

CULTURAL BARRIERS IMPACTING WOMEN VETERANS' ACCESS TO HEALTHCARE

HEARING

BEFORE THE
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OF THE
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CONTENTS

Thursday, May 2, 2019

	Page
Cultural Barriers Impacting Women Veterans' Access To Healthcare	1
OPENING STATEMENTS	
Honorable Julia Brownley, Chairwoman	1
Honorable Neal P. Dunn, Ranking Member	2
WITNESSES	
Ms. Joy Ilem, National Legislative Director, Disabled American Veterans	3
Prepared Statement	31
Ms. Lindsay Church, M.A., Minority Veterans of America	5
Prepared Statement	37
Ms. Ginger Miller, Women Veterans Interactive	7
Prepared Statement	40
Ms. BriGette McCoy, Women Veteran Social Justice Network	8
Prepared Statement	42
CAPT (Ret.) Lory Manning, Service Women's Action Network	10
Prepared Statement	46
Dr. Patricia M. Hayes, PhD, Veterans Health Administration	19
Prepared Statement	47
STATEMENTS FOR THE RECORD	
Women Who Serve	53
Iraq and Afghanistan Veterans of America (IAVA)	56
Paralyzed Veterans of America (PVA)	59
Vietnam Veterans of America (VVA)	61
Veterans of Foreign Wars (VFW)	63

CULTURAL BARRIERS IMPACTING WOMEN VETERANS' ACCESS TO HEALTHCARE

Thursday, May 2, 2019

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:04 a.m., in Room 1300, Longworth House Office Building, Hon. Julia Brownley [Chairwoman of the Subcommittee] presiding.

Present: Representatives Brownley, Lamb, Levin, Brindisi, Rose, Cisneros, Peterson, Dunn, Coleman, Barr, and Meuser.

Also Present: Representatives Houlahan and Radewagen.

OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN

Ms. BROWNLEY. Good morning, everyone, thank you for being here, and I am calling this oversight hearing to order. And, before we get started, I would like to ask for unanimous consent that Ms. Houlahan join us today on the dais.

Without objection, so moved.

I want to welcome everybody to the Subcommittee on Health's second hearing of the 116th Congress. Today is a historic day in this Committee, as it marks the first time in recent memory that this Committee has held a hearing singularly focused on serving our Nation's 2 million living women veterans.

Women have served in every American conflict since the Revolutionary War. Deborah Sampson and Margaret Corbin, the first American women known to have served in combat earned pensions for their service during the Revolutionary War. Today, 2 million women veterans live in the United States and are the fastest-growing demographic in both the military and veteran population. Currently, women comprise nearly 20 percent of military personnel and 10 percent of the veteran population, and 35 percent of whom are women of color.

Even though women have served in every American conflict, the Department of Veterans Affairs is a system created to serve men and did not serve women veterans until the 1980s. While the Department of Veterans Affairs has indeed evolved and some say that the organization is not your grandfather's VA, but there is still a long way to go. That is why the Women Veterans Task Force has been created to ensure there is equitable access to all VA services for our Nation's women veterans. And I will add that I am encouraged that the VA and the Secretary himself has committed to working with us to that end.

However, despite centuries of honorable service, the women who serve our country are still treated as second class servicemembers and veterans. A visible minority in the military, women experience everyday indignities that make them feel like they do not belong. The probable root causes range from the impacts of the long-standing prohibition on women in combat jobs, to going into combat-wearing protective equipment that was made for men.

Most troubling is the widespread incidence of sexual violence in the ranks, an epidemic that disproportionately affects women. At least one in four servicewomen experience military sexual trauma by the very teammates who are supposed to have their backs. More than half of servicemembers who report their assaults also report that their commands retaliated against them.

Therefore, it should not be surprising then when women leave the military, they are reluctant to enter veteran-serving spaces. When they do, they often find the same lack of respect that they endured on active duty. Recent research found that at least 25 percent of women veterans experience sexual harassment or questioning of service status by male veterans while at the VA.

Even the organizations meant to serve veterans are often hostile to women veterans. In her statement for the record, Army veteran Melissa Bryant, Chief Policy Officer of Iraq and Afghanistan Veterans of America explained, "Now, as a veterans' advocate, I still hear the misogyny in our community from the time I am asked who is your sponsor at VA medical centers to when I am referred to as young lady by my own veteran colleagues."

VA's system itself remains rife with barriers to care. Twenty four percent of women veterans using VA health care still do not have a specially trained woman's health primary care provider. Women veterans are 46 percent more likely to use community care than male veterans, largely to receive basic preventive services such as Pap smears and mammograms. This has resulted in billing problems, which again disproportionately affect women. In addition, women veterans face longer wait times, staffing shortages, and facilities that fail to meet basic environment-of-care standards. Even here in Washington, DC, the Women's Health Center has more limited hours available for primary care appointments than are available for men.

Women veterans are remarkable Americans and deserve equitable access to the benefits and resources that they have earned. Women represent resilient leadership in their communities and classrooms and their careers, and right here in Congress.

In short, our goal is to make the invisible woman veteran visible. So, as chair of this Subcommittee and the Women Veterans Task Force, I am well aware of the work we need to do and today is our first step in doing it.

So, with that, I would like to recognize Ranking Member Dunn for 5 minutes for opening remarks he may wish to make.

OPENING STATEMENT NEAL P. DUNN, RANKING MEMBER

Mr. DUNN. Thank you very much, Chairwoman Brownley, and thank you for having this hearing.

Today's hearing is just the start of an ongoing conversation I expect this Subcommittee to have throughout the 116th Congress. So,

in the interest of time and given the constraints we are under this morning, I will keep my comments brief and to the point.

I appreciate the opportunity to be here to discuss how to break down the barriers for women veterans in the Department of Veterans Affairs system, systemwide.

Women are a sizable and growing segment of the VA's population, as you noted, with the number of women who use the VA health care system tripling in just the last 18 years. VA has made a number of strides to address the unique and often complex needs of women veterans; however, far too many disparities continue to exist in care, benefits, services, and treatment.

I am particularly distressed to have learned that, according to a recent study, one in four women veterans report being subjected to inappropriate, unwanted comments from male veterans in the VA system; that is unacceptable. I look forward to this morning what steps we are going to be taking to eradicate this type of harassment in the VA enterprise-wide and to ensure the equitable treatment of women veterans within the VA's environment.

So, thank you again for calling this important hearing and I yield back to you, Chairwoman Brownley.

Ms. BROWNLEY. Thank you, Dr. Dunn. And thank you to our witnesses for being here today. We have two extraordinary panels joining us today.

For the first panel, we have a formation of all women veterans. First we have Ms. Joy Ilem, National Legislative Director of Disabled American Veterans; next we have Ms. Lindsay Church, Chief Executive Officer of Minority Veterans of America; next we have Ms. Ginger Miller, Chief Executive Officer of Women Veterans Interactive; next we have Ms. BriGette McCoy, Chief Executive Officer of Women Veteran Social Justice Network; and, finally, we have Captain Lory Manning, Director of Government Relations for Service Women's Action Network.

With that, I now recognize Ms. Ilem for 5 minutes. Welcome.

STATEMENT OF JOY ILEM

Ms. ILEM. Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, thank you for inviting DAV to testify today.

As a service-disabled veteran who has gotten my care at VA for more than two decades, I appreciate the opportunity to discuss cultural barriers impacting women veterans' access to health care. There is no bigger barrier to care than a culture that does not embrace women veterans or, at best, makes them feel marginalized. Ensuring that women veterans are treated with dignity and respect, have equal access to high-quality comprehensive care, and readjustment services from VA is a top legislative priority for DAV.

The number of women coming to VA for care has tripled, as you have all noted, since 2000, and many have wartime service, and more than half of the women using the VA health care system have a service-related injury and will need a lifetime of care. While VA has made progress and illustrated a commitment to improving services for women veterans, several long-standing challenges still remain.

DAV's most recent report issued in 2018, "Women Veterans: The Journey Ahead," highlighted the need for culture change in VA. We found that women veterans perceived their military service was not understood or appreciated like their male peers. Women veterans told us they want to be treated with dignity, respect, have equal access to earned benefits, and, most importantly, they want to be recognized as veterans and appreciated for their contributions in military service.

Another notable barrier to care is that many women veterans do not feel welcome or safe at VA facilities. As confirmed by the recent study just mentioned, that one in four women reported being harassed by male veteran patients. Unfortunately, women who experience this harassment were significantly more likely to report either delaying or missing care.

We applaud VA's new anti-harassment campaign and training of employees that is underway to intervene when they see harassment occurring, and encouraging veterans to immediately report such conduct.

To meet the goal of a zero tolerance policy for harassment, we challenge all veterans and Veterans Service Organizations to do their part as well.

Women veterans who have their military service questioned, who are routinely disrespected, and will not stay to find out that VA offers exceptional, evidence-based, and culturally competent clinical care and integrated services, and women veterans need that expertise, and they deserve to have a system that fully embraces and supports them.

VA researchers have been specifically looking at barriers to care for this population, as well as health impacts of wartime service and the unique transition issues women face when they return home. These concerns are heightened for women, who make greater use of community care than their male peers, and who have experienced a variety of problems under the Choice program. As VA transitions to its new community care network, it will be essentially that community providers are properly trained about women veteran culture, common military exposures and health conditions for women, and receive training and evidence-based practices for treating them.

VA health care is the best system of care for women veterans with complex health care needs. VA's veteran-focused research, comprehensive health and mental health services, and specialized programs for trauma make it uniquely suited to care for this population, but longstanding issues that persist act as barriers to that care for some women. VA still struggles at certain locations to ensure privacy, safety, a welcoming environment—all noted—and sufficient members of staff with expertise in women's health; and specialty care coordinators, women peer specialists, and dedicated women's clinics.

To address these persistent challenges, it will require the Secretary to commit to cultural transformation at all levels of the organization and to dedicate the necessary resources to achieve that change. This means keeping the needs of women veterans central to planning and decision-making in all program offices.

In closing, we are pleased with the progress VA has made, but there is so much more to do. We do, however, want to recognize the exceptional work of the Women's Health Services Office, the Center for Women Veterans, and the Veterans' Experience Office, which we are pleased to learn are listening and collaborating with women veterans to build trust and improve their health care experience, so they can count on VA for providing access to quality, timely care at all sites.

Again, Madam Chairwoman, we thank you and the Subcommittee for your continued interest in improving the health services for our Nation's women veterans, and I look forward to responding to any questions you may have.

Thank you.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Ilem.

And I now call on Ms. Church for 5 minutes.

STATEMENT OF LINDSAY CHURCH

Ms. CHURCH. Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the Committee, thank you for the opportunity to testify today about the cultural barriers impacting women veterans' access to health care.

I would like to begin by acknowledging that the land on which we gather is the unceded territory of the Piscataway and Nacotchtank people.

My name is Lindsay Church and I am the CEO and cofounder of the Minority Veterans of America. I served in the United States Navy from 2008 to 2012 as a Persian/Farsi linguist. I am a queer, gender-nonconforming women veteran that served all but 3 months under "Don't ask, don't tell." I was medically retired after three surgeries to my sternum and rib cage left me permanently disabled, and I personally receive my care at the VA.

As the CEO of MVA, I represent veterans across 46 states, two territories, and three countries; 47 percent of them are women and several of whom are in the audience today. Together, our members account for over 6,000 years of service, some dating back to conflicts and eras that predate when they were legally recognized as veterans, my mom being one of them.

In today's military, the role of women is quickly expanding and, though more jobs and occupations are opening up to women every day, the culture and institutions meant to support women veterans after service has not kept up with the rapid growth.

Similar to our male counterparts, we as women veterans are immensely proud of our service and what we have done, the service and support we have offered to our nation; however, many of us experienced instances of harassment, degradation, and discrimination based on our gender identities and/or sexual orientations. We withstood and persevered those experiences, and we did so honorably.

The harassment that happens to women in the service is magnified by the weight of the entire United States military that renders each of us powerless until the day that separate. Even if we want to leave out of fear for our own safety, we are beholden to

a system that demands compliance no matter the circumstances. Upon discharge, we must decide, based on the severity of our experiences and the intensity of our needs, whether or not we will return to a setting where military affiliation is the common thread among the community. This is the dilemma that each of us faces when we are deciding whether or not to enroll in the VA.

For many women, voluntarily reentering military culture to use our VA benefits is an insurmountable barrier. Moreover, the VA has a poor reputation among our community. We know them for perpetuating a toxic culture for women and minorities, providing sub-par care that lacks a nuanced understanding of who we are, and seemingly every day there is a new story of a veteran dying by suicide in the VA parking lots and waiting rooms.

For those of us that finally overcome these barriers, we enter VA facilities across the Nation only to be met with plaques inscribed with the words, "To care for him who shall have borne the battle, and for his widow and his orphan." Lincoln's words, which are the motto and mission of the Department of Veterans Affairs, serve as physical representations of the deep and lasting history of invisibility for women in the military and veteran community.

Changing the motto won't by itself address the deep cultural divide that exists between women and the veteran community, but it is a step in the direction toward inclusion. Continuing to maintain and uphold the motto, despite that women veterans have called for change, signals a willful desire to exclude us.

Chairwoman Brownley, Ranking Member Dunn, and members of the Committee, if we are to change the outcomes that women veterans are experiencing today and increase their access to health care, we must look to the roots of the problems and not just triage the results.

First and foremost, this starts by opening a dialogue about the inclusion of all servicemembers in the VA's motto.

Second, accessing the VA needs to be easier. We want an opt-out rather than opt-in process, not just for women, for all veterans. If we believe that veterans have earned their benefits, servicemembers should automatically be enrolled in VA benefits and rated for their service-connected disabilities before they are charged without relying on outside agencies to file their claims. Additionally, women veterans should be assigned a primary care doctor in the nearest women's clinic.

Third, women veterans need to have greater access to positions of leadership at the VA. Representation matters and if we are not represented in the places where decisions are being made about our health care and our benefits, how can we ensure that we are heard, considered fully, and that our ideas are acted upon in the same way as our male counterparts.

Lastly, all VA facilities should have community standards and expectations of staff and patients. Stories of women veterans being sexually assaulted, harassed, discriminated at VA facilities should be anomalies and not commonplace.

Thank you for your time and consideration on this matter. I look forward to your questions.

[THE PREPARED STATEMENT OF LINDSAY CHURCH APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Church.
And I now recognize Ms. Miller for 5 minutes.

STATEMENT OF GINGER MILLER

Ms. MILLER. Chairman Brownley and members of the Subcommittee, as the President of and CEO of the national nonprofit organization Women Veterans Interactive, I am grateful to present my testimony regarding the cultural barriers impacting women veterans' access to health care.

To understand the cultural barriers impacting women veterans' access to health care, one must first understand the climate in which we exist: the women veterans' climate, a hostile takeover.

Women veterans are trying to stay afloat in a culture that has been male-dominated for centuries and now we are competing to stay relevant in a culture that insists we downgrade our service to run parallel with that of a commitment by a military spouse or a husband. Women veterans are uniquely different from military spouses and it is time that this country stops lumping us together, not to mention being overshadowed by the caregivers.

Women veterans are existing in a climate where we have become good for business, but not good enough to do business with. And, even more unfortunate, women veterans are living in a culture where our voices are only heard in a celebratory fashion when we achieve something great or when we hit rock bottom and become good for press.

I am here to testify this morning in an effort to change the climate and culture that has become the norm for women veterans. Our noble service to this country is worth more than a story. Our sacrifices as women veterans are worth more than a tick mark on an outdated, one-sided survey conducted by male-dominated VSOs who may happen to have a few women veterans on staff.

Women veterans are more than objects and we don't need another survey, we need action; we don't need another national portrait campaign, we need a national outreach and engagement campaign. Women veterans don't need another male-dominated VSO to represent us at the table, we need to have a seat at the table, and, if we can't have a seat at the table, we will continue to build our own.

For women veterans, the environment in which we are expected to thrive in after serving in the military has become hostile and at times volatile, to say the least, because our voices are not being heard appropriately and we do not have adequate representation at every level of government. Women veteran nonprofit organizations are grossly overlooked and underfunded, if funded at all. Our volunteers are overworked and for some the outlook is bleak, and yet we continue to hold on and hope against hope, hope for inclusion to have a seat at the table where our voices will be heard and hope for much-needed funding to deliver the proper services to the population we serve.

Women Veterans Interactive is a solutions-driven nonprofit organization focused on outreach and engagement. WVI delivers impact in the lives of women veterans through a holistic, proactive approach that is grassroots in nature.

The mission of Women Veterans Interactive is to meet women veterans at their points of need through advocacy, empowerment into action, outreach and unification, all to break down barriers that lead to homelessness. WVI addresses the unique needs and unrecognized challenges faced by our Nation's 2 million women veterans. Since inception, Women Veterans Interactive has supported over 3500 women veterans and our network has grown past 50,000.

Women Veterans Interactive and the Department of Veterans Affairs have an intimate understanding of the importance of women veterans becoming connected to health care. Since 2012, WVI has invited the Department of Veterans Affairs into our fold to collaborate with us on all of our outreach efforts.

Most recently, WVI's 2018 and 2017 Annual Women Veterans Leadership and Diversity Conference, we had a benefits claims clinic in collaboration with the Department of Veterans Affairs, in which each clinic had approximately 150 veterans to attend. The feedback from the benefits claims clinic have been remarkable, with some women veterans stating that it is the first time the VA has treated them like their service matters, and other women veterans said they have a brighter outlook on going to the VA medical center to receive health care.

Additionally, in 2017, WVI partnered with the Center for Minority Veterans to conduct a virtual town hall with over 300 attendees. In 2016, we created the State of Women Veterans social media campaign with a goal to reach 500,000 veterans, and we surpassed that goal.

Every Women Veterans Interactive and Department of Veterans Affairs collaboration is positive. So, I pose the question, why is more not being done by the Department of Veterans Affairs to collaborate with women veteran nonprofit organizations like Women Veterans Interactive? And why are more women veterans' organizations not invited to the Veterans Affairs meetings, especially when it comes to discussing issues and solutions around women veterans?

If we are going to change the culture and we are going to have women veterans to have more access to health care, then, Madam Chairwoman, we need to be at the table. I am recommending that we work together to find solutions and have something where we can allocate funding for collaborative women veterans direct outreach and engagement with the Department of Veterans Affairs, and require the Department of Veterans Affairs to focus on consistent outreach with women veterans, and meet with the Secretary of the Department of Veterans Affairs on a biannual basis.

Thank you, Madam Chairwoman.

[THE PREPARED STATEMENT OF GINGER MILLER APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Miller, for your testimony, and I now recognize Ms. McCoy for 5 minutes.

STATEMENT OF BRIGETTE MCCOY

Ms. MCCOY. Thank you to the House Committee and Committee chair, thank you for inviting my organization and inclusion of my testimony on issues concerning women veterans, specifically the

cultural issues impacting women veterans. You will see in the notes, I have sent a document that has all of the information related to the organization that I founded 10 years ago, Women Veteran Social Justice Network, as a homeless veteran in HUD-VASH housing during my process, disability process in the VA.

So, I am an ally. I am a military sexual trauma MST survivor and advocate. My service and contributions are as important as my male veteran counterparts.

Women veterans serve, yet our visibility and opportunities have unseen barriers to accessing many of the programs that the civilian sector believes are available to all who served. It is vitally important to hold in high regard and utilize the narratives of veteran women like me of all eras and all service periods and all service backgrounds as primary sources to inform research, curriculum, and policies concerning women veterans.

The cultural issues impacting women veterans are vast; there are too many to fully note in this setting to give the full historical context, legislative background, and full unintended consequences and implications of each.

I do believe that the historical context of women not being formally included in the military structure until the 1940s is a topic for inclusion in this hearing. Women veterans were not legislated to use the VA for gender-specific medical care until the early 1990s. Only in recent years have women's specific health care spaces been constructed in VA's facilities.

In my work over the past 10 years and my personal experience interacting with the government and the community for support, a major factor that repeatedly and consistently challenged me has been the language which is used to describe and talk about me as a woman veteran. Within the context of being a woman veteran I have heard terms like low-hanging fruit, female, victim, and references by men about how easy it is for a woman to get disability benefits, and I assure you that that is categorically untrue.

These othering terms have an unintended consequence for our country and the communities that serve women veterans. How we speak about women veterans can be a part of a deeper problem of what we believe and have been socialized to believe about women in general. This is a root-cause factor that drives the cultural divisions and creates a barrier for meaningful, well-funded support for women.

The language used to speak about research, legislative, create, and institute programs for our women veteran community continues to be a major limiting factor toward addressing issues and needs. Why are organizational leaders calling us female after the military service? There are no female veteran organizations. Where is the national female veteran of America organization? Even in 1948 when President Truman signed the Armed Services Integration Act, "female" was not used in the title, but the word "women."

I know that there will be some that say that doesn't matter, but I will argue that using biological terms to dehumanize what you name or call something or the language you use to speak about a person does have impact, positively or negatively. We can trace the language in policies and legislation and funding, and see that funding drives services and programs.

Second, women veterans currently have narrowly-defined, language-specific access to some of the most well-funded and highly-engaged programs. Most are intentionally excluding a huge proportion of women, and the funding legislated for their programs is language-specific to eras, combat, and gender. It is emotionally draining as an advocate to continually send women to organizations that have veteran programs to have them told that they don't meet the guidelines.

Further, the brochures are male-centered and the veteran service community organizations and their organizing documents do not include women who have served, or they are told to go to auxiliary membership, are put together with spouses, which is a completely different population.

Third, VA medical treatment visits pose issues when organizing documents and place cards have male-centered quotes and presentations. The space was not created with women in mind.

There have been upgrades and changes in support of women in the facilities, but we are still being catcalled and harassed going into the mental health and medical appointments, when we can get them. It is never clear what the outcome will be for women who reports harassment, or for the patient or employee that harasses. My personal experiences of being harassed within the VA and the discussions with other women about the need to change their appearance, come at certain times of day, switch to other hospitals, or stop going to the VA at all is another area of discussion.

We are not always treated with the same professional respect as our male counterparts. Many times our rank and era in service are used to limit access to programs for professional advancement.

I have more, but I know that my time is winding down, and so I want to hand over the time to my colleague here.

Thank you.

[THE PREPARED STATEMENT OF BRIGETTE MCCOY APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. McCoy, and I now recognize Captain Manning.

STATEMENT OF LORY MANNING

Captain MANNING. Chairman Brownley, Ranking Member Dunn, distinguished members of the Subcommittee, on behalf of the Women's Service Action Network, I thank you for the opportunity to share our views and recommendations regarding the cultural barriers to women veterans' access to health care at the Department of Veterans Affairs.

In the past years, VA has made hard-won improvements to the quality and comprehensiveness of women's care, but all that improvement is for naught if women encounter barriers when trying to use that care. I will discuss two of these barriers today: sexual harassment and the invisibility of women veterans.

Over the years, we at SWAN have heard many complaints about groups of male veterans getting together to harass women veterans on VA grounds, including at the Washington, DC VA Hospital.

An academic study and a newspaper article both published this year elucidate the problem. The study appears in the Women's

Health Issues published by the Jacobs Institute of Women's Health; the article by reporter Jennifer Steinhauer was in the March 12th edition of the New York Times and headlined, quote, "Treated Like a Piece of Meat: Female Veterans Endure Harassment at the VA."

The study sampled women veterans who use 12 different VA hospitals and found one in four of those sampled reported receiving catcalls, derogatory comments, propositions, and denigrations of the women's status as veterans from male veterans on the grounds.

The New York Times article recounts how, quote, "An entrenched sexist culture at many veterans' hospitals is driving away female veterans," unquote. SWAN believes that what women veterans want, and warrant is for VA leaders at all levels, with oversight from Congress, to stop that harassment now and to create a VA culture in which women veterans are treated with the same respect, appreciation, and dignity as male veterans.

Women veterans also report to SWAN that they feel invisible in the office staffs of VA facilities and to the American public in general, and they are. It begins with the VA motto: "To care for him who has borne the battle, his widow and his orphan." SWAN, while appreciating Lincoln's historic words, is among the veteran's organizations which support changing that motto.

According to the Department of Veterans Affairs February 2017 report, "The Past, Present, and Future of Woman Veterans," only 22.4 percent of all women veterans use VA health care, making them a mere 7.5 percent of total VA health care users.

Women veterans are irked when they are asked for their husband's Social Security numbers at check-in desks or are refused free coffee provided at some VA facilities with the admonition that the coffee is only for veterans. These slights seem minor, but they accrete over time, leaving women veterans frustrated and disheartened.

The invisibility becomes more damaging when the gender-specific needs of women veterans are ignored as happens, for example, when they are sometimes issued prosthetic devices designed for men. This should never happen. And major damage can be done if women veterans are invisible to those at any level making tough decisions on health care resources if those decision-makers either don't understand the need for women's programs or conclude that reallocation from these programs helps many while hurting only a few. SWAN believes leadership at all levels must take great care when initially allocating or later reprogramming resources to or from women's health care programs that they have a clear understanding of the effects their actions can have.

SWAN additionally entreats Congress to exercise its oversight responsibilities to ensure the needs of women veterans and other special-focus populations are not unduly sacrificed when such actions are necessary at the national level.

Madam Chairman, let me say how deeply I appreciate the opportunity to offer SWAN's views on these critically important matters. Thank you for your time and attention.

[THE PREPARED STATEMENT OF LORY MANNING APPEARS IN THE APPENDIX]

Ms. BROWNLEY. And I thank you for your testimony, and I thank all of the witnesses here today for their testimony. To me, it sounds like we are having a veteran women me-too moment that I think all of us collectively have to make into a movement, so I think we are in the beginning steps of that.

So we will now begin the question portion of the hearing and I will recognize myself for 5 minutes.

And the first question I wanted to Ms. Ilem from DAV is, you talked about in your testimony with regards to solutions to some of the issues is to make women's health a stand-alone program with its own leadership structure at the central office, et cetera. I know in talking to some of the medical center directors who get allocated, you know, a large chunk of money and it is their responsibility then to allocate it as they see fit in terms of what their needs are, and I believe that in some situations women's needs are being overlooked across the country. But if you could just speak a little bit to how you think things should be restructured?

Ms. ILEM. Well, I think that a task force would help in terms of internally within VA. I mean, we are hoping that the Secretary will really take this to heart. I mean, he has indicated that he wants to ensure women veterans receive the care and benefits they deserve through VA.

These programs, I think you are exactly right, have been ignored because of the funding structure. They are often lumped in, their VERA allocation with, you know, primary care. We have seen report after report from the IG or GAO about these same problems. I mean, I could look back at testimony or those reports over the years and we see the continued same problems; they don't get resolved.

So I think it is going to take a different tack and I hope that VA, the Secretary, from the leadership down, will determine what would be, you know—convene a task force, determine from the leadership, at the VISN level, at the local level, how can they best serve to make sure they really get at these problems.

Ms. BROWNLEY. Thank you.

And, Ms. Church, I thank you for your testimony and I think you were very clear in saying that women veterans are more likely to be a member of an ethnic or racial minority, the LGBTQ community or the like, than are male veterans. I think the data shows that if you are a minority, if you are a part of the LGBT community, that actually the services rendered are even less than women overall.

You also talked about using the traditional VSO for accessing compensation and benefits, and you described them as insurmountable barriers for women veterans. You know, what needs to be done there?

Ms. CHURCH. Honestly, in order to be able to access your benefits, you should be able to do it automatically through the VA or through the Department of Defense. We have gone to a place where we use a third party to file our benefits and our claims; however, it should be automatic, it should be something that happens right when you get out of the service.

As a medical retiree, I was part of a pilot program in 2012 of the—I was one of the first to get DOD disability rating, as well as

a VA rating, as soon as I got out. So, as soon as I got out, I knew exactly what my benefits were going to be, I already had my service-connected disabilities, and I was able to carry on with my life. I didn't have to use a traditional VSO and I didn't have to be re-traumatized, because some of these places can be the biggest perpetrators of toxic culture. It has happened for years and years, but at the end of the day we shouldn't have to go to a third party in order to get access to our benefits through the government that we work for. So the recommendation is remove the third party.

Ms. BROWNLEY. Great. And when you exited the military, was it clear what you needed to do to receive your services?

Ms. CHURCH. Absolutely. I was actually—you are actually able to, if your unit allows you to, apply for VA benefits 6 months before you are out; however, it is not a mandate. It should be a mandate that you go 6 months before you are out, that you go and get your disability rating.

Ms. BROWNLEY. Thank you.

Ms. Miller and Ms. McCoy, you both have served our country honorably and in both of your testimonies you have talked about your homelessness and certainly I think all of us here on the dais believe that no one who wore the cloth of our Nation should be without a home, and women veterans are the fastest-growing homeless population in our country.

So if you could just describe a little bit about what the economic—how the economic stability is a factor in enabling women veterans to access their own health care?

Ms. MILLER. Thank you for that question.

From where I sit, the economic status has something to do with it, but it is really the outreach to women veterans when they get out of the military, because they are disconnecting from service and they are disconnecting from their peers. As for me, when I became homeless in the early '90s, my husband was suffering from post-traumatic stress disorder, I got a medical discharge, we stayed with family for X amount of time, then when his post-traumatic stress disorder kicked into high gear, we had to find someplace to go. I was unskilled, my son was about two years old at the time, I didn't have a college degree.

So I think for women veterans to get connected and stay connected to the source, then that will also help to prevent the homelessness. The economic status has a little bit to do with it.

One of the things we do at Women Veterans Interactive, if a woman veteran is homeless or on the brinks of being homeless and she has a claim in with the Department of Veterans Affairs, we can get that claim expedited. You know, we stopped at least two to three evictions in 2018. If a woman veteran was getting evicted, we would call the Department of Veterans Affairs, they would expedite the claim.

So I think there is just like a major disconnect when it comes to the economic status of homeless women veterans.

Ms. BROWNLEY. Thank you.

Ms. McCoy, briefly, because I am way over my time, which the chair is not supposed to do.

Ms. MCCOY. So, yes, it is economic. In my case, I came out of the military, I didn't understand that the benefits—that I needed to

keep fighting for my benefits. I was considered service-connected right out of the military at zero percent. I was a single mom with a very disabled daughter, and I had medical conditions that were already there and went untreated. And so in that process, you know, I had had some education after I got out, I did all of the things I thought were the right things, and still ended up homeless.

And so it is an economic issue, in my case it was an economic issue, but it also has to do with what Ms. Ginger said, you know, it is the disconnect. So, in my case, that is why I created the WVSJ. We started online as a community peer-supported network, supporting one another online just with information resources and through that process grew to over 12,000 followers on Facebook with over 50 networks worldwide.

So it is very important to get information and resources out to women veterans, but also the challenge with homelessness is that it keeps changing. Every year, what is homelessness keeps changing. So when I was experiencing homelessness, couch surfing was considered, and now it is not. So we have to—you know, again, language is a big part of it.

Ms. BROWNLEY. My time is up, but thank you, thank you very much.

I now call on Dr. Dunn for 5 minutes.

Mr. DUNN. Thank you very much, Chairwoman Brownley. And thank all the members of the panel for your compelling testimony, I appreciate that.

This is a question, let me just start on the right end of the panel and sort of work over. Given some of the barriers to care within the VA health care system and the other portions of the VA system, which all of you have referenced, and the fact that it can take a long time to change a culture like the culture in the VA, would you support granting women veterans greater authority to use VA health care benefits in the community to ensure they have access to care?

And I will start with Ms. Ilem, if you will start—Ilem, I'm sorry.

Ms. ILEM. Thank you for the question.

In my testimony, one of the things that I point out is that women veterans do use higher rates of community care in VA, through VA being referred to the community, because of their lack of ability to provide maternity care and some other specialty services that they don't always have a provider available for.

Mr. DUNN. So for specialty services clearly, but I was thinking more of the routine.

Ms. ILEM. Right. So the issue that I bring up in our testimony is that VA has done so much research on women veterans and they are—the women veterans who are coming to VA are very clinically complex and users of a high number of services across the board in both primary care, specialty care, and mental health, and we are just concerned that fragmentation of care can relate to gaps in care for them and we want to make sure that providers in the community have the expertise to treat them.

While we want women to get the care they need and what is best for them, and that may be the situation they prefer or want or need, but we need to make sure that the women providers—or the

providers that they are going to, that they are going to get quality care with expertise in the conditions and having an understanding of what exposures women have, you know, experienced and what are the most conditions that they are being treated for.

Mr. DUNN. And maybe quickly down, the same question about access to care in the community. I mean, we assume in the community they have—presumably, they have solved these issues, or they would be out of business. Go ahead.

Ms. CHURCH. So, I hear your question and I would like to actually say that I prefer that the VA step up first. I believe that we have a lot of work to do and that there are a lot of actionable items for us to continue to build the outreach and build the reputation up of the VA first. I do believe that we are going to see—women will experience barriers whether it be civilian care or VA. In the civilian, they will lack understanding of what it means to be a servicemember, in the VA they will lack understanding what it means to be a woman; however, breaking apart the VA doesn't necessarily accomplish that.

Mr. DUNN. As a veteran, I certainly agree with you on that.

And just we are working our way across. So, access to care in the community as a potential stopgap maneuver.

Ms. MILLER. Well, I think that would be an awesome option, because the VA has been researching women veterans for years; we are not aliens, we are women. There are plenty of doctors out in the private sector that support and service women every day. So, you know, while you are trying to figure this thing out, I would like to have an option to go get my Pap smear and to get my mammogram with a provider that I am used to when I had my private care. I mean, why should we have to suffer and walk through the halls and be catcalled and all these things while you figure it out. I would love to get a voucher to go out to a private sector, to a private doctor to get my health care, especially my women health care, because I know that, if one thing or another, at least they are certified, they are real doctors.

Mr. DUNN. Thank you. And—

Ms. MCCOY. So in my case, I spend tens of thousands of dollars outside of the VA on my own care, because there are so many different areas of gaps in services.

I agree with Ms. Lindsay and Ms. Ginger, because I think both parts are equally as strong. We don't need to just let the VA just walk away and say they don't have to do anything, they need to hold up their part of the bargain, but I also feel like, while we are waiting on that process, we do need services in place. I would love to have a voucher to pay for my chiropractic, I would love to have a voucher to pay for my acupuncture, because these are things that are coming out of my pocket. So it is very important to have these types of services and resources.

Mr. DUNN. Thank you.

Captain?

Captain MANNING. I would like to signal a little bit different notice. I mean, I live in the Washington, DC area and get most of my health care on the outside, because I am military retiree and I have no service connection. It is not that easy to get appointments

on the outside, particularly for some of the specialty things. Do you want to see a dermatologist? Call me in 3 months.

I also think that it is necessary as a stopgap sometimes, but I worry about, particularly if you address women as a group and send them outside, that VA will at some point down the road think that we don't have to be responsible for them anymore, it is just the guys we are really taking care of now.

Mr. DUNN. I appreciate your insights on that.

As you can tell, the way everybody evacuated, the votes have been called across the street. So—

Ms. BROWNLEY. So are you taking over the meeting?

Mr. DUNN. We will be back; we can come back—

Ms. BROWNLEY. I am just teasing you.

I wanted everybody to know that members are getting up because we need to go and vote on the floor. So we will pause momentarily. I anticipate it will probably be at least a half an hour, it could be a little bit longer than that. And—what?

[Pause.]

Ms. BROWNLEY. Excuse me, the terminology is we will recess.

[Laughter.]

Ms. BROWNLEY. But we will reconvene. Is that the appropriate word? Excellent.

So thank you very much for being here and we will join you shortly.

Mr. DUNN. Thank you.

[Whereupon, at 10:51 a.m., the Subcommittee recessed, to reconvene at 12:24 p.m., the same day.]

Ms. BROWNLEY. Thank you, everyone, for waiting. We had quite a few votes on the floor. So I deeply apologize, and I am afraid that some members who are needing to get back to their districts, because we are not going to be voting again today, might not be returning to the Committee. We will see how it goes, but we are reconvening, and I am gaveling back in.

And, Mr. Meuser, you have 5 minutes, and thank you for sitting in as the ranking member.

Mr. MEUSER. Well, thank you, Chairwoman, very much. It is my honor to be here with you all. And thank you all for waiting as well.

I am in Pennsylvania's 9th Congressional, we have a Veterans Administration and a VA in Lebanon, which tends to be ranked very well and we are pretty proud of it actually, always room for improvements. We also have a VA in Wilkes-Barre that many of my constituents attend. And we are a very military-focused or very military-heavy district at Fort Indian Town Gap, so we have over 50,000 veterans within my district.

Also on my district team I have three veterans, Navy and Army, and two of which are women. So I find that to be a great benefit to the type of constituent services that we provide, as well as the work that we do for veterans, men and women.

Your testimonies earlier were very compelling, very compelling. This is a very important hearing. This information is essential for us to be aware of, know better, and to respond to. That is the whole idea. It certainly sounds as if the HR departments within the VA

facilities and perhaps on a more macro level need to not just be aware of this information, but take this in and create new procedures and plans around it. I think that goes without saying and I think that is a responsibility of this Committee to assure that does in fact occur.

You mentioned that there wasn't much collaboration with your organizations, so we need to be inclusionary by all means, the Veterans Administration as a whole right up to the Secretary. The Secretary does need to engage; I am sure he has, but more so. And you mentioned other things, from homelessness to various other issues.

So do know that your words are very, very important and are resonating.

So the question I want to ask is, what is your recommendation as far as some of the things I just mentioned, what you talked earlier, what can we do within the human resources department to recognize these issues, work on them on a daily basis, on a larger scale, and right down into the VA facilities themselves?

So I think I will start with Ms. McCoy, if you could answer?

Ms. MCCOY. So I think that the big thing is going to again go back to language, crafting the appropriate language to make the changes, the appropriate changes, so that the policies, the legislation, the funding, all of those are aligned in a way that they are allied—that you are an ally and not that the agencies are hostile. They are presenting as supportive, but in their writing, in their funding, and all of these other things, they are presenting as hostile.

So I think that that is going to—that is where we have to like start, but in order to do that you have to bring subject matter experts, women veterans, to the table, not to just talk at us, but to actually have the input from us to give the insight, so that the legislation and the policies are appropriately placed and the verbiage is correct, so that it doesn't exclude people like our Reservists and our National Guard members.

Mr. MEUSER. I agree. Excellent.

Ms. Ilem, could you respond as well.

Ms. ILEM. Sure. I would agree that we need to make sure at the local facility level that facility director is engaged with their people, making sure they are out there watching that the training has occurred, making sure that, you know, harassment is not occurring, that they have a way to deal with it, that they are working with employees, and that there is a way for—if it is reported, how they are going to resolve that and what they are going to do. I mean, it has got to be at the facility level; while you want to have a national program and you want them to push that all the way down, I mean, it is at the facility where you really need to make sure wherever a veteran might go, you don't want to see that happen.

So it can't just be one program office or, you know, information coming from just one direction, it has to be across the system.

Mr. MEUSER. Thank you. And we look forward to working with you and for you.

Madam Chairwoman, I yield back.

Ms. BROWNLEY. Thank you, Mr. Meuser.

Mr. Cisneros, 5 minutes.

Mr. CISNEROS. Thank you, Madam Chair.

Thank you to all our witnesses who are here today. I really do appreciate you coming and speaking on this matter.

Care for our women veterans and the specific obstacles they face that may impact their pathways and willingness to seek out VA treatment is of utmost importance to me, being a veteran myself, especially as it relates to intimate partner violence.

Director Ilem, in your testimony you mentioned some research, that the VA researchers are becoming increasingly aware of the rise of woman veteran patients who are survivors of intimate partner violence, and in fact emerging research has proved that women veterans are at a greater risk for intimate partner violence than non-veteran women. Could you elaborate on this specific research, the data that was found, and why you think they found that data?

Ms. ILEM. Well, I think one thing that VA research has really shown—I mean, they have done more research over a short period of time, like almost in a 7-or-8-year period than they had done in 25 years, so they are really learning a lot about this population—and VA has always been forward-thinking in terms of asking questions when veterans come in, they are looking to make sure that they have the services available if someone is homeless, if someone has experienced trauma of some sort, and their findings are really I think showing that we need to, you know, pay attention, be looking for these types of things. What are the specifics within this population that seem to be—put veterans more at risk, that can help for prevention and can help moving forward in terms of addressing the issue?

So I think researchers are on the forefront and part of that whole aspect that really make VA unique and special, and they need to make sure that they continue that line to really be working with veterans.

Mr. CISNEROS. And do you have any recommendations? And, you know, it is good that you say the VA is good out there in asking the questions, but what could they do and what also could Congress do to kind of help along with that process to make it better?

Ms. ILEM. Well, I think they need to make sure that those—once they have asked the question, what are the programs and services that these women veterans need to address that issue, to make sure that they have the mental health services, to make sure they have the support services around that. So turning that into action is the most critical thing once they have asked the question, what can we do to make sure we support this veteran.

Mr. CISNEROS. So you raise another issue actually that I was going to bring up as well. You know, it is also troubling that women veterans who have experienced intimate partner violence place them at risk for developing certain mental health conditions and substance use disorder, increasing the risk of suicide.

What would you recommend are appropriate outreach programs and efforts to support women veterans that are impacted by intimate partner violence?

Ms. ILEM. Well, I think some of the organizations here at the table really also have some great—an opportunity and for a really important role to play, I think like BriGette McCoy and others,

who have a support system and have an outreach that is beyond the VA arm.

I mean, this is one thing that we know is often women veterans don't have the—they are not connected with the VA or they are not connected with the VSO community, where they might not readily know about the resources that are available. So it is important to engage the organizations that are here. This is everyone's issue and I think that that will be a critical piece in moving forward.

Mr. CISNEROS. Does any other members have any comments on this and how we can address this issue?

Ms. MCCOY. So I think one of the bigger problems related to this topic is that there will be a large group of women who will not perceive themselves as being victims of domestic violence. Having clear presentation of the awareness, being able to describe what domestic violence includes, because it is to me similar to military sexual trauma, there are a lot of people who say they didn't experience it until you start describing what it is and what it includes. And so that is one big part of the outreach.

The other part, because WVSJ has been instrumental in connecting groups of women within certain demographics, social media, although some people think it is the devil, actually we have been able to, you know, extract people from situations where it was unsafe, because we had an integrated network of peer support online, crowd-sourced, to intervene on behalf of woman veteran. So there are ways to implement those things and keep the person safe, and protect their identity as well.

Mr. CISNEROS. All right. Well, thank you for your answers. My time has expired.

Ms. BROWNLEY. Thank you, Mr. Cisneros, for being here after a long day on the floor.

I thank the panel again for being here. I think today's meeting is just a terrific start for all of the issues that we need to continue to drill down on until we really do determine solutions, and keep working and making that cultural change and shift that is so very, very necessary. And as I said earlier in my comments, I think this is, you know, a veteran women's me-too moment and I think we have to really make it into a movement, and I think that movement will help to shift a lot of the cultural issues that you all are all facing as women veterans.

So, thank you very much, and we are going to go to our second panel. And for our second panel we have Dr. Patricia Hayes. Dr. Hayes is the Chief Consultant for Women's Health Services at the Veterans Health Administration.

Thank you, Dr. Hayes, again, for having to wait for a long period of time. We appreciate you being here. And as you take your chair and get comfortable, I will recognize you for 5 minutes.

STATEMENT OF PATRICIA M. HAYES

Dr. HAYES. Thank you very much. Good afternoon, Chairwoman Brownley and Congressman Meuser, and distinguished members of the Subcommittee.

I am going to start my statement, but I have to just acknowledge the tremendous sense of being moved by the members of these—of these veterans themselves coming here today and taking time

from their lives to let us know their concerns about the VA, it is very, very important.

I wanted to talk about the number of women veterans enrolling in VA health care is increasing, which places new demands on the VA health care system. More women are choosing VA for their health care than ever before, with women accounting for over 30 percent of the increase in veterans over the last 5 years. To address this influx, VA is strategically enhancing service and access for women veterans.

Every VHA health care system has a full-time women veterans program manager who advocates for the needs of women veterans using that facility. VA has enhanced provision of care to women veterans by focusing on the goal of developing women's health primary care providers at every site of VA care. VA now has at least two women's health providers at all of VA's health care systems, and at least one at 90 percent of the community-based outpatient clinics.

VA has implemented models of care that ensure women veterans receive equitable, timely, high-quality primary health care from a single primary care provider and team, thereby decreasing fragmentation and improving quality of care for women veterans. And we have worked to implement a mobile training to specifically meet the needs of rural primary care providers and nurses at 40 CBOCs per year.

VA provides a wide scope of services to women veterans, including comprehensive primary care, gynecology care, maternity care, and fertility services other than in vitro fertilization, specialty care, and mental health services. Additionally, recent legislation authorizes IVF for married veterans with service-connected disabilities that result in infertility.

VA has witnessed 154-percent increase over the past decade in the number of women veterans accessing VA mental health care. Over 40 percent of women veterans who use VA have been diagnosed with at least one mental health condition, and many also struggle with multiple medical and psycho-social challenges, including trauma-related difficulties, and increased risk for suicide is of great concern.

To ensure that VA mental health providers have the skills and expertise to meet women veterans' unique treatment needs, VA developed innovative clinical training such as the women's mental health mini-residency. Unfortunately, some women veterans experience sexual assault or harassment during their military service and may struggle even years later with its aftereffects. VA provides free care, including outpatient, residential and in-patient care for any mental or physical health condition related to military sexual trauma, and eligibility is expansive. Veterans do not need to have reported their experiences at the time or have any documentation that they occurred, and may be able to receive free military sexual trauma-related care even if they are not eligible for other VA care.

VA is proud of high-quality health care for women veterans. Ongoing quality measures show that women veterans are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. Unlike other health care systems, VA analyzes quality performance measures by gender. This has been

key in the reduction and elimination of gender disparities in important aspects of health screenings and chronic disease management.

Since 2014, VA has tracked access by gender and identified small, but persistent disparities in access for women veterans, who overall are waiting longer for appointments than male veterans. To mitigate this disparity, VA has identified sites with longest wait times for women veterans and is working with those sites directly on initiatives to improve access, including designating more women's health providers through hiring or training, and improved team efficiency.

VA continues to make significant strides in enhancing the language, practice, and culture of the Department to be more inclusive of women veterans. My office sponsored the recently published research by Drs. Klap and Yano that found that one in four women veterans reported experiencing harassment by other veterans when they visited VA health care facilities. VA is focused on ensuring all veterans are treated with dignity and respect, and women who served in our country's military deserve to be treated with honor, just as their male counterparts are.

With input from male and female veterans, VA launched an End Harassment Program in every VA medical center in the summer of 2017 and has continued to implement this program nationally. Through increased awareness, education, reporting, and accountability, VA is working to address this issue. We have launched messaging, including, "It's not a compliment, it's harassment," directed primarily at educating male veterans that certain conduct is unacceptable.

Employees have been trained on culture-change efforts, including an awareness of the experience of women veterans, and ways to intervene and respond. We will be persistent in our culture-change efforts.

Gains for women veterans would not have been possible without consistent congressional commitment in the form of both attention and financial resources. It is critical we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing high-quality care for our veterans and their families.

Madam Chairwoman, this concludes my testimony. I am prepared to answer any questions.

[THE PREPARED STATEMENT OF PATRICIA M. HAYES APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Dr. Hayes, and I appreciate your testimony, and I will now recognize myself for 5 minutes for questioning.

The first question that I have—and I think anybody who is in the audience—I am not sure that you can answer questions beyond the medical arena around women's health in issues like homelessness and other kinds of things, so we are not going to get into those questions, but I had recently had the opportunity to visit the VA medical center which has really a very beautiful women's health center. I did mention earlier that they didn't have extended hours, but the center is absolutely beautiful, you feel like you are walking into a spa-like atmosphere. And women there can receive all of

their gender-specific care, including mammograms, they don't have to leave the clinic to make that happen. But according to a 2017 VA report—I call this the gold standard in some sense and the standard that we all want to achieve—only 7 percent of the VA facilities met this standard.

So I am wondering if you could speak to what VA's plans are in terms of replicating the gold standard across the country.

Dr. HAYES. Certainly. Thank you for the question.

We have been working for a number of years to make sure that women veterans have the right kind of care wherever they go for care. So we actually shifted away from building women's clinics for a number of years, because we wanted to make sure that women out in the more rural areas, in the distant areas geographically had access. That is our primary care provider, we are saying that—we are still concerned that 90 percent of our CBOCs have it, but 10 percent don't. So we have been focused very much on making sure that, wherever you come for care, you have a women's health provider.

In the meantime, as the population has grown exponentially, many sites have moved towards developing a women's clinic, we call it a Model 3 Women's Clinic comprehensive care with GYN on site. We are now at 75 women's clinics.

So we didn't say you have to do it. In fact, what we really said is that you must talk to the women veterans in your community; you must hold a town hall, you must have input from the women as to what do the women at that site want, and add in the issues about what is the best way to deliver care. And we have some sites that the women said we do not want a stand-alone women's clinic. We are women, we are soldiers where a soldier is a soldier, and we don't want that.

Most sites there is some combination of women's clinics, comprehensive women's clinics, and integrated primary care for women.

Ms. BROWNLEY. So women veterans disproportionately use community care compared to male veterans and we know the reasons why, but how will the women veterans be uniquely impacted by the MISSION Act and how is the VA going to ensure equitable, integrated care for women?

Dr. HAYES. The MISSION Act, of course, does allow for different kind of choice going out, but for women veterans about 30 percent of the care every year must be in the community, and that is because of maternity care, some of the infertility care, in some places mammograms, and also a lot of it is actually in-home care. As women age and live longer than men, they have more of the community care dollar.

I think that what is most critical about community care is care coordination and care navigation, and we have invested in mammogram coordinators, maternity care coordinators, and really our issue is going to be that we have right-sized our resources to have enough community care navigation and coordination and that is our challenge right now.

Ms. BROWNLEY. Thank you. And there are only 65 mammogram sites in the country and that really doesn't necessarily correspond to where there are large concentrations of women veterans. For ex-

ample, Puget Sound VA system in Washington State is used by thousands of women veterans and there is no on-site mammogram capability.

So what are the standards that the VA is using to determine where mammograms should be placed?

Dr. HAYES. We have recently developed a tool to continue to look at the key issues on where mammograms are and you are absolutely correct, most places we do not have a significant population to be able to have the highest quality of mammogram. That is critical to me, that we make sure that women are not seen by someone who hasn't seen enough mammograms.

In places like Puget Sound, the other—one of the other big issues is space and it takes considerable space and lead-lined walls. And so we are continuing to work with sites like that about how they can prioritize adding radiology space and mammogram space. So it is about a population issue and it is about making sure that we have the highest-quality care.

And the third part is navigation and if we don't have someone who is tracking to make sure that that mammogram result gets noted by the primary care provider, gets to the breast cancer surgeons or whoever they need, we are in trouble. So we need to make sure that, number one, we are tracking mammograms, and that is the biggest part of what we are doing.

Ms. BROWNLEY. Thank you very much. My time is up, so I yield to Mr. Meuser for 5 minutes.

Mr. MEUSER. Thank you, Madam Chairwoman.

Dr. Hayes, I thank you for being with us here this afternoon. I do understand that you do some really positive work for the Veterans Administration and for women veterans, so thank you.

Dr. HAYES. Thank you, sir.

Mr. MEUSER. I also understand that you were here during the testimony of the previous panel. Do you have any comments or response to some of the testimony given?

Dr. HAYES. Certainly, thank you.

I think that the issue of culture change, we really can't say enough about how that is a problem that we are focused on. We knew it was happening, we got the data to show that it was happening, we continued to throughout the country do more work on a wider spread of research on the topic, but it has been a challenge. Other systems don't actually have to manage this challenge of military culture bleeding over into veteran culture and how to deal with training our employees and our veterans to end harassment. So we do, we have worked a lot with research, but it is not good enough to say that women can just have a separate space or that they should go out to the community; we have to step up. I really like that comment about VA, it not only is stepping up, we have to step up. We have to end the harassment, not just of women, end harassment for race and ethnicity issues, for LGBT issues, we have got to change this culture.

And a lot of it is engaging Veterans Service Organization folks here, because part of VA is what I call right-thinking men who are appalled by this behavior, and empowering them as well as they come to VA to say something to the other folks that are conducting themselves this way. So, VA has this as a high agenda.

I think the other thing that was really striking in hearing the panel is kind of the disconnection, whether it is a little bit of disconnection between them, but also the ongoing issue of us making sure that we are working with these partners, these women veteran expert partners in everything that we can do. And the challenge from the level of the Center for Women Veterans and the level of every VA to make sure that we are involving these groups of women veterans and the other groups, i.e. MVA and others that have provided information, to make sure that we are hearing them and incorporating the veteran's word in what it is that we offer to veterans, and I heard that loud and clear from them today.

Mr. MEUSER. Certainly. All right, thanks.

What steps as of late has the VA taken to combat harassment when it is detected or seen at the VA facilities?

Dr. HAYES. The End Harassment Program—and you notice I call it End Harassment, because we are not anti-harassment, we are not against harassment, we want it to stop, we want it to end—and we have done a number of things. We developed an education program for veterans, which it talks about this is not a compliment, this is harassment. We have worked with male veterans to have them tell us, you know, what were some of these things, because this behavior disrupts care. It is a terrible experience for veterans who experience harassment and it just disrupts the whole system.

So we have to educate male veterans, we do it in some of the new employee orientation. We are in the process, a widespread process of educating the employees to understand these experiences, and also what is widely known in research as a bystander intervention, teaching them through a role-playing system how to actually intervene. And if they don't feel comfortable intervening, they can call their supervisor, they can call the police, there are a number of options. So we educate.

The next step is reporting. We have set up reporting systems locally. Veterans can report, staff can report; you can report to the police, you can report to the patient advocate, and you can report to the Women Veterans Program manager. There will be people that are evidenced as, you know, putting out there as you can call me, their name is on a poster.

And then there is accountability and we believe very strongly the accountability has to be at the local level. The local leadership has to be out and engaged in this, they have to know what the reports are and they have to be actively working to change this culture, to engage the employees, to engage the veterans, to walk around and themselves say this has to stop, we have to change this.

Mr. MEUSER. All right, very good.

The panel also brought up the idea of an outside agency to conduct a cultural assessment of the VA or specific VAs; what are your thoughts on that?

Dr. HAYES. I honestly don't know of groups that could do this for us. I mean, we work closely with some of the other major think tanks, Mitre and Rand and folks like that, and they have been involved in some of the research. I actually think that the best assessment is listening to the veterans themselves. We have what we call a card study, we have just done another round that we will be

publishing about what do veterans think about this effort, do they notice that we are changing the efforts.

So I would be very interested in hearing more specifically about what someone might think we could get, what would be the utility of that, but listening to the veterans is the number one strong message that we have. I encourage facility directors to call in veterans and ask them specifically about this, what have you experienced at this VA and where are the hot spots, where are the trouble spots.

Mr. MEUSER. Thank you.

Thank you, Madam Chair. I yield.

Ms. BROWNLEY. Thank you. And, Mr. Cisneros, you have 5 minutes.

Mr. CISNEROS. Thank you, Madam Chairwoman.

Thank you, Dr. Hayes for being here today. I want to ask you about a specific pilot program that is being run between the Air Force Women's Health Initiative team and the VHA's Office of Women's Health Services, the program is a Women's Health Transition Assistance Training Pilot Program. As one of the previous witnesses testified, veterans aren't always aware of their services or the benefits that they have, and I will even kind of testify that was true in my own case when I was getting out of the military. Some of the data that was collected in this for those that have gone through the program indicate 99 percent of the participants surveyed responded they would recommend this course to others; 80 percent of participants have agreed to post-course follow-up.

Could you elaborate on some of the data findings and why is this program being so successful, and why these women have said they want to continue with this?

Dr. HAYES. Absolutely. As you well know, VBA and the Department of Defense and the Department of Labor run a TAP program for servicemembers as they exit the military. We knew for a long time that women veterans have been telling us that they didn't know about their benefits. And the other thing that was brought to our attention is that the time—the year after transition, that whole transition year, is at higher risk for suicide. We are very concerned about the high suicide rate and the rising suicide rate among women veterans.

And so we worked with the great partners in the Department of Defense to design a TAP program for women, which is in addition to the regular TAP program. It does walk them through their benefits. It is a time when women are with women, so they can talk about issues, about things like reproductive health issues, gender-specific health issues, and I think that is part of why they find it a comfortable place, but it also gives them a lot more technical information about what is VA health care and how can they access it.

They also—for most sites we get them to a VA hospital, so that they can kind of blow away the myths about what is a VA hospital like and see some of these gold standard clinics that are there, and realize that they may want to enroll and use that care.

This project is a proof-of-concept project. We are in pilot phase and we are happy to announce that Navy just this week has very much agreed to come on board and help with Navy and Marine sites. So now we have participation in Air Force, Army, Navy, and

we think that we are going to get a wider ability to have people come into it and have the various services, be able to speak to what they think what benefit it is for them.

So we are going to continue to collect the data, we are going to go back to the Joint Executive Committee of DOD and VA and report our findings. And so far, people actually think it is wonderful; we are not surprised, we think it is a very important part of what we are doing. We are also going to compare it to an online version, so we can see whether it is really—what is the importance of having it in person, what can you get from an online version for those that want to take it virtually.

Mr. CISNEROS. All right. So just to be clear, it sounded like you said Army, Navy, and the Air Force are now going to implement this program?

Dr. HAYES. Yes, sir.

Mr. CISNEROS. Oh, wow, that is wonderful.

Dr. HAYES. It is wonderful, yes.

Mr. CISNEROS. So how do we get it out of the pilot program phase and to really make sure that we implement this through the entire Department of Defense or all three military branches, maybe even the Coast Guard at some point there too, to make sure that we are taking care of our women veterans?

Dr. HAYES. Well, we are going to fund up the next part of the pilot, carrying us through the end of '19 now and into 2020. We need the data. It really is important, I think, when you look at something that is going to be costly in some ways to make sure that it really is a proof of concept that this is an important addition to the TAP program.

So, as I said, the next thing would be a decision. There is a well-oiled machine that works between the TAP oversight, as I said, with the Department of Labor, VBA, and DOD, and it will go back to that group, in their wisdom, to consider it.

Mr. CISNEROS. All right. Well, thank you very much, and I yield back my time.

Ms. BROWNLEY. Thank you, Mr. Cisneros.

Mrs. Radewagen, you have 5 minutes. Thank you for joining us.

Mrs. RADEWAGEN. Thank you, Madam Chairman.

Dr. Hayes, according to DAV's written testimony, VA reports that only 70 percent of women veterans are assigned a designated women's health primary care provider. That is concerning considering the improved satisfaction and quality that data indicates are correlated with such an assignment. What steps are you taking to ensure that every woman enrolled in the VA health care system is assigned to a designated women's health primary care provider?

Dr. HAYES. Thank you for that question. We, as you have heard, are really committed to having designated women's health primary care providers. There is a national shortage of primary care providers, so we have worked a lot on training up our own providers who may have been rusty about women's health, 5800 of them have been provided, but we found that we are still having difficulty recruiting in the remote and rural areas. And so we have established a training program that takes the training to that remote site.

Our community-based outpatient clinics frequently have very few staff and can't send their staff away for a week to training. So in

the last year and a half we have actually trained up over 70 providers.

And you may be relieved to hear that the first week of May and the last week in April we trained in Hawaii, and we had several folks from the islands come, so they can now be designated women's health providers. We wanted to make sure that we reached groups that have had great difficulty in accessing this training, and you may want to interview them. I think that they were very excited to be included and we were very happy to be able to make sure that they could get their—lots of travel, as you well know, and it is a group that we wanted to make sure.

And I am glad you asked the question, because it happened to be that we reached—as I said, we are looking at those sites that are geographically dispersed that can't easily access, can't hire up. There may not be a primary care provider in that area, and we can't steal them from another—you know, we can't steal them from Indian Health Service or another federally-qualified health center. We have to make sure that we are working in partnership with all of those groups and provide the best training that we can for our women's health providers.

So we still have a long way to go. We actually have such a wave of women coming in that even with all of the training we are doing, this year we are going to hit over 700 trained and we are still going to probably have a gap of five to 700 providers. So I am continuing to look. Workforce management is working with me in terms of enhancing the recruitment under the Secretary's recruitment provisions and our goals for recruitment, but we have an uphill battle here.

Mrs. RADEWAGEN. Also, you note that provider turnout is an issue with respect to the initiatives VA is pursuing to improve training on women's health across the VA health care system. What, if any, incentives exist to encourage providers to seek out those training opportunities? And, if none exist, what incentives do you think would be helpful?

Dr. HAYES. There are not specific incentives to be a women's health provider and that is problematic. If anything, there is a bit of disincentive, because we are getting so busy that they frequently get over-paneled quickly, they have difficulty kind of keeping everything going. We do have retention—we have a turnover in retention in this group that is higher than the other primary care groups. And it is really a technical issue about there is not a separate medical certification for this group of providers, so we are not able within the laws and rules about provider groups. We would need to have some specific way to identify the work they are doing and to be able to provide additional financial incentives in this group.

Mrs. RADEWAGEN. I see. So what outcome improvements do you see for women veterans following the mini-residencies in women's health that your statement references?

Dr. HAYES. The training itself, I think that there are both kind of subtle and really obvious things. The obvious things are resolved when you can have someone not have to go somewhere else for Pap smear, because someone has been trained up on live models and

feels comfortable handling a Pap smear, handling a vaginal infection.

The more subtle things or not so direct things are about understanding the experience of veterans in the military, trying on, you know, what we call the battle rattle, and then going back and realizing that this complaint about musculoskeletal pain, about a headache or a neck problem, or a joint problem, is because of what that woman had to do with her heavy equipment on. And then we also have them trained up a lot on military sexual trauma, interpersonal violence, depression, management of basic mental health conditions in the primary care setting. So we have taken someone who is a good VA provider and helped them expand their role to really, truly be a good provider for women veterans.

Mrs. RADEWAGEN. Thank you, Madam Chair. I yield back.

Ms. BROWNLEY. Thank you, Mrs. Radewagen.

I thank you, Dr. Hayes, for being here. And I had—before we conclude, I just had one very quick follow-up question on the End Harassment Program you were speaking of.

So the last thing you said about the program is accountability and I just—I was curious to know when you are teaching employees around harassment, is that a required program that each and every employee must undergo, like we do here in Congress, and, you know, they must go through this training and must go through it on an annual basis?

Dr. HAYES. Every employee must go through the employee OPM harassment program. What we are doing in VA is we are adding to that program and to several other training programs that employees are taking. There is a new program the Secretary has been rolling out called Own the Moment, and it is about customer service, it is about direct interaction with veterans, and we are enhancing that program to add this together.

So, to answer your question directly, that is not a mandatory program. We are still in development of how to roll this out additionally. In fact, I have a meeting with the Secretary in about a week with various groups within the VA. So it is a little bit preliminary to say how much more we are going to be making sure happens, but we can get back to you on what the plans are. And not just for VHA where we have the medical centers and the accountability, but we also want to extend the program across all of VA, the cemeteries and the benefits agencies, in terms of being able to address the culture everywhere.

Ms. BROWNLEY. So it is very possible that we have employees across the VA who have been untouched by any of these programs?

Dr. HAYES. Quite—yes, sir—yes, ma'am. I believe that right now there are employees who have been untouched by the program.

Ms. BROWNLEY. And then you talked about the reporting system. So, once an incident reported, is every incident then investigated and pursued?

Dr. HAYES. The reporting is done locally, and it is done to the patient advocate and/or what is called the Disruptive Behavior Committee for mental health disruption; it is accounted to the local director, and they are tracking and accounting for what is done.

So because this range of behaviors can be everything from cat-calling, where there might be something like looking at the design

and trying to make sure that you can't congregate there and have women walk the gauntlet, that might be the action. There are many other much—I don't want to sort of qualify them, but egregious things that absolutely have to have police intervention, maybe the veteran has to be accompanied every time he comes into the setting. So there are various ranges of action that are possible.

Ms. BROWNLEY. But a supervisor or a medical director or a VISN director or anybody at central office may not hear about any of these instances?

Dr. HAYES. We actually decided not to roll them up to the central office level.

Ms. BROWNLEY. So medical director level, VISN level—

Dr. HAYES. Yes. I want the action to be accountable locally.

Ms. BROWNLEY. I agree, I agree, but sometimes one has to make sure that it is happening locally.

Dr. HAYES. I defer to your judgment. And in this area, you know, we have been going back and forth on it. I just didn't want us to create a meaningless report that people were just sending up somewhere.

Ms. BROWNLEY. Understood, yeah.

Dr. HAYES. That was the issue for me is that what is the utility in a report that just has a lot of numbers, which hopefully will go up initially, you know. We see this challenge with these kind of reports.

Ms. BROWNLEY. Yeah. I just feel like this is really, you know, we are sort of—in terms of culture, it is sort of in a crisis situation. I think everybody, including yourself and others in the VA, acknowledge that, but it just seems to me that we need to have more tools that replicate that urgency, and so that is why I am sort of following up on those questions.

But I think our time has come to a close and I really appreciate you being here. And I think just before we close the hearing, I just would like to say, I think what we have learned today has been extensive, and I think the conclusion is that women continue to face sexism and discrimination and inequities in the system, in a system that was originally built for men. And I think everyone on the Committee believes that no woman should endure sexual harassment of any kind when she is seeking her health care and no veteran should ever have her service considered less valuable because of her gender or minority status.

So I think we have got a lot of work and the work is cut out for us, and I intend on following up and having more hearings like this one, so that we can drill down further.

So I appreciate everybody's participation, and, with that, I will ask Mr. Meuser if he has any closing comments.

Mr. MEUSER. Thank you, Madam Chairwoman. No, I do not. I do too thank you very much, Dr. Hayes, and our previous panelists and their testimony. So, thank you very much.

Ms. BROWNLEY. So, thank you again.

And, with that, all members will have 5 legislative days to revise and extend their remarks, and include extraneous material.

So, without objection, the Subcommittee stands adjourned. Thank you.

[Whereupon, at 1:08 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Joy J. Ilem

Chairwoman Brownley, Ranking Member Dunn and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify today at this oversight hearing on Cultural Barriers Impacting Women Veterans' Access to Health Care. DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Ensuring that women veterans are treated with respect and dignity and have equal access to high quality comprehensive primary care, gender-specific health care services, disability benefits and the broad range of specialized care and readjustment services from the Department of Veterans Affairs (VA) is a top legislative priority for DAV.

Women are serving in the military in record numbers and represent 10 percent of the veteran population. There are more than two million women veterans in the U.S. today and according to VA it expects women will make up 18 percent of the veteran population by 2040.¹ Women are also turning to VA for care in record numbers and more than half of the women using VA services have a service-connected condition and are eligible for VA benefits and a lifetime of care.²

These sociodemographic changes led DAV to release two special reports on women veterans. *Women Veterans: The Long Journey Home* was released in 2014, with a follow-on report in 2018, *Women Veterans: The Journey Ahead*. These reports highlight the changes in this population over time, critical policy implications for VA, what was needed to ensure women veterans have access to high quality health services in all VA sites of care, and most importantly how we could better serve this population of veterans. Our 2014 report looked at barriers women veterans returning from recent deployments faced in readjusting to civilian life after military service. Our new study looks at progress made and more generally, at the needs of a diverse women veterans' population using VA health care today. We very much appreciate this opportunity to discuss the recommendations in our most recent report in relation to the barriers identified in women veterans' pursuit of veteran-centric health care.

The unprecedented growth in the number of younger women veterans coming to VA for care over the past two decades has placed specific demands on the system and relates to a number of policy changes that have taken place related to delivery of care for this population. Specifically, a national focus on oversight, starting in 2008, by the Women's Health Services Program Office and the advent of training and deployment of designated women's health primary care providers (WH-PCPs) and the provision of comprehensive primary care, including gender-specific services for women patients.

Understanding VA's specific challenges requires a look back at the changing dynamic of women veterans seeking VA health care services. The number of women seeking VA care has tripled since 2000, growing from about 160,000 to 500,000 today.³ VA has had to ensure younger women in their childbearing years have access to reproductive health services and that older women veterans, another growing population in VA, have access to age appropriate services for chronic health conditions and sex-specific care. Additionally, the increasing proportion of women veterans with a service-connected condition who use VA care (48 percent in fiscal year

¹ Department of Veterans Affairs. Women Veterans' Health Care. Women Veterans Today.

² Women's Health Services. Office of Patient Care Services. Veterans Health Administration. Department of Veterans Affairs. Sourcebook: Women Veterans in the Veterans Health Administration Vol. 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution. February 2018. P. 3

³ Department of Veterans Affairs. News Release. New Text Feature Available Through VA's Women Veterans Call Center. April 23, 2019.

(FY) 2000 compared to 63 percent in FY 2015)⁴ also required program adjustments and policy changes to ensure quality of care and effectiveness of services for this group. Higher utilization of outpatient services among women veterans, as well as increased rates of purchased care and specialized services all resulted in the need for increased capacity, research, resources and oversight of the Women's Health Program.

Women's care needs and preferences for health care in VA are often quite different than those of the male veterans the VA health care system was originally created to serve and long-standing cultural barriers that have impacted women veterans' access to VA care are often a result of failing to understand the different needs, preferences, and perspectives of women veteran patients.

While there has been significant progress in many aspects of VA health care for women, there are some longstanding issues that still exist. VA's environment of care surveys, which identify deficiencies in privacy, safety and dignity in patient care settings seem to routinely get shortchanged or ignored. In recent reports the GAO (Government Accounting Office) has highlighted these deficiencies and made recommendations about how to correct them.⁵ However, little has changed in the way VA collects or submits these surveys or holds its leadership accountable for implementing necessary changes. While Women Veterans Program Managers (WVPMs) are responsible for managing environment of care surveys, they have no authority to hold facility leadership accountable for accuracy and completion of responses to surveys or to ensure changes are made to correct identified deficiencies.

Women have been found to value privacy, safety and appearance of patient care environments. In the VA, where women are still a minority of the patient population, these aspects of health care may be even more important to ensure women are made to feel welcome and comfortable in seeking care. DAV feels strongly that women veterans should be able to take advantage of VA's comprehensive system of care and specialized programs and services. Women should be able to rely upon a system that at its best understands the unique needs of this population through its dedicated Women's Health Research program and commitment to evidence-based care.

We are pleased to learn that VA researchers are looking at how gaps in the delivery of gender-sensitive comprehensive care can result in disparities in quality and patient experience among women veterans using VA health care and more importantly that VA's Women's Health Program, in collaboration with researchers, has adopted VA's model of using evidence-based quality improvement or EBQI to see if it can be used to help facilities with gaps in delivering comprehensive services to women. These sorts of initiatives are essential for breaking down barriers to care and achieving delivery of comprehensive care in gender sensitive care environments throughout the system that ensure safety, dignity and privacy for women patients.

Research has also shown that women veterans prefer women clinical providers, particularly when it comes to "sensitive" sex-specific care such as gynecology⁶ and express a preference for women's comprehensive health clinics. Veterans who use these clinics express high satisfaction with communication and care coordination.⁷ Yet despite the efforts of many policy leaders within VA, there are still many women who lack access to women's clinics and ensuring adequate staffing for such clinics has remained an organizational challenge.

VA reports that a majority of women veterans (approximately 70 percent) are assigned to a designated women's health primary care provider. Only a small percentage receive care in designated women's health clinics-in FY 2005 and FY 2010, VA reported that only 12 percent of women used women's health clinics and 22 percent used both women's health clinics and general primary care clinics (34 percent of the total population). In FY 2015, 16 percent used women's health clinics and 17 percent used both women's health clinics and general primary care clinics (32 percent of the total population).⁸ Women's health clinics must be staffed with specialized primary care providers in addition to adequate clinical and non-clinical support staff. Ideally these clinics should also have integrated mental health care services available. Because these clinics require appropriate staffing levels and space, VA medical center directors must support their growth and maintenance as a high priority.

⁴ Sourcebook, p. 3

⁵ Government Accountability Office. VA MEDICAL CENTERS: VA Should Establish Goals and Measures to Enable Improved Oversight of Facilities' Conditions. GAO-19-21: Published: Nov 13, 2018. Publicly Released: Nov 13, 2018.

⁶ J Obstetrics Gynecology Apr 2005, Vol 105, #4, p 747-750.

⁷ Brunner, J. et al, Women Veterans: Patient-Rated Access to Needed Care: Patient-Centered Medical Home Principles Intertwined. Women's Health Issues 28-2 (2018) 165-171.

⁸ Sourcebook. P. 58

With these longstanding issues still not fully addressed it may be time for Congress and VA to consider a new hierarchy for women's health, specifically making it a program with its own leadership structure at the Veterans Health Administration (VHA), VISN and facility level. In this type of hierarchy, leadership within the program would be able to control resources within the program's budget and hold staff accountable for adhering to policies that affect women patients. Elevating the Women's Health Program in this manner would also send the message from the top down that women veterans are important to VA, perhaps leading to the important cultural change embracing women veterans as an important part of the community—a change that women veterans and their advocates have long sought.

Women Veterans under the New Veterans Community Care Program (VCCP)

Congress enacted major reforms in Public Law 115–182, the VA MISSION Act of 2018, which will soon affect health care for all veterans. While DAV supported the enactment of this bill and believes it has the potential to better serve veterans using VA services through an integrated care network of well trained and knowledgeable VHA and private-sector providers that will provide improved access to services veterans need—our confidence has waned given VA's proposed rule on access standards which is likely to cause more disruption and confusion among veterans. We sent comments reflecting our concerns about using the new “drive time” standard for primary care; about the VA's lack of requirements for comparable quality and access data for network providers; and about the dangers of using access measures for VA's specialized care models (for polytrauma care, blindness, spinal cord injury or dysfunction or homelessness among others) as inclusionary criteria for contract care. We believe implementing the access standards as proposed may have the effect of fragmenting care and unraveling some of the best systems of care available for veterans with complex care needs such as our women veterans.

The transition to the Veterans Choice Program (VCP) under Veterans Access, Choice and Accountability Act of 2014 (VACAA, P.L. 113–146) proved difficult for VA, its contractors, and most of all, veterans. Women veterans use more contract care than male counterparts because frequently, the sex-specific care they require such as mammography, maternity care, and gynecological care is not available at VA (in FY 2015, 37 percent of women veterans compared to 23 percent of male veterans used community care.)⁹ Contracting, once seen as the answer to veterans' wait times and access, was not proven to be the panacea some policy makers had hoped. A recent study found that women veterans experienced confusion about eligibility, frustration when scheduling appointments, difficulty obtaining lab and test results from contract providers and problems with being held personally liable for VA's late payments for contract care.¹⁰ Notably, a GAO study also showed that appointment waiting times for VCP providers were, on average, significantly longer than 30 days as required under VACAA.¹¹

During the implementation phase of the MISSION Act, DAV believes veteran populations who often have complex health histories and require specialized care with supportive wraparound services, such as our women veterans, should receive special attention to ensure their needs are served. Women veterans' health care must be a highly reliable service with knowledgeable women's health care providers whether at VA sites of care or in the community.

For example, VA knows that many women have experienced sexual and physical trauma that puts them at risk for a number of adverse life outcomes and health consequences. An integrated system of care allows VA to closely follow these veterans and coordinate their care and provide access to necessary supportive services—which is particularly important to women veterans dealing with intimate partner violence, homelessness or child care issues. Without special coordinated wraparound systems of care, these women could easily fall between the cracks (as was demonstrated in their experiences with VCP). In our 2014 report, *Women Veterans: The Long Journey Home*, DAV discovered this was the case with too many women returning from deployments to Iraq, Afghanistan and other combat zones. The Depart-

⁹ Women's Health Services. Office of Patient Care Services. Veterans Health Administration. Department of Veterans Affairs. Sourcebook: Women Veterans in the Veterans Health Administration Vol. 4: Longitudinal Trends in Sociodemographics, Utilization, Health Profile, and Geographic Distribution. February 2018. P. 49.

¹⁰ Mattocks, KM, et al. Examining Women Veteran's Experiences, Perceptions, and Challenges With the Veterans Choice Program, *Med Care* 2018;56: 557–560.

¹¹ Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs GAO–18–281. Published: Jun 4, 2018. Publicly Released: Jun 4, 2018.

ment of Defense and VA missed critical opportunities for communication and warm handoffs during transitions between systems. While many federal programs and services exist to serve women veterans' readjustment needs, without appropriate support and coordination too many women have been unaware of them or unsure how to access them, as evidenced by lower market penetration rates between male and female veterans—according to VA, only 22 percent of female veterans used VA in fiscal year 2015 compared to 28 percent of male veterans.¹²

Access to community health care services has been necessary and will continue to be so in a system that caters to a small, dispersed population of women. For these reasons VA must ensure the preparedness of network participants within its community care program. According to a RAND study only about two percent of New York providers surveyed were adequately prepared to address veterans' health care needs.¹³ For these reasons VA must also ensure that contractors are properly trained about military and veterans' culture, special conditions within the veterans' population and evidenced-based treatments for service-related mental health conditions. VA must provide community partners guidance on how to properly screen and treat certain conditions for which it has expertise such as PTSD and ensure referrals are made back to VA for specialized services when necessary.

To ensure quality of care integrity VA has created robust systems to coordinate the care veterans receive in the private sector. However, more contracting will require more VA coordination and case management for veterans with complex medical conditions. If their coordinator roles are collateral with other assignments, VA must ensure that each coordinator has sufficient time allotted to fulfill all their responsibilities.

Deficiencies in VA Programs and Staffing to Meet the Needs of Women Veterans

In an effort to ensure all sites of care are capable of providing high quality gender-specific care, VA has developed a program to train women's health primary care providers (WH-PCPs) yet VA's IG found that many of these designated providers do not meet VA's own proficiency standards and have too few women assigned to their panels to gain or maintain proficiency. Training and support for VHA staff and its contract providers is essential to ensure that women using VHA have knowledgeable providers wherever they seek care. DAV is pleased with VA's women's health mini-residency program which provides specialized, hands-on training to many providers, yet it appears that VA lacks the resources needed to be able to train a sufficient number of providers to meet steadily growing demands for care and replacements for staff attrition. Retention can also be difficult if providers do not believe they have adequate clinical and administrative support. Hiring and contracting knowledgeable providers is essential for filling these gaps—therefore, for FY 2020, the Independent Budget coauthors recommended adding additional funding for VA to hire 1000 new staff to include women's health providers, specialty care coordinators, peer counselors and administrative support staff to address increased demand for care.

DAV also believes Congress must make women veterans' maternity care a more robust benefit. Because women veterans have several conditions (often service-connected) including combat injuries and mental health conditions that put them at risk for adverse birth outcomes, VA should be authorized to provide at least 14 days of post-maternity care to the woman veteran and her newborn infant. Congress must also authorize emergency transportation for the newborn (without the mother) if needed care is unavailable at the facility in which the mother is receiving care.

Continued leadership at the local and national level is important to ensuring that women's programs remain a priority. Making women's health a distinct program may also ensure programs have the funding and authority necessary to implement important changes. Having a designated funding stream better ensures that women's issues remain at the forefront of VA's agenda. Strategic plans must also specifically address VA's programs for women.

Culture Changes Needed-VA's End Harassment Campaign

As VA transforms its health care system, it must ensure that its facilities offer the safety and privacy in welcoming therapeutic environments that all veterans deserve. Unfortunately, recent research indicates that women veterans still do not al-

¹² Sourcebook. Vol. 4, P. 18.

¹³ Tanielian, Terri, Carrie M. Farmer, Rachel M. Burns, Erin L. Duffy, and Claude Messan Setodji, Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans. Santa Monica, CA: RAND Corporation, 2018. <https://www.rand.org/pubs/research—reports/RR2298.html>.

ways feel safe or welcome at VA health facilities. While this may partially relate to a negative experience with VA staff or the less than optimal aspects of facility design at some facilities or lack of gender-specific supplies for women patients at certain locations, a recent study found that it often stems from male veteran patients who make inappropriate or unwanted comments or sexually suggestive remarks to women veterans or question their right to use VA care. Unfortunately, the percentage of women veterans who claim to have been subjected to sexual harassment in the military approximately 25 percent or 1 in 4,¹⁴ is similar to the proportion of women who report harassment (1 in 4) from other veterans while seeking care at VHA.¹⁵ More importantly, the study found that those that reported harassment were significantly more likely to report either delaying or missing care.

This type of harassment is most likely to impact younger women veterans who have a history of trauma exposure, or screen positive for anxiety or depression.¹⁶ We are pleased to see that VA is working to address this issue, to make needed cultural changes and to eliminate harassment or disrespectful behavior from fellow patients, visitors or staff. The Veterans Experience Office reported it convened women veterans panels who recommended that management reward and hold staff accountable for creating an empathetic and responsive culture using the VA as a way of implementing the End Harassment Campaign.¹⁷

According to VA, its End Harassment Campaign trains employees through simulations aimed at identifying and intervening in situations where women are being harassed. It creates messaging for potential harassers and urges women to report harassing incidents to VA security. We concur that it is every VA employee's responsibility to ensure that all veterans feel safe when seeking care at VA. We suggest that the facility director has the ultimate responsibility for oversight and should be accountable for ensuring that any type of harassment at the facility is immediately addressed and resolved. VA may consider offering new women patient's volunteer escorts from the main entrance to their appointments for those that want them, or any other veterans as requested. This could also serve as an opportunity to provide women veterans with a welcome package including a facility map and contact information for the women's clinic, the women veterans' program manager, military sexual trauma coordinator and the patient advocate. Escorts would perhaps allow women to feel both welcome and safe as they become oriented to the facility and access care.

VA's programs rely upon research and data to ensure effective programming. Women's research in VA has accelerated significantly over the last several years with the creation of the Women's Health Research Network and other collaborative efforts. Over a five-year period 2011–2015, VA published more studies on women veterans' health than in the previous 25 years combined.¹⁸ This research directly benefits veterans at the bedside and is part of what makes VA, in our opinion, the best place for women veterans to seek care. For example, in recent years VA clinician/researchers became aware that many of their women veteran patients were survivors of intimate partner violence (IPV). Emerging research proved that women veterans are at greater risk for IPV than non-veteran women.

This prompted VA to hire coordinators at each medical center to serve women veterans reporting IPV. We commend VA appropriators for understanding this need and providing the funding to assure all VA medical centers had these coordinators. Another issue identified within the women veterans' population is a heavy reliance on VA mental health services.

Mental Health Care

Women veterans often have a variety of exposures including combat, military sexual trauma (MST), childhood trauma, and intimate partner violence that place them at risk for developing certain mental health conditions. Eating disorders are also common among survivors of MST.¹⁹ While rates of suicide for women veterans are lower than their male peers, women veterans are twice as likely to commit suicide as women who have no military service. The rate of suicide among women veterans is also accelerating much more quickly than that of male peers. More must be done to understand risk and protective factors for women veterans and to assure there

¹⁴ <https://www.mentalhealth.va.gov/msthome/saam.asp> accessed 4/29/19.

¹⁵ Women's Health Issues 29–2 (2019) 107–115.

¹⁶ Women's Health Issues 29–2 (2019) 107–115.

¹⁷ <https://www.va.gov/ve/docs/storybookWomenVeterans.pdf>

¹⁸ Yano, E.M. Advances in VA Women Veterans' Research. Center for the Study of Healthcare Innovation, Implementation and Policy. Briefing to the Advisory Committee on Women Veterans. VA Central Office. May 9, 2018.

¹⁹ DAV Women Veterans Report. 2018 p. 32.

are more gender tailored interventions to prevent suicides among this subpopulation. Specifically, VA health care facilities must ensure that women's mental health champions and MST coordinators, whose positions are collateral duties, have the ability to independently dedicate at least 30 percent of their time to carry out required administrative responsibilities associated with these positions. Suicide prevention remains a top clinical priority for VHA and the Department has developed a number of innovative practices to assure veterans are able to have the level and type of support and services they need to recover from mental health conditions common among veterans.

Substance use disorder (SUD), is also common among women veterans who use VHA, and often co-occurs with other mental health conditions complicating diagnosis and treatment. SUD increases the risk of suicides and can make women vulnerable to intimate partner violence. SUD puts veterans at risk for a spiral of decline: job loss, adverse health effects, homelessness, criminal activity, and family dissolution. To prevent a downward trajectory, VA must ensure women veterans have timely access to services offered by VHA including the full spectrum of mental health and substance abuse treatment services from detoxification to rehabilitation. The underlying causes of women's SUDs are often different than men's, and, accordingly, VA should make women-only programs and/or topic-specific programming (based primarily on women's interests such as parenting and safe relationships) more widely available.

VA is one of the largest employers of peer specialists using them in mental health care and primary care settings. Peer counselors are generally in recovery from a mental health condition including substance use, an eating disorder, or PTSD from combat or military sexual trauma. Because they've "been there," peer specialists often serve as role models for veterans offering encouragement, helping to answer questions about options for care, supporting goals for recovery, and help veterans remain engaged in their care plan. VHA has hired a disproportionately high number of women peer specialists (relative to women's use of VA) but we understand they are not equitably distributed throughout the system. DAV urges Congress to provide dedicated resources to hire and train women peer counselors for placement within patient aligned care teams with a focus on supporting care for women veterans with mental health conditions, particularly for women dealing with MST-related health issues and those at higher risk for suicide. VA should also be provided dedicated resources to increase the number of full-time clinical staff focused on providing mental health counseling to women patients dealing with reproductive mental health issues, such as postpartum depression, perinatal loss, and menopausal transition.

Unfortunately, even with commitment from DoD leadership, improved preventive and survivor assistance programs, rates of military sexual assault continue to soar. A 2016 report indicated that officer candidates in service academies were often unaware of which behaviors might constitute sexual harassment or assault.²⁰ As the military continues to rely upon women service members to carry out its mission and women are integrated into all military occupations, DoD must redouble its efforts and focus on training troops about what constitutes inappropriate behavior and to ensure, at all levels of the command structure, there is zero tolerance for sexual harassment or assault and adherence to ethical and professional conduct toward women service members as colleagues.

Many veterans turn to VA for specialized MST-related treatment and value Vet Centers which strive to staff according to the demographics and needs of veterans they serve in the communities in which they are located. These centers offer programs for combat and military sexual trauma and other highly sought mental health services that at times involve family members in a veteran's care. Because of the knowledge of local veterans' needs and the market they are serving, local Vet Center leadership must be included in any local planning to establish community care networks. Vet Centers also offer women-only retreats for post-deployment readjustment and more than 300 women have participated in these retreats which have produced consistent and positive results. VA should conduct research to confirm long-term effectiveness of these programs and Congress should consider expansion and permanent reauthorization of retreats if warranted.

Madam Chairwoman, in closing, I want to thank you and the Subcommittee for your continued interest in improving health care programs and services for our nation's women veterans. With major reforms underway at VA, now is the time to address longstanding cultural barriers impacting women veterans' access to the high quality comprehensive gender-sensitive health care they need and deserve. As an organization, DAV also wants to ensure that the role of women in the military and

²⁰ Davis, L. et al., eds. (2017) Office of People Analytics. Defense Research, Survey, and Statistics Center. 2016 Workplace and Gender Relations Survey of Active Duty Members. XVI.

the sacrifices they have made are understood, acknowledged and fully appreciated. Please know that DAV is ready to assist you in your efforts. This completes my statement. I will be happy to respond to any questions you may have.

Prepared Statement of Lindsay Church

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, on behalf of the Minority Veterans of America (MVA), thank you for the opportunity to testify about the cultural barriers impacting women veterans' access to healthcare.

My name is Lindsay Church and I am the Chief Executive Officer and Co-Founder of MVA. I served in the United States Navy from 2008–2012 as a Persian linguist, all but three months of which were under Don't Ask, Don't Tell. I am a medical retiree and I, personally, receive my care through the VA.

Since starting MVA in 2017, we have grown to over 800 veterans across 46 states, 2 territories, and 3 countries, 47% of them are women. Together, our members account for 6,000 years of service, some, dating back to conflicts and eras that predated when they were legally recognized as women veterans.

I am here today to testify from both my own personal experience and on behalf of the countless women veterans who will never have the opportunity to be heard or accounted for.

In the military and veteran community, the role of women is quickly expanding and their stake of the community is constantly growing. With more ranks and rates opening to women all the time, the portion of the community that women make up is only anticipated to continue to grow. This rapid growth has left a lag in the culture meant to support women after service. The culture that we have created, or neglected to advance, in our military and veteran communities has left many women veterans without a community to call home.

The cultural barriers that women veterans face are complex in nature and require a unique understanding of the lived experiences of women in the military community. At the heart of the cultural barriers that we face are two primary areas of concern: 1) The toxic culture for women and minorities in the military and veteran community that have caused a loss of faith in services designed to support them; and 2) The perpetuation of systems that render our service and voices, as women veterans of all kinds, invisible.

Toxic Culture for Women and Minorities:

The military and veteran community have histories of harassment culture that have long been acceptable when directed at women and minorities. There have been instances of institutionalized discrimination that have been held in place for years, sometimes even decades, before being struck down through acts of Congress or decisions made at the highest levels. These policies create a space where harassment and discrimination of the individuals who are impacted by them is seen as acceptable and tolerated. The harassment that we face as a result of the culture that is created inflicts lasting damage on those of us who endure the behavior without an ability to change our circumstances.

The discrimination that happens in the military to women-identified individuals is compounded by the force of the entire United States military that renders each service member powerless until their date of discharge. Even if you want to leave the military because you are being harassed, assaulted, or fear for your safety in any way, you are beholden to a system that demands compliance no matter the circumstances.

Women identified individuals experience instances of gender-related discrimination, sexual harassment, and assault at rates that are exponentially higher than that of our male peers.¹ In many cases the offending individual is a supervisor or unit leader who committed the violation(s), leading to a mistrust for those in positions of authority.

In addition to harassment and discrimination based on our gender, we are often made to feel as though reporting our wounds and injuries will make us seem inferior to our male counter parts. We unnecessarily push ourselves beyond human physical capacity and often to the point of injury or permanent disability. The military perpetuates a 'culture of fitness' that unduly impacts women who serve. Com-

¹ Complete Results from Major Survey of U.S. Military Sexual Assault, Harassment Released, RAND Corporation. May 1, 2015. <https://www.rand.org/news/press/2015/05/01.html>.

pared to our civilian counterparts, women veterans experience higher rates of arthritis, cancer, cardiovascular disease, and functional impairment.²

Anecdotal evidence of this can be found in cases such as that in Naval Training Station Great Lakes where the second woman in eight weeks died after a physical fitness test in basic training on Saturday, April 27, 2019.³ I can personally attest to this culture of fitness and pushing beyond my personal limits as I treated my body as though I was invincible during service and now I live with the permanent disabilities as a result.

We carry these memories from our time in service of when we were harassed or made to feel less than worthy forward with us like battle scars into our civilian lives. When we separate from the military, we must decide, based on the severity of our treatment and the intensity of our needs after service, whether or not we will return, in any capacity, to a setting where affiliation with the military is the common thread among the community.

Like our male counterparts, we are proud of our service and what we have accomplished and, our stories are complicated. For many women, overcoming this barrier of re-entering military culture voluntarily in their life after service to use their VA care is too great, so they choose not to engage their care or benefits.

Despite the barriers, some women decide to engage and attempt to join the veteran community, either to find others with similar lived experiences or to gain access to their benefits through a Veteran Service Officer only to find themselves further harassed and discriminated against by other veterans. Traditional Veteran Service Organizations, those that were long seen as the leading experts on veteran advocacy, have held together some of the most toxic culture for women.

The Minority Veterans of America itself is an organizations whose roots are in the harassment I experienced at the American Legion.⁴ When I first shared my story publicly of the discrimination I endured and witnessed while serving as a Post Commander was met with hundreds of others who had similar stories to my own from their times trying to be a part of the American Legion of VFW. These spaces are often the places that veterans are expected to go to gain access to their compensation and benefits. This in itself can be an insurmountable barrier.

In addition to the hurdle of being forced to re-enter military culture in order to use the VA, the organization itself has a reputation in the community for being sub-par care that lacks a nuanced understanding of who we are. Whether that is true or not, perception to the user is reality if they have yet to walk through the door. If re-entering military culture alone does not prove to be a stopping point, the larger emergent narrative is that the VA does not care as it should for veterans. The stories that shake the public to the core of veterans who die by suicide in the parking lots and waiting rooms are too common for us to be assured that we will be treated with care.

Of the MVA members who are women identified individuals, 54% disclosed a story of harassment, discrimination, or feeling outside the military or veteran community on their application for membership. 14% indicated that they had been raped or sexually assaulted while serving in the military. These numbers may seem small in comparison to expectation but, these responses came solely from the prompt, "Tell us your story."

Systems that Perpetuate Invisibility and a Toxic Culture:

In addition to the issues of toxic culture, from the highest levels of the Department of Veterans Affairs, systems have been built that hold together and perpetuate the problem. In some cases, these systems are constructed through mere happenstance. In others these are constructed through willfully declination to change or adapt to the changing needs and demographics of the community.

On plaques at VA facilities across the country are the words of Abraham Lincoln, "To care for him who shall have borne the battle and for his widow, and his orphan." These words serve as the motto and mission of the organization. At the time that President Lincoln delivered this address, women were serving as nurses, spies, and some, even, as soldiers in the field. When these words were adopted as the VA's motto, in 1959, thousands of women were on their way to Vietnam as part of the Army's Nurse Corps.

²Data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), and the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health (NSDUH).

³"Navy recruit is second woman to die at Illinois boot camp in 2 months". CBS News, Apr. 27, 2019. <https://www.cbsnews.com/news/kelsey-nobles-navy-recruit-alabama-collapses-dies-boot-camp-navy-recruit-training-center-great-lakes-illinois/>

⁴Commander quits Seattle veterans group over harassment, racism. NPR. Mar. 9, 2018.

Despite the fact that they would not be given legal recognition as veterans until 1980, women have always been among the ranks of those who have served. The plaques inscribed with Lincoln's words are physical representations of the deep and lasting history of invisibility for women in the military and veteran community.

This invisibility is interwoven into the memories of our service and becomes the narrative of our experiences as veterans. Where our male counterparts are thanked for their service, women have to fight for adequate representation, especially for those of us with multiple minority identities. Women have to fight to be seen. Women have to fight against the conflicting and confusing memories we have of their service.

The outcomes that women veterans are experiencing today - rise in suicide rates and mental health crises, homelessness, health disparities - are challenges that show the results of our inequitable access to care. To change these outcomes, we must look to the root of the problem and not just triage the results. The roots in this instance are the systems that exist that continue to render our service and voices, as women veterans of all types, invisible.

Looking at one of these systems as an example is the advisory committees to the Department of Veterans Affairs. Of the 26 Advisory Committees to the VA⁵ with committee chair information available online, only six were chaired exclusively by women identified individuals. Of those six, only three had served in the U.S. military. Of those three women, one was a Woman of Color, and none were gender-diverse.

The lack of ability for women veterans to form any type of majority without the assistance of our male counterparts, reinforces the belief and understanding that we do not have the opportunity to make decisions about our own healthcare.

No matter the composition of these advisory committees, the power structures in place still ensure that an overwhelming majority of the decision-makers and advisors to those who lead the Department itself, are men.

When structures are built in a way that men must give us the ability to self-govern our own health outcomes, the power dynamic begins with an imbalance.

Without the voices of women veterans in these positions of authority, there is no assurance that that we are heard, considered fully, and that our ideas are acted upon in the same ways as our male counterparts. Instead, this structure assures women veterans are beholden to a system that lacks the insight of our lived experiences as those that are currently being underserved.

Chairwoman Brownley, Ranking Member Dunn, distinguished members of the Committee, as a representative of Minority Veterans of America, I provide the following recommendations to address the growing and complex needs of the woman veteran community:

1. Contract with an outside agency with experience working with and including women veterans to conduct a cultural assessment of the Department of Veterans Affairs and its facilities as it relates to gender identity.

- Assess internal staff culture, core values of the organization, strategic plan and initiatives, and leadership structures.
- Assess external culture and what the experience of women veterans is while navigating the VA system. Examine behaviors and mannerisms that are considered acceptable within the VA for patrons and staff.

2. Create community standards for conduct at Department of Veterans Affairs' facilities for patrons and staff.

- Eliminate harassment culture and implement and publicize department-wide anti-harassment campaign.
- Make reporting easier and accountability more transparent in instances where harassment has occurred.

3. Create a streamlined process between the Department of Defense and Department of Veterans Affairs so that VA coverage is opt-out rather than opt-in.

- Assign each woman veteran a primary care doctor in their nearest Women's Clinic.
- Invest further in the tele-mental health system and prioritize finding providers who specialize in women military and veteran communities.
- This increases access for all veterans to ensure they do not feel bad for seeking care and treatment.

⁵ There are currently 27 standing advisory committees to the Department of Veterans Affairs. 26 had current information about their members available online.

- The time a veteran is likely to use their VA healthcare is a point of crisis. That's too late if the veteran is going to navigate getting benefits.
- 4. Invest in expanded research around intersectionality as it pertains to women veterans and systemic barriers impacting minority women veterans from accessing healthcare.
- Minority women such as women veterans of color, lesbian and bisexual women (especially those that served during and prior to Don't Ask, Don't Tell), transgender women veterans, and (non)religious minority women veterans.
- 5. Open the VA's motto to public comment to consider change.
- Either maintain gender neutrality or revisit the motto and mission with representation from all communities to ensure input.

Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the Committee, thank you for the opportunity to testify today on behalf of Minority Veterans of America about the cultural barriers impacting women veterans' access to healthcare. For additional information regarding this testimony, please contact Lindsay Church, Chief Executive Officer of Minority Veterans of America at lchurch@minorityvets.org.

Prepared Statement of Ginger Miller

Chairwoman Brownley and members of the Subcommittee, as the President and CEO of the national nonprofit organization, Women Veterans Interactive, I am grateful to present my testimony regarding the Culture Barriers Impacting Women Veterans Access to Healthcare.

To understand the cultural barriers impacting women veterans' access to healthcare, one must first understand the climate in which we exist.

THE WOMAN VETERAN COMMUNITY CLIMATE (A HOSTILE TAKEOVER)

Women veterans are trying to stay afloat in a culture that has been male-dominated for centuries, and now we are competing to stay relevant in a culture that insists we downgrade our service to run parallel with that of a commitment made by a military spouse to her husband. Women veterans are uniquely different from military spouses, and it's time that this country stops lumping us together, not to mention being overshadowed by the caregivers.

Women veterans are existing in a climate where we have become good for business but not good enough to do business with and even more unfortunate, women veterans are living in a culture where our voices are only heard in a celebratory fashion when we achieve something great or when we hit rock bottom and become good for press.

I'm here to testify this morning in an effort to change to the climate and culture that has become the norm for women veterans. Our noble service to this country is worth more than a story, our sacrifice as women veterans are worth much more than a tick mark on outdated, one-sided surveys conducted by male-dominated VSO's who may happen to have a few women veterans on staff.

Women veterans are more than objects, and we don't need another survey; we need action. We don't need another national portrait campaign; we need a national outreach and engagement. Women veterans don't need another male-dominated VSO to represent us at the table, we need to have a seat at the table, and if we can't have a seat at the table, we will continue to build our own.

For women veterans, the environment in which we are expected to thrive in after serving in the military has become hostile and at times volatile to say the least because our voices are not being appropriately heard and we do not have accurate representation at every level of government.

Women veteran nonprofit organizations are grossly overlooked and underfunded if funded at all, our volunteers are overworked, and for some, the outlook is bleak, and yet we continue to hold out and hope against hope. Hope for inclusion to have a seat at the table where our voices will be heard and hope for much-needed funding to deliver proper services to the population we serve.

WHY WOMEN VETERANS INTERACTIVE EXISTS

I started Women Veterans Interactive because I became homeless after faithfully serving in the United States Navy. During my time as a homeless woman veteran

in the early '90s, I was also the caregiver to my husband who suffered from severe Post Traumatic Stress Disorder and mother to our son who was a toddler at the time. Instead of being a victim, I became a victor by working three jobs and going to school full time to pull my family and me out of the deadly jaws of homelessness.

After that horrific experience, I dedicated my life worked to support veterans, and in 2009 I formed the nonprofit organization John 14:2, Inc. In 2011, I formed Women Veterans Interactive as a division of John 14:2, Inc. Due to the growth of WVI, in 2018 we applied to IRS to become a standalone 501 c3 nonprofit organization and was approved in 15 days.

Women Veterans Interactive (WVI) is a solutions-driven nonprofit organization focused on outreach and engagement. WVI delivers a positive impact in the lives of women veterans through a holistic, proactive approach that is grassroots in nature.

Mission Statement

The mission of WVI is to meet women veterans at their points of need through Advocacy, Empowerment, Interaction, Outreach, and Unification to break down the barriers that lead to homelessness. WVI addresses the unique, and often unrecognized, challenges facing our nation's 2.3 million women veterans as they return to civilian life. With members nationwide, WVI provides outreach & support services to thousands of women veterans through the three pillars of transition, empowerment, leadership, and diversity. WVI offers tailored programs, training and resources to equip women veterans at all stages of their military transition.

Since its inception, WVI has supported over 3,500 women veterans through strategic outreach, signature events, and programs. The WVI network has grown to more than 50,000 women veterans and continues to grow every day.

The growth of Women Veterans Interactive is directly related to the need of women veterans to be connected to and supported by an organization that is "For Women Veterans by Women Veterans." We do not have a magic solution, a secret sauce, or a long drawn out dissertation but we do have a proven method that is directly related to our grassroots effort approach in engaging and empowering women veterans.

WOMEN VETERANS INTERACTIVE AND THE U.S. DEPARTMENT OF VETERANS AFFAIRS

Having an intimate understanding of the importance of women veterans being connecting to healthcare, since 2012, WVI has invited the U.S. Department of Veterans Affairs Center into our fold to collaborate with us on all our outreach efforts.

The Department of Veterans Affairs has attended and participated in every Women Veterans Interactive annual conference since 2012. Participation included keynote speeches, leadership panels and facilitation of workshops.

Most recently during WVI's 2018 and 2017 annual Women Veterans Leadership and Diversity Conference both of which had over 200 attendees, we held a veteran's benefits claims clinics in collaboration with the Veterans Benefits Administration (VBA). Each year approximately 125 to 150 veterans were able to receive onsite benefits claims assistance.

The feedback from the benefits claims clinics have been remarkable with some women veterans stating that this is the first time the VA has treated them like their service matters and other women veterans said they have a brighter outlook on going to the VA Medical Center to receiving health care from the VA Medical Center.

Additionally, in 2017, WVI partnered with the Center for Minority Veterans to conduct a virtual town hall that had 300 veteran attendees.

In 2106, WVI created the State of Women Veterans Campaign social media campaign and reached out to the Department of Veterans Affairs and formed a collaboration that to reach over 500,000 veterans. The goal of the campaign was to raise awareness of women Veterans' military and societal contributions and provide an avenue for informing women Veterans about the VA benefits they have earned. The campaign was successful and surpassed the goal of reaching 500,000 veterans.

Every Women Veterans Interactive, Department of Veterans Affairs collaboration a woman veteran encounters help to change the image of the VA in a positive matter.

So, I pose the questions, why is more not being done by the Department of Veterans to collaborate with women veteran nonprofit organizations like Women Veterans Interactive and why are women veteran's organization not invited to Department of Veterans Affairs VSO meetings, especially when it comes to discussing issues and solutions surrounding women veterans.

CHANGE THE CLIMATE TO CHANGE THE ACCESS

A significant barrier impacting women veterans' access to health care lies within a system at the Department of Veterans Affairs dominated by a climate that is neither inviting nor inclusive for women veterans. It's time to build a culture that is inclusive for women veterans rather than a culture that treats women veterans as an object of affection because it's the right thing to do.

One cannot expect a population to engage in healthcare services they are not aware of, cannot access due to personal hardships, or do not feel safe accessing because most of the services are located within a male-dominated environment.

I humbly ask this Subcommittee to work with Women Veterans Interactive to change the climate that has been set before the women who have so bravely served and sacrificed for our country.

We can change the climate by establishing legislation that will

- Allocate funding for collaborative women veteran direct outreach and engagement
- Require the Department of Veterans Affairs to focus on consistent strategic outreach and engagement strategies in collaboration with qualified women veteran nonprofit organizations
- Require the Secretary of Veterans Affairs to have semi-annual meetings with women veteran nonprofit organization.

On behalf of Women Veterans Interactive, our members and the population we serve, I am appreciative for the opportunity to share our views on the Culture Barriers Impacting Women Veterans Access to Health Care.

Prepared Statement of BriGette McCoy

The Organization

Thank you for inviting our voices and insight. For over a decade, Women Veteran Social Justice network (WVSJ), has been heralded as a safe space to land for women seeking information resources and wanting to stay informed about military sexual trauma, PTSD, domestic violence, suicide prevention, housing, peer support and events in their local and national neighborhood. We also have become known for training other non profit leaders, supporting the launch of critical programs and services and bringing communities of women veteran and military women of diverse backgrounds together online and in person through our integrated network.

WVSJ Network's digital media component manages an interconnected network of over 12,500 community connections online with a collaborative network of 50 other networks of support for the veteran population at large. Since 2008, WVSJ has been a primary source and stakeholder to national women military and veteran; outreach, research, educational and institutional programs, political policy and community-based program support. This work includes partnering with educational institutions to bring veteran and civilian communities to network, published articles within the clinical professional community, national non-profits for Art and Music organizations, been a stakeholder in Emmy Award-winning documentaries and non-profit narrative digital storytelling to bring the military and war times experiences to the public.

WVSJ advocates collection of the first person narrative for military service members working with the organizations *Unsung Heroes*, *Warrior Songs* and the National Association of Black Military Women to collect the narratives. WVSJ is instrumental in leading discussions in the community to allow a holistic compassionate and honorable way for the service members to tell their story.

Our collaborations with other community organizations allow instructional and creative work to include musical and digital art to help strengthen veteran community connections.

WVSJ community participated in musical and creative art events; 2010- 2012 Creative art in Kentucky, 2014-2015- JDTR Conference Plenary Workshop Presentations on women veteran and military sexual trauma research and government policies, Bowling Green University Fall 2013 Bowling Green, facilitate the collection of the narrative of members to educate community leaders on nuance of best practices to support. WVSJ Ambassadors have participated in the education journal writing and publishing articles in *Combat Stress E-magazine* in Spring 2014, Fall 2018 and *Warrior Songs* award-winning songwriting and music CD production of the narratives of women of all eras who have served.

For the past three years, WVSJ has participated in the Women Veterans Health Fair at Emory University, allowing the first person narratives to bring awareness and sensitivity to the medical and mental health needs of women veteran to future clinical staff.

Our founder has consulted with and been in support of graduate and doctoral student researchers across the country by insight and expertise contributions to advancing peer-reviewed research since 2012. Through our programs, national partnerships and collaborative projects, we have reached tens of thousands of women veterans, their family members and community leaders.

The Founder

BriGette McCoy is a nationally recognized keynote speaker, veteran advocate, conference facilitator, and veteran community leader. Her veteran experience has been requested by multiple media networks including CNN, MSNBC, NPR and the Today Show.

In 2011 Ms. McCoy and five other women veterans, were interviewed for the Emmy Award Winning Documentary Service: When Women Come Marching Home, about women veterans and their civilian transition. Disabled Veterans of America supported the National Distribution.

In 2013, McCoy provided Congressional testimony on her personal and professional experiences with military sexual assault, and on suicide prevention and awareness as a member of the on the Surgeon General's 2012 Suicide Prevention Taskforce.

A Gulf War era veteran who served in the US Army from 1987–1991, McCoy held a Top Secret Clearance as a data telecommunications computer operator. She is service-connected and compensated for Post-Traumatic Stress Disorder (PTSD) from Military Sexual Trauma (MST) and Neurological injuries. McCoy is one of many women veterans who have experienced difficulties reintegrating to civilian infrastructures, to include chronic homelessness with dependent children, challenges maintaining a career with multiple disabilities, and the impact of multiple sexual traumas in the military. Despite these barriers, she leads and volunteers in multiple areas collaborating with various community organizations who are engaged with veteran outreach.

Ms. McCoy embraces building community relationships inter-generationally amongst veterans while encouraging participation in quality life activities, some of which include: retreats for art and recreation within local and national communities, seeking medical care utilizing the VA as part of holistic modality for medical and psychological care, and training or education to increase availability for socio-economic growth and development.

McCoy's educational background includes a Bachelors of Science in Psychology, Masters of Theology and course completion in Education Technology and Media Design.

Her work is about connecting of communities, organizations and multidisciplinary fields of study and resources influencing technological changes of resource delivery to veterans.

Personal Testimony

To the House Committee and Committee Chair: thank you for inviting my organization and the inclusion of my testimony on issues concerning women veterans, specifically the cultural issues impacting women veterans.

I am an ally, a Military Sexual Trauma (MST) survivor and advocate. My service and contributions are as important as my male veteran counterparts. Women Veteran serve, yet our visibility and opportunities have unseen barriers to accessing many of the programs that the civilian sector believes are available to all who have served.

It is vitally important to hold in high regard and utilize the narratives of veteran women like me, of all eras, service periods and service backgrounds as primary sources to inform research, curriculum and policies concerning women veterans. The cultural issues impacting women veterans are vast. There are too many to note fully in this setting and give the full historical context, legislative background and the full unintended consequences and implications of each. I do believe that the historical context of women not being formally included in the military structure until the 1940's is a topic for inclusion in this hearing.

Women veterans were not legislated to use the VA for gender specific medical care until the early 1990's. Only in recent years have Women specific health care spaces been constructed in VA facilities.

In my work over the past 10 years and my personal experience interacting within the government and community for support a major factor that repeatedly and consistently challenged me, has been the language which is used to describe and talk about me as a woman veteran.

Within the context of being a woman veteran, I have heard terms like, “low hanging fruit”, “female”, “victim”, and references by men about how easy it is for women to get disability benefits. I assure you - THAT is categorically untrue. These “othering” terms have an unintended consequence for our country and the communities that serve women veterans.

How we speak about women veterans can be part of a deeper problem of what we believe and have been socialized to believe about women in general. This is a root cause factor that drives the cultural divisions and creates a barrier for meaningful, well funded support for the women veteran community at large.

The language used to speak about, research, legislate, create and institute programs for our women veteran community, continues to be a major limiting factor toward addressing issues and needs.

Why are organizational leaders calling us female after military service? There are no Female veteran organizations. Where is the national female veterans of america organization? Even in 1948 when then President Truman signed the Armed Services Integration Act, Female was not used in the title, but the word Women. I know there will be some that say that doesn't matter.

I will argue that using biological terms is dehumanizing; that what you name or call something, or the language you use to speak about a person does have impact positively or negatively. We can trace the language in the policies and legislation and funding and see that funding drives programs and service. Second, women veterans currently have very narrowly defined, language specific access to some of the most well funded and highly engaged programs. Most are intentionally excluding a huge proportion of women, and the funding legislated for their programs is language specific to eras, combat and to gender. It is emotionally draining as an advocate to send women to organizations that have veteran programs to have them told they don't meet the guidelines for the program. Further, the brochures are male centered and the veteran service and community organizations and their organizing documents do not include women who have served or they are told to go to auxiliary membership or put together with spouses, which is a completely different population.

Third, VA medical treatment visits poses issues when the organizing documents and placards have male centered quotes and presentations. The space was not created with women in mind.

There have been upgrades and changes in support of women using the facilities yet women are still being catcalled and harrassed going to a mental health or medical appointments - and when they can get them.(see the illustration below re:harassment).

It is never clear what the outcome will be for a woman who reports harassment, or for the patient or employee that harasses. My personal experiences of being harassed within the VA and the discussions with other women about the need to change their appearance, come at certain times of day, switch to other hospitals (where the harassment is less pronounced) or stop going to the VA at all is another area for discussion.

Next, women veteran professionals are not always treated with the same professional respect as our male counterparts. Many times rank, era and service time are used to limit access to programs for professional advancement. When Program managers ask me to send them people to fill their programs but won't make exception for a woman veteran of any era because their funding stipulates a specific era.

I recognize brands and businesses have certain markets. However, if your market is veterans - that is who I am. We are the only segment that is singled out.

Women Veterans are being leveraged and discarded based on the visibility and funding gained by our presence. There are quite a few veteran women who have needed to remove themselves from the non profit community because the environment is extremely toxic and their self care became more important than the presented image of working for the organization.

Last, we are veterans first and foremost. When we served the only time we were called “female” was when we were being seperated from our teams by our gender. Needless to say, it was not in many cases, a positive reason it was being used.

I also wish to focus on our women Reservists, and National Guard members.

The language of their service has been a factor that excludes them from much needed programs and services. With the most recent changes to service availability for these uniformed personnel it is vitally important that language includes our

women serving in these capacities. I have many other areas of concern but time is a limiting factor so I chose to highlight these areas specifically.

Recommendations for us to move forward toward positive changes are as follows:

My recommendations

- Create equity with women veteran subject matter experts as the co-leads and leads in future events including queries, discussions, panels part of best practices policy and procedures.
- Create space where veteran women thought leaders and innovators have a primary voice in their care and treatment.
- Research of impact of including narrative works, and veteran and survivor subject matter experts in the planning of programs and services for veteran women and survivors.
- Increase access to funding for women veteran led programs with cultural competence and history of serving women veterans with 3 or more years.
- Include leaders and organizations with proven results and outcomes directly benefiting women veterans of all eras and service times for legislative and policy input.
- Create Veteran Affairs medical and claims spaces no tolerance no access for veteran who harass other veterans during times veterans who are seeking medical treatment or utilizing the VA any VA programs
- Use Ally centered* language, program descriptions, and educate leaders to present and legislate from that position. *This includes disability, gender identification, race etc.

(photos upon request)

J.Payton, B.McCoy 2018 “Current Challenges and Future Directions Supporting Veteran After Military Sexual Trauma.”

Ambassador Contributions

(Board Member Sr Ambassador Connie Baptiste)

National Guard And Reserve

- Women Veterans Access to VA facilities - National Guard and Reserve Units in rural areas have to travel sometime over an hour to access a VA
- Women Veterans are younger they are only doing one term and getting out with disabilities.
- Child care and access to it during appointments
- Mental health support in rural areas
- VA education being provided to the location
- State vs VA health care for veterans who don't meet the VA's definition to receive support.
- Spousal programs of support for the caregivers
- Access to care and support for children born to women veterans with disabilities
- The new policy, Deploy or Get out, military members non-deployable for more than 12 months will be administratively discharged, more disabled veterans
- Statistics show that veterans move back to their home area, many from rural areas
- Underemployment/unemployment high for deployed Guard and Reservist.

Current Guard Posture Statement

Army 343,000 Soldiers,
8 division headquarters,
27 brigade combat teams,
96 multifunctional brigades, 8 combat aviation brigades and 2 Special Forces groups Provides the Army 39% of its operational forces Operates and manages nearly 42% of the Army's manned and unmanned aircraft. Air Guard 105,700 Airmen, 90 wings,

1,111 aircraft Flies 44% of Air Force's KC-135 air refueling missions Flies nearly 30% of the Air Force's strategic and tactical airlift (C-130s / C-17s) missions Flies 30% of the fighter / attack (A-10s, F-15s, F-16s, F-22s) missions Provides 42% of the Air Force's Prime BEEF and 53% of the deployable RED HORSE civil engineer units.

Deployments

Since 9/11, the National Guard has supported more than 850,000 overseas deployments.

More than 2,800 Guard Airmen from 48 units served in nine different locations while filling 46% of the total force's civil engineer needs overseas last year.

The Air Guard is providing 23% of the total force's Remotely Piloted Aircraft capability and 25% of the total force's Distributed Common Ground System (a system that produces military intelligence for multiple military branches) capacity in direct support of combatant commanders' intelligence, surveillance and reconnaissance requirements.

Guard Soldiers and Airmen have served on every continent and in every Combatant Command in more than 70 countries around the world

Army Reserves

Since Sept. 11, 2001, more than 300,000 Army Reserve soldiers have mobilized, some serving multiple tours, seamlessly integrating into the active Army and the Joint Force.

Suicide Rate among Guard and Reserve

In 2013, the suicide rate among reservists was 23.4 per 100,000. In 2013, the suicide rate among National Guardsmen, 28.9 per 100,000.

History Makers

The New Hampshire Army Guard's 2nd Lt. Katrina Simpson made history when she became the first woman officer in the National Guard to graduate from the U.S. Army infantry officer basic course. (The Army National Guard Warrior)

<https://www.nationalguard.mil/Portals/31/Documents/PostureStatements/2018-National-Guard-Bureau-Posture-Statement.pdf>

<https://giveanhour.org/wp-content/uploads/RCP-Fact-Sheet-March-2017.pdf>

<https://www.militarytimes.com/news/your-military/2018/02/14/dod-releases-new-deploy-or-get-out-policy/>

Prepared Statement of Lory Manning

Chairwoman Brownley, Ranking Member Dunn and Distinguished Members of the Subcommittee:

On behalf of the Servicewomen's Action Network (SWAN), I thank you for the opportunity to share our views and recommendations regarding the cultural barriers to women veterans' access to healthcare at the Department of Veterans Affairs.

In the past years, VA has made hard-won improvements in the quality and comprehensiveness of women's care, but all that improvement is for naught if women encounter barriers when trying to use this healthcare. I'll discuss two of these barriers today: 1.) sexual harassment and 2.) the invisibility of women veterans.

Sexual Harassment at VA Facilities. Over the years, we at SWAN have heard many complaints about groups of male veterans getting together to harass women veterans on VA grounds including at the Washington, DC VA hospital. An academic study and a newspaper article both published this year elucidate the problem. The first, done by Ruth Klap, Ph.D. and others, called "Prevalence of Stranger Harassment of Women Veterans at Veterans Affairs Medical Centers and Impacts of Delayed and Missed Care," appears in *Women's Health Issues*, published by the Jacobs Institute of Women's Health. ([http://whijournal.com/article/S1049-3867\(18\)30194-4/fulltext](http://whijournal.com/article/S1049-3867(18)30194-4/fulltext).) The second, by reporter Jennifer Steinhauer, was in the March 12th edition of the *New York Times* and headlined "Treated Like a 'Piece of Meat': Female Veterans Endure Harassment at the VA".

The Klap study sampled women veterans who used 12 different VA hospitals and found one in four of those sampled reported receiving catcalls, derogatory comments, propositions, and denigrations of the women's veteran status from male veterans on the hospital grounds. The *New York Times* article recounts how an "entrenched, sexist culture at many veterans' hospitals is driving away female veterans."

SWAN believes that what women veterans want, and warrant, is for VA leaders at all levels, with oversight from Congress, to stop the harassment now and to foster a VA culture in which women veterans are treated with the same respect, appreciation and dignity as male veterans.

Invisibility: Women veterans report to SWAN that they feel invisible to the office staffs of VA facilities and to the American public. And they are; it begins with the VA motto "To care for him who has borne the battle, his widow and his orphan". SWAN, while appreciating Lincoln's historic words, is among those veterans' organizations which support changing that motto.

According to DVA's February 2017 Report "The Past, Present and Future of Women Veterans," only 22.4% of all women veterans use VA healthcare making them a mere 7.5% of total VA healthcare users. Women veterans are irked when they are asked for their husbands' social security numbers at the check-in desk or are refused free coffee provided at some VA facilities with the admonition that the coffee is only for veterans. These slights seem minor, but they can accrete over time leaving women veterans frustrated and disheartened.

Their invisibility becomes more damaging when the gender-specific needs of women veterans are ignored, as happens, for example, when they are sometimes issued prosthetic devices designed for men; this should never happen.

And major damage can be done, if women veterans are invisible to those, at any level, making tough decisions on healthcare resources if the decision makers either don't understand the need for women's programs or conclude that reallocation from these programs helps many while hurting only a few.

SWAN believes leadership at all levels must take great care when initially allocating or later reprogramming resources to or from women's healthcare programs that they have a clear understanding of the effects their actions can have on these programs. SWAN, additionally, entreats Congress to exercise its oversight responsibilities to ensure the needs of women veterans and other special focus populations are not unduly sacrificed when such actions are necessary at the national level.

Madam Chairwoman let me say how deeply I appreciate the opportunity to offer SWAN's views on these critically important matters. Thank you for your time and attention.

Prepared Statement of Dr. Patricia Hayes

Good Morning Madam Chair, Ranking Member Dunn, and distinguished Members of the Committee. I appreciate the opportunity to discuss the high-quality care and support VA is providing to our women Veterans and the cultural barriers impacting women Veterans' access to VA health care.

Overview

The number of women Veterans enrolling in VA health care is increasing, placing new demands on VA's health care system. Women make up 16.2 percent of today's Active Duty military forces and 19 percent of National Guard and Reserves. Based on the upward trend of women in all service branches, the expected number of women Veterans using VA health care will rise rapidly, and the complexity of injuries of returning troops is also likely to increase. More women are choosing VA for their health care than ever before, with women accounting for over 30 percent of the increase in Veterans served over the past 5 years. The number of women Veterans using VHA services has tripled since 2001, growing from 159,810 to 500,000 today. To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and access for women Veterans.

Access to Care

Every VHA health care system across the United States now has a full-time Women Veteran's Program Manager tasked with advocating for the health care needs of women Veterans using that facility. Mini-residencies in women's health with didactic and practicum components have been disseminated system-wide to enhance clinician proficiency; since 2008, over 5,800 health care providers have been trained in this national program. Under a new collaboration with the Office of Rural Health, a pathway for accelerating access to women's health training for rural primary care providers has been established. Meanwhile, VHA is actively recruiting additional providers with experience in women's health care. Numerous initiatives have been launched to improve access to state-of-the-art reproductive health services, mental health services, and emergency services for women Veterans, and others have focused on enhancing care coordination through technological innovations such as registries and mobile applications.

VA has enhanced the provision of care to women Veterans by focusing on the goal of developing Women's Health Primary Care Providers (WH-PCP) at every site of VA care. VA has at least two WH-PCP's at each VA Medical Center and 90 percent of community-based outpatient clinics (CBOC) have a WH-PCP in place. We are in the process of training additional providers to ensure that every woman Veteran has an opportunity to receive her primary care from a WH-PCP. VA has implemented women's health care delivery models of care that ensure women receive equitable, timely, high-quality primary health care from a single primary care provider and

team, thereby decreasing fragmentation and improving quality of care for women Veterans.

VA is proud of high-quality health care for women Veterans. We are on the forefront of information technology (IT) for women's health. Because quality measures show that women Veterans using VA health care are more likely to receive breast cancer and cervical cancer screening than women in private sector health care, VA is redesigning the electronic medical record to track breast and reproductive health care. Unlike other health care ¹systems², VA analyzes quality performance measures by gender. This has been key in the reduction and elimination of gender disparities in important aspects of health screening, prevention, and chronic disease management.³

Scope of Services

VA provides full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services.

Comprehensive Primary Care

To provide the highest quality of care to women Veterans, VA offers women Veterans assignments to trained and experienced designated WH-PCPs. The providers can furnish general primary care and gender-specific primary care in the context of a longitudinal patient/provider relationship. National VA satisfaction and quality data indicate that women who are assigned to WH-PCPs have higher satisfaction and higher quality of gender-specific care than those assigned to other providers. Importantly, we also find that women assigned to WH-PCPs are twice as likely to choose to stay in VA care over time.⁴

Gynecology Care

VA offers many gynecologic services, including complex gynecology care such as gynecologic surgery and treatment of gynecologic cancers. Women Veterans have access to gynecology care as a basic component of high-quality care. One hundred and thirty-three sites have a gynecologist on site. For those facilities where VA does not have a gynecologist on site, Veterans receive services through care in the community. VA is unable to recruit gynecologists at some sites because there is no Surgery Service at those facilities and gynecology is a surgical specialty. In 2017, VA held its first-ever national VA gynecology conference: VA Gynecology Health System - Optimizing Access and Facilitating Best Practices Training. The mission of this conference was to optimize access to gynecologic services for women Veterans. A second gynecology conference is planned for June 2019, focusing on specific gynecologic surgery skills.

Maternity Care

Maternity benefits for enrolled women have been included in the VA medical benefits package since 1996. In general, these benefits begin with the confirmation of pregnancy. VA medical facilities do not provide on-site obstetric care to pregnant Veterans. However, female Veterans receiving their care through VA have their pregnancies confirmed at a VA medical facility and receive further maternity care through community (non-VA) health care providers. Some Veterans will continue to receive other health care services, such as mental health services, during their pregnancies through the VA health care system.

Once a pregnancy is confirmed, the VA Maternity Care Coordinator (MCC) educates the Veteran on maternity benefits and the process for maternity care throughout the pregnancy. MCCs help Veterans navigate and coordinate care between VA and maternity care providers in the community and are available to answer questions and remain in communication throughout the pregnancy. Because of high rates of mental health conditions in women Veterans using VA health care⁵, it is

¹Centers for Disease Control and Prevention (CDC). 2018. "Breast Cancer Statistics." <http://www.cdc.gov/cancer/breast/statistics/index.htm>

²2017 VHA Support Service Center National Performance Measure Report

³<https://www.womenshealth.va.gov/WOMENSHEALTH/docs/WVHC—GenderDisparities—Rpt—061212—FINAL.pdf#>

⁴Bastian L, Trentalange M, Murphy TE, et al. Association between women Veterans' experiences with VA outpatient health care and designation as a women's health provider in primary care clinics. *Womens Health Issues*. 2014;24:605–612.

⁵Katon JG, Zephyrin L, Meoli A, Hulugalle A, Bosch J, Callegari L, Galvan IV, Gray KE, Haeger KO, Hoffmire C, Levis S, Ma EW, McCabe JE, Nillni YI, Pineles SL, Reddy SM, Savitz DA, Shaw JG, Patton EW. Reproductive Health of Women Veterans: Systematic Review of the Literature from 2008 to 2017. *Semin Reprod Med*. 2018 Nov;36(6):315–322. doi: 10.1055/s-0039-1678750. Epub 2019 Apr 19.

essential that they are supported by MCCs during pregnancy, and women Veterans are encouraged to return to VA primary care women's health after their delivery.

VA offers newborn care for up to 7 days after the birth of a child. Newborn care includes, but is not limited to, inpatient care, outpatient care, medications, immunizations, circumcision, well-baby office visits, neonatal intensive care, and other appropriate post-delivery services.

Infertility and Adoption Reimbursement Services

VA provides infertility services, other than in vitro fertilization (IVF), to all enrolled Veterans. Veterans receiving care through VA are offered infertility evaluation and treatment, regardless of service connection, sexual orientation, gender identity, gender expression, or relationship or marital status. This includes diagnostic testing and many infertility treatments, with the exception of IVF.

Congress has authorized VA to furnish fertility counseling and treatment, including IVF, for married Veterans with a service-connected disability that results in infertility and their spouses. The Veteran must be legally married and meet the eligibility requirements of a service-connected condition that results in infertility. Eligible Veteran couples can receive a total of three IVF cycles and cryopreservation storage of their own gametes and embryos without time limits. Donor eggs, sperm, embryos and surrogacy are not covered benefits. Treatment with IVF is provided by specialists in the community, with care coordinated among relevant VA providers and the VA facility's Women Veterans' Program Manager.

VA has implemented regulations to provide reimbursement of qualifying adoption expenses incurred by Veterans with a service-connected disability that results in the inability to procreate without the use of fertility treatment. Covered Veterans may request this \$2,000 reimbursement for qualifying adoption expenses incurred for adoptions finalized after September 29, 2016.

Mental Health Services

VA has witnessed a 154 percent increase over the past decade in the number of women Veterans accessing VA mental health care. Over 40 percent of women Veterans who use VA have been diagnosed with at least one mental illness, and many struggle with multiple, clinically complex conditions, such as trauma, mood, and eating disorders⁶. VA's mental health programming for women Veterans is guided by the principles of gender-sensitive care and recognizes the importance of offering choice, flexibility, and options for care. To ensure that VA mental health providers have the skills and expertise to meet women Veterans' unique and diverse treatment needs and preferences, VA's Office of Mental Health and Suicide Prevention (OMHSP) has developed innovative clinical trainings and initiatives to strengthen mental health services for the growing population of women Veterans. These initiatives expand the portfolio of treatment options available to women Veterans and complement the strong cadre of evidence-based practices available to all Veterans.

Here are some examples:

- In 2016, OMHSP conducted the first VA Women's Mental Health Mini-Residency. During this intensive 3-day training, national experts led sessions on gender-tailored psychotherapies and psychiatric medication management, with a focus on the influence of hormonal changes and the reproductive cycle. Participants serve as local Women's Mental Health Champions and, as part of the training, developed Action Plans to disseminate women's mental health practices at their facilities. The facility Women's Mental Health Champions are now an important component of the Women's Mental Health infrastructure. In 2018, VA partnered with the Department of Defense (DoD) to conduct a joint Women's Mental Health Mini-Residency. VA now conducts a yearly Women's Mental Health Mini-Residency and partners with DoD every even year.
- OMHSP developed clinical training programs in STAIR (Skills Training in Affective and Interpersonal Regulation) and Parenting STAIR. STAIR and Parenting STAIR are cognitive-behavioral trauma treatments that focus on strengthening emotional regulation and building healthy relationships, including parenting relationships. These are important areas of functioning that can be highly disrupted in women with histories of serious interpersonal traumas, such as sexual assault. Research suggests that emotion dysregulation is associated with suicidal ideation. Parenting STAIR training teaches therapists to deliver a component of the STAIR treatment that is designed to help Veterans

⁶Greenberg, Greg; and Hoff, Rani. FY2018 Mental Health Data Sheet: National, VISN, and VAMC Tables - All Veterans. West Haven, CT: Northeast Program Evaluation Center. Annual (2010–Present).

who have persistent trauma-related reactions that negatively impact their parenting and parent-child relationships.

- To address an identified need for eating disorder treatment options, OMHSP partnered with Women's Health Services (WHS) to develop a cutting-edge multidisciplinary eating disorder treatment team training, aligned with the Joint Commission's rigorous standards for outpatient eating disorder care. Coordinated, specialized clinical care is needed to effectively treat serious eating disorders, which are associated with increased risk for suicide attempts and death by suicide.
- OMHSP developed a monthly training series to enhance knowledge of gender-tailored prescribing practices. Effective treatment of reproductive-linked mental health conditions (e.g., premenstrual dysphoric disorder [PMDD], perinatal depression and anxiety disorders, and perimenopausal depression) could reduce suicide risk for affected women Veterans. Treatment of mental health conditions during specific reproductive cycle stages differs in some respects from treating those conditions during non-reproductive parts of the life-cycle. For example, some, but not all antidepressants have efficacy for PMDD. Taking antidepressants during only the luteal phase of the menstrual cycle can be effective for PMDD.

Military Sexual Trauma

Unfortunately, some women experience sexual assault or harassment during their military service and may struggle even years later with its after-effects. VA's services for military sexual trauma (MST) can be critical resources to help them in their recovery journey. Services for any mental and physical health conditions related to MST are available for free at every VA medical center (VAMC) and eligibility is expansive: Veterans do not need to have reported their experiences at the time or have any documentation that they occurred and may be able to receive free MST-related care even if they are not eligible for other VA care. VHA has a number of initiatives to help ensure that targeted, specialized services are available, and that Veterans are aware of these services. Since Fiscal Year (FY) 2007, these efforts have resulted in a 297 percent increase in the number of women Veterans receiving MST-related outpatient care, indicating the positive impact of these efforts. Some key initiatives include maintaining a full continuum of outpatient, inpatient, and residential mental health services.

As part of the universal screening program, all Veterans seen for VA health care are asked whether they experienced MST, so that they can be connected with MST-related services as appropriate, and every VA health care system has a designated MST Coordinator who can help Veterans access MST-related services and programs.

VHA also has a range of initiatives to promote continued expansion of its MST-related programming and promote provider expertise. These include bimonthly training calls for staff, an annual conference on treatment program development, online courses, a community of practice Intranet Web site, and a national MST Consultation Program available to any VA staff member with a question related to assisting Veterans who experienced MST. These are important efforts; however, outreach and engagement efforts must remain an ongoing area of emphasis to ensure Veterans have access to the care they need.

Child Care

VA is aware of the challenges faced by Veterans with children in terms of accessing medical appointments and other medical care, counseling, and caregiving services. Women Veterans currently are and will continue to be an important part of the Veteran community and an important part of VA. The total number of women Veteran patients age 18–44 increased from 81,832 in FY 2000 to 187,137 in FY 2015, a 2.3-fold increase. From the 2015 Study of Barriers to Care for Women Veterans, when queried about the possibility of on-site child care, three out of five women (62 percent overall) indicated that they would find on-site child care very helpful, but in general this was not a significant factor in whether they choose to use VA care.

Section 205 of Public Law 111–163, Caregivers and Veterans Omnibus Health Services Act of 2010, as amended (38 United States Code § 1710 note), authorizes VA to provide child-care services through a pilot program. VA is authorized to continue this pilot program through FY 2020. Since 2011, VA has been providing child care services through the pilot program offered at Buffalo, New York, Veterans Integrated Service Network (VISN) 2; Northport, New York, VISN 3; American Lake-Puget Sound (American Lake), Washington, VISN 20; and Dallas, Texas, VISN 17.

While mothers were the largest users of drop-in child care services at 47 percent; fathers used the service nearly as much at 44 percent; and grandparents used the

service at 9 percent. Utilization and costs vary at each of the sites, but Veteran satisfaction with the service remains consistent at all locations. VA has sought permanent but discretionary authority to provide child care assistance for the children of eligible Veterans while those Veterans are accessing health care services at facilities.

Women Veterans Call Center

In 2014, VA established a hotline specific for women Veterans. The Women Veterans Call Center (WVCC) makes outgoing calls to women Veterans to provide information about VA services and resources and responds to incoming calls from women Veterans, their families, and caregivers. WVCC implemented a chat feature in May 2016, to increase access for women Veterans and has responded to 1,979 chats. As of January 31, 2019, the WVCC has received 83,984 calls and has made 1,328,256 outgoing calls, with 672,815 of these calls being successful (spoke with the Veteran or left a voice message). We are very excited to announce that VA instituted text interaction for WVCC (1-855-829-6636) on April 23, 2019.

Expanding Mammograms

Mammograms for women Veterans are available on-site at 64 VHA health care sites where digital mammography is available. Because we want to ensure that Veterans are receiving the highest quality mammograms, when there are insufficient numbers of women to support such a program in-house, VA uses its community care authorities to provide mammograms in the community. VHA has also convened a task force of subject matter experts from women's health, oncology, radiology, surgery, and radiation oncology to develop guidance to standardize and enhance breast cancer care in VA facilities nationally. Despite these accomplishments, VHA agrees with a recent VA Office of Inspector General report that tracking the results of mammograms performed outside VA has been a challenge. In response, VA has established national guidelines for mammography and cervical cancer tracking. VA is funding positions for cervical cancer and breast cancer screening coordinators at 27 rural sites and has established education materials, toolkits, and a national community of practice for Mammogram Coordinators.

VA has been working to ensure that test results from studies done outside of VA are documented in the Computerized Patient Record System and that patients are notified of normal and abnormal mammography results within an appropriate timeframe. VA completed two IT projects that will revolutionize tracking and results reporting for breast cancer screening and follow-up care: The Breast Care Registry and the System for Mammography Results Reporting. These systems are designed to work together to identify, document, and track all breast cancer screening and diagnostic imaging (normal or abnormal), order results, notify patients, and follow-up to ensure that all women Veterans receive high-quality, timely breast care, whether treatment is provided within or outside of VA.

Quality Care

VA is proud of its high-quality health care for women Veterans. Beginning in FY 2008, VHA launched a concerted Women's Health improvement effort focusing providers' attention on gender-disparity data. From 2008 to 2011, VA saw a significant reduction in gender disparity for many measures, including hypertension, diabetes, pneumococcal vaccine, and influenza prevention⁷. Improvements were also made in screening measures for colorectal cancer, depression, posttraumatic stress disorder, and alcohol misuse. In FY 2011, VA included Gender Disparity Improvement as a performance measure in the VISN Director Performance Plans, which concentrated management attention on systems to continuously reduce gender disparity. WHS has continued to publish reports on these efforts; the FY 2017 report⁸ illustrates that VA has made continued progress in closing the gap in gender disparities. At the close of FY 2017, small gender gaps existed in only a few measures including cholesterol management in high-risk patients, diabetes care, and rates of influenza vaccination.

Since 2014, VA has tracked access by gender and identified small but persistent disparities in access for women Veterans, who overall are waiting longer for appointments than male Veterans. To mitigate this disparity VA has identified sites with the longest wait times for women Veterans and is working with those sites di-

⁷ <https://www.womenshealth.va.gov/WOMENSHEALTH/docs/WVHC—GenderDisparities—Rpt—061212—FINAL.pdf#>

⁸ Improving trends in gender disparities in the Department of Veterans Affairs: 2008–2013. Whitehead AM, Czarnogorski M, Wright SM, Hayes PM, Haskell SG. *Am J Public Health*. 2014 Sep;104 Suppl 4:S529–31. doi: 10.2105/AJPH.2014.302141.

rectly on initiatives to improve access, including designating more women's health providers through hiring or training and improved provider and team efficiency.

VA has conducted site visits at all health care systems to assess the quality of the women's health program. After completing a national review in 2017, VA developed an Evidence-Based Quality Improvement (EBQI) Process to assist sites with women's health quality improvement projects. VA has completed EBQI initiatives at 14 sites and will complete 7 additional site projects in 2019.

Barriers to Care

Although VA continues to successfully expand its female-centric health care coverage, it has encountered several challenges in meeting the demand of the increasing women Veteran population. Although VA has made it a priority to provide top-notch training to providers and other clinical staff, VA is unable to keep up with the demand to have trained providers to care for women Veterans. Provider turnover continues to be an issue, and a national shortage of primary care providers results in recruitment challenges.

In 2018, VHA Leadership directed that Privacy and Dignity Standards for Women Veterans be extended to all Veterans. A Workgroup on Privacy and Environment of Care worked to define all terms and standards for privacy and environment of care. The definitions were incorporated in the Appendix C (Veterans Health Environmental Privacy and Security) of VHA Directive 1330.01(2), Health Care Services for Women Veterans, and was published on July 24, 2018. In addition, VA's Office of Construction and Facility Management (CFM) identified appropriate updates for Design Standards and released a Design Alert to the field in October 2018, which effectively updated the 2010 CFM design standards to extend to all Veterans.

New Initiatives/Outreach

Office of Rural Health (ORH) Training Initiative

WHS has partnered with ORH to develop and implement a training program to specifically meet the needs of rural primary care providers and nurses at rural CBOCs and VAMCs. This mini-residency for rural providers and nurses launched in June 2018 and is on track to visit up to 35 rural clinical sites during its first program year and up to 40 sites per year thereafter, supporting the highest level of care for women Veterans in rural areas.

Telehealth Services for Women

WHS understands it may be difficult to always make an appointment in person and is collaborating with the Office of Connected Care and ORH to ensure that primary and specialty care is delivered via telehealth to women Veterans both in rural areas of the country and in other geographical areas where there is a shortage of providers. The nationwide initiative, Virtual Integrated Multisite Patient Aligned Care Team (V-IMPACT), implements virtual women's health PACT teams in their primary care hub sites for the provision of gap coverage in VA facilities with a shortage of women's health providers. In addition, WHS has worked with ORH to ensure the inclusion of Women's Health Clinical Pharmacy Specialists (CPS) in their recent initiative to expand the availability of CPS via telehealth to rural VA facilities. Finally, WHS is actively working to promote the use of VA Video Connect among women's health providers to improve access to primary care.

Transition Assistance Pilot Program

The Women's Health Transition Assistance Training Pilot Program (WH TAP Pilot) is a collaboration between the Air Force Women's Health Initiative Team (AFWHIT) and the VHA's Office of Women's Health Services conducted under the auspices of the VA/DoD Health Executive Committee, Clinical Care and Operations Business Line, Women's Health Workgroup (HEC CCO BL WHWG). The aim of this initiative is to increase transitioning Servicewomen's knowledge about the VHA health care system, the VHA enrollment process, and eligibility and specific services and resources available for separating Servicewomen. The ultimate goal of the WH TAP Pilot Program is to increase timely enrollment and utilization of VA health care services among eligible women after they separate from the military, and to "provide a female perspective" and connect Servicewomen to relevant care services available through VHA.

Musculoskeletal Training

VA tracks the prevalence of medical conditions among women Veterans and has noted that musculoskeletal conditions such as back pain and joint pain are the most common conditions in women Veterans, often resulting in poor quality-of-life and

chronic pain. To address this problem, VA has developed a Musculoskeletal Training Program to train providers in the physical examination and diagnosis of musculoskeletal conditions common in women Veterans. This training has been conducted at seven VA sites and will be conducted at the national simulation center in 2019. An additional collaborative provider musculoskeletal training with DoD was piloted in 2018 and will be repeated in Dayton, Ohio in 2019.

Conclusion

VA continues to make significant strides in enhancing the language, practice, and culture of the Department to be more inclusive of women Veterans. These gains would not have been possible without consistent Congressional commitment in the form of both attention and financial resources. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing high-quality care for our Veterans and their families. Madam Chair, this concludes my testimony. My colleague and I are prepared to respond to any questions you may have.

STATEMENTS FOR THE RECORD

Women Who Serve

Diana D. Danis, Lead Administrator Service

Bio: Diana D. Danis is a lifelong advocate and activist on behalf of women and veterans. Her world-view focuses on changing cultural paradigms that relegate women to a second-class status and affect their full and equal participation in society.

She deeply understands that use of language, definitions, access, communication and inclusion in research determines how effectively women receive treatment in health care systems. Danis currently serves as a Senior Advisor to Women Veterans Social Justice and is a lead administrator for the social media platform of Service: Women Who Serve as well as the women Military and Veteran advisor to People Demanding Action and ERA Action.

For 16 years, she and her husband were Caregivers for six family members, gaining unique insight into insurance, medication, hospital, rehabilitation, nursing home and hospice systems. Her body of work includes contributions to the first comprehensive women veterans' health programs legislation for the Department of Veterans Affairs while Executive Director of the National Women Veterans Conference (NWVC), the first social justice women veteran organization in the country. She contributed to development of the first McKinney-Vinto Homeless Veterans Act as well as the Reasonable Accommodations in the workforce section of the Americans with Disabilities Act (ADA).

Danis was the first military woman radio network news broadcaster on the American Forces Network (AFNE) while serving in the Army. During her service in Europe, she was one of a handful of women in the International Women's Coalition for Change that created the first Women and Families Support Centers for the US Army in Europe to address domestic violence.

She formerly served on the President's Committee for Employment of People with Disabilities, was a member of the Colorado Coalition for the Homeless Board of Directors and the Veterans Program Director for the International Association for Personnel in Employment Security while serving as a training development instructor and Course Manager at the National Veterans Training Institute (NVTI). Danis developed and presented the first Diversity Training Certificate Course at the University of Colorado at Denver and is a co-developing specialized segments of Crisis Intervention Training (CIT) emphasizing Unique Populations.

Danis serves on the Advisory Committee for the Military Women's Coalition founded in 2018 and consulted to Diloitte on the anticipated needs and issues of women who serve for the next decade.

She regularly speaks on grassroots organizing for individuals and small organizations, addressing sexual assault in the military and VA, disability concerns, women's status in society and diversity issues.

Thank you Chairwoman Brownley and Ranking member Dunn a for the opportunity to submit this statement to the House committee on Veterans Affairs regarding Cultural Issues Confronting Women Veterans.

In the 1980's when I first came to the House and Senate Veterans Affairs Committees about the status of women veterans, I truly believed Congress was going to do what was necessary to right a plethora of wrongs.

Senator Inoye launched a GAO inquiry in 1981 to find out what was going on to insure women veterans had equal access to medical care and benefits. An earnest effort ensued, 13 facilities visited, calls to 32 others, interviews with VA Central Office and Veteran Service organizations. They decided the VA had made progress but because we were only 2.5% (742,000) they really hadn't focused on our needs. Mind you that's half of the number we are today, but the vet population was massive back then and even though Congress was packed with veterans, there were no women veterans and we were not even an afterthought.

Here's what they decided:

- we should have access to treatment programs and facilities.
- we should be able to get complete physical exams
- that gyn and other gender specific care should be provided
- that plans should be made for inevitable increases in our population
- And that every effort should be made to identify us and inform us of our benefits.

That 29 page report came out in 1982.

I went to the Denver VA ER in 1985 and was told they didn't treat women. After that I met a bunch of people in Congress and spent years working on changing the system, working on legislation, creating a national organization - trying to make all those changes happen.

In 1991, another GAO report requested to see what had happened since 1982 because now there were women and men in Congress asking a lot of questions and furiously working on legislation and of course the testimony around Tailhook was hammering Armed Services and Veterans Affairs in both the House and Senate and none of it was pleasant.

The gist of the 1992 publication was as expected:

- The VA had made significant progress toward providing health care to women vets. They said equal to men. I was there, not so much, though better - at least they were treating us.
- The VA Advisory Committee on Women Veterans was created and Women Veteran Coordinators were assigned in each medical center. It was an additional duty, not a regular job, but it was progress.
- They found out that doing in house Mammography required following American College of Radiology Standards and they weren't doing enough of them to be on target or proficient. Sometimes wanting a service in-house has good intentions that aren't viable and still aren't in most locations today.
- Privacy issues continued to be a huge problem and weren't being corrected with renovations to add things like women's bathrooms - true story, few VA's had women bathrooms other than for staff and outside the cafeteria.
- And finally, the report said they couldn't find any programs that were unable to accommodate female patients. Had they talked to any of us using VA services, they just would have heard peals of laughter waving across the country.
- They would have heard the laughter immediately turn to anger as they revealed sexual harassment and sexual assault IN VA facilities.
- They would have heard about safety and security and the need to never go to appointments unaccompanied
- They would have heard about providers ignoring health complaints and being shined on as malingerers
- They would have heard about not knowing about programs being offered in the VA medical centers that women could also participate in

After years of work, the Women Veterans Health Programs Act of 1992 first authorized the VA to provide gender specific care to women veterans and established mental health care, regardless of disability status for those traumatized by sexual harassment, sexual assault and rape in the military. That public law 102-585 has been amended a lot in the last two and a half decades.

I testified next to the bill's sponsor Congresswoman Patricia Schroeder, (D) (CO) and have a signed copy of the bill in a box somewhere.

So here we are, 26 years later, walking the same path.

What are the Cultural Barriers Confronting Women Veterans?

Natural progression should have brought us further than continued sexual harassment in the VA and discomfort attending appointments for many, many women

veterans along with being referred to as men - when being called back to see a provider. At this point it is not just education but an ingrained sense of disdain for those women who serve. That requires a big rethink in how the VA educates and punishes personnel.

-I recommend legislation to deal with harassment and assault on VA campuses. Clearly expecting people to be respectful and not assault others is too big of an ask, so more severe implications are in order.

For example, a staff member calls a woman veteran back who has close-cropped hair and is dressed in sweats. The individual refers to her as "Mister" or makes some other snarky remark. It is unprofessional, unnecessary and harmful.

There continue to be deep concerns about the treatment of older women veterans and the in patient status of women veterans, especially those with mental health issues and dementia problems is growing.

My husband has been going with me to VA appointments for 23 years. He has been regularly asked which doctor he is waiting for, if he would like some coffee and thanked for his service hundreds of times. He is a civilian. They don't ask me.

We have seen the Women Veteran Coordinator positions morph into Women Veteran Program manager capacities in recent years. Unfortunately, in spite of many highly qualified women veterans applying for these positions, they tend to be used as internal promotional opportunities for civilian nursing staff rather than for external hiring of competent, highly trained women veterans seeking positions where they can best use their skill, knowledge and abilities to serve their sister veterans.

The Center for Women Veterans should be a fertile information, training and education ground for feeding the best and brightest nationally to the VA facilities across the country. A full scale Train the Trainer staff preparing Women Veteran Coordinators to review problematic Claims issues - like Sexual assault claims, development of complicated records construction for those who served in Iraq and Afghanistan whose field records are lost or incomplete, aiding in the training of Women Veteran Program Managers to do the best possible outreach and assistance for women veterans, especially for those in rural areas would bridge many of the the gaps we continue to see in addressing the needs of women veterans.

Cultural issues in this day and age include ethnic, religious and regional differences. The rules and regulations that come with implementation of the Mission Act June 6th are going to have an instant impact on those already jaundiced by years of constant upheaval experienced by those impacted by Choice. Rumors are already flying and the stress level of the third of veterans who reside in rural America - many of them women - are already over the top. Rural veterans tend to be isolated and deeply suspicious of the "next great idea" being sprung on them by government.

Many have had a lot of issues with getting providers paid that they were referred to by Choice - either TriWest or HealthNet. Now, they are going to have four new entities to deal with and the rumblings, especially for women who have to get their mammograms and a lot of specialty gender specific care in the community, are growing.

Every day those of us who deal with women veterans in crisis are faced with those afraid to go to an exam alone. Many do not have anyone to take them to appointments or go with them and be there to help them just be calm. Some are unsafe driving by themselves because they are stressed beyond measure by an upcoming Compensation & Pension exam (C & P).

A couple of examples of how outlandish some of these contracted situations have become:

One of our women vets was instructed to have her C & P for Military Sexual Trauma (MST) in a Chiropractic Office, another in a Nail Salon. I repeat, A NAIL SALON!

Service: Women Who Serve, the MST Committee of the Military Women's Coalition (MWC), the 2019 VA Trailblazers, and Women Veteran Social Justice (WVSJ) are all recommending hands-on peer support and assistance for women veterans who are attending VA appointments or C & P exams by themselves and would like someone to attend with them through the process.

Another issue is the manner in which women veteran claims for PTSD or other mental health issues derived from sexual assaults are adjudicated in favor of women veterans far less often than PTSD for combat veterans. Following GAO reports highlighting additional discrepancies due to poor Claims Adjudicator training, those denied were suppose to be informed and their claims revisited. To our knowledge, that has yet to occur.

At this point I am not even going to go into legal issues, veterans family court, transportation, bad VSOs, homelessness, childcare or decent paying jobs for women who already get paid far less than their male counterparts - especially women of

color. I do thank your contemporaries in the House Judiciary Committee for the hearing yesterday on extending the deadline for the Equal Rights Amendment - We would appreciate Constitutional equality.

The big last issue I will address is women veteran suicide. When you look at the myriad of barriers women veterans face and how overwhelming these issues can become, it is no wonder that the thing someone may see as not so big a deal, is the deal breaker for continuing to ride this rock around the sun. Over the years, I have brought only the most serious cases of bad treatment at the hands of the VA to members of this committee and the members have always come through and made a difference. Please know that in doing so, you save lives.

As disabled veteran I have used VA services for many years. The majority of the time accessing benefits is reasonable and getting health care is as well. I've had some poor treatment upon occasion, and make sure the appropriate parties are informed. As an advocate, it's easier for me, I know the system. We need to make access, continuity and consistency of care reality for ALL veterans. Thank you for your time.

Iraq and Afghanistan Veterans of America (IAVA)

Statement of Melissa Bryant Chief Policy Officer

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members worldwide, thank you for the opportunity to share our views, data, and experiences on the matter of cultural barriers impacting women veterans' access to health care.

Support and Recognition of Women Veterans is an incredibly important part of our work; it is why it is included in our Big Six Priorities for 2019 which are the Campaign to Combat Suicide, Defend Veterans Education Benefits, Support and Recognition of Women Veterans, Advocate for Government Reform, Support for Injuries from Burn Pits and Toxic Exposures, and Support for Veteran Medicinal Cannabis Use.

I am here today not only as IAVA's Chief Policy Officer, but also as a former Army Captain and a combat veteran of Operation Iraqi Freedom. I was a military intelligence officer who led women and men in combat; but some of my most salient memories are from my times leading troops in garrison, when far too often the true colors of soldiers you would normally trust in battle would surface. As one of the few, if not only, women (and especially women of color) officers in my units, I can point to many an occasion where I helped women soldiers who came to me for advice and counsel in dealing with harassment in the ranks.

Sadly, I can also point to my own dealings with harassment from my peers, superior officers, and even soldiers. It was a double burden I faced when the intersectionality of being a black woman officer would creep into misogynistic and prejudiced comments made toward me—perhaps simply because I was a confident leader with a no-nonsense approach to my work. Now as a veterans advocate, I still hear the misogyny in our community, from the time I'm asked, "who is your sponsor?" at Department of Veterans Affairs (VA) medical centers to when I'm referred to as, "young lady" by my own veteran colleagues. At best, it's a casual dismissal of my credentials and expertise to have earned a seat at the table; at worst, it means just what it sounds like—flagrant disregard for my service and ultimately an emotional barrier to care at VA.

Over the past few years, there has been a groundswell of support for women veterans' issues. From health care access to reproductive health services to a seismic culture change within the veteran community, women veterans have rightly been focused on and elevated on Capitol Hill, inside VA, and nationally. In 2017, IAVA launched our groundbreaking campaign, #SheWhoBorneTheBattle, focused on recognizing the service of women veterans, closing gaps in care provided to us by VA, and finally changing the outdated VA motto to represent ALL veterans.

IAVA made the bold choice to lead on an issue that was important to not just the 20% of our members who are women, but to our entire membership, the future of America's health care and national security. We continue to fight hard for top-down culture change in VA for the more than 345,000 women who have fought in our current wars.

The number of women in both the military and veteran communities has been growing steadily since the 1970s. While more women are joining the military and are finally given unprecedented roles in combat and greater responsibilities in lead-

ership, veteran services and benefits often lag behind. Since 2001, the number of women veterans seeking care at VA has tripled, but women veterans are also more likely to fall out of VA health care due to longer wait times and opportunity costs, a sign that a lack of gender specific services and ease of access is impacting care for women veterans at the VA.

Despite the ever-growing contribution of women to our national defense, the American public still does not understand the extent of our involvement and sacrifice. This lack of understanding not only impacts our reception when seeking health care from the VA, as I outlined in my own experience, but throughout our transition home. Often having faced an unwelcoming culture in the military, the VA can seem like an equally unwelcoming place to women who are transitioning. The VA motto does not help. It explicitly excludes women and our survivors from its mandate, and it reads as outdated: "To care for him who shall have borne the battle and for his widow, and his orphan."

Women veterans are becoming more prominent in American culture overall, and are stepping up and leading: From the growing number of women veterans serving in Congress, to the highest leadership positions among the service branches, veteran and military service organizations, and other leading groups. Also, as more women veterans step into the public sphere, our contributions and sacrifices are becoming known and recognized.

However, every day women veterans enter into VAs nationwide and are not recognized for our service. Every day, women veterans are looked past in favor of the familiar image of a man serving in uniform. Until women veterans are as known and understood as our male counterparts, IAVA's work will not be done.

For women veterans who choose to seek care at the VA, finding quality providers who understand the needs of women veterans can be difficult. While VA has made progress improving women-specific care for women veterans, including expanding the services and care available within the VA, there is still much progress needed. Women veterans are more likely than our male counterparts to seek care in the community, meaning we are often seen by private care providers that may or may not understand military service and its health impacts. IAVA's recent member survey underscores this, as we found that while 70% of respondents felt that VA clinicians understand the medical needs of veterans, only 44% felt that non-VA clinicians understood them.

Among IAVA's women veterans, those that self-reported their health as terrible were more likely to report negative VA experiences and those with self-reported excellent health were more likely to report positive experiences with VA health care. These results indicate that women with more health concerns have worse experiences at the VA, even though logically they would have larger health concerns than those who feel their health is excellent. Furthermore, IAVA women veterans aged 31 to 45 were less likely to report a positive experience with the VA than older women veterans aged 46 to 65. This indicates that the younger veterans of the post-9/11 generation are the ones struggling with VA care most - an ominous sign for the future of women's health care at the VA.

Additionally, women who do seek care at the VA report the quality and standard of care are not at all uniform. According to the most recent GAO report on the standards of care of VA medical centers, VA "does not have accurate and complete data on the extent to which its medical centers comply with environment of care standards for women veterans." The same report noted a deficiency of 675 women's health primary care providers as of 2016. This means that these facilities may not meet basic privacy standards like locked doors, privacy curtains, and other adjustments to make them feel welcome.

Changing this will require establishing clear standards, training VA staff to meet these standards, and investing in appropriate facilities, including women practitioners and doctors who specialize in women's health. Facilities and providers must regularly be evaluated to ensure they meet the standards our veterans deserve. The VA, with its partners, must do a better job of reaching out to women and telling them about the resources VA has to offer.

This is why in 2017, IAVA worked with Congressional allies on both sides of the aisle and in both chambers to introduce the Deborah Sampson Act. This bill called on the VA to modernize facilities to fit the needs of a changing veteran population, increasing newborn care, establishing new legal services for women veterans, and eliminating barriers faced by women who seek care at VA. This bill would also increase data tracking and reporting to ensure that women veterans are getting care on par with their male counterparts.

Although the Deborah Sampson Act, the centerpiece of IAVA's She Who Borne The Battle campaign, was not passed in the 115th Congress, IAVA is pleased with progress made overall, with key provisions of the legislation passed or funded in the

last two years. These hard-fought victories included funding to improve services for women veterans, such research on and acquisition of prosthetics for female veterans, increased funds for gender-specific health care, women veterans' expanded access and use of VA benefits and services, improved access for mental health services, and for supportive services for low income veterans and families to address homelessness.

Similar to another Deborah Sampson Act provision, the MISSION Act created a peer counseling program that provided for at least two peer specialists in patient aligned care teams at VA medical centers to promote the use and integration of services for mental health, substance use disorder, and behavioral health in a primary care setting. The law mandated that the needs of female veterans are specifically considered and addressed; and that female peer specialists are made available to female veterans who are treated at each location. Further, we are pleased that the SUPPORT for Patients and Communities Act included language that encouraged the hiring of female peer support counselors, directed VA to facilitate peer counseling for women veterans and to conduct outreach to inform female veterans about the program. We urge your Committee to ensure these provisions are carried out appropriately.

IAVA is also pleased that the Administration recently implemented another Deborah Sampson Act provision to expand the capabilities of the VA Women Veterans Call Center to include a text messaging capability. VA provided testimony in support of this provision during a 2017 hearing on the bill before the Senate Committee on Veterans Affairs, and we are encouraged that the Department heard our calls for reform. Women veterans can now text 855-829-6636 to receive answers and guidance about VA services.

Finally, IAVA is also particularly interested in seeing the results of the report sought under the FY 2019 Energy and Water, Legislative Branch, and Military Construction and Veterans Affairs Appropriations Act that requires the VA to submit a report to Congress on retrofitting its facilities to eliminate barriers to care for women veterans. That report was due in March 2019.

While we have seen greater awareness of and progress toward improving services for women veterans, there is much more we can do. Toward this goal, IAVA strongly supports passage of the updated Deborah Sampson Act (S. 514) recently reintroduced by Sens. Jon Tester and John Boozman. Provisions of the new bill include expanded peer to peer services, such as the ability for women to receive reintegration counseling services with family members in group retreat settings, increased newborn care services, and an increase in spending in order to retrofit VA facilities to enhance the privacy and environment women are being treated in, such as privacy curtains and door locks. It also provides for legal and support services to focus on unmet needs among women veterans, like prevention of eviction and foreclosure and child support issues. This must be the year that Congress passes the Deborah Sampson Act into law.

Beyond care, ensuring women veterans have proper access at the VA requires addressing the culture problem and harassment at its facilities. While not only impacting women veterans, harassment at the VA is a systemic issue that oftentimes happens between patients, in waiting rooms, and while veterans are checking in or leaving care—just as it remains a systemic problem in the military, as I have detailed in my own experiences. It is hard to quantify just how many women veterans face harassment in or around VA facilities, but according to the VA's most recent reporting, 25 percent of women veterans faced harassment from strangers in a VA facility such as lewd comments or catcalling. And for those women that do experience harassment at VA facilities, these women are more likely to delay or miss their health care appointments. Harassment has a very real effect on the physical and mental health of women veterans and VA must do more to address it.

The VA has implemented some programs to combat sexual harassment in its facilities but ensuring patients are aware of these programs before entering the Department's doors and empowering VA staff to intervene in harassment situations and understand reporting requirements must be a top priority. This can begin by ensuring that the VA's End Harassment Campaign is fully implemented and understood across every VA facility nationwide, a move that will set the overall tone for VA culture. This public outreach campaign is a starting point for what must be a continued and robust conversation around harassment at VA facilities.

Thank you for allowing IAVA to share our views. I look forward to working with the House Veterans' Affairs Subcommittee on Health and its dedicated Women's Task Force to better remedy the problems discussed in this testimony.

Biography of Melissa Bryant:

Melissa Bryant is the Chief Policy Officer for IAVA. She leads IAVA's policy division, overseeing the legislative, research, and intergovernmental affairs departments. Melissa spearheads the development of our annual policy agenda and advocacy campaigns in collaboration with IAVA leadership, and leads IAVA's engagement with the White House, government departments and agencies, particularly the Departments of Defense and Veterans Affairs, Veteran and Military Service Organizations, and advocacy organizations.

A former Army Captain and Operation Iraqi Freedom combat veteran, Melissa has an extensive record of public service, having served on both active duty and in the civil service as an intelligence officer prior to joining IAVA. A plans, policy, and operations expert with 15 combined years of experience in the federal government, she has served in key leadership positions with the Defense Intelligence Agency, the Joint Staff, the United States Military Academy, and Army Intelligence. She was successful in building "coalitions of the willing" to advance operational and strategic objectives while developing and implementing plans and policy for the defense and intelligence communities.

Melissa is an ROTC Distinguished Military Graduate and holds a Bachelor of Arts degree in Political Science cum laude from Hampton University, is an alumna of Howard University School of Law, and also holds a Master of Arts in Policy Management from Georgetown University.

Melissa is a spokesperson for IAVA, and has been featured several times on MSNBC with Andrea Mitchell, Katy Tur and others, HLN, in The Washington DC 100, and more.

PARALYZED VETERANS OF AMERICA (PVA)

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to draw attention to barriers women veterans, particularly those with catastrophic disabilities, encounter in accessing health care. VA has made tremendous progress in improving health care programs and services for all women veterans. But there is still work to be done, and VA must continue to evolve its facilities, programs, and services to ensure they can meet the health care needs of women veterans and keep up with the increasing demand for women veterans' health care services.

Ingress/Egress

It may come as a surprise to some, but the first hurdle that women veterans with catastrophic disabilities may encounter could be the entrance to the VA women's health clinic. Because many of these locations were established in haste, they did not receive the careful level of planning necessary to ensure wheelchair users could enter the facility. For example, the outside entrance to a women's health care clinic our staff recently visited did not have an automatic door for patients to use. To complicate matters further, the entrance was not visible to VA staff so they could not see if a patient outside needed assistance, nor was there an external bell for the patient to alert them if they needed assistance. Thus, any patient needing help entering the clinic would be exposed to the elements until someone came along to help her. VA must ensure that all women's health clinics are easily accessible for disabled women veterans.

Accessible Exam Rooms

Accessibility to doctors' offices is essential in providing medical care to people with severe or catastrophic disabilities, but this is often the next hurdle a woman veteran may encounter at VA. Some of VA's exam rooms are too small to accommodate a woman veteran in a wheelchair and a portable lift. Other rooms may not be big enough for a larger wheelchair to enter at all. A portable lift would be unnecessary if the examination rooms had built-in ceiling lifts to hoist a woman veteran from her wheelchair to the examination table, but many women's health clinics do not have an installed ceiling lift.

Barriers like these tend to make individuals with severe disabilities less likely to get their routine preventative medical care. It's a major concern because wheelchair users face the insidious health threat of remaining seated at all times. Loss of muscle tone and diminished circulation cause pressure sores to develop and it is very important that seemingly minor problems like these be detected and treated early before turning into major and possibly life-threatening problems. However, if the patient cannot enter the exam room or be placed upon the exam table, the physician

may be forced to examine the patient in her wheelchair leaving her at risk of further injury and diminishing the quality of the exam and any care provided.

Mammography Exams

Some VA medical centers do not have diagnostic equipment to provide mammograms. For the facilities that do, wait times are excessively long (two months or longer), or the equipment is inaccessible for women veterans in wheelchairs, particularly quadriplegics. While there are mammography machines that allow women with physical disabilities to lay on an exam table, not every VA health care facility has this type of equipment. We urge VA to ensure that women veterans have timely access to mammograms regardless of their disabilities.

Internal Communication Barriers

Some women PVA members have expressed the need for better lines of communication between their main VA health care providers and those from other service lines. For example, certain oral contraceptives can be dangerous to women with spinal cord injuries or disorders (SCI/D) because they can cause deep vein thrombosis (blood clots) in the legs. Without specialized training, the prescribing doctor may not understand that this side-effect poses a significantly greater risk to women with impaired mobility. Therefore, PVA recommends VA establish clinical guidelines for the treating physician to follow when prescribing contraceptives for women with limited mobility issues.

In Vitro Fertilization (IVF)

Last year, Congress passed legislation extending for two more years VA's ability to offer IVF services to veterans with service-connected disabilities that result in infertility. Although VA covers certain therapies for those with service-connected disabilities that result in infertility, there are gaps in this care that primarily affect female veterans. For instance, VA does not cover surrogacy or outside donors for IVF and offers virtually nothing for women who cannot conceive or carry a child due to their service. Likewise, there has been little research and attention given to female infertility and the impact of service on reproductive health from other military-related sources like toxic exposures from chemicals and burn pits. Permanently providing procreative services through VA would help ensure that greater numbers of women veterans are able to have a full quality of life that would otherwise be denied to them as a result of their military service. We strongly support H.R. 915, which would make IVF services a permanent part of the medical benefits package at VA and help female veterans with SCI/D overcome some of the unique challenges they face in establishing or growing their families.

Importance of Prosthetics for Women Veterans

Despite the increase in the number of women veterans, the availability of prosthetic devices that meet their needs versus those of their male counterparts has been lagging far behind. VA must ensure that prosthetists and administrators at every level understand women's prosthetic needs. This understanding is necessary to ensure the outcomes and satisfaction of women veterans is equal to men in using their prosthetic aids.

All VA facility leaders must be accountable for meeting women veterans' standard of care for quality, privacy, safety, and dignity. To advance the understanding and application of prostheses for women, VA must include academic affiliates, other federal agencies, and for-profit industry in their research. Meeting the prosthetic needs of women veterans can be an opportunity for VA to excel.

Peer-to-Peer Counselors for Women Veterans

PVA supported legislation in the 115th Congress directing the VA Secretary to employ a sufficient number of peer counselors to meet the needs of women veterans, particularly to address military sexual trauma, post-traumatic stress, and those at risk of homelessness. Women veterans who have been able to access peer-to-peer counseling or retreats provided through VA reported having a better understanding of how to develop support systems and access VA and community resources. Peer counseling programs have been a marked success for participants who show consistent reductions in stress symptoms and increased coping skills. Congress should actively work to promote peer-to-peer programs which time and time again have demonstrable success in helping veterans during their time of need.

PVA will be hosting a new peer-to-peer event this fall that celebrates the service of women veterans. Our "WE Served" event will be an all-expenses-paid retreat focusing on the holistic wellbeing of women veterans with disabilities. This immersive and outcomes-driven experience will empower 50 disabled women veterans to navi-

gate the unique challenges of their daily lives and help them flourish. Attendees will receive education and advice from a host of experts on whole health practices, independent living, financial security, nutrition, finding meaningful employment, accessing veterans benefits, and women's health issues. We hope that this event will be the first of many similar outreach efforts.

PVA appreciates this opportunity to express our views on the barriers our women veterans face in accessing health care. It is important to note that many of the barriers that catastrophically disabled women veterans face in the VA health care system are just as prevalent if not worse in the community. Thus, we look forward to working with the Subcommittee to eliminate these barriers and ensure full access to VA health care and services for all women veterans.

VETERANS OF FOREIGN WARS OF THE UNITED STATES (VFW)

KRISTINA KEENAN, PAST-COMMANDER POST 605 BENJAMIN FRANKLIN POST

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide recommendations on how to improve Department of Veterans Affairs (VA) health care services for women veterans.

VA reports that nearly 492,000 women veterans used the VA health care system in fiscal year 2017, which was a nearly 150 percent increase since fiscal year 2003, and these numbers will continue to increase in years to come. VA has worked to improve the gender-specific care for this population of veterans, but more work needs to be done. Women veterans using VA often have complex health care needs that require specialty care for service-connected conditions such as post-deployment readjustment challenges, post-traumatic stress disorder due to war-related trauma and sexual trauma, mental health care, and substance use disorders - services which, on average, they use at higher rates and more often than male veterans. The VFW is disappointed not a single piece of legislation became law in the 115th Congress to address the needs of women veterans. This must change in the 116th Congress.

Peer-to-peer support has proven time and again to be invaluable to veterans and VA. This is why the VFW advocates so strongly for the constant expansion of peer-to-peer support programs. The VFW urges Congress to pass legislation to expand these programs for women veterans, providing them more peer and gender-based one-on-one assistance from those to whom they can relate and connect. This is extremely crucial in instances when a woman suffers from a mental health condition, but especially in instances when she is on the verge of homelessness. In a VFW survey of women veterans, 38 percent of women who reported experiencing homelessness also have children. These women face unique barriers to overcoming homelessness, and frequently commented on the lack of support from anyone who could understand those barriers. By providing peer-to-peer support for women with those who have gone through the same hardships, VA would provide a level of understanding and trust they desperately need. This is why the VFW urges Congress to pass H.R. 840, the Veterans Access to Child Care Act, which would provide access to child care for veterans seeking employment training who have an income at or below their states' poverty lines. This would serve as a way to reduce homelessness among women veterans.

According to VA, the majority of women veterans are assigned to Designated Women's Health Primary Care Providers (DWHP). VA and its Center for Women Veterans have worked to increase those numbers, and the VFW asks Congress to provide VA with the resources they need to continue expanding outreach for knowledge of and access to providers with necessary gender-specific specializations. Surveys conducted by the VFW have found women veterans overwhelmingly prefer to receive their health care from female primary care providers, and are more likely to be satisfied with their VA health care experience when they receive care from these providers. That is why the VFW has urged VA to allow women veterans to choose the gender of their providers when enrolling in health care.

While the DWHP program continues expanding and providing above-satisfactory care to patients, the VFW understands there is still a need for trained gynecologists within VA. Gynecology is a specialty that has traditionally been understaffed at VA medical facilities across the country. While some providers are able to perform certain gynecological procedures, it is important to increase the number of doctors trained in the specialization of gynecology.

For women veterans who rely on VA for postnatal care, the VFW urges Congress to extend the number of days newborn care is covered by VA. Currently, VA only covers newborn care for seven days. One week is not enough to provide coverage for critical care that may be necessary in the first weeks of a child's life—especially in the relatively common instance of false-positive newborn disease testing—nor is it enough to ease the new mother of unnecessary stress.

The VFW urges Congress to pass S. 514, the Deborah Sampson Act, which would expand newborn coverage for veterans who use VA while receiving maternity care. In addition to expanding this care, the legislation would provide many other improvements to women veterans' needs within VA. Some of these improvements include analysis of staffing needs, the establishment of a women veteran training module for non-VA health care providers, expansion of legal services for women veterans, and information to be added to the VA website relating to women veteran programs.

The VFW applauds VA and Congress for their work to provide more access to gender-specific health care providers for women veterans. While overall progress has been made, gender-specific mental health care is still lacking. In VFW surveys, women veterans have voiced concerns over what they view as a lack of gender-specific training for mental health care providers. Congress and VA must work to ensure every VA medical center has mental health care providers who are well trained in conditions such as postpartum depression and conditions that stem from menopause or sexual trauma.

Women service members and veterans have also been found to have an increased risk for eating disorders, which have serious consequences for both physical and psychological health as well as high mortality rates. Some of the risk factors which contribute to women veterans struggling with eating disorders include military sexual trauma and combat exposure. As VA continues to meet the needs of women veterans, it is important that VA establishes a comprehensive program for the treatment of eating disorders.

The VFW has noticed a much lower utilization and awareness of benefits among older women veterans compared to their younger counterparts. In one of the VFW's surveys, we found older women veterans were less likely to report receiving disability compensation, but equally as likely to have been injured or made ill as a result of their military service. Similarly, older veterans were less likely to report that they use VA health care, but equally as likely to report being eligible for VA health care. We are also concerned that several respondents who reported being 55 years old or older believed that they did not rate the same benefits as their male counterparts, which is an egregious misperception that must be addressed.

No veteran should be left to wonder what, if any, benefits she is eligible to receive. Furthermore, it must be clear that women veterans have earned the exact same benefits as their male counterparts. That is why the VFW urges Congress and VA to continue improving outreach to women veterans and conduct targeted outreach to older women veterans to ensure they are aware of all the benefits and services VA provides.

The VA formulary currently carries all categories of pharmaceuticals deemed preventive by the U.S. Preventive Services Task Force. However, VA is not required to comply with the Affordable Care Act requirement for all private sector insurance providers to cover preventive care and services without cost-shares.

Cost is a significant barrier for lower income veterans who use VA health care. There are currently 11 categories of preventive medications found to be effective by the U.S. Preventive Services Task Force, such as prescribing aspirin to lower the risk of cardiovascular disease. Cardiovascular disease is the number one cause of death in the United States and is highly prevalent among the veteran population. Additionally, folic acid is recommended for pregnant women to prevent neural tube defects. It is unjust to require women veterans to pay for preventive medication to prevent such birth defects. Vitamin D is another preventive medicine which is often prescribed to prevent bone fractures, which benefits traumatic brain injury patients with hindbrain injuries. There is also breast cancer prevention medication which is useful not just for individuals with a family medical history of breast cancer, but for Camp Lejeune toxic water survivors who have been found to suffer from increased rates of breast cancer.

These pharmaceuticals have been found to prevent possible disease and have shown to be cost-saving. The VFW calls on Congress to swiftly pass legislation which would eliminate this inequity and ensure veterans have access to lifesaving preventive medicine.

VIETNAM VETERANS OF AMERICA (VVA)

Kate O'Hare Palmer

Chair, Women Veterans Committee

Good morning, Madam Chairwoman Brownley, Ranking Member Dunn and distinguished members of the Subcommittee on Health. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to submit our statement for the record regarding "Cultural Barriers Impacting Women Veterans' Access to Healthcare."

"By March 1973 and the withdrawal of US troops and the remaining WACs, an estimated four million people had died in the Vietnam War. For most returning veterans there was no welcome home. Being heckled and spat on at the airport was the beginning of their private aftermath. Women, especially, learned to keep silent about being in 'Nam. Many just tried to get on with life, careers and families, burying their inward and outwards scars, shame or pride, horror or honor, all mixed up with memories of friendships forged and loves found. Many have died without daring to reveal they served in Vietnam. All believe it changed their lives, for better or worse, but certainly forever."—The Women Who Served in Vietnam BBC 2016

Since 1982, Vietnam Veterans of America has been a leader in advocacy and championing appropriate and quality health care for all women veterans. The Department of Veterans Affairs (VA) has made many innovations, improvements and advancements over the past thirty years. However, some concerns remain respective of its policies, care, treatment, delivery mode, and monitoring of services to women veterans.

MEDICAL TREATMENT OF WOMEN VETERANS

VA-eligible women veterans are entitled to complete health care including care for gender-specific illnesses, injuries and diseases. The VA has become increasingly more sensitive and responsive to the needs of women veterans and many improvements have been made. Unfortunately, these changes and improvements have not been completely implemented throughout the entire system. In some locations, women veterans experience barriers to adequate health care, and oversight with accountability is lacking. Primary care is fragmented. What would be routine primary care in the community is referred out to specialty clinics in the VA. Over the last five years the percent of women veterans using the VA has grown from 11% to 17%, with 56% of OEF/OIF women Veterans having enrolled in the VA. Their average age of women veterans using the VA is 48; the age of a Vietnam woman veteran is 72.

VVA will continue its advocacy to secure appropriate facilities and resources for the diagnosis, care and treatment of women veterans at all VA hospitals, clinics, and Vet Centers. We ask the VA Secretary ensure senior leadership at all facilities and all regional directors be held accountable for ensuring women veterans receive appropriate care in an appropriate environment. Further, we seek that the Secretary ensure:

- The competency of staff who work with women in providing gender-specific health care;
- That VA provides reproductive health care;
- That appropriate training regarding issues pertinent to women veterans is provided;
- That an environment is created in which staff are sensitive to the needs of women veterans; that this environment meets the women's needs for privacy, safety, and emotional and physical comfort in all venues;
- Those privacy policy standards are met for all patients at all VHA locations and the security of all veterans is ensured;
- That the anticipated growth of the number of women veterans should be considered in all strategic plans, facility construction/utilization and human capital needs;
- That patient satisfaction assessments and all clinical performance measures and monitors that are not gender-specific be examined and reported by gender to detect differences in the quality of care;
- That general mental health care providers are located within the women's and primary care clinics to facilitate the delivery of mental health services;
- Ensure that sexual trauma care is readily available to all veterans;
- Provide support services for women veterans seeking legal assistance;
- Require VA to report on availability of prosthetics for women;
- That an evaluation of all gender-specific sexual trauma intensive treatment residential programs be made to determine if this level is adequate as related to level of need for each gender;

- That a plan is developed for the identification, development and dissemination of evidence-based treatments for PTSD and other co- occurring conditions attributed to combat exposure or sexual trauma;
- That women veterans, upon their request, have access to female mental health professionals, and if necessary, use VA outsource to meet their needs;
- That all Community-Based Outpatient Clinics (CBOCs) which do not provide gender-specific care arrange for such care through VA outsourcing or contract in compliance with established access standards;
- That evidence-based holistic programs for women's health, mental health, and rehabilitation are available to ensure the full continuum of care;
- That the Women's Health Service aggressively seek to determine root causes for any differences in quality measures and report these to the Under Secretary for Health, Assistant Secretary for Operations and Management, the VISN directors, regional directors, facility directors, and providers;
- That legislation be enacted to ensure neonatal care is provided for up to 30 days as needed for the newborns of women veterans receiving maternity/delivery care through the VA;
- That H.R. 840, the Veterans Access to Child Care Act, introduced by Congresswoman Brownley, is enacted into law.

HOMELESS WOMEN VETERANS

Over the past several decades, we have become increasingly more vested in the recognition of the situation of homelessness among veterans. VVA well remembers the time when the VA acknowledged that as many as 275,000 veterans were homeless on any given night. Currently the VA cites that the number of homeless veterans has been reduced to 37,878 as reported by the most recent Point in Time count. VVA recognizes this as a useful tool but doubts that this number is necessarily a solid number. It is a snapshot: it is impossible to have on record all veterans who are homeless. Nonetheless, it is a true indicator that all the energy surrounding the above-mentioned programs has made a difference. It is undeniable that the number of homeless women veterans has been climbing; however, collection data on homeless women veterans is not reliable as indicated in the Government Accountability Office's (GAO) 2011 report, "Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing." The report also cited some significant barriers to access of housing for homeless women vets:

- They are not aware of the opportunities available to them;
- They don't know how or where to obtain housing services;
- They are not easily found/identified in the community;
- They often "couch surf";
- They have children and avoid shelters because of the safety factor;
- They avoid social service agencies for fear of losing their children to the system;
- Some 24 percent of VA Medical Center homeless coordinators indicated they have no referral plans or processes in place for temporarily housing homeless women while they await placement in HUD-VASH and GPD programs;
- Nearly two-thirds of VA HGPS programs are not capable of housing women with children;
- The expense of housing women with children is a disincentive for providers.

VVA believes that the VA's "plan" to end homelessness among veterans is quite ambiguous, and that it needs to address several key questions: Are women veterans and their needs truly being met by the programs that exist for them today? What will be done to reach them, to know them, to meet their needs and provide them a safe environment in which to address these needs? VVA believes that a coordinated plan needs to be developed at the local level by the leadership of the respective VA medical center within its homeless veterans program. The influx of women in the military - one of every ten soldiers serving in Iraq is a woman - the female homeless population will only grow, making the need for additional facilities dedicated to women.

WOMEN VETERANS RESEARCH

Because women veterans have historically been a small percentage of the veteran population, many issues specific to them have not been researched. General studies of veterans often had insufficient numbers of women veterans to detect differences between male and female veterans and/or results were not reported by gender. Today, however, women are projected to be more than 12% of the veteran population by 2020 and 15% by 2025.

Vietnam Veterans of America asks the Secretary to conduct several studies specific to women and that Congress pass legislation to mandate such studies if the Secretary does not act:

- A comprehensive assessment of the barriers to and root causes of disparities in the provision of comprehensive medical and mental health care by VA for women;
- A comprehensive assessment of the capacity and ability of women veterans' health programs in VA, including Compensation and Pension examinations, to meet the needs of women;
- A comprehensive study of the relationship of toxic exposures during military training and service, and the infertility rates of veterans;
- A comprehensive evaluation of suicide among women veterans, including rates of both attempted and completed suicides, and risk factors, including co-morbid diagnoses, history of sexual trauma, unemployment, deployments, and homelessness;
- VA evaluation of the integration of services to support veterans.

CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS

VVA requests that any proposed legislation should include language to increase the time for neonatal care to 30 days, as needed for the newborn children of women veterans receiving maternity/delivery care through the VA. Certainly, only newborns with extreme medical conditions would require this time extension. VVA believes that there may be extraordinary circumstances wherein it would be detrimental to the proper care and treatment of the newborn if this provision of service was limited to less than 30 days. If the infant must have extended hospitalization, it would allow time for the case manager to make the necessary arrangements for necessary medical and social services assistance for the woman and her child. This has important implications for our rural women in particular. And there needs to be consideration given for a veteran's service-connected disabilities, including toxic exposures and mental health issues, especially during the pre-natal period, or in cases of multiple births or pre-mature births. Prenatal and neonatal birthrate demographics (including miscarriage and stillborn data) would seem to be an important element herein.

WOMEN VETERANS AND VETERANS BENEFITS

The Veterans Benefits Administration (VBA), and to a lesser extent, the National Cemetery Administration (NCA), have been less proactive than the Veterans Health Administration in targeting outreach to women veterans and in ensuring competency in managing claims filed by women veterans.

VVA asks the Secretary to ensure:

- That leadership in all VA Regional Offices is cognizant of and kept current on women veterans' issues; that they provide and conduct aggressive and pro-active outreach activities to women vets; and that VBA leadership ensures oversight of these activities;
- That a national structure be developed within VBA for the Women Veteran Coordinator (WVC) positions at each VARO;
- That VBA establish consistent standards for the time allocated to the position of WVC based on the number of women veterans in the VARO's catchment area;
- That VBA develop a clear definition to the job description of the WVC and implement it as a full-time position with defined performance measures;
- That VBA identify a subject matter expert on gender-specific claims as a resource person in each regional office location;
- That the WVC is utilized to identify training needs and coordinate workshops;
- That the WVC have a presence in the local VHA system;
- That VBA ensure that all Regional Offices display information on the services and assistance provided by the Women Veteran Coordinator with clear designation of her contact information and office location;
- That VBA establish a method to identify and track outcomes for all claims involving personal assault trauma, regardless of the resulting disability, such as PTSD, depression, or anxiety disorder;
- That VBA perform an analysis and publish the data on Military Sexual Trauma (MST) claims volume, the disparity in the claim ratings by gender, assess the consistency of how these claims are adjudicated, and determine if increased training and testing are needed;

- That all claims adjudicators who process claims for gender-specific conditions and claims involving personal assault trauma receive mandatory initial and regular on-going training necessary to be competent to evaluate such claims;
- That the VARO create an environment in which staff are sensitive to the needs of women veterans, and the environment meets women's needs for privacy, safety, and emotional and physical comfort;
- That the National Cemetery Administration enhances its targeted outreach efforts in those areas where burial benefits usage by women veterans does not reflect the women veterans' population. This may include collaboration with VBA and VHA in seeking means to proactively provide burial benefits information to women veterans, their spouses and children, and to funeral directors.

WOMEN VETERAN PROGRAM MANAGERS

Women Veteran advocates call for congressional oversight and accountability during this Congress. We are weary of hearing that the position of facility Women Veteran Program Managers would be full-time positions, while in reality, after all this time, this isn't necessarily true. As a system-wide directive, the VA 2017 Handbook 1330.01, Health Care Services for Women Veterans, defines the responsibilities of both the VISN and VAMC directors. Additionally, both WVPM positions are further defined in the VA 2018, Handbook 1330.02 Women Veteran Program Managers.

MILITARY SEXUAL TRAUMA (MST)

Currently, instances of sexual assault in the military must be reported through the chain of command. The creation of a separate and independent office to address such crimes would remove barriers to reporting and provide additional protection and safety for victims.

According to the DoD Sexual Assault Prevention and Response Office (SAPRO), 71% of survivors of MST are under 24 years old and of lower rank; whereas just under 60% of assailants are between 20 and 34 years old and of a higher rank. Military groups are extremely small communities and when reports of assault must proceed through the chain of command, it is impossible to guarantee that confidential information will stay with those who have a 'need-to-know'. Additionally, survivors may fear that their own actions may be cause for punishment. The threat of retaliation or fear of being reprimanded is enough to silence many survivors or have them recant their stories. A defined system of checks and balances is needed to level the playing field.

VVA is aware that this issue is outside the purview of the House Veterans' Affairs Committee. However, VVA would urge members who sit on the House Armed Services Committee to join your colleagues in pursuing legislation that reassigns MST complaints by service members and all alleged perpetrators outside of their immediate chain of command.

SUICIDE RISK

Suicide has become a major issue for the military over the last decade. Most research by the Pentagon and the Veterans Affairs Department has focused on men, who number more than 90% of the nation's 22 million former troops. Little has been known about female veteran suicide until recently. According to an LA Times article in July 2016, the suicide rates are highest among young female veterans—for women ages 18 to 29, veterans kill themselves at nearly 12 times the rate of non-veteran women. And, according to the Times, among the cohort of nearly 174,000 veteran suicides in 21 states between 2000 and 2010, the suicide rate of female vets closely approximates that of their male counterparts—women vets 28.7 per 100,000 vs 32.1 per 100,000 male vets.

VVA would like to thank Congresswoman Brownley for her hard work and dedication to women veterans, and we thank this Subcommittee for the opportunity to submit our views for the record.

IN CLOSING

More than 250,000 women served during the Vietnam era worldwide; eight women are listed on the Vietnam Veterans Memorial here in our nation's Capitol. The Angels on the Wall listed below served with honor and made the ultimate sacrifice. Please remember them and all the women who served during the Vietnam War.

- 1st Lt. Sharon Ann Lane
- 2nd Lt. Pamela Dorothy Donovan
- Col. Annie Ruth Graham
- Mary Therese Klinker

- 2nd Lt. Carol Ann Elizabeth Drazba
- 2nd Lt. Elizabeth Ann Jones
- Eleanor Grace Alexander
- 1st Lt. Hedwig Diane Orlowski

