and the Center for Minority Veterans were established by Congressional mandates to ensure that the needs of the growing populations of women and minority veterans are reflected in policies implemented and services and benefits provided by the Department of Veterans Affairs (VA). Through these offices, VA has improved access to benefits and services for women and minority veterans and shaped policy addressing the provision of health care for female veterans.

The Center for Women Veterans' activities include monitoring changes in VA policy to ascertain the impact of the changes on the delivery of services to homeless women with children, rural and elderly women veterans, and minority women veterans; ensuring that active duty women are provided access to information on VA benefits and services available to them, prior to their release from active duty; conducting outreach to allow women veterans to express their needs and concerns; ensuring that VA research initiatives include adequate consideration for the effects of the military experience on women veterans; and working with Veteran Service Organizations (VSO) to disseminate information. The Center for Women Veterans also serves as a conduit through which the Advisory Committee on Women Veterans makes recommendations to the Secretary of VA.

The Center for Minority Veterans' activities include ensuring that minority veterans are aware of VA programs, benefits, and services; conducting outreach initiatives to allow minority veterans to voice concerns; making VA benefits and health care services more accessible to minority veterans; and making recommendations on how VA can better serve minority veterans. The Center for Minority Veterans also supports an advisory Committee and works with the Center for Women Veterans to address concerns faced by minority women veterans.

The VA offers a full continuum of comprehensive medical services to include disease prevention, primary care, women's gender-specific health care, acute medical/surgical, substance abuse and mental health treatment, domiciliary, rehabilitation and long-term care options.

Present and Future Needs

The current Global War on Terror illustrates a few deficiencies in services provided for women veterans. Never before have women service members been engaged in constant combative environments. Participation in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) has forced them to expand their military roles to ensure their own survival, as well as the survival of their units. They sustain the same types of injuries that their male counterparts endure. Any future women veterans' research conducted by VA will need to take into consideration the physical effects of combat on women veterans, not just mental effects of combat and military sexual trauma (MST).

Since women veterans are sometimes the family's sole care givers, services and benefits designed to promote independent living for combat-injured veterans will

need to consider other needs—like child care during rehabilitation. This dynamic should also be considered more when designing domiciliary and homeless women veteran programs. Not making provisions that would accommodate the children of homeless women veterans would bring more devastation to an already unstable home life and may actually be a deterrent for seeking assistance from the VA.

Providing quality health care in a rural setting has proven to be very challenging, given factors such as limited availability of skilled care providers and inadequate access to care. Even more challenging will be VA's ability to provide treatment and rehabilitation to rural veterans, to include women veterans, who suffer from the signature ailments of the on-going Global War on Terror—traumatic blast injuries and combat-related mental health conditions. VA's efforts need to be especially focused on these issues.

Gaining access to the nearest facility providing gender-specific services can prove even more of an obstacle, since the nearest facility may be a Community Based Outpatient Clinic (CBOC) which may not offer these services.

The American Legion believes veterans should not be penalized or forced to travel long distances to access quality health care because of where they choose to live. Women veteran who reside in rural areas need to have improved timely, access to gender-specific care. We urge VA to improve access to quality primary and specialty health care services—to include gender-specific services—using all available means at VA's disposal, for veterans living in rural and highly rural areas.

Some minority veterans, especially those who suffer from combat-related injuries, have to rely on family and friends as care givers. In this situation, communication can literally be a matter of life, or death. Some of these care givers may not speak English as their first language. When there is a language barrier, there is a great chance that the veteran may not be informed of benefits and services to which he/she may be entitled and coordinating rehabilitation or care becomes daunting.

VA has made the effort to have several of its brochures printed in Spanish and is attempting to make staff and health care providers more knowledgeable about cultural diversity. However, given the diverse make-up of the veteran population, materials and outreach have to address more than Spanish-speaking populations. The American Legion believes that VA needs to remove any hindrance that prevents veterans from obtaining the care they have earned through their military service.

VA Outreach Efforts

The Center for Women Veterans outreach activities include: a national Summit on Women Veterans Issues to address emerging needs facing female veterans and provide information about VA benefits and services that female veterans have earned through their military service; creation of the Women Veterans Frequently Asked Questions pocket guide; and conducting townhall meetings and community forums.

The Center for Minority Veterans provides veteran outreach through minority veteran program coordinators, who inform minority veterans of VA benefits and services on the local level; collaboration with VA's Office of Small and Disadvantage Business Utilization (OSDBU) to cosponsor business outreach activities to sponsor business and entrepreneurial outreach conferences for minority and disabled veterans; and through the Advisory Committee for Minority Veterans, conducts site visits and townhall meetings.

The VA utilizes opportunities to address veteran service organizations (VSO) to disseminate information. These opportunities or information exchanges include: participating in VSOs annual conventions and training conferences; collaborating in writing informative articles for membership magazines and newsletters; and inviting VSOs to participate in focus groups/work groups and planning for outreach activities. By participating in activities sponsored by the various VSOs, VA provides information to advocates who directly work with and for veterans to ensure that they receive the quality of care and benefits to which they are entitled.

The Center for Women Veterans, the Center for Minority Veterans and the Office of Research and Development eagerly participate in The American Legion's annual Convention and training conferences. They provide speakers to address specific topics affecting women and minority veterans.

Again, thank you for allowing the American Legion this opportunity to present its views on women and minority veterans. We look forward to working with the subcommittees and VA to improve access to quality health care for all veterans.

Statement of Hon. Corrine Brown,
a Representative in Congress from the State of Florida

Thank you, Mr. Chairman for holding this hearing.

I am pleased to hear the testimony from the many interested parties today.

As we are all aware, the face of the military has changed dramatically over the last 10 years. With the all-volunteer force the military is made up of now, more minorities and women are choosing this career.

I am sure you have noticed, I am both a woman and a minority. This issue is very important to me.

The total veteran population in the United States and Puerto Rico, is about 24 million. The population of women veterans approaches 2 million. Florida is the third largest state with the women veterans.

Almost 20 percent of the veterans in this country, in the 2000 census, are of a minority.

Is the VA addressing the needs of this changing military? Are they adequately addressing the needs of the increasing number of women and minorities coming out of the minorities?

I look forward to the answers of these and other questions as the hearing moves forward.

Thank you again, Mr. Chairman.

Statement of Hon. Jeff Miller,
Ranking Republican Member, Subcommittee on Health,
and a Representative in Congress from the State of Florida

Thank you, Chairman Michaud.

I ask unanimous consent that my statement be included in the record, and that I may have 5 legislative days to revise and extend my remarks.

It is good to be here with our colleagues from the Subcommittee on Disability Assistance and Memorial Affairs, and I would like to welcome Chairman Hall and Ranking Member Lamborn.

We have seen both women and minorities answer the call of duty in growing numbers and it is vitally important that we make sure that there are not any barriers for these veterans to access VA benefits and services, and that VA provides specialized services to meet their unique needs.

Seven percent of our Nation's veterans or roughly 1.7 million are women. My home state of Florida is 1 of the 5 States with the largest number of women veterans, with over 132,000. As the number of women serving in the active duty, guard and reserve continue to increase, so must our over oversight to monitor the activities of VA to serve this population.

I am pleased to see our colleague, Representative Heather Wilson from New Mexico before the Subcommittees. She holds the distinct honor of being the only woman veteran of the United States Congress. Previously, she testified before the Health Subcommittee in the 107th Congress. I look forward to her testimony and to learn how VA's performance in meeting the specialized needs of women veterans has evolved over the past 5 years.

Similarly, there are over 3.8 million minority veterans, accounting for roughly 15 percent of the veteran population according to the 2000 Census. We need to be aware of the actions VA is taking to support the use of VA benefits, programs, and services by minority veterans; to target outreach efforts through community networks and to initiate activities that educate and sensitize staff to the unique needs of minority veterans.

I thank all of our witnesses for joining us today. Your testimony will provide us insight into how well VA is attending to the specific needs of women and minority veterans and help us to identify gaps in services and necessary improvements with respect to both benefit and health care programs including outreach and mental health treatment.

Thank you and I yield back the balance of my time.

Statement of Dennis Cullinan,
Director, National Legislative Service,
Veterans of Foreign Wars of the United States

MESSRS. CHAIRMEN AND MEMBERS OF THE SUBCOMMITTEES:

On behalf of the 2.4 million members of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for allowing us to express our views on this very important and timely subject.

According to recent Department of Veterans Affairs and Military Services data 10% of all veterans are women and 15% of today's active duty military are women. VA has made vast improvements in care and services provided to female veterans in the last 10 years, but with increasing numbers of females deployed to Iraq and Afghanistan a system-wide change may be in order. VA must be prepared to meet the needs of the increasing number of women veterans who will be seeking health care services, including mental health care and ensure that its special disability programs are tailored to meet their unique health concerns, especially those who have served in combat.

VFW is concerned that although VA has markedly improved the way health care is provided to women veterans, deficiencies still arise in the area of privacy and delivery of services across the Veterans Integrated Service Networks (VISN). The Independent Budget, of which VFW is a co-author, found that the model used for delivery of primary health care to women veterans using VA health care services is variable. The trend has been to move away from full-service women's health clinics dedicated to both primary and gender-specific health care to providing mixed gender primary care teams and contracting out other more specific gender care.

VA's 2000 conference report "The Health Status of Women Veterans Using Department of Veterans Affairs Ambulatory Care Services" noted that with the advent of primary care in VA, many women's clinics were dismantled and female veterans were assigned to primary care providers on a rotating basis. The report also found that this further reduced the ratio of women to men using VA, making it more unlikely that a clinician will gain clinical knowledge to develop and maintain expertise in women's health.

VFW believes that VA needs to increase the priority given to women veterans and take the necessary steps to focus on research and programs that enhance their understanding of women veterans' health issues. This will enable them to evaluate which health care delivery model demonstrates the best clinical outcomes for women. VA must ensure that clinicians caring for women veterans are knowledgeable about women's health and that they participate in ongoing education about the health care needs of women and be competent to provide gender-specific care to women. They must also ensure that its specialized programs for post-traumatic stress disorder, spinal cord injury, prosthetics and homelessness are equally available to women veterans as to male veterans. Most importantly VA needs to increase its outreach efforts toward this population as women veterans tend to be less aware of their veteran status and eligibility for benefits than their male counterparts.

VFW believes that the future needs of women veterans can only be met through continued research and studies specifically tailored toward women veterans. VA should collaborate with DOD to collect critical information about the health care needs of women veterans to identify current priorities of returning female servicemembers. An improved environment of sharing data and health information between Departments is essential to ensuring a truly seamless transition from military service to veteran status.

We are pleased to hear that a national survey currently being conducted by the Women Veterans Health Strategic Healthcare Group (WVSHCG) will survey 2,500 to 3,200 women veterans across the Nation, including VA users and non-users. The objectives of the survey include identifying the current demographics, health care needs and VA experiences of women veterans. It will also address how health care needs and barriers to VA health care differ among periods of service including OEF/OIF veterans and earlier periods and last assess women veterans' preference for and perceived value of types of VA services and how to improve access to care. We look forward to reading the findings of the report due out in December 2008.

The challenges facing minority veterans are both similar and different to those facing women veterans. Barriers to service and health care access among minority veterans remain prevalent within the VA system. VA's Health Services Research and Development Service released a report in June 2007 entitled *Racial and Ethnic Disparities in the VA Healthcare System: a Systematic Review*. The findings of the study concluded that disparities appear to exist in all clinical areas of VA. Most troubling was the fact that researchers commented in nearly each case that the underlying cause of these disparities were not explored or remained unclear.

The study did offer a number of future research ideas to help reduce racial disparities within VA—the VFW acknowledges that increased outreach and marketing geared toward literacy, language and cultural issues is a start. Studies centered on diseases and illness that disproportionately affect minorities, along with creating an environment where patients are more active participants in their health care deci-

sions are also keys to change. Materials (federal benefit handbooks, brochures and other materials) printed and made available in Spanish are also critical.

We would also like to recognize recommendations made in the July 1, 2006 report of the (VA) Advisory Committee on Minority Veterans (ACMV).

The ACMV conducts site visits and meets with VA officials in preparation for their annual report of recommendations to better service minority veterans. Their input as to what improvements need to be made is invaluable. Some of the current recommendations include:

- Coordination with local, Federal and state veterans services organizations in VA outreach activities.
- Periodic Town Hall meetings to discuss minority veteran issues/concerns.
- Expanding and improving Internet-based access to VA benefits/health care with particular attention given to cultural and linguistic diversity.
- Full-time Minority Outreach Coordinators.
- More staff diversity in VA facilities.
- Research that focuses on minority veterans issues to help understand potential barriers to access and find ways to eliminate the barriers.
- More funding for minority veterans programs.

We applaud the efforts VA has made to reach out to identify and care for the current generation of returning veterans but much remains to be done to improve care and services provided all veterans, in particular women and minority veterans. VA must continue to work to provide an appropriate environment so that all veterans can access the health care, benefits and services they have so deservedly earned.

Mr. Chairman and Members of the Subcommittees, this concludes the VFW testimony. We again thank you for including us in this important discussion.

Statement of Marsha Four, Chair, Women Veterans' Committee, and John Rowan, National President, Vietnam Veterans of America

Good morning Chairman Michaud, Chairman Hall, and Ranking Member Miller, Ranking Member Lamborn and distinguish Members of these Subcommittees. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to offer our comments for the record on the issues facing Women Veterans.

WOMEN'S HEALTH ISSUES

According to figures supplied by the Department of Defense (DoD), 20% of new recruits are women, almost 15 percent of America's active duty military is women, and nearly half of them have been deployed to Iraq and Afghanistan (i.e., 1 in 7 Americans deployed to Iraq is a woman). This has particularly serious implications for the VA health care system because the VA itself projects that by 2010, over 14 percent of all veterans will be women, compared with 2 percent in 1997. The VA has made vast improvements in treating women veterans since 1992. However, this increase in potential health care system "users" coupled with returning female OIF and OEF veterans, who, in particular, face a variety of co-occurring ailments and traumas heretofore unseen in the VA health care system, we believe that the VA is in need of ramping up its efforts to bring into modern times, the delivery of its medical and mental health care to women veterans. Even today, some women continue to report a less than "accepting", "friendly", or "knowledgeable" attitude or environment both within the VA and/or by its third party vendors. This may, in part, be the result of a system that has evolved principally on the medical needs of the male veteran. Reports also indicate that in mixed gender residential programs women remain fearful and unsafe.

Compounding the emotional turmoil for women are wounds and injuries that range from life-changing—the loss of limbs and brain injuries—to temporary, such as infections and rashes. Although some of the short-term health problems are likely tied to the harsh realities of war, where women can go weeks without a shower and spend months hauling gear and lifting heavy weapons in triple-digit heat, the VA has found 29 percent of the women veterans it evaluated returned with genital or urinary system problems, 33 percent had digestive illnesses and 42 percent had back troubles, arthritis and other muscular ailments.

This obviously points up the need for a well-conceived and well-implemented long-range plan for health care services and delivery for our women veterans. To VVA's knowledge there is no such plan that exists today. As we have already noted, the VA has taken great strides in the past 15 years toward improvement of the quality of care for female veterans, but there is always room for improvement. While it is

fair to say that the quality of care at most VA facilities is equal to that of any other medical system in the world, it does not help women veterans who cannot access that fine care because it's not available.

DELIVERY OF SERVICES

Providing care and treatment to women veterans by professional staff that have a proven level of expertise is vital in delivering appropriate and competent gender-specific care. It is not sufficient to simply have training in internal medicine. Women's health care is a specialty recognized by medical schools throughout the country. Providers who have both a knowledge base and training in women's health are able to keep current on health care and its delivery as it relates to gender. In order to maintain proficiency in delivering care and performing procedures, these providers must meet experience standards and maintain an appropriate panel size. This cannot occur if women veterans are lost in the general primary care setting. It is critical that women receive care from a professional who is experienced in women's health. If attention is not given to defining qualified providers, it will be a detriment to the quality of care provided to women veterans.

VVA does, however, feel comprehensive women's health care clinics are most desirable where the medical center populations indicate because comprehensive consolidated delivery systems present increased advantage to the patients they serve.

Vietnam Veterans of America (VVA) believes women's health care is not evenly distributed or available throughout the VA system. Although women veterans are the fastest growing population within the VA, there seems to remain a need for increased focus on women health and its delivery. It seems clear that although VACO may interpret women's health as preventative, primary and gender specific care, this comprehensive concept remains ambiguous and splintered in its delivery throughout all the VA medical centers. Many view women's health as only a GYN clinic. As you are aware, throughout medical schools across the country and in the current health care environment, women's health is viewed as a specialty onto itself and involves more that gender specific GYN care. VVA is hopeful that the revision of VHA Services for Women Veterans, Handbook 1330.1, and its recommendations for an integrated primary care/mental health model of service delivery will pass concurrence. Additionally, that after concurrence it will be strongly supported and recommended to all medical centers in the VHA system.

VVA supported VHA's past creation of "Centers of Excellence" for women veterans' health. We believe these should be evaluated for standard compliance and reestablished. These Centers of Excellence are an investment in innovative health care delivery specifically addressing the unique needs of women, serving as a model in prevention, education, outreach, and research programs. This emphasis could lead to the creation of VA training fellowships in women's health care. These centers could also assist in the recruitment and retention of women health care specialists.

There are increasing numbers of women veterans of childbearing age. More than 62 percent of all women veterans are under 45, and of women veterans seeking health care from the VA, 56 percent are under 45. Providing for the cost of maternity services but not providing newborn care for a reasonable post-delivery period presents an unfair financial burden to the woman veteran. It could additionally compromise adequate health care for her newborn. VVA seeks legislation to provide contract care, for up to 14 days post-delivery, for infants born to women veterans who receive delivery benefits through the VA and are in need of this extended care.

WOMEN VETERAN PROGRAM MANAGERS

The duties, responsibilities, advocacy, oversight and reporting of the VA Women Veteran Program Managers, as defined in their handbook (1330.2), are substantial. As such, it is not difficult to understand why VVA stands with a firm resolve to call for the VA to provide the Women Veteran Program Managers with a minimum of 20 hours per week to accomplish the responsibilities of the position. VVA believes that these significant duties and responsibilities are essential and should not be minimized in light of the collateral duties they usually must perform. 'Further, we believe that while each VISN must designate, support, and utilize one of its Medical Center Woman Veteran Program Managers as the VISN Women Veteran Program Manager, we believe additional time must be allocated for these increased duties and responsibilities.

PTSD AND SUBSTANCE ABUSE

The VA counts PTSD as the most prevalent mental health malady (and one of the top illnesses overall) to emerge from the wars in Iraq and Afghanistan, but the VA is facing a wave of returning veterans who are struggling with memories of a war where it's hard to distinguish innocent civilians from enemy fighters and where

the threat of suicide attacks and roadside bombs hovers over the most routine mission. Moreover, the return of so many veterans from Afghanistan and Iraq is squeezing the VA's ability to treat yesterday's soldiers from Vietnam, Korea, the Cold war, and World War II. Top VA officials have said that the agency is well-equipped to handle any onslaught of mental health issues and that it plans to continue beefing up mental health care and access under the administration's budget proposal released in mid-February.

Yet according to a GAO report issued in November 2006, the VA did not spend all of the extra $300 million budgeted to increase mental health services and failed to keep track of how some of the money was used. The VA launched a plan in 2004 to improve its mental health services for veterans with PTSD and substance-abuse problems. To fill gaps in services, the department added $100 million for mental health initiatives in 2005 and another $200 million in 2006. That money was to be distributed to its regional networks of hospitals, medical centers, and clinics for new services. But the VA fell short of the spending by $12 million in 2005 and about $42 million in fiscal 2006, said the GAO report. It distributed $35 million in 2005 to its 21 health care networks but didn't inform the networks the money was supposed to be used for mental health initiatives. VA medical centers returned $46 million to headquarters because they couldn't spend the money in FY'06.

More troubling, however, is the fact that the VA cannot determine to what extent about $112 million was spent on mental health services improvements, or new services in 2006. In September 2006, the VA said that it had increased funding for mental health services, hired 100 more counselors for the Vet Center program, and was not overwhelmed by the rising demand. That money is only a portion of what VA spends on mental health. The VA planned to spend about $2 billion on mental health services in FY'06. But the additional spending from existing funds on what the VA dubbed its Mental Health Care Strategic Plan was trumpeted by VA officials as a way to eliminate gaps in mental health services now and services that would be needed in the future.

Furthermore, an investigation by McClatchy Newspapers in early February of this year found that even by its own measures, the VA isn't prepared to give returning veterans the care that could best help them overcome destructive, and sometimes fatal, mental health ailments. For example, the McClatchy report found that VA mental health care is extremely inconsistent and highly variable from state to state and from facility to facility. In some places, there is no mental health care, while at others, veterans may get individual psychotherapy sessions, or in others, they meet mostly for group therapy.

Some veterans are cared for by psychiatrists; others see social workers. Some veterans get in quickly. Others wait. Once they're in the door, some veterans get visits of 75 to 80 minutes, while others get 20 to 30-minute appointments. In other words, the VA's mental health system is nonexistent for many of the veterans it is supposed to be serving.

Last, the nature of the combat in Iraq and Afghanistan is putting service members at an increased risk for PTSD. In Iraq, close-quarters urban combat is unpredictable, with a constant risk of roadside bombs. Troops end up feeling out of control of their surroundings, a major risk factor for PTSD. Service members are serving multiple tours, and the intensity of the conflict is constant.

In these wars without fronts, "combat support troops" are just as likely to be affected by the same traumas as infantry personnel. This has particularly important implications for our female soldiers, who now constitute about 16 percent of our active-duty fighting force. Returning female OIF and OEF troops face ailments and traumas of other sorts. For example, studies conducted at the Durham, North Carolina Comprehensive Women's Health Center by VA researchers have demonstrated higher rates of suicidal tendencies among women veterans suffering depression with co-morbid PTSD. And according to a Pentagon study released in March 2006, more female soldiers report mental health concerns than their male comrades: 24 percent compared with 19 percent. In addition, roughly 40 percent of these women warriors have musculoskeletal problems that doctors say likely are linked to carrying too-heavy and ill-fitted equipment. A considerable number—28 percent—return with genital and urinary system infections. In addition, there are gender-related societal issues that make transitioning tough.

For example, women are more likely to worry about body image issues, especially if they have visible scars or amputations, and their traditional roles as care givers in civilian life can set them back when they return. They are the ones who have traditionally had the more nurturing role within our society, not the ones who need nurturing. Although the VA has, after much prodding by Congress, finally come to implement services to women to treat PTSD and other after-effects of military sexual trauma at VA medical centers, there are very few clinicians within the VA who

are prepared to treat combat situation-induced PTSD as opposed to MST-induced PTSD. Additionally, there are already cases where returning women service personnel have a combination of the 2 etiologies, making it extremely difficult for the average clinician to treat, no matter how skilled in treating either combat-incurred PTSD in men, or MST-induced PTSD in women. Because of the number of women who are now de facto combat veterans and because of the nature of the conflicts in both Afghanistan and particularly Iraq, VVA believes that we have entered a whole new world of mental health needs for our veterans.

Furthermore, VVA believes there is a need for increased VA research specifically focused on women veterans' health care issues. For example, as of August 2006 VA data showed that 25,960 of the 69,861 women separated from the military during fiscal years 2002–06 sought VA services. Of this number approximately 35.8 percent requested assistance for "mental disorders" (i.e., based on VA ICD–9 categories) of which 21 percent was for post traumatic stress disorder or PTSD, with older female vets showing higher PTSD rates. Also, as of early May 2007, 14.5 percent of female OEF/OIF veterans reported having endured military sexual trauma (MST). Although all VA medical centers are to have MST clinicians, very few clinicians within the VA are prepared to treat co-occurring combat-induced PTSD and MST. These issues singly are ones that need address, but concomitantly create a unique set of circumstances that demonstrates another of the challenges facing the VA. The VA will need to directly identify its ability and capacity to address these issues along with providing oversight and accountability to the delivery of services in this regard. VVA believes that the VA has twelve programs that address PTSD in women veteran, but they are not exclusively for MST (some are general PTSD programs), and not all are gender specific programs.

As previously mentioned, studies conducted at the Durham, North Carolina Comprehensive Women's Health Center by VA researchers have demonstrated higher rates of suicidality among women veterans suffering depression, substance abuse and co-occurring PTSD. But at the present time there are only 3 VA women's residential treatment centers for PTSD and substance abuse in the country (i.e., a fourth with 8 beds is scheduled to open later this summer in the Boston area).

VVA calls upon this Committee to appoint a task force within the VA to begin work to produce a reasonable and practical plan of how VA can best reach this ever increasing veteran cohort in the coming years, providing them a delivery model of inclusive comprehensive and integrated care.

Few of us can know the dark places in which those who have suffered as the result of rape and physical violence must live every day for the rest of their lives. It is a very long road to find the path that leads them to some semblance of "normalcy" in order to feel the free, outside of the secluded, lonely, fearful, angry corner into which they have been hiding. A concern for the environment of the delivery of services also exists in the residential programs of the VA. Most, if not all residential programs, are designed for treatment of mental health problems. The veterans of these programs are a very vulnerable population. This was particularly brought to our attention in regard to women veterans, who, in light of the high incidence of past sexual trauma, rape, MST, and domestic violence find it difficult, if not impossible, to share residential programs with male veterans. They openly discuss their concern for a safe treatment setting, especially on units where the treatment unit layout does not provide them with a physically segregated, secured area. They also discuss the need for gender specific group sessions, in light of the nature of some of their personal and trauma issues. VVA asks that all residential treatment areas be evaluated for the ability to provide and facilitate this environment and that medical center facilities develop cost plans to address this accommodation.

This submission points to the need for a well-conceived and well-implemented long-range plan for medical and mental health care services and delivery for our women veterans. VVA has not been made aware that any such inclusive comprehensive plan exists today. As we have already noted, the VA has taken great strides in the past 15 years toward improvement of the quality of care for female veterans, but there exists a need for increased attention, followed by enhancement of programs and services, in a concerted effort to meet the increasing demand and complexity of women's health. This enhancement will certainly put a demand on the ever-present budget. VVA respectfully requests that women's health care be evaluated for budgetary consequences and that Congress considers this when determining the dollars required to meet these needs. VVA also respectfully requests that continued oversight be requested of the VA in regard to the issues of this submission and those of others during this hearing. While it is fair to say that the quality of care at most VA facilities is equal to that of any other medical system in the world, it does not help women veterans who cannot access that fine care because it's not available.

Vietnam Veterans of America thanks the Committee for this opportunity to provide submitted testimony.

Statement of Susan Scanlan,
President, Women's Research and Education Institute

Military Women and Women Veterans and Stress Urinary Incontinence

On behalf of the Women's Research and Education Institute (WREI), I appreciate the opportunity to submit this written testimony to the Committee. I am Susan Scanlan, President of the Women's Research & Education Institute. For thirty years, WREI has provided timely information and expert issue analysis about women and their families to policymakers and the public.

For nearly that long, WREI has been one of the few, if not the only progressive organization with a nonpartisan focus on the rights and responsibilities of women in uniform. The Women in the Military project was established in 1983, and is now headed by Captain Lory Manning, a veteran of 26 years of service in the U.S. Navy. This project provides research and analysis of issues of importance to military women and female veterans to legislators, the media, scholars, and the general public. WREI publishes *Women in the Military: Where they Stand*, now in its 5th edition, and we also hold a Women in the Military Conference every other spring.

Women veterans are the second fastest growing segment of the veteran population. By 2040, it is estimated that women will exceed 11% of the veteran population. Women veterans today are younger, more ethnically diverse, and have fewer socioeconomic resources than previous generations of military women. In addition, the changing nature of war and its porous battlefields means servicewomen—and men—are faced with new health risks.

I want to bring to the Committee's attention a health condition that affects up to 30% of military women—namely, stress urinary incontinence (SUI). At our May 2007 Women in the Military Conference, Lieutenant Colonel Irene Rosen, M.D., Assistant Chief of Family Medicine at Madigan Army Medical Center in Fort Lewis, Washington, reported that genitourinary problems are the fifth most common disease and non-battle injury (DNBI), and accounted for 5% of hospital admissions during Desert Shield/Storm. The VA Health Services Workgroup also identified urinary incontinence among women veterans as a high-priority issue for research.

Stress urinary incontinence is the involuntary leakage of urine associated with laughing, coughing, sneezing, sexual, and recreational activities. The condition is caused by a variety of factors, most commonly childbirth, and often restricts the social, professional, and personal lives of an estimated 15 million women in the U.S. alone. Physical fitness requirements and the demands of military life put both men and women, but particularly women, at risk for SUI during and after their military service. Environmental barriers in the field often limit access to hygienic measures and can lead to urinary tract infections that can lead to incontinence.

According to Dr. Rosen's research, 30% of female soldiers reported urinary incontinence in the field. Similarly, Dr. Roger Dmochowski, a professor of urology and researcher at Vanderbilt University, cited studies that found that 30% of female parachutists reported experiencing urinary incontinence when they hit the ground. An April 2001 article entitled "Urinary Incontinence in Vulnerable Populations: Female Soldiers" published in *Urologic Nursing* (attached) reported the following additional statistics:

- Nearly one-third of 450 female soldiers in field-oriented environments at Fort Lewis had significant problems with exercise-induced urinary incontinence.
- At Fort Benning, 100% of active duty women airborne trainees (n=10) who had no incontinence before airborne training demonstrated SUI after training.
- In a study involving 563 female soldiers from several units at Fort Lewis, Fort Benning, and Fitzsimons Army Medical Center, 33% reported UT during physical training.
- 24% reported urine loss during recreational activities such as exercise and walking and 30% reported urine loss during the annual 2-mile physical fitness run.
- Field exercises, which involve long road marches with heavy field backpacks, precipitated urinary incontinence.
- Alarmingly, 30% of active duty military women with SUI reported restricting fluid intake in order to control symptoms.
- Women veterans of the Persian Gulf War have a higher proportion of genitourinary problems than other populations.

Given that approximately 20% of the total U.S. military active duty force in the future will be women, it is important for the military—both the Department of Defense and the Veterans Health Administration—to address this growing problem.

As Dr. Rosen's research found, lack of awareness or embarrassment or reluctance concerning SUI may preclude optimal prevention and treatment of this common problem. This research reinforces the results of a June 2007 Lewin Group report, *Prevalence and Treatment Patterns of Pelvic Health Disorders Among U.S. Women*, which found that approximately 50 to 75 percent of women who likely have SUI fail to tell their health care providers about their symptoms and, therefore, are never properly diagnosed and treated.

Non-treatment of SUI can put women at increased risk for numerous physical, social, and psychological conditions. Avoidance of exercise and an active life, depression, loss of self-esteem, loss of a sense of control over one's life, social withdrawal, and sexual dysfunction related to embarrassment, are just a few of the potential physical, psychological, and social impacts associated with non-treatment of SUI. Withdrawal from physical and social activities can lead to a reduction in physical well-being, which may in turn lead to obesity, diabetes, heart disease, and other medical complications.

In order to properly diagnose and treat SUI, Dr. Rosen recommends educating and screening military women and veterans for the condition, and providing appropriate treatment. Walter Reed Army Medical Center's Internet fact sheet on stress incontinence (which was last updated in September 2004) recommends the following treatments:

- Practicing good hygiene.
- Learning and practicing Kegel pelvic floor muscle exercises.
- Weight loss, smoking cessation, and cough suppression.
- Biofeedback, electrical stimulation, or special weights to strengthen pelvic muscles.
- Wearing absorbent underpants or incontinence pads.
- A pessary (support device) made of rubber or other materials to fit inside the vagina for support.
- Surgery.

With regard to medications, alpha-adrenergic drugs or estrogen therapy may be prescribed.

Walter Reed's list of treatments fails to include Renessa, an FDA-cleared non-surgical treatment for SUI that would be particularly beneficial in the military and VA health care settings. This procedure is a non-surgical approach that can be performed in the convenience of a physician's office or other outpatient setting. It takes less than 30 minutes and involves the use of radiofrequency energy to treat tissue targets within the lower urinary tract. Most importantly, the procedure allows women to return to their duties quickly. Most patients return to normal activities within 24 hours, and heavy lifting within days, not weeks.

It is my understanding that this procedure has already been performed at several military facilities, including Dr. Rosen's institution—Madigan Army Medical Center, Evans U.S. Army Community Hospital (Fort Carson, CO), and Travis Air Force Base in California. A non-surgical option for the treatment of SUI would also be an attractive option for female dependents of military men.

As Members of Congress know, FDA approval does not automatically lead to the adoption of new medical technologies. The Veterans Health Administration and the Department of Defense should do more to ensure that women veterans and active duty women are educated about stress urinary incontinence, screened, and provided with access to the full range of FDA-approved treatments—including non-surgical procedures—to address this debilitating condition.

Thank you for the opportunity to submit this testimony and bring this important women's health issue to the attention of the Veterans' Affairs Committee.

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC
July 26, 2007

Honorable R. James Nicholson
Secretary
Department of Veterans Affairs
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Subcommittee hearing on Issues Facing Women and Minority Veterans on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Orfa Torres and fax your responses to Orfa at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

JOHN J. HALL
Chairman

Questions for the Record

The Honorable John J. Hall Chairman
Subcommittee on Disability Assistance and Memorial Affairs,
House Committee on Veterans' Affairs

July 12, 2007

Issues Facing Women and Minority Veterans

Questions for Center for Minority Veterans

Question 1: Please explain in detail what the VA is doing to address the findings in the report entitled *Racial and Ethnic Disparities in the VA Health System,* dated June 2007, which found that health disparities exist throughout all of the VA and that these disparities in treatment yielded poorer health outcomes for minority veterans.

Response: The Department of Veterans Affairs' (VA) Office of Research and Development (ORD) within the Veterans Health Administration (VHA) is continuing to support a broad portfolio of research into health care disparities. While earlier ORD-funded research focused on identifying disparities, more recently funded studies have highlighted important determinants explaining ethnic minority health care disparities, such as patient-physician communication, patient attitudes and health literacy; suggesting that patients, providers, health care facilities and health care systems may all contribute to these disparities. Accordingly, ORD has issued a priority solicitation for research proposals to develop and evaluate interventions to reduce racial and ethnic disparities in health care. ORD understands that interventional studies aimed at these sources, as well as other identified sources, may playa significant role in promoting equitable health care services among all veterans.

ORD strives to obtain adequate representation of minorities in its funded clinical trials. ORD requires potential investigators to acknowledge its policy to include women and minorities in clinical research.

Questions for Center for Women Veterans

Question 1: The Committee is aware that the Director of the Center reports to the Secretary.

Question 1(a): Does the Center provide any type of annual updates to the Secretary?

Response: The Center for Women Veterans (CWV) provides quarterly reports on its outreach activities, performance measures and financial obligations to the Secretary. The CWV director presents updates on key issues related to women veterans at the Secretary's senior staff meetings; and provides a monthly update on its key activities to the Deputy Secretary.

Question 1(b): Please describe the Center's annual performance goals?

Response: CWV's annual performance goals are linked to VA's Strategic Goal 2 and its Enabling Goal.

Strategic Goal 2 is to ensure a smooth transition for veterans from active military service to civilian life. In order to achieve this goal VA's operational objective is to increase awareness of, access to, and use of VA health care, benefits and services. CWV's goal (in support of VA's goal) is to attend transition assistance program (TAP) briefings and assess the quality of the briefing materials and its focus on women veteran-specific issues.

VA's *Enabling Goal* is to apply sound business principles, and one of the objectives to meet this goal is to improve communications with veterans, employees and stakeholders about VA's mission, goals and current performance as well as benefits and services that VA provides. CWV's goal linked to this is to facilitate, sponsor, or attend collaborative meetings with agencies representatives and stakeholders; and community-based forums for women veterans. CWV also has as its goals to provide prompt responses to inquiries and resolve complaints timely.

Question 1(c): How does the Secretary measure the Center's effectiveness in meeting its performance goals?

Response: The Secretary measures CWV's effectiveness in meeting its performance goals by reviewing its quarterly and annual reports.

Question 2: The Center provides administrative support to the Advisory Committee and the Advisory Committee through its site visits prepares reports which are transmitted to the Secretary and then to Congress.

Question 2(a): Please explain what if any interface occurs between the Center and the Advisory Committee.

Response: There is extensive interface that occurs between CWV and the Advisory Committee on Women Veterans (ACWV). CWV collects data, provides written materials on key issues, and obtains subject matter experts to address ACWV at its bi-annual meetings and annual site visits to a medical center. CWV and ACWV collaborate on developing legislative proposals affecting women veterans; and annual Congressional meetings. CWV hosts ACWV meetings, arranges lodging, transportation and conference room space. CWV introduces new ACWV members to VA, and arranges ethics briefings.

Question 2(b): For the recommendations made by the Advisory Committee, and for which the VA concurs, who is responsible for ensuring implementation of the recommendations?

Response: VHA, Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA), along with various staff offices are responsible for implementing the recommendations of ACWV. CWV tracks the status of recommendations to ensure implementation; and requests briefings on unresolved recommendations at ACWV bi-annual meetings.

Question 2(c): How are these missives sent down throughout all of the VA?

Response: CWV assigns each recommendation to the appropriate administration or staff office, and then monitors and follows up as needed.

Questions for VA

MINORITY VETERANS

Question 1: It seems as if both Directors of the Centers and the Advisory Committees report directly to the Secretary.

Question 1 (a): Please explain the working relationship, if any, between the Centers and the Advisory Committees and the VA (Secretary's office) and the Advisory Committees?

Response: Both the Center for Minority Veterans (CMV) and CWV fall under the Office of the Secretary. The directors of CMV and CWV serve as the primary advisors to the Secretary and Deputy Secretary on all issues related to minority and women veterans and serve as the designated Federal officials to the Advisory Committee on Minority Veterans (ACMV) and ACWV. CMV and CWV facilitate ACMV's and ACWV's outreach to minority and women veterans by ensuring they are kept abreast of VA's policies, programs, and services that may impact minority and women veterans, and coordinating the logistics and travel for all site visits and busi-

ness meetings. In addition, CMV and CWV track VA's action taken on ACMV and ACWV recommendations.

Question 1(b): Whose role is to ensure that there are no disparities in the receipt of benefits and services for these veterans?

Response: CMV, CWV, ACMV, and ACWV identify needs of minority and women veterans and make recommendations to address unmet needs. The administrations and staff offices are responsible for ensuring that the areas highlighted as in need of improvement are addressed in a timely manner. It is every VA employee's responsibility to ensure all veterans are treated equally without regard to sex, race, or ethnicity.

The Secretary directed the appointment of the minority veterans' program coordinators (MVPC) to be located at each VA health care facility, regional office and national cemetery, thus ensuring that issues regarding benefits and services for minority and women veterans are addressed at the local level. CMV provides oversight, and training to the MVPCs in cultural competency and outreach strategies. MVPCs educate facility personnel to the needs of minority veterans in the community. MVPCs promote the use of VA benefits, programs and services by minority veterans. In addition, each administration has a designated MVPC liaison at VA central office. CMV staff meets monthly with these liaisons and quarterly with the senior leadership of each administration to discuss outreach activities, issues and concerns that impact minority veterans.

VHA medical facilities have specially designated outreach coordinators who conduct outreach to various populations (i.e., minority veterans, women veterans, homeless veterans, former prisoners of war, recently separated veterans) to provide these individuals information about VA health care issues. VHA central office provides guidance and support to these coordinators.

VHA has implemented various programs within the networks to ensure that the issues and needs of minority veterans are adequately addressed. Some examples of this in action are:

- Veteran Integrated Service Network (VISN) 15's *Diversity Implementation Plan* a 3 pronged approach to implementing diversity within the Heartland Network.
- Fargo VA Medical Center's (VAMC) *Comprehensive Diversity Management Program* dedicated to promoting diversity awareness through training with special emphasis on outreach programs, and clinical guidelines to promote the concept of culturally competent care and quality improvement in various community partnerships. In collaboration with the Dakotas VA Regional Office, veterans service organizations, and the Social Security Administration, the Fargo VAMC sustained outreach efforts on 7 of the 8 Native American Nations and cosponsored with Indian Health Services (IHS) the first Annual/Tribal Open House.
- Southern Arizona VA Healthcare System (VAHCS) is recognized for its sustaining leadership, governance, and incorporation of diversity management into strategic business plans. The Southern Arizona VAHCS sponsored the first Annual Diversity Day that incorporated educational information on special emphasis groups and MVPCs.

In addition, VHA's Office of Research and Development (ORD) continues to support a broad portfolio in health disparities research. While earlier ORD-funded research focused on identifying disparities, more recently funded studies have highlighted important determinants explaining ethnic minority health care disparities, such as patient-physician communication, patient attitudes and health literacy, suggesting that patients, providers, health care facilities and health care systems may all contribute to these disparities. Accordingly, ORD has issued a priority solicitation for research proposals to develop and evaluate interventions to reduce ethnic minority health care disparities. ORD understands that interventional studies aimed at these sources, as well as other identified sources, may play a significant role in promoting equitable health care services among all veterans.

VBA regional offices have also specially designated outreach coordinators who conduct outreach to various populations (i.e., minority veterans, women veterans, homeless veterans, former prisoners of war, recently separated veterans) to provide these individuals information about VA benefits and services. VBA central office provides guidance and support to these coordinators to ensure that they provide all needed services and benefits. VBA coordinators work closely with their counterparts in VHA, NCA, veterans service organizations, and other Federal and State agencies to provide complete assistance to all veterans.

In addition to its outreach coordinators, VBA uses the systematic technical accuracy review (STAR) to assess accuracy of claims processing decisions made at all regional offices. VBA also regularly conducts site visits to regional offices to ensure that policies and procedures pertaining to compensation and pension are consistent

nationwide. During these site visits outreach practices are reviewed to ensure activities are reaching targeted groups.

NCA conducts local and national initiatives in an effort to identify minority veterans. The outreach practices to these veterans include all national cemetery directors having the responsibility to identify groups of veterans within the service area of their cemetery and providing information about VA memorial benefits to these individuals. NCA regularly attends 10 to 12 national conferences each year to increase awareness of memorial benefits among minority groups.

NCA memorializes every deceased veteran who has served honorably in the Armed Forces, regardless of their race, sex, religion, or national origin. Every day the 1,500 employees of NCA commemorate the service of America's veterans at 125 national cemeteries, where more than 2.7 million gravesites are maintained. NCA provides headstones and markers for placement on the graves of eligible veterans, provides Presidential Memorial Certificates to veterans' loved ones, and assists States and tribal governments in the construction of veterans' cemeteries.

Question 2: In the Minority Advisory Committee's last Report dated July 2006, it recommended that the VA clarify and disseminate its policies pertaining to the issue of marketing, as it had observed during its field visits to VA facilities that the confusion served as a "serious impediment" to minority veterans' knowledge of their VA benefits and VA health care entitlements. What has the VA done to educate staff at VA facilities of the rescission of this 2002 rule regarding marketing? Please explain.

Response: VA supports an extensive array of outreach efforts to inform and educate veterans about their eligibility for health care, benefits, and other services. In fact, VA strongly encourages its leadership and staff to participate in community activities as a forum for outreach. Every separating service member receives a letter from the Secretary to advise them on how they might receive VA benefits (including health care). Additionally, VA is working closely with the Department of Defense (DoD) to ensure that returning Global War on Terror (GWOT) veterans are aware of the services VA offers. One example is the post deployment health reassessment activity (PDHRA) which provides outreach, education, screening for deployment-related health conditions and readjustment issues, outreach and referrals to military treatment facilities (MTFs), VA health care facilities, TRICARE providers and others for additional evaluation and/or treatment.

Question 3: The IOM in its report Separate and Unequal regarding Healthcare and Health Disparities found that Minorities receive disparate health care treatment regardless of income or insurance status and that as a direct result, they suffer higher mortality and morbidity rates. Has the VA performed any research to determine whether there are parallels in the VA health care and benefits system? Are you aware of any parallels that translate in poorer health and benefits outcomes for minority veterans?

Response: Because of its structure, VA's health care system provides unique opportunities for researchers to distinguish racial and ethnic differences from economic differences in health care. Minorities are well represented in ORD's cooperative studies program clinical trials and currently comprise 20 percent of participants in trials that have ongoing recruitment.

ORD funds a research center of excellence for health equity research and promotion. Its mission is to reduce disparities and promote equity in health and health care among vulnerable groups of veterans and other populations. The center's research agenda is based on the natural progression of research projects from detecting unrecognized disparities, to identifying and understanding reasons for these disparities, to designing interventions to promote equity in health care among vulnerable populations.

ORD also funds a targeted research enhancement program to understand racial and ethnic variations in health outcomes for chronic diseases. The goals of this program are to advance knowledge on racial and ethnic variations in care by focusing on patient trust and patient preferences for care, and to evaluate the incremental effect of these patient level factors on racial and ethnic disparities in health outcomes for chronic medical conditions such as diabetes and hypertension.

Examples of recently completed ORD-sponsored health disparities research include:

- While demographics and health experiences vary by race among women veterans, race was not significantly associated with any primary care domain (i.e., patient preference for provider, interpersonal communication, accumulated knowledge and coordination) or satisfaction among women receiving care at VA (*Journal of General Internal Medicine,* Vol. 21, October 2006, 1105)

- There are no significant racial differences in general innovativeness between Black and White veterans, but White veterans had higher medical technology innovativeness scores
  - Medical technology innovativeness scores correlated with a greater likelihood that veterans would be favorably oriented to new medical devices and prescription drugs
  - Both Black and White veterans with low innovativeness scores were hesitant to accept a new medical device, but White veterans were more likely to adopt a new prescription than Black veterans
  - More Black than White veterans expressed discomfort with taking risks (*Journal of General Internal Medicine,* June 2006)
- Black veterans had less severe coronary artery disease than White veterans, and treating physicians' estimates of the probability of coronary disease were similar for Black and White veterans
  - Findings suggest that despite less frequent use of coronary angiography, Black veterans who undergo the procedure are at lower risk for having coronary obstructive disease than White veterans who undergo the procedure (*Journal of the American College of Cardiology,* May 2006)
- Black patients appear to have lower trust in physicians regarding lung cancer treatment because of poorer physician-patient communication
  - Physician communication was perceived as less supportive, less partnering and less informative, accounting for Black patients' lower trust in physicians (*Journal of Clinical Oncology,* Vol. 24, 2006 Feb 20. 904)
- End of life wishes vary among racial and ethnic groups, as a result of divergent views regarding health care, spirituality, family and dying (*Journal of the American Geriatrics Society,* Vol. 54, No.1, January 2006)
- There are ethnic variations in the use of nicotine replacement therapy (NRT) among smokers receiving care from VA, with Black and Hispanic smokers about half as likely as White smokers to use NRT to quit smoking
  - These disparities were not explained by social, physiologic or psychological factors or by facility differences in prescribing policy of tobacco dependence medications (*American Journal of Health Promotion,* Nov/Dec 2005, 20 (12):108)
- Black and White patients in VA displayed similar knowledge about coronary heart disease (CHD) risk factors. However, Black patients had
  - Less specific knowledge, such as the difference between "good" and "bad" cholesterol
  - More fear related to physical activity after a CHD diagnosis
  - Belief that racism contributed to stress as a risk factor (*Patient Educ. Couns.* 2005 May;57(2):225–31)
- Hispanic and Black VA patients had a higher frequency of severe diabetic retinopathy
  - This was not accounted for by traditional risk factors (*Diabetes Care 28:* 19541958, 2005)
- In the year following prostate specific antigen (PSA) testing, Black patients strictly under VA care were more likely to
  - Know about their PSA test
  - Have higher rates of urology referrals and prostate biopsies
  - However, for Black patients under partial VA care, these differences did not occur (*Am J Public Health.* 2004 Dec;94(12):2076–8)
- Black veterans in VA had poorer outpatient access to mental health services than White veterans during 1995–2001
  - On some measures their access to care improved relative to White veterans (*Adm. Policy Mental Health.* 2003 Sep;31(1):31–43)
- In VA stroke patients referred to inpatient rehabilitation
  - No racial differences in proportion of patients referred or in the intensity of rehabilitation
  - However, there was less recovery of function in Black patients (Stroke. 2003 Apr;34(4): 1027–31)

- No significant systematic differences in post traumatic stress disorder (PTSD) treatment or outcome between White, Black and Hispanic VA patients overall (*Med Care.* 2002 Jan;40(1 Suppl):I52–61)
- In a VA administrative database (28,934 White and 7,575 Black), Black patients had lower mortality rates than White patients at 30 days and 6 months in
  - Pneumonia
  - Angina pectoris
  - Congestive heart failure
  - Chronic obstructive pulmonary disease
  - Diabetes
  - Chronic renal failure (JAMA. 2001 Jan 17;285(3):297–303)

It is important to note that ORD-sponsored studies focus on health and health care related research and not on the services provided by VBA or NCA.

ORD did, however, recently fund a study examining racial disparities in PTSD disability awards. The study reported a significant difference in Black veterans odds of being service connected for PTSD compared to other veterans' odds, and this could not be explained by variation in PTSD symptom severity, degree of disablement or race differences in combat exposure. Among veterans who were awarded PTSD disability benefits, the service-connected rating ("degree of service connection") did not vary by race (Medical Care. 2003;41(4):536–549).

Past ACMV reports findings/recommendations have addressed minority veterans' perceptions of disparities in the VA claims process. VBA presently does not collect racial or ethnics data that can be used to make a comparative analysis. VBA has responded that it will give consideration to collecting this data as it modifies its business practices.

Question 4: The Advisory Committee also recommended that the DVA design, develop and fund research agendas focusing on minority veteran issues in order to inform minority veterans and those entities serving the minority community of potential barriers to access. Please update the Committee on efforts to promote this recommendation and eliminate this barrier.

Response: ORD strives to disseminate its research results to all applicable parties. While this is accomplished primarily through publication of research results in scientific journals and presentations at scientific meetings, ORD also publishes a variety of publications highlighting recent research advances, such as its monthly *Research Currents* newsletter. A diverse audience, including VA staff, Congressional staff and veterans service organizations (VSO) receives *Research Currents* newsletter. ORD also supports speakers and information booths about its research programs and projects at numerous VSO meetings and conventions, including organizations such as the Montford Point Marine Association that was established to perpetuate the legacy of the first African Americans who entered the United States Marine Corps from 1942 to 1949, at Montford Point Camp, New River, NC. Finally, ORD maintains a Web site containing information on research programs and recent findings (http://www.research.va.gov). and so do many of its centers of excellence (http://www.cherp.research.med.va.gov).

In addition, ORD has been working with CMV to develop other mechanisms for disseminating research results to veterans. Currently, CMV's Web site has a link to the ORD Web site for research related to minority veterans.

Question 5: Has the VA performed research to identify barriers that prevent minority veterans from accessing and using their benefits? Has the VA identified any culturally appropriate practices that would support greater participation in VA benefits and services by minority veterans as advocated by the Committee? (p.21).

Response: ORD has funded extensive research examining barriers to health care for minority veterans and, in recent years, considerable attention has been focused on cultural factors that affect the use of VA health care services, and potentially the health care status and outcomes of veterans. Those areas where potential barriers, cultural factors and other contributors to racial disparities in VA health care have been identified in ORD-sponsored research are summarized below.

- **Veteran medical knowledge and information sources.** Minority and non-minority veterans differ in their degree of familiarity with and knowledge about medical interventions. This difference stems from different levels of experience with those interventions among minority vs. non-minority veterans and their families, friends, and communities; from different amounts of information conveyed by health care providers; and from different levels of health literacy and understanding among veterans. Different knowledge and information may affect patients' perceptions of, or degree of uncertainty about, the necessity and bene-

fits of medical interventions in relation to their risks. Uncertainty about the necessity of interventions may in turn reduce patients' willingness to accept and adhere to them. Several studies indicate that minority veterans are less informed about their care, compared to non-minority veterans, and that this difference affects decisionmaking.

- **Veteran trust and skepticism.** Minority veterans tend to harbor less trust and more skepticism about the benefits of medical interventions, relative to their risks. These perceptions appear to be influenced by lack of familiarity with medical interventions, by historical or personally experienced discrimination, and for some Black veterans in particular, by a reliance on religious and spiritual avenues for coping with illness as opposed to medical therapies. Studies in our review suggest that minority veterans are more skeptical of information provided by health care professionals, as compared to non-minority veterans. It is important, however, not to misconstrue this skepticism as unwarranted. Non-minority veterans' general lack of skepticism may be more problematic if it leads to acceptance of unnecessary or undesired care.
- **Racial/cultural milieu.** Some have suggested that a more racially and culturally congruent health care environment (including racially concordant health care providers) for minority veterans may elevate trust, reduce skepticism, and enhance the acceptability of care. Two studies directly examined this issue and found that Black veterans experienced better interactions and fared somewhat better clinically, when cared for by Black vs. White providers. Another study suggested that Black patients in group therapy might fare better when grouped with other Black patients.
- **Patient participation.** Several studies suggest that minority veterans are less active participants in their care as compared to non-minority veterans. Minority veterans tend to ask fewer questions of their providers, who in turn provide less information. Less information may lead to lower acceptance of and adherence to medical interventions. In addition, lower patient participation diminishes the strength of the patient-provider partnership, which may in turn lead to less investment by both parties in following recommended care plans, and to lower trust and greater skepticism among minority veterans.
- **Clinician judgment.** Studies suggest that clinicians' diagnostic and therapeutic decisionmaking varies by veteran race. The degree to which this differential decisionmaking is based on clinical factors vs. non-clinical factors, including racial stereotypes, is unclear. For instance, in one study clinicians judged Black veterans to be less appropriate candidates for coronary interventions, even after accounting for chart-documented variables. The degree to which this judgment reflected undocumented clinical factors vs. non-clinical influences was not clear. Similarly, clinicians prescribe opioid medications less frequently to Black vs. White veterans and are more likely to diagnose Black veterans presenting with mental illness as having psychotic vs. affective disorders. The degree to which these phenomena are driven by racial differences in co-existing substance abuse disorders, by cross-cultural misunderstanding of symptom presentations, or by racial bias, remains unclear.
- **Veteran social support and resources.** Minority veterans may have fewer social support and other external resources to help with both illness management and decisionmaking. This is particularly relevant in that minority veterans may rely more heavily on external resources than on health care professionals for information and support. This may particularly affect adherence and decisionmaking around high-risk procedures.
- **Health care facility characteristics.** Some disparities are at least partly explained by the fact that minority and non-minority veterans tend to receive care at different VA medical centers (VAMCs). In some cases, VAMCs that disproportionately serve minority veterans have fewer available services or deliver lower quality care overall than VAMCs serving predominantly non-minority veterans. This potential source of disparities, however, remains under-explored. It should be noted that many studies have demonstrated disparities within single VAMCs, suggesting that system-level factors are unlikely to explain all observed disparities.

CMV and ORD have collaborated to provide a link from the CMV Web site to the ORD Web site to provide veterans information related to VA research initiatives. Minority veterans program coordinators (MVPC) were provided cultural competency training during their biennial training conference in June of 2007.

At CMV's request, ORD has provided briefings to our MVPCs during the biennial MVPC training conferences and to minority groups such as: Tuskegee Airmen, Buf-

falo Soldiers, Montford Point Marines, and the National Association of Black Veterans.

Question 6: Please advise what the VA is doing with regard to its land use policies that allow greater flexibility to make business decisions that would result in more funds for ancillary programs such as those that address outreach to minority veterans and homeless veteran populations.

Response: VA has been using its enhanced use (EU) leasing program to turn underused land and buildings into transitional housing for homeless veterans. This has been successful in 12 instances providing housing to more than 550 homeless veterans; and will be used more in the future as properties are identified via the Capital Asset Realignment for Enhanced Services (CARES) reuse studies, VA's own internal site review initiative, and individual initiatives presented by homeless providers through a sponsoring VAMC.

In addition VA has numerous sharing agreements and sort term leases that are allowing more than 2 dozen nonprofit organizations to provide transitional housing to more than 1,300 homeless veterans. The more than half of all veterans seen in VA's homeless providers grant and per diem program are identified as minority. The largest single program for women veterans in the country is operated on the grounds of the VAMC at Coatesville, Pennsylvania.

Question 7: The Advisory Committee observed that staff diversity during its Los Angeles VA facilities was not representative of the Minority Veteran population, especially with regard to the higher pay grades and for African Americans, Hispanics, and Americans Indians. The ACMV noted that this appears to be a systemic problem throughout VA. Please advise what the VA is doing to ensure staff diversity in these subsets of veterans.

Response: The Los Angeles Regional Office (RO) has 221 employees serving approximately 737,000 veterans. Of the 221 employees, 40.7 percent are veterans. Within that number, minorities comprise the following: 15.4 percent Black, 8.6 percent Hispanic, 1.4 percent Native American, and 2.7 percent Asian American and Pacific Islander American. Of the veteran employees at the higher grade levels, GS–12 and above, 53 percent are minority veterans.

VA work force is comprised of 74 percent women and minorities; 24.43 percent of the work force is Black, 7 percent Hispanic, 1 percent Native American, and 6.24 percent Asian American. Veterans make up 33 percent of VA's work force. Of employees at a GS–13 and above, 38 percent are minorities.

VHA work force is comprised of 75 percent women and minorities; 24 percent of the work force is Black, 7 percent Hispanic, 1 percent Native American and 7 percent Asian American. Veterans make up 31 percent of VHA's work force. Of employees at a GS–13 and above, 30 percent are minorities.

VHA has consistently provided career development training opportunities designed to prepare all VA employees with knowledge and skills necessary to perform in higher grades. These programs include the technical career field program (TCF)-GS–5-9; the leadership, effectiveness, accountability, development program (LEAD)-GS–11–13; the executive career field candidate development program (ECFCDP)-GS–1314/nurse IV/physician tier 2), and Leadership VA (LVA)-G8–13 and higher. The percentages of minority participation for these programs in FY 2006 were: LEAD, 27.12 percent; TCF, 29.90 percent; ECFCDP, 20 percent; and LVA, 24.29 percent.

VBA's work force of over 13,000 employees is comprised of 69 percent women and minorities; 27 percent of the work force is Black, 6 percent Hispanic, 2 percent Native American, and 3 percent Asian American. Veterans make up 48 percent of VBA's work force. Of employees at a G8–13 and above, 51 percent are minorities.

The Under Secretary for Benefits aggressively supports hiring veterans as reflected in the high percentage of veterans in the workforce. Within the next 18 months, VBA plans to hire more than 2,000 employees. Recruitment of veterans and any underrepresented minority groups will be a focus of this hiring effort.

NCA's work force is comprised of 49 percent women and minorities; 20 percent of the work force is Black, 9 percent Hispanic, 1.55 percent Native American and 3.58 percent Asian American. Veterans make up 72 percent of NCA's work force. Of employees at a GS–13 and above, 64 percent are minorities.

NCA strives to increase the percentage of women and minorities in the ranks of leadership by providing career development training. In 2006, 40 percent of the participants in the training program for cemetery directors were women and 30 percent were Black. In this year's class, 33 percent are women, 22 percent are Black, and 11 percent are Hispanic.

Staff offices' work force is comprised of 59 percent women and minorities; 22 percent of the work force is Black, 6 percent Hispanic, 1 percent Native American, and

5 percent Asian American. Veterans make up 40 percent of staff offices' work force. Of employees at a G8–13 and above, 44 percent are minorities.

Question 8: The ACMV also recommended that the VA should hire OIF/OEF Minority veterans into the agency to ensure departmental sensitivity to a new generation of minority veterans seeking services.

Question 8(a): What processes has the VA put into place to advance this recommendation?

Response: VA remains committed to hiring veterans, particularly disabled veterans and those transitioning from active service in OEF/OIF. VA's National Veterans Employment Program (NVEP) continues to advance efforts by the Department to employ veterans VA-wide, promoting or participating in targeted outreach and recruiting events nationally. VA is a regular participant of the DoD *Hiring Heroes Career Fairs, the Annual Road to Recovery Conference* hosted by the Coalition to Salute America's Heroes and other events targeting seriously injured and wounded OEF/OIF servicemembers transitioning to the civilian work force. NVEP has also helped establish veteran employment coordinators (VEC) at human resource facilities throughout the department to lead local efforts to attract, recruit, and retain veterans in VA.

VHA's fiscal year (FY) 2007 equal employment opportunity Initiatives were to increase the representation of individuals with targeted disabilities, particularly increasing the veterans and disabled veterans, and the number of minorities and women in the qualified applicant pool. To enhance the employment of OEF/OIF minority veterans and people with disabilities, VHA will continue to network with military installations, State vocational rehabilitation services, the Work force Recruitment Program, and community organizations (i.e. job accommodation networks and computer electronic accommodation program). VHA has an overall plan to increase the number of people with targeted disabilities. Each VISN director was asked to increase the employment of individuals with targeted disabilities to 1.5 percent in FY 2007, and incremental increases to 2.2 percent by FY 2011. It is anticipated that this effort will also increase the number of disabled veterans in the Department's work force.

VHA has appointed 98 transition patient advocates (TPA) since March 2007 when the Secretary authorized 100 new positions in VA's continuing commitment to help severely injured OEF/OIF veterans and their families navigate VA's system for health care. The TPAs serve as the point of contact for these veterans transitioning to VA from military treatment facilities. As in other recruitment activities, selecting officials were instructed to make every effort to ensure a representative number of women and minority candidates were selected. VHAs commitment of hiring OEF/OIF veterans was demonstrated during this recruitment effort by including qualification requirements that targeted these veterans. VHA continues to aggressively use the special veteran appointing authorities, including the veterans' recruitment appointment, the veterans' preference program for disabled veterans, and the Veterans Employment Opportunities Act 1998.

Currently, no means exists to identify employees who are OEF/OIF veterans, minority or otherwise. VA has addressed this issue with the Office of Personnel Management (OPM). So, until OPM establishes a code for OEF/OIF veterans, much in the same way Vietnam Era veterans were coded, their numbers in VA and the rest of the Federal work force will remain unknown. Certain programs (i.e. Coming Home to Work) can possibly provide raw numbers of OEF/OIF veterans hired, but when it comes to sorting them demographically, that presents a greater challenge.

Question 8(b): For instance has the VA established processes at the Cabinet level to ensure that all applicable agencies are engaged?

Response: VA participates with the Department of Labor (DoL), Department of Transportation and DoD in the transitional assistance program (TAP) to provide servicemembers who are within 6 months of discharge or 2 years of retirement with information and assistance they need to transition to civilian life.

Question 8(c): Can the VA seamlessly help these veterans transition?

Response: In January 2005, VA established a permanent Office of Seamless Transition which reports through VA/DoD coordination officers to the Principal Deputy Under Secretary for Health and is composed of representatives from VHA and VBA, as well as an active duty Marine Corps officer and an Army officer. Since its inception, the seamless transition program has achieved numerous accomplishments that result in great strides toward the seamless transition of OEF/OIF servicemembers into civilian life, including minority and women veterans. The ability to register for VA health care and file for benefits prior to separation from active duty is the result of the seamless transition.

VA/DoD social work liaisons and VBA benefit counselors are now located at 10 military treatment facilities (MTFs) to assist active duty servicemembers as they

transfer from MTFs to VAMCs. In addition, our VHA liaisons help newly wounded servicemembers and their families plan a future course of treatment for their injuries after they return home. VA nurses, social workers, benefits counselors, and outreach coordinators advise and explain the full array of VA services and benefits. VHA staff has coordinated over 7,900 transfers of OEF/OIF servicemembers and veterans from a MTF to a VA medical facility. Active duty Army liaison officers are assigned to each of the 4 VA polytrauma rehabilitation centers to assist servicemembers and their families from all branches of service on issues such as pay, lodging, travel, movement of household goods, and non-medical attendant care orders.

The Office of Seamless Transition established an OEF/OIF Polytrauma Call Center to assist our most seriously injured veterans and their families with clinical, administrative, and benefit inquiries. The Call Center which opened February 2006, is operational 24 hours a day, 7 days a week to answer clinical, administrative, and benefit inquiries from polytrauma patients and their families. In addition, the Call Center has contacted 950 veterans since February 2007. Through these outreach phone calls, we have been able to provide these veterans additional assistance with health or benefits concerns.

VA has implemented an automated tracking system to track servicemembers and veterans transitioning from MTFs to VA facilities. As part of this system, VHA implemented a 2007 performance measure to ensure VHA assigns a case manager to seriously injured servicemembers being referred from a MTF to a VA treatment facility in a timely fashion. This performance measure monitors the percent of severely ill/injured servicemembers and veterans who are contacted by their assigned VA case manager within 7 days of notification of transfer to the VA system.

In April 2007, VA integrated the tracking system with DoD's joint patient tracking application (JPTA) which tracks servicemembers from the battlefield through Landstuhl, Germany, to MTFs in the States. The new application, known as the veterans tracking application (VTA), is a modified version of DoD's JPTA—a web-based patient tracking and management tool that collects, manages, and reports on patients arriving at MTFs from forward-deployed locations. VTA is compatible with JPTA and allows the electronic transfer of DoD medical data JPTA on medically evacuated patients to VA on a daily basis.

VA is participating in DoD's post deployment health reassessment (PDHRA) program for returning deployed servicemembers at Reserve and Guard locations by providing information on VA care and benefits, enrolling interested Reservists and Guardsmen in the VA health care system, and arranging appointments for referred servicemembers. Since its inception, over 121,721 Reserve and Guard members have completed the PDHRA on-site screen resulting in over 27,755 referrals to VA facilities and 13,848 referrals to vet centers.

In order to ensure that OEF/OIF combat veterans receive high quality health care and coordinated transition services and benefits as they transition from the DoD system to the VA, VA developed a robust outreach, education and awareness program. The signing of a memorandum of agreement (MOA) between the National Guard and VA, in May 2005, and the formation of VA/National Guard State coalitions in each of the 54 States and territories now provides the opportunity for VA to gain access to returning troops and families as well as join with community resources and organizations to enhance the integration of the delivery of VA services to new veterans and families. This is a major step in closer collaboration with the National Guard soldiers and airmen. A similar MOA is being developed with the U.S. Army Reserve Command and the U.S. Marine Corps at the national level. VA and the National Guard Bureau teamed up to train 54 National Guard transition assistance advisors who assist VA in advising Guard members and their families about VA benefits and services.

VA participates in TAP workshops to provide servicemembers who are within 6 months of discharge or 2 years of retirement with information and assistance as they transition to civilian life. Part of the briefing conducted by DoL includes reviewing servicemembers' job seeking skills and allowing them to use DoL services to obtain employment following separation from service. At this time DoD does not make attendance at TAP briefings mandatory for servicemembers. The Marine Corps is the only branch of service that requires all discharging and retiring Marines to attend TAP. Currently just over 50 percent of all eligible servicemembers attend TAP. Following TAP briefings VA military service coordinators are available on most military bases to meet with interested servicemembers to discuss VA services and benefits.

The Secretary of Veterans Affairs sends a personal "thank you" letter together with information brochures to each returning OEF/OIF veteran based on lists routinely provided by the DoD. These letters provide information on health care and

other VA benefits, toll-free information numbers, and appropriate VA Web sites for accessing additional information. In addition, VA and DoD are collaborating to ensure VA is notified of severely ill or injured servicemembers transitioning to civilian life. Under this initiative, DoD is transmitting the names of servicemembers entering Do D's physical evaluation board (PEB) process. This list enables VA to contact active duty servicemembers to inform them of VA benefits and health care services available to them and to assist them in accessing these services.

Question 8(d): Has the VA pursued the collection of DoD data identifying the upcoming release/discharge of minority servicemembers within 90 days of their release to assist the VA with outreach to the service member?

Response: VA and DoD are collaborating to ensure VA is notified of severely ill or injured servicemembers transitioning to civilian life. Under this initiative, DoD is transmitting the names of servicemembers entering DoD's physical evaluation board (PEB) process. This list enables VA to contact active duty servicemembers to inform them of VA benefits and health care services available to them and to assist them in accessing these services. In addition the Secretary of *Veterans* Affairs sends a personal "thank you" letter together with information brochures to each returning OEF/OIF veteran based on lists routinely provided by the DoD. These letters provide information on health care and other *VA* benefits, toll-free information numbers, and appropriate VA Web sites for accessing additional information.

Question 9(a): How does the Center/VA identify Minority Vets?

Response: CMV uses the U.S. Census data to identify minority veterans. In order to identify minority veterans using VA health care services, veterans applying for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits, veterans (or their legal proxies) must complete the 1010 EZ form. The form includes 2 questions, similar to those used in the 2000 Census, asking the applicant to self-identify Spanish, Hispanic or Latino ethnicity (yes or no) and to self-identify race (one or more). This information is self-reported, is strictly voluntary, and a disclaimer is offered that any information collected is used for statistical purposes only. Enrollment and benefit eligibility decisions are not influenced by the answer to one or both of these questions, including a non-response. Once a veteran is enrolled, information on ethnicity and race is not routinely collected, although it may be referenced in the enrollee's confidential electronic health record.

Since 1999, VHA has conducted comprehensive nationwide surveys designed to provide input into estimates of enrollees' demand for health care services. Surveys consist of telephone interviews with random stratified samples of enrolled veterans. Recognizing that good administrative data on race and ethnicity are lacking, the 2005 survey, for the first time, asked respondents their race and ethnicity.

Question 9(b): What are your outreach practices to these subsets of veterans for VA facilities to ensure equitable access to benefits?

Response: CMV has program analysts who serve as veterans liaisons for each of the 5 minority groups: Asian Americans, Blacks, Hispanics, Native Americans, and Pacific Islander Americans. They establish partnerships with VSOs as well as internal and other external stakeholders to increase awareness of minority veterans' issues and develop collaborative strategies to address unmet needs.

VHA has developed a wide range of outreach programs in response to the health care and other benefits needs of veterans and their families, which focus on minority, women, newly separated and younger veterans, as well as on their health care providers. Many of these represent "lessons learned" from VA's experiences responding to the outreach, education, health care and other benefits needs of minority and women veterans returning from the 1991 gulf war, and from the Vietnam War.

These include:

- Since 2005, VA has published and distributed over 250,000 brochures titled *VA Reaching Out to Women Veterans.*
- VA's Secretary sends a letter to all newly separated OEF/OIF veterans, based on records provided by DoD, thanking them for their service, welcoming them home, and providing basic information about VA health care and other benefits.
- Expanded VA provider education on combat health care including:
  - *Preparing for the Return of Women Veterans from Combat Theater,* USH IL 10–2003–011, on special care needs for women OEF and OIF combat veterans;
  - *A Guide to gulf war Veterans Health* originally for 1991 gulf war combat veterans, remains relevant for OEF/OIF combat veterans;
  - *Endemic Infectious Diseases of Southwest Asia,* on infectious disease risks not typically seen in North America;
  - *Military Sexual Trauma* on recognition and treatment of health problems related to military sexual trauma;

- *Post-Traumatic Stress Disorder (PTSD): Implications for Primary Care* on PTSD diagnosis, treatment, referrals, support and education;
- *Traumatic Amputation and Prosthetics for patients with traumatic* amputations, their rehabilitation, primary and long-term care, prosthetic, clinical and administrative issues.

- Publish the quarterly *OIF and OEF Review* newsletter mailed to all separated OEF/OIF veterans (nearly 700,000 as of May 2007) and their families, on VA health care and assistance programs for these newest combat veterans.
- Published and distributed more than 1 million copies of brochure *A Summary of VA Benefits for National Guard and Reservists Personnel,* which summarizes health care and other benefits available to this special population of combat veterans upon their return to civilian life.
- Published *Health Care and Assistance for U.S. Veterans of Operation Iraqi Freedom,* a brochure on basic health issues for that deployment.
- Developed and distributed the *VA Health Care and Benefits Information for Veterans,* wallet card concisely summarizing all VA health and other benefits for veterans, along with contact information, in a single, wallet-sized card for easy reference.
- Promoted eligibility rules providing reservists and active duty personnel who served in a designated combat zone such as Afghanistan or Iraq with 2 years of free VA health care, in posters, information letters and news letters for veterans.
- Developed a clinical reminder (part of VA's computerized reminder system) to assist VA primary care clinicians in providing timely and appropriate care to new combat veterans.
- Sponsored a 3-day National Conference on *Providing Health Care for a New Generation of Combat Veterans Returning From OEF/OIF,* April 10–12, 2007, in Las Vegas, Nevada to sharpen VA's response to new and transitioning combat veterans coming to VA, and to the new physical and behavioral health care challenges they bring with them. The national conference attracted 1,400 primary care providers from around the country, including social workers, psychologists and mental health professionals, physicians, physician assistants, nurses and others who provide direct care to new combat veterans returning from Afghanistan and Iraq.

VBA's outreach efforts are designed to reach a broad spectrum of veterans, generally irrespective of race. However, each regional office has specially designated outreach coordinators who conduct outreach to various populations, including minority veterans, to provide these individuals information about VA benefits and services. MVPCs are also available to respond to requests concerning VA benefits and services.

NCA conducts local and national initiatives in an effort to identify minority veterans. The outreach practices to these veterans include all national cemetery directors having the responsibility to identify groups of veterans within the service area of their cemetery and providing information about VA memorial benefits to these individuals. NCA regularly attends 10 to 12 national conferences each year to increase awareness among minority groups of memorial benefits.

Question 9(c): How do they differ for non-minority vets?

Response: Minority veterans experience many of the same challenges that all veterans experience. However, minority veterans have experienced and often experience racial/ethnic discrimination or lack of cultural sensitivity more often than non-minority veterans. Minority veterans are more likely to be effected by chronic diseases, disparities in health care, homelessness, and unemployment.

Question 10: During its last site visit to the Los Angeles Ambulatory Center, the ACMV was overwhelmed by the staggering number of homeless veterans. In Los Angeles, it was reported that the veterans' homeless population comprised 23 percent of the total 90,000 total population in Los Angeles. Despite the fact that Los Angeles has the highest homeless population in the country, the Committee believed that these numbers might be similar throughout the country. While it wasn't clear what percent of these veterans were minority veterans.

Question 10(a): Please update the Committee on what the VA is doing to stem the rising tide of homeless amongst our veterans?

Response: Since 1987, VA has developed the largest integrated network of services and programs designed to address the treatment, rehabilitation, and residential needs of homeless veterans. VA specialized homeless programs include domiciliary care for homeless veterans (DCHV); compensated work therapy/transitional residence (CWT/TR); health care for homeless veterans (HCHV), homeless providers grant and per diem [GPD], and supported housing [SH]. VA in partnership with

Housing and Urban Development (HUD) provides HUD–VA supported housing program [HUD–VASH]).

VA homeless programs are designed to provide a continuum of care for homeless veterans. Key elements of this continuum are:

- *outreach* to identify veterans among homeless persons encountered in communities
- *clinical assessment* to determine the needs of those veterans;
- *rehabilitation* in VA domiciliary, in community-based contracted residential treatment facilities, or in transitional residences;
- *supportive transitional housing* to facilitate community re-entry (such as those supported by the VA grant and per diem program);
- *supportive case management* to maintain independent jiving in the community (such as the supportive housing program provided by HUD–VA).

For the past several years, VA specialized homeless programs have treated 70,000 to 75,000 homeless veterans. In fiscal year (FY) 2006, VA homeless programs provided services to approximately 72,000 homeless veterans. Approximately 4 percent of VA homeless program clients are female; about 46 percent are White; about 46 percent are Black; about 5 percent are Hispanic; about 1 percent are Native American; and 1 percent are Asian American and Pacific Islander American. Consistent with the missions of the programs, the vast majority of clients have serious psychiatric, substance abuse or medical problems.

About two-thirds of clients in these programs are seen on an outpatient basis, receiving direct services and referral to other treatment as needed. About one-third are seen more intensively in the residential programs. A recent longitudinal study of clients discharged from VA residential treatment programs indicated that approximately 80 percent are stably housed 1 year later. Similarly favorable housing outcomes have been observed in studies of VA's longer term supportive case management programs.

Question 10(b): What is it doing for homeless Minority vets with dependents?

Response: VA homeless programs provide outreach and assessment services to minority veterans with dependents. The programs provide referral to community resources for dependents of homeless patients requiring shelter, residential services, medical and psychiatric care, or other social services.

Question 11: The ACMV was concerned that the early identification of PTSD and the accompanying services might not be readily available to minority veterans who have served in the Vietnam Conflict. What is the VA doing to ensure access to treatment and benefits, when warranted, are made available to this particular subset of veterans?

Response: VA is successful in providing mental health services to minority veterans of the Vietnam era and other service eras. VA has had clinical practice guidelines (CPG) that include PTSD since the mid eighties with the current PTSD CPG released in 2004. Following the release of the 2004 PTSD CPG, all veterans have been screened for PTSD (as well as for depression and alcohol abuse) on an annual basis. Beginning in FY 2007, PTSD screen is completed once every 5 years for Vietnam era veterans.

Data from the *National Vietnam Veterans Readjustment Study,* that sampled Black and Hispanic veterans, and the subsequent Matsunaga study that specifically targeted Native American and Pacific Islander American veterans, showed increased incidence of PTSD among minority veterans. As a result, in the 1990s, training videos were created by VA's National Center for PTSD directed at providers and veterans and their families on PTSD in these minority groups.

Data on use of VA mental health services by minority Vietnam era veterans indicates that overall, minorities are no less likely than non-minorities to use VA services (Rosenheck & Fontana, Journal of Nervous & Mental Disease, 1994).

VA's ongoing program evaluation of PTSD care, entitled the *Long Journey Home,* is produced annually by VHA's Northeast Program Evaluation Center (NEPEC). NEPEC data for FY 2000 indicated that 33 percent of veterans using special outpatient PTSD services were members of minority groups. For FY 2006, the percentage was 35 percent. A special survey of the 10,131 new Vietnam era veterans, who received intake assessments for the specialized outpatient PTSD program in FY 2006, showed that 37.5 percent were members of minority groups. This is about double the proportion of minorities in the general population of Vietnam era veterans.

While VBA does not conduct specific outreach to veterans who may suffer from PTSD, all outreach coordinators and telephone representatives are knowledgeable about the condition. They can inform an inquirer what is needed to file a claim and how to request treatment. They are also trained in how to deal with callers with extreme mental conditions, including PTSD, who are threatening suicide. Addition-

ally, VA's Web site has a wealth of information on PTSD for the veteran and his or her family.

Question 12(a): Please provide a demographic breakdown of the number of Minority Veterans, African American, Hispanic, Samoan, Native American, and so forth.

Response: The U.S. Census Bureau, Census Bureau 2006 American Community Survey data show the following veteran demographics:

Race	Number
Blacks	42,436,205
Hispanic	1,100,977
American Indian/Alaskan Native	163,975
Asian American	281,100
Native Hawaiian/Other Pacific Islander	23,425

Question 12(b): How does the VA gather this information and make determinations for resources accordingly, please explain? For instance the Advisory Committee was very concerned about how the VA collects its data on ethnicity, especially as it seemed to disadvantage Native American veterans.

Response: The VA Office of the Actuary within the Office of Policy and Planning develop estimates of veterans by race and ethnicity based on assumptions derived from analysis of U.S. Census Bureau data. Since 1999, VHA has conducted comprehensive nationwide surveys designed to provide input into estimates of enrollees' demand for health care services. Surveys consist of telephone interviews with random stratified samples of enrolled veterans. Recognizing that good administrative data on race and ethnicity are lacking, the 2005 survey, for the first time, asked respondents their race and ethnicity.

National estimates of enrollee demographics derived from responses to the 2005 Annual Survey of Veteran Enrollees, a telephone survey random stratified sample of approximately 42,000 enrollees. The estimated distributions from each source are as follows:

	Hispanic	American Indian or Alaska Native	Asian	Black/ African American	Native Hawaiian or Other Pacific Islander	White	More than one race
Office of the Actuary (2007)	5.6%	0.8%	1.2%	10.9%	0.1%	79.9%	1.4%
Survey of Veteran Enrollees (2005)*	4.5%	4.6%	0.7%	10.0%	0.5%	84.1%	2.8%

*Does not add to 100% because of non-responses

In addition, to apply for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits, veterans (or their legal proxies) must complete the 1010 EZ form. The form includes 2 questions, similar to those used in the 2000 Census, asking the applicant to self-identify Spanish, Hispanic or Latino ethnicity (yes or no) and to self-identify race (one or more). This information is self-reported, is strictly voluntary, and a disclaimer is offered that any information collected is used for statistical purposes only. Enrollment and benefit eligibility decisions are not influenced by the answer to one or both of these questions, including a non-response. Once a veteran is enrolled, information on ethnicity and race is not routinely collected, although it may be referenced in the enrollee's confidential electronic health record.

Each administration is responsible for making resource determinations in order to serve this minority population. At the Department level the Secretary established minority veterans' program coordinators (MVPC) at each VA health care facility, regional office and national cemetery. The directors of the health care facility, regional office and national cemetery are responsible to ensure that MVPCs have the necessary resources to be effective and efficient to perform the functions needed (e.g., numbers of hours allocated to perform the duties, computer access/email, and funding for projects and/or special programs as required).

Question 13(a): For the recommendations made by the Advisory Committee, and for those in which the VA concurs, who is responsible for ensuring implementation of the recommendations made by the Advisory Committee?

Response: The administrations along with various staff offices are responsible for implementing the recommendations of ACMV. CMV tracks the status of recommendations to ensure implementation; and requests briefings on unresolved recommendations at ACMV bi-annual meetings.

Question 13(b): How are these missives sent down throughout all of the VA?

Response: CMV assigns each recommendation to the appropriate administration or staff office, and then monitors and follows up as needed.

Questions on the Backlog

Question 1: During its visit, the Committee also noted that the LA VARD had a significant backlog in its appellate reviews. In fact, it was reported to the Advisory Committee that 4,000 appeals were pending but that only 8 percent of the VARO staffing was designated to work on those appeals. How does the VA determine the allocation of resources for these backlogged areas?

Response: Under the claim process improvement (CPI) model, a regional office has established claims processing teams performing the functions of triage, pre-determination, rating, post-determination, appeals, and public contact.

The claims processing taskforce recommends the following distribution of staffing:

Triage:	20–25 percent
Pre-determination:	15–20 percent
Rating:	20–25 percent
Post-determination:	10–15 percent
Appeals:	5–10 percent
Public contact:	15–18 percent

The Los Angeles RO allocates 12.4 percent of its Veterans Service Center decisionmakers, to the appeals process. Because of the complexity of the appeals process, these decisionmakers are highly skilled and more experienced.

Since October 2006, the Los Angeles Regional Office has reduced its appeals workload by 15 percent, and improved the timeliness of the notice of disagreement process by 24 percent. There are currently 3,673 appeals pending.

Question 2: Has been omitted.

Question 3: What percentage of the VA population is Native American?

Response: Public Law 103–446 denotes that Native Americans include American Indians, Alaskan Natives, and Native Hawaiians. The U.S. Census 2006 reflects that there are 163,975 American Indian veterans and 23,425 Native Hawaiians and Pacific Islanders. U.S. Census data doesn't provide a separate breakdown for Native Hawaiians and Pacific Islanders.

Question 4: What is being done in terms of outreach for this special set of Minority Veterans?

Response: The Department of Health and Human Services (HHS) and the VA signed a memorandum of understanding (MOU) in February 2003 to encourage cooperation and resource sharing between the Indian Health Service (IHS) and VHA to deliver quality health care services and enhance the health status of American Indian and Alaska Native (AI/AN) veterans.

Outreach. Most networks are engaged in a variety of outreach activities, including meetings and conferences with IHS program and tribal representatives, VA membership in the Native American Healthcare Network, VA participation in traditional Native American ceremonies, transportation support to AI/AN, and so forth.

Education. VHA Employee Education Service (EES) provides training programs to IHS staff and the tribal community. In FY 2007, VHA has delivered 123 training programs to IHS staff and the tribal community of which 68 were made available using satellite technology and 55 using web based technology. These educational programs will be continued in 2008, and VHA will also provide selected IHS staff an opportunity to attend regional EES workshops.

Behavioral Health. The Behavioral Health workgroup developed a framework for AI/AN communities to assist returning OEF/OIF AI/AN servicemembers and veterans reintegrate with their families and communities and readjust to civilian life. The objective is to promote a community health model with tools that is provided to Tribal communities and families to help returning veterans address emerging ad-

justment reactions, traumatic stress, and PTSD, emphasizing recovery as the goal. The Joint Committee has developed a slide presentation to be used by outreach teams. There have been briefings using the slide presentation in Montana, with approximately 30 veterans now receiving services from VA.

Expanded Health Care Services. At the local level, 10 VHA networks are engaged in targeted initiatives aimed at providing a full continuum of health care services, such as; health fairs, VA/IHS advisories, use of *Health Buddy,* and education and/or shared services in substance abuse, domestic violence programs, cardiac rehabilitation, dietetics, behavioral medicine, and so forth.

Care Coordination. The VHA–IHS Shared Health Care workgroup is working on developing an Inter-Departmental coordinated care policy. The goals are to optimize the quality, appropriateness and efficacy of the health care services provided to eligible AI/AN veterans receiving care from both VHA and IHS or Tribes and to improve the patients' satisfaction with the coordination of care between the 2 Departments. A separate memorandum of understanding to facilitate electronic record sharing was signed in August 2007.

Tribal Veteran Representatives. In July 2007 9 Tribal veteran representatives (TVRs) and a drum group participated in a *Wounded Warriors* program in Park City, Utah for returning OEF/OIF veterans. A similar program is being considered for women and then another for men. *American Vet* video filmed and will have a new film come out soon. TVRs are working on an outreach program to urban veterans in October 2007. Training to add TVRs continues.

Telemedicine. Telemedicine has proven to be an extremely effective in the treatment of PTSD in Alaskan Native villages. VA and IHS are working to spread the use of telemedicine services by AI/AN veterans, which will allow VA to bring physical and mental health care to the tribes, especially those in remote areas of the country.

Traditional Healing. Some VHA facilities and Vet Centers have incorporated traditional healing ceremonies along with modern methods of treatment and counseling. As a national initiative, VA has sent over 500 letters to tribal leaders to ask them to provide information on appropriate providers of traditional practices so that they may be called upon for religious/spiritual care of AI/AN veterans.

The majority of VBA's outreach to this group is in those States where there are concentrations of Native American veterans. Several regional offices have been very successful in establishing relationships with tribal councils to allow VBA to meet with Native American veterans in familiar settings. Currently, VBA works closely with TVRs a liaison between the Tribes and VBA in processing of claims.

NCA has recently added a Native American member to its Advisory Committee on Cemeteries and Memorials. In addition to his regular duties as a Committee member he will assist in identifying and conducting outreach to Native American populations unaware of VA memorial benefits.

Public Law 109–461, Veterans Benefits, Health Care, and Information Technology Act of 2006 amended section 2408 of title 38, United States Code, to allow the Secretary to make cemetery grants to tribal organizations in the same manner, and under the same conditions, as grants to States are made under the State cemetery grants program.

Inclusion of tribal organizations into the State cemetery grants program will assist NCA in identifying groups of veterans interested in learning about VA memorial benefits when they initiate the grant process.

Question 5: What metrics does the VA use to measure success in its outreach programs to Minority veterans?

Response: The purpose of outreach is to make individuals aware of the benefits available from VA. Of course, awareness does not always translate into applying for benefits. Under section 805 of Public Law 108–454, VA is charged with conducting a national survey to ascertain servicemembers' and veterans' and their family members' and survivors' levels of awareness of VA benefits and services. When this survey is completed we will have a better understanding of the effectiveness of the outreach initiatives.

Question 6: What has the VA done to implement the establishment of full-time Minority Outreach Coordinators where warranted?

Response: The Secretary's memorandum dated April 25, 1995, established MVPCs at each VA medical center, regional office, and national cemetery. VA Directive 0801, *Minority Veterans Program Coordinator* signed by the Secretary of Veterans Affairs on April 15, 2007 States that each administration shall support facility MVPCs and ensure they are provided the necessary resources to be effective and efficient to perform the functions needed (e.g., numbers of hours allocated to perform the duties, computer access/email, and funding for projects and/or special programs as required).

VHA has designated MVPCs at each medical center. The MVPC assist the medical center director and CMV with identifying the needs of minority veterans through outreach activity. The primary goal of this outreach initiative is to increase local awareness of minority veteran related issues and develop strategies for increasing their participation in existing VA benefit programs for eligible veterans. MVPC's are responsible for:

- Promoting the use of VA benefits, programs, and services by minority veterans.
- Supporting and initiating activities that educate and sensitize internal staff to the unique needs of minority veterans.
- Targeting outreach efforts to minority veterans through community networks.
- Advocating on behalf of minority veterans by identifying gaps in services and make recommendations to improve service delivery within their facilities.

VBA has designated outreach coordinators at every regional office for several specific audiences of servicemembers and veterans including minority, OEF/OIF, women, the elderly, Native American, former prisoners of war, and homeless. Because of the overlap of groups, a few regional offices have consolidated their outreach activities with one coordinator. In 20 States, the homeless coordinator is a full-time position because of the size of the homeless veteran population in those States. In only a few other cases is there a substantial specific population to justify assigning a full-time coordinator to any specific targeted group.

NCA now has an outreach coordinator staff position at the national level within the Communications Management Service. The position includes responsibilities for minority outreach as well as other program outreach on the national level.

Questions for Women Veterans

Question 1: In its 2004 Report, the VA Advisory Committee on Women Veterans indicate that the VA perform a study to determine the prevalence of Military Sexual trauma among homeless women veterans and the psychosocial consequences of Military Sexual Trauma (MST) and whether a correlation exists between MST and homelessness. The VA concurred. Please update the Committee on the results of any follow-up studies that may have been conducted. (p. 36).

Response: North East Program Evaluation Center (NEPEC) has conducted a follow-up study of homeless female veterans in the course of which we have collected data on military sexual trauma (MST). These data show that among female veterans being served at 1 of the 11 specialized homeless women veterans programs throughout the country, 43 percent reported being raped while in the military. This rate of MST can be compared to rates reported among VA ambulatory female outpatients of 23 percent (Skinner, 2000) and rates noted through mandatory VA screening procedures of 21 percent (external peer review package data). Skinner, Katherine M; Kressin, Nancy; Frayne, Susan; Tripp, Tara J; Hankin, Cheryl S; Miller, Donald R; Sullivan, Lisa M. The prevalence of military sexual assault among female Veterans' Administration outpatients. *Journal of Interpersonal Violence.* Vol. 15(3) Mar 2000, 291–310.

Question 2: Are there any correlations between MST and Homelessness?

Response: NEPEC collected data on homeless female veterans. These data show that among female veterans being served at specialized homeless women veterans programs throughout the country, 43 percent reported being raped while in the military. This rate of MST can be compared to rates reported among VA ambulatory female outpatients of 23 percent (Skinner, 2000) and rates noted through mandatory VA screening procedures of 21 percent (external peer review package data). This difference suggests that homeless female veterans under VA care may be more likely to have suffered MST than non-homeless female VA clients. However, without longitudinal data it is not possible to conclude that experiencing MST significantly increases the risk of homelessness among all female veterans. Skinner, Katherine M; Kressin, Nancy; Frayne, Susan; Tripp, Tara J; Hankin, Cheryl S; Miller, Donald R; Sullivan, Lisa M. The prevalence of military sexual assault among female Veterans' Administration outpatients. *Journal of Interpersonal Violence.* Vol. 15(3) Mar 2000, 291–310.

Question 3(a): As women are increasingly prevalent on the frontlines of combat, what is the VA doing to prepare for and address the needs of the growing number of veterans who are minority?

Response: VA is aware that the number of women serving on active duty and in combat area deployments has dramatically increased. Because of the numbers of new OEF/OIF veterans, VA is preparing for the population of women veterans to double in the next 2 to 5 years. To address the needs of these women veterans, including minority women, VA plans to:

- Enhance the skills of primary care providers treating women through primary care education initiatives;
- Increase the focus on comprehensive care, including those conditions that have high mortality for women, such as heart disease and obesity; and,
- Help new OEF/OIF women veterans stay fit and healthy for life, since we expect them to be receiving care from VA throughout their adult years. Special attention to issues for minority veterans, and veterans' perception of health care are being addressed in this program.

Question 3(b): Please inform the Committee what percentage of OIF/OEF women veterans are minority?

Response: As of August 31, 2006, of the 69,861 women veterans who had served in OEF/OIF 42 percent are minorities. Of this 42 percent, 26 percent are Black, 9 percent are Hispanic, and 7 percent are members of other minority groups or multiple races.

Question 4: Based on a recommendation by the Women's Advisory Committee, what has the VA done specifically to ensure that Veterans Benefits advisors at the Transition Assistance Program (TAP) briefings specifically address MST (military sexual trauma) information, Le. placing in packets?

Response: The VA TAP benefits briefing presentation used by military services coordinators includes 5 slides on Military Sexual and Other Personal Trauma. These slides are mandatory at all VA benefits briefing presentations conducted for separating and retiring servicemembers. When VBA conducts site visits to evaluate TAP VA benefits presentations, this requirement is on our checklist to confirm it is included in the briefings.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Shirley Ann Quarles, R.N., Ed.D
Chairwoman, Advisory Committee on Women Veterans
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Shirley:

In reference to our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Dr. Shirley Quarles, R.N., Ed.D.
Response to Follow-Up Questions for the Record
From Joint Subcommittee Hearing
U. S. House of Representatives Committee on Veterans' Affairs
Subcommittees on Health and the
Subcommittee on Disability Assistance and Memorial Affair

Question 1—

I was pleased to see that there is a national Survey of Women Veterans being implemented with the results expected in December 2008.

- In your estimation, what are the 3 most prevalent and urgent issues facing women veterans today?

As stated in earlier testimony in July 2007, 1) access to care for women veterans in rural areas, 2) primary care in community-based outpatient clinics that offer the same services that are provided at VA medical centers, and 3) that women veterans receive health care on par as male veterans.

Question 2—

To my knowledge, VA has not yet held any type of summit or conference on OEF/OIF female veterans and the unique needs that are arising as a result of women in combat.

- Has the Advisory Committee looked at this, and if so, what have you found?

In April 2007, VA held a national conference in Las Vegas, Nevada called "Evolving Paradigms: Providing Health Care to Transitioning Combat Veterans". The main attendees to the conference were VA and DoD primary care givers and related health care professionals from all disciplines who work with new combat veterans returning from Iraq and Afghanistan to include: physicians, nurses, pharmacists, psychologists, social workers, rehabilitation and mental health staff. The primary purpose of the conference was to disseminate information to VA and DoD health care providers on unique and challenging health care needs for transitioning veterans with war wounds. Veterans transition to VA with multiple and complex war wounds and the environment of care is critical to the healing process. VA health care providers need to understand all of these complex health care needs in a variety of settings, as these new veterans transition from DoD to VA for their immediate and long-term health care needs. Sessions focused toward women included: Health Issues of Female Soldiers in Garrison, Combat and VA; Sexual Trauma; and Gender Differences: What the Data Shows.

More recently, on February 19, 2008, the Department of Veterans Affairs held a 1-day conference entitled *Update on Health Care: Responding to the Needs of VA's Newest Generation of Combat Veterans,* in the Sonny Montgomery Conference Center. Speakers from VA and the Department of Defense covered such topics as traumatic brain injury and polytrauma; mental health, post-traumatic stress disorder, and readjustment issues; DoD/VA data sharing, changes in VA and DoD disability evaluation; an individual veteran's experience, case management: role of the Federal recovery coordinators, transition patient advocates, and VA social workers; pay and compensation; and special issues for national guard and reserve.

Veterans Health Administration is scheduled to participate in the 6th Annual Battlefield Healthcare Combat Casualty Care from the Front Line to CONUS on March 31–April 2, 2008 at *Georgetown University Conference Center (and Hotel), Washington, DC.* The conference will discuss the continued operations in Iraq and Afghanistan and addressing new challenges in care for combat veterans who serve in theater.

Also, The Department of Veterans Affairs, Center for Women Veterans is planning the 2008 National Summit on Women Veterans Issues scheduled for June 20–22, 2008 in Washington, DC. This is the 4th such Summit, the prior Summits having been held in 1996, 2000, and 2004. Summit 2008 will look at the issues and recommendations from the 2004 Summit, review VA's progress on these issues, provide information on current issues, and develop recommendations and a plan for continuous progress on women veterans' issues. A special focus of this Summit is on updates for the Reserve and Guard. Breakout sessions have been designed for our returning OEF/OIF service members and veterans, however, there will be breakout sessions that are relevant for women veterans of all eras as well. A townhall meeting and health expo are also planned.

Question 3—

Could you tell me what the biggest barriers to care for women veterans are?

Access to care continues to be a barrier for women veterans. We continue to outreach to the women veterans' community with increased emphasis, working with our partnerships with Federal, state, and county agencies, national veterans service organizations and community organizations. HVAC, Subcommittees on Health and DAMA, 7–12–07, Questions for the Record, Malebranche

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Colonel Reginald Malebranche, USA (Ret.)
4919 Donovan Dr.
Alexandria, VA 22304

Dear Reginald:

In reference to our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Follow-Up Questions for
Col. Reginald Malebranche, USA (Ret.)

Question:

In your testimony you stress the absence of diversity at the senior staff level.

- When the Committee presented their concern to the VA about this issue, how did they respond?

Answer:

VA's answer has been to "concur in principle." The Committee did note that VHA planned on adding a 2007 work force performance measure for diversity management for all Senior Managers that includes the following:

"a. VISNs will take action to remove any barriers to full participation of the local work force.

"b. Based on the analysis of the results from the Diversity Acceptance factors from the 2006 All Employee Survey (AES), VISNs will develop goals for improvement and implement the resulting action plan."

The absence of diversity at the senior staff level is a systemic issue, which has been addressed and discussed in the majority of ACMV reports. Yet, diversity at the senior staff level continues to be a major problem at and within VA.

VA perceives its problem to be the lack of white and Hispanic females at its senior staff level, even though the supportive data is inconclusive. It stands to reason that VA's targets will be white and Hispanic females, although analysis of VA data would suggest that minorities, excluding white and Hispanic females, were significantly absent from senior staff level positions at and in VA settings.

The Committee has been on record to recommend that VA exercise all leverage available, including performance bonuses to bring required changes, including the establishment of goals or floors, and hold all leaders and managers personally accountable to meet established or required goals, for the hiring of minority staff. The Committee believes that **these actions would result in a work force population which would be more representative of the veteran population being served.**

Question:

- To your knowledge, has the VA put forth a strategic plan that would target recruitment and retention of minority veterans among the senior staff level?

Answer:

I am unaware of a specific strategic plan, which would remedy the issue. During the Committee's meeting in Washington, DC, April 16–19, 2007, the Office of Diversity Management and EEO Administration, VA, presented data in the Executive Summary, EEOC Form 715–01 Part E, for Fiscal Year 2007, which may be construed as VA's strategic plan. The Executive Summary, EEOC Form 715–01, offered the following:

"WORKFORCE PROFILE: **VA has a workforce of approximately 238,580 employees. During Fiscal Year (FY) 2006, total VA staffing increased by more than 4,700 employees, including about 600 temporary appointments. White women are 35.7% of the permanent positions, significantly below their 47.5% in the Relevant Civilian Labor Force (RCLF) for VA occupations, and declining slightly. Hispanic women are 3.6% of the permanent positions, well below their 4.4% in the RCLF, and not making meaningful progress toward RCLF parity. Hispanic men and American Indian women are slightly underrepresented, but at the current rate of gains should reach parity within 2 years. No other groups are underrepresented in national total. Black men are represented at almost 3 times the RCLF and Black women are represented at almost double the RCLF."**

This would suggest that VA's strategic plan is to focus on the recruitment, hiring, and training of white and Hispanic females, only. This would also suggest that VA does not consider having problem with minorities hiring, promotion, and so forth., except for White and Hispanic females. Data available at VA does not support this conclusion.

There have been indications that VA had developed strategic initiatives targeting the recruitment and retention of minority veterans at the senior staff level. The plan and/or programs have not, to my knowledge, been presented to the Committee, which will ask for a comprehensive brief during its fall 2007 meeting in Washington, DC.

Question 2:

A big concern regarding the provision of care to the minority veteran population is sensitivity to the cultural differences of minority veterans—for instance, the differences in how to approach the Alaska Native veteran community as opposed to the Hispanic veteran community.

- Does VA provide education to its many employees on cultural competencies and sensitivity, particularly to the frontline medical personnel?

Answer:

Indications are that the Veterans Health Administration (VHA) is developing a 3-year phased cultural competency plan, targeting Alaska Natives, Native Americans and Hispanic Americans veterans. The Committee will endeavor to seek a comprehensive brief on the plan, during its fall 2007 meeting in Washington, DC.

The Center for Minority Veterans does conduct a biennial training conference for its Minority Veterans Program Coordinators (MPVC). Included in that format is a cultural and sensitivity competency module.

Question 3:

Outreach is a major challenge for the VA. In your testimony you mention transportation to VA centers, in major metropolitan, rural, and isolated areas, is a major impediment for minority veterans.

- What kinds of recommendations concerning outreach has the committee made to VA to be more effective?

Answer:

In its July 1, 2006 report, the Committee recommended:

Outreach Program

"The Secretary mandates that an outreach program be established by all Veterans Affairs Administrations and appropriate staff offices to reach out and support all veterans. As a minimum, the program must incorporate the following goals/activities:

a. "Inclusion of and coordination with local, Federal and state veteran serving organizations in VA facilities' outreach activities. These entities should include, as a minimum, state and county Veterans Affairs Agencies, Veteran Service Organizations (VSOs), veteran serving organizations (i.e. minority veterans' organizations that have not been granted VSO status), agencies and organizations that serve the minority community in the local area, faith-based organizations that serve veterans, etc.;

b. "Establishment of periodic Veteran Town Hall meetings with veterans and their families to determine needs and issues; meetings/processes must ensure that minority veterans and communities are targeted in culturally appropriate venues;

c. "Allow facilities to advertise veteran benefits and health care services and consult Marketing experts to help VA facilities conduct effective communication of VA offerings with particular attention to marketing to minority communities;

d. "Expand and improve the use of Internet based access to VA benefits and health care, with particular attention given to cultural and linguistic diversity;

e. "Establish Minority Outreach Coordinators that are full time, where warranted. Further recommend that these be additional billets that are fully resourced for those facilities, rather than requiring facility directors to give up other billets to fill those positions;

f. "Mandate enhanced outreach communication and coordination between VHA, VBA, NCA and appropriate staff offices;

g. "Identify Federal grants for states to conduct grassroots outreach programs."

The Committee also recommended that That VA's Outreach program is extended and/or modified to include all means and processes to advise minority veterans of their entitlements.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Saul Rosenberg, Ph.D.
Associate Clinical Professor of Medical Psychology
University of California, San Francisco
401 Parnassus Avenue
San Francisco, CA 94143

Dear Dr. Rosenberg:

In reference to our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Joint Subcommittee Hearing
"Issues Facing Women and Minority Veterans"
held on July 12, 2007, 10:00 a.m.
Room 334, Cannon House Office Building

Follow-Up Questions for Saul Rosenberg, Ph.D.

I was particularly interested in the part of your testimony that comments on the fact that African American veterans were about half as likely as other veterans to receive service connected disability for PTSD.

- Was there an explanation as to why this was so?

You also mention in your testimony an idea promoted by the DoD Task Force on Mental Health regarding Centers of Excellence for the Study of Resilience.

- Would you elaborate on that for the Subcommittee?

[DR. ROSENBERG DID NOT RESPOND TO THESE QUESTIONS SUBMITTED BY THE SUBCOMMITTEE.]

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Joy J. Ilem
Assistant National Legislative Director
Disabled American Veterans
807 Maine Ave. SW
Washington, DC 20024

Dear Joy:

In reference to our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

POST-HEARING QUESTIONS FOR
JOY J. ILEM
OF THE
DISABLED AMERICAN VETERAN

Question 1:
In testimony provided, DAV gives 8 recommendations to better serve women veterans from combat theaters. The first recommendation concerns barriers to seeking health care through VA.

- In your estimation, what are the 3 biggest barriers female veteran encounter when trying to access health care through VA?

Response: DAV believes women veterans face many barriers, some very tangible and others that are seemingly invisible. As for the top 3 I offer the following remarks.

Women's programs are small. When a new VA initiative or program is created, for mental health, homeless veterans, or residential care, for example, women typically constitute the smallest fraction of veterans to be served. Sometimes this causes VA planners and managers significant difficulty in program design and management. Additionally, women's care is often complicated by a history of military sexual assault, or they have minor children. Program planners typically design these programs for the majority of patients who will use them, and the majority of VA's patients are males. Fitting in women with their special needs is often problematic, or women are required to accept the program designed "as is," without special consideration for their circumstances. This is a barrier to care.

Second, there are no "best models" of care for women in VA. VA is becoming recognized as a system that bases its services on evidence and efficacy. We believe evidence-based care is the best care because VA has tested its methods and has measured its outcomes for certain health issues versus other health care techniques and practices that have not been subjected to rigorous review. DAV supports this policy because it produces higher quality of care for veterans. In respect to women, however, until 2006 VA had no systematic research agenda for women's health. While now underway, the results of this research agenda will not be known or implemented for some time. In the interim, VA clinicians are treating women without best-practices guidance. This is a barrier to care.

Third, privacy and security for women remains a problem in VA facilities. DAV continues to hear from women veterans that their personal security and privacy are regularly compromised in VA facilities that lack adequate space, secured rooms, private restrooms, dressing rooms and sufficient privacy curtains in some VA clinics. Women are frequently integrated into VA primary care teams, often without regard

to these gender and privacy issues. DAV and the Independent Budget veterans service organizations have raised these issues in the past, but progress in improving privacy and security for women patients has been slow. This is a barrier to care.

Today's military will soon be comprised of 20 percent women. Additionally women veterans are the fastest growing segment of the VA-enrolled population. VA Central Office has established an Office of Women's Health and a Center for Women Veterans, and VA has a Women's Advisory Committee. Field facilities of the VA have designated women's coordinators to help women move more smoothly through VA's various processes. We hope that some of these developments and efforts will help VA better address the needs of women who need VA health care as urgently as their male counterparts who do not face these barriers to care.

Question 2:

Women and minority OEF/OIF veterans returning from theater face, what I believe, are additional challenges than their returning peers, due, in part, to the lack of cultural education, lack of adequate research on meeting their unmet needs and other issues.

- What has your organization done to help in the outreach effort?

Response: While outreach is a statutory responsibility of the Department of Veterans Affairs, to ensure veterans are fully aware of the benefits and services for which they may be eligible, DAV has a fully trained corps of 260 National Service Officers (NSOs) who work in both VA regional offices and VA medical centers, to ensure veterans have full access to their rights and benefits. Also, DAV has stationed NSOs and special Transition Service Officers (TSOs) in or near major military treatment facilities to aid active duty members and veterans who are under care in those facilities. The primary purpose of our out-stationing the NSOs and TSOs in military facilities is to ensure that claims for benefits are filed early and that we at DAV are able to help get those claims processed in an expedited fashion. The TSO corps of over 30 specially trained individuals plays an additional key role, of providing VA benefits presentations, reviewing service medical records, and assisting transitioning servicemembers with filing original VA claims for benefits at nearly 100 military separation sites in the U.S. These TSOs also participate in Department of Labor programs in transition assistance.

Question 3:

Does your organization have any recommendations as to how to address the growing need for specialized services for both women and minority veterans?

Response: DAV believes that these matters are improved when they are not concealed within VA but are properly brought out and to the attention of the veterans service organization community and to Congress. The more oversight the Committee is able to provide helps keep these important issues surfaced. If the Department sees that the Committee places a high priority on them, they will draw necessary resources (in whatever form) so that progress can be made.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Betty Moseley Brown, Ed.D.
Associate Director, Center for Women Veterans
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Betty:

In reference to our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Hon. Michael H. Michaud, Chairman
Subcommittee on Health, House Committee on Veterans' Affairs
July 12, 2007
"Issues Facing Women and Minority Veterans"

Question 1: Your testimony indicates that there are 22 VA health care facilities that have dedicated comprehensive women's center space. I have 3 questions on that:

Are you saying that 22 of the 154 VA Medical Centers have space for women? That isn't a very good percentage if that is what you are saying. Why don't all of the V AMC's have dedicated space for women? Is the space proportionate to the number of female veterans provided services at those locations?

Response: The Veterans Health Administration (VHA) provides high quality primary and specialty health care to women veterans at its facilities and clinics throughout the country. At 22 of these facilities, VHA has comprehensive women's primary care clinics that provide coordinated care such as mental health treatment, and gynecological and breast services at the same visit and within the same physical space.

Any specialty care that is needed but not available at a specific facility can be provided by another Department of Veterans Affairs (VA) facility in the same geographic area, or fee-for-service arrangements with a community provider.

The women veterans' strategic health care group monitors services provided to women veterans through an annual, Web-based survey, *Plan of Care/Clinical Inventory* (POC/CI). The fiscal year (FY) 2006 Annual Report of 153 VA medical facilities found that 41 percent of VA medical facilities have designated women's primary care clinics and teams. An additional 43 percent of VA medical facilities provide separate gender-specific care in a women's health clinic, with the woman veteran receiving her primary care in a mixed gender primary care clinic. Only 16 percent of VA facilities have no separate women's health clinic to provide care to women veterans. The Under Secretary for Health has asked for program proposals to address gender gaps during FY 2008. Decisions on those proposals will occur in the next 60 days.

With regard to space, the women's comprehensive health clinic spaces are designed locally to meet the needs of the women veterans in that geographic area. Most commonly the development has been in response to the increasing numbers of women presenting for care and using the medical facility. In addition, VA research has shown that having strong physician leadership in women's health has been a key factor in development of comprehensive women's clinics.

Question 2: Are the Military Sexual Trauma (MST) Coordinators that are designated in every VA facility full time?

Response: Every VA facility is required to appoint an MST coordinator to serve as a point person for staff and veterans regarding MST issues. This position is currently a collateral one, such that coordinators are usually performing their MST coordinator duties along with other clinical and/or administrative duties related to their primary position. Many MST coordinators provide clinical care to veterans with experiences of MST as part of their primary position. However, clinical care is not a required component of the MST coordinator position itself.

Question 3: The MST Support Team that was established in FY 2007 in VA's Office of Mental Health Services help to ensure that VA is in compliance with mandated monitoring of MST screening and treatment. When in FY 2007 was this team established? How are they monitoring compliance of MST screening and treatment? What have been the findings so far?

Response: The MST support team was established in October, 2006. The MST support team uses data from VHA electronic medical records to monitor MST screening and treatment. The team submits annual screening reports that describe the proportion of all veteran patients who have been screened for MST in the past fiscal year. A screening rate is provided for VHA nationally and for each VHA facility. The information is also aggregated by gender, as is mandated by public law.

The team also submits annual treatment reports, which contain the proportion of all veterans with positive MST screens that have received free MST-related treatment, and the amount of treatment provided. These reports also provide both national treatment rates and treatment rates for each VHA facility, and provide data aggregated by gender.

During FY 2007 the MST support team accomplished the following:

- Produced and distributed MST screening reports for FY 2005 and FY 2006. These reports improved upon existing MST monitoring by aggregating data by VA facility, and for the first time enabled VA facilities to monitor the proportion of all patients screened for MST. Prior to this time, only national MST Screening rates were reported.
- Created benchmarks for MST screening performance and identified facilities functioning below the benchmark. VA's Office of Mental Health Services (OMHS) set the target MST screening rate at 90 percent and above. The target was met by 96 out of 127 VA facilities. There were 13 facilities with rates below 90 percent but greater than or equal to 80 percent and 18 facilities with rates below 80 percent.
- Provided consultation to sites regarding issues of monitoring and performance benchmarking, with special attention to sites not meeting the 90 percent criterion.
- Identified that MST-related treatment is provided at all VA facilities. These data also provide key feedback to VA clinicians regarding the proportion of MST patients they are able to engage in treatment.
- Identified facility-based information resources management (IRM) errors in clinical reminder implementation and provided technical assistance for these facilities to correct implementation and effectively screen for MST.
- Identified the need to develop a more refined screening tool that provides more specific data about the range of MST.

Question 4: What do you believe is the biggest challenge facing women veterans today?

Response: The biggest challenge facing women veterans today is gaining awareness of the benefits and services for which they are entitled. According to a VA study, titled *Women Veterans' Perceptions and Decision-Making about Veterans Affairs Health Care* (Washington et al 2007), in spite of efforts to make women veterans knowledgeable about available gender-specific services, there is an information gap regarding women veterans' VA eligibility and advances in care. A second article, titled *To Use or Not to Use: What Influences Why Women Veterans Choose VA Health Care* (Washington et al 2006), cited that" . . . non-VA users had substantial knowledge deficits of VA benefits, eligibility, and availability of women's health care service." The study notes that 48.5 percent of non-VA users cite lack of knowledge of VA eligibility and benefits as the reason for not using them.

VA is tenaciously addressing this information deficit. Not only are we aggressively informing women veterans of their benefits, we have women veterans program managers at each VA medical center and women veteran coordinators at each VA regional office to assist women veterans.

The number of women using VA health care continues to rise, and is projected to be 8.11 percent of all veteran users by FY 2011. VA is committed to meeting the needs of returning deployed women veterans as well as those of our aging women's population, and to create an environment that serves the woman veteran by providing excellent comprehensive health care services.

In order to increase focus on quality of care issues and comprehensive longitudinal care for women veterans, additional initiatives in FY 2008 are focused on comprehensive care of women, including those conditions which have high mortality for women, such as heart disease, obesity, and cancers such as lung cancer and colorectal cancer. HVAC, Subcommittees on Health and DAMA, 7–12–07, Questions for the Record, McClenney

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Lucretia McClenney
Director, Center for Minority Veterans
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Lucretia:

In reference to our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Hon. Michael H. Michaud, Chairman
Subcommittee on Health, House Committee on Veterans' Affairs
July 12, 2007
"Issues Facing Women and Minority Veterans"

Question 1: In your testimony you indicate that the Minority Veterans Program Coordinators' annual report has been converted to a quarterly web based report.

Question 1(a): Could you elaborate on what measures are taken once your Center identifies opportunities for improvement?

Response: The Center for Minority Veterans (CMV) meets on a monthly basis with senior Department of Veterans Affairs (VA) officials and program offices to identify opportunities for improvement, to develop strategies, and to track progress. The Director of CMV meets monthly with the Deputy Secretary and provides updates on the status of these opportunities.

Question 1(b): What type of support do the coordinators get at the local level from the director's of the facilities?

Response: The directors of the health care facility, regional office and national cemetery are responsible to ensure that MVPCs have the necessary resources to be effective and efficient to perform the functions needed (e.g., numbers of hours allocated to perform the duties, computer access/email, and funding for projects and/or special programs as required). In addition, each administration has a designated MVPC liaison at VA central office. CMV staff meets monthly with these liaisons and quarterly with the senior leadership of each administration to discuss outreach activities, issues and concerns that impact minority veterans.

Question 1(c): Are these full time positions?

Response: As of September 2007, 5 minority veterans program coordinators are full time positions. The majority are part time or collateral duties.

Question 2: You mention that the Center provides cultural competency training to the field.

Question 2(a): How comprehensive is the training and is it hands on or remote training as in web based?

Response: CMV provides training to the minority veterans program coordinators by 2 primary means:

- Biennial Training Conference—Every 2 years, CMV sponsors a minority veterans program coordinator training conference. During these conferences attendees are provided instruction on various topics of interest to support their local programs. Cultural competencies are one of the subject areas covered. After the recent 2007 conference, slides from the cultural competencies presen-

tation were posted on the VA Employee Education Service (EES) website for use by minority veteran program coordinators who were not able to attend the conference.
- Monthly Conference Calls—Cultural competencies have been a training topic during monthly conference calls with minority veterans program coordinators.

Question 3: Outreach to minority veterans can be particularly challenging given the differences in cultures. There are many ways to conduct outreach, but to conduct effective outreach is critical. How does the center measure its success in reaching minority veterans through the various partnerships and programs that you have?

Response: CMV measures its success in reaching minority veterans by tracking the number of veterans calling or writing directly for assistance, participation at outreach activities, and partnerships that have been established with external stakeholders.

Question 4: What do you believe is the biggest challenge facing minority veterans today?

Response: Minority veterans experience many of the same challenges that all veterans experience. However, minority veterans have experienced and often experience racial/ethnic discrimination or lack of cultural sensitivity more often than non-minority veterans. Minority veterans are more likely to be effected by chronic diseases, disparities in health care, homelessness, and unemployment. HVAC, Subcommittees on Health and DAMA, 7–12–07, Questions for the Record, Middleton

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Shannon L. Middleton
Deputy Director, Veterans Affairs and Rehabilitation Division
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Shannon:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, and our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Joint Subcommittee Hearing
Issues Facing Women and Minority Veterans
Held on
July 12, 2007, 10:00 a. m.
Follow-Up Questions for Shannon L. Middleton

1. In testimony provided, DAV gives 8 recommendations to better serve women veterans from combat theaters. The first recommendation concerns barriers to seeking health care through VA.

- **In your estimation, what are the 3 biggest barriers female veterans encounter when trying to access health care through VA?**

The 3 biggest barriers female veterans encounter when trying to access health care through VA are: lack of knowledge about VHA services, not knowing that they

may be eligible for health care benefits, and the perception that VA only caters to male veterans.

2. Women and minority OEF/OIF veterans returning from theater face, what I believe, are additional challenges than their returning peers, due, in part, to the lack of cultural education, lack of adequate research on meeting their unmet needs and other issues.

- **What has your organization done to help in the outreach efforts?**

The American Legion publishes a booklet entitled Guide for Women Veterans that provides information about VA health care, services provided by The American Legion, information about health issues (like breast cancer, PTSD, sexual trauma, heart disease, drug and alcohol addiction) and a list of resources to enable them to find information about various issues. We disseminate them through our department service officers, outreach events, on our website and make them available upon request to the public.

In the past, The American Legion has participated in a homeless female veteran workgroup for the Southeast Veterans Service Center and served on Subcommittees for the 2004 Women Veterans Summit hosted by the Department of Veterans Affairs.

The American Legion is currently planning to collaborate with the Center for Women Veterans to organize a Women Veterans' Forum to be held in conjunction with the organization's mid-winter conference. The American Legion is also participating in the 2008 Women Veteran's Summit.

We are constantly seeking new ways to bring information to veterans, all veterans.

- **Does your organization have any recommendations as to how to address the growing need for specialized services for both women and minority veterans?**

One effective way to ascertain the need for specialized services is to find various ways to ask women and minority veterans what needs they have that are not being met by current services. This can be patient survey, or an outreach initiative that includes a survey that VA disseminates by mail or via web. The information gathered would be useful in determining system-wide need for specific programs or services and may be useful in depicting geographical or population trends for needed services.

Once these needs are identified, The American Legion recommends that VA develop and implement policy to address these deficiencies in a timely manner and conduct an extensive outreach campaign to make these special populations—and those who serve them—aware of the enhancements. The organization also recommends that Congress appropriate adequate funding to maintain these enhancements, once they are in place.

Finally, DAV's recommendations that VA and DoD collaborate to conduct surveys of recently discharged active duty women and recently demobilized female Reserve component members to assess the barriers that they perceive or have experienced in seeking health care through VA and that VA Medical Centers establish a consumer council that includes veterans' service organizations, family members, and veterans—especially OEF/OIF veterans—would be excellent approaches as well.