

**ELIMINATING THE GAPS:
EXAMINING WOMEN VETERANS' ISSUES**

JOINT HEARING
BEFORE THE
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS
AND THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
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**ELIMINATING THE GAPS:
EXAMINING WOMEN VETERANS' ISSUES**

THURSDAY, JULY 16, 2009

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

The Subcommittees met, pursuant to notice, at 10:01 a.m., in Room 334, Cannon House Office Building, Hon. John Hall [Chairman of the Subcommittee on Disability Assistance and Memorial Affairs] presiding.

Present for Subcommittee on Disability Assistance and Memorial Affairs: Representatives Hall, Rodriguez, and Lamborn.

Present for Subcommittee on Health: Representatives Brown of Florida, Teague, and Boozman.

OPENING STATEMENT OF CHAIRMAN HALL

Mr. HALL. Good morning, ladies and gentlemen. The Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs and the Subcommittee on Health joint hearing, Eliminating the Gaps: Examining Women Veterans' Issues; will now come to order.

I am grateful to have the opportunity to Chair or Co-Chair, as the case may be, the hearing today and would start by asking you to rise for the Pledge of Allegiance.

[Pledge of Allegiance.]

Mr. HALL. Thank you.

The Ranking Member, Mr. Lamborn, from the Subcommittee on Disability Assistance and Memorial Affairs is here. We are awaiting the arrival of hopefully our triple booked Chairman of the Subcommittee on Health, Mr. Michaud, but we will go ahead and get things underway.

I am particularly eager to recognize the women veterans in this room today and to be enlightened by their experiences with the U.S. Department of Veterans Affairs (VA).

VA owes them the proper benefits and care just like their male counterparts. They are a unique population since they comprise only 1.8 million of the 23.4 million veterans nationwide and deserve specialized attention.

So VA's mission to care for them must not only be achieved, but also monitored and supported as well. Sadly that is not always the case.

In response to reports of disparities during the 110th Congress, the Disability Assistance and Memorial Affairs and Health Subcommittees held a joint hearing on women and minority veterans.

This Congress, the 111th, too, has been very active in its oversight activities to assist women veterans and a record number of them have testified at various hearings.

Additionally, on May 20th, full Committee Chairman Filner hosted a special roundtable discussion with women veterans from all eras who were able to paint a picture of military life as a female in uniform and then as a disabled veteran entering the VA system.

In many cases, they have served alongside their male counterparts, but have not had the same recognition or treatment.

Chairman Filner also hosted a viewing and discussion session with the Team Lioness Members who were on search operations and engaged in firefights. But, since there is no citation or medal for this combat service, their claims are not always recognized by the VA as valid, and, so they are denied compensation.

The Disability Assistance and Memorial Affairs Subcommittee has all too often received reports about destroyed, lost, and unassociated records that either never make it from the U.S. Department of Defense (DoD) to the VA or the VA loses them once they are in its possession.

Therefore, it is no surprise that women veterans are at a greater disadvantage since their military assignments and records are less likely to reflect their actual service, their exposure to combat, or other traumatic events.

Also, women who have suffered the harm of military sexual trauma (MST) often do not report those crimes; therefore, they have limited documentation that can be used as evidence when they seek VA assistance. This often results in a denial of benefits.

Even when they do report incidents of harassment or assault, perpetrator conviction rates are only 5 percent. These reports are seen as unsubstantiated.

This result is especially unfair given that 78 percent of female servicemembers report some form of sexual harassment according to a DoD survey.

Studies have shown that for generations, women veterans have been less likely than men to be granted service connection for their post-traumatic stress disorder (PTSD) even though data shows that women are more likely to report symptoms and to seek treatment.

Also, I fear that when the 5 years of open enrollment afforded to current conflict veterans ends, then these women will be denied treatment as they will no longer qualify for health care since they are not service-connected.

Without service-connection, they are not eligible for other VA assistance, such as vocational rehabilitation and employment services or housing, their problems do not get better, they get worse.

Congress cannot allow that to happen to our Nation's daughters who have served. VA needs to ensure that their claims for disability benefits are fairly and judiciously heard. Women veterans

should be able to request female compensation and pension (C&P) service officers, adjudicators, and examiners if they so desire.

VA employees should be properly trained to be sensitive to the injuries and illnesses women veterans claim and to treat them with the dignity and the respect that they deserve.

VA should collect gender-specific data and conduct research on the disabilities that specifically afflict female veterans. VA outreach efforts should target women of all ages, ethnicities, and communities. They must know that they are indeed veterans and deserve the same benefits, services, and burial rights as their brothers in arms are afforded.

The future of the military will be more reliant on the selfless service and the sacrifices of this Nation's daughters, mothers, and sisters. Coming home must be free of abuse, disparity, and inequality so that transitioning female servicemembers can continue to be productive employees and community leaders while maintaining healthy lifestyles and raising families.

I look forward to hearing from the esteemed panels of witnesses assembled today as we attempt to eliminate any gaps hindering access to benefits and to care for our women veterans.

I yield to Ranking Member Lamborn for his opening statement.
[The prepared statement of Chairman Hall appears on p. 58.]

OPENING STATEMENT OF HON. DOUG LAMBORN

Mr. LAMBORN. Thank you, Mr. Chairman.

I welcome our witnesses to this hearing to discuss challenges facing women veterans. I appreciate your contributions to this discussion and hope they will lead to improvements that we can all agree on.

Without question, America's women, are and always have been, an integral part of our Nation's defense. In more than two centuries of service to our country, women servicemembers have produced an honorable legacy. This legacy has only been enriched by the intrepid and resolute accomplishments of today's women in the Global War on Terror. Women make up nearly 10 percent of our Nation's 24 million living veterans and those serving on active duty represent more than 15 percent of our Armed Forces.

Our challenge is to ensure that women veterans, and indeed all veterans, received world-class health care and benefits for their service to our Nation.

The VA Centers for Women Veterans and the Departments' 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 seek their input to effect policy and to help bring about the intended results.

In that regard, I look forward to hearing about the challenges facing women such as gender-specific health care, PTSD, and military sexual trauma.

I thank the witnesses for their testimony and I yield back.

[The prepared statement of Congressman Lamborn appears on p. 59.]

Mr. HALL. Thank you, Mr. Lamborn.

Mr. Teague, would you like to make an opening statement? Welcome, by the way.

OPENING STATEMENT OF HON. HARRY TEAGUE

Mr. TEAGUE. Yes. Thank you. Mr. Chairman, Ranking Member, I would. I will be brief in my statement so that we can get on to business.

But I think that everybody has had enough of us talking about this issue and we need to hear from the experts and let them tell us what the problems are and what we need to do to ensure that all female veterans get a chance to get the help that they deserve and the benefits that they have earned.

I would like to thank all of the panelists for coming forward today and testifying. To all the women who have served in our Armed Forces, let me say thank you for your service. You have defended our Nation with honor and dignity and the work that you are doing now, the fight you are engaged in now on behalf of all of your compatriots is to be commended.

Once again, it seems that we as a government are falling short. I think that most of us on this Committee are frankly quite shocked at some of the stories and incidents that we have heard over the past few months during hearings on different legislation and the roundtable that Chairman Filner hosted earlier this year.

It seems that far too many gaps exist and too many obstacles have been erected that keep women from getting the care that they need and deserve.

Basic information that should be gathered by the VA is not being processed and far too many instances when we try to find new ways to fix these problems and close the gender disparity that exists, we cannot create a solution because we do not have the basic statistics that would tell us what we need.

I am afraid to say that from the looks of things, the answer that we would get when we ask for information would be a simple we do not know. That is just unacceptable to me and I would say that it is unacceptable to the Members of this Committee. And that is what leads us here today.

I want all of you to know that your statements and your recommendations are not falling on deaf ears. I hear you. This Committee hears you and we will do what we can to make sure that the entire country and our VA hears you and your concerns.

All veterans deserve to get the treatment we promised regardless of their gender. If there are barriers to accessing that care, then we will just have to knock them down one at a time. So let us get started.

Thank you, Mr. Chairman.

Mr. HALL. Thank you, Mr. Teague.

I will remind the panelists that your complete written statements have been made a part of this hearing record. Please limit your remarks, if you can, so that we may have sufficient time to follow up with questions once everyone has had the opportunity to testify.

On our first panel is Ms. Joy J. Ilem, Deputy National Legislative Director for the Disabled American Veterans (DAV); Ms. Anuradha P. Bhagwati, Executive Director for Service Women's Ac-

tion Network (SWAN); Ms. Dawn Halfaker, Vice President on the Board of Directors for the Wounded Warrior Project (WWP); Ms. Delilah Washburn, President of the National Association of State Women Veterans Coordinators, Inc., and Houston Regional Director for the Texas Veterans Commission; and Ms. Kayla M. Williams, MA, Member, Board of Directors, Grace After Fire, Author, *Love My Rifle More Than You: Young and Female in the U.S. Army*.

Welcome to all of our panelists, and we will start with Ms. Ilem or Ilem?

Ms. ILEM. Ilem.

Mr. HALL. Ms. Ilem, you are now recognized for 5 minutes.

STATEMENTS OF JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; ANURADHA P. BHAGWATI, MPP, EXECUTIVE DIRECTOR, SERVICE WOMEN'S ACTION NETWORK; DAWN HALFAKER, VICE PRESIDENT, BOARD OF DIRECTORS, WOUNDED WARRIOR PROJECT; FIRST SERGEANT DELILAH WASHBURN, USAF (RET.), PRESIDENT, NATIONAL ASSOCIATION OF STATE WOMEN VETERANS COORDINATORS, INC., AND HOUSTON REGIONAL DIRECTOR, TEXAS VETERANS COMMISSION; AND KAYLA M. WILLIAMS, MA, MEMBER, BOARD OF DIRECTORS, GRACE AFTER FIRE, AND AUTHOR, *LOVE MY RIFLE MORE THAN YOU: YOUNG AND FEMALE IN THE U.S. ARMY*

STATEMENT OF JOY J. ILEM

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

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

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

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

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

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

It plans to achieve these goals through a number of key policy recommendations and if implemented, these reforms will change the face of VA health care for women veterans in the VA health care system and in turn greatly improve the health of women.

This ground-breaking report represents progress. However, we question if the women's health program directors have the resources to build adequate infrastructure and program capacity and the internal support necessary at the highest levels to make the reforms it says are necessary.

Without question, this is a major undertaking for VA, but we are hopeful with the attention, oversight, and collaboration of the Health Subcommittee that an implementation plan can be expeditiously carried out.

Identifying and eliminating gaps that exist for women in VA disability benefits is also critical to DAV. Although certainly not exclusive to women, military sexual trauma and compensation claims for related conditions continue to affect many women veterans.

Unfortunately, if a sexual assault is not officially reported during military service, establishing service connection for a related condition is very challenging.

According to an Institute of Medicine (IOM) report on PTSD compensation, significant barriers prevent women veterans from being able to substantiate their experiences of MST, especially in combat arenas.

An area of special concern for DAV relates to collaboration between the DoD Sexual Assault Prevention Response Office or SAPRO and the Veterans Benefits Administration (VBA). Current DoD policy allows servicemembers to file restricted or unrestricted reports of sexual assault.

In the case of a restricted report, the servicemember opts to not initiate an investigation but does have the right to have an official record of the incident filed, a medical examination conducted, and access to medical and mental health treatment as necessary.

Obviously these records are critical to substantiating a claim for disability compensation from the VBA if the veteran has a chronic disability related to the MST and chooses to file a claim following military service.

DAV is concerned that VBA policy manuals lack reference to SAPRO or how to obtain documentation from restricted DoD MST reports. We ask the Disability Assistance Subcommittee to work with VBA to confirm their collaboration with DoD on this issue.

Women veterans also report difficulty in verifying special assignments during military service outside their established military occupational specialty that exposed them to combat. As you noted, the prime example are the women Lioness Team Members, many of whom have had difficulty verifying combat stressors associated with their claims for PTSD due to lack of documentation in their military records or on discharge forms.

Women veterans report that lack of understanding on behalf of Veterans Health Administration (VHA) and VBA staff about the changing nature of modern warfare and women's roles in the military further complicate these matters.

Although there has been increasing attention paid to the impact of military service on women, it is clear that a number of gender disparities exist for women in accessing VA benefits and services. Therefore, we appreciate the attention to these issues and hope the Subcommittees will consider other gaps that may exist beyond the limited number we have brought forth in our statement today.

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

[The prepared statement of Ms. Ilem appears on p. 59.]

Mr. HALL. Thank you, Ms. Ilem.

Ms. Bhagwati, you are recognized for 5 minutes.

STATEMENT OF ANURADHA P. BHAGWATI, MPP

Ms. BHAGWATI. Good morning, Mr. Chairman and Members of the Committee. My name is Anuradha Bhagwati and I am a former Captain in the United States Marine Corps.

I currently serve as Executive Director of the Service Women's Action Network, SWAN, a nonpartisan, nonprofit organization founded by female veterans based out of New York City. SWAN specializes in policy analysis, advocacy, and legal services for all servicewomen and women veterans and their families.

Despite the progress that the VA has made in addressing the recent influx of women veterans into the VA system, the delivery of health care and the awarding of disability ratings to women veterans remains grossly inadequate.

Every day SWAN receives calls from women veterans of all eras and ages whose experiences at VA hospitals or with the VA claims system has led them to give up not just on the VA, but also on life.

Mistreatment by the VA is enough reason for many traumatized women veterans to fall through the cracks and end up victims of drug and alcohol abuse, unemployment, homelessness, or suicide.

Women veterans who have already been mistreated by the military are often doubly traumatized by harassment or mistreatment at VA facilities.

Knowledge about the epidemic of military sexual trauma, MST, sexual harassment, assault, and rape, which is yet to be fully recognized by the Armed Forces, has also yet to be adequately integrated into the daily operations of VA hospitals and the awarding of VA compensation to both male and female veterans.

MST screening at hospitals around the Nation appears to be inconsistent at best. A shortage of female physicians and counselors, a rapid turnover of inexperienced residents, a preponderance of culturally conservative administrative staff, and poorly trained, apathetic, or unprofessional medical staff contributes to a lack of understanding about how to treat veterans who suffer from symptoms related to MST.

However, I must emphasize that regardless of medical condition, women veterans when compared to their male counterparts, are largely subjected to unequal treatment at VA facilities nationwide.

The following anecdotes illustrate just a few of the VA's institutional failures to deliver proper health care to women veterans.

One Iraq veteran who checked herself in to inpatient psychiatric care during a particularly bad PTSD episode was forced to share a bathroom with male veterans, including a peeping Tom. When she told her nurse she felt uncomfortable eating her meals with male veterans, the nurse threatened that she would not be fed at all.

An Afghanistan veteran, a single mother, who was raped in theater by a fellow servicemember cannot bear to enter a VA facility out of sheer terror of retriggering the trauma from her assault. Like many other women veterans, she pays for counseling out of pocket so as not to subject herself to further trauma.

One veteran recently received her annual PAP smear with a male gynecologist, who did not enforce the requirement to have a female staff Member present during the examination. When this veteran mentioned to the gynecologist that she had experienced MST, he left the room and barked down the hall we have another one.

Many of these examples illustrate a larger point that VHA requires an enormous cultural shift in order to treat female patients with dignity and respect and to acknowledge the specific needs of women veterans.

With respect to benefits, both female and male veterans applying for compensation from the VBA for conditions related to MST face overwhelming odds against being awarded a disability rating. However, the full extent to which women veterans are denied disability compensation has yet to be comprehensively examined.

Veterans with MST often feel that the benefit system is rigged against them as proving that one's stressor occurred in service can be extremely difficult, if not impossible.

The VBA fails to understand that servicemembers rarely feel comfortable or sufficiently safe from harm to report rape, sexual assault, or harassment for two main reasons. Reports of sexual assault and harassment are often simply ignored by commanders military-wide and servicemembers who report sexual assault or harassment are often threatened or punished after reporting.

While DoD's failure to enforce its own sexual assault and equal opportunity (EO) policies are the subject of another hearing, it must be emphasized that unless the climate within the Armed Forces changes such that servicemembers are guaranteed protection and support after reporting sexual assault or EO violations that it is unjust and grossly irresponsible of the VA to expect veterans to provide the current standard of proof for a stressor related to MST.

H.R. 952, entitled the "Combat PTSD Act" introduced by Representative Hall presumes that a combat veteran's PTSD is a result of exposure to a stressor while in theater. I suggest that similar legislation be proposed for veterans who suffer from PTSD or other symptoms of military sexual trauma so that veterans with MST are not punished or traumatized further by the VA.

MST counseling and a physician's diagnosis of MST related medical conditions should be sufficient for VBA to award a disability rating to a veteran.

Recommendations to bring the gaps in care for women veterans: Require that the VA remedy the shortage of female physicians, female mental health providers, and MST counselors at VA hospitals nationwide.

Also, require that VA provide the option of female-only counseling groups for female combat veterans and female as well as male only counseling groups for female and male survivors of MST.

Require VA to implement a program to train, educate, and certify all staff, including administrative and medical, in Federal equal opportunity regulations on MST to reduce the discriminatory and hostile atmosphere toward women veterans.

I am running out of time here, Mr. Chairman, so I have included a few recommendations for the record as well. Thank you.

[The prepared statement of Ms. Bhagwati appears on p. 68.]

Mr. HALL. Thank you, Ms. Bhagwati for your very excellent and moving testimony. We will come back to those remaining points during the question and answer period.

Ms. Halfaker, is that the correct pronunciation?

Ms. HALFAKER. Yes, sir.

Mr. HALL. You are now recognized for 5 minutes.

STATEMENT OF DAWN HALFAKER

Ms. HALFAKER. Thank you.

Mr. Chairman and Members of the Subcommittees, thank you for inviting Wounded Warrior Project to offer our views on eliminating gaps facing women veterans.

Mr. Chairman, I am testifying not only this morning as Vice President of the Wounded Warrior Project but as a retired Army Captain who was severely injured in combat in Baquba, Iraq, in 2004. After that, I spent nearly a year in Walter Reed Army Medical Center and I continue to receive treatment at VA facilities.

It has been my experience that VA hospitals can be imposing. VA hospitals do not offer the level of comfort and security necessary for women like me and female veterans to cope with mental and physical injuries of combat.

With unprecedented numbers of women veterans returning from Iraq and Afghanistan with visible and invisible wounds like me, I would like to focus my remarks on the health-related issues.

Women now make up 11 percent of veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). VA reports that some 44 percent of female OIF and OEF veterans have enrolled with VA and use VA health care from 2 to 10 times.

Women in the military are at significantly higher risk of developing PTSD, depression, and other war-related mental disorders than their male counterparts and are also at higher risk for sexual trauma than their civilian peers.

Sexual assault has long-lasting effects on women's health, particularly mental health. Given the likely prevalence of PTSD and other mental health problems in this population and the health risk of such conditions going untreated, we must focus not on only those who are seeking treatment but also on those who are not.

While women have become one of the fastest-growing VA patient populations, studies indicate that many women veterans are simply not availing themselves of VA care. There are several reasons. Frequent lack of knowledge regarding eligibility for VA care, widespread perceptions that pursuing VA care would be stigmatizing, and concern regarding hassles and quality of VA care.

We certainly cannot assume that those who are forgoing VA care have no health issues. To the contrary, given the prevalence and unique impact of PTSD among those who deployed to Iraq and Afghanistan, we see a need for greater focus on the mental health of all returning warriors.

And given the high rates of military sexual trauma among those who are deployed, it is particularly important that the VA reach out to returning women veterans.

VA certainly has attempted to increase its outreach to new veterans, but no single step is likely to change the perception of those who, for example, view VA as a system for older males or have concerns about the quality of VA care and their own safety and security at the facilities.

The bottom line is that VA should take an aggressive approach to eliminating barriers that deter returning women veterans from pursuing the help that they need.

Specifically we propose that Congress direct VA to employ, train, and deploy women OEF/OIF veterans to conduct outreach to their peers to include one-on-one outreach to address negative perception and to build trust.

Clearly VA also faces difficult systemic problems in bridging the gaps in care and services for women veterans. Among them is the wide variability women veterans encounter in care at VA facilities.

As documented in a 2007 survey, VA facilities have adopted a variety of clinic models for providing primary health care to women veterans. Those facilities also reflect significant variability in whether specialized women's health service such as mammography are available on site or only through contract arrangements.

Ongoing research should help determine how best to structure VA care delivery for women's health to achieve quality of care and patient satisfaction. But difficulty in determining what are optimal models for delivering that care should not stand in the way of setting sound policy on clear-cut health delivery issues.

To illustrate, VA has failed to take a firm position on the question of providing access to female mental health professionals where there is a history of sexual trauma. The VA directive that sets minimum clinical requirements for providing mental health care states only that facilities are strongly encouraged, when clinically indicated, to give veterans being treated for military sexual trauma the option of being assigned a same sex mental health provider.

This extraordinarily sensitive subject is not one which VA should provide encouragement. Rather, VA should require that a woman veteran who has experienced sexual trauma have access to a female health professional on request.

While access to needed care for women veterans has improved markedly in the last decade, the overwhelming majority of VA's patients are men. Many VA providers have limited exposure to

women patients, but VA facilities do appear to be working to adapt to the changing demographics of our Armed Forces.

The Department and its facilities must continue to take steps to accommodate women veterans from modifying delivery systems to ensuring that they meet privacy expectations, but they must be cognizant of the still widespread perceptions that VA facilities are geared only toward male patients and that some Department clinicians lack sensitivity to women's issues. Addressing those concerns is an issue of leadership that will become ever more important if the VA is going to win trust of this new generation of women veterans.

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

[The prepared statement of Ms. Halfaker appears on p. 70.]

Mr. HALL. Thank you, Ms. Halfaker.

Ms. Washburn, you are recognized for a 5-minute statement.

**STATEMENT OF FIRST SERGEANT DELILAH WASHBURN,
USAF (RET.)**

Sergeant WASHBURN. Mr. Chairman and distinguished Members of the Subcommittees, on behalf of the National Association of State Women Veterans Coordinators, I am honored to have this opportunity to testify this morning and to present the views of the State Women Veteran Coordinators of all 50 States.

The primary barriers women veterans face in accessing the VA health care across the country are lack of reliable transportation, unavailability of child care, lack of an integrated primary care and mental health care, lack of gender sensitivity of health care providers and staff to women-specific issues, limited hours of women veterans' clinics, women veterans' clinics that are difficult to locate or are not perceived as personally safe and comfortable for women veterans and their children, and unsafe inpatient VA health facilities for women veterans.

And we are happy to expound on any of these barriers at the conclusion of my remarks.

We found that the VA medical centers (MCs) do not consistently assess and treat domestic violence victims across the country. VA medical providers must be trained to ensure women veterans who are victims of domestic violence are treated to the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations and that State reporting requirements are consistently met to protect these victims.

Mammography is another area that quality care is an accident of geography for women veterans. There is no formal program for tracking mammography results and follow-up of abnormal mammograms to ensure women veterans receive consistent, timely, and high-quality care.

We suspect Congress would be appalled by the differences in timeliness-to-treatment data for abnormal mammograms at VA medical centers across this Nation.

Because females are officially excluded from combat roles in the military, women veterans have a greater burden of proof in establishing the link between post-traumatic stress disorder and combat. There is no such thing as an infantry woman. So women who are

supply clerks, mechanics and truck drivers are going on combat patrols with the infantry and with the Marines. And because there is no clear front line on the ground in Iraq and Afghanistan, female servicemembers are exposed to direct fire, improvised explosive devices, sniper fire, and constant threats from insurgents without the benefits of the awards and decorations to prove they were in combat.

We wholeheartedly endorse H.R. 952, which would amend Title 38 to presume service connection for post-traumatic stress disorder based solely on a servicemember's presence in a combat zone. The legislation would not only appropriately recognize the service and sacrifice of women veterans, it would significantly decrease the backlog of VA claims for our combat veterans.

Psychiatric conditions related to sexual trauma have a devastating effect on women veterans' health functioning. We are strongly supporting the VA Advisory Committee on Women Veterans' recommendation that the VBA develop the ability to identify and track the status and outcome of all claims related to sexual assault.

VBA cannot currently speak with any authority as to the number of military sexual trauma-related claims submitted annually, the processing times for these claims, the rate of compensation that is granted or denied, or the types of disabilities that are most often associated with MST.

There are insufficient therapists licensed and experienced in counseling sexual trauma victims in the VA system to provide appropriate care for women veterans.

Additionally, many women are not comfortable with male therapists or mixed-gender therapeutic groups. Women veterans should have the option to use fee-based or contract services to obtain mental health care if a qualified MST counselor is not available or if a woman provider and/or women's groups are not available.

Many women veterans still lack information and awareness of benefits. The VA and the State Department of Veterans Affairs must reduce this inequity by reaching out to women veterans regarding their rights and entitlements.

We suggest implementation of a grant program that would allow the VA to partner with the State Women Veteran Coordinators to perform outreach specifically targeted to women veterans at the local level.

Finally, we strongly recommend a plot allowance for veterans' interment be increased to a thousand dollars in order to offset operational costs to State Veterans Cemeteries. The current burial plot allowance of \$300 per qualified interment provides less than 15 percent of the average cost of interment.

In conclusion, Chairman and distinguished Members of the Subcommittee, we respect the important work that you are doing to provide support and services to women veterans who answered the call to serve our country.

The National Association of State Women Veteran Coordinators remains dedicated to doing our part, but we urge you to be mindful of the increasing financial challenge States face. As you address the fiscal challenge at the Federal level, we ask that you keep this mindful.

This concludes my statement and we are happy to answer any questions.

[The prepared statement of Sergeant Washburn appears on p. 73.]

Mr. HALL. Thank you, Ms. Washburn.

Ms. Williams, you are now recognized for 5 minutes.

STATEMENT OF KAYLA M. WILLIAMS, MA

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

My name is Kayla Williams. I am on the Board of Directors of Grace After Fire, a nonprofit dedicated to helping women veterans.

As a soldier with the 101st Airborne Division, I spent a year in Iraq serving alongside my male peers. With our flak vests on, we were all soldiers first.

However, it was clear on our return that people did not understand what military women experience. I was asked both whether I was allowed to carry a gun and if I was in the infantry. This confusion extends beyond the general public. Women veterans are less likely to self-identify as veterans, which is the first barrier to accessing benefits. You must be aware that you are eligible for them.

An active outreach program for those leaving military service is necessary but insufficient. Women who served in previous eras must also be made aware of their eligibility for veterans' benefits and health care through vigorous outreach and education.

There are a number of challenges for women seeking or using VA benefits or health care. Some of the same impact on male and female veterans and others disproportionately affect women. Here are some that I consider particularly important.

Women who are supposedly barred from combat may face challenges proving to VA employees who are unclear about the nature of modern warfare that their PTSD is service connected. It is, therefore, vital that all VA providers and particularly health care providers fully understand that women do see combat in OEF and OIF so that they can better serve women veterans.

The transition from DoD to VA remains imperfect. As you mentioned, Mr. Chairman, lost records and missing paperwork are frequent complaints. Electronic medical records are absolutely imperative.

The backlog of unprocessed disability claims is now over 400,000. Though average processing time has declined, it is still too long.

My husband, a disabled veteran, had to go on unemployment while waiting for his VA disability benefits to go through, a humiliating experience for a combat-wounded warrior.

Adequate training of claims processors is also vital. Inconsistencies in disability ratings have resulted in thousands of dollars in annual payment differences between regions for veterans with similar disabilities.

The Post-9/11 GI Bill, a significant improvement in education benefits that will allow many thousands of veterans the chance to attain first-rate education, also has several gaps.

For example, time that National Guard Members have spent while activated under Title 32 does not count toward Post-9/11 GI Bill eligibility. A legislative fix is required to repair this inequity.

In addition, while time and brick and mortar schools may be best for both veterans and their peers, those who are struggling to raise small children who are more likely to be women or those coping with PTSD may face significant barriers getting into classrooms. Full benefits, including the housing allowance, should be provided to veterans pursuing their educations online.

Raising the amount of tuition assistance for veterans attending private schools on only the tuition at State schools hurts those who attend private schools in States like California which charges only fees at State schools. The calculation should be based on both tuition and fees at State schools.

Astonishingly, the housing stipend for disabled veterans in this area is less than half of what it would be for those using the Post-9/11 GI Bill if they choose to use vocational rehab. I find that absolutely outrageous. Don't our injured heroes deserve the same housing allowance that I would receive?

Finally, due to the complicated provisions of the Post-9/11 GI Bill, I believe that the decision to switch to it from the Montgomery GI Bill should be reversible for 1 year and not permanent as it is currently.

Women who are more likely to be the primary caregivers of small children may require help getting that child care in order to attend appointments at the VA. Currently, VA facilities are not always prepared to accommodate the presence of children. Veterans have to change babies' diapers on the floors of some VA hospitals because restrooms lack even the most basic changing facilities.

A friend of mine whose babysitter canceled at the last minute and brought her infant and toddler to a VA appointment was told by her provider that that was not appropriate and she should not bother to come in if she could not find child care.

Facilities in which to nurse and change babies, increased use of telehealth programs, child care assistance, or at least patience with exigent circumstances would ease burdens on all veterans with small children.

Veterans have made up a disproportionate percentage of the homeless population for some time. Although VA has initiatives to try to help homeless veterans, they are insufficient. In addition, although the number of homeless women veterans has begun to rise dramatically, VA programs to serve this population and especially those with children are wholly inadequate. Changes are urgently required to better meet the needs of this population.

Women in the military are also far more likely to be married to other servicemembers than their male counterparts. These women veterans must worry not only about their own readjustments but also their husbands' challenges. The VA must consider this dual role that women veterans may be balancing as both the givers and seekers of care. And legislators should back bills providing increased support to caregivers of wounded warriors.

In order to best meet the needs of all veterans, I urge the development of enhanced relationships not only between the DoD and the VA but also with those community organizations that stand

ready and willing to fill gaps in services. Public/private partnerships can allow all of us to come together to meet the needs of our veterans in innovative and exciting ways.

Thank you for your attention.

[The prepared statement of Ms. Williams appears on p. 76.]

Mr. HALL. Thank you, Ms. Williams.

I just wanted to mention, counsel has reminded me to tell you that the full House Veterans' Affairs Committee just passed H.R. 3155, the Caregivers Assistance Bill, out of the full Committee to the floor of the House. So that bill is moving.

Thank you, all of you, for your testimony, for your service to our country and to our veterans.

I would start with Ms. Ilem and ask when the DAV trains its service officers, does it provide special sensitivity training on issues pertinent to female veterans, for instance, MST?

Ms. ILEM. Yes. As far as I am aware within our service program, I mean, there is definitely discussion of MST claims. We have a number of women national service officers (NSOs) around the country, but it is provided to all of our NSOs, information about VA's, you know, manuals and regulations looking for different evidence to help them support their claims and different ways that they can help—

Mr. HALL. How many of your service officers are female? Can they assist in developing claims even if the veteran is from another State?

Ms. ILEM. Yes. Our NSOs can provide services to anyone. I think of our NSO Corps of about 260, I would have to look at the exact number, but I think there is a range of about 30 now. There has been a number of recent new hires of women veterans, especially from OEF/OIF populations.

Mr. HALL. During the time that the DAV has been working with VA on these issues relating to women veterans, what is your observation on how well VA has responded to the concerns you have raised and how successfully are they addressing those issues?

Ms. ILEM. I think I mentioned in my testimony one of the concerns I have had, I have been reaching out to VBA for some time, and we would appreciate the Subcommittee's assistance just to verify especially on the SAPRO/DoD, the DoD Sexual Assault Response and Prevention Office. Looking at their policy issues, it appears that, you know, there is some problem that they may have in being able to release those records even with the—for restricted reports of military sexual assault even with the consent of the veteran. And so trying to work with VBA staff just to try and see if they are collaborating with them to work through some of these barriers and to make sure that their claims developers are aware of the SAPRO policies and where in each of the military services these records are kept and for how long and can VA with the consent of the veteran get access to those reports which can include a physical examination as well as mental health and counseling treatment.

So we think those records are critical and we would ask that the Subcommittee try and work to see if VA does, in fact, collaborate with SAPRO on those policies.

Mr. HALL. Thank you.

And, Ms. Bhagwati, is the lack of legal representation more detrimental to women when their claims are the result of a crime?

Ms. BHAGWATI. I am sorry. The lack of legal work?

Mr. HALL. Legal representation.

Ms. BHAGWATI. Absolutely, sir. I am finding that without the assistance of an attorney, many of those legal claims would just be left behind. It takes a lot of courage, stamina, financial assistance for a veteran, either male or female, to pursue and appeal reconsideration of a claim.

A lot of pride and a lot of issues wrapped around a veteran's identity go into the claims process. And when a claim is rejected by the VA, even when the claim is deemed to be sort of sufficient to get an awarding of compensation, when that denial happens, it can be life shattering. And many veterans, both male and female, just fall off the map.

Mr. HALL. I understand more all the time as we have these hearings about the issues surrounding reporting problems with MST, but what about domestic violence that takes place while the wife is on active duty? How are those instances of PTSD or other disabilities resulting from those injuries adjudicated by the VA?

Ms. BHAGWATI. Sir, that remains to be seen. I mean, I think a lot of data, as both the Congressman and Ms. Halfaker pointed out, has not been collected on domestic violence in particular.

Right now I can tell you anecdotally. We are working on a case in the Marine Corps with a non-commissioned officer (NCO) who is going through a commissioning program whose partner spent 5 days in jail for attempting to kill her. And that partner who spent 5 days in jail is now in Officer Candidate School. So that shock factor, I mean, it is almost unbelievable that that could happen. But there are ways around the system and DoD needs to explore that.

Mr. HALL. Unfortunately, there are ways around the system, not just for men who assault women, but also for men who assault men. There is one case in particular that I am familiar with in my district. But it is more egregious and harder to rectify when it is an attack on a female soldier.

Ms. Halfaker, for the more seriously injured female veteran, is there an outreach effort made directly to them? Are there OEF/OIF coordinators trained to specifically interact with them regarding their needs?

Ms. HALFAKER. Sir, I think there are much needed outreach programs. I do not think there is anything specifically targeted for women veterans. And I think that that is where you get a lot of women initially slipping through the cracks, especially with the Guard/Reserve component.

And I also believe that, you know, peer support is probably a good way to start advocating. It has been the Wounded Warrior Project's experience that women, and particularly this generation, of veterans are much more responsive and receptive to kind of learning about programs and things like that through their peer network. So I think that the VA needs to explore ways to promote outreach using peer networks and things like that.

As far as the OEF/OIF coordinators at the hospitals, I mean, it was my experience that there is a lot of inconsistency and variability. The VA facility that I go to, the model just to have any kind

of coordinator was stood up incredibly late and it is my sense that the coordinators could use a lot more education on the specific programs and clinical care that women need and how women can best access that care.

Mr. HALL. Thank you.

Ms. Washburn, your suggestion to track MST data has been made by the Center for Women Veterans and its Advisory Committee but has not yet been implemented by the VBA.

How effective do you think the Center and the Committee are in promoting these issues and acting as change agents on behalf of the women they represent?

Sergeant WASHBURN. I believe those things that are imposed by Congress get done. I believe those recommendations sometimes do not.

Mr. HALL. Can you provide us with any more information on the training protocol that the State Women Veterans Coordinators receive in order to assist veterans in filing claims. Second, what outreach activities do your women coordinators perform?

Sergeant WASHBURN. Most of our women veteran coordinators are also State service officers and are also accredited with other service organizations such as the American Legion, Veterans of Foreign War, Military Order of Purple Heart. So we hold more than just one military organization credential.

So whenever we have the opportunity to counsel with our veterans, whether it is male or female, we have to maintain the accreditation that the Department of Veterans Affairs mandates for service officers. So we have annual training. We have testing and we are proficient at doing those jobs as service officers.

And in most cases, with the new training force that we see in the regional offices with all the new employees that have been hired, most of our service organizations and veteran coordinators are more knowledgeable than the new VA employees.

So we are doing the very best job that we can do to help train up some of the new VA employees by pointing out things that they have missed in the letter of the law that says that they can grant benefits.

So we are doing our very best job as service officers to continue to not only help them through the maze, the bureaucratic maze of getting their VA claims processed.

Mr. HALL. Thank you.

Ms. Williams, I am going to ask you this question and then ask each of the other panelists quickly, because my time is long expired here, quickly give me an answer.

If VA and the DoD could do one thing to better assist women veterans, what would that be?

Ms. WILLIAMS. I believe that electronic medical records are absolutely imperative to prevent problems with lost paperwork and missing files, missing records, and that that would really help smooth the transition from the DoD to the VA.

Mr. HALL. Ms. Washburn?

Sergeant WASHBURN. Yes, sir.

Mr. HALL. Ms. Washburn. I am just asking for an answer to that same question just quick if you could.

Sergeant WASHBURN. The one thing that I think that they could do immediately that will make a difference, and not just for gender-specific issues we are talking about, we no longer have to worry about providing the stressor for post-traumatic stress disorder.

If you are in combat, it is conceded and let us press on with getting a diagnosis and rate those claims and get them off the table because the near million claims that are pending is just something that we cannot continue to live with. It is a barrier to veterans getting their benefits.

Mr. HALL. Thank you for the wonderful endorsement of my bill, H.R. 952.

Ms. HALFAKER. Outreach.

Mr. HALL. Ms. Bhagwati?

Ms. BHAGWATI. The one thing—

Mr. HALL. Microphone, please.

Ms. BHAGWATI. Sorry, sir. One thing on the DoD side would be enforcement of EO policy and sexual assault policy. On the VA side, it would be education and training of claims officers about what it is like to be a woman in uniform.

Ms. ILEM. I think just true collaboration on all levels within VHA and VBA would be really extremely important. There are just so many areas where they can benefit working together to really solve the problem. It just cannot be done piecemeal and it helps to work on the preventative side with DoD and during that transition period for women coming to VA.

Mr. HALL. Thank you.

If our Members from the Disability Assistance Subcommittee would not object, I would go to our only Member of the Health Subcommittee who is here, Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman, and thank you for holding this hearing.

I am going to be very brief. In the early nineties, I called for the first women veterans' hearings and then we had a roundtable discussion a couple of months ago and it seems as if things have not improved. Part of it is the culture.

If you were making recommendations to VA or to Congress, what would you recommend that we do to change the culture? This question is for all panelists. We can start with Ms. Williams.

Ms. WILLIAMS. That is a great question and I think one that both the Department of Defense and the VA are struggling with every day.

I truly believe that this conflict is going to change the way that women are treated within the military and the VA because young leaders, young soldiers, and servicemembers, they serve alongside women in combat. As they grow in their leadership positions through time, they are used to serving alongside women. They are beginning to recognize that women are servicemembers, too, that they are not just females that happen to show up sometimes.

And that change in attitude will slowly trickle through the rest of the system, but that is going to take a very long time. I do think cultural change can also come from systemic changes.

When I first got out of the military, I went to the VA facility in Washington, DC, which I must admit was an atrocious experience for me. The facility was not clean. I was not given coordinated care

and I had a truly unpleasant experience that scared me away from the VA for many years.

Just last month, I went to the VA facility in Martinsburg, West Virginia, and had a profoundly different experience at their OEF/OIF integrated care clinic. I saw several providers. I was led from one appointment to the other to make sure that I knew where I was going. I was sensitively asked about MST, about my combat experiences. And this model is one that I think is worthy of emulation, though it may not be perfect in every facility.

They also have a women's care clinic. So I know that by putting these facilities in place, staffing them with the right people that proper care can be given.

Ms. BROWN OF FLORIDA. When you first went to the facility, that was when?

Ms. WILLIAMS. I went to the DC VA in 2006 and then I went to the Martinsburg VA just last month.

Ms. BROWN OF FLORIDA. Okay.

Yes, ma'am.

Sergeant WASHBURN. That is an excellent question. There are several points that I would like to share with you.

In today's culture, I can see just from the veterans that talk with us that some of the problems they face are that now we have appointments that come in the mail to us and we are notified of five or six different appointments. They are not on the same day. And these are people that are trying to hold a job down and they just cannot go to all of these appointments.

And then we have child care on top of that. We cannot take off from work, so the hours that they are being seen is an issue. We have children that we have to provide care for because we cannot take them to the VA. We already know that. And those are concerns.

And why can we not do a better job at scheduling? Why can we not provide it during hours that they are available? If it is once a month on a Saturday, why can we not do a women's clinic once a month on a Saturday? If we are doing women's health on a Wednesday, why can we not do that from 12:00 noon to 6:00 p.m. to give them an opportunity to go after work and where there would be someone else to help with children?

So those are some things that we need to look at that I think culturally we have to change.

When we are talking about military sexual trauma, there are so many of the cases that are identified by DoD and where DoD is taking action under the Uniform Code of Military Justice. And we already see that these women are having medical problems, physical as well as mental health issues. And why don't we get them through the medical evaluation process because that is a disability?

And it would help us if DoD would step up and if they have an opportunity to be afforded a Military Evaluation Board or a Physical Evaluation Board, let us get it done because we are finding all too often after we do finally get them through the VA system, we are going back to do correction in the military record.

So DoD could do a better job. If it is an opportunity where they can meet the requirements of a medical evaluation, let us get it done.

Ms. BROWN OF FLORIDA. Those are very good suggestions. I do not know why we cannot do that Saturday or Sunday afternoon and have someone there to take care of the kids. I do not see why we cannot, because you were talking about the waiting list and what did you say it was, the waiting list for women?

Sergeant WASHBURN. We do have appointments that come out through the VA computer system that will oftentimes not consolidate those appointments to get you there on 1 day. And oftentimes we have folks that are coming in from a rural area—

Ms. BROWN OF FLORIDA. Right.

Sergeant WASHBURN [continuing]. That are traveling 100 or 200 miles to the large VA medical center. So that is a hardship. Transportation is a hardship.

Ms. BROWN OF FLORIDA. Right. It is a hardship. Question, do we have any, and I have been thinking about it, do we give any kind of a gas voucher or anything like that?

Sergeant WASHBURN. There are some organizations, whether it is Disabled American Veterans, where they have a transportation program. There are some organizations, Veterans of Foreign Wars, that give vouchers. And oftentimes the VA medical centers have moneys for that as well, but it is not the norm and not everyone knows that they can get help. We are just not advertising it.

Ms. BROWN OF FLORIDA. Okay. All right. Thank you.

Ms. HALFAKER. Yeah. I think that, perception and culture can change through action. I think, some of the recommendations that Wounded Warrior Project is prepared to make are actions such as outreach, peer support, consistency in the way VA delivers care and services to women veterans.

And it is interesting. I have had the exact same experience as Ms. Williams. First went from Walter Reed Army Medical Center to the VA facility in Washington, DC, and just have had horrible experience after experience there. And, you know, again, they have made some strides in trying to coordinate an OEF/OIF care model where they have the case managers and things like that, but, again, I do not think that the women veterans who are continuing to receive care have actually felt any of the changes. Certainly there has been no change in culture at that particular VA.

Ms. BROWN OF FLORIDA. That is the one in DC?

Ms. HALFAKER. Yes, ma'am.

Ms. BROWN OF FLORIDA. Is it just bad for women or is it bad for everybody?

Ms. HALFAKER. I think that is a good question. I mean, I think that it was initially bad for me just because, you know, when you do just walk through the doors of the VA, it is not a pleasant environment. It is not a safe environment. You know, oftentimes you may encounter somebody, you know, yelling, catcalling at you, making a crude remark. And I think it is a true culture shock going from the military where that would never be tolerated to a VA facility, you know, where you are trying to get care—

Ms. BROWN OF FLORIDA. You know, this is the second or third time I have heard about the catcalls and I just do not know how you deal with it because they are not in the military any longer. They are a civilian and we face this problem if we are walking down the street and we see a work crew or something.

Ms. HALFAKER. Yes, ma'am. I mean, I think that it is a leadership issue, if I was the Director of that hospital, I would do whatever I had to do to ensure that that environment could not happen. So I think it is a leadership issue.

Ms. WILLIAMS. And, if I may, ma'am, I do believe that that facility inadequately serves both male and female veterans. My husband's care at that VA was so bad. He was sent back and forth between multiple clinics, told he was in the wrong place. His paperwork was lost. He felt the doctors did not care about him. His experience there was so bad that he has since refused to go back to the VA at all and relies exclusively on civilian providers even though they are less familiar with blast injuries and post-traumatic stress that results from combat.

Ms. BROWN OF FLORIDA. Just quickly, Ms. Bhagwati.

Ms. BHAGWATI. Ma'am, my personal experiences with the VA hospital in New York City have been personally devastating and I pay out of pocket for as much care as I need. I use the VA right now for emergency care.

You know, I have experienced MST and I had a very bad experience with a claim. And, you know, it does not take much to disappoint me right now with VA care. Every time I walk in there, I go with, you know, open arms, a generous spirit. I hope to be received well. There are some fantastic health care providers there, but by and large, both male and female staff members and medical staff do not understand what it is like to be a woman in uniform.

Ms. BROWN OF FLORIDA. You know, part of the problem is the VA and the number. When I suggested that perhaps we may need to do vouchers so that people can go outside, I got real push-back on the women.

So, if the service is not there. What can we do to change the system? When I talk to women veterans, they want to go to the VA, but the service is not what they want.

Ms. BHAGWATI. Well, ma'am, I think we need to push the VA to provide equal services for women.

Ms. BROWN OF FLORIDA. Yes.

Ms. BHAGWATI. That needs to be done comprehensively. We cannot give up on the VA. But I just need to stress that especially for women who have been traumatized, now, that can be through sexual trauma, post-traumatic stress from combat, whatever the case may be, if they are experiencing negative episodes at the VA hospitals, they may just turn away and never come back. So fee-based care needs to be an option.

If you talk to women who have been working around MST for a while, they will, I would say by and large, they agree that fee-based care needs to be accessible for survivors of MST, whether that is harassment—

Ms. BROWN OF FLORIDA. It should be an option?

Ms. BHAGWATI. Absolutely.

Ms. BROWN OF FLORIDA. Okay. That is what I am thinking.

Yes, ma'am.

Ms. ILEM. I would just say very briefly I think one of the best things that is happening is this hearing right here today with VA staff from both VHA and VBA being here able to listen to women veterans recount their experiences both in the health care and ben-

efit system. I think that is the beginning of cultural change for the VA itself.

And I was pleased in the recent report on the Women's Health Work Group that they talked about this very thing, the cultural shift that needs to take place in VHA all the way from every staff member who comes in contact with women and not just the clinicians but everyone needs to be brought up, you know, be educated and given information about the roles of women in the military today.

But most of all, accountability is mentioned, that it is a leadership issue. And I am hoping we can come back in short time for a followup hearing and you will hear some different, you know, that change has occurred.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman, for being patient with me.

Mr. HALL. Thank you, Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you.

Mr. HALL. Mr. Rodriguez, you are now recognized for 11 minutes.

Mr. RODRIGUEZ. Thank you very much. Thank you and let me apologize for being here late.

I know now more than ever we have the largest number of women than we have ever had in the military, so the numbers are going to grow on the VA side. I know that we have done some legislation to try to look at providing the care that is needed out there and we are not anywhere close to what is needed.

So, I know that, for example, in the rape area, what else do we need to do in there to really provide the services?

I just visited a couple of the sites and I know that in some areas, we are doing a clinic and section within the hospital for women. If that is the direction that we need to take, I know that we will probably need to look at using a peer group also that will go around the country as a commission just to look at women's services in our hospitals, whether that might make any sense to oversee that and come back with recommendations to us like we have done on post-traumatic stress.

So we are trying to establish centers of post-traumatic stress in our hospital facilities, but what has startled me now is that we still continue to have a large number of rapes that should not be there, the suicides that are occurring.

I know that in terms of the treatment that women get in comparison to men is still in some cases discriminatory because I have received situations and feedback from that.

I was wondering from a policy perspective, what should we be looking at long term? Do we need a commission to oversee that and come back with recommendations or do we need something else, especially as it deals with rape and suicide and those kind of things?

Ms. ILEM. I mean, the VA Advisory Committee on Women Veterans makes a number of—they do a site visit every year, an annual site visit to VA and then each do different site visits to different facilities and they correlate that in their report. I think that is one opportunity to really, you know, review those recommendations. The women veterans that serve on there do a very thorough job, I think, in addressing that.

But I think at the facility level, it would be really good to have women veteran users of the system to participate with the women veterans' coordinators to have either regular townhall meetings or discussion groups where women can really give them feedback, continual feedback on these services, how they are being treated, how they feel their care, the quality of care that is being provided. And I think that is critical to the users of each system to really get at the different facility—

Mr. RODRIGUEZ. To localize it.

Ms. LEM. At a local level.

Mr. RODRIGUEZ. I hear the reports on Walter Reed and supposedly that is one of our better hospitals. So I can just imagine in terms of how it is elsewhere where you do not have, you know, as much services as you do have up here, because in other areas, the veterans are even worse situations.

And so—I am sorry?

Ms. BHAGWATI. Sir, veterans, both male and female, who have been assaulted or harassed and are experiencing symptoms of military sexual trauma need a safe space within VA hospitals. That is very difficult to provide when you are dealing with gigantic facilities. The preponderance of patients are male.

Mr. RODRIGUEZ. Is there a need for a new component or something or outreach?

Ms. BHAGWATI. I mean, service needs to be done. I think the VA has headed in the right direction. There are some facilities which do provide sort of safer access, women only, and I know there is research being done into what women patients prefer.

But, again, male veterans also suffer from MST and so, you know, just focusing on the gender exclusively does not really serve the male veterans with MST because they will not feel safe entering a male facility either. So there needs to be private, safe spaces in which men or women who have experienced MST can heal.

Mr. RODRIGUEZ. Is there any model out there that we can look at that might be different, maybe an outreach model?

Ms. BHAGWATI. I know that there are hospitals which are exploring that and I cannot name them, sir, but I am pretty sure that members of the VA can answer that question.

Ms. HALFAKER. Yes, sir. There is a great facility. I was on the Veterans' Affairs Committee for OEF/OIF veterans and families. And we had the privileges of looking at, I think, what I would consider one of the best practices in VA as far as military sexual trauma treatment. It is a residential facility. I believe it is in Menlo Park, California.

And, you know, it is a phenomenal facility, but the problem is outreach. I do not know any woman that knows that it exists. There were certainly women patients that were there. I mean, they had incredible stories of how they had progressed through their trauma. It was an all female facility. They segregated obviously males and females. They also have a male clinic there. And it was incredible to hear the stories.

And I think that, you know, some type of commission, whether it is the Standing Women's Committee or another Committee, can go out there, identify those best practices, and also not only in dealing with, you know, sexual trauma and things like that but

also in just care delivery, standard female care delivery and figuring out what are the best practices, doing some research, and then—

Mr. RODRIGUEZ. What is the name of that facility in California?

Ms. HALFAKER. I believe it is the one in Menlo Park. And I am sure that VA could follow up and give you a lot of information.

Mr. RODRIGUEZ. Do you know if they have any others besides that one?

Ms. BHAGWATI. Sir, there are several residential programs for MST around the Nation. I have also heard very good things about them.

I would say the problem is, though, that most of these residential programs require that you take time off from your life, whether it is work, your children, whatever the case may be, for 2 to 3 months at a minimum, which is excellent treatment. The quality of treatment is great for survivors of MST, but to actually be able to enroll can be a problem. You really need to take time off and that is difficult for anyone who needs to work a job, anyone who is trying to keep their lives together or who has children.

The other thing I would say to answer your original question is we need to look closer at the relationship between health and benefits because lots of women I know who have been assaulted or raped, who have been denied by the benefit side, it is doubly traumatizing because you are basically getting a diagnosis from VHA counselors, psychiatrists, and physicians saying, yes, you have PTSD from your assault, yes, you have depression from your assault. But then for the VBA to say you do not have PTSD, you do not have depression, and maybe you were not even assaulted to begin with, it is not a very efficient system.

I think the VHA and VBA need to coordinate better so that the benefit side supports the physicians, the counselors, and psychiatrists who are treating MST patients.

Mr. RODRIGUEZ. I know we have had one too many suicides, also. In terms of the number of women's in proportion to the number of men's suicides, if there are any differences there or anything? I also want to go back to the original questions also on rape.

Sergeant WASHBURN. One of the things that I think that we need to consider is that women are also looking at whether or not we have integrated care. If I can go to a women's clinic and have care for primary care needs or wellness needs and I also can have mental health care in that same clinic, that means I am not having to walk over four or five different buildings to the place where the mentally ill are being treated because, okay, I had a traumatic event. I am not mentally ill.

So you can understand their perception. They are not going to want to go to those facilities where it is VA mentally ill are housed. There is a difference. So the integrated care for where I can go to get my wellness care or to go to get my mammography or my PAP smear, this is a place where I am comfortable. Maybe it is pink. Maybe there are a lot of women there. And, oh, by the way, they have someone there that wants to talk to them about mental health.

And, you know, those are the women that are going to sit back and say I did have a traumatic event and I do want to talk about

it now because the environment is right to do that in. It is not the stigmatism of I am mentally ill and I have to go over to where the mentally ill patients are. There is a difference.

Mr. RODRIGUEZ. Thank you.

Ms. WILLIAMS. We all know that the suicide rate among soldiers has been shockingly high this year. Unfortunately, I do not think that any of us have any real solid sense of the numbers among the veterans' population. And that is something that I think would be an important area for research. Since not all veterans enroll in the VA, I am not convinced that anybody is fully tracking the number of veteran suicides.

In terms of military sexual trauma, I would like to address a slightly different angle, which is trying to tackle it on the front end. It is my understanding that rapists tend to be repeat offenders. And, unfortunately, as the Chairman mentioned, the number of prosecutions within the Department of Defense is atrociously low.

I understand that during these conflicts the military may be worried about retaining qualified soldiers and I would love to see a paradigm shift within the Department of Defense in which they would understand that they can choose to lose either one male soldier who may be a repeat rapist or multiple female servicemembers who may be sexually assaulted by that man.

So if we look at it in that frame of retention, it is important to realize that female soldiers are just as vital as male soldiers. And it is important to dramatically increase the number of prosecutions so we can try to drive down the rate of military sexual trauma at the front end.

Mr. RODRIGUEZ. Okay. I know you gave me 11 minutes, but let me ask another question and you do not have to respond, but maybe you can get to our staff.

If in the process of bringing to light, for example, the suicide, where we are at in terms of those issues, rape, and then services or even recommendations for a commission to oversee that or how we use peer to peer, if you have any suggestions, especially on the U.S. Government Accountability Office (GAO) making an assessment on one thing or another that might help us come up with some solution, feel free to contact the office and see what we might be able to do.

And thank you very much for your testimony. Thank you.

Mr. HALL. Thank you, Mr. Rodriguez.

I would now recognize our acting Ranking Member, Dr. John Boozman.

OPENING STATEMENT ON HON. JOHN BOOZMAN

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

I just want to very briefly thank you all for being here, for your service, and also for a very, very good discussion on such an important topic.

Like all shortfalls that we try and address in the VA, you have to understand the problem first and you all have really been very, very helpful not only in discussion today but in your written testimony. So I thank you and I thank you for your advocacy.

I have three daughters and, you know, really am very, very interested in this and really quite alarmed about some of the things that you brought up. And I have heard this in the past, so it's something that we need to deal with. We do appreciate your advocacy. Our women are serving our country in a very valiant way as they have for many years, but particularly now. And so, again, thank you for your service and, again, thank you for your contribution.

Mr. HALL. Thank you, Dr. Boozman.

To all of our panelists, thank you so much for your testimony and for your service to our country, to our veterans and to our female veterans.

Before we wrap this panel up, Ms. Brown has one more question.

Ms. Brown.

Ms. BROWN OF FLORIDA. Yes. It is just a follow-up question because the more I listen, the more I am convinced that we may need additional options for the VA veteran because we seem like kind of an isolated situation.

I mean, I have gone to Walter Reed and I have gone to Bethesda and I am very pleased with the services that are provided there. But, the VA has a different culture, and I do not mean—it is just a different culture and we are working through it and trying to improve it.

But I do not believe that you can wait until they get there. Every single one of you has said I do not go there, I do not use it, it is not an option. Well, if you are taking the money out of your purse to pay for the services, why can you not take a voucher and go to the services that you are going to?

I am just saying I think that should be an option. Can you respond to that because each one of you are going somewhere else and you are paying for it? We have made a commitment to you that you are going to have a certain quality of service.

Ms. ILEM. I would just say that it is very distressing to hear that so many of the women here on the panel have had such a negative experience with VA. And I myself use the Washington VA Medical Center. I have had a good experience. I have been going there for 12 years since I have been here in DC.

Is it perfect? No. But I found the women veterans' program to be very good as well as the primary care services that I have personally received.

However, I think VA does have an option to provide fee-based care if they have a particular situation, especially if somebody is very uncomfortable, they have experienced MST or they have a situation where they have had a negative experience with the VA. They do have the option to provide fee-based care where VA can pay for that.

And certainly if VA cannot provide a certain type of care, they do not have the specialists, you know, they definitely, you know, need to fee base that care out and give that person the option. But they do that for, for example, maternity care routinely.

So I think, you know, the options are there. I think people have had difficulty in getting VA to do that.

We heard on a panel just the other day in the Senate, one woman veteran let me know that, you know, she had asked for a

different therapist. She did not get along with that therapist that she was assigned but was told no, you know, that she could not change. And that is obviously a very personalized relationship. You need to have somebody that you trust and that you have a good rapport with.

So, again, I mean, I think in those cases, they definitely should have that option, but I would like to see VA step up to meet the needs of women veterans, change the culture in VHA and VBA so that VA can be a provider of choice for women.

Ms. BHAGWATI. Ma'am, at the New York Hospital, the New York VA Hospital, I have been a patient there for at least 3 years now and I attend the pain management clinic. And I am telling you this story because I think it is a good example of why the fee-based care system needs to be improved.

It took me 10 months to get an appointment. I was on a waiting list for 10 months for an acupuncture pain management clinic which is an excellent clinic, but took quite a while and I could not wait a year. I mean, chronic pain is not something that you really wait around for a year to resolve.

And then following that, I waited an additional 3 to 4 months for a chiropractic appointment. During that time, I had to pay out of pocket and the care that I get paying out of pocket is better.

I think that the VA is making strides, especially in the sort of holistic department, and that I think it can be incredibly helpful for both male and female veterans. But the services need to be improved.

There is very little understanding about, again, what it is like to be a woman in uniform, what the specific needs of women veterans are in those clinics even though they do provide decent care.

When I did eventually a year and a half later apply for fee-based care because it was an option at that point and I found a couple of allies within the hospital who were helping me with that, it was rejected because, again, of a sort of defunct, inefficient system in which an attending physician who has been at the VA hospital for probably the greater part of his life refused permission for me to get fee-based care because he did not believe in chiropractic care.

Now, I do not know if personal opinions—I do not think personal opinions should have anything to do with the providing of health care to veterans, but you find a lot of that kind of, you know, maybe the older, more conservative elements of the VA basically working against the more modern, effective, efficient methods and modalities.

Ms. BROWN OF FLORIDA. And so in that case—

Mr. HALL. Ms. Brown, excuse me.

Ms. BROWN OF FLORIDA. Yes.

Mr. HALL. I am going to have to—that is a second 5 minutes now. We have two other panels waiting.

Ms. BROWN OF FLORIDA. Yes.

Mr. HALL. So if I could ask our other witnesses to submit their response to your question.

Ms. BROWN OF FLORIDA. Right, right. And thank you. You have been very patient.

Mr. HALL. Thank you very much.

Ms. BROWN OF FLORIDA. Thank you.

Mr. HALL. Thank you.

Mr. RODRIGUEZ. Can I just ask a quick question?

Mr. HALL. Mr. Rodriguez, one quick follow-up, please.

Mr. RODRIGUEZ. This has nothing to do with that, but I want to know how you reckon with the “do not ask, do not tell” policy, and if you think it is appropriate to leave it intact, raise your hand and not just—do not raise your hand. You do not even have to. No tell—

Ms. WILLIAMS. Do not ask, do not tell.

Mr. RODRIGUEZ. Do you think you could deal with that, change that?

Mr. HALL. Okay. Thank you, all of our first panelists, for your eloquent statements. We will take them to heart and do the best we can to implement the suggestions you have made. You are now excused.

We will call our second panel to the witness table. Mr. Randall B. Williamson, Director of Health Care for the U.S. Government Accountability Office; Ms. Phyllis Greenberger, Chief Executive Officer and President for the Society of Women’s Health Research; and Ms. Janice L. Krupnick, Ph.D., Professor for the Department of Psychiatry, Director, Trauma and Loss Program at Georgetown University Medical Center, on behalf of the Committee on Veterans’ Compensation for Post Traumatic Stress Disorder, Institute of Medicine (IOM) and National Research Council, the National Academy of Sciences.

Welcome to our three witnesses. Your full statements have been entered into the record.

Mr. Williamson, you are now recognized for 5 minutes.

STATEMENTS OF RANDALL B. WILLIAMSON, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; PHYLLIS E. GREENBERGER, M.S.W, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SOCIETY FOR WOMEN’S HEALTH RESEARCH; AND JANICE L. KRUPNICK, PH.D., PROFESSOR, DEPARTMENT OF PSYCHIATRY, DIRECTOR, TRAUMA AND LOSS PROGRAM, GEORGETOWN UNIVERSITY MEDICAL CENTER, ON BEHALF OF COMMITTEE ON VETERANS’ COMPENSATION FOR POST TRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, THE NATIONAL ACADEMIES

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Thank you, Mr. Chairman and Members of the Subcommittees. I am pleased to be here today as the Subcommittees consider issues related to VA’s delivery of health care services for women veterans.

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

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

In addition, women veterans from conflicts in Iraq and Afghanistan present new challenges for VA's health care system. These women have experienced a greater exposure to combat than women participating in previous conflicts.

VA data show that as many as 20 percent of the women veterans of Iraq and Afghanistan have been diagnosed with post-traumatic stress disorder. An alarming number have also experienced sexual trauma while in the military. As a result, many have complex physical and mental health care needs.

VA has taken some bold steps to fulfill its commitment to provide high-quality health care service for women veterans. However, much remains to be done in some areas to fully implement the new initiatives.

In my testimony today, I will discuss three aspects of our ongoing work on women's health care issues based largely on work we did at 19 VA facilities.

First, the on-site availability of health care services for women veterans at VA facilities; second, the extent to which VA facilities are following VA policies for delivering health care services for women veterans; and, third, some key challenges that VA facilities face in providing health care for women.

Regarding the availability of services, we found that basic gender-specific services, including pelvic and clinical breast examinations, were available on site at all nine VAMCs and eight of the ten community-based outpatient clinics (CBOCs) that we visited. All of the VAMCs we visited offered at least some other specialized gender-specific services such as treatment for abnormal cervical screening tests and breast cancer.

Among CBOCs, the two largest facilities we visited offered an array of specialized gender-specific care on site. The other eight referred women to other VA or non-VA facilities for most of these services.

Outpatient mental health services for women were widely available at VAMCs and most of the eight Vet Centers we visited, but were more limited at some CBOCs.

Also, only two VAMCs offered residential treatment programs for women who experienced sexual trauma. None had dedicated inpatient psychiatric units for women.

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

For example, many of the facilities we visited lacked adequate visual and auditory privacy in their check-in areas, proper orientation of exam tables, and access to private restrooms adjacent to rooms where gynecological examinations were performed.

Further, the facilities we visited were in various stages of implementing VA's new initiative to provide comprehensive primary care for women veterans.

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

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

Officials also reported challenges in hiring providers with specific training and experience in women's health care, including treatment for women veterans with post-traumatic stress disorder or who had experienced military sexual trauma.

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

Mr. Chairman, that concludes my remarks.

[The prepared statement of Mr. Williamson appears on p. 78.]

Mr. HALL. Thank you, Mr. Williamson.

Ms. Greenberger, your statement is entered into the record. You are recognized now for 5 minutes.

STATEMENT OF PHYLLIS E. GREENBERGER, M.S.W.

Ms. GREENBERGER. Thank you very much.

Thank you, Mr. Chairman and Members of the Subcommittees, for the opportunity to address this important and timely issue.

The Society for Women's Health Research is a nonprofit advocacy organization dedicated to improving women's health through research and through the advancement of the science of sex and gender differences.

The Society's focus since 1995 has clearly demonstrated that sex and gender differences exist throughout all conditions that affect women differently, disproportionately, or exclusively and research needs to be done to identify those differences and to understand their implications for diagnosis and treatment.

Since this area of research is relatively new in scientific terms, we have many more questions than answers. Women veterans and the VA in general needs to take what we already know and recognize and apply it and use their unique network to advance research into those conditions that disproportionately affect women veterans where little is known. And as we have discussed, women are currently the fastest-growing sector of VA users.

The most pressing issues, as you have heard, of course, are related to mental health issues, including PTSD, depression, anxiety, and behavioral issues, which often may result in suicide, alcohol and drug abuse. Differences in chronic pain and immune response, and possibly cancer related to chemical and biological exposures as well as musculoskeletal issues. And, of course, conditions that affect all women to some extent, but in many cases are amplified by the unique experience of women veterans.

Although the Society has been advocating for research and funding in sex differences, we know that research done at both public and private institutions as well as research at the VA that there

are still few trials that include women and in those that do, insufficient numbers in clinical trials to identify differences.

Sex analysis in animal samples in basic research is generally not even noted or examined. As more women enter the military and both those women who are currently serving and as these women veterans grow older, there needs to be greater examination and understanding of the differences in order for them to receive the appropriate care.

The Society has long encouraged women to participate in research. In addition, we pioneered the field of sex and gender differences and we remain the preeminent organization in this field.

We sponsor interdisciplinary research in sex differences in both the Society and its new Organization for the Study of Sex Differences, hold scientific conferences, and publish information how sex and gender differences can affect a person's health.

The Society stands ready to assist the VA in increasing participation of women in research and building its research capacity.

In a recent scientific symposium that we held on PTSD in women returning from combat, it was noted that therapy needs to be different, that some antidepressants work better in men, and that a significant number of women veterans have the dual trauma from their combat experience, as was said earlier, combined with sexual and psychological abuse in the military.

A 2008 VA study reported that 15 percent of women in Iraq and Afghanistan experienced sexual assault or harassment and 59 percent of those were at a higher risk for mental health problems. With the VA currently reporting that 71 percent of the military now have been exposed to combat, getting proper mental health treatment is critical.

This meeting that we held also illustrated what is not yet known and developed a research agenda, which is encapsulated in the White Paper that we submitted to the Committee for this meeting.

Not surprisingly, the VA, along with many public and private institutions, still maintains a male norm and atmosphere where women's unique needs and sensibilities are not taken into consideration or understood.

Women may feel stigmatized and are hesitant to speak out. Many women veterans do not identify themselves as veterans and seek care outside the system.

The Society recommends that Congress request an update on the research conducted by the Veterans Health Administration since the establishment of its women's health research agenda in November 2004 and further recommends that Congress provide the VA with the funding necessary to conduct research that will result in improved care for women veterans.

More funding needs to be available for research into sex differences and better coordination is needed among the VA Centers throughout the country to increase the number of women in clinical trials to understand the differences and their implication for treatment.

I want to thank you again for this opportunity.

[The prepared statement of Ms. Greenberger appears on p. 97.]

Mr. HALL. Thank you, Ms. Greenberger.

Dr. Krupnick, you are now recognized for 5 minutes.

STATEMENT OF JANICE L. KRUPNICK, PH.D.

Dr. KRUPNICK. Good morning, Mr. Chairman, Mr. Ranking Member, and members of the community. I would like to thank you for the opportunity to testify on the content of the National Academies' report on PTSD compensation and military service.

I will briefly address five issues in this testimony, the prevalence of military sexual assault, the relationship between sexual assault and PTSD, PTSD comorbidities and recovery for women, PTSD compensation and women veterans, and the PTSD Compensation report's conclusions and recommendations regarding women veterans.

As has been discussed earlier, the prevalence of reported sexual assault in the military is alarming. A synthesis of studies found that 4.2 to 7.3 percent of active-duty military females had experienced a military sexual assault, MSA, while 11 to 48 percent of female veterans reported having experienced a sexual assault during their time in the military.

A 2005 survey found that among 104 female veterans and Reservists who disclosed they were sexually assaulted while in military service, 13 percent reported sexual assault from a marital partner and 8 percent from a date. Eighty-two percent of the perpetrators in these MSAs were military peers or supervisors.

The women in the sample also reported a great deal of secondary victimization by the military and by the VA system, an experience that is known to make PTSD symptoms worse.

Other studies have found subsequent secondary victimization and sexual harassment exposing the women to additional trauma over and above rape and combat.

A substantial body of literature documents measurable gender differences in PTSD frequency and severity. A meta-analysis published in 2006 found that PTSD was twice as prevalent in females as in males after controlling for potential confounders.

There are several possible reasons for this, including sex differences and the cognitive response to the traumatic event, immediate coping strategies, and the willingness to admit symptoms.

Women are more likely to experience chronic trauma such as repeated childhood sexual assault by a family member or intimate partner violence. Women are also more commonly the victims in cases of multiple traumas.

Research indicates that sexual assault experiences are strongly associated with PTSD in both civilian and military populations. Studies of female veterans indicate that PTSD symptoms and PTSD diagnoses are associated with comorbidities such as depression, substance abuse, smoking, and physical health problems as well as with increased medical utilization.

Females are more likely than males to have major depressive disorder along with PTSD and tend to experience symptoms for a longer duration. They also have more physical problems than do males.

For female veterans, post-military social support from family and friends both reduces the risk of developing PTSD and aids in recovery from the disorder according to the few studies of PTSD recovery in this population.

Female veterans were more comfortable in a specialized treatment program for women which increased their participation as measured by attendance and commitment although it had no affect on outcomes.

The PTSD Compensation Committee observed that studies of PTSD treatment for female veterans are badly needed and noted that it was important to ensure that study samples were sufficiently large to disentangle the differential treatment effects for women whose trauma is primarily military sexual assault versus those whose trauma is primarily combat or to determine if multiple traumas are part of the etiology of the PTSD experience.

Very little research exists on the subject of PTSD compensation and female veterans. A 2003 study determined that a significantly smaller proportion of females had their PTSD deemed to be service-connected as compared to males. And this was primarily related to the lower rate of combat exposure among females.

Subsequent research found that when MSA was substantiated by a Veterans Benefits Administration, VBA, claim file, service-connected PTSD determinations increased substantially.

Unfortunately, there are huge barriers to women being able to independently substantiate their experiences of MSA especially in the combat arena.

I just want to get to the several conclusions and recommendations that were made with regard to women veterans. The Committee concluded that the most effective strategy for dealing with problems with self-reports of traumatic exposure is to ensure that a comprehensive, consistent, and rigorous process is used throughout the VA to verify veteran-reported evidence. It, therefore, recommended that the VBA conduct more detailed data gathering on the determinants of service connection and ratings for MSA-related PTSD claims, including the gender-specific coding of MSA traumas for analysis purposes.

Since I am out of time, I will just refer you back to the written materials that you have received, which indicate the rest of the other recommendations.

[The prepared statement of Dr. Krupnick appears on p. 99.]

Mr. HALL. Thank you, Dr. Krupnick.

Because we have votes about to be called, I am going to defer my questions and recognize Ms. Brown for some questions.

Ms. BROWN OF FLORIDA. I am going to be very brief.

Mr. Williamson, in reading your testimony, you indicated that one of the major problems is women's privacy that the VA has not established in the facilities.

Given the financial situation and given the number of males, what would be your recommendation? You heard my questions earlier and you have seen the push-back that women are giving to this issue. But, what would you recommend that we recommend to the VA?

Mr. WILLIAMSON. I think, Ms. Brown, that, as I have said before, I think that things such as privacy requirements are fairly easy to accomplish, things like orienting exam tables in the right direction away from the door are fairly easy.

So I think one of the solutions is to instill management commitment at the local level that will make sure that these get done, these kinds of things get done.

Part of it is attributed to facilities as well. I mean, many of the VA facilities are older and——

Ms. BROWN OF FLORIDA. That is right.

Mr. WILLIAMSON [continuing]. They are not set up for that, but they are working in that direction. But I really think that management commitment, that commitment exists at the top, I think.

But I think as you get down into the facilities, you know, if I were to do one thing, it would be try to instill that, have oversight and accountability as part of it. I mean, you need information to make sure people are doing what they are supposed to. So that is the kind of thing I would do.

Ms. BROWN OF FLORIDA. Well, you know, when I first got elected in what, 1992, we had a facility in Orlando that was older and I went in there and it was just like a zoo because there were so many people. Well, we were able to get a new hospital and we were able to set it up where women could have their privacy. So I think part of it is that we have a lot of old facilities that are overcrowded.

Mr. WILLIAMSON. Right. Exactly. And I think one of the other things that is very important is get the people who design the facilities and set up the specifications in tune with Dr. Deyton's office and Dr. Hayes' office to really make sure that communication exists and that we really have the specifications for privacy and other things built into those new facilities or facilities that get modified.

Ms. BROWN OF FLORIDA. Thank you.

And another issue was the catcalls.

Mr. WILLIAMSON. You want me to——

Mr. HALL. You have a written response to that.

Ms. BROWN OF FLORIDA. Yeah. I am going to yield back my time.

Mr. HALL. Thank you, Ms. Brown.

Mr. Boozman?

Mr. BOOZMAN. Thank you, Mr. Chairman.

In the interest of time with votes coming up, I really just want to ask one question. Then we will have some others that we would like to submit for the record.

Again, thank you for your testimony.

Mr. Williamson, your review has shown that the facilities that you visited were in various stages of compliance in implementing VA's comprehensive primary care initiative for women and that the VA had not set a deadline for compliance with the policy.

I guess what I would like to know, I think really what we would all like to know is what a reasonable timeframe is for which VA should require full compliance and then, you know, kind of go from there. And then further, you know, do you think that VA will be capable of meeting, you know, some sort of timeframe?

Mr. WILLIAMSON. That is a very good question. I do not have a total answer. I mean, that is a tough one.

About a third of the facilities now are what you would say complying with that and two-thirds are not obviously. But it involves a lot of different issues. It involves the facilities themselves which I have talked a little bit about in terms of having the facilities seg-

regated and providing the exam rooms that would, you know, be suitable for women.

But it is also having providers, a set of providers that can provide comprehensive primary care and that does not exist in many facilities right now. They have not had a chance to develop a cadre of providers that they need to.

Other facilities have done quite well. So it is those kind of things. But, you know, I think it may be a good question for Dr. Deyton on the third panel to ask him that question because I do not have a time table and I could not answer that question.

Mr. BOOZMAN. Okay. Well, I really think we need to get one.

And the other thing is I know myself, Mr. Hall, Ms. Brown, you know, all of us are very willing to provide the resources. We all agree, I think everybody in this room agrees that this is something that just has to be done. But unless we do start setting time tables and things like that, it will get done eventually, but it will get done a lot longer than, you know, if we have some reasonable goals. And, yet, we need to provide the resources if you need some more.

Thank you.

Mr. HALL. Thank you, Dr. Boozman.

Mr. Williamson, based on your analysis of VA's provision of health care services to women veterans, in your opinion, what are the implications for women veterans in need of compensation and pension exams and is VA properly equipped to conduct these exams given the gender differences in disease onset and the presentation of symptoms?

Mr. WILLIAMSON. Mr. Chairman, our work on this particular body of this engagement did not consider the benefit side. And so I really am not equipped to answer that question.

However, if you submit that for the record, we do have my colleagues who do the disability side of those issues can certainly address those questions.

Mr. HALL. I am a little bit concerned that women veterans who are going outside the system and paying to get private diagnosis and care and treatment may run into problems when they come back to ask for compensation from the VBA, that is a question, I guess, that our next panel can address also.

But moving on, Ms. Greenberger, are there unique assessment instruments for women's health and quality of life that VA could apply to its disability claims processing system?

Ms. GREENBERGER. Well, I do not know in terms of the claims systems.

Mr. HALL. Would you please push your mic?

Ms. GREENBERGER. I am sorry. It is on.

What we address is there are two issues, a lot of issues, but one, of course, is issues, conditions that affect women exclusively, gynecological, reproductive. And obviously with the right specialists, you know, OB/GYNs, that is pretty much taken care of.

Our major concern is all these other conditions that affect women veterans and also affect other women that we do not really know how they should be treated differently. That is the research that we are doing and that is why we think that the VA, particularly because of your focus and other Committees' focus and the time and what we are seeing now, that they are in a unique position

with the women's population, and all these VA Centers to start looking at what these differences are. And that information could be translated not only to the women veterans but to women generally because we do not have this kind of research yet and this is what we are trying to advance.

Mr. HALL. Thank you.

Dr. Krupnick, can you expound on the IOM report recommendation that the VA provide a minimum level of benefit without regard to a person's state of health at a particular point in time after a C&P exam? Would a minimum benefit package be advantageous in addressing evidentiary issues faced by women veterans?

Dr. KRUPNICK. Well, I do not know that the Committee spoke to that, but I can say that I think that a minimum package would be advantageous.

I think one of the big problems with documentation of some of the traumatic stressors for women is that, for example, in the case of military sexual assault or even sexual harassment, it is difficult to document because many of these events occur in secret. It is not the same as being able to document having been at a specific combat area.

So I think it would be wise to have a minimum package that is available for anybody who is in a combat area.

Mr. HALL. The IOM noted the disparities in the rates of service-connection between male and female veterans and recommended further research.

What were the specific areas or conditions that it thought were more in need of future study?

Dr. KRUPNICK. Let me see if I have that in the—felt that more research was needed on the as yet unexplained gender differences and vulnerability to PTSD, which could identify sex specific approaches to prevention and treatment and on more effective means for preventing military sexual assault and sexual harassment.

I know that at the moment, there, at least in the Washington, DC, VA, there is some attempt to move in the direction of more gender-specific treatment and adapting some treatments that were used for civilian sexual assault for women who have experienced military sexual assault. And I am personally starting a pilot study myself to do a gender-specific treatment for women who have experienced trauma in the military.

Mr. HALL. Last, when the IOM made its recommendation on training and testing materials on military sexual assault-related claims, did it review literature that it thought pertinent, which could be incorporated into such a syllabus for raters?

Dr. KRUPNICK. There was a whole report on PTSD diagnosis and assessment, which was very specific about instruments and methods that could be used for raters.

Mr. HALL. Doctor, one last question. If the VA was using a standard electronic template to conduct C&P exams, might women get a more complete exam that better associated their symptoms with the criteria for certain conditions and MST outlined in the rating schedule?

Dr. KRUPNICK. Well, I agree that the idea of electronic records would be a great boon to things being done. I think there is already in the system a very comprehensive method for assessments for

VBA ratings. Unfortunately, they are not always used as comprehensively as the specifications provide.

So perhaps if there was an electronic template, that might be advantageous in making sure that that happens.

Mr. HALL. Well, I thank you all on this panel for your testimony. It has been extremely illuminating and helpful.

We have about 10 minutes remaining on this vote, so we will ask our third panel to be patient. They are used to this, I am afraid, by now.

But thank you, Mr. Williamson, Ms. Greenberger, and Dr. Krupnick, for your participation and contribution to our learning process and developing solutions to these problems for women veterans.

The hearing will now recess until votes are completed.

[Recess.]

Mr. HALL. The hearing of the joint Health and Disability Assistance and Memorial Affairs Subcommittees of the Veterans' Affairs Committee will resume.

Thank you for your patience.

Members of our third panel, Bradley Mayes, Director of Compensation and Pension Service of the Veterans Benefits Administration, U.S. Department of Veterans Affairs; accompanied by Dr. Patricia Hayes, Chief Consultant, Women Veterans Health Strategic Health Group, Veterans Health Administration; Lawrence Deyton, M.D., Chief of Public Health and Environmental Hazards Office, Veterans Health Administration; and Irene Trowell-Harris, RN, Ed.D., Director of the Center for Women Veterans for the Office of the Secretary, U.S. Department of Veterans Affairs.

I thank you for your patience and, again, for being here to testify before the Subcommittee and for your work on behalf of our Nation's veterans. Your full statement, as always, is entered into the record.

Mr. Mayes, you are now recognized for 5 minutes.

STATEMENTS OF BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA M. HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH GROUP, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; IRENE TROWELL-HARRIS, RN, ED.D., DIRECTOR, CENTER FOR WOMEN VETERANS, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND LAWRENCE DEYTON, M.D., MSPH, CHIEF PUBLIC HEALTH AND ENVIRONMENTAL HAZARDS OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF BRADLEY G. MAYES

Mr. MAYES. Thank you, Mr. Chairman, and thank you for providing me the opportunity to speak today on the important topic of assisting women veterans.

Although women have been associated with military activities since the founding of our Nation, their role has increased dramati-

cally in recent years. The expanded role of women in the military has also brought about increased responsibilities and risk taking.

Women serving in Iraq and Afghanistan face combat activity similar to their male counterparts as aircraft pilots, convoy transportation specialists, military police officers, and members of civilian pacification teams. Women have increasingly been in harm's way and have incurred more service-related physical and mental disabilities as a result.

America has approximately 1.8 million women veterans. They make up approximately 7.7 percent of the total number of veterans awarded service connection. The number of women receiving VA compensation and pension increased from 203,000 in 2006 to over 250,000 in June of 2009. This represents a 23-percent increase in less than 3 years.

So far this fiscal year, the number of women veterans receiving benefits who served in the current overseas contingency operations has increased by nearly 10,000. Although women veterans represent 12 percent of those who served in these operations, they represent 15 percent of those awarded service connection for a disability.

VA has taken a number of steps to keep pace with women veterans' changing role in the military and their increased prevalence within the VA system. VA established the Advisory Committee on Women Veterans in 1983 as a panel of experts on issues and programs affecting women veterans. Since then, we have worked to implement its recommendations for improving services to women veterans.

A major issue of current concern for this Committee, as we heard from the earlier panels as well, is the occurrence of military sexual trauma among women on active duty and the disabilities that may result.

The Committee has recommended that VA address this issue to the greatest extent possible. The claims of women veterans who seek disability compensation for post-traumatic stress disorder based on military sexual trauma are specifically addressed in VA's regulation at 38 CFR section 3.304(f)(4).

In 2002, VA amended its PTSD regulations to emphasize that if a PTSD claim is based on an in-service personal assault which includes military sexual trauma claims, evidence from sources other than the veteran's military records may be used to corroborate the in-service traumatic event. Such evidence may include, but is not limited to, records from law enforcement authorities, rape crisis centers, mental health counseling centers, and hospitals, as well as statements from family members, associates, or clergy.

Service medical and personnel records are also reviewed in order to discover evidence of behavior changes that may support the occurrence of the traumatic event.

In addition, prior to making a decision on the claim, VA provides an appropriate medical or mental health professional with the available evidence and asks for an opinion as to whether the evidence is consistent with a military sexual trauma incident.

These procedures take into account the sensitive nature of military sexual trauma and the difficulty in obtaining supporting evidence.

As a further means to implement recommendations of the Advisory Committee on Women Veterans, the Veterans Benefits Administration has engaged in outreach efforts. When active-duty military personnel are separated from service or National Guard and Reserve Members are demobilized, we provide information to them under the Transition Assistance Program (TAP) at their military base. This pre-discharge program explains the array of benefits available from VA and assists individuals with filing disability claims.

One mandatory section of the TAP briefing is a presentation on military sexual and other personal traumas. This is intended to alert separating servicemembers that VA is aware of the military sexual trauma problem and inform them that counseling, treatment, and disability compensation are available.

Outreach efforts are also conducted at the VA regional offices on a continuing basis. Each office employs a women veterans' coordinator who is well-versed in personal trauma issues, including those of military sexual trauma, as well as gender-specific disability issues, and who acts as a liaison with the women veterans' program manager at the local VA health care facility.

These coordinators also work with the regional office homeless veterans' coordinators to address the problems of homeless women veterans.

A nationwide VA women veteran coordinator training conference is scheduled for later this year in August in St. Paul, Minnesota. At the conference, VA will present updated information and skill training to the coordinators and topics will include outreach methods, clinical perspectives on personal trauma, and women veterans' health issues.

In conclusion, VA has recognized the service provided to our Nation by women veterans and the importance of providing them with the assistance that they so much deserve.

VBA has moved forward along with VHA to address the issues that are unique to women veterans. We have developed special regulations for the adjudication of PTSD claims based on military sexual trauma.

Regarding compensation for gender-specific disabilities, we provide special monthly compensation for breast tissue loss and monetary assistance for the children of women veterans who develop birth defects.

We have also engaged in nationwide outreach to facilitate women veterans' access to VA benefits. We realize that VA needs to keep pace with the changing needs of women who have served in the military and we are ready to take whatever steps are necessary in the future to properly assist women veterans.

Thank you, Mr. Chairman, and I will be happy to answer questions.

[The prepared statement of Mr. Mayes appears on p. 102.]

Mr. HALL. Thank you, Mr. Mayes.

Director Trowell-Harris, you are now recognized for 5 minutes.

STATEMENT OF IRENE TROWELL-HARRIS, RN, ED.D.

Dr. TROWELL-HARRIS. Chairman Hall, Members of the Subcommittees, I am pleased to testify today on behalf of the Department of Veterans Affairs regarding women veterans' issues.

Through recommendations made by the Secretary's Advisory Committee on Women Veterans, collaborations between the Center for Women Veterans and VA administrations and proactive measures taken by the Veterans Health Administration, Veterans Benefit Administration, and National Cemetery Administration (NCA), VA continues to transform to meet the anticipated needs of women veterans.

I greatly appreciate the Committee's diligence in bringing forth discussion on this very important and timely issue.

The Center for Women Veterans was created by Public Law 103-446 in November 1994. As Director, I serve as the Chief Advisor to the Secretary on all issues related to women veterans and serve as a designated Federal officer to the Secretary's Advisory Committee on Women Veterans.

The Center's mission is to ensure that women veterans have access to VA benefits and services on par with male veterans, that VA programs are responsive to the gender-specific needs of women veterans, and that joint outreach is performed to improve women veterans' awareness of VA services, benefits, and eligibility criteria, and that women veterans are treated with dignity and respect.

The Center accomplishes its mission by monitoring the Department's programs and policies to ensure that they are responsive to the needs of women veterans. This is done by recommending policies and legislative proposals to the Secretary and analyzing the impact of these proposals on women veterans, by collaborating with VA's administrations to make women veterans more knowledgeable about changes in VA policies, by ensuring that the Advisory Committee on Women Veterans is educated about VA to ensure clear, meaningful recommendations, and by coordinating the development, distribution, and processing of Committee reports and by coordinating an annual Committee site visit to VA health care facilities, regional offices, Vet Centers, national cemeteries, and other related programs such as homeless and transitional housing.

Caring for our women veterans does not stop within the confines of the Department. We conduct extensive outreach, coordination, and collaboration with other agencies that is Federal, State, and local as well as with veterans' organizations and community-based organizations concerned with women veterans' issues.

The Advisory Committee was established in 1983 pursuant to Public Law 98-160. The Committee is charged with advising the Secretary of benefits and health 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 is required to submit a biennial report to the Secretary incorporating its findings and recommendations. There are currently 13 Committee Members, including two Operation Enduring Freedom and Operation Iraqi Freedom veterans.

The Advisory Committee meets twice a year at VA's Central Office (VACO) and receives briefings from VHA, VBA, NCA, and staff

offices. These briefings update the Advisory Committee on the status of VA programs and the progress and recommendations and respond to concerns raised during site visits.

The Advisory Committee uses information from the site visits and briefings to formulate its recommendations to the Secretary in biennial reports. To obtain information regarding the delivery of health care and services for women veterans, the Advisory Committee conducts site visits to VA facilities throughout the country. During these visits, the Committee tours the facilities and meets with senior officials to discuss services and programs available to women veterans.

In addition, the Committee also hosts open forums at site visits with the women veterans' community encouraging women veterans to discuss issues and ask questions related to VA benefits and services. Copies of the 25 most frequently asked questions are distributed at the town hall meeting.

The Advisory Committee completed a site visit in June 2009 to the Veterans Affairs North Texas Healthcare System facilities in Dallas and Bonham, Texas.

The purpose of site visits are to provide an opportunity for Committee Members to compare the information they receive from briefings provided by administrations with the activity in the field. This effort is to ensure that policies established in VACO are implemented in VA medical facilities and other facilities that serve and impact women veterans which are people-centric, results driven, and forward looking.

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

In the 2008 report, the Advisory Committee on Women Veterans made 20 recommendations with supporting rationale, including ten topical areas.

The Center collaborates frequently with veterans administrations and staff offices to ensure that the Department thoroughly addresses the Committee recommendations.

The 2008 report, including responses, was provided to House and Senate Veterans' Affairs Committees on September 26, 2008.

Recommendations stem from data and information gathered in briefings from VA officials, Department of Labor and Defense, Members of the House and Senate Congressional Committee staff offices, women veterans, researchers, veterans service organizations (VSOs), internal VA reports, and site visits to VHA, VBA, and NCA facilities.

The Committee is confident that the 20 recommendations and supporting rationale reflect value-added ways for VA to strategically and efficiently address many needs of women veterans.

Anecdotally and in research, women veterans tell us they want and need recognition and respect, employment, suitable housing, access to and receipt of high-quality health care, child care options, opportunities for social interaction, and that they want to make a difference.

Every 4 years, VA sponsors a summit on women veterans' issues. The fourth quadrennial summit was held on June 20–22, 2008, in Washington, DC. The purpose of the summit was to 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 continuously addressing the progress on women veterans' issues.

More than 400 individuals attended, including women veterans, women veterans' program managers and coordinators, Congresswoman Susan Davis and Congressional staff from the Senate and House Veterans' Affairs Committees, women veterans' organizations, representatives from other collaborating Federal, State, and local agencies, VSOs, and members of active-duty military, Guard and Reserve.

The program consisted of 11 breakout sessions, plus VA updates since 2004. For the first time, we held a town hall meeting to discuss national issues affecting women veterans, viewed the Public Broadcasting Service *Lioness* documentary. *Lioness* looks at five women from an Army Engineering Battalion in Iraq who were drawn into battle and the fallout from their experiences, and had an open discussion with the directors and soldiers featured in that film.

Based on feedback received from the summit participants, the Center is posting updates on women veterans' issues on its Web site. We change those quarterly.

Many of the recommendations made by the Advisory Committee have been instrumental in transforming VA to assist in meeting the needs of women veterans and to help bridge the gaps in services and benefits.

To address the challenges of enhancing primary care for women veterans, VA has done the following:

Elevated the Women Veterans Health Program Office on VA's organizational chart to the Women Veterans Health Strategic Health Care Group as part of VA's readiness for the influx of new women veterans. This group provides programmatic and strategic support to implement positive changes in the provision of care for women veterans. Appointed a full-time Women Veterans Program manager at every VA medical facility. Initiated implementation of comprehensive primary care, including gender-specific care, at every VA site. Ensured accurate representation of women veterans' population through analysis and data. Expanded the women's health knowledge base among VA providers. Sought to recruit primary care physicians who have knowledge and interest in women's health. Started to integrate mental health with primary care to enable a comprehensive women's health care program. Started to change the overall culture of VA to become more inclusive of women veterans, and recognize their military service and contributions to the Nation.

In conducting collaborative outreach, the Center takes every opportunity to collaborate with VSO, policy, women and minority groups, other Federal and State agencies and community organizations to outreach to women veterans.

This is done by providing keynote speeches at national conventions and women veterans' forums, participating in Congressional roundtable discussions on the needs of women veterans, collaborating with VA administrations, staff offices, and other advisory Committees, providing information to minority women, including

those who live on reservations, through the Center for Minority Veterans, participating on the homeless veterans' work group to ensure that the needs of women veterans who are homeless with children are addressed, working with the Congressional Caucus for Women's Issues to recognize and honor our Nation's servicewomen and women veterans at an annual wreath laying ceremony at the Women in Service for America Memorial, and representing the Secretary at the monthly White House Interagency Council meeting on women and girls, addressing the needs of women veterans nationally in collaboration with the Department of Defense.

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

[The prepared statement of Dr. Irene Trowell-Harris appears on p. 103.]

Mr. HALL. Thank you.

Dr. Dayton, you now are recognized.

STATEMENT OF LAWRENCE DEYTON, M.D.

Dr. DEYTON. Good afternoon, Mr. Chairman. Thank you for the opportunity to discuss how VA has provided and will continue to improve health care available for women veterans.

As you know, Mr. Chairman, VA Secretary Shinseki has testified that enhancing primary care for women veterans is one of VA's top priorities.

VA has a long history of serving women who have served our Nation and the documentation of continued improvements in VA's service to these women and heroes is a fact of which all VA employees and the Nation can be proud.

With the recognition of the significant increases in the numbers and the new roles of women in service in recent years, VA has redoubled our efforts to assess and improve the care and services delivered to our women veterans.

These efforts were initiated by the creation of the Women Veterans' Strategic Health Care Group into 2008. And as Dr. Trowell-Harris has said, that was a recommendation of the commission.

And since her appointment as its first chief last spring, Dr. Patricia Hayes, sitting to my right, has led VA in an intense and continuing effort to improve health care delivery to women veterans.

With the support of VA leadership, this systemwide effort has revitalized VA's women veterans' health programs and expanded the focus beyond gender-specific care to comprehensive care for our women veterans.

VA is currently in the midst of implementing an aggressive and innovative program to deliver comprehensive women's health care that specifically addresses concerns that we heard on the first panel about fragmented care, quality disparities, and the lack of provider proficiency in women's health.

Our goal is to fundamentally improve the experience of women veterans when they come to their VA.

At its core, Dr. Hayes and her colleagues have designed a system for VA care, which will ensure every woman veteran has access to a VA primary care provider capable of meeting all her health care needs.

Women veterans need to feel welcomed in their VA setting and we well recognize that has not always been the case. As part of re-defining how comprehensive care will be delivered, adjustments to the VA health care environment are being made to assure all women veterans' dignity, privacy, and security.

Mr. Chairman, many new programs have been initiated, which are indicative of the change in the culture of VA and how we assure our women veterans receive the very best care they deserve from a grateful Nation.

These programs include promulgation of VA-wide standards for comprehensive women veterans' health and a requirement that all VA facilities meet those standards, targeted enhancement of mental health services for women veterans' needs, distribution of over \$32 million to purchase diagnostic equipment, including mammography, scanners for assessment of osteoporosis, and other health care equipment, requirement for every VA medical center to employ a full-time Women Veterans Program Manager by December 1st, 2008, creation of educational programs on women's health for VA primary care providers, which has trained 216 VA providers to date, creation of the first women veterans' reproductive health program to address those crucial concerns, particularly of our younger women veterans, supportive multifaceted research on women veterans' health, and improvement of communications and outreach to women veterans.

While significant efforts are underway, Mr. Chairman, for both improved care and outreach, we recognize that more must be done. We appreciate the GAO's preliminary findings on VA's provision of health services to women veterans, which has allowed us to identify additional opportunities to improve.

While some of the GAO preliminary findings represent improvements which are in process, others represent a lapse in our attention to the standards VA has set.

My colleagues and I are particularly distressed to learn about the lapses which GAO documented in established VA standards for privacy and dignity. Based on GAO's preliminary report, the acting Under Secretary for Health has ordered an immediate VA-wide review and assurance of compliance with existing privacy, security, and dignity policies to be completed by August 31st.

In addition, the acting Under Secretary for Health has asked that review of privacy, security, and dignity measures be set as a vision performance monitor for next fiscal year.

Mr. Chairman, VA's commitment to women veterans is unwavering. We stand now at a unique moment in time where our actions and plans today will build the system that will provide equal care to all of America's veterans regardless of gender.

Thank you, Mr. Chairman, for holding this hearing. We appreciate it and are happy to take your questions.

[The prepared statement of Dr. Deyton appears on p. 106.]

Mr. HALL. Thank you, Dr. Deyton.

Dr. Hayes, would you like to make a statement before we go to questions.

Ms. HAYES. No. I appreciate the offer, sir, but I will wait for questions.

Mr. HALL. Okay. Thank you.

Director Mayes, in your testimony, you noted that 250,000 women are receiving compensation and pension. Do you have a further breakdown between the rates of pension and the rates of compensation? In spite of that increase, the IOM noted that women were less likely to be granted claims for PTSD. Do you have any data on the number of women service-connected for PTSD?

Mr. MAYES. Mr. Chairman, I do not have that data with me, but that is one I would like to take for the record and we can provide that following the hearing.

[The VA subsequently provided the following information:]

Seventeen thousand, seventy-five women veterans are service-connected for PTSD. This includes 56 women veterans who are in receipt of non-service-connected pension but also are service connected for PTSD.

Mr. HALL. That would be much appreciated. Thank you.

In 2006, VA opposed implementing a new diagnostic code for military sexual trauma and, yet, in 2006 and in 2008 in response to the recommendations contained in the Advisory Committee on Women Veterans' reports, VA stated that it agreed with the underlying rationale for tracking MST claims.

I understand that the VBA indicated that it checks its system against the VHA system to identify any records that are not properly matched as MST. However, it seems that VA can only properly track these claims if they are labeled as such when they are entered into the VA system.

So three-part question here. Would not an initial diagnostic code for MST further increase the ability of the VBA to track MST claims and would not labeling claims as MST as early as possible help prevent claims from being labeled more generically or not labeled at all? I will let you answer that one first.

Mr. MAYES. Okay. Thank you, Mr. Chairman.

First of all, we agree we need to be able to collect data regarding military sexual trauma claims. Let me take the issue of a unique diagnostic code first.

Military sexual trauma is not a disability per se. Military sexual trauma or personal assault can lead to disabling conditions. What we are dealing with frequently is veterans, both male and female, dealing with post-traumatic stress disorder as a result of military sexual trauma or personal assault which is a form of military sexual trauma.

So when we evaluate an individual for disability compensation, what we are looking to do is to assign compensation based on a disabling condition or disease. And so in the case of these MST claims, it is frequently post-traumatic stress disorder.

We do have the capability to identify decisions on post-traumatic stress disorder claims that are related to military sexual trauma. And, in fact, in fiscal year 2008, we assigned service connection for post-traumatic stress disorder for female veterans 2,465 times. So 2,465 female veterans were granted service connection for PTSD due to military sexual trauma.

I believe that the recommendation made by the Advisory Committee is trying to get at other disabilities that could result from military sexual trauma and we do not have those tags, military sexual trauma tags associated with other disabilities.

But since it is not necessarily a disability, we would not have a diagnostic code for that.

Does that answer the question, sir?

Mr. HALL. Yes, it does. Thank you. Yes. Does the VBA currently have a method for identifying and tracking MST claims and how can it be improved to ensure that all women veterans' claims for MST are identified and tracked?

Mr. MAYES. When we have a claim that is pending, if it is a post-traumatic stress disorder claim, we do have a mechanism to differentiate that claim from other types of claims. We have what is called an end-product modifier. And in our system, we can segregate out those PTSD claims.

I would like to take for the record the question regarding military sexual trauma because I am not absolutely sure that we can further segregate out MST-related PTSD claims. So I will take that one for the record.

[The VA subsequently provided the following information:]

VA tracks claims for PTSD that are granted due to personal trauma. VA defines personal trauma as events of human design that threaten or inflict harm that have lingering physical, emotional, or psychological symptoms. VA further classifies "personal trauma" cases into subcategories. The total number of women veterans who are service-connected for PTSD under the applicable subcategories:

Sexual Assault/Harassment	4,400
Personal Assault	960
Other Unknown—Trauma	372
User made no selection	42
Total Number of Female Veterans with service-connected PTSD due to Personal Trauma	5,774*

* Entry of a designation of the source of PTSD is not a mandatory field to successfully prosecute a claim. Therefore, the number may be higher than the 5,774.

Mr. HALL. Okay. Thanks. You can get back to us on that.

What is the VBA doing to track disability claims by gender specifically for MST and domestic violence? This might be another one for the record. Can you provide a breakdown on the conditions for which female veterans are granted or denied service connection? And what percentage of disabled female veterans take advantage of the insurance programs?

Mr. MAYES. Well, I will start with the insurance programs. That one I will have to take for the record. I do not have information on that.

[The VA subsequently provided the following information:]

Although VA does not have actual participant numbers for the Service-members' Group Life Insurance (SGLI) program, VA can estimate the number of active-duty women covered based on the average participation rate of 99 percent. Currently there are about 205,000 women on active duty, therefore, VA estimates approximately 203,000 would have SGLI.

The participation rate for Members of the Guard and Reserve is 94 percent. There are about 151,000 women in the Guard and Reserves. VA estimates approximately 142,000 women in the Reserves/Guard have SGLI. Participants in SGLI are automatically covered by Traumatic SGLI.

Of the 431,792 veterans currently enrolled in Veterans' Group Life Insurance (VGLI), 52,376 (12.13 percent) are women. Approximately 188,000 cov-

ered by VGLI are service-connected. Of that, 25,259 (13.43 percent) are women.

Veterans Mortgage Life Insurance (VMLI) participation rates—Of the 174,500 veterans currently enrolled in Service Disabled Veterans Insurance, approximately 9,200 (5.2 percent) are women. Approximately 100 (4.3 percent) of the 2,300 VMLI participants are women.

Mr. MAYES. But, again, I can give you a breakdown of male and female veterans that have been granted or denied for post-traumatic stress disorder due to military sexual trauma.

Now, I have the number granted. I do not have the numbers denied with me today, but I can get those. It would require a query into our database.

[The VA subsequently provided the following information:]

Twenty-two thousand, two hundred eighty-three women veterans have been denied service connection for PTSD.

Mr. HALL. Okay. Thank you.

What are the most prevalent conditions for which women file claims? Does this match the prevalence for treatment of those conditions and has VBA obtained the list of women treated for MST that it committed to get from VHA?

Mr. MAYES. I will answer the first question. The types of claims that female veterans are submitting does in general, I would say, mirror the claims submitted for male veterans. By far and away, the most frequent claimed disabilities are orthopedic disabilities or musculoskeletal conditions. And that sounds reasonable to me given the fact that these servicemembers, whether they are men or women, are carrying a lot of weight on their person with the body armor and the rucks that they are carrying.

So hearing loss is another frequently claimed disability. PTSD is also in the top ten. So we have that information. I do not have all of those disabilities at hand right now, but those would be the types of disabilities that veterans would be claiming, whether they were men or women.

Mr. HALL. In response to a recommendation in the Women Advisory Committee's 2006 report, VA used gender and diagnostic codes in a VA Office of Policy, Planning, and Preparedness and Institute for Defense Analyses (IDA) joint study on State-by-State VA regional office (VARO) variation, variation in disability claims ratings and benefits to find any significant correlations.

Can you tell us the results of this study, if it has been completed, and how the data has been used?

Mr. MAYES. Could you repeat that study? I am not sure I am familiar with—

Mr. HALL. Sure.

Mr. MAYES [continuing]. What you are referring to, Mr. Chairman.

Mr. HALL. It is a study by the VA Office of Policy, Planning, and Preparedness and the Institute for Defense Analyses, joint study in response to a recommendation by the Women's Advisory Committee's 2006 report, a study on State-by-State VARO variation in disability claims ratings and benefits to find any significant correlations.

We just want to know if the study has been done, if you have seen it, what the results are, if they are in, when will the study be completed. If it is not completed, we request a status report.

Mr. MAYES. I am aware that the Institute for Defense Analyses did a variance study following the Office of Inspector General's (OIG's) review of post-traumatic stress disorder and individual unemployability claims. I believe that was in 2005. And we actually contracted with the Institute following the OIG's findings and looked at the variance across regional offices.

I am not aware that that was gender specific. So if that is the study that you are referencing, what they found was that the variance across jurisdictions was—they were looking at the average annual benefit payment. And because there were some States that had more veterans that were either 100 percent or in receipt of a total evaluation due to individual unemployability, those States, because of the difference between the 90 percent and the 100 percent rate, it is significant, those States were skewed higher.

And so, what the IDA found was that those States where you had a higher proportion of veterans in receipt of benefits, whether male or female, as I recall, those States that had a higher percentage of veterans either service-connected for PTSD or in receipt of benefits due to individual unemployability, they were more likely to have a higher average annual payout. So that was a driver of some of the variance that was observed by both the OIG and the Institute for Defense Analyses.

And then they went on to talk about other variables such as, as I recall, whether or not you were enlisted or officer, whether you were represented or not. For example, there was some significance, statistical significance associated with being represented by a veterans service organization as opposed to not being represented.

So if that is the study you are referencing, those are some of the findings that IDA found following the OIG review.

Mr. HALL. Thank you, Mr. Mayes.

I have one more thing if you could respond to us for the record. By correspondence, the Advisory Committee on Women Veterans recommended also in 2006 that VA should expand its Web site to include a secure site where veterans can check the status of their claims. VA concurred in this recommendation indicating that the one VA registration and eligibility and contact management program has been under development since 2005.

So if you could get back to us on the status of that program and how successfully you think it has been implemented.

[The VA subsequently provided the following information:]

VBA is actively participating and leveraging the work being accomplished within the Benefits Executive Council for the eBenefits portal. This provides an opportunity to leverage capabilities that are being implemented to meet the needs of both VA and DoD that will ultimately enhance our Web presence. The eBenefits portal was directed in July 2007, as a result of the President's Commission on the Care for America's Returning Wounded Warriors, to provide a single information source for servicemembers/veterans. Through the continual involvement of the eBenefits portal, users can find tailored benefit information and services in one place, rather than scattered across multiple Web sites.

The eBenefits portal has been developed as a secure servicemember/veteran-centric Web site focused on the health, benefits, and support needs of servicemembers, Veterans, and their family members. The portal consists

of both a public Web site and a secure portal that allows an authenticated user personalization and customized benefit information based upon the user's profile. VBA is able to take advantage of this design to allow our users to find the information and services they need, when they need them. There are currently several major milestones that are scheduled for the March 2010, eBenefits release that will be instrumental in providing self-service capabilities (such as checking claim status, automatically requesting a certificate of eligibility for the home loan program, and electronic submission of an application for the Specially Adapted Housing Grant.

Mr. HALL. I wanted to ask since this is officially a Health Subcommittee meeting as well, although we do not have Members of that Subcommittee here due to double and triple booking of Committee meetings, but on their behalf, I would like to ask Dr. Deyton and Dr. Hayes what does VHA do to ensure that female veterans are getting competent and qualified C&P examiners? Does the mini-residency training program that you mentioned address the issues of conducting C&P exams?

Dr. DEYTON. Let me take a bigger picture first. The issue of competency is huge for the VA system. We all know it has been a predominantly male health care system for a long time.

I am a VA clinician myself. I have a clinic every Friday. And I am one of those clinicians who need the mini residency competency for seeing female veterans.

The program that Dr. Hayes and her colleagues in the Employee Education System has put together is a very intense mini residency to bring a primary care provider like myself up to speed on women veterans' health issues. I think 216 clinicians have gone through that now.

I do not know whether C&P clinicians have gone through that or not. Do you?

Ms. HAYES. Not to date. And we have trained primarily community-based outpatient clinic providers and 90 medical center providers right now. That particular mini residency is for basic primary care skills. So that would not necessarily direct specifically to some of the questions that might be raised in a C&P exam.

Dr. DEYTON. But I think your point is a very good one and it is something that frankly we can go back and begin to work with our colleagues both who run the C&P program itself as well as our colleagues in the Employee Education System because there may be a focused set of educational materials that we will want to develop specifically targeted to C&P.

And so thank you very much for the question and we will take that and go back with it.

[The VA subsequently provided the following information:]

The Compensation and Pension Examination Program (CPEP) provides training on gender and certain specific examination types. CPEP training does not specifically provide training on women's health issues (other than as appropriate to the specific examination or disability type). However, the Veterans Health Administration (VHA) does have a primary care training program for VHA providers that addresses gender-based issues and Compensation and Pension (C&P) practitioners are eligible for this training program.

The current Women's Health Mini Residency Training is designed for primary care providers who need to enhance or refresh their skills in providing gender specific care, performing cervical cancer screenings and breast evaluations while also expanding their knowledge of contraceptive counseling and treatment, osteoporosis management and treatment, and menopause counseling and treatment. Most female-specific issues that are

presented during C&P examinations are referred to the Women's Health providers at the facility because these practitioners are experienced in providing these women's health examinations.

Mr. HALL. Thank you.

What do you do when a female veteran has requested a female examiner and none are currently available on staff at a medical center?

Ms. HAYES. If you are speaking about the C&P exams, the female veteran has a distinct right and may request a female examiner. The policy right now would be that the VA would either arrange for an alternate site or work with her in terms of when they could arrange that exam.

But I will get back to you if there is any specific question about those not being provided. I am not aware of those not being provided.

Mr. HALL. I guess this probably varies from facility to facility, region to region, but what are we talking about in terms of scheduling delays ordinarily?

Ms. HAYES. That one I am actually not prepared. What really I think the focus is the patient has the right to request a same gender provider, a female provider in the case of women. And we honor that in terms of our policy.

So I do not know of any delays caused by it, but we are really focusing on the issue that the patient has that right and we want to respect that.

Mr. HALL. Right. I understand that. But are we talking hours, days? Assuming there is nobody currently at the facility, a female examiner available at that time—

Ms. HAYES. I think, sir, it would be totally dependent on what type of exam it was—

Mr. HALL. Uh-huh.

Ms. HAYES [continuing]. And how specialized the provider would need to be.

Mr. HALL. Yes.

Ms. HAYES. And so I do not know that I can answer that specifically.

[The VA subsequently provided the following information:]

The VHA national average for C&P examinations is 29 days. C&P examinations for females asking to be seen by a female provider only are scheduled in as timely a manner as possible to accommodate the veteran's request.

Mr. HALL. Okay. At what forum does VA regularly address women's issues jointly with the DoD? During the Joint Executive Council?

Ms. HAYES. I think you and Dr. Trowell-Harris.

Dr. DEYTON. Why don't you start with that?

Dr. TROWELL-HARRIS. At the Advisory Committee on Women Veterans, we have the DACWITS Director. It is the Defense Advisory Committee on Women in the Services. She is on the Advisory Committee on Women Veterans as an ex officio.

I attend DACWITS meetings as an ex officio for VA. We do have staff members also attending the Secretary's Benefits Executive Council, and the Health Executive Council. And when they address women veterans' issues, they make sure that those are all included.

We also have on our Committee representatives from the U.S. Departments of Labor, Health and Human Services, and other agencies also currently working with DoD in conjunction with the White House Interagency Council on Women and Girls that is looking at women veterans' issues, but we constantly coordinate with DoD on various issues and they do call on us frequently when they have their meetings to help them set up the agenda.

I have presented at the DACWITS Committee several times. Dr. Hayes was there recently and other va staff members with expertise on women veterans' issues do present there. So we constantly are in contact with them and they are in contact with us addressing mutual interest items on servicemembers' and women veterans' issues.

Dr. DEYTON. Let me add to that, sir. As part of the Health Executive Council, there are multiple Subcommittees and work groups, joint VA/DoD Committees, one called Deployment Health of which I am the VA Co-Chair. I know Dr. Hayes has talked to that group. And there are issues related to deployment health and the women veterans who are deployed, women servicemembers who are deployed. Topics have come up there. I think there is also a sexual assault—

Ms. HAYES. I am the VA representative to the Sexual Assault Advisory Committee of the Department of Defense and also attend the meetings for the Sexual Assault Prevention and Response Office. So we collaborate in terms of these issues of transition of servicemembers who have experienced sexual assault. Particularly that is my area of representation and policy on that Committee.

Mr. HALL. The IOM suggested a prevalence of domestic violence among male veterans and the data shows that over 50 percent of female veterans marry other servicemembers and that they may experience domestic violence, but the VA has a limited number of batterer intervention programs throughout its entire system.

What is VA doing to expand the Batterer Intervention Programs and does it have a strategic plan to address domestic violence?

Dr. DEYTON. I do not know. We are happy to get—

Mr. HALL. Well, honest answers are good.

Dr. DEYTON. That is right. We will get back to you on that.

[The VA subsequently provided the following information:]

VA recognizes the importance of addressing this issue and is taking action to focus on issues for perpetrators or victims of domestic violence. The following information describes specifically what mental health services VA provides for victims of domestic violence as well as for those at risk of becoming abusive.

With regard to providing care for victims of domestic violence, VA has several programs:

1. VHA sponsors trainings and ongoing consultations to implement "Seeking Safety," a present-focused therapy originally designed for clients with trauma histories who are simultaneously experiencing symptoms of post-traumatic stress disorder (PTSD) and substance use disorders. Maintaining overall safety is the goal of this therapy, but it also helps clients attain safety in their relationships, as well as with their thinking, behavior, and emotions. "Seeking Safety" includes 25 treatment topics including Setting Boundaries in Relationships, Healthy Relationships, Taking Good Care of Yourself, and Red and Green Flags. Given the significant focus on maintaining safe and healthy interpersonal relationships, "Seeking Safety" has great relevance for the treatment of women and men who have experienced

interpersonal violence. "Seeking Safety" also has been empirically tested among homeless women veterans (Desai et al., 2008) and is widely used among VA's Mental Health Residential Rehabilitation Treatment Programs.

2. VA has developed a Continuing Medical Education Program on Military Sexual Trauma. This independent study module contains both a chapter on Risk for Revictimization and one on Intimate Partner Violence.
3. VHA's Employee Education System (EES) is in the final stage of reviewing an online training module on Family Relationship Issues, to be used by clinicians serving currently returning veterans. There is also an EES Satellite Broadcast on Domestic Violence scheduled for FY 2010.
4. Across the VA system there are examples of trainings and emerging best practices related to domestic violence. For example, the Bedford VA Medical Center (VAMC) held a daylong conference for mental health providers on working with both perpetrators and survivors of domestic violence. Also at Bedford a psychologist has been working within the integrated primary care service to screen women veterans coming to their women's health clinic to determine if they have experienced domestic violence and to coordinate both crisis and long-term care plans for those who screen positive as current victims of domestic violence or who are looking for treatment for emotional consequences of domestic violence that may have occurred in the past. They recently received a \$25,000 grant from the Women Veterans Health Strategic Health Care Group to continue this screening and to provide education and training for all primary care providers on the overall health effects of domestic violence on veterans and the importance of primary care screening.

For veterans with anger management problems who are, or are at risk of becoming, physically abusive to family members, VA also offers several programs:

1. PTSD programs in VA offer anger management services as a component of care, given the prominence of irritability and anger-related aggression as a potential feature of the PTSD syndrome.
2. EES is in the final stages of revising an online training module on anger management for clinicians assisting currently returning veterans.
3. Eight VAMCs offer Intimate Partner Violence (IPV) programs directed at the abusing partner. These programs employ a variety of models, including the Duluth IPV model and Cognitive Processing Therapy. For example, at the Boston VAMC, a psychologist is conducting research on preventive couples' groups for Operation Enduring Freedom and Operation Iraqi Freedom veterans and their significant others. This individual also runs a group for veterans who are currently involved in violent relationships. The Cincinnati VAMCs IPV program has been certified since 2004 for use with the prison reentry population by the Ohio Department of Corrections.
4. The Veterans Integrated Systems Network 2 has provided training during Fiscal Year 2009 on addressing domestic violence with an emphasis on detecting suicidality in violent partners. The training was provided by two experts in the field: Dr. Susan Horwitz and Dr. Kate Cerulli, University of Rochester Department of Psychiatry. The 6 hour training was entitled "Partner Violence and Military Veteran's Relationships: Recognition and Response", was provided to clinicians in—Albany, Syracuse, Canandaigua, Buffalo, and Bath VA Medical Centers.

Mr. HALL. Thank you.

African American women are joining the military at a greater rate than any other cohort. What is the VA doing about outreach to this population and addressing their specific needs when they submit applications for assistance?

Dr. DEYTON. Sir, I know that we have a very proactive Center for Minority Veterans Affairs and I know that the Director of that

would love to be sitting here and answer the question in much more detail than I can. But I know that they have multiple programs and services and outreach to minority veterans.

Irene, do you have any specifics about—

Dr. TROWELL-HARRIS. We work very closely with the Center for Minority Veterans looking at issues related to African Americans and others, and especially looking at issues related to Native American women on reservations, but we do work very closely with them on—with their recommendations on that.

[The VA subsequently provided the following information:]

The Center for Women Veterans and Center for Minority Veterans address the needs of women veterans for VA as an integrated outreach program. This is done by extensive collaboration, outreach and participation in joint initiatives and workgroups on women veterans issues including African American women veterans.

- Department of Defense—work in collaboration with the DoD Advisory Committee on Women in the Services (DACOWITS)
- VA administrations and staff offices
- Other Federal agencies such as DOL, HHS, HUD
- State agencies
- State women veterans coordinators
- Faith-based and Community Initiatives
- Policy and legislative groups
- Veterans Service Organizations
- County and private agencies
- Women and minority groups such as NAACP, LULAC, National Association of Black Veterans

There were no recommendations in the 2008 Advisory Committee on Women Veterans (ACWV) report to Congress specifically addressing the needs of African American women veterans. Based on ACWV discussion with the National Cemetery Administration, an outreach Web site was established specifically targeting women and minority veterans (www.cem.va.gov). The Center for Minority Veterans does have designated staff members assigned to monitor and address the needs of various minority groups including African American women and men veterans.

Mr. HALL. Dr. Trowell-Harris, you also stated that progress was being made on a number of women veterans' issues, but none of those areas were related to benefits, if I remember correctly.

What has the Center done or what is it doing to improve awareness and access to VA compensation and pension for women veterans?

Dr. TROWELL-HARRIS. When we have a recommendation on that, the ones that have already been addressed regarding the military sexual trauma, we make those recommendations to the VA. And the way we get those issues is, again, from working with veterans nationally, with Congressional staff, and with VA administrations. So any benefits issue that comes to us, we make that as part of the recommendation.

And we did have several in the 2008 report to the Secretary and the Congress. Any new issues coming up now will be dealt with in the 2010 report which we are crafting now based on site visits, information from various sources to look at the new recommendations for the Secretary.

Mr. MAYES. Mr. Chairman, if I might add to that, one of the things that the Committee recommended was that in our outreach material we make reference to women in the military, women in uniform. And we are working right now on a tri-fold pamphlet

similar to what we put together for the predischARGE Benefits Delivery at Discharge Program and the Quick Start Program.

So we have a draft of that pamphlet that will outline specific benefits that are available to female women veterans. And also, as I mentioned in my testimony, we target women veterans and in particular, we talk about military sexual trauma in our TAP briefings. So we are trying to raise awareness in those TAP briefings.

Last year, we did 108 stand-downs. Again, we are out there in the community and it is all veterans, but there are some unique things that we are doing for female veterans as well.

Mr. HALL. In a study conducted by Dr. Maureen Murdoch, she found that 71 percent of male veterans had their claims for PTSD granted while only 52 percent of females were granted their claims.

Furthermore, the IOM concluded that there are huge barriers to women being able to independently substantiate their experiences of MSA, especially in a combat arena, as we heard from our earlier panel, which results, of course, in less service-connection awards for PTSD.

What has the Center for Women Veterans done? What can the VBA do to address these claims and the disparity issues identified by Dr. Murdoch and the IOM?

Dr. TROWELL-HARRIS. You can address that one.

Mr. MAYES. Well, I can take that. There are a number of things that we have done and there are some things that we are doing.

The first thing we did is we reduced the evidentiary burden through rule making for female—well, any veteran, not just female veterans, any veteran filing a claim for post-traumatic stress disorder due to military sexual trauma. That was the regulation that I referenced in my testimony.

So we understand that there may not be records for a variety of reasons, such as people do not want to go to their supervisors and talk about this. We understand that. In some cases, there can be a stigma attached. There is the assertion that commands do not deal with this well.

So we understand that there is difficulty in sometimes securing those records. So we reduced the evidentiary burden such that we look for markers. And I believe I mentioned some of those in my testimony and I will just reference back to that.

It could be things like evidence from law enforcement authorities or rape crisis centers, mental health counseling centers. There could be a degradation in a servicemember's performance, absenteeism. There are many things that we are looking for and we will accept those, that evidence, those markers as evidence.

And then what we will do before we decide that claim is we will collect that evidence and present that evidence to the examining clinician and ask for their opinion. Does this evidence suggest that, in fact, there was a military sexual trauma incident that warrants service connection?

But there is no question that these claims can be difficult to prove.

Mr. HALL. No doubt. The fog of war enveloping all and then, of course, if an incident happens, it involves two people, and when there are no other witnesses this can be very difficult. But those are some ways to approach it by analyzing the results.

I wanted to ask about the media advertising and outreach that VA is doing to promote the awareness of benefits provided under laws that Congress has passed either by VSOs advertising or VA in concert with them or VA by itself. There is advertising done for personnel recruitment and for loan guarantee activities.

Has the Center for Women Veterans done anything so far to recommend or advocate for VA to improve its outreach to women or advertising to women about the benefits and services that are available for their specific problems or is this something you are already working on? Is this something that we could encourage you to work on?

Dr. TROWELL-HARRIS. Yes. In our 2008 report, we recommended that in all publications to the media, et cetera, that they include and portray women veterans because originally and initially when you look at VA pamphlets, you do not see the face of a female veteran on there. And many times you do not see the face of a minority women veteran on there.

So that was one of our recommendations. And there have been several pamphlets produced within the past 8 months since our report that accurately reflect in the media, that, you know, of all the women veterans.

As a good example of that, too, we ask NCA to do outreach particularly targeting women and minorities. And they have a pamphlet out, but they also have a wonderful Web site, which is really very nice, which really targets women veterans, including women of color.

And we are constantly monitoring when we see pamphlets or we see posters or magazines out there to make sure that they are really diverse. And, again, once in a while, we do come across something that is not diverse and we let the division know about that, whether it be VHA, VBA, NCA, or other offices.

So thank you.

Mr. HALL. Thank you.

I wish we had somebody from DoD here that I could ask this question to as well, but I would ask you to, if you can, get back to us with any observations that you may have on this question.

In the last year or so since the economic downturn started in this country, there has been no problem in recruiting for our Armed Forces. They have all met their recruitment goals as other employment became harder to find.

But for a couple years before that, with the War in Iraq producing heavy casualties and the economy doing better, there were well-publicized and published reports about an increase in morals waivers by the Armed Services in terms of recruiting. Reports stating that they were accepting people into the Armed Services who previously would not meet their standards under their ordinary rules.

I do not know if there is a way of correlating the timeframe when that was happening, the numbers of people, the recruits who were brought under morals waivers, and see if there is any correlation between that timeframe and any change in the incidence of military sexual trauma.

But I for one would be interested in knowing if there is. And, Dr. Deyton, you seem to—

Dr. DEYTON. Actually, I do not have data, but I would like to tell you, Mr. Chairman, that some of the surveillance and epidemiology of the whole population that my office does may pick up some data as the surveillance data matures.

We are the Office of Public Health and Environmental Hazards and we do long-term surveillance of the populations of veterans from the various conflicts and the various eras of service. We can determine the kinds of utilization and diagnostics that these veterans when they come to VA, what services they use, what their diagnoses are, not individuals, but as a whole group of veterans.

And so the hypothesis, sir, we could put to a test of taking eras of service or years within eras and ask certain questions about diagnoses or we would work with our DoD, frankly, if there are reports in military service records or law enforcement records about certain events or behaviors.

So it is a testable hypothesis and I am trying to tell you we do have some resources that we could use to begin to try and address that kind of question. So just information. I do not have the answer though.

Mr. HALL. Well, I did not expect that you would, but that is a good start. I think obviously it is important for the future of our military, for the future of our male and female, but especially our female servicemembers' safety and health.

I represent West Point. I am on the Board of Visitors at West Point. We have had there among cadets who are not yet deployed but are going through the rigors of training, extremely high academic achievement standards, parental pressure, and peer pressure and at the same time that they are probably at the peak hormonal output a human being might be at, which has some bearing on incidents of sexual harassment and incidents that the Academy is dealing with.

All of the Academies have had this problem and they are dealing with it as are the Services in trying to communicate that we are on a team, the cadets and soldiers are brothers and sisters who should be defending each other and sticking up for each other, and what once was essentially a male fighting force is now a co-ed fighting force and becoming more female all the time. Regardless of what is classified as combat, they are serving side-by-side as several of our panelists have pointed out.

So, this is extremely important. I commend you for the work that you have done. I know that you want this problem addressed and solved as quickly as possible.

I am looking forward to the August 30th deadline that the Secretary asked to be met. Also, I hope that we will not have more hearings where we hear about facilities that are not set up for the privacy that is needed for women to have examinations or meetings or discussions that they need to have about problems relating to these issues.

It is a process that will take us some time, but we are serious about it. We, on this side of the table, are serious about it. I know you are as well.

I thank you for your work for our veterans and I thank those veterans and advocates who testified in the earlier panels. I look forward to your written responses.

The Health Subcommittee Chairman, Congressman Michaud's opening statement is accepted in the record. All Members will have 5 days to revise and extend their remarks.

Thank you again for your patience. This hearing is adjourned.
[Whereupon, at 2:15 p.m., the Subcommittees were adjourned.]

A P P E N D I X

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

Good Morning Ladies and Gentleman:

I am grateful for the opportunity to be here today for a joint hearing with my colleagues, Health Subcommittee Chairman Michaud, and our Ranking Members, Mr. Lamborn and Mr. Brown. But, I am particularly eager to recognize the women veterans who are in this room today and to be enlightened by their experiences with the Department of Veterans Affairs. VA owes them the proper benefits and care—just like their male counterparts. However, they are a unique population, since they comprise only 1.8 million of the 23.4 million veterans nationwide, and deserve specialized attention. So, VA's mission to care for them must not only be achieved, but monitored, and supported as well.

Sadly, that is not always the case. In response to reports of disparities, during the 110th Congress the Disability Assistance and Memorial Affairs and Health Subcommittees held a joint hearing on women and minority veterans. This Congress too has been very active in its oversight activities to assist women veterans and a record number of them have testified at various hearings. Additionally, on May 20th, Chairman Filner hosted a special Roundtable discussion with women veterans from all eras who were able to paint a picture of military life as a female in uniform and then as a disabled veteran entering the VA system. In many cases, they have served alongside their male counterparts, but have not had the same recognition or treatment. Chairman Filner also hosted a viewing and discussion session with the Team Lioness Members who were on search operations and engaged in firefights, but since there is no citation or medal for this combat service, their claims are not always recognized by VA as valid, so they are denied compensation.

The Disability Assistance and Memorial Affairs Subcommittee has all too often received reports about destroyed, lost, and unassociated records that either never make it from the Department of Defense to VA or VA loses once in their possession. Therefore, it is no surprise that women veterans are at a greater disadvantage since their military assignments and records are less likely to reflect their actual service, exposure to combat or other traumatic events. Also, women who have suffered the harm of military sexual trauma often do not report those crimes and have limited documentation that can be used as evidence when they seek VA assistance, often resulting in a denial of benefits.

Even when they do report incidences of harassment or assault, perpetrator conviction rates are only 5 percent, so these reports are seen as unsubstantiated. This result is especially unfair given that 78 percent of female servicemembers reported some form of sexual harassment according to a DoD survey. Studies have shown that for generations women veterans have been less likely than men to be granted service connection for their post-traumatic stress disorder, even though data shows women are more likely to report symptoms and seek treatment.

Also, I fear that when the 5 years of open enrollment afforded to current conflict veterans ends, then these women will be denied treatment as they will no longer qualify for health care since they are not service connected. Without service connection, they are not eligible for other VA assistance, such as vocational rehabilitation and employment services or housing, so problems don't get better, they get worse.

Congress cannot allow that to happen to this Nation's daughters who have served her. VA needs to ensure that their claims for disability benefits are fairly and judiciously heard. Women veterans should be able to request female compensation and pension service officers, adjudicators, and examiners, if they so desire. These employees should be properly trained to be sensitive to the injuries and illnesses women veterans claim and to treat them with the dignity and respect that they deserve. VA should collect gender-specific data and conduct research on the disabilities that specifically afflict female veterans. VA outreach efforts should target women of all ages, ethnicities, and communities. They must know that they are indeed vet-

erans and deserve the same benefits, services and burial rights as their brothers in arms have come to expect.

The future of the military will be more reliant on the selfless service and the sacrifices of this Nation's daughters, her mothers, and her sisters. Coming home must be free of abuse, disparity, and inequality so that transitioning female servicemembers can continue to be productive employees and community leaders while maintaining healthy lifestyles and raising families.

I look forward to hearing from the esteemed panels of witnesses assembled today as we attempt to eliminate any gaps hindering access to benefits and care for our women veterans.

Thank you. I now yield to Ranking Member Lamborn for his opening statement.

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

Thank you Mr. Chairman,

I welcome our witnesses to this hearing to discuss Challenges Facing Women Veterans.

I appreciate your contributions to this discussion and hope they will lead to improvements we can all agree on.

Without question, America's women are, and always have been, an integral part of our Nation's defense.

In more than two centuries of service to our country, women servicemembers have formed a glorious legacy.

That legacy has only been enriched by the intrepid and resolute accomplishments of today's women in the global war on terror.

Women make up nearly 10 percent of our Nation's 24 million living veterans, and those serving on active duty represent more than 15 percent of our armed forces.

Our challenge is to ensure that women veterans—and indeed all veterans—receive world class health care and benefits for their service to our Nation.

The VA centers for women 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 seek their input to affect policy and to help bring about the intended results.

In that regard, I look forward to hearing about the challenges facing women, such as gender-specific health care, PTSD, and Military Sexual Trauma.

I thank the witnesses for their testimony and I yield back.

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

Messrs. Chairmen and Members of the Subcommittees:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this joint oversight hearing focused on eliminating the gaps and examining women veterans' issues. This hearing is extremely timely given the changing roles of women serving in our armed forces today, the 1.7 million women veterans who served previously, and the dramatically growing number of women seeking health care and other benefits from the Department of Veterans Affairs (VA).

NEED FOR GUARANTEEING EQUAL ACCESS TO SERVICES

Ensuring equal access to benefits and high quality health care services for women veterans is a top priority for DAV. We have a longstanding resolution from our membership of 1.2 million wartime disabled veterans that seeks to ensure VA health care services for women veterans, including gender-specific care, are provided to the same degree and extent that services are provided to male veterans. Also, given the undoubted greater exposure of servicewomen to combat, we believe they should have equal access to supportive counseling and psychological services incident to combat exposure. Military sexual trauma (MST), while not exclusively a women's issue, is also of special concern to DAV. Additionally, we urge VA to strictly adhere to its stated policies regarding privacy and safety issues related to the treatment of women veterans and to proactively conduct research and health studies as appropriate, periodically review its women's health programs, and seek innovative

methods to address women's barriers to VA health care and services, thereby better ensuring women veterans receive the treatment and specialized services they rightly earned through military service.

Likewise, for many years, the organizations that make up the *Independent Budget*, (IB) AMVETS, DAV, Paralyzed Veterans of America (PVA) and Veterans of Foreign Wars of the United States (VFW), have included a special section in the IB emphasizing women veterans, in an effort to call attention to the need to address many of the challenges VA faces in providing high quality health services to women veterans in a predominantly male-oriented health care system. Additionally, DAV included a special focus on women veterans as part of our ongoing *Stand Up For Veterans* campaign—focusing public attention on the unique needs of women veterans—with a special emphasis on women who became disabled during their wartime service.

Women veterans are the fastest growing segment of the veteran population—and according to the Veterans Health Administration (VHA), women are projected to account for one in every seven enrollees within the next 15 years, compared to the one in every sixteen enrollees today. Because of the large and growing number of women serving in the military today, the percentage of women veterans is projected to rise proportionately from 7.7 percent of the total veteran population in 2008, to 10 percent in 2018.¹ Additionally, VA notes that women who served in Operations Iraqi and Enduring Freedom (OEF/OIF) utilize VA services at a higher rate than other veterans, including other women veterans and male OEF/OIF veterans—with 44.2 percent of the 102,126 OEF/OIF women veterans having enrolled in VA, and 43.8 percent who consume a range of two to ten visits annually. Earlier generations of women veterans enrolled in VA health care at a 15 percent average rate.²

As reported by VA, historically, women have underutilized VA health care services in comparison to male veterans. In the past 5 years, on average, 22 percent of men versus 15 percent of women have accessed VA health care. Women veterans using VA health care are also younger—with an average age of 48 compared to male veterans' average age of 61. Among women users from OEF/OIF, more than 85 percent are under age 40 and of childbearing age, and nearly 60 percent are between the ages of 20–29.³ In addition, women veterans have been shown to have unique and more complex health needs with a higher rate of comorbid physical and mental health conditions; for example, 31 percent of women have such comorbidities versus 24 percent of men. Even with this higher rate of comorbidity, women veterans receive their primary and mental health care in a fragmented model of VA health care delivery that complicates continuity of care. In fact, according to the VHA Plan of Care Survey for fiscal year 2007, 67 percent of sites provide primary care in a multi-site/multi-provider model (*i.e.*, with primary care provided at one visit and gender-specific primary care at another visit), while only 33 percent of facilities offered care to women in a one-visit model for both services.

We have read with great interest a recently released VA publication titled: *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, dated November 2008. VA's 2008 report reflects the most pressing challenges VA faces related to caring for women veterans: specifically, developing the appropriate health care model for women in a system that is disproportionately male focused, the increasing numbers of women coming to VA for care, the impact of changing demographics in the women veteran population and the impact on VA health care delivery as well as the identified gender disparities in quality of care for women veterans.⁴ Given the changes in recent years, the Under Secretary's workgroup concluded that there are now sufficient numbers of women veterans to support coordinated models of service delivery to meet their needs, and that while

¹U.S. Dept. of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, Page 5. Washington, DC: November 2008.

²Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 4. June 2009. www.amsus.org/sm/presentations/Jun09-B.ppt.

³Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Pages 6–7. June 2009. www.amsus.org/sm/presentations/Jun09-B.ppt.

⁴U.S. Dept. of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, Page 13. Washington, DC: November 2008.

women will always comprise a minority of veterans in the VA system, they now represent a critical mass as a group and should therefore be factored into plans for focused service delivery and improved quality of care.⁵

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

We are impressed with the thoroughness of the review of women's care in VHA by the workgroup, and also with the optimism of its recommendations to improve women's health. If implemented nationally its recommendations could assure that women veterans receive coordinated, comprehensive, primary care at every VA facility from clinical providers who are trained to meet their needs; an integration of women's mental health with primary care in each clinic treating women veterans; the promotion of innovation in women's health delivery; enhanced capabilities of all staff interacting with women veterans in VA health care facilities; and an achievement of gender equity in the provision of clinical care within VA facilities.

VA HEALTH CARE FOR WOMEN VETERANS: CURRENT CHALLENGES

In the *Provision of Primary Care to Women Veterans* report the workgroup identified seven specific challenges that VA must overcome in order to deliver quality, comprehensive primary care to women veterans.

- *Challenge 1:* VA recognizes that women have been under-served in the veterans health care system. Utilization rates for men have held at approximately 22 percent for many years—while utilization rates for women range between 11–19 percent. Research shows that women veterans do not self-identify as bona fide veterans, and are more unlikely to be unaware of their enrollment eligibility.
- *Challenge 2:* VA acknowledged there is a clear and growing need for improved service delivery to women veterans in VHA. Given the significantly higher VA utilization rates among women returning from OEF/OIF as indicated above, VA expects the number of women veterans coming to VA for care will likely double within the next 4 years.
- *Challenge 3:* In recent years, VA reports have shown a significant demographic shift related to women VA-users and notes the impact of age-related health concerns for this population.
- *Challenge 4:* The workgroup identified and acknowledged gender disparities in quality of care in VHA between men and women.
- *Challenge 5:* The workgroup identified routine fragmentation of health care delivery to women veterans that poses possible negative health outcomes.
- *Challenge 6:* One of the most significant challenges VHA faces according to this workgroup report is an insufficient number of clinicians with specific training and experience in women's health.
- *Challenge 7:* Finally, the workgroup identified that there is inconsistent policy in place for women's health care delivery in VHA.

Collectively these challenges constitute serious gaps in health care services available to women veterans. Most notable is the finding that the historical predominance of male veterans in the VA setting has resulted in many providers lacking or having limited exposure to women patients. According to the workgroup, women veterans' numerical minority in VHA has created unique logistical challenges in creating and sustaining delivery systems that assure VA's goal of equitable access to high quality comprehensive services that include gender-specific care. The workgroup however, noted there are now sufficient numbers of women to justify a VA effort to produce coordinated models of service delivery to meet their needs—and that as a group women veterans should be factored in as a special population

⁵U.S. Dept. of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, Page 6. Washington, DC: November 2008.

cohort in any new strategic plans for service delivery.⁶ According to the report, to a large extent, health care services offered to women veterans have evolved in a patchwork fashion. Some facilities have strong champions with expertise in women's health and offer comprehensive services in one location; other facilities, however, require women to see several providers for basic primary care services, and some VA facilities rely heavily on fee-basis providers to care for enrolled women veterans.

Likewise, the workgroup noted that almost all new users of the system are under age 40—and of childbearing age—therefore, there is a need for a focused shift in the provision of health care services. We appreciate the workgroups sensitivity to all eras of women veterans as it mentioned VA must continue to be sensitive to the needs of older women veterans as well, since women over 55 years of age face high risks for cardiac disease, cancers and the consequences of obesity (such as Type 2 diabetes). One of the most troubling findings brought forward in the report is that despite positive results on gender-specific measures such as screening for cervical and breast cancer, significant differences are recorded in VHA performance scores between men and women on certain outpatient quality measures that are common to both men and women. Specifically, depression and PTSD screening, colorectal cancer screening and vaccinations were reported as less favorable for women.

Of special note to DAV is reference in the report to a 2006 VA study among women veterans who had not had access to health care in the past 12 months. Of that group 18.7 percent were service-connected for disability incurred in the line of duty.⁷ This finding—that service-connected women veterans without access to health care, are not enrolled in nor using VHA services—is especially troubling to DAV. Clearly, there is a need to better understand why women choose to use—or not use VA services and for improved outreach to this population of service disabled veterans.

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

WORKGROUP REPORT RECOMMENDATIONS

Based on its findings—the workgroup made five key recommendations: A summary of each recommendation is provided below.

- *Recommendation 1* focuses on the delivery of coordinated, comprehensive primary women's health care at all VA facilities, including the development of systems and structures for care delivery that ensure every woman veteran has access to a qualified primary care physician who can provide care for acute and chronic illnesses, gender specific care, and preventative and mental health services.
- *Recommendation 2* seeks to ensure integration of women's mental health care as a part of primary care.
- *Recommendation 3* focuses on promoting new ways of providing care delivery for women through support of best practices fitted to a particular facility or VISN configuration and the women veteran population in that location or region.
- *Recommendation 4* addresses the need to cultivate and enhance the capabilities of all VHA staff—including medical providers, clinical support, non-clinical, and administrative staff, to meet the comprehensive health care needs of women veterans.
- *Recommendation 5* seeks to achieve parity in clinical performance measures and gender equity in clinical quality of care issues by addressing the systemic rea-

⁶U.S. Dept. of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, Page 16. Washington, DC: November 2008.

⁷U.S. Dept. of Veterans Affairs, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group; *Report of the Under Secretary for Health Workgroup: Provision of Primary Care to Women Veterans*, Page 15. Washington, DC: November 2008.

sons for the identified disparities in outcomes for women using VA in order to effect change in clinical practice.

These internal VA recommendations thoroughly address quality, efficiency, access and equity of VA care for women who use VA services. The workgroup found the need to improve all these areas in today's VA health care programs for women veterans, and to better prepare these programs for tomorrow's women veterans. We fully concur with the recommendations made and urge that immediate action be taken to reform the system to better meet the needs of women veterans and correct these serious self-identified deficiencies.

WOMEN'S HEALTH RESEARCH AGENDA

Research plays an integral role in developing the most appropriate health care delivery model for women veterans and promoting access to high quality health care services. Over the years, VA researchers have brought to light a number of important facts that, if acted upon, would greatly improve the care that women veterans receive in VA health care facilities.

DAV is pleased that VA's Office of Research and Development (ORD) supports a comprehensive women's health research agenda, and that VA has intensified its research on women's health in the last decade. The first comprehensive VA women's health research agenda, which covered biomedical, clinical, rehabilitative and health services research (HSR&D), was directed by ORD in 2004 with the goal of positioning VA as a national leader in women's health research. HSR&D is also currently funding 27 research projects that examine the health and health care of women veterans; the consequences of military sexual trauma and other military traumas on both sexes; PTSD treatment in women; screening and utilization as well as post deployment access and reintegration issues; utilization; outcomes and quality of care for women veterans related to ambulatory care; chronic mental and physical illness, alcohol misuse, breast cancer and pregnancy outcomes. HSR&D is also in Phase II of a study examining VA's approaches for delivering care to women veterans, while another study is assessing the implementation and sustainability of VA women's mental health clinics. These studies include OEF/OIF populations.

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

HEALTH CARE GAPS/SUMMARY

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

We fully concur with the workgroup's conclusion that "the debt owed to all our veterans and to women in particular demands nothing less than our full attention." However, addressing the goals identified in the report will require VA's building the proper resources, adequate infrastructure, program capacity and internal support necessary at the highest levels to make the changes it says are needed. Without question, this is a significant undertaking by VA and a lot of hard work lies ahead to achieve the goals it has set out for itself, but we are hopeful. We believe that, with the attention, oversight and collaboration of the House Veterans' Affairs Committee, VA can achieve implementation of the recommendations in this report.

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

We would like to point out that as of March 11, 2009, this landmark report on women veterans was distributed to VA field facilities and to regional network management offices within VHA. However, its transmittal to the field by VA Central Office did not take the form of a VHA directive; nor did it appear to convey any mandatory implementation requirements or accountability on the part of local or regional officials. It was simply transmitted to VA field elements as an informational device, apparently for their discretionary use in planning. We recognize that VA has been making a good faith effort to move forward on its plans for improving women

veterans' health services, and it is clear from VA correspondence included at the end of the report that at multiple levels work is underway to assess and implement principles outlined in the report. However, we again note there is no formal expression of policy or directive to fill the gaps that this report identified.

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

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

WOMEN VETERANS: BENEFIT-RELATED ISSUES

Another area of concern for DAV relates to veterans' claims for conditions resulting from military sexual trauma (MST). The prevalence of sexual assault in the military is alarming and has been the object of numerous military reports and Congressional hearings. Servicemembers who have suffered MST often do not report the assault during military service but experience lingering physical, emotional or psychological symptoms following the incident. Unfortunately, many men and women who experience these types of traumas do not disclose them to anyone until many years after the fact. Under VHA policy, all patients are screened for MST and free treatment is available for MST-related conditions at VA health care facilities. Service connection or disability compensation is not required for eligibility to treatment. A recent VA study of 573,640 veterans screened for MST found that 22 percent of women and 1.2 percent of men had positive screens.⁸ Another VA study found that of 125,000 veterans screened, about 15 percent of OEF/OIF women veterans, who use VA health care, reported experiencing sexual assault or harassment during military service.⁹ VA research also indicates that men and women who report sexual assault or harassment during military service were more likely to have a diagnosis of a mental health condition. According to VA, women with MST had a 59 percent higher risk for mental health problems, with the risk among men was slightly lower, at 40 percent.¹⁰ The most common conditions linked to MST were depression, PTSD, anxiety and adjustment disorders and substance-use disorders.

Unfortunately, if an assault is not officially reported during military service, establishing service connection later on for conditions related to MST is very challenging. These claims are frequently denied by VA due to lack of evidence that causing extreme frustration for veterans seeking VA disability compensation benefits. Although VHA openly provides treatment for alleged MST victims, many would be eligible for compensation benefits but are unable to support their claims with documentation of the stressor incidents. According to an Institute of Medicine (IOM) National Research Council report on PTSD compensation, significant barriers prevent women from being able to independently substantiate their experiences of MST, especially in combat arenas.¹¹ The IOM report concluded that little research exists on the subject of PTSD compensation and women veterans. The Committee noted that available information suggests that women veterans are less likely to receive service

⁸Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health, Strategic Health Care Group, Department of Veterans Affairs; *Women Veterans Health Care, Evolution of Women's Health Care in the Veterans Administration*, Page 13. June 2009. www.amsus.org/sm/presentations/Jun09-B.ppt.

⁹U.S. Dept. of Veterans Affairs, VA Research Currents. November–December 2008. http://www.research.va.gov/resources/pubs/docs/va_research_currents_nov_dec_08.pdf.

¹⁰Ibid.

¹¹Institute of Medicine and National Research Council of the National Academies, Committee on Veterans' Compensation for PTSD, Board on Military and Veterans Health, Board on Behavioral, Cognitive, and Sensory Sciences; *PTSD Compensation and Military Service*. Washington DC, 2007.

connection for PTSD and that this is related to being unable to substantiate non-combat traumatic stressors such as MST. (Also, with regard to women who were traumatized by direct or indirect combat exposure, DoD faces several additional challenges that are discussed farther on in this testimony.) The Committee further noted that VA materials for rating these types of cases address MST but that little attention is paid to the unique challenges of documenting an in-service stressor or approaches for solving this problem.

In 2005, the Department of Defense (DoD) established the Sexual Assault Prevention and Response Office (SAPRO). This organization is responsible for all DoD sexual assault policy and provides oversight to ensure that each of the military service's programs complies with DoD policy. SAPRO serves as the single point of accountability and oversight for sexual assault policy, provides guidance to the DoD components, and facilitates the resolution of issues common to all military services and joint commands. The objectives of DoD's SAPRO policy are to specifically enhance and improve: (1) prevention through training and education programs, (2) treatment and support of victims, and (3) system accountability.

Under DoD's confidentiality policy, military victims of sexual assault have two reporting options—*Restricted reporting* and *Unrestricted reporting*. Restricted reporting allows a sexual assault victim to confidentially disclose the details of his or her assault to specified individuals and receive medical treatment and counseling, *without triggering the official criminal or civil investigative process*. Servicemembers who are sexually assaulted and desire restricted reporting under this policy may only report the assault to the Sexual Assault Response Coordinator (SARC), Victim Advocate or a Health Care Personnel (HCP). According to SAPRO, health care personnel will initiate the appropriate care and treatment, and report the sexual assault to the SARC in lieu of reporting the assault to law enforcement or to the unit commander. Upon notification of a reported sexual assault, the SARC will assign a Victim Advocate to the victim. The assigned Victim Advocate will provide accurate information on the process of restricted versus unrestricted reporting. At the victim's discretion/request, appropriately trained health care personnel will conduct a sexual assault forensic examination (SAFE), which may include the collection of evidence. According to SAPRO, in the absence of a DoD provider, the service Member can be referred to an appropriate civilian facility for the SAFE.

Unrestricted reporting is recommended for victims of sexual assault who request *an official investigation of the crime* in addition to treatment and counseling. When selecting unrestricted reporting, current reporting channels are used, e.g. chain of command, law enforcement, report of the incident to SARC, or request health care personnel to notify law enforcement. Upon notification of a reported sexual assault, the SARC assigns a Victim Advocate. At the victim's discretion/request, the health care personnel may conduct a sexual assault forensic examination (SAFE), which may include the collection of evidence. Details regarding the incident are limited to only those personnel who have a legitimate need to know, according to SAPRO policy.

According to the Director of SAPRO, in 2007, service Members made 2,688 total reports of sexual assault and that in 2,085 of those cases, the unrestricted reporting option was chosen.¹² While DoD reports that it prefers complete reporting of sexual assaults to activate both victims' services and law enforcement actions, it recognizes that some victims desire only medical and support services and no command or law enforcement involvement. The Department states its first priority is for victims to be protected, treated with dignity and respect, and to receive the medical treatment, care and counseling that they deserve. We agree with that policy but we also want to protect each MST victim's rights and benefits as a veteran.

DAV's primary concern is that VA be able to access the restricted DoD records documenting reports of MST for an indeterminate period. We have contacted Veterans Benefits Administration (VBA) staff on a number of occasions to try to verify that VA is collaborating with DoD/SAPRO to ensure access to these records if authorized by the veteran in support of a benefits claim for conditions related to MST. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that the stressful event actually occurred. Once a claim is filed VA has a number of standard sources it examines for records to support a claim for a condition secondary to personal trauma or MST. However, we do not see SAPRO-related reports listed in any of VA's training and reference materials/manuals for developing claims for service connection for PTSD based on MST. At this juncture we are unable to confirm if VBA searches for "restricted" reports as an al-

¹² Department of Defense; *The Defense Resource on Sexual Assault Prevention and Response*, Volume 2, Issue 2; Spring 2008. <http://www.sapr.mil/Contents/News/ArchiveNewsletters/Spring%202008.pdf>.

ternative evidence source for information to substantiate the veteran's claim. VA does list medical reports from civilian physicians or caregivers who treated the veteran immediately after the trauma as alternative evidence to seek out in these cases; however, we do not know if VBA staff developing these claims are aware of DoD SAPRO policies and would contact the veteran to see if a restricted report was in fact filed, a physical examination conducted and if follow up medical or mental health treatment records exist.

To maintain confidentiality in the case of restricted reporting, DoD policy prevents release of MST-related records with limited exceptions. However, VA is not specifically identified as an "exception" for release of records in DoD's policy and it is unclear if VA, could gain access to these records even with permission of the veteran. DoD does list VA is an advisory Member of the Sexual Assault Advisory Council or (SAAC) which coordinates policy and review of the Department's sexual assault prevention and response policies and programs. We also have questions with respect to where and how physical assessment records that are completed following the assault and subsequent mental health treatment records related to the restricted MST reports are kept and for how long. We are concerned that these records may be kept separate from victimized service Members' medical treatment and personnel records and whether each service maintains these records in a different manner. According to DoD policy *physical* evidence collected associated with a restricted report of the event is destroyed after 1 year if the service Member or veteran does not wish to pursue civil or criminal sanctions against the perpetrator.

We hope to confirm with the Subcommittee's oversight that VA is indeed fully collaborating with DoD to ensure veterans who have suffered MST and have filed claims for benefits for related conditions gain VA's full assistance in accessing these important records in support of their claims for disability. Additionally, we concur with the recommendation made in the 2008 report of the VA Advisory Committee on Women Veterans that suggested VBA identify and track claims related to personal assault/MST to determine the number of claims submitted annually, grant rates, denial rates, and types of conditions most frequently associated with these claims. The Committee stated that development of tracking systems could further guide studies on research on all aspects of MST. Finally, we ask that VBA provide the Subcommittees any information it has in its reference materials for claims developers/raters that reflect its collaboration with DoD/SAPRO and guidance to MST-related claims developers on how to access supporting documentation from each military service in the case of both restricted and unrestricted reporting options, including any differences in records retention, security and disposal policies.

LIONESSE TEAMS

As you may be aware, on March 31st of this year, DAV cosponsored a screening of the LIONESSE documentary on the Hill, hosted by Chairmen Filner and Representatives Herseth Sandlin, Susan Davis and Judy Biggert. The film was well received and told the story of the first group of women Army support soldiers who were assigned to all-male Marine infantry units in the Al Anbar province of Iraq during some of the toughest fighting seen in that region. The role of the Lioness was, and is, to defuse tension with Iraqi women and children during searches of their homes and their persons. When these women first deployed to Iraq, they performed their original military occupational specialty (MOS) duties including truck mechanic, clerk and engineer, but were called to serve in a different capacity inside male combat arms units.

The Lioness teams are still being deployed today in both Iraq and Afghanistan, and unfortunately, starting from the first teams to the present, this "extraordinary" service is not routinely noted in key official DoD record documents, including the DD-214 or veterans military discharge certificate. This absence of documentation makes following up their care for PTSD or other post-deployment mental health re-adjustment issues difficult when their worst hurdle is having to prove that they served their country in this capacity and were exposed to combat. We need to ensure that women who serve are cared for when they return home no less so than men who served, and those who have risked their lives, often without the additional training needed to ensure their safety in theater, are not left to fend for themselves to access needed VA benefits and services later in their lives.

A great deal of guidance is given to VA compensation claims developers/raters on various service medals and devices that can be used to support PTSD claims and on how to use DoD resources to corroborate possible combat-related traumatic exposures. However, in the case of many Lioness team members no award was provided and no documentation exists in their discharge papers or in their military records to confirm participation in this unique program.

We are aware that former service women, particularly those who volunteered during the early stages of the Lioness program, have encountered difficulties in gaining proper recognition for their service, both within the services and when they leave active duty and seek assistance from VA. Some former Lioness members report they have had to find their own witnesses and documentation needed in recognition of their actions under fire and to establish their combat experience while deployed, in order to establish claims for disability benefits from VBA. We remain concerned that there is no mechanism in place within the military services to properly document servicemember participation in unique operational missions outside of the requirements of their assigned MOS—such as Lioness.

Several of the women featured in the Lioness documentary spoke about the difficulties they personally experienced in accessing VA health care and benefits related to post-deployment mental health issues. One of the women reported that her male Vet Center counselor found it difficult to believe she had participated in dozens of missions where she was armed and engaged in combat. She hoped that in the future VA would be better prepared and recommended VA hire more women Vet Center counselors, women therapists, and OEF/OIF women veteran peer counselors. One of the other women reported she had been service connected for PTSD—but a 0 percent even though she complained of chronic disturbing memories, difficulty sleeping and anxiety. Clearly, the lack of documentation in these cases makes it more difficult for adjudicators to establish service connection for conditions related to military service. For these reasons we encourage DoD and VA to collaborate to ensure the military services document the additional duties some servicemembers perform and that VHA and VBA staff are fully informed about these special duties women are asked to carry out in today's military.

HOMELESS AND BURIAL BENEFITS FOR WOMEN VETERANS

Finally, we note two other areas that warrant the Subcommittees' attention. The first being homelessness among women veterans. VA has excellent programs for homeless veterans but women veterans present unique challenges for VA within its programs. Frequently women are reluctant to take advantage of VA's stellar programs such as transitional housing, substance-use disorder programs and residential rehabilitation and treatment programs, due to personal safety concerns and because often they are the sole or primary caretakers of minor children. In some facilities VA has struggled to maintain a welcoming, secure and safe treatment setting especially for women who have serious mental illness and/or been victims of MST.

While the overall number of homeless veterans has been decreasing (approximately 131,000 on any given night), according to VA, the number of homeless women veterans has nearly doubled to 6,500 in the last decade, which equals approximately 5 percent of total homeless veteran population. In a recent newspaper article¹³ VA is cited as reporting that overall, female veterans are now between two and four times more likely to end up homeless than their civilian counterparts. This alarming jump is coupled with the report that 1 in 10 homeless veterans under the age of 45 are women, and as more veterans return from deployments in Iraq and Afghanistan, these numbers are expected to rise. Combat-related stress and MST are both risk factors for homelessness. These women present unique challenges to the VA system, designed for use primarily by men, and very few facilities have homeless programs designed specifically for women—and by law none are able to accommodate children. It is also noted that about 75 percent of these female veterans have been victims of sexual abuse and many have substance-use and mental health problems that require specialized care. Programs and treatment services for mental health, MST, substance-use disorders, maintaining independent housing and gainful employment are all essential to this vulnerable population. Therefore, we must ensure that VA programs are properly adjusted to meet the unique and growing needs of women veterans and that women have equal access to these specialized services.

We are pleased that Congress has supported and VA is providing grants to homeless veterans with special needs, including women veterans who care for dependent children as well as HUD-Veterans Affairs Supported Housing vouchers some of which, according to VA, have now been awarded to women veterans with children. VA estimates that of the 7,300 vouchers awarded to homeless veterans to date, 12 percent are occupied by women veterans and 14 percent have one or more children

¹³Bryan Bender. *More Female Veterans Are Winding Up Homeless*. The Boston Globe, July 6, 2009. http://www.boston.com/news/nation/washington/articles/2009/07/06/more_female_veterans_are_winding_up_homeless/.

in the unit. We hope there is continued support to ensure women too have access to these critical resources.¹⁴

The final issue for consideration relates to the 2008 report from the Advisory Committee on Women Veterans, which notes an apparent disparity of usage of VA burial benefits between eligible men and women veterans through the National Cemetery Administration (NCA). The Committee recommended that NCA enhance targeted outreach efforts in areas where usage by women veterans does not reflect the women veterans' population. NCA concurred with the recommendation and asserted it would collect and analyze data concerning burial rates, assess opportunities to reach more veterans, both male and female through outreach activities and make a concerted effort to include underrepresented veteran populations, to include women veterans, in its outreach endeavors.

Messrs. Chairmen, again we thank you for the opportunity to share our views at this important hearing focused on women veterans—and eliminating the gaps in their care and benefits. It is clear that a number of gender disparities exist for women veterans in both the VA health and benefits systems. We appreciate the attention to these issues and hope the Subcommittees will consider the vast array of gaps that currently exist beyond the limited number we have brought forth in our statement. We also ask that attention be paid to women within the special disability populations to ensure their unique needs are met and that they too are aware of their VA benefits and eligibility for health care and specialized rehabilitation programs. We will appreciate your consideration of our views on these pressing and important matters to our Nation's women veterans. Thank you once again for the opportunity to testify at this hearing. I would be pleased to address your questions, or those of other Subcommittee Members.

**Prepared Statement of Anuradha P. Bhagwati, MPP,
Executive Director, Service Women's Action Network**

Good morning. My name is Anuradha Bhagwati. I am a former Captain in the United States Marine Corps. I currently serve as Executive Director of the Service Women's Action Network (SWAN), a non-partisan, non-profit organization founded by female veterans, based out of New York City. SWAN specializes in policy analysis, advocacy, and legal services for all servicewomen, women veterans, and their families.

Despite the progress the Department of Veterans Affairs has made in addressing the recent influx of women veterans into the VA system, the delivery of health care and the awarding of disability ratings to women veterans remains grossly inadequate.

Every day, SWAN receives calls from women veterans of all eras and ages whose experiences at VA hospitals or with the VA claims system has led them to give up not just on the VA, but also on life. Mistreatment by the VA is enough reason for many traumatized women veterans to fall through the cracks, and end up victims of drug and alcohol abuse, unemployment, homelessness, or suicide.

Women veterans who have already been mistreated by the military are often doubly traumatized by harassment or mistreatment at VA facilities. Knowledge about the epidemic of Military Sexual Trauma (MST)—sexual harassment, assault and rape—which has yet to be fully recognized by the armed forces, has also yet to be adequately integrated into the daily operations of VA hospitals and the awarding of VA compensation to both male and female veterans.

MST screening at hospitals around the Nation appears to be inconsistent, at best. A shortage of female physicians and counselors, a rapid turn-over of inexperienced residents, a preponderance of culturally conservative administrative staff, and poorly trained, apathetic or unprofessional medical staff contributes to a lack of understanding about how to treat veterans who suffer from symptoms related to MST.

However, I must emphasize that regardless of medical condition, women veterans, when compared to their male counterparts, are largely subjected to unequal treatment at VA facilities nationwide. The following anecdotes illustrate just a few of the VA's institutional failures to deliver proper health care to women veterans:

- One Iraq veteran who checked herself into inpatient psychiatric care during a particularly bad PTSD episode was forced to share a bathroom with male vet-

¹⁴Peter H. Dougherty, Director, Homeless Veterans Programs, Veterans Health Administration, U.S. Department of Veterans Affairs; Testimony before the House Veterans' Affairs Committee on *A National Commitment to End Veterans' Homelessness*. June 3, 2009. <http://veterans.house.gov/hearings/hearing.aspx?NewsID=404>.

erans, including a peeping tom. When she told her nurse she felt uncomfortable eating her meals with male veterans, the nurse threatened that she would not be fed at all.

- An Afghanistan veteran—a single mother—who was raped in theater by a fellow servicemember, cannot bear to enter a VA facility out of sheer terror of re-triggering the trauma from her assault. Like many other women veterans, she pays for counseling out of pocket so as not to subject herself to further trauma.
- One veteran recently received her annual pap smear with a male gynecologist who did not enforce the requirement to have a female staff member present during the examination. When this veteran mentioned to the gynecologist that she had experienced MST, he left the room and barked down the hall, “We’ve got another one!”

Many of these examples illustrate a larger point: that the VHA requires an enormous cultural shift in order to treat female patients with dignity and respect, and to acknowledge the specific needs of women veterans.

With respect to benefits, both female and male veterans applying for compensation from the VBA for conditions related to MST face overwhelming odds against being awarded a disability rating. However, the full extent to which women veterans are denied disability compensation has yet to be comprehensively examined. Veterans with MST often feel that the benefits system is rigged against them, as proving that one’s stressor occurred in service can be extremely difficult, if not impossible. The VBA fails to understand that servicemembers rarely feel comfortable or sufficiently safe from harm to report rape, sexual assault or harassment, for two main reasons: reports of sexual assault and harassment are often simply ignored by commanders military-wide, and servicemembers who report sexual assault or harassment are often threatened or punished after reporting.

While the DoD’s failure to enforce its own sexual assault and EO policies are subject of another hearing, it must be emphasized that unless the climate within the armed forces changes such that servicemembers are guaranteed protection and support after reporting sexual assault or EO violations, it is unjust and grossly irresponsible of the VA to expect veterans to provide the current standard of proof for a stressor related to MST.

H.R. 952 (entitled the COMBAT Act), introduced by Representative Hall, presumes that a combat veteran’s PTSD is a result of exposure to a stressor while in theater; I suggest that similar legislation be proposed for veterans who suffer from PTSD or other symptoms of MST, so that veterans with MST are not punished or traumatized further by the VA. MST counseling and a physician’s diagnosis of MST-related medical conditions should be sufficient for the VBA to award a disability rating to a veteran.

Recommendations to Bridge the Gaps in Care for Women Veterans:

1. Require that the VA remedy the shortage of female physicians, female mental health providers and MST counselors at VA hospitals nationwide. Also require that the VA provide the option of female-only counseling groups for female combat veterans, and female—as well as male—only counseling groups for female and male survivors of MST.
2. Require the VA to implement a program to train, educate, and certify all staff, including administrative and medical, in Federal Equal Opportunity regulations and MST, to reduce a discriminatory and hostile atmosphere toward women veterans.
3. Require the VA to increase accessibility of fee-based care for veterans (both male and female) who have been diagnosed with Military Sexual Trauma.
4. Require day-care facilities for veterans who are parents, as well as more flexible evening or weekend hours for working veterans and parents, at every VA hospital.
5. Require the VA to conduct a study into what percentage of claims are denied with a breakdown by gender as well as type of injury/condition, including both combat-related PTSD, and PTSD or other conditions resulting from MST.
6. Require that VBA claims officers undergo intensive training and education in MST and MST-related medical conditions.
7. Require that the VBA’s submission requirements for MST claims reflect a reasonable standard, such as proof of MST counseling during or after service, and diagnosis of MST-related medical conditions.

8. Require the DoD to conduct a retention study to determine the total impact of MST on re-enlistment rates of servicemembers.

Thank you for your time.

**Prepared Statement of Dawn Halfaker, Vice President,
Board of Directors, Wounded Warrior Project**

Mr. Chairmen and Members of the Subcommittees:

Thank you for inviting Wounded Warrior Project (WWP) to offer our views on eliminating the gaps facing women veterans.

Wounded Warrior Project brings an important perspective to this morning's hearing in light of the organization's goal—to ensure that this is the most successful, well-adjusted generation of veterans in our Nation's history.

Wounded Warrior Project was founded on the principle of warriors helping warriors, and we pride ourselves on outstanding service programs built on that principle. Our signature service programs include peer mentoring, adaptive sporting events, and Project Odyssey—a potentially life-changing program that engages groups of veterans with combat stress and post-traumatic stress disorder in outdoor adventure activities that foster coping skills and provide support in the recovery process. (WWP is mounting its first Odyssey program for women veterans.) WWP aims to fill gaps—both programmatic and policy—to help wounded warriors thrive.

With growing numbers of women in uniform serving in hostile theaters and exposed as never before to combat environments, women are not only playing a much larger role in bolstering our war-fighting capability, but unprecedented numbers are returning home with visible and invisible wounds.

Let me note that I am testifying this morning not only as Vice President of the Board of WWP, but as a retired Army captain who was severely injured in combat in Baquba in 2004, and after nearly a year at Walter Reed, have undergone further treatment at VA facilities.

I know this Committee appreciates the debt owed those who have served their country. In meeting that obligation to this new generation of warriors, we must examine the adequacy of existing programs. It is vital that we identify and fill gaps that could compromise realization of the high goals we should have for these young men and women.

I applaud this Committee and the Congress for its critical role in moving the Department of Veterans Affairs to better serve women veterans. With your insistence on affording women veterans equitable access to needed care, women veterans today have access to a wide array of gender-specific services (as well as primary care) in VA settings, where a decade earlier such care was often provided only through contract arrangements.

We focus our remarks this morning on key gaps in the health-care arena. In doing so, we by no means suggest that there are not gaps in benefits or other programs. Certainly pertinent advisory Committee reports would suggest otherwise.

Today, with women making up 11 percent of veterans of Operations Enduring and Iraqi Freedom, VA reports that some 44 percent of female OEF/OIF veterans have enrolled with VA health care, and used VA health care from two to ten times.¹ Women veterans have become one of the fastest growing VA patient populations. Notwithstanding these statistics, there remain real concerns.

According to recent VA testimony, 45 percent of all veterans who utilized VA health care through the end of fiscal year 2008 had a possible mental health diagnosis.² Women in the military are at significantly higher risk of developing PTSD, depression, and other war-related mental disorders than their male counterparts.³ Women in the military are also at higher risk for sexual trauma than their civilian

¹VA Healthcare Utilization among OEF/OIF Veterans 3rd Quarter FY08, V1a, Table 3. As cited in an online fact sheet from the Department of Veterans Affairs Web site, Office of Public Health and Environmental Hazards. Available from <http://www.publichealth.va.gov/womenshealth/facts.asp>. Accessed 6 July, 2009.

²United States House of Representatives, *Testimony of Dr. Ira Katz, Deputy Chief Patient Care Services Officer for Mental Health, Veterans Affairs Administration, U.S. Department of Veterans Affairs, before the House Committee on Veterans' Affairs, Subcommittee on Health*, Ira Katz (Washington DC: April 30, 2009).

³James R. Riddle, Tyler C. Smith, Besa Smith, Thomas E. Corbeil, Charles C. Engel, Timothy S. Wells, Charles W. Hoge, Joyce Adkins, Mark Zamorski, and Dan Blazer from the Millennium Cohort Study Team, "Millennium Cohort: The 2001–2003 baseline prevalence of mental disorders in the U.S. military," *Journal of Clinical Epidemiology*, 60, 2007: 198.

peers,⁴ and the numbers of such occurrences are thought likely to be significantly under-reported.⁵ Sexual assault has long-lasting effects on women's health, particularly mental health.⁶ Thus, given the likely prevalence of PTSD and other mental health problems in this population, and the health risks of such conditions going untreated, it is critical that we focus not only on those who are seeking treatment, but also on those who are not.

Evidence suggests a number of reasons that lead returning women veterans to forego VA care. One recent research study involving OEF/OIF Reserve and National Guard servicewomen, for example, found frequent lack of knowledge regarding eligibility for and access to VA care; widespread perceptions that pursuing such care would be stigmatizing; and consistent concern regarding hassles and quality of VA care.⁷ These findings generally mirror research results from a population-based study of women veterans' perceptions about VA health care.⁸

We certainly cannot assume from these data that female OEF/OIF veterans who are forgoing VA care have no health issues. To the contrary, given the high prevalence and unique impact of PTSD and other war-related mental health conditions among those who have deployed to Iraq and Afghanistan, WWP urges that we focus on the mental health of all returning warriors. And given the high rates of military sexual trauma among women veterans of these deployments, it is particularly important that VA reach out to returning women veterans.

Needed Outreach: Despite significant advances in VA health care for women veterans, researchers have found that many women veterans are unaware of the existence of VA women's health care services or of their eligibility for such VA care. Such findings, along with research indicating that women veterans may have adverse perceptions about VA care, highlight the importance not only of providing more information to this population, but of overcoming perceptions and misperceptions. We see a need for aggressive, targeted outreach that takes account of research showing that women veterans who have experienced military sexual assault experience more distrust directed at medical staff, and reduced willingness to seek further help at military and VHA facilities than women who have sought treatment related to sexual assault at civilian facilities.⁹

VA certainly has attempted to increase its outreach to new veterans, and better inform them regarding their health care eligibility, as well as on readjustment and psychological health issues. But no single step can be expected to change the paradigm for women veterans who may view VA as a system for older male veterans, or who may have concerns about the quality of its care or who—having experienced sexual trauma in service—may be distrustful of government-provided care. In that regard, there is a clear need for an aggressive approach to eliminating the barriers that deter at least some returning women veterans from pursuing needed help. We propose, in this regard, that Congress direct VA to employ, train and deploy peers (other women OEF/OIF veterans, including those who have had readjustment or mental health issues) to conduct outreach to women OEF/OIF veterans, including one-on-one outreach efforts to address negative perceptions and build trust.

Peer-support: Given the importance of addressing the mental health needs of returning veterans, it is not enough, in our view, simply to get new veterans into treatment. Our treatment goals for veterans with war-related mental health problems must be more than simply diminishing or alleviating symptoms of a mental health condition. Rather, the treatment goal should be focused on these veterans' thriving and achieving productive, satisfying lives. (VA, as a matter of policy, has

⁴R. Kimerling et al., "The Veterans Health Administration and Military Sexual Trauma," *American Journal of Public Health* 97, no. 12 (2007): 2160.

⁵James R. Rundell, "Demographics of and diagnoses in Operation Enduring Freedom and Operation Iraqi Freedom personnel who were psychiatrically evacuated from the theater of operations," *General Hospital Psychiatry* 28 (2006): 355.

⁶MA Mengeling, AG Sadler et al., "The effect of women's health outcomes by type of trauma exposure," Abstract presented at VA HSR&D 2009 National Meeting, Feb. 11, 2009. Available from http://www.hsrd.research.va.gov/meetings/2009/display_abstract.cfm?RecordID=410. Accessed 6 July, 2009.

⁷MA Mengeling, BM Booth et al., "Barriers to DVA care access for Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Reserve and National Guard Servicewomen," Abstract presented at VA HSR&D 2009 National Meeting, Feb. 11, 2009. Available from http://www.hsrd.research.va.gov/meetings/2009/display_abstract.cfm?RecordID=522. Accessed 6 July, 2009.

⁸Donna Washington, Susan Kleimann, Ann Michelini, Kristin Kleimann and Mark Canning, "Women Veterans' Perceptions and Decision-Making about Veterans Affairs Health Care," *Military Medicine* 172, no. 8 (2007): 813–815.

⁹MM Kelley, DS Vogt et al., "Effects of military trauma exposure on women veterans' use and perceptions of Veterans Health Administration care," *Journal of General Internal Medicine* 23, no. 6 (2008): 741–7.

adopted this “recovery” model of mental health care, though the gap between policy and practice can be wide.) This “recovery” paradigm does not dismiss the importance of medical treatment. But it recognizes that approaches like peer-mentoring and peer-support can be critically important to effective mental health care in empowering patients in a way that clinicians generally cannot. In WWP’s experience, peer-mentoring and support can be powerful in helping OEF/OIF veterans cope with PTSD and other war-related mental health conditions, and there is ample research to suggest that peers’ social support is an important influence on psychological recovery and rehabilitation.¹⁰ Moreover, we see evidence that this generation of veterans values peer-services. To illustrate, a recent WWP survey of wounded warriors with whom we have worked showed that:

- Seventy-five percent of respondents reported that talking with another OEF/OIF veteran was helpful in dealing with mental health concerns;
- Fifty-six percent expressed the belief that peer to peer counseling would be helpful in addressing their mental health concerns; and
- Forty-three percent reported that talking with another OEF/OIF veteran had been the one most effective resource in helping with mental health concerns.

In our view, peer-outreach and peer-mentoring and support can be important elements in any strategic plan for meeting the mental health needs of women OEF/OIF veterans (as they can be for all OEF/OIF veterans).

Variability in provision of services: In offering these suggestions, we must at the same time acknowledge that there are difficult, systemic problems that VA faces in bridging gaps in care of, and benefits and services for, women veterans. Among these challenges is the fact that women veterans encounter wide variability in care from facility to facility. As documented in a 2007 VA survey of its women’s health programs and practices, VA facilities have adopted a variety of clinic models for providing primary health care for women veterans, ranging from separate women’s health clinics to mixed-gender general primary care clinics. (And while most VA facilities have established women’s health clinics, many of those women’s clinics offer gender-specific exams only.)¹¹ Significant variability also exists in provision of specialized women’s health services (such as mammography), provided on-site in some instances and offsite under contract in others.¹² The 2007 survey also found that only a minority of facilities have designated women’s health providers in general outpatient mental health care, an area VA acknowledges is one of special concern for women veterans.¹³

Ongoing VA health-systems research should help determine how best to structure VA care-delivery for women’s health to achieve quality care and patient satisfaction. But difficulty in determining what are optimal models of care-delivery should not stand in the way of setting sound policy on clear-cut health-delivery issues.

Access to same-gender health professionals: To illustrate, VA has failed to take a firm position regarding the question of providing access to female mental health professionals where there is a history of sexual trauma. The VA directive defining minimum clinical requirements for provision of mental health services states only that “facilities are strongly encouraged, when clinically indicated, to give veterans being treated for [military sexual trauma] the option of being assigned a same-sex mental health provider . . .”¹⁴ It is no accident that facilities are simply being “strongly encouraged,” and that clinicians are free, under that guidance, to ignore that suggestion or reject a woman veteran’s request for a same-sex provider on the ground that it is not “clinically indicated.” The VHA Handbook is otherwise quite clear in estab-

¹⁰C. Brewin, B. Andrews and J. Valentine, “Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-exposed Adults,” *Journal of Consulting and Clinical Psychology* 68, no. 5 (2000): 748–766; A Klein, R Cnaan and J Whitecraft, “Significance of Peer Social Support for Dually-Diagnosed Clients: Findings from a Pilot Study,” *Research on Social Work Practice* 8 (1998): 529–551, as cited in Phyllis Solomon and Jeffrey Draine, “The State of Knowledge of the Effectiveness of Consumer Provided Services,” *Psychiatric Rehabilitation Journal* 25, no. 1 (2001): 24; David Riggs, Margaret Rukstalis, Joseph Volpicelli, Danielle Kalmanson and Edna Foa, “Demographic and social adjustment characteristics of patients with comorbid posttraumatic stress disorder and alcohol dependence: Potential pitfalls to PTSD treatment,” *Addictive Behaviors* 28 (2003): 1726.

¹¹Elizabeth Yano, Bevanne Bean-Mayberry, and Andrew Lanto on behalf of the Department of Veterans Affairs, Center for the Study of Health Care Provider Behavior, “What Does Women’s Health Care Look Like in the VA?” A PowerPoint presentation (Washington, DC: June 10, 2008).

¹²Ibid.

¹³Ibid.

¹⁴Department of Veterans Affairs, Veterans Health Administration, *Uniform Mental Health Services in VA Medical Centers and Clinics, VHA Handbook 1160.01* (September 11, 2008), para. 9, a(1).

lishing requirements regarding many other aspects of mental health delivery, and it specifically advises “[s]ome services . . . are mentioned with wording indicating such that they ‘may’ be delivered, or that facilities are ‘encouraged’ or ‘strongly encouraged’ to provide them. These indicate suggestions, not requirements.”¹⁵ WWP believes that VA should go further and require that a woman veteran who has experienced sexual trauma have access to a female health professional, on request.

The challenge of leadership: While access to needed care for women veterans has undoubtedly improved markedly over time, the overwhelming majority of those who obtain care at VA facilities are men. Many VA providers have had limited exposure to women patients,¹⁶ but VA facilities do appear to be working to adapt to the changing demographics of our armed forces. The Department and its facilities face challenges. They must continue to take steps to accommodate women veterans—from modifying delivery systems to ensuring that they meet privacy expectations. But they must be cognizant of still-widespread perceptions that VA facilities are geared only to male patients and that some Department clinicians lack sensitivity to women’s issues. Responding to and addressing those concerns are issues of leadership that will become ever more important if VA is to win the trust of this new generation of women veterans.

VA and women veterans can continue to benefit, in that regard, from the special oversight and advice provided by the Department’s Advisory Committee on Women Veterans and similar advisory bodies, as well as from congressional oversight Committees. Today’s hearing is an important and welcome step in the ongoing effort to eliminate the gaps facing women veterans.

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

**Prepared Statement of First Sergeant Delilah Washburn, USAF (Ret.),
President, National Association of State Women Veterans Coordinators,
Inc., and Houston Regional Director, Texas Veterans Commission**

INTRODUCTION

Mr. Chairmen and distinguished Members of the Subcommittees, on behalf of the National Association of State Women Veterans Coordinators (NASWVC) I am honored to have this opportunity to testify this morning and present the views of the State Women Veterans Coordinators of all fifty States.

The purpose of our Association is to facilitate reciprocal veterans benefits and services for women veterans across the country. We identify issues of concern to the women veterans community and develop recommendations to address those concerns through legislative, programmatic and outreach activities at both the State and Federal level. Our vision is for women veterans to have equal access to the benefits and services they have earned through military service without problems or delays. We strive to ensure women veterans are aware of their benefits by providing a network of advocates that spans the country to conduct outreach, address questions, and resolve problems as they arise.

The vast majority of our coordinators are themselves women veterans, representing all branches of service, active duty and reserves, officer and enlisted. We are primarily State veterans affairs employees or designees. Because State government is the second largest provider of services to all veterans and the ranks of women serving in the military are steadily increasing, our role as Women Veterans Coordinators continues to grow. We are partners with the Federal Government, State governments, and Veterans Service Organizations. We feel it is our responsibility to help Congress understand the unmet needs of women veterans so that government at all levels can work together to better accomplish our Nation’s goals.

We applaud the leadership of Chairman Filner and Ranking Member Buyer and the other distinguished Members of the House VA Committee, in focusing attention on the capacity and capability of VA to equitably and effectively provide care and services to women veterans. We strongly support H.R. 1211 as passed by the House of Representatives on June 23, 2009. We believe planning, readiness, oversight and accountability are all necessary to meet the goals, requirements and standards of the Nation and its veterans.

¹⁵ *Ibid*, para. 3, a(3).

¹⁶ Yano, “What Does Women’s Health Care Look Like in the VA?”

Health Care for Women Veterans

VA has already identified that our country's new women veterans are younger and expect to use the VA health care system more consistently. VA reports that of the more than 102,000 female OEF/OIF veterans, over 45,000 have enrolled in VA health care and nearly 20,000 of these women use the system for between 2 and 10 visits. Among these returning women veterans, 85 percent are below the age of 40 and 58 percent are between 20 and 29. In fact, the average age of female veterans using the VA health care system is 48 compared to 61 for men. The needs of women veterans are growing and already taxing the VA system, which historically has focused on an older population of men.

The primary barriers women veterans face in accessing VA health care across the country are:

- Lack of reliable transportation
- Unavailability of childcare
- Lack of integrated primary care and mental health care
- Lack of gender sensitivity of health care providers and staff to women-specific issues
- Limited hours of women veterans clinics, particularly for working women
- Women veterans clinics that are difficult to locate or are not perceived as personally safe and comfortable for women veterans and their children
- Unsafe inpatient VA health facilities for women veterans

VA Medical Centers (VAMCs) do not consistently assess and treat domestic violence victims across the country. VA medical providers must be trained to ensure women veterans who are victims of domestic violence are treated to the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations and that State reporting requirements are met. Domestic violence is an area where central oversight is necessary to ensure VAMCs are better able to serve victims of violence, perhaps by placing the program under the Women's Mental Health Program in the Office of Mental Health Services and including domestic violence initiatives in VA's Uniform Mental Health Services Package, these objectives could be met.

Mammography is another area that quality care is an accident of geography for women veterans. There is no formal program for tracking mammography results and follow-up of abnormal mammograms to ensure women veterans receive consistent, timely, and high-quality care. We suspect Congress would be appalled by the differences in timeliness-to-treatment data for abnormal mammograms at VAMCs across the Nation.

Women Veterans Benefits

Because females are officially excluded from "combat roles" in the military, women veterans have a greater burden of proof in establishing the link between PTSD and combat. There is no such thing as an "infantry woman," so women who are supply clerks, mechanics, and truckdrivers are going on combat patrols with the infantry and the Marines. Because there is no clear frontline on the ground in Iraq and Afghanistan, female service Members are exposed to direct fire, Improvised Explosive Devices (IEDs), and constant threats from insurgents without the benefit of the awards and decorations to prove it. NASWVC wholeheartedly endorses H.R. 952, which would amend Title 38 to presume service-connection for PTSD based solely on a service Member's presence in a combat zone. This legislation would not only appropriately recognize the service and sacrifice of women veterans; it would significantly decrease the backlog of VA claims for our combat veterans.

Sexual harassment and sexual assault are far too prevalent in the military; with the Pentagon confirming 1 out of 3 women who served her country have been the victim of sexual assault. Psychiatric conditions related to trauma have a devastating effect on women veterans health functioning. NASWVC strongly supports the VA Advisory Committee on Women Veterans' recommendation that VBA develop the ability to identify and track the status and outcome of **all** claims related to personal/sexual assault, not just the claims that happen to have been entered as such in the claims processing system and not just the claims of women veterans who have sought treatment at the VA. The Veterans Benefits Administration (VBA) cannot currently speak with any authority as to the number of Military Sexual Trauma (MST) related claims submitted annually, the processing times for these claims, the rate compensation is granted or denied, or the types of disabilities that are most often associated with MST. The development of tracking systems could further guide studies and research on all aspects of MST.

Just as more data is needed to assess the health needs and outcomes of women veterans, so is more data needed to evaluate women veterans' access to and receipt

of VA compensation and pension benefits. VBA must establish a method to consistently identify and track claims outcomes for veterans by gender.

Mental Healthcare for Women Veterans

There are insufficient therapists licensed and experienced in counseling sexual trauma victims in the VA system to provide appropriate care for women veterans at VAMCs, clinics and Vet Centers. Additionally, many women are not comfortable with male therapists or mixed gender therapeutic groups. Women veterans should have the option to use fee-based services to obtain mental health care if a qualified MST counselor is not available or if a woman provider and/or women's groups are not available.

Communication Within VA

The Veterans Health Administration (VHA) and the VBA obviously deliver separate and distinct services to veterans. However, they serve the same population and therefore, they should routinely communicate with one another and ideally their information technology systems should be linked. When veterans report something as simple as a change of address or more importantly are granted a benefit, VBA does not communicate the change to VHA even though it is likely to directly impact enrollment, eligibility, and payment for VA health care. This lack of communication adds to VA's image as a cumbersome and unresponsive organization. Improvements in the ability of organizations within VA to more effectively communicate would enhance the agency's service capability to veterans.

Outreach to Women Veterans

While growth has occurred in VA health care due to increased funding and improved access with Community Based Outpatient Clinics, many women veterans are still shortchanged because they live in rural areas or they lack information and awareness of their benefits. VA and State Departments of Veterans Affairs must reduce this inequity by reaching out to women veterans regarding their rights and entitlements. NASWVC suggests implementation of a grant program that would allow VA to partner with the State Women Veterans Coordinators to perform outreach specifically targeted to women veterans at the local level.

Memorial Affairs

Although this is not a women veteran specific issue, NASWVC strongly recommends the Plot Allowance for veterans' interment be increased to \$1,000. The average operational cost of interment in a State veterans cemetery is over \$2,000. This adds to the fiscal burden of many State Departments of Veterans Affairs. The current burial plot allowance of \$300 per qualified interment provides less than 15 percent of the average cost of interment. NASWVC recommends the Plot Allowance be increased to \$1,000 in order to offset operational costs. The increase should also apply to the Plot Allowance for veterans' interment in private cemeteries.

CONCLUSION

Mr. Chairman and distinguished Members of the Subcommittees, we respect the important work you are doing to improve support and services to women veterans who answered the call to serve our country. NASWVC remains dedicated to doing our part, but we urge you to be mindful of the increasing financial challenge that States face, just as you address the fiscal challenge at the Federal level. I would like to emphasize again, that we are advocates for women veterans and partners with VA in ensuring equitable delivery of benefits and services to our women patriots.

This concludes my statement and I am happy to respond to your questions.

**Biography for
First Sergeant (Retired) Pamela J.B. Cypert, M.Ed., LPCA,
Executive Advisor-Field Operations,
Kentucky Department of Veterans Affairs**

First Sergeant (Retired) Pamela Cypert entered the Army directly after graduating from High School in 1982. She completed Basic Training and Advanced Individual Military Police Training at Fort McClellan, Alabama and went on to successfully complete Basic Airborne Training at Fort Benning, Georgia in 1983.

Throughout her 21 year career as a military police officer, 1SG Cypert's leadership positions included team leader, squad leader, platoon sergeant, drill sergeant, senior drill sergeant, instructor, personal security agent, military police assignment

manager, operations sergeant and first sergeant. 1SG Cypert broke several barriers as a female soldier. She was the first of her gender ever selected Installation Drill Sergeant of the Year for Fort McClellan, Alabama, she was the first female First Sergeant of an Airborne Military Police Co. in the U.S. Army and she was the first female paratrooper in her brigade to attain the prestigious title of a Centurion Jumper. She is a Master Jumpmaster with over 100 military parachute jumps. Her duty stations included Fort Bliss, Texas; Fort McClellan, Alabama; Stuttgart, Germany; Department of the Army, Alexandria, Virginia; Fort Myers, Virginia; and Fort Bragg, North Carolina.

1SG Cypert attended the full complement of military leadership schools, culminating with the First Sergeant Course. In addition to her entry-level training, she also successfully completed Drill Sergeant School, Air Assault School, the Master Fitness Training Course, Rappel Master School, the Protective Services Training Course, three Counter-Terrorism Evasive Driving Courses, and the Advanced Airborne School's Jumpmaster Course. She earned her Bachelor of Science Degree in Psychology from Fayetteville State University, her Masters of Education Degree in Mental Health Counseling from the University of Louisville, and is a Licensed Professional Counseling Associate in the State of Kentucky.

1SG Cypert's awards include six Meritorious Service Medals, three Army Commendation Medals, seven Army Achievement Medals, the Joint Meritorious Unit Award, seven Good Conduct Medals, two National Defense Service Medals, the Master Parachutist Badge, Drill Sergeant Identification Badge, Air Assault Badge, Gold German Armed Forces Proficiency Badge, and German Parachutist Badge.

Upon her retirement from the Army in 2003, Mrs. Cypert began her career in State government. She is currently an Executive Advisor for the Kentucky Department of Veterans Affairs and the Women Veterans Coordinator for the Commonwealth of Kentucky. She serves her community as a therapist with Shelby Counseling Associates and resides in Shelbyville, Kentucky with her husband, Tom and her youngest daughter, Heather.

BERTHA CRUZ HALL

Bertha Cruz Hall served in the U.S. Air Force from August 1968 to August 1972. She worked in Personal Affairs and assisted survivors of servicemen to obtain their benefits.

Immediately after her discharge from the Air Force she went to work for the Texas Veterans Commission.

She retired as a Veterans Assistance Counselor Supervisor in 2002 with 30 years of service. She was the first Women Veterans Coordinator for the State of Texas and held that title until her retirement. She received numerous honors throughout her career from Service and community organizations.

Bertha was appointed by the Secretary of Veterans Affairs to serve on the VA Advisory Committee on Women Veterans in 1998 and served until the expiration of her second term in 2004. She has served as a Member and secretary of the Tarrant County Veterans Council; District Service Officer for the American Legion; Adjutant of the Disabled American Veterans Chapter 20, and Director VIP of the 20/4 Honor Society of Women Legionnaires, Echelon 31 of Texas.

Bertha currently serves on the Fort Worth Homeless Veteran Program and holds the office of secretary/treasurer. She serves on the Board of Directors to the National Association of Women Veteran Coordinators, Inc. and hold the office of Treasurer. She serves on the Board and holds the office of Treasurer for the Disabled Veteran National Foundation.

She resides in Hurst, Texas with her husband, Frank. They have 2 children and 4 grandchildren.

Statement of Kayla M. Williams, MA, Member, Board of Directors, Grace After Fire, Author, *Love My Rifle More Than You: Young and Female in the U.S. Army*

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

My name is Kayla Williams. As a Soldier with the 101st Airborne Division (Air Assault), I took part in the initial invasion of Iraq in 2003, and was there for approximately 1 year. As an Arabic linguist, I went on combat foot patrols with the Infantry in Baghdad. During the initial invasion, my team came under small arms fire. Later, in Mosul, we were mortared regularly. I served right alongside my male

peers: with our flak vests on during missions, we were all truly Soldiers first. However, it became—was clear upon our return that most people did not understand what women in today’s military experience. I was asked whether as a woman I was allowed to carry a gun, and was also asked if I was in the Infantry. This confusion about the role of women in the military today extends beyond the general public. Women veterans are less likely to self-identify as veterans, which is the first barrier to accessing benefits: you must be aware that you are eligible for them! An active outreach program for those leaving military service is crucial, but insufficient. Women who served in previous eras must also be made aware of their eligibility for veterans’ benefits and health care through vigorous outreach and education.

Even Veterans Affairs (VA) employees are still sometimes unclear on the nature of modern warfare, which presents challenges for women seeking care. For example, being in combat is linked to post-traumatic stress disorder (PTSD), but since women are supposedly barred from combat, they may face challenges proving that their PTSD is service-connected. One of my closest friends was told by a VA doctor that she could not possibly have PTSD for just this reason: he did not believe that she as a woman could have been in combat. It is vital that all VA employees, particularly health care providers, fully understand that women do see combat in Operations Iraqi Freedom and Enduring Freedom so that they can better serve women veterans.

Many of the other problems that women face when seeking to get health care or benefits through the VA are by no means exclusive to women: the transition from DoD to VA remains imperfect, despite efforts to improve the process. Lost records and missing paperwork are frequent complaints. The backlog of unprocessed disability claims is now over 400,000; though average processing time has declined, it is still over 5 months long.¹ Efforts to alleviate this problem are laudable and must be continued. Adequate training of claims processors is also vital; inconsistencies in disability ratings has resulted in thousands of dollars in annual payment differences for veterans with similar disabilities.²

Despite a growing number of community clinics and vet centers, many veterans face lengthy travel times to reach a VA facility—a particular burden during tough economic times. The falling housing market has also hit veterans as it has so many other segments of the population. When we bought in the DC area, for example, the average home price exceeded the VA maximum; now that the value of our house has fallen we are unable to refinance to a lower VA-backed rate despite the increased loan ceiling because we owe more than our home is worth.

The Post-9/11 GI Bill, a significant improvement that will allow many thousands of veterans the chance to attain first-rate educations, does still have gaps. For example, time that National Guard Members have spent while activated under Title 32 for domestic emergencies, homeland security missions, or serving full-time under the AGR (Active Guard and Reserve) program does not count toward Post-9/11 GI Bill eligibility. A legislative fix is required to repair this inequity.³ In addition, while time in brick-and-mortar schools may be best for both veterans and their peers, those who are struggling to raise small children or cope with PTSD may face significant barriers getting into the classroom. Providing full benefits, including the housing allowance, would help veterans facing those barriers continue their educations as well.

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

In addition, military women are far more likely to have suffered Military Sexual Trauma (MST) than military men. When filing VA disability claims for MST, there

¹Dao, James. “Veterans Affairs Faces Surge of Disability Claims,” *New York Times*, 12JUL09. <http://www.nytimes.com/2009/07/13/us/13backlog.html?em>.

²Maze, Rick, “Disability Pay Can Depend on Where You Live,” *Army Times*, 17OCT07. http://www.armytimes.com/news/2007/10/military_states_disabilitypayments_071016w/.

³Philpott, Tom. “Many Activated Guard Members Left Out of New GI Bill Benefits,” *Kitsap Sun*, 11JUL09. <http://www.kitsapsun.com/news/2009/jul/11/tom-philpott-many-activated-guard-members-left/>.

is a real risk that survivors will be re-traumatized due to lack of sensitivity training for service providers and because the burden of proof is placed on the survivor of MST, who must provide written stressor statements, which is not the case for men presenting with combat-related PTSD. Veterans lacking lengthy and complete documentation may face significant challenges—yet the current climate in the military still discourages victims of MST from coming forward, limiting the likelihood that they will be able to provide such documentation.

Veterans have made up a disproportionate percentage of the homeless population for some time. Although the VA has initiatives to try to help homeless veterans, they are insufficient. In addition, although the number of homeless women veterans has begun to rise dramatically, VA programs to serve this population are wholly inadequate: “within the VA’s homeless shelter system, only 60 percent of shelters can accept women, and less than 5 percent have programs that target female veterans specifically or offer separate housing from men,” a particular problem for women vets who have suffered MST. In addition, although 23 percent of female veterans in the VA’s homelessness programs have children under age 18, and meeting their needs is a significant unmet challenge.⁴

Women in the military are also far more likely to be married to other service-members; throughout the Department of Defense (DoD), 51.3 percent of married female enlisted active duty personnel reported being in dual-service marriages, compared to only 8.1 percent of their male counterparts.⁵ These women veterans must worry not only about their own readjustments, but also their husbands’ challenges. The VA must consider the dual role women veterans may be balancing as both givers and seekers of care.

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

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

Thank you for working to assess the VA’s gaps in and barriers to benefits and health care services for women veterans, and for your efforts to help all our Nation’s veterans.

**Prepared Statement of Randall B. Williamson, Director, Health Care,
U.S. Government Accountability Office**

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

GAO Highlights

Why GAO Did This Study

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

⁴Williamson, Vanessa and Erin Mulhall, “Coming Home: The Housing Crisis and Homelessness Threaten New Veterans,” IAVA Issue Report, JAN09.

⁵“Population Representation in the Military Services,” Table 3.7, FY2004, available at: http://www.defenselink.mil/prhome/popprep2004/enlisted_force/marital_status.html.

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

What GAO Found

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

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

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

Mr. Chairmen and Members of the Subcommittees:

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

ber of veterans will decline by 37 percent between 2008 and 2033, the number of women veterans will increase by more than 17 percent over the same period.

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

In addition, women veterans of OEF/OIF present new challenges for VA's health care system. Almost all of these women are under the age of 40—58 percent are between the ages of 20 and 29. VA data show that almost 20 percent of women veterans of OEF/OIF have been diagnosed with post-traumatic stress disorder (PTSD).¹ Additionally, an alarming number of them have experienced sexual trauma while in the military.² As a result, many women veterans of OEF/OIF have complex physical and mental health care needs.

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

VA has taken some steps to improve the availability of services for women veterans, including requiring that all VA medical facilities make the Women Veterans Program Manager (WVPM)—an advocate for the needs of women veterans—a full-time position and providing funding for equipment to help VA medical facilities improve health care services for women veterans. Additionally, in November 2008, VA began a systemwide initiative to make comprehensive primary care for women veterans available at every VA medical facility—VA medical centers (VAMC) and community-based outpatient clinics (CBOC). In announcing this initiative, VA established a policy defining comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, gender-specific care, and mental health care—from one primary care provider at one site.

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

To examine the availability of health care services at VA facilities for women veterans and to determine the extent to which VA facilities are following VA policies

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

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

³ See GAO, *VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans*, GAO-09-884T (Washington, D.C.: July 14, 2009).

that apply to the delivery of health care services for women veterans, we reviewed applicable VA policies⁴ and available VA data, and interviewed officials from VA headquarters, Veterans Integrated Service Networks (VISN),⁵ and VA facilities. In addition, we conducted site visits to a judgmental sample of nine VAMCs located in Atlanta and Dublin, Georgia; San Diego and Long Beach, California; Minneapolis and St. Cloud, Minnesota; Sioux Falls, South Dakota; and Temple and Waco, Texas. We also visited 10 VA CBOCs affiliated with these nine VAMCs, and eight Vet Centers, which are counseling centers that help combat veterans readjust from wartime military service to civilian life. We used VA data to select these sites based on several factors, including the number of women veterans using health care services at each VAMC and whether facilities offered specific programs for women veterans, such as outpatient or residential treatment programs for women who have PTSD or have experienced military sexual trauma (MST). See appendix I for additional details on the selection criteria we used and information on the number of women veterans using health care services at each VAMC and CBOC we visited. To further examine the availability of services for women veterans, we obtained information from each VAMC and CBOC regarding the organization and availability of primary care services, basic gender-specific services, specialized gender-specific services, and mental health services in outpatient, residential, and inpatient settings; and the availability of specific clinical services such as prenatal care, osteoporosis treatment, mammography, and counseling for MST. When services were not available on site, we determined whether they were available through fee-for-service arrangements (fee basis), contracts, or sharing agreements with non-VA facilities. During our site visits we also toured each facility and documented observations of the physical space in each care setting. We examined how facilities were implementing VA policies pertaining to ensuring the privacy of women veterans in outpatient, residential, and inpatient care settings; and VA's model of comprehensive primary care for women veterans. Finally, to identify key challenges that VA facilities are experiencing in providing health care services for women veterans, we reviewed relevant literature; interviewed VA officials in headquarters, medical facilities, and Vet Centers; interviewed VA experts in the area of women veterans' health; and documented challenges observed during our site visits. The findings of our site visits to VA facilities cannot be generalized to other VA facilities. We shared the information contained in this statement with VA officials, and they generally agreed with the information we presented.

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

Background

Health Care System

VA's integrated health care delivery system is one of the largest in the United States and provides enrolled veterans, including women veterans, with a range of services including primary and preventive health care services, mental health services, inpatient hospital services, long-term care, and prescription drugs.⁶ VA's health care system is organized into 21 VISNs that include VAMCs and CBOCs. VAMCs offer outpatient, residential, and inpatient services. These services range from primary care to complex specialty care, such as cardiac and spinal cord injury care. VAMCs also offer a range of mental health services, including outpatient counseling services, residential programs—which provide intensive treatment and rehabilita-

⁴The scope of services VA requires to be provided to women veterans, including requirements for ensuring the privacy of women veterans, are outlined in Veterans Health Administration (VHA) Handbook 1330.1, and the requirements for WVPM are outlined in VHA Handbook 1330.02 and in a July 2008 VA directive titled "Women Veteran Program Managers Full-Time FTEE Positions."

⁵The management of VAMCs and CBOCs is decentralized to 21 regional networks referred to as VISNs.

⁶See 38 U.S.C. § 1710(a), 38 CFR § 17.38 (2008). Any veteran who has served in a combat theater after November 11, 1998, including OEF/OIF veterans, and who was discharged or released from active service on or after January 28, 2003, has up to 5 years from the date of the veteran's most recent discharge or release from active duty service to enroll in VA's health care system and receive VA health care services. See 38 U.S.C. § 1710(e)(1)(D), (e)(3)(C). Veterans who were discharged or released before January 28, 2003, and who did not enroll in VA's health care system are eligible for these VA health care services for 3 years after January 28, 2008.

tion services, with supported housing, for treatment, for example, of PTSD, MST, or substance use disorders—and inpatient psychiatric treatment. CBOCs are an extension of VAMCs and provide outpatient primary care and general mental health services on site. VA also operates 232 Vet Centers, which offer readjustment and family counseling, employment services, bereavement counseling, and a range of social services to assist combat veterans in readjusting from wartime military service to civilian life.⁷

When VA facilities are unable to efficiently provide certain health care services on site, they are authorized to enter into agreements with non-VA providers to ensure veterans have access to medically necessary services.⁸ Specifically, VA facilities can make services available through:

- referral of patients to other VA facilities or use of telehealth services,⁹
- sharing agreements with university affiliates or Department of Defense medical facilities,
- contracts with providers in the local community, or
- allowing veterans to receive care from providers in the community who will accept VA payment (commonly referred to as fee-basis care).

VA Policies Pertaining to Women's Health

Federal law authorizes VA to provide medically necessary health care services to eligible veterans, including women veterans.¹⁰ Federal law also specifically requires VA to provide mental health screening, counseling, and treatment for eligible veterans who have experienced MST.¹¹ Although the MST law applies to all veterans, it is of particular relevance to women veterans because among women veterans screened by VA for MST, 21 percent screened positive for experiencing MST. VA provides health care services to veterans through its medical benefits package—health care services required to be provided are broadly stated in a regulation and further specified in VA policies. Through policies, VA requires its health care facilities to make certain services, including gender-specific services and primary care services, available to eligible women veterans.¹² Gender-specific services that are included in the VA medical benefits package¹³ include, for example, cervical cancer screening, breast examination, management of menopause, mammography, obstetric care, and infertility evaluation. See table 1 for a list of selected basic and specialized gender-specific services that VA is required to make available and others that VA may make available to women veterans.

⁷All veterans who have served in a combat theater, including OEF/OIF veterans, are eligible for Vet Center services. See 38 U.S.C. § 1712A(a).

⁸See 38 U.S.C. § 1703.

⁹Telehealth is the provision of health services from a distance using telecommunications technologies, such as videoconferencing.

¹⁰38 U.S.C. § 1710.

¹¹38 U.S.C. § 1720D.

¹²These services are defined in VHA Handbook 1330.1, *VHA Services for Women Veterans* (revised July 16, 2004) and VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008).

¹³See 38 CFR § 17.38 (2008).

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

	Services that VA medical facilities may make available to women veterans
Primary care/basic gender-specific services^a	<ul style="list-style-type: none"> • Intake and initial assessment, including screening for military sexual trauma (MST)^b • Routine physical exams • Intimate partner violence screening • Smoking cessation counseling • Smoking cessation treatment • Nutrition counseling • Weight management and fitness • Urgent/emergent gender-related care—normal hours • Urgent/emergent gender-related care—evenings, weekends, and holidays • Pelvic examination^b • Clinical breast examination^b • Education on performing breast self-examination^b • Cervical cancer screening^b • Menopause management^b • Uncomplicated vulvovaginitis treatment^b • Osteoporosis screening^b • Osteoporosis treatment^b • Hormone replacement therapy^b • Prescription of oral contraceptives^b
Specialized gender-specific services^a	<ul style="list-style-type: none"> • Treatment after abnormal cervical cancer screening^b • Surgical sterilization—evaluation^b • Surgical sterilization • Sexually transmitted disease (STD) screening • STD counseling • STD treatment • Intrauterine device (IUD) placement • Pregnancy test—urine • Pregnancy test—serum • Prenatal care • Labor and delivery • Postpartum care • Infertility evaluation^b • Endometriosis treatment • Evaluation of polycystic ovarian syndrome^b • Treatment of polycystic ovarian syndrome^b • Screening mammography^b • Diagnostic mammography • Surgical treatment of breast cancer^b • Surgical treatment of reproductive cancer^b • Medical treatment of breast cancer^b • Medical treatment of reproductive cancer^b

Source: GAO review of VA data.

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

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

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

In November 2008, VA established a policy that requires all VAMCs and CBOCs to move toward making comprehensive primary care available for women veterans. VA defines comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, basic gender-specific care, and basic mental health

care—from one primary care provider at one site. VA did not establish a deadline by which VAMCs and CBOCs must meet this requirement.

VA policies also outline a number of requirements specific to ensuring the privacy of women veterans in all settings of care at VAMCs and CBOCs.¹⁴ These include requirements related to ensuring auditory and visual privacy at check-in and in interview areas; the location of exam rooms, presence of privacy curtains, and the orientation of exam tables; access to private restrooms in outpatient, inpatient, and residential settings of care; and the availability of sanitary products in public restrooms at VA facilities.

In 1991, VA established the position of Women Veteran Coordinator—now the WVPM—to ensure that each VAMC had an individual responsible for assessing the needs of women veterans and assisting in the planning and delivery of services and programs to meet those needs. Begun as a part-time collateral position, the WVPM is now a full-time position at all VAMCs. In July 2008, VA required VAMCs to establish the WVPM as a full-time position (no longer a collateral duty) no later than December 1, 2008. Clinicians in the role of WVPM would be allowed to perform clinical duties to maintain their professional certification, licensure, or privileges, but must limit the time to the minimum required, typically no more than 5 hours per week.

VA Mental Health Services

In September 2008, VA issued the *Uniform Mental Health Services in VA Medical Centers and Clinics*,¹⁵ a policy that specifies the mental health services that must be provided at each VAMC and CBOC.¹⁶ The purpose of this policy is to ensure that all veterans, wherever they obtain care in VA's health care system, have access to needed mental health services. The policy lists the mental health care services that must be delivered on site or made available by each facility. To help ensure that mental health staff can provide these services, VA has developed and rolled out evidence-based¹⁷ psychotherapy training programs for VA staff that treat patients with PTSD, depression, and serious mental illness. VA's training programs cover five evidence-based psychotherapies: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE), which are recommended for PTSD; Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT), which are recommended for depression; and Social Skills Training (SST), which is recommended for serious mental illness. The training programs involve two components: (1) attendance at an in-person, experientially based, workshop (usually 3–4 days long), and (2) ongoing telephone-based small-group consultation on actual therapy cases with a consultant who is an expert in the psychotherapy.

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

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

¹⁴VHA Handbook 1160.01 and VHA Handbook 1330.1.

¹⁵VHA Handbook 1160.01.

¹⁶The mental health services that must be provided in CBOCs differ according to the size of the clinics.

¹⁷Psychotherapies that have consistently been shown in controlled research to be effective for a particular condition or conditions are referred to as "evidence-based."

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

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

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

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

Source: GAO.

Key:

- Service available on site
- ⊗ Refer to another VA facility

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

*This facility may also fee-charge this service to an outside provider on a case-by-case basis.

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

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

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

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

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

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

Source: GAO.

- Service available on site
- Refer to another VA facility
- Refer to a contract provider
- Refer to a fee-basis provider

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

*This facility may refer this service to another VAMC.

**This facility refers this service to a large CBOC located approximately 13 miles from this facility.

***This facility may also fee-basis this service to a non-VA provider on a case-by-case basis.

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

††This facility contracts for associated stereotactic biopsies.

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

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

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

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

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

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

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

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

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

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

Table 4: VA Facilities' Compliance with VA Privacy Requirements

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

Source: (40)

- Facility was compliant with requirement in all clinical settings
 - Facility was compliant with requirement in at least one—but not all—clinical settings
 - Facility was not compliant with requirement in any clinical settings
- N/A. We did not have any clinical settings at this facility where this requirement must be applied
- Notes: We collected this information using data collection instruments during site visits to VA medical facilities from October 2008 through April 2009.
- We did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the doorway.
- ¹At this facility, sanitary napkins, tampons, or both were available free of charge in lockers that had been placed in public restrooms.

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

- Visual and auditory privacy at check-in. None of the VAMCs or CBOCs we visited ensured adequate visual and auditory privacy at check-in in all clinical settings that are accessed by women veterans. In most clinical settings, check-in desks or windows were located in a mixed-gender waiting room or on a high-traffic public corridor. In some locations, the check-in area was located far enough away from the waiting room chairs that patients checking in for appointments could not easily be overheard. In a total of 12 outpatient clinical settings at six VAMCs and five CBOCs, however, check-in desks were located in close proximity to chairs where other patients waited for their appointments. At one CBOC, we observed a line forming at the check-in window, with several people waiting directly behind the patient checking in, demonstrating how privacy can be easily violated at check-in.
- Orientation of exam tables. In exam rooms where gynecological exams are conducted, only one of the nine VAMCs and two of the eight CBOCs¹⁸ we visited were fully compliant with VA's policy requiring exam tables to face away from the door.¹⁹ In many clinical settings that were not fully compliant at the remaining facilities, we observed that exam tables were oriented with the foot of the table facing the door, and in two CBOCs where exam tables were not properly oriented, there was no privacy curtain to help assure visual privacy during women veterans' exams. At one of these CBOCs, a noncompliant exam room was also located within view of a mixed-gender waiting room. Figure 1 shows the correct and incorrect orientation of exam tables in two gynecological exam rooms at two VA medical facilities.

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



¹⁸We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams.

¹⁹According to VA policy, if it is not possible for exam tables to be placed with the foot facing away from the door, they may be placed so that they are fully shielded by privacy curtains. However, we did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the door.

- **Restrooms adjacent to exam rooms.** Only two of the nine VAMCs and one of the eight CBOCs we visited were fully compliant with VA's requirement that exam rooms where gynecological exams are conducted have immediately adjacent restrooms.²⁰ In most of the outpatient clinics we toured, a woman veteran would have to walk down the hall to access a restroom, in some cases passing through a high-traffic public corridor or a mixed-gender waiting room.
- **Access to private restrooms in inpatient and residential units.** At four of the nine VAMCs we visited, proximity of private restrooms to women's rooms on inpatient or residential units was a concern. In one mixed-gender inpatient medical/surgical unit, two mixed-gender residential units, and one all-female residential unit, women veterans were not guaranteed access to a private bathing facility and may have had to use a shared or congregate facility. In two of these four settings, access to the shared restroom was not restricted by a lock or a keycard system, raising concerns about the possibility of intrusion by male patients or staff while a woman veteran is showering or using the restroom.
- **Availability of sanitary products in public restrooms.** At seven of the nine VAMCs and all 10 of the CBOCs we visited, we did not find sanitary napkins or tampons available in dispensers in any of the public restrooms.

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

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

Officials at some medical facilities we visited were unclear about the steps needed to implement VA's new policy on comprehensive primary care for women veterans. For example, at one VAMC, primary care was offered in a mixed-gender primary care clinic and basic gender-specific services were offered by a separate appointment in the gynecology clinic, sometimes on the same day. The new comprehensive primary care initiative would require both primary care and basic gender specific services to be available on the same day, during the same appointment. Officials at this facility said that they were in the process of determining whether they can adapt their current model to meet VA's comprehensive primary care standard by placing additional primary care providers in the gynecology clinic so that both primary care services and basic gender-specific services could be offered during the same appointment, in one location. Facility officials were uncertain about whether it would meet VA's comprehensive primary care standard if primary care and basic gender-specific services were still delivered by two different providers. However, VA's comprehensive primary care policy is clear that the care is to be delivered by the same provider. Another area of uncertainty is the breadth of experience a provider would need to meet VA's comprehensive primary care standard. Officials from VA headquarters have made it clear that it is their expectation that comprehensive primary care providers have a broad understanding of basic women's health issues—including initial evaluation and treatment of pelvic and abdominal pain, menopause management, and the risks associated with prescribing certain drugs to pregnant or lactating women. However, in one location, we found that the only provider who was available to deliver comprehensive primary care may not have had the proficiency to deliver the broad array of services that are included in VA's definition, because the facility serves a very low volume of women veterans and opportunities to practice delivering some basic gender-specific services are limited.

²⁰We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams, so this requirement was not applicable at those 2 CBOCs.

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

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

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

Officials at VA medical facilities we visited reported that space constraints have raised issues affecting the provision of health care services to women veterans. In particular, officials at 7 of 9 VAMCs and 5 of 10 CBOCs we visited said that space issues, such as the number, size, or configuration of exam rooms or bathrooms at their facilities sometimes made it difficult for them to comply with some VA requirements related to privacy for women veterans. At some of the medical facilities we visited, officials raised concerns about busy waiting rooms and the limited space available to provide separate waiting rooms for patients who may not feel comfortable in a mixed-gender waiting room, particularly women veterans who have experienced MST. Officials at one CBOC said they received complaints from women veterans who preferred a separate waiting room. At this facility, space challenges that affected privacy were among the factors that led to the relocation of mental health services to a separate offsite clinic. VA facility officials told us that some of the patient bedrooms at two VAMC mixed-gender inpatient psychiatric units that were usually designated for female patients were located in space that could not be adequately monitored from the nursing station. VA policy requires that all inpatient care facilities provide separate and secured sleeping accommodations for women and that mixed-gender units must ensure safe and secure sleeping arrangements, including, but not limited to, the ability to monitor the patient bedrooms from the nursing station.

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

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

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

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

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

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

VA officials have acknowledged some of the challenges involved in training additional primary care providers to meet their vision of delivering comprehensive primary care to women veterans. A November 2008 report on the provision of primary care to women veterans cites insufficient numbers of clinicians with specific training and experience in women's health issues among the challenges VA faces in implementing comprehensive primary care.²¹ To help address the knowledge gap, VA is using "mini-residency" training sessions on women's health. These training sessions—which VA designed to enhance the knowledge and skills of primary care providers—consist of two and one-half days of case-based learning and hands-on training in gender-specific health care for women. During the mini-residency, providers receive specific training in performing pelvic examinations, cervical cancer screenings, clinical breast examinations, and other relevant skills.

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

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

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

²¹ Department of Veterans Affairs, *Report of the Under Secretary for Health Workgroup, Provision of Primary Care to Women Veterans*, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group (Washington, D.C.: November 2008).

situation was not ideal, but said that he consults with mental health providers at the associated VAMC on some of these cases, and that without his services some of these women might not receive any counseling.

VA officials told us that they are aware of the challenges involved in finding clinical staff with specialized training and experience in working with veterans who have PTSD or have experienced MST. A VA official told us that as part of a national effort to enhance mental health providers' knowledge of clinically effective treatment methods and make these methods available to veterans, VA has developed evidenced-based psychotherapy training for VA mental health staff. In particular, CPT, PE, and ACT are evidence-based treatment therapies for PTSD and also commonly used by providers who work with patients who have experienced MST.²² A VA headquarters official who is responsible for these training programs told us that as of May 4, 2009, 1,670 VA clinicians had completed VA-provided training in evidence-based therapies. Although VA is providing training in these evidence-based therapies, VA officials stated that this training is not mandatory for VA mental health providers who work with patients who have PTSD or have experienced MST.

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

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

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

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

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

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

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

²² According to VA officials, these therapies address the PTSD diagnosis commonly associated with sexual trauma. Other diagnoses commonly associated with MST are depression and generalized anxiety.

factors listed below, we examined available facility- or market-level data to identify facilities of interest:

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

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

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

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

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

Source: VA data and GAO analysis.

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

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

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

Source: VA data and GAO analysis.

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

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

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

Prepared Statement of Phyllis E. Greenberger, M.S.W, President and Chief Executive Officer, Society for Women's Health Research

Thank you for the invitation to address the Subcommittee on Disability Assistance and Memorial Affairs and the Subcommittee on Health of the U.S. House of Representatives Committee on Veterans' Affairs on the important topic of eliminating the gaps in women veterans' health care. I am Phyllis Greenberger, the CEO and President of the Society for Women's Health Research (SWHR), an advocacy organization dedicated to improving women's health and their health care. The Society encourages the study of differences between men and women that affect the prevention, diagnosis, and treatment of disease and conditions.

At our inception, the Society fought for legislation to require the inclusion of women in federally funded clinical research and for guideline changes at the Food and Drug Administration to regulate women's participation in pre-market clinical trials. As a result of these successes—and our efforts to encourage women to participate in research—we learned that sex matters in health care. A 2001 report of the Institute of Medicine (IOM), "Exploring the Biological Contributions to Human Health: Does Sex Matter?" validated our thinking that sex differences important to health and human disease occur in the womb and throughout the lifespan, affecting behavior, perception, and health. With the Society's support, the field of sex and gender differences research is flourishing, and through our advocacy we are ensuring that what we learn about health care differences between the sexes becomes translated into clinical practices to benefit both women and men.

The Society strongly believes that the Department of Veterans Affairs (VA) is in a unique position to lead the Nation in furthering essential sex differences research and in translating that research into clinical practice. Lessons learned at the VA can be applied to the private sector. The Society recommends that Congress request an update on the research conducted by the Veterans Health Administration (VHA) since the establishment of its women's health research agenda in November 2004¹ and further recommends that Congress provide the VA with the funding necessary to conduct research that will result in improved care for women veterans.

STATUS OF THE VA WOMEN'S HEALTH RESEARCH AGENDA

The Society applauds the VA Office of Research and Development (ORD) for its determination that women's health services research is a high priority and for establishing evidence-based research priorities that, if implemented, will help improve women veterans' health and health care. We are pleased that the agenda-setting process included identification of conditions that affect women disproportionately and those that affect women differently than they affect men. We are particularly pleased that the Biomedical Workgroup established as its "overarching focus," "sex-based influences on prevention, induction, and progression of diseases relevant to women veterans."

The Society advises that a status report is needed on the progress the VA has made in initiating research in these critical areas. This report should address the following questions:

- Has the VA's Health Services Research & Development (HSR&D) completed its "Evidence Synthesis Program" on women veterans' health and health care?
- What are some important sex differences that have come out of VA research that are likely to be translated into improved health care for women?

¹Yano, EM., Bastian, LA., Frayne, SM., et al. Toward a VA women's health research agenda: Setting evidence-based priorities to improve the health and health care of women veterans, *Journal of General Internal Medicine*, 2006; 21(Suppl 3); S93-S101, S96.

- Currently, what percentage of clinical trials conducted by the VA are populated by women? What percent of the trials that include women have appropriate representation of women in proportion to burden of disease?
- What is the status of a “women veterans’ practice-based research network” that could set up an infrastructure for clinical trials with larger volumes of female patients recently described by HSR&D investigator Elizabeth Yano, PhD, MSPH.² What other systems are currently in place with regards to the recruitment of women to participate in clinical trials?
- What are the success rates of these efforts?
- What are the barriers to effective recruitment and retention of women in VA clinical trials?
- What steps has the VA taken to ameliorate these barriers?

The Society notes that the VA ORD “needs to build research capacity, solve methodologic issues that limit participation of women in research, and increase the awareness and visibility of women’s health research.”³ The Society is the pioneer in encouraging women’s participation in clinical trials and in encouraging clinical trial design that allows for subsequent analysis by subgroups (including women).

The Society sponsors small, interdisciplinary research networks that focus on understanding sex differences in various critical areas of research, including neuroscience, metabolism, musculoskeletal health, and cardiovascular disease. These networks are composed of scientists and clinicians within various fields who identify gaps of knowledge in each subject area and develop strategies and methods to fill those gaps. Members of the first of these networks edited a text book, *Sex Differences in the Brain: From Genes to Behavior*,⁴ described in a review in the *New England Journal of Medicine* as “an excellent overview of the latest research in basic and health-related science in an important area.” A review in *Science* stated that “information content is high, references are ample, and the continuity between different chapters has been skillfully coordinated. . . .” Nancy Yanes-Hoffman, from the Writing Doctor blog, called the text “a brilliant, long-overdue guidebook leading us to better understanding, treatment, and care of men and women.”

In addition, the Society is the founding partner of the Organization for the Study of Sex Differences (OSSD), a professional membership society for researchers and clinicians who have adopted a transdisciplinary approach to understanding the basic mechanisms of biological sex differences and how those can be translated into better clinical practice. In the first three annual meetings, OSSD members have reported on sex differences in a wide array of areas, including immunity and infection; drug abuse; stress; sleep disorders; vascular and renal disease; obesity; autoimmunity; tissue injury, repair and regeneration; stroke; and osteoarthritis.

Both prior to and after the establishment of the OSSD, the Society has sponsored scientific conferences that explore cutting-edge research in women’s health and sex differences. Topics covered include neurology, immunity, pharmacology, digestive diseases, sexually transmitted diseases, and pain. One recent conference (December 2008) was on sex differences in post-traumatic stress disorder (PTSD), cosponsored by the VA (among others). Researchers from academia and Federal health agencies, including the Department of Defense, National Institutes of Health, and VA, presented the latest findings about differences in diagnosis and treatment of PTSD in men and women. Attached to this testimony is the conference summary, which includes recommendations for future research.

The Society publishes many conference reports and other information for both researchers and the general public on how sex and gender differences can affect a person’s health. At www.womenshealthresearch.org are two electronic resources: “Just the Facts: What Women Need to Know About Sex Differences in Health” and “Just the Facts: Sex-Based Biology.” Along with Jennifer Wider, MD, I edited the only patient reference book on sex differences, *The Savvy Woman Patient: How and Why Sex Differences Affect Your Health*.

With such expertise and resources, the Society stands ready to assist the VA in building its research capacity, increasing participation of women in research, and increasing the visibility of its women’s health research.

²Yano, EM., Achieving equitable high-quality care for women veterans, *VA HSR&D Forum*. Nov 2008.

³Yano, EM., Bastian, LA., Frayne, SM., et al. Toward a VA women’s health research agenda: Setting evidence-based priorities to improve the health and health care of women veterans, *Journal of General Internal Medicine*, 2006; 21(Suppl 3): S93–S101, S100.

⁴Becker JB., Berkley KJ., Geary N., Hampson E., Herman JP., Young EA. (eds). *Sex Differences in the Brain: From Genes to Behavior*. (New York: Oxford University Press, 2008), 185.

VA WOMEN'S HEALTH RESEARCH FUNDING

The Society has long advocated for the "Women's Health Office Act," which would ensure that the women's health offices at Federal health agencies—the Department of Health and Human Services (HHS), the Agency for Health care Research and Quality (AHRQ), the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA)—be made permanent in statute. Without permanent authorization, these offices face underfunding, understaffing, or elimination in the future. These offices are of critical importance to health and health care services for all women, providing leadership on research, dissemination of information, education, and health care service delivery.

The Society recommends that Congress authorize the VA to establish an office within its ORD, similar to those in other Federal agencies, with the appropriate powers and authority, including grant-making and provision of contracts, to direct the women's health and the sex differences research agenda for the VA.

The VA's health research budget for FY2009 is \$510 million. In moving forward the efforts on women's health at the VA, it is important that we understand how much of this funding is directed toward women's health research and how much is applied to sex differences research that benefits both men and women. The Society encourages Congress to provide sufficient appropriations to the Department of Veterans Affairs to ensure that the VA will be able to fulfill its women's health research agenda. Further, if an office to direct women's health research is established within ORD, the Society recommends that it be appropriately funded to carry out its duties, including entering into grants, contracts, and other cooperative agreements directing the women's health and the sex differences research agenda for the VA.

CONCLUSION

I want to thank you again for this opportunity to discuss the important topic of women's health research at the VA. The Society looks forward to continuing to work on this important matter with the Subcommittee on Disability Assistance and Memorial Affairs and the Subcommittee on Health of the U.S. House Committee on Veterans' Affairs.

[The attached report entitled, "PTSD in Women Returning from Combat: Future Directions in Research and Service Delivery" a Report by the Society for Women's Health Research, is being retained in the Committee files. The Report can also be accessed online at http://www.womenshealthresearch.org/site/DocServer/PTSD_in_Women_Returning_From_Combat--reduced_file_size.pdf?docID=2661.]

**Prepared Statement of Janice L. Krupnick, Ph.D., Professor,
Department of Psychiatry, Director, Trauma and Loss Program,
Georgetown University Medical Center, on behalf of Committee on
Veterans' Compensation for Post Traumatic Stress Disorder, Institute of
Medicine and National Research Council, The National Academies**

Good morning, Mr. Chairman, Mr. Ranking Member, and Members of the Committee. My name is Janice Krupnick and I am a Professor in the Department of Psychiatry at the Georgetown University Medical Center and Director of the Center's Trauma and Loss Program. Thank you for the opportunity to testify on the content of the National Academies report *PTSD Compensation and Military Service*. The committee's work—which was conducted between March 2006 and July 2007—was requested by the Department of Veterans Affairs, which provided funding for the effort. I provided input to this committee while serving as a member of the Institute of Medicine Committee on Gulf War and Health—Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress and its Subcommittee on post-traumatic stress disorder (PTSD).

I'm pleased to be here today to share with you some of the results of the *PTSD Compensation . . .* report and the knowledge I've gained as a clinical psychologist and researcher on traumatic stress. I will briefly address five issues in this testimony:

- the prevalence of military sexual assault,
- the relationship between sexual assault and PTSD,
- PTSD comorbidities and recovery for women,
- PTSD compensation and women veterans, and

- the *PTSD Compensation* . . . report's conclusions and recommendations regarding women veterans.

The prevalence of military sexual assault

It is recognized that the circumstances of military service may create barriers to reporting sexual assault above and beyond those extant in other sectors of the population. That said, the prevalence of reported sexual assault in the military is alarming. A synthesis of 21 studies by Goldzweigh and colleagues found that 4.2 to 7.3 percent of active duty military females had experienced a military sexual assault (MSA), while 11 to 48 percent of female veterans reported having experienced a sexual assault during their time in the military. A survey by Campbell and Raja (2005) found that among 104 female veterans and reservists who disclosed that they were sexually assaulted while in military service, 13 percent reported sexual assault from a marital partner and 8 percent from a date. Eighty-two percent of the perpetrators in these MSAs were military peers or supervisors. The women in this sample also reported a great deal of secondary victimization by the military and by the VA system, an experience that is known to make the PTSD symptoms worse. Other studies have found subsequent secondary victimization and sexual harassment, exposing the women to additional trauma over and above rape and combat.

The relationship between gender, sexual assault and PTSD

A substantial body of literature documents measurable gender differences in PTSD frequency and severity. A well-conducted meta-analysis published in 2006 by Tolin and Foa found that PTSD was twice as prevalent in females as in males after controlling for potential confounders. There are several possible reasons for this, including sex differences in the cognitive response to the traumatic event, immediate coping strategies, and the willingness to admit symptoms. Women are more likely to experience chronic trauma, such as repeated childhood sexual assault by a family member or recurring intimate partner violence. Women are also more commonly the victim in cases of multiple traumas. Research indicates that sexual-assault experiences are strongly associated with PTSD in both civilian and military populations.

PTSD comorbidities and recovery for female veterans

Studies of female veterans indicate that PTSD symptoms and PTSD diagnoses are associated with comorbidities such as depression, substance abuse, smoking, and physical health problems as well as with increased medical utilization. Females are more likely than males to have major depressive disorder along with PTSD and tend to experience symptoms for a longer duration and have more associated physical health problems than do males.

For female veterans, post-military social support from family and friends both reduces the risk of developing PTSD and aids in recovery from the disorder, according to the few studies of PTSD recovery in this population. Female veterans were more comfortable in a specialized treatment program for women; it increased their participation as measured by attendance and commitment, but had no effect on outcomes.

The *PTSD Compensation* . . . committee observed that studies of PTSD treatment for female veterans are badly needed, and noted that it was important to ensure that the study samples were sufficiently large to disentangle the differential treatment effects for women whose trauma is primarily MSA versus those whose trauma is primarily combat or to determine if multiple traumas are part of the etiology of the PTSD experience.

PTSD compensation and female veterans

Very little research exists on the subject of PTSD compensation and female veterans. A 2003 study by Murdock and colleagues did determine that a significantly smaller percentage of females had their PTSD deemed to be service connected as compared to males, and that this was primarily related to the lower rates of combat exposure among females. Subsequent research by Murdock (2006) found that, when MSA was substantiated in a Veterans Benefits Administration (VBA) claim file, service-connected PTSD determinations increased substantially. Unfortunately, there are huge barriers to women being able to independently substantiate their experiences of MSA, especially in a combat arena. A 2004 U.S. Air Force report cited by the committee noted that these barriers included:

lack of privacy/confidentiality[,] . . . stigma, fear, or shame; fear of disciplinary action because of a victim's misconduct; fear of being reduced in the eyes of one's commander/colleagues; fear of re-victimization; and fear of perceived operational impacts, including loss of security clearances, effect on training, and impact on overseas deployments (U.S. Air Force, 2004; p. 10).

Available information suggests that female veterans are less likely to receive service related compensation for PTSD and that this is, at least in part, a consequence of the relative difficulty of substantiating exposure to noncombat traumatic stressors—notably, MSA. The committee noted that PTSD training and reference materials for VBA raters address MSA, but scant attention is paid either to the challenges of documenting it as an in-service stressor or to approaches to addressing this problem.

The *PTSD Compensation . . . report's conclusions and recommendations regarding women veterans*

The committee responsible for the *PTSD Compensation . . . report* reached several conclusions and recommendations related to women veterans on the basis of their review of papers, reports, and other scientific information. It also identified research needs.

The committee concluded that “the most effective strategy for dealing with problems with self reports of traumatic exposure is to ensure that a comprehensive, consistent, and rigorous process is used throughout the VA to verify veteran-reported evidence.” It therefore recommended that the Veterans Benefits Administration “conduct more detailed data gathering on the determinants of service connection and ratings level for MSA-related PTSD claims, including the gender-specific coding of MSA-related traumas for analysis purposes.”

The committee observed that appropriate management of MSA-related claims begins with the proper documentation of incidents that occur during active service. Therefore, improved training of military medical and nursing personnel on how to document and collect evidence regarding sexual assault is needed. The committee thus recommended that VBA “develop and disseminate reference materials for raters that more thoroughly address the management of MSA-related claims” and that “training and testing on MSA-related claims should be a part of [a] certification program . . . for raters who deal with PTSD claims.”

Citing the gaps it found in the information base, the committee noted that “more research is needed on the as yet unexplained gender differences in vulnerability to PTSD, which could help identify useful sex-specific approaches to prevention and treatment, and on more effective means for preventing military sexual assault and sexual harassment.”

The *PTSD Compensation . . . committee* also reached a series of other findings and recommendations regarding the conduct of VA's compensation and pension system for PTSD that are detailed in the body of our report. The National Academies previously provided the Subcommittee with copies of this report and would happy to fulfill any additional requests for it.

Thank you for your attention. I'm happy to answer your questions.

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**Prepared Statement of Bradley G. Mayes, Director, Compensation and
Pension Service, Veterans Benefits Administration,
U.S. Department of Veterans Affairs**

Chairman Hall, Chairman Michaud, and Members of the Subcommittees, thank you for providing me an opportunity to speak today on the important topic of assisting women veterans.

I. Changing Demographics of Women Veterans

Although women have been associated with military activity since the founding of our Nation, their role has increased dramatically in recent years. From the time of the American Revolution, women have supported the military service of their male counterparts and sometimes took up arms themselves. Their work and sacrifice as military nurses saved innumerable lives and contributed immeasurably to the efforts of all military campaigns. These medical efforts were especially valuable during World War II and the wars in Korea and Vietnam. However, despite their major contributions, the percentage of servicemembers in these conflicts who were women was relatively small. According to U.S. Census Bureau statistics, 5 percent of veterans who served in World War II were women veterans, 2 percent who served in Korea were women veterans, and 3 percent who served in Vietnam were women veterans. However, during the Gulf War 1991–1992, the percentage of women veterans increased to 16 percent. This reflects a significantly expanded role for women in the military. As a result, the Department of Veterans Affairs (VA) has adjusted its programs accordingly.

The expanded role of women in the military has also brought about increased responsibilities and risk taking. Women serving in Iraq and Afghanistan face combat activity similar to their male counterparts. As aircraft pilots, convoy transportation specialists, military police officers, and members of civilian pacification teams, women have increasingly been in harm's way and have incurred more service-related physical and mental disabilities as a result.

The following VA statistics illustrate the significance these changing roles have had on VA. America has approximately 1.8 million women veterans. They make up approximately 7.7 percent of the total number of veterans awarded service connection. The number of women receiving VA compensation and pension increased from 203,000 in 2006, to over 250,000 in June of 2009. This represents a 23-percent increase in less than 3 years. So far this fiscal year, the number of women veterans receiving benefits who served in the current overseas contingency operations has increased by nearly 10,000. Although women veterans represent 12 percent of those who served in these operations, they represent 15 percent of those awarded service connection for a disability.

II. VA Efforts to Assist Women Veterans

VA established the Advisory Committee on Women Veterans in 1983 as a panel of experts on issues and programs affecting women veterans. Since then, we have worked to implement its recommendations for improving services to women veterans. A major issue of current concern for this Committee is the occurrence of military sexual trauma (MST) among women on active duty and the disabilities that may result. The Committee has recommended that VA address this issue to the greatest extent possible.

The claims of women veterans who seek disability compensation for post-traumatic stress disorder (PTSD) based on MST are specifically addressed in VA's regulations at 38 CFR § 3.304(f)(4). In 2002, VA amended its PTSD regulations to emphasize that, if a PTSD claim is based on in-service personal assault, which include MST claims, evidence from sources other than the veteran's military records may be used to corroborate the in-service traumatic event. Such evidence may include, but is not limited to, records from law enforcement authorities, rape crisis centers, mental health counseling centers, and hospitals, as well as statements from family Members, associates, or clergy. Service medical and personnel records are also reviewed in order to discover evidence of behavior changes that may support the occurrence of the traumatic event. In addition, prior to a decision on the claim, VA provides an appropriate medical or mental health professional with the available evidence and asks for an opinion as to whether the traumatic event occurred. These procedures take into account the sensitive nature of MST and the difficulty in obtaining supporting evidence.

Another general recommendation from the Advisory Committee on Women Veterans is that proper health care and compensation should be provided for service-connected disabilities that are unique to women veterans. Unique disability compensation evaluation criteria for women veterans are provided in the VA Schedule for Rating Disabilities under the section for gynecological conditions and disorders

of the breast. An additional monetary benefit, referred to as special monthly compensation, is also available for loss, or loss of use, of a creative organ as the result of a service-connected disability. This applies to the male and female reproductive systems. In 2000, VA amended 38 CFR § 3.350(a) to authorize special monthly compensation for women veterans who suffer a service-connected loss of 25 percent or more of breast tissue from a mastectomy or radiation treatment.

Congress has acknowledged the effects of herbicide exposure on women veterans who served in Vietnam and the potential for birth defects that may occur in their children as a result. Chapter 18 of title 38, United States Code, authorizes a monetary allowance for the children of any Vietnam veteran for disability attributable to spina bifida and for the children of women veterans who served in Vietnam for disability due to a covered birth defect. A long list of birth defects that qualify a child for a monetary allowance are described in VA regulations. This list reflects the findings of a VA study that indicated an association between numerous birth defects among the children of females, but not males, who were exposed to herbicides.

As a further means to implement recommendations of the Advisory Committee on Women Veterans, the Veterans Benefits Administration (VBA) has engaged in outreach efforts. When active duty military personnel are separated from service or National Guard and Reserve Members are demobilized, VBA provides information to them under the Transitional Assistance Program (TAP) at their military base. This pre-discharge program explains the array of benefits available from VA and assists individuals with filing disability claims. One mandatory section of TAP is a PowerPoint slide presentation on "military sexual and other personal trauma." This is intended to alert separating servicemembers that VA is aware of the MST problem and inform them that counseling, treatment, and disability compensation are available.

Outreach efforts are also conducted at all VA regional offices on a continuing basis. Each regional office employs a Women Veterans Coordinator who is well versed in personal trauma issues, including those of MST, as well as gender specific disability issues, and who acts as a liaison with the Women Veterans Program Manager at the local VA health care facility. These coordinators also work with the regional office Homeless Veterans Coordinators to address the problems of homeless women veterans. A nationwide VA Women Veterans Coordinator Training Conference is scheduled for August 2009 in St. Paul, Minnesota. At the conference, VA will present updated information and skill training to the coordinators. Topics will include: outreach methods, clinical perspectives on personal trauma, and women veterans health issues. In addition to these personal outreach efforts, VBA maintains a public Internet Web site devoted to the unique issues associated with women veterans. This VBA Web site is in addition to Web sites maintained by the VA Center for Women Veterans and the Veterans Health Administration (VHA) on women veterans health care.

III. *Conclusion*

VA has recognized the service provided to our Nation by women veterans and the importance of providing them with the assistance they deserve. VBA has moved forward, along with VHA, to address the issues that are unique to women veterans. We have developed special regulations for adjudication of PTSD claims based on MST. Regarding compensation for gender specific disabilities, we provide special monthly compensation for breast tissue loss and monetary assistance for the children of women Vietnam veterans who develop birth defects. We have also engaged in nationwide outreach to facilitate women veterans' access to VA benefits. We realize that VA needs to keep pace with the changing needs of women who served in the military, and we are ready to take whatever steps are necessary in the future to properly assist women veterans.

Prepared Statement of Irene Trowell-Harris, RN, Ed.D., 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) regarding women veterans' issues. Through recommendations made by the Secretary's Advisory Committee on Women Veterans, collaborations between the Center for Women Veterans and VA's Administrations, and proactive measures taken by the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA), VA continues to transform to meet

the anticipated needs of women veterans. I greatly appreciate the Committee's diligence in bringing forth discussion on this very important and timely issue.

Center for Women Veterans

The Center was created by Public Law 103-446 in November 1994. As Director, I serve as chief advisor to the Secretary on all issues related to women veterans and serve as the Designated Federal Officer to the Secretary's Advisory Committee on Women Veterans.

The Center's mission is to ensure that women veterans have access to VA benefits and services on par with male veterans; that VA programs are responsive to the gender-specific needs of women veterans; that joint outreach is performed to improve women veterans' awareness of VA services, benefits and eligibility criteria; and that women veterans are treated with dignity and respect.

The Center accomplishes its mission by monitoring the Department's programs and policies to ensure that they are responsive to the needs of women veterans by:

- recommending policy and legislative proposals to the Secretary and analyzing the impact of these proposals on women veterans;
- collaborating with VA's Administrations to make women veterans more knowledgeable about changes in VA policies;
- ensuring that the Advisory Committee on Women Veterans is educated about VA to ensure clear, meaningful recommendations;
- coordinating the development, distribution, and processing of the Committee reports; and
- coordinating an annual Committee site visit to VA health care facilities, regional offices, Vet Centers, national cemeteries, and other related programs such as homeless and transitional housing.

Caring for our women veterans does not stop within the confines of the Department. We conduct extensive outreach, coordination and collaboration with other agencies (Federal, state, and local), as well as with Veterans Service Organizations (VSO) and community-based organizations concerned with women veterans issues.

Advisory Committee on Women Veterans

The Advisory Committee was established in 1983 pursuant to Public Law 98-160. The committee is charged with advising the Secretary on VA benefits and health 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 is required to submit a biennial report to the Secretary incorporating its findings and recommendations. There are currently 13 committee members, including two Operation Enduring Freedom and Operation Iraqi Freedom Veterans.

Committee Meetings and Site Visits

The Advisory Committee meets twice a year at VA Central Office (VACO) and receives briefings from VHA, VBA, NCA and from staff offices. These briefings update the Advisory Committee on the status of VA programs and progress on recommendations, and respond to concerns raised during the site visits. The Advisory Committee uses information from the site visits and briefings to formulate its recommendations to the Secretary in biennial reports.

To obtain information regarding the delivery of health care and services to women veterans, the Advisory Committee conducts annual site visits to VA facilities throughout the country. During these site visits, the Committee tours the facilities and meets with senior officials to discuss services and programs available to women veterans. In addition, the Committee also hosts open forums at site visits with the women veterans' community, encouraging women veterans to discuss issues and ask questions related to VA benefits and services. Copies of the "25 Most Frequently Asked Questions" are distributed at the townhall meeting.

The Advisory Committee completed a site visit in June 2009 to the Veterans Affairs North Texas Health Care System facilities in Dallas and Bonham, Texas. The purpose of site visits are to provide an opportunity for Committee Members to compare the information they received from briefings, provided by the administrations with the activity in the field. This effort is to ensure that policies established in VACO are implemented in VA medical centers and other facilities that serve and impact women veterans which are people-centric, results driven, and forward looking.

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

Advisory Committee on Women Veterans 2008 Report

In the 2008 Report of the Advisory Committee on Women Veterans, the Committee made 20 recommendations—with supporting rationale—addressing 10 topical areas. The Center collaborates frequently with Administrations and staff offices to ensure that the Department thoroughly addresses the Committee's recommendations. The 2008 Report, including VA's responses, was provided to the House and Senate Veterans Affairs' Committees on September 26, 2008.

Recommendations stem from data and information gathered in briefings from VA officials, Departments of Labor (DOL) and Defense (DoD) officials, Members of House and Senate Congressional Committee staff offices, women veterans, researchers, VSOs, internal VA reports, and site visits to VHA, VBA, and NCA facilities. The Committee is confident that the 20 recommendations and supporting rationale reflect value-added ways for VA to strategically and efficiently address many needs of women veterans.

What Women Veterans Tell Us They Want and Need

Anecdotally and in research, women veterans tell us they want and need recognition and respect, employment, suitable housing, access to and receipt of high quality health care, childcare options, opportunities for social interaction, and that they want to make a difference.

Summit on Women Veterans' Issues

Every 4 years, VA sponsors a Summit on Women Veterans' Issues. The fourth quadrennial Summit was held on June 20–22, 2008, in Washington, DC. The purpose of the Summit was to 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.

More than 400 individuals attended, including women veterans, women veterans' program managers and coordinators, Congresswoman Susan Davis and Congressional staff from the Senate and House Committees on Veterans' Affairs, women veterans' organizations, representatives from other collaborating Federal, state and local agencies, VSOs, and members of the active duty military, Guard, and Reserve. The program consisted of 11 breakout sessions plus VA Updates since 2004. For the first time, we held a townhall meeting to discuss national issues affecting women veterans, viewed the Public Broadcasting Service *Lioness* documentary (*Lioness* looks at five women from an Army engineer battalion in Iraq who were drawn into battle and the fallout from their experiences), and had an open discussion with the directors and soldiers featured in the film. Based on feedback received from Summit participants, the Center is posting updates on women veterans' issues to its Web site.

Progress on Women Veterans' Issues

Many of the recommendations made by the Advisory Committee have been instrumental in transforming VA to assist in meeting the needs of women veterans and to help bridge the gaps in services and benefits. To address the challenges of enhancing primary care for women veterans, VA has done the following:

- Elevated the Women's Veterans Health Program Office on VA's organizational chart to the Women Veterans Health Strategic Health Care Group, as part of VA's readiness for the influx of new women veterans. This group provides programmatic and strategic support to implement positive changes in the provision of care for all women veterans.
- Employed a full-time Women Veterans Program Manager at every VA health care facility.
- Initiated implementation of comprehensive primary care (including gender specific care) at every VA site.
- Ensured accurate representation of the women veterans population through analysis and data.
- Expanded the women's health knowledge base among VA providers.
- Sought to recruit primary care physicians who have knowledge and interest in women's health.
- Started to integrate mental health with primary care to enable a comprehensive women's health care program.
- Started to change the overall culture of VA to be more inclusive of women veterans, and recognize their military service and contribution to this Nation.

Conducting Joint and Collaborative Outreach Efforts

The Center takes every opportunity to collaborate with VSO, policy, women and minority groups, other Federal and state agencies, and community organizations to outreach to women veterans by:

- Providing keynote speeches at national conventions and women veterans forums;
- Participating in Congressional round table discussions on the needs of women veterans;
- Collaborating with VA Administrations, staff offices, and other advisory Committees;
- Providing information to minority women, including those who live on reservations through the Center for Minority Veterans;
- Participating on the homeless veterans workgroup to ensure that needs of homeless women veterans with children are addressed;
- Working with the Congressional Caucus for Women's Issues to recognize and honor our Nation's service women and women veterans at an annual wreath laying ceremony at the Women in Service for America Memorial; and
- Representing the Secretary at the monthly White House Interagency Council Meeting on Women and Girls, addressing the needs of women veterans nationally in collaboration with the Department of Defense.

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

Prepared Statement of Lawrence Deyton, M.D., MSPH, Chief Public Health and Environmental Hazards Officer, Veterans Health Administration, U.S. Department of Veterans Affairs

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

The Secretary recently testified before this Committee that enhancing primary care for women veterans is one of VA's top priorities. VA recognizes that a growing number of women veterans are choosing VA for their health care. Of the 1.8 million women veterans in the United States more than 450,000 have enrolled for care. This number is expected to grow by 30 percent in the next 5 years. Women currently comprise approximately 14 percent of the active duty military, 17.6 percent of Guard and Reserves and 5.9 percent of VA health care users.

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

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

Current Challenges

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

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

Moving to a more comprehensive primary care delivery model could challenge VA clinicians, who may have dealt predominately with male veterans and sometimes have little or no exposure to female patients. VA facilities may also need to increase

both focus and resources on women's health (e.g., space, staffing, appropriately equipped exam rooms) to ensure adequate privacy for women during examinations. Initiatives are underway and under development to address these and other changes brought on by the increasing number of women veterans seeking care from VA.

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

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

Current Initiatives

VA recognizes the need to continually improve its services to women veterans, and has initiated new programs including the implementation of comprehensive primary care throughout the Nation; enhancing mental health for women veterans; staffing every VA medical center with a women veterans program manager; creating a mini-residency education program on women's health for primary care physicians; supporting a multifaceted research program on women's health; improving communication and outreach to women veterans; and continuing the operation of organizations like the Center for Women Veterans and the Women Veterans Health Strategic Health Care Group.

Comprehensive Primary Care for Women Veterans

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

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

To implement these goals and recommendations, the Women Veterans Health Strategic Health Care Group developed a women's comprehensive health implementation planning (WCHIP) tool to assist facilities in analyzing their own current health care delivery for women veterans and plans for primary care delivery enhancement. Every VA health care facility was requested to convene a multidisciplinary planning and implementation team to address comprehensive primary care for women veterans. The WCHIP tool outlines an analysis of current services and

projected use, a market analysis and a needs assessment, which facilitated the development of a business plan. This plan includes resource needs, goals, timelines, budgets, training needs and program evaluation metrics to deliver comprehensive health care to women veterans.

No later than August 1, 2009, facilities will finalize their analyses and action plans based on the WCHIP tool. These plans will be instrumental in decisions for directing resources for fiscal years 2010 and 2011.

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

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

Enhancing Mental Health

VA has identified that 37 percent of women veterans who use VA health care have a mental health diagnosis; these rates are higher than those of male veterans. Women veterans also present with complex mental health needs, including depression, post-traumatic stress disorder (PTSD), military sexual trauma (MST), and parenting and family issues.

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

Women Veterans Program Managers

In order to ensure improved advocacy for women veterans at the facility level, VA has mandated all VA medical centers appoint a full-time Women Veterans Program Manager. These Women Veterans Program Managers support increased outreach to women veterans, improve quality of care provision, and develop best practices in organizational delivery of women's health care. They serve as advisors to facility directors in identifying and expanding the availability and access of inpatient and outpatient services for women veterans and provide counseling on a range of gender specific care issues. Women Veterans Program Managers also coordinate and provide appropriate local outreach initiatives to women veterans. As of June 2009, each of VA's 144 health care systems has appointed a full-time Women Veterans Program Manager.

Mini-Residency Training in Women's Health

As the number of women veterans continues to grow, particularly women of child-bearing age, VA recognizes many primary care providers need to update their women-specific clinical experience. VA is offering waves of mini-residencies in women's health across the country in strategic geographic locations. Each mini-residency lasts 2½ days and is taught by national women's health experts. Clinical staff receive presentations on contraception, cervical cancer screening and sexually transmitted infections, abnormal uterine bleeding, chronic abdominal and pelvic pain, post-deployment readjustment issues for women veterans, and other women's health topics. Early results from this program indicate its success in increasing competencies in 12 areas of women's health care. As of June 2009, 216 participants (119 physicians, 77 nurse practitioners, 10 physician assistants, 9 registered nurses and one therapist) from 90 VA medical centers and 28 community-based outpatient clinics have either scheduled or completed this program.

Research on Women Veterans' Health Issues

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

Outreach Initiatives

Effective internal and external communication and outreach to women veterans is critical to the success of implementing comprehensive care. Surveys and research show that women veterans are often not aware of the services and benefits available to them. VA is engaging in multiple efforts to correct this. For example, VA's Center for Women Veterans and the Women Veterans Health Strategic Health Care Group will continue to expand its ongoing outreach and communications plan to ensure increased public awareness of women veterans and their service to our country and increased awareness by women veterans of VA health care.

Center for Women Veterans

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

Women Veterans Health Strategic Health Care Group

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

Future Plans

While significant efforts are underway, we recognize that more still needs to be accomplished. VA must provide women veterans with adequate infrastructure for primary care and expand services to provide a full continuum of care for women veterans at its secondary and tertiary care facilities. This investment of resources will

contribute to the continuing goal of delivering quality health care focused on privacy, safety, sensitivity, dignity and continuity.

Expanding Access to Gynecology

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

Expanding Innovative Technology

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

Conclusion

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

Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health, and a Representative in Congress from the State of Maine

Good morning. I would like to thank everyone for attending today's hearing on women veterans.

I am happy to join my colleagues, DAMA Subcommittee Chairman Hall and our Ranking Members Mr. Brown and Mr. Lamborn, in holding this joint hearing. Together, we have a shared interest in ensuring that women veterans receive the health care and benefits that they deserve.

Today's hearing will help us further explore the issues and gaps facing women veterans, as we work toward a VA for the 21st Century, a VA, that must fully embrace the growing and unique needs of women veterans.

Women have answered the call and today serve our country alongside their male counterparts. The changing role of women who serve in the armed forces demands a thorough and comprehensive look at what needs to be done to better serve them after they separate from service. I am sure we would all agree that women veterans must have equal access to gender-specific and comprehensive health care and benefits as their male counterparts. As a Committee, we have taken key steps toward realizing this goal of equal health care and benefits for women veterans.

First, under the leadership of Chairman Filner, we held a roundtable discussion on May 20, 2009 when we heard from women veterans representing veteran service organizations and their auxiliary organizations. The roundtable participants identified many issues, which included military sexual trauma, combat post-traumatic stress disorder, denied benefits claims and lengthy appeals, barriers to health care utilization, and health care research on women veterans.

Another example of this Committee's commitment to women veterans is our work on H.R. 1211, the Women Veterans Health Care Improvement Act, which was introduced by Ms. Stephanie Herseth Sandlin. My Subcommittee favorably reported this bill to the Full Committee in early June and this important legislation passed the House recently on June 23, 2009. Specifically, H.R. 1211 requires key studies assessing the VA health care services provided to women veterans, including an assessment of barriers. The bill also provides 7 days of medical care for newborn children of women veterans receiving maternity care, authorizes a child care pilot program, requires mental health professionals to receive training on caring for veterans suffering from military sexual trauma and PTSD, and empowers OEF/OIF women veterans to serve on the VA's Advisory Committee on Women Veterans and the Advisory Committee on Minority Veterans.

While we have made some progress on the issues facing women veterans, it is clear that more needs to be done. Just earlier this week, there was an article in

MSNBC about the VA inadequately serving women veterans. This article described the key findings of a GAO report which revealed that no VA hospital or outpatient clinic is complying fully with Federal privacy requirements. In other words, many VA facilities had gynecological tables that faced the door, including one door that opened to a waiting room. Beyond these privacy concerns, VA facilities were built to serve male veterans and therefore, do not accommodate the presence of children. This means that some women veterans have had to resort to changing babies' diapers on the floors of VA hospitals due to the absence of changing tables in the women's bathrooms. In light of these challenges which continue to face women veterans, it is important that we do more to address these issues.

I look forward to hearing from our witnesses today and learning more about the potential barriers facing women veterans, including the detailed findings of the GAO report entitled "Preliminary Findings on VA's Provision of Health Care Services to Women Veterans".

MATERIAL SUBMITTED FOR THE RECORD

U.S. House of Representatives
 Washington, DC.
July 24, 2009

Judith Sterne
 Director
 Office of Congressional and Legislative Affairs
 U.S. Department of Veterans Affairs
 810 Vermont Avenue, NW
 Washington, DC 20420

Dear Ms. Sterne:

Thank you for the Department of Veterans Affairs testimony at the joint Disability and Memorial Affairs and Health Subcommittees hearing on Tuesday, July 14, 2009. Review of the testimony for this hearing yielded three questions I ask for the record.

1. Can you please explain how the Director of the Center for Women Veterans fits into the leadership structure of the Department of Veterans Affairs?
2. Who is responsible for reporting to the Secretary on the Department of Veterans Affairs health care facilities' implementation of policies for improved women veterans' services?
3. Has there been a consideration of creating a position in the secretariat for women's affairs?

I appreciate your response to these questions for the record and look forward to working with you and the Department of Veterans Affairs in the future. If you have any questions, please feel free to contact Tim Leahy on my staff at (202) 225-3635.

Sincerely,

Debbie Halvorson
Member of Congress

Questions for the Record
Hon. Debbie Halvorson
Subcommittee on Health
House Committee on Veterans' Affairs
July 16, 2009

Eliminating the Gaps: Examining Women Veterans' Issues

Question 1: Can you please explain how the Director of the Center for Women Veterans fits into the leadership structure of the Department of Veterans Affairs?

Response: The Center for Women Veterans is located within the Office of the Secretary, Department of Veterans Affairs (VA). The Director reports to the VA Chief of Staff. The Director serves as the primary advisor to the Secretary on all matters related to policies, legislation, programs, issues, and initiatives affecting women veterans. The Director's duties include:

- Monitoring VA's programs for women veterans and working closely with VA's staff offices and three administrations—Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration—to identify policies, practices, programs, and related activities that may need enhancements or revisions to accommodate the needs of women veterans; may be disparaging to women veterans or hinder the receipt of services; or may need to be established to facilitate access to care and benefits.
- Fostering communication among all elements of VA on research findings and ensuring that women veterans' issues are incorporated into VA's strategic plan.
- Recommending policy and legislative proposals to the Secretary.
- Providing support to the Advisory Committee on Women Veterans (ACWV) which provides advice to the Secretary on the needs of women veterans with respect to health care, rehabilitation benefits, compensation, outreach, and other relevant programs administered by VA.

Question 2: Who is responsible for reporting to the Secretary on the Department of Veterans Affairs health care facilities' implementation of policies for improved women veterans' services?

Response: The Under Secretary for Health is responsible for reporting to the Secretary and for overseeing the implementation of policies on women's health care needs at VA health care facilities involving over 1,400 sites, including hospitals, clinics, nursing homes, domiciliaries, and readjustment counseling centers.

Question 3: Has there been a consideration of creating a position in the secretariat for women's affairs?

Response: The Center for Women Veterans is organizationally positioned in the Office of the Secretary.

