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FULFILLING THE PROMISE TO WOMEN VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

APRIL 21, 2015

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FULFILLING THE PROMISE TO WOMEN VETERANS

TUESDAY, APRIL 21, 2015

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

The Committee met, pursuant to notice, at 2:32 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Heller, Rounds, Tillis, Sullivan, Blumenthal, Brown, Hirono, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. I call this meeting of the Veterans' Affairs Committee of the U.S. Senate to order. I am taking executive privilege to name the new Ranking Member Sherrod Brown from Ohio.

Senator BROWN. Permanently, I might add. [Laughter.]

Chairman ISAKSON. When Senator Blumenthal comes in, he will assume his appropriate place next to the new Ranking Member and we will go forward accordingly.

Seriously, your time is valuable and our time is valuable, so we want to get started. So, I will let Sherrod make an opening statement in just a second on behalf of the minority.

Let me say two things before I start. Last night, or early this morning, America lost a great veteran. Pete Wheeler, the Commissioner of Veterans Services in the State of Georgia for 61 years, appointed first in 1954, served under 11 Governors, has been given every award possible by a decorated veteran in the United States of America and has served for six decades, passed away in the Atlanta Veterans Hospital at Clairmont Road in Atlanta. I want to start this meeting by paying tribute to a personal friend of mine, a veteran for life, Pete Wheeler, the Commissioner of Veterans Affairs in Georgia, who passed away early this morning. I know that he will be remembered by all that he has helped and all that he has served for many, many years to come.

Second, I had a great privilege on Sunday. I gave the Congressional Gold Medal to a Tuskegee Airman, Amelia Robinson Jones, who in 1943, when there were no African Americans in the United States military in an integrated position, nor were there any women—African American women—she volunteered for the Army Air Corps and flew with the Tuskegee Airmen in World War II, which broke the glass ceiling for women, broke the glass ceiling for African Americans. She is 95 years old and I was able to give her

the award in a hospice facility where she is in Savannah, GA. I want to remember today Amelia Robinson Jones, a great United States veteran, a great lady, and one of the original Tuskegee Airmen. I want to throw both those two comments in.

I want to welcome everybody to our hearing today, which is about fulfilling our promise to America's women veterans. You know, up to 9.2 percent of our military is made up of women. Soon, it will be 15 percent of our active duty services are women and 18 percent of our Guard and Reserve are women, so it is growing. By the year 2020, 10.5 percent of our veterans will be women. By the year 2040, 16 percent will be women. There are 90,000 women veterans in the State of Georgia, the fifth largest women's population in the country.

One in five women veterans who use VA health services have experienced military sexual trauma (MST). Women veterans are also three times more likely to experience homelessness than non-veterans, and when a woman experiences homelessness, her children experience it with her. It is important that we do everything we can to meet and fulfill the promise to women.

In that weekend trip where I gave the Congressional Gold Medal and was able to visit the Savannah VA, I also saw firsthand what the VA is doing in its planning for women's services in their new community-based outpatient clinics (CBOCs). They are doing a good job of offering mental health services, gynecological services, OB/GYN services, and the services that are unique to women. We must ensure that our veterans of military service in America, when they leave the DOD and become active members of the veterans' society, they get the same services that a woman would expect in the private sector from the VA health services.

This is an important hearing. Women play an important role in our United States military in the defense of our country. They fight in every capacity possible, they volunteer in every capacity possible, and they do a great job. We need to make sure we are doing the same.

I see the Ranking Member is here. I took a little advantage of leadership and replaced you for a couple minutes so we could get started. Now it is my privilege to introduce our Ranking Member, Sen. Richard Blumenthal from Connecticut.

OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman, and I appreciate your leadership in calling this hearing which deals with perhaps one of the most critical and important issues facing this Committee, the Veterans Administration, and our Nation today.

Women are, in fact, one of the fastest growing segments of the overall veterans' population. By 2020, they are expected to grow to 11 percent of the total veterans' population. Yet, for too long, the VA has essentially ignored many of the most pressing needs that our women veterans face.

In Connecticut, for example, the facility serving women veterans has been in the basement of our West Haven VA Hospital. They have now upgraded that clinic, or at least are in the process of

doing so, and I want to make sure that those improvements are completed.

I have stories that are recounted in the full statement, which I would ask permission be entered into the record.

Chairman ISAKSON. Without objection. Thank you.

Senator BLUMENTHAL. Since I am intent on hearing and listening more than talking during this session—which we have a very, very expert and competent panel—I am going to close at this point by saying there are too many homeless women veterans. There are too many women veterans in need of medical care that is simply inaccessible to them. There are too many veterans whose job needs have been disregarded, maybe not purposely, but in effect, negligently. There are too many veterans, women and men, who need better treatment from the VA. This hearing is a very, very important step toward meeting the needs of women veterans, the challenges that our Nation faces in keeping faith with all our veterans.

Thank you, Mr. Chairman.

[The prepared statement of Senator Blumenthal follows:]

PREPARED STATEMENT OF SENATOR RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Women veterans are one of the fastest growing segments of the overall veteran population and by 2020, they are expected to grow to 11 percent of the total veteran population. Despite their prominent role in the wars being fought overseas, fewer than 30 percent of women veterans self-identify as veterans in their community and they are often unaware of the benefits and services that are available to them.

For too long, VA has been thought of as somewhat of an old-boys club, and changing that culture requires making important infrastructure and staffing changes as well as shifting a long-entrenched culture that has perceived veterans to be male.

I do want to recognize the fact VA has made some progress toward addressing the under-recognition of women veterans and the lack of gender-specific services for women veterans, but VA is still far from where it needs to be. In 1994, VA established the Center for Women Veterans, to coordinate VA programs across the Federal Government and also to work with public and private partners to raise awareness of the services and benefits available to women veterans. VA has also worked to ensure there is a designated women's health provider at every VA Medical Center and at the vast majority of all Community-Based Outpatient Clinics. I look forward to hearing Dr. Hayes's testimony about other efforts to improve access to health care for women veterans.

Part of improving that access is ensuring VA has an adequate number of trained medical professionals, but another equally important component of that access is ensuring that women feel comfortable utilizing the services that are available to them. I have visited the West Haven VA many times, and while I applaud their efforts to establish a women's clinic on-site, putting that clinic in the basement doesn't exactly create an environment in which women are likely to feel that they are welcome.

There are obviously physical restrictions on the actual footprint of the building that require constructing more space to move the women's clinic elsewhere, and I am told that change will be completed later this year. However, the reality is we have to find a way to make sure that while we are improving services available to all veterans, that we are specifically ensuring we take into account the needs of women veterans in addition to male veterans.

In advance of this hearing, my staff to reached out to some of the veterans networks in Connecticut to hear directly from constituents about their experiences accessing benefits and health services from VA. The experiences that constituents shared are invaluable in understanding the scope of reforms needed to truly ensure that VA is serving women veterans as well as they need to be. The veterans in Connecticut reached out to others across the country including female alumni from West Point and Annapolis. Excerpts from the stories they shared on their experiences utilizing VA services follow:

- When I was transitioning out of the Navy knowing that I needed some mental health help I was lost and didn't know what to do. I did what you

are supposed to do when you are getting out. I registered for school, before I left on my last deployment I went to Navy TAP (transition assistance program), which was great but not useful. I did not know about the VA nor did anyone from the VA come and speak with us. Granted this was in 2005 and things were a bit different. I would have used the VA if I knew, but I didn't know and my family didn't know. I was somewhat fortunate and I lived with my now husband when he worked for a major insurance company who allowed for co-habitation partners to be covered under his insurance. When he had to change jobs we lost my coverage. That was in October 2005. I was a student and not working. I got one last check up and finished up the 6 month supply of birth control the Navy had given me prior to my discharged and then prayed that I didn't get sick or pregnant. I went to Planned Parenthood when I got a UTI and they helped. I never would have gone to the VA. I would have never thought about going there. I spent 2 years being harassed and other things by "salty dogs" (read old Navy guys). That was not happening.

• Even though the women's clinic in West Haven is the farthest possible location from the entrance and located in the basement, it was nice to have all of my care go to one central location and have a dedicated team [At a VA hospital in New Jersey]. I had to get an x-ray one time. Because I am a woman in her child bearing years, I am required to take a pregnancy test before getting the x-ray. The hospital had no idea how to do this. It became a several minute conversation about whether to send me to the lab or to just hand me a pregnancy test or some other option. There was no standard for how to get a pre-x-ray pregnancy test. I don't even remember what the final decision was but I do remember thinking it was really odd that they didn't know how to handle something so simple that is specific to women.

Until some of the areas got to know me, almost every time I checked into an appointment, I was asked if I was the sponsor or an employee. I thought this was a standard question that was asked of everyone; I started listening to how the VA employees interacted with other patients. As it turns out, that was NOT a standard question. I had another female veteran friend who used the facility often and had a similar experience. It was almost as if they had never had a female veteran patient before and assumed that I am either there with my father or a VA employee. One nurse even commented one time that they "don't get a lot of young females in here."

• I have extremely bad hirsutism due to hormonal issues. I had one doctor who didn't believe that I grew a beard. I mentioned my daily process to keep my face [clear]. The doctor still didn't believe me and asked me to grow my facial hair for two weeks and then come back in so she could see if "it is as bad as [I] claim." I asked if I could just come in first thing in the morning and she could observe one day's growth. When she said no, I got a little anxious and teary eyed thinking about walking around town & graduate school with a full beard for two weeks (which would have been the case). How did she react to my reaction? She said, "Oh come on. There are worse things in the world." That is true; there are worse things in life but at that moment, I was reacting to a prospective situation which was highly uncomfortable for me. Ultimately, I ignored her request and came in with only one-day's growth and she saw that I was, in fact, not making up my hirsutism.

I went to the VA's emergency clinic one time with a condition related to my hormonal imbalance. The Doctor admitted to never having dealt with women and being visibly nervous and uncomfortable with the situation. Not his fault, but I felt the need to try to calm his nerves. It was overall awkward.

• I left active duty in 1992 and was never told about possible VA benefits. When I was mobilized and subsequently demobilized, we were rushed through the process.

My care has been pretty good overall. 2 exceptions:

1) Women's health has an older male doctor. He isn't bad, but it would be better if all the OB/GYNs were female. I had a less than pleasant experience with him, but couldn't wait to get on the female doctor's schedule (2 or 3 month wait to see her).

2) Mental Health—I had been seeing a counselor/doctor for sleep issues, stemming from my deployment and major depression. Sleep doctor was wonderful and I felt cared for. The Mental Health counselors are nice people, but I don't feel like CBT (Cognitive Based Treatment) is the best for

an issue that occurred at 18 and I am still dealing with. I have asked for help in putting it aside, but the counseling is focused on how you interpret today, not exorcising demons. Also, I feel like as soon as I agreed to go on an antidepressant, my counseling was halted—I was considered finished. The Rx helps, but the underlying issue is still there. The Psychiatrist who monitors my Rx is awesome and helpful, but she can't take on patients for counseling. I would like to see more small groups for women only. I was put into a group initially before I could get into the counseling and it consisted of 2 addicts and a gentleman and I. I never really talked because I couldn't relate to their issues.

• I want to share that I have had, thus far, nothing but good experiences with the VA. I have many military-related issues—to include a sexual assault—but my Compensation and Disability assessment was extraordinarily thorough and swift.

I will acknowledge that I approached my retirement physical and the VA evaluation with great care in documenting my health status. It took me several months to collect all the necessary records and documentation for my various ailments and injuries, since the period of service was over 30 years, military medical records were incomplete, and some of my "worse" conditions (such as cancer) had been diagnosed and treated at civilian medical care facilities, with little shared documentation between the referring military physicians and the civilian ones. In some cases, there was simply no documentation at all—such as my sexual assault—because I had not reported to a medical facility at the time (and my "command" did not suggest it to me when I reported it to them).

However, I carefully laid out a chronology of concerns (and also grouped the concerns in terms of "function") and carefully showed where there was documentation (by tabbing my medical records appropriately) and indicated where documentation was missing. I asked for and received a "pre-filing" face-to-face appointment with a VA representative and got some tips on requesting the documentation from the non-military treatment facilities (due to privacy laws, the patient has to ask for the documentation). By the time I was ready to file, my packet (which was several inches thick) was ready as a "Fully Developed Claim."

My first appointments were scheduled within 60 days of my filing. My disability determination was awarded within 90 days of my appointments.

Perhaps most importantly, when I went through the evaluation, I was asked very pertinent questions about my obstetric/gynecological health—as well as my emotional health. This was both "in general" as well as specific to my sexual assault experience. Some of the questions related directly to my own health history, but some were more generic. I certainly felt as if I had the opportunity to address ANY female-specific issue—or issue relating to sexual harassment/assault/marginalization—with any of the doctors or staff that I met at this VA.

In fact, the only time I have been disconcerted with my Lebanon VA is when I got letters addressed to me as "Sir." They also had me as "male" for my first appointment, but made the change to their database on site and I have not had a "sir" since then.

Now, I already pointed out that I did A LOT of work on my own behalf to make my medical records as complete as possible beforehand. I will also point out that I have been comfortable as my own advocate for many years, so nothing about the VA process was difficult for me. Third, I made myself as accommodating as I could to the process. Therefore, my experience may not be the experience of others.

• A little history about myself, I am a West Point graduate, and experienced several issues while at West Point and in the Army. I was sexually assaulted and never reported it because of the stigma at the time, I suffered numerous head traumas while serving, and a severe concussion from a biking accident while I was in graduate school after leaving the Army.

I used the services of Vocational Rehab when I left the Army, they were very helpful, kind, and advised me about education options, and after graduation assisted my job search. They provided me a whole new direction and new start for a career when I was unable to continue in the job for which I was trained and could no longer perform due to medical issues. I have nothing but high praise for them.

My VA hospital system experiences have been a mixed bag. They have been changing over the years as I have aged and learned more about the

> system and how to deal with everything. When I visit the VA hospital in West Haven, in order to get to the women's clinic, I have to go through what can only be described as somewhat of a gauntlet of vets who are either there waiting for an appointment or prescription, or just there to socialize. If I look them in the eye this seems to give them permission to hit on me or make some kind of harassing comment. Given my traumas this is extremely stressful and I avoid eye contact when I am even able to get myself to go to the hospital. When I am able to get an appointment and deal with going there, the staff is wonderful, and my psychologist is very kind and helpful with my PTSD and anxiety with new doctors.

Other issues were raised by the veterans who responded to our outreach, but I wanted to highlight these particular stories because they are especially informative regarding the problems faced by women veterans. I hope their stories will help VA see exactly where the gaps in service are. They will certainly help me to exercise appropriate oversight of VA and push for reforms to address issues faced by women veterans. It should not be the case that veterans who have fought so valiantly for our country have to fight just to reaffirm their status as veterans and to get basic access to health care services.

Additionally, VA needs to ensure that gender-specific health care for women covers more than reproductive and gynecological care. It means offering treatments across all specialties that is appropriate for that individual, taking into account factors like gender. As a part of gender-specific services, we need to ensure that specialty care, such as mental health care for PTS and TBI reflects the different care needs of women veterans.

Finally, the unemployment rate is currently higher for women veterans than for male veterans and civilian women. Unemployment is strongly associated with adverse health and is highly correlated with homelessness. We need to determine whether the transition and employment services that are offered through the joint VA, DOD and DOL Veterans Employment Center are appropriately reaching women veterans in order to help them establish and meet career goals. In some cases, this might mean that child care is provided at locations where veterans must go to obtain job training and benefits. It might also mean that employees at the Veterans Employment Center have training in how to best prepare women veterans to enter the job market.

There are a number of specific steps that VA must take to address the needs of women veterans. DAV has been particularly active on bringing outstanding issues to the attention of VA and of this Committee, and I thank them for their strong advocacy and service to this country. Ultimately, VA must ensure that it is bridging the existing cultural gap and fully including women veterans in the general veteran population the Department serves in order to ensure that women veterans and their children do not end up homeless.

There are still too many homeless veterans period. However, we must address all of the services whether offered by VA alone or in partnership with other Federal agencies or private partners to ensure that women veterans truly have access to the services they may need.

I look forward to the testimony today and to hear from VA about what they plan to do to ensure that the women separating from service feel comfortable proudly identifying as veterans and can safely use the benefits and services that they have earned. I especially look forward to hearing from the women veterans on the second panel about their individual experiences so that we can learn what will most make a difference to them and others who have served. Thank you in advance for your testimony today and for your service to this country.

Chairman ISAKSON. As is our tradition, the other Members of the Committee can submit statements for the record or remain to make a closing statement if they wish, but we want to get straight to our witnesses, then questions and answers.

For our first panel I will introduce Patricia Hayes, Ph.D., Chief Consultant, Women's Health Services, Veterans Health Administration, U.S. Department of Veterans Affairs; accompanied by Dr. Susan McCutcheon, National Mental Health Director for Family Services, Women's Mental Health and Military Sexual Trauma, Veterans Health Administration; and Rosye Cloud, Acting Director of the Office of Transition, Employment and Economic Impact, Veterans Benefits Administration.

Dr. Hayes, welcome.

STATEMENT OF PATRICIA HAYES, Ph.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY SUSAN McCUTCHEON, NATIONAL MENTAL HEALTH DIRECTOR FOR FAMILY SERVICES, WOMEN'S MENTAL HEALTH AND MILITARY SEXUAL TRAUMA, VETERANS HEALTH ADMINISTRATION; AND ROSYE CLOUD, ACTING DIRECTOR, OFFICE OF TRANSITION, EMPLOYMENT AND ECONOMIC IMPACT, VETERANS BENEFITS ADMINISTRATION

Ms. HAYES. Thank you very much, Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Senate Committee on Veterans' Affairs. Thank you for the opportunity to discuss the high-quality care and the support that VA is providing to our women veterans.

I am accompanied today, as you mentioned, by Dr. Susan McCutcheon, the National Mental Health Director of Family Services, Women's Mental Health and Military Sexual Trauma, and Ms. Rosye Cloud, who is the Acting Director of Veterans Benefits Administration Office of Transition, Employment, and Economic Impact.

The number of women veterans enrolling in VA health care has increased rapidly, placing new demands on the VA health care system that historically treated mainly men. In fiscal year 2014, there were more than two million women veterans in the United States. Of those women veterans, 635,000 are enrollees, to include more than 400,000 users of VA health care services.

To address the growing number of women veterans who are eligible for health care, VA is strategically enhancing services and access for women veterans.

In 2008, VA first identified the necessary actions for ensuring that every woman veteran has access to primary care. Since then, our plan of delivering care to women veterans has come to fruition. VHA Women's Health Services oversees program and policy development for women's health and provides strategic support to implement positive changes in the provision of health care to all women veterans. Women's Health Services works to ensure that timely, equitable, high quality, comprehensive health care services are provided in a safe and sensitive environment at VA facilities nationwide. Women's Health Services programs include comprehensive primary care, women's health education, reproductive health, communication, and our partnerships.

To provide the highest quality of care to women veterans, VA offers women veterans trained and experienced designated women's health providers who can provide general primary care and gender-specific primary care in the context of a long-term patient and provider relationship. Today, designated women's health providers are available at all VA medical centers and 90 percent of our community-based outpatient clinics.

With the launch of such a large-scale change in services, Women's Health Services recognized the need to assess the progress toward implementation of these goals. We evaluated all the women's health programs throughout several mechanisms, and in addition,

we use an independent contractor to conduct detailed site visits to objectively assess the implementation of services for women veterans nationwide. Also, recent analysis indicates that VHA outperforms private and public sector health care in many quality performance measures.

As a recognized leader in the provision of high-quality health care, VHA initiated efforts to address the gender disparity, a problem that affects health care nationwide. Since 2006, VHA's Office of Informatics and Analytics has analyzed all external peer reviewed program data by gender and published the quarterly Gender Report on its Web site.

Over the years, we have been working very hard to close the gender disparities gap. In 2008, VHA launched a concerted Women's Health Improvement Effort, focusing the providers' attention on gender disparity data. From 2008 to 2011, VA saw a significant reduction in gender disparity for many measures. At the close of 2013, small gender gaps still existed in only a few measures, including cholesterol management in high-risk patients, diabetes care, and rates of influenza vaccination. VA continues to address such key clinical issues and others, including cardiac care, to improve women veterans' health.

VA recognizes the importance of providing services to women veterans over their life span. VA provides a full continuum of mental health services to women veterans, including outpatient, inpatient, and residential treatment options. VA also recognizes the significance that support groups and partnerships with our local communities have in our transition and recovery for women veterans. A number of programs connect women veterans and veterans with families with health care, employment, financial counseling, and housing.

In conclusion, our mission at VA is to care for those who shall have borne the battle, as well as their families and their survivors. We are providing the highest quality care for today's women veterans while actively working to meet the needs of those who will come to us in the future. We have made significant strides in recent years. However, we know we still have much to do as VA continues to focus on a nationwide effort to enhance the language, the practice, and the culture of VA to be more inclusive of women veterans. We will continue to improve our efforts to provide high quality, timely health care to our women veterans, and we appreciate this Committee's support in doing so.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions you or other Members of the Committee may have.

[The prepared statement of Ms. Hayes follows:]

PREPARED STATEMENT OF DR. PATRICIA HAYES, CHIEF CONSULTANT FOR WOMEN'S HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Isakson, Ranking Member Blumenthal, and Distinguished Members of the Senate Committee on Veterans' Affairs, Thank you for the opportunity to discuss the high quality care and support VA is providing to our women Veterans. I am accompanied today by Dr. Susan McCutcheon, National Mental Health Director for Family Services, Women's Mental Health and Military Sexual Trauma, as well as Ms. Rosye Cloud, Acting Director of the Veterans Benefits Administration (VBA) Office of Transition, Employment & Economic Impact (OTEEI).

OVERVIEW OF WOMEN'S HEALTH

The number of women Veterans enrolling in VA health care is increasing, placing new demands on a VA health care system that historically treated mostly men. There are more than 2.0 million women Veterans in the United States accounting for more than 400,000 users of VA health care services in fiscal year (FY) 2014. To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and access for women Veterans.

VHA's Women's Health Services (WHS) oversees program and policy development for women's health and provides strategic support to implement positive changes in the provision of care for all women Veterans. WHS works to ensure that timely, equitable, high quality, comprehensive health care services are provided in a sensitive and safe environment at VA facilities nationwide. WHS programs include comprehensive primary care, women's health education, reproductive health, communication, and partnerships. WHS' goals are to:

- Transform health care delivery for women Veterans using a personalized, proactive, patient-centered model of care;
- Develop, implement, and influence VA health policy as it relates to women Veterans;
- Ensure a proficient and agile clinical workforce through training and education;
- Develop, seamlessly integrate, and enhance VA reproductive health care; and
- Drive the focus and set the agenda to increase understanding of the effects of military service on women Veterans' lives.

IMPLEMENTING COMPREHENSIVE PRIMARY HEALTH CARE MODEL FOR WOMEN VETERANS

To provide the highest quality of care to women Veterans, VA offers women Veterans assignments to trained and experienced Designated Women's Health Providers (DWHP) who can provide general primary care and gender-specific primary care in the context of a long-term patient/provider relationship. In 2009, we had women's health providers at 33 percent of medical centers. Today, DWHPs are available at 100 percent of VA medical centers (VAMC) and 90 percent of Community-Based Outpatient Clinics (CBOC). National VA satisfaction and quality data from 2014 indicate that women who are assigned to DWHPs have higher satisfaction and higher quality of gender-specific care than those assigned to other providers. VA's plan is that whenever a woman Veteran enters the health care system, she will have access to a DWHP. To meet this plan, VA must ensure that all new primary care hires are proficient in the care of women as well as men. VA is continuing to train and update skills of current VA primary care and emergency providers in the care of women. Since 2008, VA has provided intensive training to over 2,000 women's health providers and provided over 50 different online, accredited women's health classes, which can be taken 24/7 to enhance the flexibility of learning opportunities for employees. The combination of educational offerings provides not only basic training in women's health but advance courses so that providers and other staff can keep their skills and knowledge up-to-date.

ASSESSING WOMEN'S COMPREHENSIVE HEALTH

With the launch of such a large scale change in services, WHS recognized the need to assess the progress toward implementation of high quality programs focused on women Veterans. WHS evaluates all women Veterans' health programs through several mechanisms. Every VAMC completes an annual self-assessment of the implementation of comprehensive women Veterans' services through the Women's Assessment Tool for Comprehensive Health. This tool includes an assessment of the Enrollee Health Care Projection Model's current and future enrollment and utilization projections, strategic planning for women Veterans' services, and reports on the providers and capacity for clinical services, such as primary care, gynecology, and emergency services.

In addition, VHA uses an independent contractor to conduct detailed site visits to objectively assess the implementation of services for women Veterans nationwide. Over the course of each year, the independent assessment team conducts a more intense review at 25 VAMCs. Each year, the independent contractor provides an evaluation of the state of implementation and a national roll-up report highlighting both areas where capacity has been built and areas that still need development. The annual reports have been provided to VHA Central Office and Veterans Integrated Service Network (VISN) leadership teams. This allows leadership to examine trends in implementation and to identify and address gaps in services available for women Veterans.

NARROWING GENDER DISPARITIES

Recent analysis indicates that VHA outperforms private and public sector health care in many quality performance measures.[1] As a recognized leader in provision of high-quality health care, VHA initiated efforts to address gender disparity, a problem that affects health care nationwide.[2] In an effort to measure the quality of care provided to women Veterans, since 2006 VA's Office of Informatics and Analytics (formerly Office of Quality and Performance) has analyzed all External Peer Review Program Data (EPRP)[3] by gender and published the quarterly Gender Report on its Web site. Starting in 2006, a number of gaps were identified in the quality of care for men and women, including disparities in measures for screening, prevention, and chronic disease management.

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 prevention. Improvements were also made in screening measures for colorectal cancer, depression, Post Traumatic Stress Disorder (PTSD), 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 2013 report illustrates that VA has made continued progress in closing the gap in gender disparities. At the close of FY 2013, small gender gaps existed in only a few measures including cholesterol management in high-risk patients, diabetes care, and rates of influenza vaccination.

WOMEN VETERANS ECONOMIC OUTCOMES

In addition to addressing women Veterans' health care concerns, VA is committed to working with our partner Federal agencies to help transition female Servicemembers and Veterans achieve strong economic outcomes through meaningful employment and suitable housing.

In January 2015, VA's Veterans Economic Opportunity Report examined how Veterans compare to their non-Veteran counterparts in obtaining meaningful employment, increasing their income, accessing education, and other indicators of success. VA reported that female Veterans are doing well compared to their non-Veteran female and Veteran male peers in both career earnings and education. Specifically, VA's Economic Opportunity Report[4] cited that female Veterans attain 14 percent higher median earnings than the non-Veteran female population with similar demographic characteristics; and that female Veterans participating in the GI Bill had a 10 percent higher program completion rate compared to male Veterans for all ages combined, an 8 percent higher program completion rate across all individual age groups, and a 5 percent higher program completion rate when compared to female students in the general population. This report provides valuable insight, and VA continues to work with our Federal partners to ensure all women Veterans, like their male counterparts, are empowered with the tools necessary to gain meaningful employment and career mobility.

One program contributing to this effort is the interagency Transition Assistance Program (TAP), through which VA equips Servicemembers and their families with the tools they need to make a smooth, successful transition to civilian life. A key component of TAP is Transition Goals, Plans, Success (GPS), a curriculum jointly managed by VA, DOD, and DOL, designed to help transitioning Servicemembers connect with jobs, training, and other benefits prior to leaving service. To support TAP, VBA has more than 300 VA benefits advisors permanently located at more than 100 military locations worldwide. From beginning of FY 2014 to date, VBA has conducted 12, 342 briefings to an estimated 329,400 separating Servicemembers. As part of Transition GPS, VA benefits advisors not only provide a day long briefing

[1] Gender Differences in Performance Measures VHA 2008–2011 Women Veterans Health Strategic Health Care Group, Patient Care Services, VHA, Washington DC, June 2012

[2] JGIM Vol 28 Supp 2 July 2013. Women's Health During Health Care Transformation, Clancy and Sharp

[3] EPRP is designed to provide medical centers and outpatient clinics with diagnosis and procedure-specific quality of care information. It provides a database for analysis and internal and external comparison of clinical care. Data used for these analyses are abstracted from a random sample of both paper and electronic medical records. EPRP data is primarily used for quality improvement, evaluation and benchmarking with external organizations. (VHA DIRECTIVE 2008–032)

[4] VA's Economic Opportunity report: http://www.benefits.va.gov/benefits/docs/VeteranEconomicOpportunityReport2015.PDF

on VA benefits and services but also provide the Career Technical Training Track, an optional 2-day workshop, which helps transitioning Servicemembers identify relevant civilian occupations, establish career goals, and begin applying for credentials and vocational training. Additionally, VA benefits advisors work to ensure Servicemembers are referred to appropriate services such as VA's Vocational Rehabilitation and Employment (VR&E) Program.

The VR&E Program provides comprehensive services and assistance to enable Veterans with service-connected disabilities and an employment handicap prepare for, find, and maintain suitable employment. For Veterans with service-connected disabilities so severe that they cannot immediately consider work, VR&E offers services to improve their ability to live as independently as possible in their homes and communities. Vocational rehabilitation counselors and employment coordinators work closely with their DOL counterparts to help Women Veterans find meaningful, sustainable careers. Services provided include training and career assessment to help them reach their career goals, individual counseling and direct assistance to VA-specific services, homeless placement services, and referrals for VA medical services.

VA, DOD, and DOL also partnered to launch the Veterans Employment Center (VEC) in April 2014. The VEC provides transitioning Servicemembers, Veterans, and their families with a single authoritative Internet source that connects them with job opportunities, and provides tools to translate their military skills into plain language and build a profile that can be shared—in real time—with employers. Over 1.7 million private and public-sector jobs are listed on the VEC. As of February 15, 2015, 844 employers made public hiring commitments to hire over 553,500 individuals. In addition, committed employers have reported hiring over 286,000 Veterans and family members.

VA has also initiated an aggressive rollout of innovative public-private partnerships that are leveraging best practices and tools of premier companies in private industry to provide unique support to transitioning Servicemembers, Veterans, and their families and to help bridge the cultural gap. For example, VA has strategic partnerships with LinkedIn and Coursera. Most recently, VA partnered with TriWest Healthcare Alliance to connect women Veterans who are homeless or at risk of being homeless with meaningful and stable employment.

VA is also exploring various learning opportunities as potential alternatives or supplements to traditional education that yield career competitive skills and employment opportunities for Veterans. VA will be opening accelerated learning opportunities this fiscal year to help bridge the gap between Veterans' separation from service and successful civilian employment outcomes. Additionally, VA is establishing 20 learning hubs that will provide space and resources, such as computers for Veterans, transitioning Servicemembers, and military spouses to complete the online educational courses available in a classroom environment.

VA's efforts to improve economic outcomes for women Veterans include providing greater access to suitable housing through VA's Home Loan Guaranty Program. The Home Loan Program assists eligible Veterans in obtaining, retaining, and adapting their homes. In each of the past 10 fiscal years, the numbers of VA loans to women Veterans averaged between 10 and 12 percent of the VA guaranteed loan portfolio. Over the last decade, VA has guaranteed 3.5 million home loans, including loans for nearly 400,000 women Veterans. This figure does not include women Veterans who have entitlement, but elected to use their spouse's eligibility for the home loan benefit.

Additionally, VA pursued, and Congress passed as Public Law 112–154, legislation that affords more single, active-duty Veterans with children the opportunity to obtain a home using their VA home loan benefit. This law expanded the occupancy requirement attached to VA home loans to include not just the Veteran or a spouse but also a dependent child of an active duty Servicemember. A key impact of this legislative change is that single Veterans with children, many of whom are women, are not adversely impacted by their active duty service and can provide housing for their children, and as necessary, caretakers and guardians.

DISABILITY ASSISTANCE AND BENEFITS

Women Veterans are eligible for the wide variety of VA benefits available to all U.S. Military Veterans. These benefits include disability compensation, pension, education, vocational rehabilitation, home loan guaranty, and life insurance as well as monetary burial allowances.

VA is committed to ensuring that all Veterans, Servicemembers and their families are aware of and know how to access the benefits they have earned and deserve. VA conducts targeted outreach to women, minorities, elderly, and homeless. VA also

uses social media such as Twitter and Facebook and electronic communication through GovDelivery for targeted messaging. Of the 4.3 million registered eBenefits users, 24 percent are women. Through these outreach efforts, VA has seen an increase in utilization of benefits by women Veterans. In 2014, 356,748 women Veterans received compensation benefits; an 8 percent increase over 2013. In addition, 12,624 women Veterans received pension benefits, 128,800 used Post-9/11 GI Bill education benefits, and 46,714 received VA guaranteed home loans totaling $10.5 billion in FY14.

One of VA's outreach goals is to ensure the National Guard and Reserve population receive information about VA health care, benefits, and services. This is accomplished through consistent dialog with leadership within the Reserve Components and the Army and Air National Guard and participation in Yellow Ribbon Reintegration Programs (YRRP). VA participated in over 1,600 of these events throughout the United States and territories, providing more than 190,000 OEF/OIF/OND Servicemembers, Veterans and their families with vital information. Additionally, VA staff frequent demobilization events (post-deployment health reassessments), job fairs, stand down events for homeless Veterans, and activities on active duty bases as well as Reserve and National Guard Armories.

MILITARY SEXUAL TRAUMA (MST) CLAIMS

VA is committed to serving Veterans by accurately adjudicating claims based on military sexual trauma (MST) in a thoughtful and caring manner, while fully recognizing the unique evidentiary considerations involved in such an event. The Under Secretary for Benefits has spearheaded the efforts of VBA to ensure that these claims are adjudicated compassionately and fairly, with sensitivity to the unique circumstances presented by each individual claim.

VA is aware that, because of the personal and sensitive nature of MST stressors in these cases, it is often difficult for the victim to report or document the event when it occurs. To remedy this, VA developed a regulation (38 CFR § 3.304(f)(5)) and procedures specific to MST claims that appropriately assist the claimant in developing evidence necessary to support the claim. As with other Post Traumatic Stress Disorder (PTSD) claims, VA initially reviews the Veteran's military service records for evidence of the claimed stressor. VA's regulation also provides that evidence from sources other than a Veteran's service records may corroborate the Veteran's account of the stressor incident, such as evidence from mental health counseling centers or statements from family members and fellow Servicemembers. Evidence of behavior changes, such as a request for transfer to another military duty assignment, deterioration in work performance, and unexplained economic and social behavior changes, is another type of relevant evidence that may indicate occurrence of an assault. VA notifies Veterans regarding the types of evidence that may corroborate occurrence of an in-service personal assault and asks them to submit or identify any such evidence. The actual stressor need not be documented in service records. If evidence of a stressor is obtained, VA will schedule an examination with an appropriate mental health professional and request an opinion as to whether the evidence indicates that an in-service stressor occurred.

When a Veteran files a claim for mental or physical disabilities other than PTSD based on MST, VA will obtain a Veteran's service medical records, VA treatment records, relevant Federal records, and any other relevant records, including private records, identified by the Veteran that the Veteran authorizes VA to obtain. VA must also provide a medical examination or obtain a medical opinion when necessary to decide a disability claim. VA will request that the medical examiner provide an opinion as to whether it is at least as likely as not that the current symptoms or disability are related to the in-service event. This opinion will be considered as evidence in deciding whether the Veteran's disability is service-connected.

VBA has placed a primary emphasis on informing VA regional office personnel of the issues related to MST and providing training in proper claims development and adjudication. Women Veterans Coordinators are located in every regional office to assist Veterans. In December 2014, MST Coordinators were assigned at each regional office to address MST-specific concerns of both male and female Veterans. In addition, under VBA's new standardized organizational model that has been implemented at all of our regional offices, all MST-related claims are now processed in the special operations lane, ensuring that our most experienced and skilled employees are assigned to manage these complex claims.

GENDER-SPECIFIC HEALTH SCREENINGS

VA exceeds the private sector in gender-specific health screening rates including cervical cancer screening and mammography.[5] Mammograms for women Veterans can be provided on-site at 52 VHA health care sites where digital mammography is available. When VA or other Government facilities cannot provide these services, VA may contract for non-VA medical care using applicable statutory authority, i.e., 38 United States Code §§ 1703, 8153, 8111. WHS has also convened a task force of subject matters 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 (OIG) report that tracking the results of mammograms performed outside VA has been a challenge. Recently VA completed work on breast cancer treatment guidance which advises the field of optimal pathways and processes to ensure that mammography orders are standardized and that results are tracked and communicated to patients appropriately.

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 has two information technology (IT) projects underway 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. Both IT enhancement projects are scheduled for completion by the end of 2015. These systems are designed to work together to identify, document, and track all breast cancer screening and diagnostic imaging (normal or abnormal), orders results, patient notification, and follow-up to ensure that all women Veterans receive high-quality, timely breast care whether treatment is provided within or outside of VA.

IMPROVING COORDINATION AND ACCESS: WOMEN VETERANS PROGRAM MANAGERS

In order to ensure improved advocacy for women Veterans at the facility level, VA has mandated all VAMCs appoint a full-time Women Veterans Program Manager (WVPM). These WVPMs increase outreach to women Veterans, improve quality of care provision, and develop best practices in organizational delivery of women's health care. They serve as advisors to facility directors in identifying and expanding the availability and access of inpatient and outpatient services for women Veterans and provide counseling on a range of gender specific care issues. WVPMs also provide appropriate local outreach initiatives to women Veterans. Each of VA's 144 health care systems have appointed a full-time WVPM, and VHA carefully tracks this position with regard to orientation and training.

IMPROVING ACCESS TO WOMEN'S HEALTH THROUGH TECHNOLOGY

Women's Health Telehealth Programs and Mobile Applications

Since 2011, WHS has awarded funding to 26 VHA facilities for projects that offer telehealth programs to female Veterans. Telehealth projects that received funding involve tele-mental health, tele-gynecology, tele-pharmacy, and telephone maternity care coordination.

VA is currently developing six mobile applications (apps) for women Veterans' use. Patient-facing apps will provide information on VA eligibility and services and health information for women Veterans. Provider-facing apps will provide information to enhance knowledge of both VA and non-VA medical care providers about special health issues of women Veterans.

Women Veterans Call Center

The Women Veterans Call Center, 1–855-VA-WOMEN (1–855–829–6636), was created to increase women's knowledge of VA benefits and services, enrollment, and utilization of health care services. We are pleased to see that the Call Center is being utilized. In FY 2014, the Call Center received nearly 15,000 incoming calls and made over 190,000 outbound calls, successfully reaching over 100,000 women Veterans. The Call Center is staffed by trained operators who provide information on VA's benefits and services. Call Center staff make referrals to WVPMs, the VHA Health Eligibility Center, VBA, and suicide and homeless crisis lines as needed. The outbound, outreach Call Center was moved to the Canandaigua VAMC in October 2012, and the inbound Call Center launched in April 2013.

[5] http://www.womenshealth.va.gov/WOMENSHEALTH/docs/OIA-BRCO_GenderHealthCareReport.pdf

READJUSTMENT AND INTEGRATION

Vet Center Services

Life is not always easy for women Veterans after a deployment, and Vet Centers have developed services to assist Veterans in re-integration. Vet Centers across the country provide a broad range of counseling, outreach, and referral services to women combat Veterans, Servicemembers, and their families. Vet Centers guide women Veterans, Servicemembers, and their families through many of the major adjustments in life that often occur after they return from combat. Services for a woman Veteran or Servicemember may include individual and group counseling in areas such as the symptoms associated with PTSD, Military Sexual Trauma (MST), alcohol and drug assessment, and suicide prevention referrals. All services are free of cost and are strictly confidential.

The Vet Center program was established by Congress in 1979 out of the recognition that a significant number of Vietnam-era Vets were still experiencing readjustment problems. Over time, Congress extended eligibility to all Veterans who served in a combat zone or area of hostility or who have experienced MST.

Recent legislation now authorizes Vet Centers to provide readjustment counseling services to certain active duty Servicemembers and their families. Vet Centers are community-based and part of VA. Vet Center program staff welcome home war Veterans and Servicemembers with honor by providing quality readjustment counseling in a caring manner. Vet Centers understand and appreciate these individuals' war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community. Recognizing the increased roles for women in the military, the Vet Centers provide an important place outside of the traditional sites of care for women Veterans to receive services related to those experiences.

WOMEN VETERANS REPRODUCTIVE HEALTH

Reproductive health is a critical component of women's health. It encompasses gynecologic health throughout life such as pre-conception care, infertility care, maternity care, cancer care, and the interaction of these with other health conditions (e.g., mental health). VHA's Reproductive Health Program initiatives include enhancing VHA's reproductive health workforce; providing high quality maternity and mental health care; delivering high-quality emergency services for women; and ensuring safe prescribing, pre-conception care, and care for aging women Veterans. WHS has several key accomplishments specific to reproductive health including:

- Decreasing fragmentation of maternity care in VHA through the implementation of Maternity Health Care and Coordination policy and supporting the development of Maternity Care tele-health pilots at 11 VA Healthcare Systems serving over 500 women Veterans.
- Developing a prototype maternity dashboard named "Maternity Tracker" that will enhance the delivery of high-quality maternity care and facilitate care coordination between VA and non-VA medical care providers. The "Maternity Tracker" is set to pilot in a VHA facility during FY 2015.
- Awarding funds to VHA facilities to support the development of innovative tools and purchase of gynecologic equipment to enhance the quality of care delivered to women in VA emergency departments and launching and disseminating the VA Emergency Services for Women (ESW) Toolkit, an online database of searchable tools and resources for VA Emergency Medicine providers and staff.

Gynecological Care—Enhancing the Reproductive Health Workforce

VA recognizes the availability of on-site gynecologists plays a critical role in providing comprehensive care to women Veterans. In collaboration with primary care, emergency medicine, mental health, and other subspecialty providers, obstetrics and gynecology providers strengthen the team of providers caring for women Veterans. VHA provides high-quality gynecologic care to all women Veterans, either in VHA facilities or locally through non-VA medical care mechanisms.

However, gynecology specialty providers are not available on-site at all VA health care centers. Therefore, VA intends to address the hiring of gynecologists and improved access by expanding on-site gynecologic services and support as we implement the Veterans Access, Choice, and Accountability Act of 2014.

Reproductive health also includes care related to infertility, menopause, and subspecialty gynecology care including female pelvic medicine (urogynecology) and reconstructive surgery, high-risk maternity care, and gynecologic oncology. We are planning to expand the scope of VA practice in reproductive health through additional resources and innovative technologies and partnerships with local experts and key stakeholders particularly in areas of urogynecology and infertility care. We also

plan to address key issues in specialty gynecological care coordination for women with gynecologic cancers to improve delivery and coordination of care between VA and non-VA medical care settings.

VHA is already enhancing gynecology care to women in rural areas through innovative technologies such as e-consults, tele-gynecology, and tele-maternity services. Expansion of these innovative technologies is being explored as a mechanism to ensure access to gynecology care in parts of the country where recruitment of gynecologists is a challenge.

MILITARY SEXUAL TRAUMA

Military sexual trauma (MST) is a VA term that refers to sexual assault or repeated, threatening sexual harassment experienced during military service. In FY 201, 85,033 or 25.04 percent of female Veterans seen for VA health care had reported a history of MST when screened by a VA health care provider. Not all MST survivors have long-term difficulties, but some experience chronic physical and mental health problems, including PTSD, depression, and substance use disorders.

All VA treatment for physical and mental health conditions related to MST is provided free of charge. Service connection is not required, and Veterans may be able to receive free MST-related care even if they are not eligible for other VA services. VA offers a wide range of treatment services: Outpatient MST-related mental health care is available at every VAMC, and residential and inpatient programs are available for Veterans who need more intense treatment and support. Community-Based Vet Centers also offer MST-related counseling and services. Among Veterans who screen positive for MST in VA, rates of engagement in care and amount of care provided continue to increase every year. In FY 2014, 64,696 or 76.1 percent of women who screened positive for MST received outpatient care for either a mental or physical health condition related to MST. This is an increase of nearly 11 percent from FY 2013, where 58,061 or 74.7 percent of women who screened positive for MST received MST-related outpatient care. These women Veterans had a total of 735,608 MST-related visits in FY 2014, which represents an increase of 11.4 percent (from 660,398 visits) from FY 2013.

Every VA health care system has a designated MST Coordinator who serves as the local point person for MST-related issues. In FY 2014, VA initiated a continuation and expansion of its successful National Review of the Accessibility of MST Coordinators. This program is an innovative "secret shopper" initiative to survey the experiences a Veteran would be likely to have in attempting to reach an MST Coordinator via telephone. This initiative was expanded in FY 2014 to include calls to one CBOC as well as one VAMC for each health care system. In early FY 2014, over 80 percent of VA health care systems received a satisfactory rating, a nearly 30 percentage point improvement since the review began.

In order to ensure VA's capacity to provide MST-related care, VA annually evaluates the number of full-time equivalent employees required to meet the outpatient MST-related mental health treatment needs of Veterans. In the most recent analyses (based on FY 2013 data), all 140 VA health care systems were above the minimum threshold indicating adequate capacity to provide MST-related mental health care.

The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) contained several provisions relevant to VA MST services. VA now provides free treatment for conditions related to sexual assault or sexual harassment during inactive duty training (primarily drill weekends for Reservists and National Guard members). The new law also allows VA to provide MST services to active duty Servicemembers without a referral from DOD; VA is working with DOD on plans for implementation. Finally, VA will produce two new reports for Congress on its MST services. The first compares VA MST services available for male and female Veterans. The second describes processes for transitioning care for MST Survivors from DOD to VA and joint efforts to assist Veterans in filing a disability claim related to MST.

VA is committed to ensuring that providers and key staff receive appropriate training to address the needs of Veterans who have experienced MST and may be at risk of suicide. VA's Veterans Crisis Line (VCL) is a hotline for Veterans experiencing suicidal thoughts. In FY 2014, specialized materials were developed to further enhance VCL staff's understanding of issues specific to MST and facilitate sensitive and effective handling of calls from Veterans who experienced MST. Additionally in FY 2014, an initiative was developed to strengthen collaboration between MST Coordinators and Suicide Prevention Coordinators, who serve as local points of contact and facilitators of MST and suicide prevention program efforts, respectively, at every VAMC. Finally, all VA mental health and primary care providers are required to complete a mandatory training on MST. The training includes clini-

cally relevant topics such as working with Veterans who have experienced MST and may exhibit self-destructive behavior or are at risk of suicidal ideation. This training program will receive a major update in FY 2015 that will provide an opportunity to further strengthen and expand upon content on suicidal behavior and self-harm.

MENTAL HEALTH SERVICES

VA provides a full continuum of mental health services to women Veterans, including outpatient, inpatient, and residential treatment options. Evidence indicates that women differ from men in the prevalence and expression of certain mental health disorders, as well as in their responses to treatment. These differences may be due to biological sex differences, such as the impact of the female reproductive cycle on mental health, or social and cultural differences, such as the impact of gender-related violence. Awareness of these differences informs VA's Women's Mental Health Services. VA policy requires that mental health services be provided in a manner that recognizes that gender-specific issues are indeed important components of care.

Gender-Sensitive Mental Health Care

In 2012, VHA surveyed mental health leadership within each VA health care system (N = 141) to determine the availability of gender-sensitive mental health care for women Veterans. VA conceptualizes gender-sensitive mental health care as containing these key components:

- *Comprehensiveness:* Includes full continuum of service availability for women (e.g., general mental health, specialty mental health, residential/inpatient);
- *Choice:* Considers treatment modality (e.g., mixed-gender, women-only service options);
- *Competency:* Addresses women's unique treatment needs, and;
- *Innovation:* Provides creative options and settings for subgroups of women, especially when caseloads of women are small.

Survey results indicate that women Veterans have access to general and specialty outpatient mental health treatment options at all VHA health care systems. Findings also indicate that mental health services for women Veterans are most commonly provided in mixed-gender settings. Individual therapy was the most frequently reported alternative, when clinically indicated, to mixed-gender group therapy. Other frequently reported alternatives to mixed-gender outpatient care included tele-mental health, referrals to Vet Centers or community resources, and non-VA medical care. Overall, survey results indicated numerous and varied general and specialty outpatient options are offered to female Veterans seeking VA mental health services.

Mental Health Across the Life Span

Life transitions and physiological hormonal changes that occur during a woman's life cycle may serve to increase her risk of developing a mental health disorder. For example, sex-specific hormonal differences and reproductive life-cycle stages, such as pregnancy and perimenopause, can have effects on mental health. These changes across the reproductive life-cycle are particularly relevant for VHA, as over 40 percent of women Veterans seen in VHA are within their reproductive years (ages 18–44), and over 25 percent are aged consistent with perimenopause (ages 45–55).

Physiological changes across the life cycle can complicate treatment decisions; for example, maternal and fetal benefits and risks must be considered in medication management among pregnant women. Because of this, it is critical that providers for women Veterans are aware of the impact of biology on mental health and knowledgeable about the implications and efficacy of pharmacologic and behavioral intervention choices.

To ensure this, VHA has initiated collaborations between mental health, primary care, pharmacy, and women's health. We have assessed needs across VA for training about the impact of life cycle biological changes on women's mental health; over 600 providers were surveyed. Based on the results of this assessment, we have developed and disseminated educational tools for VA providers in the form of six module curricula. Currently, there are virtual pilots at two VA health care facilities and five VA virtual university trainings taking place.

Supporting Women's Transitions from Military to Civilian Life

VA recognizes the importance of coordination with DOD to support Veterans' reintegration and transitions from military to civilian life. DOD and VA Integrated Mental Health Strategy (IMHS) Strategic Action #28 examined gender differences in delivery and effectiveness of mental health services for female Servicemembers and Veterans, and those who have experienced military sexual assault (MSA), mili-

tary sexual harassment (MSH), or MST. Findings from the Strategic Action #28 Task Group informed the development of recommendations to address identified gaps, developed strategies for overcoming health care disparities and barriers to care, identified the need for further research, and improved quality of care for these populations. The final report (still in the review /concurrence process) presents recommendations to address key research, surveillance, prevention and treatment gaps, and proposes a structure and processes for the continuation of DOD and VA collaboration in support of this initiative.

WOMEN'S TRANSITION SUPPORT GROUPS

VA recognizes the significance that support groups have in the transition and recovery of Veterans and especially in the transition and recovery of women Veterans. VA is able to offer a broad range of resources and programs for women Veterans within the scope of current legal authority. VHA has implemented a number of services to address the unique needs of women Veterans. The graduated continuum of family member services include:

- Family Education
- Support and Family Education (SAFE)
- National Alliance on Mental Illness (NAMI) Family-to-Family Education Program
- Family Consultation
- Family Psychoeducation
- Marriage and Family Counseling
- Coaching Into Care
- AboutFace
- Military Kids Connect
- Caregiver Support Program
- Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Care Management Teams
- The Federal Recovery Coordination Program (FRCP)
- VA's Fisher House and Temporary Lodging Program
- The Domestic Violence/Intimate Partner Violence (DV/IPV) Assistance Program
- Family Readjustment Counseling

LOCAL PARTNERSHIPS AND OUTREACH FOR WOMEN VETERANS

VA recognizes the importance of outreach and partnership with our local communities. Several VHA specialized homeless programs include efforts designed to connect Veterans. These include connecting women Veterans and Veterans with families with health care, employment, financial counseling, and housing. Initiatives within VHA's continuum of homeless programs and services include:

- The Health Care for Homeless Veterans (HCHV) program:
  – During FY 2014, the total number of unique homeless Veterans served through HCHV outreach was over 158,000; of which 11 percent were females as compared to 10 percent of the total from the previous fiscal year.
- The Supportive Services for Veteran Families (SSVF) program:
  – SSVF continues to serve women in greater proportion than they appear in the general homeless population (15 percent in SSVF versus 10 percent in the general homeless population). Also, as women are more commonly the custodians of dependent children, SSVF serves many female Veterans and their dependent children. Fifteen percent (11,702 of 79,449) of Veterans served were female—the highest proportion of women Veterans served of any VA homeless initiative. Nearly one quarter (29,884 of 127,829) of all those served were dependent children.
- Grant and Per Diem (GPD) funded outreach programs:
  – In FY 2014, more than 200 GPD projects had some capacity to serve women Veterans. Of those projects, approximately 40 were women-specific and 38 had the capacity to serve women with dependent children; although per diem was only paid for the women Veterans. In FY 2014, over 45,160 Veterans were served through the GPD program; of these, approximately 7 percent were women. In the first 4 months of FY 2015, over 24,000 unique Veterans were provided services through GPD; the percentage of homeless women Veterans has remained consistent at approximately 7 percent.
- The Department of Housing and Urban Development—VA Supportive Housing (HUD-VASH) program:
  – During FY 2014, about 12 percent of those admitted to HUD-VASH were women. In FY 2014, there were 17,829 families served by HUD-VASH an in-

crease of 3,195 new families housed with the Veteran by HUD-VASH. At the time of entry into the program, approximately 36 percent of females and 13 percent of males planned to live with their children and/or other family members when housed.

- Veterans Justice Programs (VJO):
  – In FY 2014, HCRV provided services to over 16,700 Veterans of which 2.2 percent were women. In FY 2014, VJO served to nearly 41,700 justice-involved Veterans, of which 5.6 percent were women.
- Community Employment Coordinators (CEC) for homeless Veterans program:
  – Of the 121 CECs who have been hired thus far, 10 percent are women Veterans, and 7 percent are women Veterans who have exited homelessness.

CONCLUSION

Our mission at VA is to care for those "who shall have borne the battle" and their families and Survivors. While we have made significant strides in recent years, we still have much to do as VA develops a nationwide effort to enhance the language, practice, and culture of VA to be more inclusive of women Veterans. We will continue to improve our efforts to provide high-quality, timely health care to our women Veterans and we appreciate this Committee's ongoing support in doing so.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions you or the other Members of the Committee may have.

Chairman ISAKSON. Thank you very much, Dr. Hayes, and thank you for your commitment to America's veterans and our women veterans.

Let me begin the questioning. We will do 5-minute rounds for the Committee and we will operate under the early bird rule.

Let me ask you this question, Dr. Hayes. Privacy is particularly an issue with women veterans, and I have toured a number of CBOCs and a number of hospitals that are obviously busting at the seams with our veteran population. How is privacy being provided for women and what have you done to make sure women have the privacy they deserve and need in the facilities?

Ms. HAYES. I absolutely agree that privacy is very important. What privacy means is the ability to feel safe and secure in the environment and to feel that there is a place for women who do not feel like they are being stared at by men and that they have that kind of safety in their care.

We, for a number of years, since 2009, have guidelines for privacy and we have actually done a paper and pencil checklist for a number of years detailing each and every privacy deficiency. However, we found that system really did not get at all of our space and deficiencies in an organized way. So, last year we launched what is basically a tablet-based system for rounds which detail every privacy deficiency, including missing locks, missing curtains, and has a deadline with a timeline on that electronic system saying how long until that particular deficiency is corrected.

We are rolling it up nationally. We will not be able to have national reports until later this year, but we have local reports and we know how many have exceeded 14 days to correction of the deficiencies.

Chairman ISAKSON. Dr. McCutcheon, given your expertise and your title, I am going to direct this question to you. What percentage of the mental health issues that women have are directly related to military sexual trauma, or to what extent is that a problem?

Ms. MCCUTCHEON. Certainly, in your opening statements you mentioned military sexual trauma, and when we look at this year's

results, we find that it is closer to 25 percent of the women who utilize the VA health care system have experienced military sexual trauma. Military sexual trauma in itself is not a mental health diagnosis, and the most common mental health diagnosis associated with military sexual trauma is PTSD, second by depression. Certainly, with the numbers of 25 percent, it is a significant issue for many of our women.

The majority of care for those that do screen positive, 76 percent of those women end up receiving either physical health or mental health treatment who have been screened positive, and a smaller amount do just mental health treatment. You do see there is a small percent of those individuals, those women who have experienced military sexual trauma also have physical health care needs.

At 25 percent, yes, it is a significant number.

Chairman ISAKSON. I know this would be probably a DOD question more than a Veterans Affairs question, but I have toured a number of warrior transition units where the warfighters come home. They are getting ready to sever from DOD and they go through a battery of questionnaires required, generally by computer, where they are asked whether they have ever been traumatized, have they ever had nightmares, or all kinds of things that lead toward mental health problems.

Ms. MCCUTCHEON. Mm-hmm.

Chairman ISAKSON. What specific, or do you know if the DOD does anything specifically to try to early identify women who might have had military sexual trauma before they leave the military to go into VA?

Ms. MCCUTCHEON. You are correct. I cannot speak for what occurs in DOD, but certainly in transitioning, we make sure that that is an item. In the separation health exam, there is also an item on MST. You probably know that at every VA medical center, we screen every veteran who comes to us for experiences of military sexual trauma, and it is just two simple questions, one that addresses sexual assault and the other that addresses sexual harassment. By answering yes to either one of those questions, that veteran is entitled to free health care—mental health care, physical health care, and pharmaceuticals. There is no need to have proof that this experience happened to them.

Chairman ISAKSON. Dr. Hayes, I was at Fort Stewart about 6 months ago in a warrior transition unit, talking to some members of the Third ID who were female in the transition unit. I asked them what was the single biggest problem they thought they faced medically versus a man. Almost every person said it was musculoskeletal recovery after coming back from combat. Is that true?

Ms. HAYES. Absolutely, sir. We find that for both men and women, that musculoskeletal injuries are the number 1 reason that they seek health care, either from VA or while they are still in the transition. I think when we think about the roles that women serve today, it is quite natural that they would have the same kind of injuries from jumping off of a truck or from carrying heavy packs and that chronic pain and musculoskeletal issues are number 1.

Chairman ISAKSON. Just following up on that, since I have got 9 seconds to go, we had a hearing here on opiates a while back. Are you all paying attention to the prescription of opiates and pain

killers to make sure we are not over-prescribing them in cases where it is musculoskeletal injury and not something that should get opiates?

Ms. HAYES. We are very much involved in the issues of chronic pain for women as well as for our male veterans and looking at the issues of opioids and also the alternative medication and non-medical ways, complementary therapies that are effective in treatment of chronic pain. It takes a very comprehensive look for the person so that we are not just somehow cutting off and worrying about substance use disorder, but also trying to find adequate solutions for their chronic pains.

Chairman ISAKSON. Thank you very much.

Ranking Member Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

Let me sort of try to focus a bit on numbers, on specialties that would affect women directly, and primarily OB/GYN. What is your estimate as to the number that are needed now and in the future compared to the number available? In other words, what is the gap that has to be met?

Ms. HAYES. First, I want to be clear that we have OB/GYN care—I should say, we have gynecology care at every VA medical center. What we do not have is a gynecologist actually on the staff at, right now, about 35 of our sites. The distinction is that some of those sites have access to gynecology from the community. The women are not going without care, but the care is available through VA Coordinated Care, sometimes on site, but not necessarily on staff.

Senator BLUMENTHAL. But, they are not available in sufficient number.

Ms. HAYES. That is correct, sir. But, I think——

Senator BLUMENTHAL. You may say they are at the site, but they are not there when the veterans need them and they are not there in sufficient numbers to meet the volume of care. I am asking, essentially, how many do you need to hire or get on board somehow?

Ms. HAYES. Right now about 35——

Senator BLUMENTHAL. Thirty-five——

Ms. HAYES [continuing]. Full or part-time——

Senator BLUMENTHAL [continuing]. New doctors?

Ms. HAYES. We need to have part-time gynecologists available on staff at about 35 sites. Now, what we are doing about that is we are talking to the leadership at each site and working on ways for that to happen. It is an individual conversation between my office, the Chief of Surgery, and the leadership at that site to see what are the barriers. Sometimes, it is a recruitment issue from the community. Sometimes it is just not actually having brought the person on staff.

Senator BLUMENTHAL. Do you regard Connecticut as one of those sites, the VA facility in West Haven?

Ms. HAYES. The VA facility in West Haven currently has gynecologists on staff.

Senator BLUMENTHAL. But, my understanding is that it needs more.

Ms. HAYES. That is part of——

Senator BLUMENTHAL. That is an example of the point I am trying to make. In other words, to say you have an OB/GYN on site may mean, well, she is there a half-day a week, or there is one and you need five. I am trying to drill down on how many you need—what the universe of need is compared to what you have and what it will be in the future——

Ms. HAYES. Right.

Senator BLUMENTHAL [continuing]. As the number of women veterans increases.

Ms. HAYES. What I can say is I would agree that we have not had an effective planning mechanism up until this time. As part of VACA Section 301 and the adoption of the Workforce Planning Model, we have been looking at every site and the workforce that is needed in gynecology, women's health, primary care, specialty care, and that project is underway. It is not yet at fruition in terms of exactly what is needed where.

In the meantime, we have addressed that each site must strategically plan for the number of women who are there and start increasing the gynecology——

Senator BLUMENTHAL. Here is what I would suggest, and I do not mean to interrupt you, but for planning and management within the VA with regard to this specific specialty to be regarded as effective and competent. I would think you could give us numbers of doctors in this specialty that are available now to meet the need, what the unmet need would require in additional numbers, and what it will be in the future. You cannot really tell whether you are meeting the need unless you have that estimate of numbers. I think the same should be done in other specialties, as well. I hope that you will be able to provide those numbers to us.

Since my time is limited, I am going to go to another topic, which is mental health care. This morning in the Commerce Committee, we had a hearing on telemedicine, including tele-mental health care, which often is very promising and effective because it provides for the kind of privacy and anonymity that people seeking mental health care need and deserve. What has been your experience, Dr. McCutcheon, in treating military sexual trauma, which is one area of mental health care that has to be addressed, with telemedical health care?

Ms. MCCUTCHEON. Thank you for that question. I do not have personal clinical experience, but I do know that, as I mentioned before, military sexual trauma is not a diagnosis in itself, but, let us say, Post Traumatic Stress Disorder. There have been some pilots with using tele-mental health in the delivery of prolonged exposure or cognitive processing therapy, which is the gold standard for treating Post Traumatic Stress Disorder, and I think for the reasons that you mentioned, some women, do not feel comfortable coming to the VA. There also may be an issue of distance. I think that is an alternative to treatment that we should embrace and we do embrace. Thank you.

Senator BLUMENTHAL. Thank you.

My time has expired, but I want to just emphasize again, Dr. Hayes, that my feeling is that the VA should supply to the Committee numbers as to specialties in women's health care, numbers of doctors on board now, numbers that are needed now to meet

women's health care needs, and numbers that will be needed 5 and 10 years out. I cannot accept that the VA is unable to provide those kinds of numbers.

Ms. HAYES. I agree, sir; I'll take that for the record.

Senator BLUMENTHAL. Thank you.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. RICHARD BLUMENTHAL TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. The current number of Designated Women's Health Providers (DWHP) across VHA is 2,168 as of the end of FY 2014. DWHPs are specially trained and certified to provide primary care specific to women Veterans. Our target is for every VHA site of primary care to have a sufficient number of DWHPs to provide support for the local women Veteran population, to include redundancy when a given provider may be on leave or otherwise unavailable.

To that end, VHA needs to immediately train and certify, or recruit an additional 675 DWHPs to meet the current demand. We will leverage all means at our disposal, to include training of existing providers and hiring of additional providers through our Medical Services appropriation and through VACAA funds. Within the next fiscal year, accounting for primary care provider turnover rate of 18 percent per year, and a projected 10 percent increase in the number of women Veterans, it is estimated that an additional 521 primary care providers will be needed; bringing the total near-term need to 1196 Primary care Designated Women's Health Providers.

As for our requirements in the out-years, VHA is developing models to more precisely project both the number of women Veterans in need of care and the number of DWHPs required to support them. Women Veterans health care is more than just a subset of the overall health care infrastructure—and the future demographics of women Veterans will not mirror those of men. The models we craft will focus on understanding this distinction and deriving useful provider projections in turn.

Chairman ISAKSON. Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman.

I would like to just begin by following up on Ranking Member Blumenthal's comments and thoughts in terms of the number of individuals available for providing care, and in particular, could you provide us the number of women gynecologists that you have available for our veterans?

Ms. HAYES. We can provide that, sir.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MIKE ROUNDS TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Overall, women comprise 37 percent of VHA's physician workforce. Nearly half of providers in both gynecology and primary care are female (48% and 47% respectively).

The table below shows the breakout in greater detail.

	Physicians	Gyne-cologists	Primary Care Physician	% by Gender All Medical Officers	% by Gender Gynecology	% by Gender Primary Care
Male	14,948	64	3,354	63.13%	52.03%	53.42%
Female	8,732	59	2,925	36.88%	47.97%	46.58%
Grand Total	23,680	123	6,279			

Additional Background on Gynecology:

The DAV and other VSO's continue to report that we don't have gynecologists at "1/3" of VA medical centers." However, we have increased significantly, from 60 sites a few years ago, to 118 VAMCs now (78%).

That said, more work remains to be done: we need to add Gynecology surgical clinics and a minimum of one staff Gynecologist at five Intermediate Surgical Complexity sites.

For the 26 remaining sites, VHA is working directly with VISN, facility, Surgery and other leaders to assess the population of women Veterans at each site, how offsite gynecology is managed, and coverage for emergency conditions. Many of the 26 sites do not have surgery in-house; hence VHA needs to ensure coverage of Emergency needs/high risk conditions. The outcome of this work is a plan to appropriately manage gynecology staffing or coordination at each of the 26 VAMCs. We anticipate completion by Fall, 2015.

Senator ROUNDS. Would you, please.

Ms. HAYES. Yes. One of the things I want to make clear, though, is that we have the kind of women's health for basic gynecological procedures, meaning pap smears, mammograms, treating menopause, birth control. That is available everywhere, and that is why we went to the comprehensive women's health, designated women's health provider model. I think sometimes people confuse the need for gynecology—gynecology is needed in our centers for specialty care, for surgery, for removal of fibroids, for hysterectomies, but for basic gynecological, what most people think of as basic gynecological care, that is treated everywhere by our designated women's health providers.

Making that distinction, we have that available, the providers, and most of them, actually, 98 percent of those providers are female. Very few men have chosen to become designated women's health providers in our system. We want to make sure that we address both the basic gynecological needs, or women's health gender-specific needs, and the gynecology needs, which is a more scarce resource and sometimes harder to obtain in certain communities.

Senator ROUNDS. I was pleased to hear that you had some very favorable reports in your opening comments with regard to the performance, or at least the analysis. Could you provide us, or have you provided the Committee with a copy of those most recent results, the data that was completed and how it was determined?

Ms. HAYES. Absolutely, and I would like to just highlight that, for example, for many years, VA has exceeded the private sector, scoring 87 percent on getting mammograms, breast cancer screening. The comparable rate in 2011, which is the last time that gender was put out in HEDIS measures, the private insurance rate is between 60 and 70 percent, and the Medicare rate is 52 percent.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MIKE ROUNDS TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. The National Committee for Quality Assurance (NCQA) produces the Healthcare Effectiveness Data and Information Set (HEDIS) tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The NCQA State of Healthcare Quality Report 2014 shows breast cancer screening rates (women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years) for 2013 were: Commercial Health Maintenance Organization (HMO) 74.3 percent Commercial Preferred Provider Organization (PPO) 69.5 percent; Medicaid 57.9 percent; Medicare HMO

71.3 percent; and Medicare PPO 69.1 percent. In comparison, VA screening rates for the same time period were 86 percent.

The NCQA State of Healthcare Quality Report 2013 shows cervical cancer screening rates (women 21–64 years of age who received one or more Pap tests to screen for cervical cancer in the past 3 years) for 2012 were: Commercial HMO 75.5 percent); Commercial PPO 73.6 percent; and Medicaid 64.5 percent. In comparison, VA screening rates for the same time period were 93 percent.

Senator ROUNDS. The numbers that you are talking about are basically the metrics of the numbers of specific tests and so forth that have been performed as opposed to an analysis of the satisfaction of the individuals that have been involved.

Ms. HAYES. We actually also have satisfaction data, and we can show you data regarding, for example, our designated women's health providers. Those women patients who see those providers are much more satisfied than the women who see other providers.

Senator ROUNDS. If you could. I would appreciate that, Mr. Chairman, if they could provide that to the Committee.

Chairman ISAKSON. Absolutely.

Senator ROUNDS. Thank you.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MIKE ROUNDS TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. In 2010, the VA established policy requiring the provision of comprehensive women's health care by specially trained and designated women's health providers (DWHPs) who can provide both general primary care and gender specific care within the context of a longitudinal relationship.

In an analysis of data from the VA Survey of Healthcare Experience of Patients (SHEP) using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient-centered medical home (PCMH) survey from March 2012 through February 2013, a survey designed to measure patient experience with care, satisfaction with provider responses were measured for 8151 women, providing data on 3147 providers, 1,267 of whom were DWHPs. Scores for six outpatient satisfaction composites were higher for women Veterans assigned to DWHPs than for women who were assigned to primary care providers who were not designated as Women's Health Providers.

Scores for six outpatient satisfaction composites were higher for women Veterans assigned to DWHPs than non-DWHPs: Access 42.1 vs. 37.7, Communication 74.1 vs. 71.0, Shared Decision Making 61.6 vs. 58.8, Self-management Support 56.0 vs. 50.3, Comprehensiveness 67.4 vs. 62.0, and Office Staff 66.0 vs. 64.4. In a multivariable model, patients seen by DWHPs reported higher overall experiences with care compared to patients seen by non-DWHPs.

Reference: Bastian LA1, Trentalange M2, Murphy TE2, Brandt C2, Bean-Mayberry B3, Maisel NC4, Wright SM5, Gaetano VS2, Allore H6, Skanderson M7, Reyes-Harvey E8, Yano EM9, Rose D3, Haskell S10.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 Nov-Dec;24(6):605–12. doi: 10.1016/j.whi.2014.07.005. Epub 2014 Oct 28.

Senator ROUNDS. When you indicated currently one-third of the VA medical centers do not have a gynecologist on staff and refer women to other VA facilities or community providers. Just thinking out loud with regard to the Choice Program and the opportunity, how far away are you from being able to provide the necessary services or the desired services at the level that you would like to within the facilities, and is there another alternative out there in terms of amending the existing Choice Act that we have got right now to allow women to be able to go outside of the VA if they want

to for their services? Is that another option? Have you explored that?

Ms. HAYES. I cannot speak specifically to the elements of the Choice Act. What I can tell you is that for many years, about 30 percent of our women needed to go outside of VA for various kinds of care, for mammograms, for breast cancer treatment, for gynecological cancers and such. We have been using non-VA care and the PC–3 contract, and absolutely where appropriate, the Choice Card eligibility, in order that we give the best opportunity for the veteran to access outside the VA.

When we talk about gynecologists on staff, we are talking about bringing in the knowledge and skill level to up our level overall of providing appropriate health care to women. I am as concerned about risk, making sure that when someone comes into our emergency room, they get the appropriate gynecological care. We could always send people out, but that does not make sure that we have got the right kind of care in-house.

Out of our 150 centers, we are down to about 30 that we do not have on staff, even though we may have available nearby. That is the number we are still working on. We have actually improved over the last 2 years from about 60 sites to over 90 sites where we have gynecology on site. On the whole, they are smaller sites, less complex sites, and they are a challenge to bring that kind of expertise in-house.

Senator ROUNDS. Thank you.

Mr. Chairman, I will leave back my 4 seconds. Thank you.

Chairman ISAKSON. Thank you, Senator Rounds.

Senator Manchin.

HON. JOE MANCHIN, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman, and thank all of you for your service.

The VA is committed top ending veteran homelessness by 2015. We have all talked about that. While the nationwide veteran homeless rate has dropped by 33 percent since 2010, we still have nearly 50,000 veterans without a home. Of that number, 13,000 are women. Their rate of homelessness is twice as high as men's, and worse than that, many of them have dependent children with them. Forty-five percent suffer from mental health issues. Seventy percent are affected by substance abuse. Forty percent report experiences of sexual assault in the military.

How do we best attack the problem, and do you believe you will achieve the VA's goal of ending homelessness for these women and their children? Are we able to really get a handle on this? This has been so elusive for so long. Can you give me an idea of where you might be on that issue.

Ms. HAYES. Thank you very much. Certainly, the issues of homelessness for women are intense and they are multi-factorial, as you have just pointed out. We want our women veterans to be successful and we certainly want to be able to have in place the programs that we need to meet each of those types of needs. Depending on where she comes into our system, in terms of whether it is needing counseling, whether it is poverty and she needs a job, whether it

is additional just basic housing for her and her child, our homelessness programs are set up.

Particularly the ones that are seeing the most use by women are the supportive services for veterans and their families, which is about 15 percent of their services go to women and children. Our HUD-VASH program, about 14 percent. That is in contrast to the fact that 7 percent of VA users are women. You see about double that proportion are being seen in our homeless programs.

I also think we have quite a bit to offer in terms of that juxtaposition between those who need jobs and the jobs that are available, and I actually would like to call upon Ms. Cloud for a moment to talk about VA's efforts in this area.

Ms. CLOUD. Thank you, Senator Manchin. We have, in partnership with the Veterans Health Administration, worked hard to support our women veterans who many times suffer from rates of homelessness with children. We have entered into a public-private partnership in key cities where we have high rates of homelessness for women with children, and with the private sector and local community leaders are working together to fast track, if you will, the sponsorship and mentorship of the employment community.

Our benefits advisors, who provide transition benefits briefings across the country to all of our active duty and Guard and Reserve personnel, are part of this pilot. They are bringing in the cutting edge tools that are being provided to our transitioning population to our veterans who are a part of this pilot, as well. We have kicked off in Seattle-Tacoma and are moving to five other locations this year.

Senator MANCHIN. The other thing that I have a tremendous problem in the State of West Virginia is prescription drug abuse. In all honesty, I see so many of our veterans being diagnosed and given pain pills. We are addicting a generation of our veterans, I do not think intentionally. I do not think we really know what we are doing. There have to be alternatives, and I know you must see it with all of the women you are dealing with and all the patients that you deal with. Does the VA at the higher levels see what we are doing, and is there any other alternative to using just prescription drug medication for PTSD?

Ms. HAYES. On two fronts, one is making sure that we have the right treatments for chronic pain, because when someone has become addicted, cutting them off is not the answer. We need to make sure we have the right comprehensive treatments available. This is where I think we have found that——

Senator MANCHIN. I am so sorry, because my time is running, but it seems like the pathway of least resistance is, let me write you a prescription for that, and it starts us down a road that we cannot get off. The opiate road is horrific, not just in the VA, but all through society. Do you all have an alternative way of prescribing any other alternative method than just writing a prescription?

Ms. HAYES. Yes, we do, and women appreciate and have more uptake of the complementary treatments such as: yoga, acupuncture, chiropractic, and meditation.

Senator MANCHIN. You are pushing that in the VA?

Ms. HAYES. We are pushing those in VA, and our women are asking for them. We know that in a complex addressing of this problem, all of those options need to be available to our veterans.

Senator MANCHIN. Do you have drug treatment centers for——

Ms. HAYES. Every veteran who comes in, we do assess substance use disorder——

Senator MANCHIN. Can you help them get——

Ms. HAYES. We have treatment centers, yes. I do not know if you wanted to add to that in terms of——

Ms. MCCUTCHEON. Just quickly, as far as West Virginia, as you mentioned, of your four VA medical centers, you have both our standard addiction outpatient treatments, you have two with intensive addition outpatient treatments, and you have two facilities that actually have residential programs that treat addiction. In the State of West Virginia, you do have great resources for addictions.

Senator MANCHIN. I am looking for the effectiveness of those resources, because I can tell you, it is the number 1 killer in my State. It comes out of the medicine cabinet. It does not come off the street corner. It is an epidemic and as a society, we have gotten to accept that everybody knows somebody that is addicted or has a drug problem. We are not talking about it. We are not doing anything about it. We are not trying to prevent it. I think it starts here and we can do something from the type of drugs that are coming on the market, the way they are prescribing it, and it really starts in the medical profession of how you look toward this as far as they are trained properly to be dispensing this. I am just happy to hear what you are doing. I would like to see some of the alternative programs and see them in West Virginia. I will do that.

My time has expired, but I appreciate very much your efforts.

Chairman ISAKSON. Thank you, Senator Manchin.

Senator Heller.

STATEMENT OF HON. DEAN HELLER, U.S. SENATOR FROM NEVADA

Senator HELLER. Mr. Chairman, thank you for holding today's hearing. I also want to thank the Ranking Member. I also appreciate the fact that we are holding this so early in the session. This is an important issue, I think, for everybody that is here in this room and an issue that, I think, is very important.

We raised the question early on about when was the last time we actually had a hearing on women's health care issues facing our veteran women and it had been quite some time. Again, I am very appreciative. This hearing does not happen unless the Chairman decides that it is a priority to him, so I am just grateful that we are having this discussion. I also want to thank those witnesses here that are with us today and for taking time and sharing your expertise.

Chairman ISAKSON. The record should reflect that the Senator from Nevada was the first person to ask for this hearing and we are happy to respond to him. Thank you.

Senator HELLER. Thank you.

I am looking at some statistics—we will shift from West Virginia, I guess, over to Nevada a little bit—and looking at the new hospital that was built down there in Las Vegas. It is a great facility.

It really is. The problem was is that they failed to recognize or realize how much use that facility would have, and because of that, after only being 2 years old, they are back to construction and other add-ons to meet the demands.

I think women veterans may have part of the reason that we are seeing these add-ons and this extra construction. I am just looking at some statistics here. In the past 10 years—I think you alluded to this, Dr. Hayes—the number of women veterans using the VA clinic or health care system has increased by 80 percent.

Ms. HAYES. Yes.

Senator HELLER. Last year, the Las Vegas VA Hospital served a total of 4,500-plus women veterans. This year, in the first 6 months of the fiscal year, we have exceeded that number. You can see that it is growing and growing quickly.

Are there any statistics out there of what you anticipate the statistics to be for women veterans using our health clinics and hospitals over the next 5 years, 10 years, 15 years so we can prepare?

Ms. HAYES. Absolutely. Our enrollment projection model was adjusted, actually, when I came on board to include gender projections, so that we work very closely with the group in OPP, Policy and Planning in the VA, to go very carefully over those projections. We expect the near term, 6 to 9 percent, basically kind of what you were seeing, year over year. That has been borne out in the last couple of years, so we have had a 29 percent increase in the last 3 years.

We know, however, that when you think about the number inside is 7 percent today, but 11 percent in Gulf War I, which some people remember—I certainly remember—and 15 percent active duty, that we are just getting to the point where we are going to have lots and lots of women on our doorstep and we have to ramp this up even more quickly than we have been.

I agree that we can give you the enrollment projection model and the numbers at each site and what we project. We are looking at things like space. We now have new design guides for women and space because we know that we are going to be bursting at the seams with women. We do not have the capacity and resources in place for what is coming in the door tomorrow.

Senator HELLER. Let me go back to the Las Vegas Hospital. Like you said, it has a great women's health clinic in that particular hospital. But, if you go up to Reno, that hospital was built in 1939 and older facilities are finding quite a challenge to meet some of these health care needs. What is the VA doing to meet some of these challenges?

Ms. HAYES. Each site is obligated to do a strategic plan for women. What is important about that is we have a town hall method and we have input from the women veterans at that site so that what type of women's clinic or other type of facilities that are going to be built have the input of the local women veterans. In some sites, we do integrate care with women and men in the same type of clinics, and in other sites, women prefer that we have a standalone women's clinic.

I have been to Reno. I know that they have been trying to expand the space that they had for women's clinic. It is bursting at the seams. In each site, it has to be based on the local needs, and

we are supporting that through an oversight of the strategic planning nationally.

Senator HELLER. I would anticipate that you would incorporate into any new building, new hospital, a women's clinic?

Ms. HAYES. Absolutely.

Senator HELLER. Would you anticipate in the next 10 years that there would be a women's clinic in every hospital across the country?

Ms. HAYES. Within 10 years? That would be my guess, but I think what I can tell you is we have been very involved in the SCIP process, where they put in their bids to do more construction. We have been looking at every project, because it is not just building a women's clinic that is important. It is, as was mentioned before, it is every site in the hospital, wherever women may go, whether it is the cardiac stress test area, where there has to be the appropriate accommodations for both women and men in each and every one of those sites.

While it is looking at if they have enough of the right primary care space for women or gynecological procedure rooms for women, it is also do they have the right bedrooms for women and inpatient facilities for women and every other possible kind of space is adjusted to the needs of the women coming in.

Senator HELLER. Dr. Hayes, thank you.

Ms. HAYES. Thank you.

Senator HELLER. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Heller.

Senator Sullivan.

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman, and I also want to echo Senator Heller's comments about you and Ranking Member Blumenthal, and this hearing is a very important topic.

I would like to drill down a little bit more on Senator Manchin's focus on homelessness. I saw a recent fact sheet from the Office of the First Lady on the strategy of ending homelessness within 5 years. I think that is a great goal. I think that is something we should all be rallying around. I commend the VA and the White House for doing that.

With regard to women's homelessness there was a recent GAO study that mentioned that women veterans were three times as likely to be homeless than non-veterans. What do you think the factors are? What is driving that? That is a startling statistic to me.

Ms. HAYES. I think that the issues for women are different than they are for men. Women veterans coming out of the military, particularly those deployed, have a tremendous challenge in the reintegration period, and it is about reintegrating with their family. It is about the emotional issues, many of the physical issues we just talked about, and the overall societal issues, as well, and not being recognized as veterans, not necessarily seeking out the care that is helpful to them. Put on top of that that they have children in tow. We also know that there is a challenge in terms of divorces and disruption in marriages.

If we do not get to them early in that process through our Vet Centers or through our other outreach programs, we do not identify their needs and help them soon enough, then they spiral down pretty quickly. I think we have kind of lost some of the ground at that point.

Senator SULLIVAN. If we are looking at the core top principles that we would want to be implementing, either as part of the VA or as part of Congressional action, on this issue of women veterans' homelessness, what would the top three be?

Ms. HAYES. I think one of them is transition, and I want Ms. Cloud to talk a little bit about getting them before they are out.

Senator SULLIVAN. Good. That is my next question.

Ms. HAYES. That is it. The other, I think, is an early assessment of what help do they need. We have got to get them in so we can assess what they need, and we have lots of things to give them. We have things to prevent homelessness.

Senator SULLIVAN. Does the VA have the authority to do these things, to focus on these things? Do you need that from the Congress, or do you have that right now?

Ms. HAYES. We have the ability to provide almost everything in order to prevent homelessness if we get them at a point where we are assessing them in our health care system or elsewhere to figure out if they need these things.

Senator SULLIVAN. Ms. Cloud, I am glad that Dr. Hayes raised the issue of the TAP program. You know, as somebody who has been through that a couple times in my own career, as somebody who is the father of three teenage daughters, I would be very proud if one of them chose or all of them chose to be in the military. I certainly would want, when they left the service that they would have more opportunities than when they started.

When I went through the TAP programs in the Marine Corps, it was pretty much standardized. Are there any things that we are doing right now that are more tailored to the issues of women veterans with regard to transition assistance, and if so, what?

Ms. CLOUD. In addition to the benefits advisors, who are 90 percent of them are veterans who provide that service of transition——

Senator SULLIVAN. Are they women advisors, for the women?

Ms. CLOUD. Thirty-five percent of them are female——

Senator SULLIVAN. Good.

Ms. CLOUD [continuing]. We are able to provide in a high-intensity rate that one-on-one connection point for that warm handover, not only to VA services, but also to Department of Labor American Job Center services. Our regional offices also have women veteran coordinators, MST coordinators, and dedicated resources. Those warm handovers are a lot cleaner than they were in the past.

To your previous point, in many cases, our women veterans as they enter and reintegrate, the private sector many times does not have visibility, not only of their service, but will automatically look for their skills translation as a veteran.

Senator SULLIVAN. Yes.

Ms. CLOUD. Helping the private sector truly understand that not only are we transitioning male veterans, but we have a high per-

centage of women veterans who are also coming out the door and oftentimes are more hesitant to recognize their own——

Senator SULLIVAN. These veterans should be viewed as some of the top candidates for jobs, as you well know—motivation, discipline, they have it all, right? This is a win-win for corporate America, for anyone who hires a veteran. Do you think that there is an issue that women are not being recognized as veterans that have these great skill sets that all of our veterans, men or women, have?

Ms. CLOUD. I think we have taken on the challenge to speak to the private sector. We looked at a million records—many of them are women—and found that the story of women veterans who graduate at a higher rate than their male counterparts by 10 percent, who outperform when they connect to competitive employment the general population of women, we need to tell that story. We are working in community-based efforts, in partnership with not only homelessness teams but employment teams and our Federal partners, to tell that story, why they are a good bet.

Senator SULLIVAN. Great. Thank you.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Sullivan.

Senator Tillis.

HON. THOM TILLIS, U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chair, and thank you for having this meeting on a very important topic.

Mr. Chair, over the past 10 days, I have gone to three different VA facilities down in North Carolina, Fayetteville, Durham, and Salisbury. I saw some good things there. I saw some challenges in terms of facilities and other things, but a number of really good and promising things, in Salisbury, in particular, some things particularly focused on women veterans. While we hold you all to a high standard for the things we want fixed, I also want to recognize some good work that is going on there that, hopefully, will be replicated over time.

To go back to the questions that Senator Blumenthal asked about getting information on providers specifically for women, I think it would be also helpful to get information on facilities and how we would grade the current facilities in terms of serving the needs of women. Some of the new health care centers that are coming online in North Carolina are far better equipped, I mean, physically better configured to be able to provide segregated service when needed, and I think probably a better setting.

I would like to know how we are looking, and it really gets back to Senator Heller's question about what can we look at over the next 10 years. I would like to see what is already in the pipeline, things that are going to happen versus things that are subject to future funding and other constraints so that we can get a better feel for what we can reasonably expect. Is that information readily available? Is that something we can get follow-up?

Ms. HAYES. We can follow up with that. We do have each facility do what we call a WATCH, Women's Assessment Tool for Comprehensive Health, each year and report on a number of things, including the number of providers, the number of women that they

see, how many women they project, and what their strategic plan is.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. THOM TILLIS TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. The Women's Health (WH) Dashboard monitors elements from the Women's Assessment Tool for Comprehensive Health. Each quarter, Network Lead Women Veteran Program Managers upload facility data on the requested data. The WH Dashboard includes strategic planning; market penetration; the implementation of women's health care and extended hours; privacy and security corrections; and gender specific rural and telehealth initiatives. Attached are the most recent results submitted for 4th quarter FY 2014.

In regards to facility settings, in accordance with VHA Handbook 1330.01, "Health Care Services for Women Veterans," (2010) a VHA facility may choose one or more of the following Comprehensive Primary Care Clinic Models to best meet the needs of women Veterans and the achieve the standards for Comprehensive Primary Care for Women Veterans:

"a. *Model 1. General Primary Care Clinics.* Comprehensive primary care for the women Veteran is delivered by a designated WH PCP who is interested and proficient in women's health. Women Veterans are incorporated into the WH PCP panel and seen within a general gender-neutral Primary Care clinic. Mental health services for women should be co-located in the general gender-neutral Primary Care Clinic in accordance with the Primary Care-Mental Health Integration. Efficient referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance (less than 50 miles).

b. *Model 2. Separate but Shared Space.* Comprehensive primary care services for women Veterans are offered by designated WH PCP(s) in a separate but shared space that may be located within or adjacent to Primary Care clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.

c. *Model 3. Women's Health Center (WHC).* VHA facilities with larger women Veterans populations are encouraged to create Women's Health Centers (WHC) that provide the highest level of coordinated, high quality comprehensive care to women Veterans.

(1) WHC offers comprehensive primary care services by a designated WH PCP(s) in an exclusive separate space. Whenever possible, a WHC needs to have a separate entrance into the clinical area and a separate waiting room with attention to privacy, sensitivity and physical comfort.

(2) Specialty gynecological care, mental health and social work services must be co-located in this space.

(3) Other sub-specialty services such as breast care, endocrinology, rheumatology, neurology, cardiology, nutrition, etc., may also be provided in the same physical location.

(4) Women Veterans receiving comprehensive primary care through general primary care clinics in sites with WHC need to be referred to the WHC for gynecological care, mental health treatment, and other sub-specialty care."

To summarize, Model 3 clinics are Comprehensive Women's Centers that have dedicated separate space, Model 2 are women's clinics that also have a separate space, but the space may be shared with other services when the women's clinic is not in session. Model 1 clinics provide women's health primary care in integrated settings. All three models should have Designated Women's Health Primary Care Providers (DWHP) and can be available at either medical centers or CBOCs. From the definitions it can be determined that all Model 2 and Model 3 are "women's clinics."

Women's Health Models of Care as of September 30, 2014 are: Model 1–841; Model 2–99; and Model 3–77.

Senator TILLIS. Yes. Part of the reason why I am interested in getting that, it probably dovetails with a question or comment that Senator Rounds made as to figure out what more we may need to

do based on the short, intermediate, and long-term plans for providing care to women veterans. Are there other things that we should look at that would be a safety valve through Choice, and then any other things that we do with our non-VA care? I know you are actively leveraging them, and I think for women's health care service. I would like to kind of get those two things together so we can match it up and see if there is any short-term relief we can provide.

I am going to try and cover a few things and not re-cover ground that some of the other members discussed. With the transition assistance, are the advisors particularly trained to identify a potential risk situation for people who are going through transition? Are we just providing them a road map for transitioning, or are they trained in a way that could identify people that may be at risk for one form of transition problems or another?

Ms. CLOUD. Both Department of Defense with their in-transition program is focused on supporting the identification and the warm handover for individuals that are needing mental health or more direct engagement from mental health practitioners. In the TAP program, we also provide specific training for all of our benefits advisors on the identification and the referral of resources available for things such as military sexual trauma, but also for very specific employment efforts. That is part of the core curriculum for our benefits advisors.

Ms. HAYES. I would like to add that we also, our primary care providers, have developed a tool which gets at the risk for problems and for homelessness, and they administer this tool for women in the primary care setting. We also put the same tool online in a site called Unidas so that veterans can actually take the tool themselves and see some of their own risks for having problems in employment or homelessness.

Senator TILLIS. One other thing I wanted to mention in my visits to the VA was the good news that I got from Fayetteville in terms of their dealing with pain medication, very positive results that they have down there. It is in contrast to some of the stories we have heard in other facilities, but I am very happy about that. Hopefully, it is something that we are, to the extent we can, replicating elsewhere.

The last question I have in my time remaining relates to suicide rates among female veterans versus the male population. Is there anything there that we should be concerned with? I mean, aside from the horrible reality that we have 22 veterans dying every day.

Ms. HAYES. We are concerned for women veterans. Some of the other problems are duplicated also in the rates of suicide attempts and suicides. We know that women veterans are at higher risk than their non-veteran counterparts. We are examining that in terms of our mental health approach. We also know that some of our most vulnerable women veterans are at risk for higher possibilities of suicide attempts.

Senator TILLIS. Are there, within the suicide data that we have today, is there a disproportionate number of men or women, or is it roughly proportionate to the veterans' population? Is there a disproportionate number of women potentially at risk of suicide over male veterans?

Ms. HAYES. Male veterans are at higher risk, but women are at higher risk than their non-veteran counterparts. It is hard to measure those kind of things.

Senator TILLIS. Yes.

Ms. HAYES. It is tragic. We are looking at those issues in general in primary care and in every place in which we connect with our veterans so that we do not look at it as data later, but it is, rather, an issue that we are very concerned about.

Senator TILLIS. If we can, just back on the first question, that when we get the information, or if you can get the information on facilities, I assume that some of the other members may be interested, but I am particularly interested in getting some of that long-term information for the Southeastern States, where we have one of the fastest growing veterans' populations. I would like to see that data. Thank you.

Chairman ISAKSON. Thank you, Senator Tillis.

Senator Moran, did you want to ask a question or go ahead to the second panel?

Senator MORAN. Go ahead, Mr. Chairman. Thank you.

Chairman ISAKSON. Let me thank the first panel for being here. Dr. Hayes, thank you for your service, Dr. McCutcheon, Ms. Cloud. Please understand, this focus today is not a passing focus. This Committee has a supreme interest in women's health, our veterans' health, and continuing services to our women veterans. Consider us a resource and consider us a sounding board as you have issues that come up that we need to know about. Please volunteer them to us. Do not make us have to come look for them.

Ms. HAYES. Thank you, Mr. Chairman. We appreciate the opportunity to be here today.

Chairman ISAKSON. Thank you very much.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

MILITARY SEXUAL ASSAULT

Question 1. VA's written testimony mentions it is working on implementing a provision from the Veterans Access, Choice, and Accountability Act that allows VA to provide MST services to active duty Servicemembers without a referral from DOD. I highly suspect that much like in the general population, there are many survivors of sexual assault who have not reported their assault that could be eligible for services through VA. A reluctance to report, particularly in environments like the military or on a college campus where reports were not historically taken seriously, does not in any way indicate that the survivor does not need assistance and services related to his or her assault. In many cases, the survivor may be unwilling to even access services through VA because using VA may remind them of the trauma that happened while serving. We must do all we can to make services available to survivors, including providing services to all who need them, even if there is no formal referral from DOD.

Can you please provide an update for when those services for active duty Servicemembers will be available?

Response. Section 402 of the Veterans Access, Choice and Accountability Act authorizes VA, in consultation with DOD, to provide Military Sexual Trauma (MST)-related healthcare to Active Duty Servicemembers (ADSMs) without the need for a referral from DOD. VA and DOD are proposing a phased approach starting at as of yet to be identified VA site(s) that will provide MST-related confidential healthcare services for ADSMs without requiring a referral. VA and DOD are currently working toward identifying the pilot site(s) and reaching a clinical consensus on any restrictions to confidentiality such as duty limitations as part of the treat-

ment plan. The phased implementation of Section 402 is scheduled to begin August 2015.

WOMEN HEALTH PROVIDER TRAINING

Question 2. As the Fiscal Year (FY) 2016 budget submission noted, the number of women using VA's health care system has doubled since 2001. This number is projected to continue to grow. By FY 2023, women will represent over 10 percent of the enrollee population at VA. As a result it is essential VA ensures it is equipped to serve the diverse needs of this group of Veterans. VA's testimony discussed intensive training for over 2,000 women's health providers as well as online, accredited women's health classes.

a. Can you please provide a summary of the material covered in these trainings?

Response. The intensive Women's Health update for primary care providers includes lectures and facilitated small group case discussions with expert facilitators on topics such as contraception, vaginitis and sexually transmitted infections, cervical cancer screening, menopause, abnormal uterine bleeding, breast health and breast cancer screening. In addition, there is a post-deployment session that includes a demonstration of military equipment used by women during deployment and a discussion about deployment issues specific to women Veterans. Training on performing breast and pelvic examination is done using simulation equipment, training videos, and trained, live actors. Participants have access to a women's health pharmacist on-site for medication questions.

b. How much of the current workforce is represented by the 2,000 providers who have received the intensive training and how many have taken the online training?

Response. As of September 30, 2014, there were 2,168 primary care providers specifically designated to care for women Veterans. Of the 2,168 providers 55 percent (1193) have taken the comprehensive VHA training and an additional 21 percent (455) have taken women's health training of similar scope (roughly 20 credit hours). The remainder of these individuals are designated to care for women Veterans because they have recent prior experience (ex: in a non-VA practice with substantial numbers of female patients) or professional residency or fellowship (ex: Family Medicine residency or Women's Health fellowship) but they still may benefit from attending the Women's Health Mini-Residency.

It is estimated that at a minimum an additional 675 providers need to be trained, or recruited and designated, so that there are at least two designated women's health providers (DWHPs) at each site to ensure continuity related to leave and turnover. Sites with larger numbers of enrolled women Veterans need at least one additional DWHP per 1000 women Veterans.

Given that, and accounting for provider turnover and the continued increasing numbers of women Veterans anticipated to use VA for health care, it is estimated that up to 900- 1,200 additional providers are in need of the VHA intensive training in the near future.

Of note, roughly 800 providers have taken the mini-residency training program in the past six years who currently are not in this group of designated providers because they are: no longer employed by VA; no longer care for women in VA; have not yet received an official designation; or have taken the training for their own professional development.

In addition to face-to-face courses for primary care providers, nurses, and emergency care staff, VHA has launched more than 50 online courses and awarded more than 20,000 hours of professional continuing education credits to clinicians in women's health topics in the past four years.

ACCESS TO CONTRACEPTIVES

Question 3. Given VA is witnessing an influx of young female Veterans who are of child bearing age, interest in reproductive contraception is no doubt growing. According to VA data, over 40 percent of women Veterans seen in VHA are within their reproductive years. Requirements that private insurers provide free preventive care services do not apply to VA.

a. What is VA doing to ensure it is offering this group of Veterans access to a wide range of contraceptive options?

Response. VA provides the full continuum of health care for women Veterans including a wide range of contraceptive services including availability of: intrauterine devices (IUDs); hormonal methods (implant, injection, oral pills, ring, and patch); barrier methods; emergency contraception and tubal ligations; and occlusion procedures.

b. If a Veteran seeks a method of contraception that is not on VA's national formulary, what options do they have?

Response. The Veteran's provider can place a non-formulary request that indicates a clinical reason the method is preferred over what is on the national formulary.

c. Has VA done any outreach to determine whether women Veterans are satisfied with the contraceptive options available through VA?

Response. Women's Health Services sponsored a project involving pilot implementation of a reproductive life planning counseling intervention in a Women's Clinic, followed by qualitative interviews to assess women Veterans' perceptions of this counseling. As a part of this project, primary care providers (PCPs) and women Veterans engaged in a patient-centered conversation to (1) identify their reproductive goals, (2) identify preconception health risks and develop strategies to address these risks, and (3) choose a contraceptive method that aligns with their reproductive goals. The results demonstrated that women Veterans generally perceived reproductive life planning discussions with their PCPs as important opportunities to obtain new and relevant information about contraception and planning healthy pregnancies. Available data do not suggest that women Veterans are dissatisfied with the VA's contraceptive options.

MENTAL HEALTH CARE

Question 4. Given VA's desire to offer women Veterans access to high-quality comprehensive health care that includes reproductive health care and focused mental health care:

a. Please provide a summary of the specific training that providers and other clinical staff at VA are receiving to achieve this goal.

Response. Beginning in FY 2012, the Reproductive Mental Health (RMH) Steering Committee has worked to enhance the care of women Veterans with mental health conditions. A Needs Assessment was developed and implemented across the VA system that assessed VA mental health providers' need for Reproductive Mental Health education, resources, and tools. VA has launched a new online RMH curriculum which supports VA providers' knowledge of reproductive mental health and their ability to best meet the reproductive mental health needs of women Veterans. Six modules are available online through VA's Talent Management System (TMS) addressing the following topics:

- Overview and History of Reproductive Mental Health
- Course and Treatment of Psychiatric Illness during Pregnancy
- Course and Treatment of Psychiatric Illness during Postpartum and Lactation
- Treatment of Psychiatric Disorders and Menopausal Symptoms in Midlife Women
- Special Topics in Reproductive Mental Health: Focus on Treatment Emergent Side Effects
- Gender based Differences in Presentation and Treatment of Posttraumatic Stress Disorder

Additionally in fiscal year (FY) 2013 and 2014, VA launched a total of five MyVEHU (www.MyVeHUcampus.com) learning sessions on reproductive mental health. During the live viewing, over 300 learners participated in each session.

b. Please describe any research efforts in specialized areas like mental health, including PTS and TBI, that VA is pursuing that relate specifically to women Veterans. Further, how does VA anticipate those efforts will translate into improvements for clinical care?

Response. The mental health of women Veterans has long been an important priority in VA women Veterans' research, and over time has often been the most important focus of women's health research at VA. This has been evident in five VA Health Services Research and Development Service systematic reviews of published women Veteran's research since 2006, and in particular, in an additional systematic review in 2014, by VA Mental Health services specifically focused on women Veterans' mental health. These studies have examined the full spectrum of women Veterans' mental health for different military era cohorts and ages (including women from the Vietnam era and Iraq and Afghanistan). The studies also assessed gender differences between male and female Veterans. Research addressed: the prevalence of various mental health conditions among women Veterans; screening for these conditions; risk factors; the prevalence and association of medical or physical health conditions and functional impairment with mental health care.

In 2010, VA's Health Services Research and Development Service funded the Women's Health Research Network (WHRN) in order to build women's health re-

search capacity, expand research, and also expand the recruitment of women Veterans nationwide in VA research. The primary goals of the WHRN are to: examine VA's research portfolio; identify gaps in research; accelerate the development, testing and dissemination of interventions, implementation and high-impact research to improve women Veterans' health and healthcare. Among the initial WHRN strategic research portfolio areas was mental health. A dedicated Mental Health Work Group of both researchers and VA program and policy managers was organized to develop a strategic research agenda for mental health. More recently, additional work groups have been developed for depression and for trauma (sexual trauma, Post Traumatic Stress Disorder and intimate partner violence). In addition to identifying research gaps and new research areas, the WHRN plays a major role in testing new innovations in mental health care and facilitating implementation of improvements in care into practice.

The emphasis on mental health within the WHRN and VA research has been demonstrated in recent research findings. Two special VA journal supplements have included extensive research on mental health issues. Research has addressed: the relationship of military sexual trauma and homelessness among women Veterans; gender differences in prescribing among Veterans with PTSD; gender differences in mental health conditions and stressors associated with military deployment; gender differences in mental health and substance use disorders and treatment entry among Veterans in the criminal justice system; the relationship between the experience of intimate partner violence and presence of Traumatic Brain Injury among women Veterans; and the effect of medical comorbidities on male and female Veterans' use of psychotherapy for PTSD. Findings that Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) women Veterans had a greater number of healthcare visits than women from other military eras, and also higher rates of mental health disorders, suggest a need for better integration and coordination of primary, reproductive health and mental health care.

Numerous other studies highlight the need for improved screening and attention to mental health issues in multiple healthcare delivery settings. The first such study involving reproductive health indicated a higher prevalence of mental health conditions among pregnant Veterans enrolled in VA healthcare than among non-pregnant women Veterans; this finding helped shape national policy requiring coordination of maternity care, and informed development of a national initiative on reproductive mental health. Recent research confirms the importance of addressing mental health issues for reproductive care and health:

- Mothers with active PTSD are significantly more likely to suffer spontaneous preterm birth;endometriosis among those 18–44, or menopausal disorders) were more likely to have concomitant medical and mental health diagnoses and also more VA outpatient encounters; and
- Pregnant women Veterans who use VA prenatal benefits (vs. those who do not use these benefits) are a high risk group: they were more likely to have self-reported depression, and current depression or PTSD symptoms or PTSD.

The importance of VA mental health services to women Veterans has been demonstrated by a recent nationwide survey of over 6,000 women Veteran VA primary care users. This survey, which focused on gender-sensitive access to mental health care, showed that almost all women who used mental health services in the past year used VA care for at least some of their mental health care; however, only about half of these women indicated their mental health care met their needs completely or very well, suggesting gaps in perceived access. Higher levels of patient activation were associated with better ratings of mental health experiences and gender-related or—sensitive care experiences contributed to greater perceived access. In a related analysis, researchers examined women Veterans' needs, priorities and preferences for behavioral services, which included: treatment for depression; pain management; coping with chronic conditions; sleep problems; weight management; and Post Traumatic Stress Disorder (PTSD). This relatively new area of research is focused on understanding women Veterans' experiences with care and preferences (e.g., co-located primary care and mental health services, and designated women's health services and providers)—both for behavioral and physical health. These findings will inform development of models of care (e.g., integrated primary care and mental health care) that are more in line with women Veteran preferences, and support development of tools for enhanced patient activation and health management that ln turn will improve perceived access and guide implementation of more patient-centered behavioral health services.

Other current and past research will also guide development and implementation of more patient-centered mental health services for women Veterans. Important areas of research include: examination of the impacts of sexual and combat trauma,

as well as PTSD, on seeking care and patient experiences; examining the impacts of trauma, PTSD and depression in lesbian, bisexual and heterosexual women; determining other barriers to mental health care use such as stigma (particularly self-stigma), personal mental health beliefs, and perceptions of VA care; further analysis of the impacts of deployment and military related risk factors on mental health, physical health and Veteran functioning; longitudinal study of an OEF/OIF/OND cohort regarding predictors and psychiatric and psychosocial modifiers of treatment patterns, use of services and health outcomes associated with mental health conditions, musculoskeletal pain and cardiovascular disease; and development and assessment of web-based and shared decisionmaking interventions to improve evidence-based mental health and PTSD care for Reserve/National Guard women Veterans with PTSD.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO PATRICIA HAYES, PH.D., CHIEF CONSULTANT, WOMEN'S HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Every piece of testimony-from both panels-reflects the changing demographics of today's Veterans and recognizes the need for the VHA to adapt to serve all Veterans, especially the growing female Veteran population. I was pleased to join Senator Murray and Senator Heller on their bill, Women' Veterans Access to Quality Care Act, to ensure that all female Veterans have access to a full-time obstetrician or gynecologist at every VA medical center. This seems to be a common sense approach to properly care of our women Veterans, in addition to steps to update training for primary care professionals.

Question 1. My question for Dr. Hayes is this, why, when the VHA is aware of military's changing force structure, would it take an act of Congress to make access to a full time obstetrician or gynecologist possible? Why did the VHA not take proactive steps to address critical gaps in medical coverage for the rising number of female Veterans?

Response. VA has been taking proactive steps to enhance access to medical care for women Veterans. VA has enhanced access to Designated Women's Health Primary Care Providers and developed training to enhance a provider's ability to care for women Veterans. A Gynecology Health Care Delivery Workgroup has been assembled to develop guidance on enhancement of gynecology services across VA and is actively contacting health care systems with no gynecologist on site to collaboratively determine plans for future enhancements in this area.

Question 2. In your testimony Dr. Hayes, you mention the yearly assessments conducted by an independent contractor regarding the implementation of services for women Veterans. What was the result of the most recent report, and what, if any, gaps were detailed in the report? How is VHA working to address those gaps, and what is the timeline to fix them?

Response. In FY 2014, the independent contractor conducted 24 comprehensive evaluations, to bring the total completed to 94 site evaluations (67 percent of Women's Health Programs). The primary purpose of this program evaluation was to gauge progress toward the full implementation of comprehensive health care for women Veterans as delineated in VHA Handbook 1330.01: "Health Care Services for Women Veterans" (May 2010). The assessment teams used a Capability Review Tool that addressed five essential Women's Health Program domains or "components:" 1) Program features; 2) Health Care Services; 3) Outreach, Communication, and Collaboration; 4) Patient Centered Care (PCC)/Patient Aligned Care Teams (PACTs); and 5) Education and Training. Within these components there are 33 capabilities comprising more than 300 evaluation criteria.

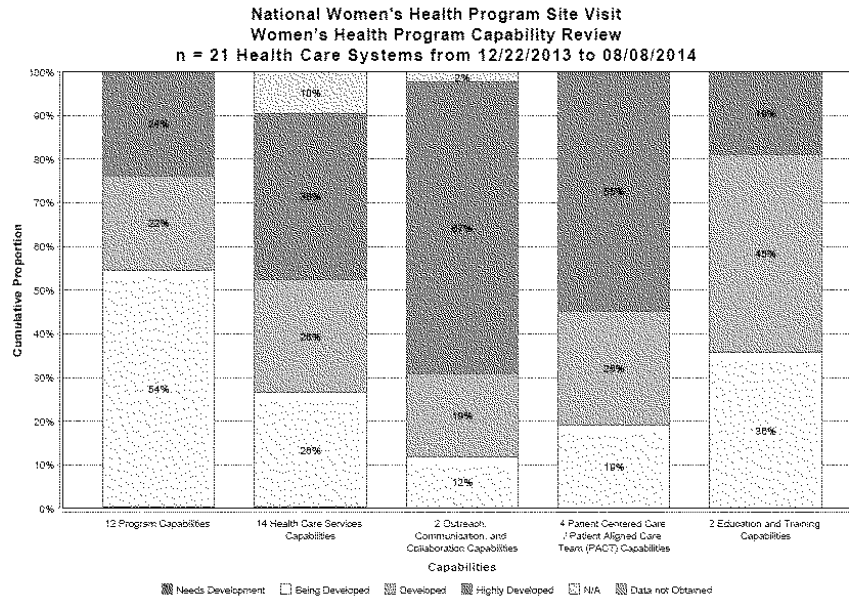
Each capability was scored on a four-point Likert scale:

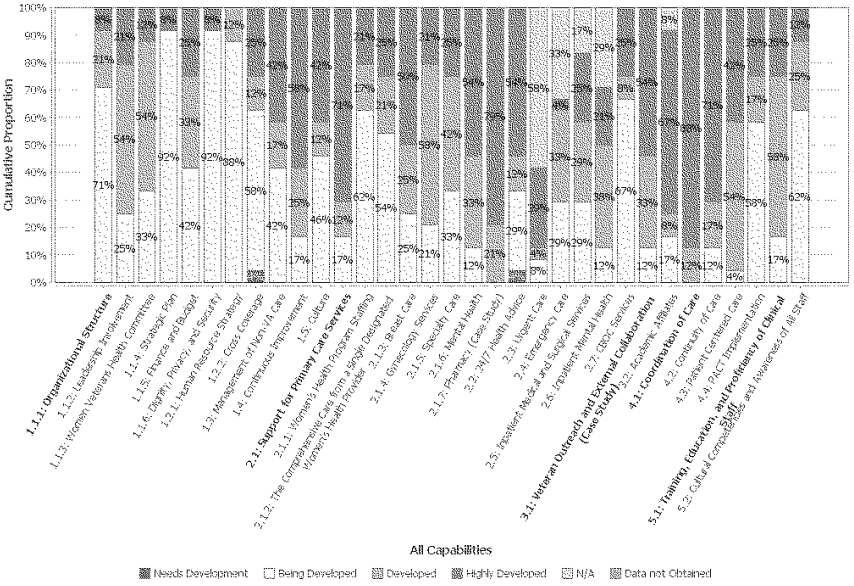
1 = "Needs Development"—No ongoing plans to meet critical success factors
2 = "Being Developed"—At least one critical success factor not met
3 = "Developed"—All critical success factors met
4 = "Highly Developed"—All criteria met

Data for this report were analyzed by examining "High Performance" versus "Less than Developed" across components and capabilities. Recommendations were based on capabilities that emerged as "Less than Developed," where critical success factors were not met at the majority of sites. As a result of the analysis, Component 2 (Health Care Services), Component 3 (Outreach, Communication, and Collaboration) and Component 4 (Patient Centered Care/Patient Aligned Care Team (PCC/PACT))

emerged as High Performance components. Component 1 (Program) emerged as a Less than Developed component reflecting opportunities for further improvement.

Below are summary charts of the 2014 report results:





VHA has developed tools and trainings to assist Women Veteran Program Managers (WVPMs) to address opportunities for improvement in the programmatic func-

tions of the Women's Health Program (WHP) such as strategic planning, organizational structure, human resources planning and cross coverage. In FY 2013, Women's Health Services developed a strategic planning tool kit specific to women's health as a resource for the field. The ultimate goal was for each local WHP to have a usable, sustainable strategic planning process. The toolkit materials are meant to assist the WVPM lead a planning process that assesses the current status of its WHP, identifies areas for growth and improvement in order to meet future needs, and implements target objectives. In 2014, VHA held a large national training for all WVPMs and Women's Health Medical Directors in topics that included: strategic planning, leadership skills, finance and budget issues, enhancing maternity and breast care coordination, and addressing gender gaps in quality measures. In addition, through the implementation of a Women's Health Dashboard, VHA is able to monitor facility implementation of the WHP.

Chairman ISAKSON. We invite the second panel to come forward at this time. [Pause.]

I would like to welcome our second panel. We look forward to your testimony, and I will introduce two of the members and then turn it over to Senator Heller for a third introduction.

First is Joy Ilem, Deputy National Legislative Director of the Disabled American Veterans. We are glad to have you with us today, Joy.

Christina Mouradjian, U.S. Army veteran. Thank you for your service to the country and thank you for being here.

Senator Heller will introduce our third guest.

Senator HELLER. Thank you very much, Mr. Chairman. I want to welcome Dr. Davis being with us here today. She is the Chairwoman of the Nevada Women Veterans Advisory Committee, which Nevada Governor Brian Sandoval established so that the Committee could provide recommendations to how to improve care for women veterans in our State. I am thrilled to have you here. She is a graduate from the U.S. Military Academy, served in the Army for 29 years. Thank you very much for being with us today.

Chairman ISAKSON. We welcome all of you here to the hearing and we will hear first from Ms. Ilem. Everybody will have up to 5 minutes for your testimony.

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

Ms. ILEM. Thank you, Mr. Chairman. We appreciate your invitation for DAV to testify at this important hearing.

Over the past decade of war, women have been a rapidly increasing and important component of the military services. Women now routinely serve in occupations that put them in harm's way in combat, often resulting in trauma, injury, and environmental exposures associated with modern warfare.

Following military service, as you have heard, women are turning to VA in record numbers. In fact, the number of women seeking VA care has more than doubled over the past decade and continues to rise.

The experiences of current wartime deployments have contributed to the number of new transition and reintegration challenges for these servicemembers. As a result, DAV commissioned a study in 2014 to look at women transitioning from the military and the existing Federal programs and services available to aid them in that transition. Our report, "Women Veterans: The Long Journey

Home," represents a comprehensive assessment of the existing programs and policies serving women across the Federal landscape.

One of DAV's key legislative priorities has been to ensure that women veterans are properly recognized for their military service and receive equal benefits and high-quality health care in the VA health care system. DAV's report highlights that despite a government that provides a generous array of benefits to assist veterans with transition and readjustment following military service, gaps do exist, are evident for women in existing programs, and these gaps can impede a successful transition and negatively impact their health outcomes. The majority of these deficiencies result from a disregard for the differing needs of women veterans and a historic focus on developing programs for men who are prominent in numbers and the public consciousness.

Research demonstrates that when compared to men, women veterans returning home from current wartime deployments are more likely to be divorced, a single parent, and unemployed after their service, have higher rates of homelessness, at least twice as high as women non-veterans, limited access to safe housing options in certain cases, especially for homelessness women veterans with minor children, high rates of military sexual assault, and higher use of VA mental health services. Women also continue to report limited access to child care services as a barrier to needed health care.

Despite the fact that VA has made tremendous progress to improve services for women, they still lack consistent access to a full range of gender-sensitive health care benefits and services. To correct these deficiencies, DAV makes a number of key recommendations, including requiring every VA medical center to hire a gynecologist and address more appropriate staffing levels to meet current demand; implementation of gender-specific clinical IT tools; improving access to gender-sensitive mental health programs; tailored transition assistance, education, and career guidance programs; increased access to safe transitional beds and housing for homelessness women with children; improved access to specialized prosthetic items and treatment for military sexual trauma; permanent authorization for child care service and women-focused post-deployment readjustment retreats; and an effective plan overall for systemic culture change to ensure women experience a welcoming, safe, and private environment of care at all VA facilities.

Over the history of our country, millions of women have answered the call to duty and put themselves at risk to preserve our Nation's security. They have kept their promise and served this country faithfully, many with distinction. Now, it is time we keep our promise to them. We can do that by acknowledging their dedicated military service and serving them with greater respect, consideration, and care. Given the fact that more than half of the women veterans under VA care are service-disabled, the Department must step up its efforts to address their unique health maintenance needs, reallocate resources, and ramp up clinical training for these high-priority VA beneficiaries with age-appropriate lifelong specialized care.

This is a transformative moment for the VA. Secretary McDonald is leading an ambitious effort to change the Department's overall

culture and to direct resources where they will ensure that VA health care services meet the needs of every veteran. That cannot happen without a strong focus on women veterans and a detailed plan of action.

For these reasons, we call on Congress to legislate and set a firm deadline of Memorial Day 2016 for action by the Department to complete the steps outlined in DAV's testimony. This will ensure that women veterans have equal access to high-quality gender-sensitive health care and benefits.

Again, DAV appreciates the opportunity to testify before the Committee today on this important topic and I am pleased to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Ilem follows:]

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

Mr. Chairman and Members of the Committee: Thank you for inviting DAV (Disabled American Veterans) to testify at this hearing examining access to, and quality of care and services for women veterans at the Department of Veterans Affairs (VA). Ensuring that women veterans gain equal access to benefits and high quality health care services is a top legislative priority for DAV. We have a long-standing resolution from our membership of 1.2 million service-disabled wartime veterans that seeks to ensure VA health care services for women veterans, including gender-specific care, are equitable and provided to the same degree and extent that VA services are provided to male veterans.

As a service-disabled veteran, I know first-hand the challenges women face during military service and when they return home. I, like many women who served, did not understand on leaving military service the benefits and services to which I was entitled, despite the fact that I suffered an injury during my service as an Army medic while stationed at the Army 67th evacuation hospital in Wurzburg, Germany. It was not until nearly a decade after I had discharged from the military that a fellow veteran contacted me and told me about DAV. He urged me to file a VA disability claim and seek VA treatment. I resisted for months and remember asking him, "are you sure I can use the VA health care system?" I didn't think of myself as a veteran, and knew next to nothing about filing a disability claim or for which benefits I might be eligible. Today, many women who have served still do not readily self-identity as veterans. The good news is a concerted effort is being made to change this trend and ensure that women veterans are recognized for their military service and gain information about their earned benefits.

The number of women serving in the military, their roles, and their exposure to combat has dramatically changed during our war years in Iraq and Afghanistan. Likewise, over the past decade we have seen a dramatic rise in the number of women seeking health care and other benefits from VA with expectations that this trend will continue. According to VA, the number of women veterans using Veterans Health Administration (VHA) services increased by 80 percent between fiscal year (FY) 2003 and FY 2012.[1] Currently, over 635,000 women veterans are enrolled in the VA health care system, and over 400,000 actively use VA health care; more than double the number of women who used VA health care in the year 2000 (160,000).[2]

Along with this significantly increased demand, VA experienced a shifting age demographic and inclusion of younger women veterans enrolling in VA health care, which required significant changes in both policies and clinical practice. According to VA, the number of women veteran patients under 35 years of age has increased by 120 percent between FY 2003 and FY 2013.[3] New providers with expertise in women's health were needed; clinical space in many locations was insufficient to meet rising demand; and privacy and safety concerns were prevalent. VA providers suddenly needed to be knowledgeable about reproductive health services, conducting

[1] U.S. Dept. of Veterans Affairs, VHA, Office of Patient Care Services, Women's Health Services, "Sourcebook: Women Veterans in the VHA, Vol. 3: Sociodemographics, Utilization, Costs of Care, and Health Profile." Feb 2014.

[2] United States. Cong. House. Committee on Veterans Affairs. U.S. Dept. of Veterans Affairs Budget Request for FY 2016. Hearings, Feb. 11, 2015. 114th Congress. 1st Sess. Washington (Statement of Robert McDonald, Secretary, U.S. Dept. of Veterans Affairs.)

[3] U.S. Dept. of Veterans Affairs, "Sourcebook: Women Veterans in the VHA, Vol. 3." Feb 2014.

breast and gynecological examinations and becoming aware of the possibility of pregnancy when treating younger women of child-bearing age to ensure medications and recommended treatments did not pose a risk of birth defects. Many VA providers were not seeing enough women patients to be proficient in women's health, necessitating VA to institute a mini-residency program to help clinicians refresh their knowledge and skills. All prenatal and obstetric care is referred to private providers, and mammography services are provided by non-VA providers for about 75 percent of enrolled patients through VA's fee basis medical care program, complicating coordination of care for women veterans.[4] Other trends in this population that impact health policy and planning became evident as well.

According to VA, more than half (57 percent) of women veterans under VA care are service-disabled, some of whom are very young.[5] These women will be eligible for lifelong VA care for their service-connected conditions. Women veterans were also presenting with unique post-deployment health care and mental health needs. More than half (57 percent) of the women who served in the wars in Iraq and Afghanistan (OEF/OIF/OND) have sought VA care following military service and have targeted health care needs, including chronic musculoskeletal pain; mental health conditions including Post Traumatic Stress Disorder (PTSD), anxiety, depression, and substance-use disorders (SUD); genitourinary system, endocrine and metabolic disorders; and respiratory conditions.[6] Given the greater exposure of service women to combat, the specific medical profile of this group, and women who have sustained traumatic war-related injuries, it became clear there was a need for adjustments to not only primary care services but specialized care, transition services including supportive counseling, and psychological services.

To address these challenges, in 2008, VA launched a five-year plan to redesign the women's health care delivery system with a goal of reducing fragmentation of care and ensuring women receive comprehensive primary care services, including gender-specific care, by competent clinicians. To date, significant progress has been made to implement comprehensive primary care and patient-centered medical home programs (patient aligned care teams, or PACTS, to include integrated mental health, clinical, pharmacy, and social work support) for women, to increase capacity in women's clinical services, and to ensure that VA health professionals are properly trained and skilled in women's health through its mini-residencies in women's health programs. Nevertheless, VA is still working to ensure that women gain access to comprehensive primary care services throughout its health care system as evidenced by the absence of gynecologists at one-third of VA health care sites, as well as continuing deficits in safety, privacy and related physical space.[7] Even though gaps in services still exist, we applaud VA's efforts to date and the exceptional work done by the Women's Health Services (WHS) program office in collaboration with VA's women's health researchers, to improve access and quality. Measurable progress has been made and we now urge the new leadership in VA to develop a specific timeline and include targeted resources to complete the goals set out by the WHS.

Despite all of the changes over the past decade, women are still frequently underrecognized for their military service. Transitions can be more complex for women who served in a combat theater as they process what they experienced while deployed, and return home to deal with societal assumptions that women are not exposed to direct combat. Today women serve on female engagement teams; as military police; truck drivers; fighter pilots; combat medics; trauma nurses and physicians; and a variety of other occupations that expose them to the same dangers as male servicemembers. It became clear to DAV, that if we wanted women to be valued and recognized for their military service, and have VA meet their unique needs, it was essential for VA staff and care providers to be aware of the diverse range of modern military experiences of women.

For these reasons, over the past decade-plus of war DAV made it a priority to highlight and celebrate the stories and experiences of women serving in the military and to address the distinctive issues and barriers they face when they return home. We have sponsored three Congressional screenings of documentaries focused on women veterans—followed by panel discussions with the women featured in the

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[4] Elizabeth Yano, Ph.D., MSPH. VA Women's Health Research Network, Center for the Study of Healthcare Innovation, Implementation & Policy, Spotlight on Women's Health Cyberseminar "Women's Health CREATE Overview." January 27, 2014. PowerPoint presentation.

[5] U.S. Dept. of Veterans Affairs, "Sourcebook: Women Veterans in the VHA, Vol. 3." Feb 2014.

[6] Dept. of Veterans Affairs, VHA, Office of Public Health, Epidemiology Program, "Analysis of VA Health Care Utilization Among OEF, OIF and OND Veterans." 4th Qtr FY 2014. Released Jan. 2015.

[7] DAV Special Report, "Women Veterans: The Long Journey Home." September 2014.

films to spark dialog among policymakers. DAV sponsored a "Stand up for Women Veterans" campaign and produced two special edition magazines highlighting service-disabled women veterans. DAV's efforts are aimed at ensuring that women are treated with the same dignity and respect provided to male veterans and that they receive equitable benefits and services. Women veterans consistently tell us they do not want or need special treatment—but simply access to the same treatment and consideration afforded to male veterans.

In 2014, with the wars in Iraq and Afghanistan winding down and women turning to VA in record numbers, DAV commissioned a special report on women transitioning from military to veteran status. *Women Veterans: The Long Journey Home* (hereafter, "Report") presents a comprehensive assessment of the existing programs and services women veterans are provided by the VA, and the Departments of Defense, Labor and Housing and Urban Development (HUD).

The Report highlights that despite a generous array of government provided benefits to assist veterans with transition and readjustment, serious gaps are evident for women in nearly every aspect of current Federal programs. Although DAV's Report addresses programs across the Federal landscape, I will focus my testimony and recommendations today primarily on the services that involve VA.

Since the release of our Report, we have been repeatedly asked why so many identifiable gaps exist in services for women. The answer is simple—the vast majority of these deficiencies result from a disregard for the differing needs of women veterans and a historic focus on developing programs to meet the health care needs of men, who are prominent as veterans in both numbers and public consciousness. Although there has been dramatic growth in the number of women coming to VA, they will always be a statistical minority within the system. VA has an estimated 6.6 million users; of these, women represent only about 6.8 percent of the patient population.[8] This reality poses a number of specific and ongoing challenges for VA—but the challenges can and must be resolved.

DAV's Report identifies 27 key policy and programmatic recommendations necessary to overhaul the culture and various services provided by the Federal agencies mandated to assist veterans. I urge the Committee to review our Report in its entirety; however, for the sake of brevity in my statement I will highlight only three key areas of main concern: access to gender-specific care, women veteran-centered care, and the government's culture:

- Today, women veterans lack consistent access to a full range of primary care and gender-sensitive benefits and services.
- Many specialized transition programs developed to assist veterans have not been tailored to meet the unique needs of women veterans—especially those returning from war-time military service.
- The Federal Government has not ensured that the staffs of each agency responsible to serve veterans, and the elements within them, are promoting a culture that fully supports women veterans.

ACCESS TO EQUITABLE QUALITY HEALTH CARE

We recognize that some VA health care facilities serve only a small number of women, or have experienced difficulty in recruiting or retaining specialty providers in certain locations; however, these services are essential to providing comprehensive health care. We urge the Department to reallocate the necessary resources to ensure women veterans gain access to a full continuum of gender-specific, age-appropriate, high quality health care at all VA facilities.

- VA needs to ensure access to gender-specific health care services for women veterans by requiring every VA medical center to employ a part-time or full-time gynecologist or obstetrician and ensure 24/7 access to such services for emergencies. VA should explore the wider use of e-consults and tele-gynecology to address existing limitations to access of these gender-specific services in certain locations.

The last Government Accountability Office (GAO) report on women veterans programs, in 2009, reported on the extent to which VA personnel were following existing health care delivery policies, and identified key challenges that VA facilities were experiencing in providing care to women. GAO conducted a series of site visits at VA medical centers, community-based outpatient clinics (CBOCs) and Vet Centers, and identified variability in delivery of gender-specific services as well as a number of related challenges including space constraints that impacted patient privacy; difficulty in hiring providers with specific training and expertise in women's

[8] U.S. Dept. of Veterans Affairs, "Sourcebook: Women Veterans in the VHA, Vol. 3." Feb 2014.

health care; and, a need for specialized mental health providers for survivors of sexual assault.[9]

• DAV urges the Committee to request that GAO conduct a follow-on study and comparative review from its work in 2009 to evaluate VA's current ability to meet the needs of all eras of women veterans across the array of VA services, including current findings on compliance with privacy and safety policies.

VA'S SPECIALIZED HEALTH SERVICES

The Committee should also request that GAO assess VA's specialized services for women with amputations, PTSD, SUD, blindness, spinal cord injury, Traumatic Brain Injury (TBI), and burns to determine whether these programs meet the needs of women veterans who use them. With the wars in Iraq and Afghanistan, we saw for the first time a number of women with war-related blast injuries resulting in TBI, single and bilateral traumatic amputations, and other life-altering injuries. Although the number of women who have suffered war-related amputations is small compared to men (23 vs. 1,626 respectively[10]), according to VA, women veteran amputees use more health care and rehabilitation services, and are seen more frequently than men. Research also indicates women are more likely to be unsuccessful in fitting of their prostheses and present other distinct needs. Women veterans with traumatic war injuries note that the social dialog about combat experiences and the impact of these injuries often omits them from the discussion. Women veterans with limb loss also stressed the psychosocial differences in how war-related amputations are viewed by the public for women versus men, and the resultant impact on self-esteem, mental health and intimate relationships.

While there are a relatively small number of war-related amputations noted for women veterans, there is a much larger population of women who have non-war-related medical conditions that required amputations, such as diabetes. DAV has received numerous calls from women veterans complaining about the quality of VA prosthetic care; the apparent lack of knowledge about specialized prosthetic appliances for women; various challenges related to properly fitting prosthetic items and VA's unwillingness in certain cases to order special gender-specific prosthetic hardware, such as knee replacements. Special prosthetics needs occur in women, especially during pregnancy. Weight fluctuation directly impacts the fitting of prostheses—providers must be aware when women become pregnant that they will likely need more frequent prosthetic modifications and adjustments during and after pregnancy. Women with above-the-knee leg amputations who require delivery by caesarian section need a higher abdominal incision than would normally be expected to avoid irritation of the socket brim.[11] Women veterans needing prosthetic items would be better served by VA if it appointed a clinical advisor that has special expertise in prosthetics and women's health, who would be available for consultation and develop a guide on various vendors and options for items needed by women.

Women veterans with poly-traumatic injuries, including spinal cord injury, also present special challenges. Modernized medical equipment for gynecological examinations is necessary for VA to provide comprehensive care and to ensure safety. Women with spinal cord injury and dysfunction, and those with other severe wartime injuries, also express concern about the impact of their injuries related to the aging process such as out-living their spouses, the ability to conceive children, and to gain access to comprehensive reproductive and long-term care services. Despite the type or level of injury, it is important for women, like men, to have peers provide a source of support and experience post-injury and during the rehabilitation phase, and for individualized treatment plans to be developed for women by providers who have an understanding of these factors.

• VA should assess the specialized services it offers to ensure all existing programs meet the unique needs of women veterans and consider appointing clinical advisors with expertise to act as a resource and consultant for other providers related to the special needs of women patients seeking care for amputations, PTSD, burns, blindness, spinal cord injury or TBI.

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[9] U.S. Govt. Accountability Office, "VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans." GAO 09–899T. Released July 16, 2009.

[10] DOD/VA Extremity Trauma and Amputation Center of Excellence Registry (EACE-R), excludes finger(s), thumb(s); includes partial foot and hand amputations. Aug. 1, 2014.

[11] DAV Special Report, "Women Veterans: The Long Journey Home." September 2014.

THE IMPACT OF INFORMATION TECHNOLOGY AND INFRASTRUCTURE ON WOMEN'S HEALTH

The VA's Office of Public Health and Environmental Hazards and the Women Veterans Health Strategic Health Care Group developed a roadmap in November 2008, entitled *Provision of Primary Care to Women Veterans*, to correct many of the gaps identified. However, it appears that competing budgetary priorities in many locations stalled the full implementation of necessary changes and modernization that were recommended. Two prime examples are: the aging infrastructure of VA has made it difficult to ensure privacy, safety and appropriate clinic space for women at many locations; and, competing information technology (IT) priorities have delayed full implementation of an electronic clinical reminder about prescribing certain medications to women of childbearing age at risk of potential birth defects. We understand the addition of this clinical tool is part of the upgrade being made to VA's electronic clinical patient records system (CPRS) later this year. Likewise, the IT smart system for breast and cervical cancer screening and tracking abnormalities and a registry for breast cancer are still pending. IT tools such as breast health registries that help track mammography results, cervical screening results and other critical preventative gender-specific information should be a priority for VA as delays have the potential to negatively impact direct patient care and can result in poor health outcomes for women patients. For example, the majority of mammograms (75 percent) are done in the private sector[12] and although VA pays for those services and is provided a copy of the test results, there are a number of steps that must occur to have those results scanned into VA's computerized records system. These health care tools would allow for more timely tracking of testing and appropriate follow-up of abnormal results.

• Increased attention should be given to requesting and appropriating funds needed for IT clinical updates, and in both major and minor construction projects, correct identified environment-of-care deficiencies that directly impact the care of women veterans.

NEED FOR CULTURE CHANGE

One of the most perplexing problems is a culture in VA that is not perceived by women as welcoming to them, and does not afford them or their needs equal consideration. VA's own Women Veterans' Task Force noted the, "need for culture change across VA to reverse the enduring perception that a woman who comes to VA for services is not a veteran herself, but a male veteran's wife, mother, or daughter."

While VA deserves praise for its excellent targeted communications initiatives such as "She Wore These" [combat boots], "Please Don't Call Me Mister," "She Was There," and "She Earned These" [military medals]. While these public service announcements and poster campaigns are effective, it does not appear that a full assessment by all service lines of VA has been made to assure that women veterans' needs are incorporated into overarching strategic plans and policies at all levels of the organization. We fully concur with VA's Advisory Committee on Women Veterans 2014 Report findings and recommendations that Women Veterans Program Managers (WVPMs) located at each VA medical center are instrumental in coordinating services for women veterans, and the Lead WVPM should be part of the strategic planning process to ensure each Veterans Integrated Service Network (VISN) is involved in addressing the gender-specific gaps and needs of women and how they will be met and resourced. While VA reports that 96 percent of facilities now have a Women's Health Strategic Plan, it notes that only 50 percent of WVPMs are involved in strategic planning at the health care system level. Likewise, VA notes that in 2012, as VISNs reorganized, Lead WVPMs were decreased to a part-time position and subsequently six of the 11 that did have full-time positions (in the 21 VISNs) either retired or left the position.[13] We want VA to be the health care system of choice for women veterans so they too can benefit from the specialized services and care VA provides. Therefore, it is essential that the system fully recognizes and can meet the primary and specialized health care needs of women veterans, has sufficient staffing levels, is focused on women's health needs, and undergoes a culture change that is more sensitive of women's needs.

• We recommend that VA examine the role, responsibility and impact of the Lead Women Veterans Program Manager on the Women's Health Program and aggres-

[12] Elizabeth Yano, Ph.D., MSPH. Cyberseminar "Women's Health CREATE Overview." January 27, 2014. PowerPoint presentation.

[13] U.S. Dept. of Veterans Affairs, Advisory Committee on Women Veterans, 2014 Report, "Women Veterans—Proudly Breaking Barriers." Sept. 2014 (9, 16).

sively pursue staffing, culture and organizational changes to ensure that experiences of women in the military are understood by health care providers and staff, that women veterans are treated with respect, and that they encounter a safe, welcoming environment as they seek VA services.

EMPLOYMENT

The Department of Labor (DoL) has conducted research on how to best serve the employment needs of women veterans and provide them with many customized programs, communications and supports; however, despite these targeted efforts, the unemployment and under-employment rates for women veterans are slightly higher than their male counterparts.[14] While DoL found no employment challenges that are exclusive to women veterans, it indicated that the demographics of this group make it more likely they are in subpopulations that have higher unemployment rates.[15] Innovative outreach efforts to ensure women are aware of these services are necessary. Additionally, employment assistance will become even more pressing as DOD executes its current downsizing plan. Some servicemembers who may have expected to complete full military careers will be thrust, with little preparation, into civilian communities and job markets.

With an estimated 200,000 women expected to leave the military over the next four to five years, it is imperative that we improve our efforts and support for women veterans' employment. We are pleased that organizations such as the Business and Professional Women Foundation and the VA's Center for Women Veterans have focused on helping women veterans better prepare for the civilian workforce, utilize their military experience, and refine skills to improve their competitiveness in the civilian work force so they have optimal employment opportunities and can obtain and sustain rewarding careers.

HOMELESSNESS

Another troubling trend that has emerged is women veterans experience higher rates of homelessness—at least twice as high as women who have not served. Most women who return from deployments are stronger from their military experience, but some have difficulty in their transitions and are not fully supported by existing programs. VA research shows that unemployment, disability and unmarried status are among the strongest predictors of homelessness for women. Women without strong support systems, those who have a service-connected disability and chronic health issues, or experienced sexual or physical trauma in the military or who have significant mental health or substance-use challenges can easily spiral downward losing connection with family, friends and community—resulting in homelessness.

VA's efforts to eliminate veterans' homelessness have been impressive and are showing significant success. However, women veterans, especially single women with children, are often not able to take full advantage of VA's comprehensive array of services to regain health, improve work skills, and secure stable employment—or housing opportunities are not suitable to women veterans with children. GAO's 2011, report on Homeless Women Veterans noted that women veterans face barriers to accessing and using veterans housing, including lack of awareness about existing programs, lack of referrals for temporary housing while awaiting placement in a HUD-VASH arrangement, limited housing for women with dependent children and continuing concerns about personal safety and security.[16] In 2010, nearly 40 percent of women veterans served by HUD-VASH entered the program with their dependent children.[17]

While women veterans continue to report access to child-care services as a key barrier to needed health care, mental health care, and other supportive services, we were pleased to see VA's March announcement awarding nearly $93 million to the Supportive Services for Veteran Families (SSVF) program in the form of three-year grants to help at-risk veterans and their families stay in their homes.

• Based on the success of the VA's congressionally mandated child-care pilot program, authorized by Public Law 111–163, DAV urges the Committee to establish

[14] U.S. Dept. of Labor, Economic News Release, "Employment Situation of Veterans—2014." Mar. 18, 2015.

[15] U.S. Dept. of Labor, Fact Sheet, "Women Veterans: Equally Valued. Equally Qualified. Equally Served." Retrieved Apr. 2015.

[16] U.S. Govt. Accountability Office, "Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing." GAO 12–182. Published Dec. 23, 2011. Released Jan. 23, 2012.

[17] Syracuse Univ. Inst. for Veterans and Military Families, Natl. Veterans Tech. Asst. Center. "Lessons learned from the U.S. DOL grantees: Homeless female veterans and homeless veterans with families." Syracuse, NY. 2013.

child-care services as a permanent program to support better access to health care, vocational rehabilitation, education, and supported employment services. Also, VA and HUD should invest in additional safe transitional and supportive beds designated for women veterans. Finally, VA should work with community partners to provide housing programs to accommodate women veterans with dependent family members, and especially targeted on those with minor children.

MENTAL HEALTH SERVICES

VA offers a comprehensive array of mental health and specialized post-deployment mental health services. VA's Uniform Mental Health Services Handbook requires that mental health services be provided as needed to women veterans at an equivalent level to that of their male counterparts system-wide, and that providers be capable and competent to meet the unique needs of women.

Women's military and wartime deployment experiences and reintegration processes are inherently different from those of their male peers. Research indicates that men and women may develop PTSD as a response to combat exposure, and women are more likely to manifest depression as a co-occurring disorder, but are less likely to display anger and resort to substance use. Women are also more likely than men to experience depression or develop an eating or anxiety disorder without a diagnosis of PTSD. Findings also show that when women return from deployment, the camaraderie and support from their male peers is often curtailed—resulting in isolation for many. Studies have shown that peer support is important to a successful transition, but women report they often experience difficulty finding a network of women who relate to their military or wartime experience. While VA is recognized for its long-standing expertise in specialized mental health and post-deployment mental health services, it continues to lag in establishing system-wide access to gender-specific group counseling, residential treatment, and specialty inpatient programs that serve women. Improved access to these programs is essential for recovery and effective reintegration. Existing programs should be re-evaluated to ensure they are appropriately tailored to meet the unique mental health care and post-deployment transition challenges women experience related to wartime service and trauma.

DAV recognizes the challenges VA faces in establishing and maintaining specialized programs in every treatment location for a highly variable population cohort; therefore, we recommend that VA and DOD work collaboratively to:

- Explore innovative programs such as telehealth for providing gender-sensitive mental health programs for women. An interagency work group should be tasked to review options, develop a plan, fund pilots, and track outcomes.
- Coordinate structured women transition support groups to address unique issues of deployment, post-deployment readjustment, marriage, reintegration with children and spouses, child care and living as a dual military family.
- Establish joint group therapy options, peer-support networks, and inpatient programs for women.
- Develop a standardized approach to transition women with serious mental health issues and those who have experienced sexual assault from DOD to VA care.

While the VA's women veterans' mental health retreat pilot program, established under Public Law 111–163, has been a resounding success in reducing stress, improving coping skills, and improving women's sense of psychological well-being, it is only a small pilot effort and has served a limited number of women. In its report to Congress, VA noted that 85 percent of participants showed improvement in psychological well-being, 81 percent showed significant reduction in stress symptoms, and 82 percent showed an improvement in positive coping skills. These findings warrant permanent reauthorization of the program, and justify a research study of long-term outcomes of participants.

- Congress should make permanent and expand the authority for the VA Readjustment Counseling Service's women veterans retreat program. The VA Office of Research and Development should study the program to determine its key success factors, its effectiveness as an alternative treatment regimen, and whether it can be replicated in other settings.

MILITARY SEXUAL TRAUMA

Military sexual trauma (MST), while not exclusively a women's issue, is also of special concern to DAV. Sexual assault and rape are crimes. In order to successfully eliminate rape, other forms of sexual assault, and sexual harassment in the Armed Forces, DOD must address organizational, cultural, and preventive solutions.

VA testified in February 2014 that in FY 2013, 93,439 veterans received MST-related care in the veterans health care system—a 9.3 percent increase from FY 2012. There was also a 14.6 percent increase in the total number of MST-related visits during the same period—an increase from 896,947 visits to 1,027,810 respectively. Research has found that both men and women are at increased risk of developing PTSD after a sexual assault. MST screening and related services are mandated to be available at all VA medical centers, and that VA provides specialized MST-related PTSD care in a variety of settings. According to VA, in FY 2013, among the 77,681 female veterans who screened positive for MST, 58.7 percent received outpatient MST-related services compared to 57,856 male veterans who screened positive, and 44.3 percent received outpatient treatment.[18]

There is also an indication that MST is significantly associated with risk of suicide for both men and women. DAV's Report noted that while 10 percent of all patients in VA's specialized outpatient PTSD Treatment programs are women, VA has only three women's stress disorder treatment teams for the entire VA system. They are similar in structure to specialized PTSD clinical teams and provide individual and group treatment to women veterans. VA also has two women's trauma recovery programs; these are 50-day live-in rehabilitation programs that include PTSD treatment and coping skills for re-entering the community. In 2012, the two programs served only 73 women.[19] Given the high rates of PTSD and other mental health conditions in women, and the number of men and women seeking care for MST-related conditions, the current number of specialized programs that serve them is inadequate.

Additionally, although VA has excellent evidence-based treatments for MST survivors, preliminary information suggests VA needs more qualified providers with specific training and expertise in treating the consequences of MST and helping veterans recover. In 2013, VHA reported that 31 percent of VAMCs and CBOCs are challenged to provide adequate care for MST, often because of staffing shortages.[20] Experts note that MST-related cases are frequently complex, with high rates of comorbidity including alcohol misuse, depression, suicidal ideation and other mental health problems requiring intensive case management, frequent clinic visits, and comprehensive treatment.

- VA should evaluate and publicly report the number of providers system-wide who are trained to deliver specialized care for MST-related PTSD, and develop a staffing model that ensures a sufficient number of staff are available to meet demand for these specialized services.
- We recommend that DOD redouble its efforts to eliminate rape, sexual assault, and sexual harassment in every part of its organization and take action to establish a culture that does not tolerate sexual assault and sexual harassment.

TRANSITION ASSISTANCE PROGRAM

No comprehensive studies have been completed that evaluate the effectiveness of the long-standing Transition Assistance Program (TAP). The hallmark of learning is that individuals seek out and absorb information when they perceive they need it, not necessarily when it is made available. Some transitioning servicemembers may not be prepared to absorb TAP training during their pre-separation periods but would be more receptive once they are actively seeking help and assistance several months or more after their discharge.[21]

- To judge the success of TAP, data on participation, satisfaction, effectiveness, employment outcomes and educational attainment should be tracked and reported on a rolling basis, stratified by gender, ethnicity, and race, for all separated servicemembers.
- TAP partners should conduct an assessment to determine unique needs of women veterans and incorporate specific breakout sessions during the employment workshops, or add a specific track for women in the three-day sessions to address identified needs.
- VA should evaluate the effectiveness of transition support groups that address issues with marriage, deployment, changing roles, child care, and life for dual mili-

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[18] United States. Cong. Senate. Committee on Armed Services. Subcommittee on Personnel. The Relationships Between MST, PTSD and Suicide, and on DOD and VA Medical Treatment and Management of Victims of Sexual Trauma. Hearings, Feb. 26, 2014. 113th Congress. 1st Sess. Washington (Dr. Susan J. McCutcheon, Natl. Mental Health Dir., Family Services, Women's Mental Health and MST, Dept. Of Veterans Affairs)

[19] Institute of Medicine. Treatment for PTSD in Military and Veteran Populations: Final Assessment. National Academies Press. June 20, 2014.

[20] Ibid.

[21] DAV Special Report, "Women Veterans: The Long Journey Home." September 2014.

tary families, and determine whether these efforts help achieve more successful outcomes for women.

• VA and DoL should provide gender-sensitive follow up with all servicemembers six to 12 months after separation to offer additional support and services, if needed.

DISABILITY COMPENSATION

The burden of wounds, illness and injury in post-9/11 veterans is high, and nearly half who served have applied to VA for disability compensation. Regarding MST-related PTSD claims, VA confirmed that approval rates for service connection were lower for women veterans than for men who made PTSD claims based on combat exposure. The Veterans Benefits Administration (VBA) took action to educate and retrain staff on existing policy and proper adjudication of these specific claims. We are pleased that VBA acknowledges the need to do further data collection and analysis in this regard, and we encourage additional analysis to assure that women are receiving fair and equitable adjudication of all their claims, for whatever disability is being claimed.

• The VBA should track, analyze, and report all its rating decisions separated by gender to ensure accurate, timely, and equitable decisions on claims filed by women veterans.

THE NEED FOR DATA COLLECTION BY GENDER

In order to better understand the experience of women in the military, data needs to be routinely collected, analyzed and reported by gender and minority status. DAV recommends improved data collection on women and minorities for health care, disability compensation, justice involvement, education, transition assistance, sexual trauma, employment, and housing programs. Congress, policymakers, program directors, and researchers need this information in order to monitor and appropriately enhance services for women veterans.

• The Federal Government should collect, analyze, and publish data by gender and minority status for every program that serves veterans, to improve understanding, monitoring, and oversight of programs that serve women veterans.

WOMEN'S HEALTH RESEARCH

VA's Health Services Research and Development (HSR&D) function continues to contribute to a growing body of women's health research that is aimed at improving the health and health care of women veterans. This research effort focused on women's health became a priority in the early 1990s and has increased dramatically over the past two decades. Early on, a VA Women's Health Research Planning Group was established and worked to develop a comprehensive research agenda for women veterans. Key research priorities were identified in November 2004, and a special supplement on VA research on women's health was published in the *Journal of General Internal Medicine* with several contributions from VA HSR&D investigators.

VA researchers began to focus on chronic illnesses and mental health conditions in women and in 2010 sponsored a conference titled, "Using Research to Build the Evidence Base for Improving the Quality of Care for Women Veterans." In 2014, VA hosted a Women's Health Research Conference, bringing together investigators interested in pursuing research on women veterans and women in the military, with a goal to advance the state of and potential impact on VA women's health research. VA recently published a second women veterans' research journal supplement in *Medical Care* and announced that Phase 2 of the Women Veterans Cohort Study has begun. VA researchers have been studying women and the impact of exposure to combat during the wars in Iraq and Afghanistan—specifically the impact of military service on women's physical health, unique health care needs, and subsequent utilization of VA services. In addition to ongoing research in women's health and health care, HSR&D is funding a women veterans Practice-Based Research Network and established the Women's Health Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE) initiative to focus on accelerating implementation of research findings into practice.

All of these targeted research efforts and studies to date have provided a solid foundation on which to shape national policy and improve the overall health of women veterans.

• We urge Congress to provide sufficient resources to support VA research efforts.

CLOSING

Millions of women have answered the call of duty and put themselves at risk to preserve our Nation's security and our way of life. They served this country faith-

fully and many with distinction. Acknowledging their dedication and resilience and serving women veterans with greater respect, consideration, and care must become a priority.

This is a transformative moment for the VA—Secretary Robert McDonald is leading an ambitious effort to change the culture at the VA and to direct resources where they will ensure that VA health care can meet the needs of every veteran. That cannot happen without a strong focus on women veterans and a detailed, action-orientated plan. For these reasons, we call on Congress to set a firm deadline for action by the Department to ensure that women veterans have equal access to high-quality health care services and benefits.

While DAV's report makes a number of key recommendations, today, we call on Congress to authorize or exercise its oversight authority and responsibility and require that, by Memorial Day, 2016, at a minimum, the following steps are completed by VA:

- Every VA medical center must employ a part-time or full-time gynecologist.
- VA must complete implementation of IT solutions that directly impact women's health including clinical reminders in its electronic medical record system on prescribing teratogenic medications to younger women and capturing vital gender-specific information, such as breast and cervical cancer screening results and abnormalities.
- VA must develop standards to ensure VA health care facility infrastructure meets the specific needs of women veterans. These standards should be integrated into prioritization for VA construction projects under VA's Strategic Capital Investment Plan.
- Authorize child-care services as a permanent program to support better access to VA health care, mental health programs, vocational rehabilitation, education, supported employment and other specialized services.
- Create a VA/DOD interdisciplinary work group to develop gender-sensitive mental health programs for women veterans, including peer-to peer support and services for post-deployment transition challenges. A full report, including recommendations of the work group, must be provided to Congress by the deadline.
- Increase the number of safe transitional and supportive beds designated for women veterans to meet demand and the number of housing programs available to women veterans with dependent family members, especially minor children.
- Conduct a GAO study on VA's ability to meet the health care needs of women veterans including an assessment of specialized programs for women seeking care for amputations, PTSD, burns, blindness, spinal cord injury and TBI.

DAV is pleased to support S. 471, the Women Veterans Access to Quality Care Act introduced by Senators Heller and Murray. This measure seeks to ensure VA adapts programs and services to meet the needs of women veterans, and that women veterans can access safe, comfortable and high quality care at all VA health facilities. We also support S. 469, the Women Veterans and Families Health Services Act of 2015, a bill introduced by Senator Murray to expand VA's current reproductive health and fertility treatment options to assist injured veterans who want to start families. The measure also includes a provision to make permanent the highly successful child care pilot program in VA. Both of these bills are in line with recommendations put forth in DAV's Report and DAV Resolution Number 040, which supports enhanced medical services and benefits for women veterans.

Again, DAV appreciates the opportunity to testify before the Committee today on this important topic and will be happy to address any questions the Committee may have.

Chairman ISAKSON. Well, thank you, Ms. Ilem, very much for your testimony.

I want to acknowledge to the Members of the Committee that are here and to the audience, there is a book at each Member's seat called "The Long Journey Home," which is the Disabled American Veterans report on women's transitional issues from service to veterans services, and your report is the foundation of this hearing. We intend to follow through on your deadline for Memorial Day weekend and see if we cannot foster good response to you for the work that you have done. Thank you for your testimony.

Dr. Davis.

STATEMENT OF ANNE DAVIS, CHAIR, NEVADA WOMEN VETERANS ADVISORY COMMITTEE

Ms. DAVIS. Chairman Isakson, Ranking Member Blumenthal, members of the Senate Veterans' Affairs Committee, it is my honor to be here today. As Senator Heller mentioned, I am serving as the Chairperson of Nevada's Women Veterans Advisory Committee and our charter is to support and assist the State Women's Veterans Coordinator in locating, educating, and advocating for all women veterans in the State.

One of the central issues we encounter is the identification of women veterans. As of September 30 of 2014, the U.S. Department of Veterans Affairs estimated the total veteran population within the State of Nevada at 228,027, with 21,362 of those being female veterans. But, these are just numbers and do not translate to the actual women within the State. To date, the Nevada Department of Veterans Services has identified by name approximately 2,500 female veterans, or only 11.7 percent of the estimated total number of women veterans in the State.

To help connect veterans with service providers, Nevada has implemented a Statewide effort called the Green Zone Initiative which aligns operations under three pillars: The policy development pillar, the service provider coordination pillar, and the connecting to veterans pillar.

According to the Nevada Department of Veterans Services, the connecting to veterans pillar presents the single most difficult challenge, especially for our women veterans. Meeting the needs of the individual women veterans requires a connection with them, and this cannot occur unless we know where our women veterans are.

While the Department of Defense and Department of Veterans Affairs have taken some initial steps to create a handoff system, much more needs to be done. How can you connect a woman veteran to benefits and opportunities their service to our Nation has earned them if you cannot find the veterans? To truly identify our veterans, better collaboration between the Department of Defense and the VA and timely and in-depth information sharing with State governments is critically needed.

Anecdotal evidence indicates that women are less likely to identify themselves as veterans than are men. We recommended that the State of Nevada agencies who collect veteran data replace the question, "Are you a veteran?" with the question, "Have you ever served in the United States military?" on their forms and applications during their next program update. Studies have shown that women veterans do not self-identify as a veteran, and so asking if they have served in the military may ensure their status as a veteran is identified.

Many women veterans are taking advantage of their education benefits within the State, and most, if not all, of the college campuses throughout the State have someone on their staff who deals with veterans issues. While women will always be in the minority within the veteran population, women feel more comfortable attending veteran events when other women veterans attend. Women do not seem to be participating in large numbers at the University of Nevada-Reno as compared to the University of Nevada-Las Vegas campus due to the smaller number of women if they also are

the sole women attending veterans' events and meetings. Other reasons women do not attend include the timing of these events and meetings and the lack of child care.

At a recent committee meeting, the UNR Director of Veterans Services noted women are hesitant to join campus veterans groups because they see the military part of their life as being behind them and women veterans would rather move forward through their education toward a new career. The UNR Director of Veterans Services is looking at ways to collaborate with the colleges and groups on campus to bring integrated services to our women veterans rather than stovepiping services solely within veteran organizations.

Another initiative is a collaboration between the Sierra Nevada Health Care System and the University of Nevada at Reno, where they are putting a social worker on both the UNR and the Truckee Meadows Community College campuses through a program called VITAL, Veterans Integration to Academic Leadership. The goal of this veteran-centered, results-oriented collaboration is to enhance academic retention and success. The social worker noted that her workload was low initially as veterans seemed reluctant to seek out the services of the social worker, but trust has grown and she is now quite busy serving veterans on both campuses. It is important to note, however, that not a single woman veteran has contacted her for assistance.

Women veterans have unique challenges in gaining employment. For example, they are twice as likely to be divorced or more often single parents, and their earnings average $6,000 per year less than male veterans. Women veterans also have higher military disability in general.

Helping women veterans translate their military skills for use in the civilian workforce and emphasizing mentoring programs designed specifically to assist women veterans should be continued areas of emphasis.

The VA has instituted an extensive initiative to eliminate homelessness by the end of 2015, which means finding homes for approximately 50,000 veterans. But, how can we eliminate homelessness if we are not properly identifying our women veterans? Due to the small numbers of homeless women veterans in any given location, the VA must encourage and support the partnering of Federal, State, and local agencies to find space for these homeless women veterans.

With respect to health care and the health needs of women veterans, our committee believes telehealth initiatives need to be further expanded to better serve women veterans in rural and frontier communities outside of the large urban areas to reduce the need for travel and to access medical care and advice.

I would also like to touch on military sexual trauma just briefly. Although our committee has not spoken to any women who have experienced military sexual trauma, I did reach out to a group of women veterans to try to understand their experiences. One woman shared her personal story with me, noting that the children of those suffering from military sexual trauma with a subsequent Post Traumatic Stress Disorder diagnosis may be the unseen victims of military sexual trauma.

If approved, the PTSD-MST diagnosis may result in a disability rating below 100 percent, but often these veterans are unable to work and, therefore, rely solely on the VA benefits, and this may leave them operating below the Federal poverty level. Because the veterans may be unable to work, they often do not have health insurance for their children. Many of the MST victims are single parents. When their claims are denied, they are forced to rely on the generosity of county and State children's health and mental health insurance programs rather than on the VA dependent health care benefits. These children of PTSD-MST veterans also need to receive mental health care due to their parent's disability. Furthermore, parents with PTSD-MST tell us the VA claims process can actually exacerbate their condition.

College-age children of these PTSD and MST veterans have limited access to affordable higher education, and a 100 percent permanent and total disability rating would allow veterans to take advantage of the VA's dependent education benefits. A lack of education benefits may contribute to a continued cycle of poverty for affected children.

The title of this hearing is "Fulfilling the Promise to Women Veterans." I believe the way to do this is to push to identify our women veterans and to understand their needs. Committees such as Nevada's Women Veterans Advisory Committee are a good start and I would encourage other States to institute similar committees to better understand and support the needs of our women veterans. Our goal is not to find fault, but rather to support our women veterans who have served and sacrificed.

Again, thank you for this opportunity to speak with you today.

[The prepared statement of Ms. Davis follows:]

PREPARED STATEMENT OF ANNE L. DAVIS, COL., USA (RETIRED), CHAIRPERSON, NEVADA'S WOMEN VETERANS ADVISORY COMMITTEE

Chairman Isakson, Ranking Member Blumenthal, and Members of the Senate Veterans' Affairs Committee, it is my honor to appear here today. My name is Dr. Anne Davis. I am a retired Army Colonel who served 29 years on active duty. In June 2014, Nevada's Governor, Brian Sandoval, appointed me to serve on his Women Veterans Advisory Committee. I serve as Chairperson of that committee and our charter is to support and assist the State Women Veterans Program Coordinator in locating, educating, and advocating for all women veterans in the state. Our goal is not to find fault, but rather to understand the issues women veterans are facing and work toward finding solutions.

INTRODUCTION

Nevada's Women Veterans Advisory Committee currently consists of four members from throughout the state. Our initial members included women who are veterans of the Army, Air Force and Marine Corps, and represent both officer and enlisted ranks. Our meetings are open to the public and we welcome all who want to participate. We have two additional advisory members to our committee. These advisors represent the Veterans Health Administration organizations in Reno and Las Vegas. To date we have submitted an interim report with ten recommendations to Governor Sandoval and have a final report due by June 1, 2015.

We use information from surveys, face-to-face conversations with women veterans, presentations from the Nevada Department of Veterans Services (NDVS) and the U.S. Department of Veterans Affairs, and our own personal knowledge and experiences to develop our recommendations. To assist us in our efforts, we also seek information from experts and from others who are in positions that allow them to interact with women veterans.

One of the central issues we encountered is the identification of women veterans. As of September 30, 2014, the U.S. Department of Veterans Affairs (VA) estimated

the total veteran population within the state of Nevada at 228,027 with 21,362 of those being female veterans. But these are just numbers and do not translate to the actual veterans within the state. To date, the Nevada Department of Veterans Services has identified (by name) approximately 2,500 female veterans or only 11.7% of the estimated total of women veterans in the state. This indicates that the state could do a better job of identifying and recognizing our female veteran population. It is difficult to support and advocate for women veterans without having contact with a larger number of them.

To help connect veterans with service providers, Nevada has implemented a statewide effort, the Green Zone Initiative, which aligns operations under three pillars: The Policy Development Pillar, the Service Provider Coordination Pillar, and the Connecting to Veterans Pillar. According to the Nevada Department of Veterans Services, the "Connecting to Veterans Pillar" presents the single-most difficult challenge, especially for our women veterans. Meeting the needs of the individual woman servicemember, veteran, or family member requires a connection with them, and this cannot occur unless we know where our women veterans are. While the Department of Defense and the U.S. Department of Veterans Affairs have taken some initial steps to create a "hand-off" system that helps states know when servicemembers return home, much more needs to be done. How can you connect a woman veteran to benefits and opportunities their service to our Nation has earned them, if you cannot find the veteran? Nevada has undertaken local initiatives to learn where our women veterans live, such as the identification of veterans' status on driver's licenses, but to truly identify our returning servicemembers, better collaboration between the Department of Defense and the VA and timely, in-depth information sharing with state governments is critically needed.

Anecdotal evidence indicates that women are less likely to identify themselves as veterans than are men. Our committee has made several recommendations to try to remedy this situation. First, we endorsed the Nevada Department of Veterans Services continuing efforts to develop a Veterans Information System to identify veterans throughout the state so that all veterans are informed about their available benefits and opportunities. Furthermore, we recommended that the State of Nevada agencies who collect veteran data add a data collection question asking "Have you ever served in the United States Military?" to their forms/applications during their next programmed update. This question would replace the question "Are you a veteran?" Studies have shown that many women veterans do not self-identify as a veteran, so asking if they have served in the military may ensure their status as a veteran is identified.

Our committee also recommended that Governor Sandoval direct the Nevada Department of Veterans Services develop a Strategic Communications Plan that includes how to reach women veterans throughout the state. One additional recommendation was for the Nevada Department of Veterans Services to develop a white paper in collaboration with our committee that would inform our legislators and state agencies of facts regarding Nevada's women veterans. Such facts would include demographics, contributions to national and state security, and unique needs of the women veteran population. This white paper may help reduce misinformation and improve programming support for women veterans.

EDUCATION

Many women veterans are taking advantage of their education benefits within the state. Most, if not all, of the college campuses throughout the state have someone on their staff dealing with veterans issues. Many of the colleges also have veterans groups on campus. While women will always be in the minority within the veteran population, women feel more comfortable attending veterans' events when other women veterans attend. As there are more women veterans in the Las Vegas area than in other parts of the state, a greater percentage of the available women veterans participate in veterans' events and clubs at the University of Nevada, Las Vegas (UNLV) than participate in other parts of the state. Women do not seem to be participating in large numbers at the University of Nevada, Reno (UNR) campus due to the smaller number of women, as they often are the sole woman attending veterans' events and meetings.

At a recent committee meeting, the UNR Director of Veterans Services noted that women are hesitant to join these groups because they see the military part of their life as being behind them and women veterans would rather move forward with their education toward a new career. Some women veterans feel they are better served joining groups and attending events that meet their needs. The UNR Director of Veterans Services is looking at ways to collaborate with other colleges and

groups on campus to bring integrated services to women veterans rather than stovepiping services solely within veterans' organizations.

Another UNR initiative is a collaboration with the VA Sierra Nevada Health Care System. Through this collaboration, the VA Sierra Nevada Health Care System has been able to put a social worker on the UNR and Truckee Meadows Community College campuses on a regular basis. The enabling mechanism is a program called Veterans Integration to Academic Leadership (VITAL). This is a Veteran-centered, results oriented collaboration between the VA Medical Center and state higher education, whose goal is to enhance academic retention and success. The social worker noted that her workload was low initially as veterans seemed reluctant to seek out the services of a social worker, but trust has grown and she is now quite busy serving veterans on both campuses. It is important to note, however, that not a single woman veteran has contacted her for assistance.

EMPLOYMENT

Unemployment for women veterans is over 8%, which is 20% above their male counterparts. Women veterans have unique challenges in gaining employment. For example, they are twice as likely to be divorced, are more often single parents, and their earnings average $6,000 per year less than male veterans. Women veterans also have higher military disability ratings in general.

Women veterans face some of the same challenges as do men in translating their military skills into the civilian workforce. This will continue to be an issue as the services downsize. State and Federal VA agencies, as well as other organizations, continue to assist veterans in this area. Helping veterans translate their military skills for use in the civilian workforce should be a continued area of emphasis.

As noted earlier, women do not identify themselves as veterans and therefore some will not take advantage of career fairs directed toward the hiring of veterans. Some women veterans feel uncomfortable in this setting, as the majority of the job seekers will be men and many of those hiring will expect the veterans they hire to be men.

Several organizations offer mentoring programs for veterans. Mentoring is designed to be a helping relationship where a mentor and protégé work closely together. Having men mentoring women can be a challenge when either the man or the woman feels uncomfortable in this relationship. Fewer female mentors are available to assist our women veterans although several professional women's' groups do offer mentoring services. Mentoring programs should also be a continued area of emphasis.

HOMELESSNESS

Women are the fastest growing segment of the homeless veterans population and are more likely to be homeless with children. One in five women homeless veterans is typically diagnosed with Post Traumatic Stress Disorder (PTSD). There is a link between homelessness and military sexual trauma for women veterans.

The VA has instituted an extensive initiative to eliminate homelessness by the end of 2015, which means finding homes for approximately 50,000 veterans. But how can we eliminate homelessness if we are not properly identifying our women veterans? A 2014 research article published in Public Health Reports noted that women and younger veterans are at a higher risk of not being identified as veterans among the homeless population.

Homeless women veterans do have unique needs, however, in that they often have children. Homeless shelters often do not mix males and females. Some shelters place restrictions on the ages of children within their facilities. These restrictions place an additional burden on homeless women to keep their families together.

Due to the small number of homeless women veterans in any given location, the VA must encourage and support the partnering of Federal, state, and local agencies to find space for these homeless women veterans.

HEALTH CARE

Overall, the health needs of women veterans are being met within the state of Nevada. We have access to Obstetrician/Gynecologist care but our committee has recommended that Governor Sandoval communicate the need for a full time Obstetrician/Gynecologist at Southern Nevada Veterans Medical Center to serve women veterans in the Las Vegas area. Within the state of Nevada, most of our veterans are clustered in the urban areas of Las Vegas and Reno. We believe tele-health initiatives need to be further expanded to better serve women veterans in rural and frontier communities outside of these urban areas to reduce the need for travel to access medical care and advice.

Nevada is unique in that we have three VA Veterans Integrated Service Networks (known as VISNs) operating within the state boundaries while all other states only have one or two VISNs. VISN 19 serves Northeastern Nevada, Utah, Colorado, Wyoming, and Montana. VISN 21 serves Northern California and Northwestern Nevada. VISN 22 serves Southern California and Southern Nevada. Having different parts of our state belonging to different VISNs has allowed our committee to see that each VISN operates differently. The three VISNs serving Nevada's veterans conduct business differently, particularly in regard to support, events, and celebrations of and for women. While I see a need for some flexibility to adapt to the needs of local veterans, some services should be standardized across all VISNs. The Women Veterans Access to Quality Care Act introduced by U.S. Senator Heller (R-NV) and U.S. Senator Murray (D-WA) may go a large way toward accomplishing this goal. I thank you for sponsoring this important legislation.

To date, our committee has not come across any issues with regard to mental health care for women veterans. Does this mean that we are taking good care of our women veterans or does this mean women veterans are not seeking assistance within the VA or not seeking assistance at all? Without being able to identify more women veterans and their needs, it is difficult to answer this question. Some women who have experienced military sexual trauma find it difficult to walk into a VA health care facility to seek assistance. This is an area requiring further exploration.

MILITARY SEXUAL TRAUMA (MST)

Our committee has not spoken to any women who have experienced military sexual trauma. Remember that our meetings are open to the public and some women veterans who have experienced MST report a reluctance to speak in such a forum. Although our committee has not spoken to any women who have experienced MST, I did reach out to a group of women veterans to try to understand their experiences. One woman shared her personal story with me, noting that the children of those suffering from Military Sexual Trauma with a subsequent Post Traumatic Stress Disorder (PTSD) diagnosis may be the unseen victims of military sexual trauma. A PTSD/MST diagnosis allows a veteran a 70% disability rating. Often, however, these veterans are unable to work and therefore rely solely on this VA benefit. This 70% rating puts a family of three below the Federal poverty level. A 100% disability rating would enable food, shelter, and heating oil security. Because the veteran may be unable to work, they often do not have health insurance for their children. Many of these MST victims are single parents. When their claims are denied, they are forced to rely on the generosity of county and state children's health and mental health insurance programs rather than on VA dependent health care benefits. These children of PTSD/MST veterans often need to receive mental health care due to their parent's disability. Furthermore, these parents with PTSD/MST have noted that difficulties with the VA claims process can exacerbate their condition. College-age children of these PTSD/MST veterans have limited access to affordable higher education. A 100% permanent and total disability rating would allow these veterans to take advantage of the VA's dependent education benefits. A lack of education benefits may contribute to a continuing cycle of poverty for these children.

Based on my discussion with women veterans, I offer the following recommendations regarding MST:

1. Congress should mandate the release, publication, and monitoring of disaggregated data to include the number, age, background, and treatment by geographic VA location and regional office of those women and men being treated for PTSD/MST. The data should also include the number of single parents with young children and grandchildren within this population. These children are at risk. When PTSD/MST women veterans are denied access to care, a generation of children bear the brunt of poverty, disability, and lack of access to medical and mental health care. The VA should also look at the population most likely to be outside the system in need of treatment given the rate of MST prevalence within the ranks. The VA should report on grants versus denials in PTSD/MST disability claims. This data may expose critical systemic issues and force accountability. These actions will enable the Veterans Administration to have a complete view of this issue.

2. Congress should order an immediate review of all PTSD/MST claims currently in the appeals process. In particular, the VA should be directed to review those claims impacted by the backlog (>120 days) and specifically those claims which have undergone more than one review at the Board of Veterans Appeals level. Congress should direct the VA to resolve all cases involving single parents of minor children within the next 6 months. The VA should track this review and report progress weekly on the resolution of these PTSD/MST cases.

CONCLUSION

The title of this hearing is "Fulfilling the Promise to Women Veterans." I believe the way to do this is to push to identify our women veterans and to understand their needs. Committees, such as Nevada's Women Veterans Advisory Committee, are a good start and I would encourage other states to institute similar committees to better understand and support the needs of our women veterans. Our goal is not to find fault, but rather to support our women veterans who have served and sacrificed.

Again, thank you for this opportunity to speak with you today.

Chairman ISAKSON. Thank you, Dr. Davis.

Ms. Mouradjian.

STATEMENT OF CHRISTINA L. MOURADJIAN, U.S. ARMY VETERAN

Ms. MOURADJIAN. Chairman Isakson, Ranking Member Blumenthal, Members of the Committee on Veterans' Affairs, it is a distinct honor to appear before you today as a military retiree and a female combat veteran.

As a woman veteran, I have a personal stake in seeing that the unique issues we face are addressed and addressed properly so that future servicewomen do not face the same obstacles that this Committee is assembled here to address today. While there are many concerns to tackle, I would like to take this opportunity to concentrate on the one that has proved most difficult in my own life, access to and the quality of care at the VA.

As a patient at the VA, I have received some of the best care and from some of the best doctors. However, that experience is tempered by the fact that I have also received some of the worst care, not only by doctors and care providers, but by the system itself.

For years, I complained to my doctors at the VA of numerous symptoms that were summarily dismissed. I was told I was too young to have any issues. I was told the basic blood work came back normal. The ultimate betrayal, I was told I was not really being honest.

These symptoms worsened and worsened until finally I was forced to pursue medical advice out of the VA and on my own. Once my blood work and MRIs proved positive for Cushing's disease and the brain tumor that caused it, the VA started to take me seriously. It is hard to argue when you are staring at an MRI with a big white mass in the middle of someone's head. But, the years of suffering, both physically, mentally, and emotionally, that I had to endure in order to get someone just to listen is not something I would wish on anyone and something that should not happen to any veteran.

The road to recovery for Cushing's patients is not easy. There are countless tests and months of observation and the inevitable brain surgery. There are the frequent visits to endocrinology, neurology, the ENT. The list is very long. But, what complicates this is that at the VA, you may never see the same doctor twice. Not only do you have to repeat your story to every specialist under the sun, you have to repeat it to a revolving door of white coats who are hearing it for the very first time, or even worse, the specialist you may need to see may have left and it may be months before a new one is found and you can even get an appointment. I know this because I have lived it.

While I was stated at New York City, I had to travel to three separate VA facilities in three separate boroughs because no one facility had all the specialists I needed. For allergy treatments alone, I had to travel from Brooklyn to the Bronx, sit through what could easily be hours in traffic and $30 in tolls for a 15-minute appointment.

Coordination of care is essential in any system that aims to treat the whole person, and at the VA, the system is counterproductive to enabling this process. Prior to my brain surgery, which the VA only did on the second Tuesday of every month, my surgery date was canceled three separate times. Three separate times, I prepped. I had family travel down from Rhode Island and take off work, as I could not be left alone for the first few days of recovery. Three separate times, I was told another case was more important, they could not get all the required doctors in the same room together, or that the doctors did not have a chance to review my case. They would have canceled the fourth time had I and my family not contacted the patient advocate and voiced our complaints boisterously.

After brain surgery, there were other nightmares. There was the MRI in which the attendant, rushing because I was the last patient before she could leave for the day, did not remove the metal nodes from my body, and too weak to squeeze the panic button because my arm was sewn to a stabilizer in order to keep the PIC line in, I could do nothing but weep silently while the metal nodes burned welts into my skin.

There was the resident doctor who had not researched my disease before morning rounds, and not knowing the main symptoms of Cushing's is weight gain could not tell if I was presenting because, quote-unquote, "I was too heavy." It is hard to have faith in a system when you know more about your condition than the doctors who are supposed to be treating you.

Navigating the VA can be daunting, and even more so as a female veteran. The women's clinic is often well segregated from the rest of the facility. Oftentimes, you have to traverse to the basement of the hospital, next to the lab, to find it. And, once you get there, it is obvious that it is an afterthought. As a resident of Ranking Member Blumenthal's district in Connecticut, he knows well of what I speak.

Perception is part of the issue. For women veterans to feel like they belong, they need to know that their care is just as important as their male counterparts. They need to trust that their care providers, and they need to know that their care is a priority.

In the past few years, I have seen with my own eyes the VA's renewed commitment to women's health, and while I am heartened to see these changes, I know that more needs to be done. Female veterans need quality health care now and they need to be confident in that care so they are not afraid to access it.

I thank you for your time this afternoon and the opportunity to appear before the Committee. I thank you for allowing me to share my story, but remind you that my story is not unique. There are countless women veterans that have endured far worse than me, and it is for them that I am here today. Thank you.

[The prepared statement of Ms. Mouradjian follows:]

PREPARED STATEMENT OF CPT CHRISTINA L. MOURADJIAN, U.S. ARMY (RET)

Chairman Isakson, Chairman Blumenthal, Members of the Committee on Veterans' Affairs, It is a distinct honor to appear before you today as a military retiree and a female combat veteran.

As a woman veteran, I have a personal stake in seeing that the unique issues we face are addressed, and addressed properly, so that future service women do not face the same obstacles. And while there are many concerns to tackle, I would like to take this opportunity to concentrate on one of the obstacles that has proved most difficult in my own life—access to and the quality of care at the VA.

As a patient at the VA, I have received some of the best care, from some of the best doctors, however that experience is tempered by the fact that I have also received some of the worst care not only by doctors and care providers but by the system itself.

For years I complained to my doctors at the VA of numerous symptoms that were summarily dismissed; I was told I was too young to have any issues, I was told the basic blood work came back normal, and the ultimate betrayal, I was told I was not really being honest. These symptoms worsened and worsened, until finally I was forced to pursue medical advice out of the VA on my own.

Once my bloodwork and MRIs proved positive for Cushing's disease and the brain tumor that caused it, the VA started to take me seriously, it's hard to argue when you're staring at an MRI with a big white mass in the middle of someone's head. But the years of suffering both physically, mentally and emotionally that I had to endure in order to get someone to listen is not something I would wish on anyone, and something that should not be happening to any veteran.

The road to recovery for Cushing's patients is not easy, there are countless tests and months of observation and then the inevitable brain surgery. There are the frequent visits to Endocrinology, neurology, the ENT, the list is long. But what complicates this, is that at the VA you may never see the same doctor twice. So not only do you have to repeat your story to every specialist under the sun, you have to repeat it to a revolving door of white coats who are hearing it for the first time. Or even worse, the specialist you may need to see may have left and it may be months before a new one is found and you can get an appointment. I know this because I have lived it.

While I was stationed in NYC, I had to travel to three separate VA facilities in three separate boroughs because no one facility had all the specialists I needed. For allergy treatment alone I had to travel from Brooklyn to the Bronx, sit through what could easily be over an hour in traffic and $30 in tolls, for a fifteen minute appointment.

Coordination of care is essential in any system that aims to treat the whole person, and at the VA the system is counterproductive to enabling this process. Prior to my brain surgery, which the VA only did on the second Tuesday of every month, my surgery date was canceled three separate times. So three separate times I prepped, I had family come down and take off work as I could not be left alone for the first few days of recovery, and three separate times I was told another case was more important or that they could not get all the required doctors in the same room together, or that the doctors did not have a chance to review my case yet. They would have canceled the fourth date also had I and my family not called the patient advocate and voiced our complaints.

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Navigating the VA can be daunting, and even more so as a female veteran. The women's clinic is often well segregated from the rest of the facility. Often times you have to traverse to the basement of the hospital next to the lab to find it, and once you get there it is obvious that it is an afterthought. Perception is part of the issue. For women veterans to feel like they belong, they need to know that their care is just as important as their male counterparts. They need to trust their care providers and they need to know that their care is a priority.

In the past few years, I have seen with my own eyes the VA's renewed commitment to women's health, and while I am heartened to see these changes, I know

that more needs to be done. Female veterans need quality health care now and they need to be confident in that care so they are not afraid to access it.

I thank you for your time this afternoon and the opportunity to appear before the Committee. I thank you for allowing me to share my story but remind you that my story is not unique, there are countless women veteran's that have endured far worse than me, and it is for them that I am here today.

Chairman ISAKSON. Well, thank you, Ms. Mouradjian. Your story is compelling, and I want to follow up on your last sentence as my first question.

You said you are not an isolated case and you referred to many, many women who had similar cases, obviously not with Cushing's, necessarily, but with other complications. Would you elaborate on that for just a minute?

Ms. MOURADJIAN. That is correct. I know myself and several of my friends in the service have had a hard time just either accessing care or getting doctors to listen to the particular issues that are unique to them. Particularly with mental health issues, there is oftentimes lack of a response to women, just one of the big issues is getting a female provider.

I know a lot of the female veterans that I have served with do not necessarily feel comfortable telling their story to a male, who might not be able to sympathize with what they have gone through just as a woman in general. The physical issues aside, some of the very delicate issues that we face as women, we are just not comfortable sharing those with a male.

One of the biggest hurdles is just being able to get access to a provider and feeling comfortable enough to get the help they need.

Chairman ISAKSON. That actually is the point I was going to lead up to. One of the things we are looking at in the Veterans Choice bill, we had two issues. One was the 40-mile rule, which we have dealt with; and the other was the nearest to care the veteran needs. In your particular case, you had a very specialized need. Cushing's is a rare condition, is that not correct?

Ms. MOURADJIAN. It is very rare.

Chairman ISAKSON. Obviously, the VA was not prepared initially either to diagnose or recognize it. Is that correct?

Ms. MOURADJIAN. That is correct.

Chairman ISAKSON. Yet, you had enough symptoms to know something was still wrong and you needed care. Was that the case?

Ms. MOURADJIAN. Yes.

Chairman ISAKSON. Did you ever consider going anywhere for a second opinion outside of the VA, or were you limited and not able to do that on your own?

Ms. MOURADJIAN. No, I am fortunate enough that my mother is in the medical field, so I did have an advocate in my corner who had enough background to guide me. So, I had personal resources in my life that could verify that the treatment I was getting at the VA was actually, after I was diagnosed, sufficient to deal with it.

Chairman ISAKSON. But, without the advocate, you may have never gotten to that care. Is that correct?

Ms. MOURADJIAN. Absolutely.

Chairman ISAKSON. That is my point. I see the VA folks are staying for the rest of the hearing, which I appreciate you all staying for. There is a message in this story to us. Obviously, there are things we can do to help make sure that you go from lack of diag-

nosis or misdiagnosis to appropriate diagnosis and there is an ombudsman to help you along the way. You were fortunate enough to have a mother to do that, but a lot of our women veterans are not. I think it is important we recognize there ought to be some way for communication or ombudsmanship to be available to the veteran who thinks they need the service and the care.

Ms. Ilem.

Ms. ILEM. I would just like to follow up. I think that is a great idea. I think with the cultural transformation that Secretary McDonald is trying to implement throughout the system, there needs to be a specific line for women veterans, you know, to take on this role. I know VA has lost some of their lead Women Veteran Program managers throughout the system. I mean, they have been critical over the years when I have had a problem. When a woman veteran calls and I call the Women's Veterans Health Service, they are right on it. They want to know. They want to help. But, they have to have the staff out there of somebody leading that understands these particular issues.

Chairman ISAKSON. I would like for you to consider this an order from the Committee, for you to submit to us some ideas that you think might help facilitate exactly that.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOHNNY ISAKSON TO JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DAV

In testimony before the Senate Veterans' Affairs Committee on April 21, 2015, DAV recommended that the Committee and the Department of Veterans Affairs (VA) take legislative and policy actions, respectively, based on dozens of recommendations contained in our 2014 report, Women Veterans: the Long Journey Home. After acknowledging the importance of our report, the Chairman indicated the Committee would appreciate receiving further information about DAV's priorities for specific legislation or other actions that would aid women veterans. While the report speaks for itself, and all of the recommendations are important, at the request of the Chairman, we outline some associated topics that need to be addressed by Congress and the VA.

Given that women veterans are turning to VA in record numbers, especially young women veterans, now is not the time to retrench VACO positions in this crucial program. At times of retrenchment, VACO generally tends to fall back on the inevitability of random attrition to meet its personnel reduction goals. In our view, and especially because this technique dramatically affects the women's health program across the VA system, this is unwise policy. If personnel restructuring is required, VHA should develop its plans in a more strategic manner. At a time of unprecedented growth in the number of women veterans enrolling in VA health care, we believe the women's health program should be enhanced with additional personnel, not be allowed to shrink along with other VACO programs as if no negative outcomes would occur.

The women veterans health program at VA is led by a capable but very small staff. One key position, that of Deputy Director for Reproductive Health, is now vacant. Also, one of three authorized Deputy Field Director positions in women's health is now vacant. Because these positions are journalized to VA Central Office (VACO), they are caught in the ongoing hiring freeze affecting all VACO personnel.

Also in VA Central Office, we believe the Center for Women Veterans is in need of a program analyst to collect and analyze relevant data on women veterans. VA should take action immediately to identify suitable candidates for this important program management position. Without the ability to collect and analyze data (among the functions of this position), the Center is challenged to know whether VA's numerous programs for women veterans are meeting their responsibilities and intended outcomes.

Secretary McDonald announced the VA system is reorganizing through the advent of five new entities he has described as "districts." These districts when formed will integrate all VA missions, whether in health, benefits, memorial affairs or other VA

activities. Given the growth rates of women seeking VA services of all kinds, DAV believes each district, each Veterans Integrated Service Network, and each VBA equivalent office should be staffed with full time women's coordinators or program managers. Also, at the local medical center level, DAV believes VA should deploy one or more women's peer support specialists in an expansion of the existing peer support and counseling concepts VA has advanced in recent years. These peers could serve women veterans as guides and coaches to introduce them to VA health care and key women's health staff, help them navigate the system and to pave the way for new women veterans to have a more positive experience in their contacts with VA.

Most if not all of these essential actions to improve services for women veterans could be taken by VA without enactment of new legislation. With the strong support and determined oversight of the Committee, however, we believe VA might be encouraged to address these unmet needs as a higher priority.

Chairman ISAKSON. Ms. Mouradjian, anything you might have to give this Committee information-wise to help us understand how we could avoid having the situation that happened to you. I am just going on here, and I ask the Committee to pardon me for going over a little bit. It seems to me that you had a different doctor every time you went to the VA, plus you mentioned coordinated care. I am a big advocate for seniors, which I fall into that category. You are a woman, I am a senior. We need coordinated care, too, because we have unique needs, just as women do. I think the fact that you had to see a different physician each time, or a different specialist each time, you lacked the continuity that you really need to care for something, particularly something as dangerous as Cushing's. Would that be correct?

Ms. MOURADJIAN. That is correct, and one of the issues was the doctors would often communicate very hastily through e-mail or try to get each other on the phone. There was not necessarily a chance for them to consult each other on a more thorough basis. Obviously, the system has constraints, but when you are dealing with brain surgery and something that serious, you would hope that your doctors would have had an ample opportunity to actually get together and consult your case.

Chairman ISAKSON. That actually magnifies the point I was going to close with. You said at the outset of your testimony that you really had no issue with the quality of care that you had received, that you had, in fact, received excellent quality of care, except for the fact you were never really believed or accepted. You continued to tell them that you felt you had problems, even though they said the blood work they had done did not indicate it. The frustration, the lack of seeing the same doctor twice, three times, or four times to follow your case probably led to some of that misunderstanding between the VA and yourself.

I would think there is a lesson to be learned, not that it is an indictment of the quality of care, but it may be an indictment of the system of care and the continuity of information that you, the patient, and the VA have over your particular case.

Ms. MOURADJIAN. I am sorry. I would agree with you. I think one of the issues is, oftentimes, I was not seen as a veteran. I know in the ICU after brain surgery, several times, a care provider would be surprised that I was in the bed and I would hear the comment, "Oh, we were expecting a vet." To them, I think the perception is a veteran is an older male. Because they had that perception, sometimes you are just not taken seriously.

Chairman ISAKSON. We appreciate your service to the country and we appreciate your testimony today. Thank you very much.

Ranking Member Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman, and thanks for giving me the opportunity to invite Ms. Mouradjian to be here today.

I am familiar with your story, but I want to make sure that as much as possible of it is in the record, because my other colleagues who were not here today or who may be unfamiliar with that very impressive story should also learn about it, and I appreciate the Chairman's questions to you.

I just want to clarify that you actually had to seek help outside the VA simply to get a diagnosis of a problem that was bothering you for some time, is that correct?

Ms. MOURADJIAN. That is correct. I went to a doctor that I knew back home and described the symptoms to him, and he did some blood work and it really only took one test. It was pretty immediate after the blood work was ordered.

Senator BLUMENTHAL. If I were your mom or your parent, or if you were one of my two sons who has served in our military, one in the Marine Corps Reserve, the other in the Navy, my opinion would be—and I would be angry about it—that the VA failed you.

Ms. MOURADJIAN. My mother was very irate, yes.

Senator BLUMENTHAL. It was more than just the revolving door of white coats. It was the delay of the surgery, by my calculation, at least 3 months, because they only do the surgery on the Tuesday of 1 month; hence, your surgery for a very dire, potentially dangerous condition was delayed month after month after month. Is that correct?

Ms. MOURADJIAN. That was one of the complications—because it is so rare, it is seen as an opportunity, I think, by the specialists in the community to observe. For the patient, obviously, the only cure is surgery, so you want to have that immediately. But, I do realize that doctors, because of the rarity, wanted to sort of just test me and collect some data. Unfortunately, at the VA, one of the other complications is oftentimes there is a protocol. You are not necessarily allowed to be involved in your own care and make the choices that you think is appropriate for your own care.

Senator BLUMENTHAL. When, in fact, involvement of patients in care, listening to the patient, is one of the preeminent principles of modern health care. I am not asking you as an expert, because you are not a doctor, but I will say it for the record that most good doctors will tell you, listen to the patient and heed what he or she has to say.

You seem fine now, is that correct?

Ms. MOURADJIAN. I am, thank you.

Senator BLUMENTHAL. Tell us what you are doing at this point.

Ms. MOURADJIAN. Currently, I work at Sikorsky Aircraft Corporation in the legal department. I actually received my law degree right after commissioning and I am a productive member of the workforce. I think I would like to be an example that you can be a veteran, you can be a disabled veteran, but you can still be productive and contribute.

Senator BLUMENTHAL. I can tell you, my impression is from what I have heard about your work that you are more than just productive. You are very exceptional, an expert at what you do. I thank you for your service to our Nation in the military, and I thank you for your service now.

Dr. Davis and Ms. Ilem, what is your reaction to this story?

Ms. DAVIS. It is obviously disappointing, sir, to hear stories like that.

Senator BLUMENTHAL. Let me be a little more precise, in fairness to you, rather than just asking you such an open-ended question. Do you know of similar stories?

Ms. DAVIS. I have heard some women's stories where they have not felt comfortable with the diagnosis they have received and they have sought help elsewhere. But, I would say that for the most part, the women that I know that are receiving medical care through the VA system are fairly happy with that care. But, I would also say they have not experienced what Captain Mouradjian has experienced, as well.

Senator BLUMENTHAL. Similar delays?

Ms. DAVIS. There have been some delays. I have heard of surgeries being delayed on a couple of occasions. Again, I believe they are isolated incidents, but it does occur.

Senator BLUMENTHAL. Thank you, and thanks for your work in Nevada as a member of the Advisory Committee.

Ms. Ilem, thank you for your work on behalf of disabled veterans. What is your reaction? Do you know of similar stories, delays, seeking treatment outside the VA system, and so on?

Ms. ILEM. Well, I would like to say first that I have been a patient of the VA health care system for over 20 years and I have seen tremendous progress and a reinvigoration of—real hope there that we are going to be getting the best care anywhere. That is, I think, from DAV's point, we really want to make sure that women veterans can take advantage of the VA health care system and all that it has to offer.

Dr. Hayes and her staff have done an outstanding job over the past 6, 7, 8 years that I have known her. I have seen them using the research and really making progress for the first time. That is so essential. For the patient care coordination, making sure that what has happened does not happen to anyone else and making sure VA recognizes our women veterans.

I would say specific to women, I have heard a number of things from DAV members that have called with regard to prosthetic items. One of our members talked about needing a knee replacement and was told they were not going to order the prosthetic hardware that would be used in the surgery. They would not use one for women. They would just use the same that they do for men, when there was a specific opportunity for them to do that. You know, things like that just should not be happening. They need to have that sensitivity to women. They need to know the products, the items, whatever is needed for women needs to be there, even if they are in small numbers.

Senator BLUMENTHAL. Thank you very much.

Chairman ISAKSON. Senator Heller.

Senator HELLER. Thank you, Mr. Chairman. Again, thanks to the witnesses for being here today.

Dr. Davis, I have, of course, traveled throughout the State and recently had a roundtable. Numerous VSOs were present representing men and women veterans. But, I think there are a couple of themes in today's hearing, and one of them being, in fact, that a lot of combat veterans do not consider themselves to be veterans. I never got a specific number. Somewhere between 14,000 and 27,000 female veterans in the State of Nevada, and you gave a specific number. I am wondering why the VSOs do not know these numbers but you do.

Ms. DAVIS. Sir, I am getting the information from the VA Web site, and so I do not know how accurate that information is, as well. I guess it is an estimate. It is a moving target. Veterans come into the State every day. Veterans leave the State every day. It is a snapshot in time. Those were the best numbers that I had available to me. I think they are illustrative, if nothing else. They might not be exactly accurate.

Senator HELLER. I am assuming you talk about outreach all the time. What more can the VA be doing to try to identify who and where these veterans are?

Ms. DAVIS. It is a great point, sir. I think one of our key issues is identifying who these women veterans are, and one of the things that we have heard, and I think you heard down in Las Vegas, as well, is that women do not often call themselves a veteran. And, when you ask them if they have served in the military, they will say, yes, I have served.

Senator HELLER. Right. You mentioned that in your opening statement.

Ms. DAVIS. Yes, sir. Maybe we are asking the wrong question. If we can understand who has served in the military, then we can connect them to their veterans' benefits, even if they do not personally self-identify themselves as veterans.

Senator HELLER. So, instead of asking them if they are a veteran, ask them if they have served in the military.

Ms. DAVIS. Yes, sir. I think it would go a long way toward identifying more of our women veterans.

Senator HELLER. Thank you.

Captain Mouradjian, do you feel that the VA failed you?

Ms. MOURADJIAN. I feel at a certain moment in time, yes, they did. Right now, I am receiving excellent care. I cannot be more pleased with the care I am receiving in Connecticut. My doctors are very responsive. They are available to me. I can contact them when I need to. That is why I state in my statement I recognize that there has been a shift in the care and the VA's responsiveness to women's issues.

Senator HELLER. Do you think your experience was an aberration, or do you think it was a common occurrence?

Ms. MOURADJIAN. I think it was a culmination of several factors, the rarity of my condition. You know, I was in my late 20s at the time, so I necessarily was not seen as someone who would get sick. I do not think it is endemic of the system as a whole. I think it was more of an isolated case, but at the same time, still a failure.

Senator HELLER. Captain, in your day-to-day work, you probably meet up with other women veterans. Do they share similar stories with you?

Ms. MOURADJIAN. They do. One of the biggest issues is they do not even know what is available at the VA. I like to share what is available because I think it is important that they have access to the services. I think the major complaint is they just do not know what is there.

Senator HELLER. Do you believe that services for women veterans are inferior to services to male veterans?

Ms. MOURADJIAN. I believe they are getting better, sir. I do not believe they are at the same level yet. I do believe that there is a concentrated effort. I know that every time I go to the VA—I just went last week—the women's coordinator, when I checked into my appointment, made it a point to come out and introduce herself to me and tell me she was available should I need anything. I realize that I am more vocal an advocate for my own health than maybe most veterans, but I do know that in the time that I have been receiving VA care, there has been a marked increase just in the VA's involvement.

I completed the survey when they called me 2 weeks ago because I think it is important to give my feedback. Before 3 weeks ago, I do not think I have ever gotten a call for a survey before. I do believe that the response is increasing.

Senator HELLER. Captain, thank you for sharing your story with us and thank you also for your service.

Ms. MOURADJIAN. Thank you, sir.

Senator HELLER. Ms. Ilem, when was the last time the VA conducted a comprehensive study on hospitals to determine whether or not they are meeting the needs of women veterans?

Ms. ILEM. There was a GAO study in 2009 that did sort of an overlook of VA services and programs, but I know the VA itself in the Women's Health Service uses a private vendor to do some evaluation, and I think that would be important for the Committee to see the results of those visits that they are doing to really look for deficiencies. They have laid out a great plan. Their policies are where they should be, but——

Senator HELLER. Is that current? Are you saying this is current?

Ms. ILEM. Yes. They have been doing that the last several years.

Senator HELLER. OK.

Ms. ILEM. But, 2009 is the last GAO study that has been done, and I think it would be warranted to see where VA has come in terms of that last evaluation they did.

Senator HELLER. Do we know when that will be readily available? When will that report be available?

Ms. ILEM. I am recommending that they do a follow-on study from 2009. But, VA has some internal data that may be of interest to the Committee.

Senator HELLER. OK. Mr. Chairman, if we can get access to any of that data or information, I think it would be very helpful for this Committee. Ms. Ilem, thank you.

Chairman ISAKSON. My Staff Director will follow up on that request.

Senator HELLER. Thank you.

Chairman ISAKSON. Thank you very much.
Senator Hirono.

HON. MAZIE HIRONO, U.S. SENATOR FROM HAWAII

Senator HIRONO. Thank you, Mr. Chairman. I particularly want to thank you for focusing on whether we are keeping our promises, as indicated in the hearing notice, to our women veterans. I think that we should look at the particular issues as they confront women veterans, and I want to thank our witnesses for being here.

One of the issues that confronts our work with veterans is that it is not easy to find them, whether they are women veterans or men veterans. I am finding that to be the case in Hawaii and I would think that that is an issue elsewhere.

I think Ms. Davis or Ms. Ilem, you mentioned that there should be better collaboration between the DOD and the VA, and perhaps the right questions should be asked. I was wondering, since there is an entire process for the active duty people to get the information that they need regarding VA regarding the G.I. Bill and all of that before they muster out, why can they not get a tamper-proof card, for example, that indicates or that attests to their service that can just be then taken to the VA?

Ms. ILEM. I think one of the things that they are doing is trying to enroll people right at the sites when they are coming off active duty, especially for Guard and Reserve, as far as we have understood. They try to really make available, and I am sure, you know, pamphlets and information. You are saying a specific card for them to just be able to——

Senator HIRONO. Yes, so that we do not have to find them after they have already gotten out.

Ms. ILEM. Mm-hmm. Yes, I think the Transition Assistance Programs are trying to educate them. One of the things the DAV found in the report is that, oftentimes, veterans are not ready to intake information at the time of their out-processing——

Senator HIRONO. Oh, I know.

Ms. ILEM [continuing]. So, they leave——

Senator HIRONO. I have heard those.

Ms. ILEM. So, there needs to be follow-on.

Senator HIRONO. But, something like an ID card, something that is akin to an ID card is not something that you would normally just toss aside——

Ms. ILEM. I see.

Senator HIRONO [continuing]. I would think. That may be another way for us to locate the veterans. I really think that once they are out of the system, out of the active duty system, it is really a challenge to find them.

Ms. ILEM. I know with the OEF/OIF population, they have had a high rate of those, especially women veterans, about 57 percent of women veterans who served and separated from OEF/OIF have come to the VA system for care or enrolled and users of the system. That is a pretty high rate, and they might look at that for these follow-ons that they are doing——

Senator HIRONO. A model.

Ms. ILEM [continuing]. To make sure they locate them. I believe they went through DOD to get Social Security numbers or tracking of where to send them a letter.

Senator HIRONO. I think we should make it as simple as possible for people who are transitioning from active duty to veteran status to be able to access the information. I realize that the TAP program is there, but there are some concerns about whether or not all of that information in the last month or so is really being taken in. That is also an issue.

Now, Secretary McDonald has said that he would like to eliminate homelessness in veterans by 2015 and I am wondering whether any of you are familiar with how the homelessness issue is being addressed with regard to women veterans, since I believe you testified that there is a higher chance of women being homelessness than men. Are they doing anything special to deal with homelessness among women veterans?

Ms. ILEM. I think just within VA, because of the small percent and the statistical minority of women, only about 7 percent out of the six million veterans that VA treats, it is always difficult and a challenge with women veterans. That is one of the things that is so important, is for each program office, including the Homeless Program Office, to be working in coordination with the community, with their Women Veteran Program managers, with the State agencies, all trying to circle around women veterans to make sure prevention, if possible, obviously, first, but when they do have a woman veteran that shows up, that they are going to have some sort of services for that person and get them immediate intake and housing.

Senator HIRONO. Especially if there is a higher percentage of them, one, being homeless, two, having employment issues, and three, having children.

Ms. ILEM. The risk factors, right.

Senator HIRONO. Yes. Ms. Davis, you noted that Nevada has a Women's Veterans Advisory Committee. That sounds like a really great idea, that there is an advocacy group, people coming together to focus on specific issues. Do you know if other States have similar——

Ms. DAVIS. We have been talking to some other States and we have heard about other groups similar to that, but I would certainly encourage other States to institute such committees. I think it has been very helpful. It has been enlightening to us to hear from women throughout the State and learn about the issues.

Senator HIRONO. Good. I am going to check to see if Hawaii has one like that.

Regarding military sexual trauma, do you know what percentage of women who serve in the military have experienced MST, anybody?

Ms. DAVIS. I know VA just testified, maybe before you came in, I think it was at the 25 percent rate of women in VA who have screened positive for MST.

Senator HIRONO. Those are the women who are actually accessing the system. I have a feeling it might be a higher percentage. Are any of you familiar with the VA special lane to process MST claims?

Ms. ILEM. I am aware of that.

Senator HIRONO. Do you know if it is working?

Ms. ILEM. I have heard that it has been. We were very pleased that Under Secretary Hickey instituted it; really went back and looked and saw that those claims for MST-related conditions were being processed at a lower rate for PTSD. They went back and did training, re-education of their adjudication officers, and then developed these fast track or lanes for people who really specialize and look at those cases frequently. We have heard good reports from that.

Senator HIRONO. Good. Thank you.

Thank you, Mr. Chairman. My time is up.

Chairman ISAKSON. Thank you, Senator Hirono.

Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you all so much for being here. It is so important for you to come and share your real-life stories.

I am working with Senator Tester on the Homeless Vets Reintegration Reauthorization Program, and that includes homeless women veterans with children, trying to get those programs reauthorized. One of the problems that we have is that if you are homeless and then we provide shelter for you, provide a home for you, then you lose benefits that would make it such that it would break the cycle, in other words, getting you the skills that you need to actually be able to make a living wage.

Can you all comment about that, the importance of trying to get, like I say, getting people not homeless, but again, at the same time, when they are in that shelter, in that home, providing the resources that they need so that they can get themselves in a situation where they can provide for themselves and their families. Yes, either one or all.

Ms. DAVIS. I think that is critically important, because you have to have that coordinated effort, because between getting them a home so that they have some stability in the short term, but you need that longer-term stability that the employment is going to provide, and that may require the skills and training needed in order to find that right job for that person in that particular situation. Then, again, it is exacerbated by the fact that many homeless women are also with children with them and child care seems to be a critical issue for these women.

Senator BOOZMAN. That is a good point.

Ms. ILEM. I think the awareness, as has been mentioned, making sure that women are aware of what services VA has to offer them. Their homeless programs are second to none. They have an array of benefits and services, especially for employment, sustained employment, and to really support them through the process, that transitional process, if they are suffering with because of their disability, mental health issues, substance use disorder, and they have those wrap-around services.

We really want to make sure that women do not get discouraged. If they show up and for some reason they do not have an opportunity with the community to have a place for them and their chil-

dren to stay together, we have often heard they walk away and they look elsewhere, and that is a disadvantage to them.

Senator BOOZMAN. Very good. That is very helpful. Again, thank you all so much for being here and we appreciate your service to your country.

Thank you, Mr. Chairman.

Chairman ISAKSON. I would like to thank the Members for their attendance and their participation. Thanks, Senator Heller, for bringing this to our attention early on.

I thank our witnesses for being here. Again, Ms. Mouradjian and all the others here, thank you for your service to the United States of America and we appreciate your service to veterans today. We want to be a conduit and an asset for all of you to come back to us as we improve the plight of women in veterans health care and we look forward to hearing from each of you whenever you have something for us.

Thanks to the members of the VA who came and testified. I will report that you all did a great job. Thank you for being here.

This meeting stands adjourned.

[Whereupon, at 4:14 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF MONIQUE SPILLMAN, M.D., PH.D., FACOG, THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Senate Veterans' Affairs Committee, Thank you for giving the American Congress of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners in women's health, the opportunity to submit our written testimony for your hearing on Fulfilling the Promise to Women Veterans.

I am a Fellow of ACOG, subspecializing in gynecologic oncology, and am the former Chair of ACOG's Committee on Ethics. Prior to my current position as a gynecologic oncologist with Texas Oncology, I was an Associate Professor at a large academic hospital in Colorado. While in Colorado, I received regular referrals from the VA in Denver as well as other Western Mountain States.

Military service is associated with unique risks to women's reproductive health. As increasing numbers of women are serving in the military, and a greater proportion of United States Veterans are women, it is essential that ob-gyns are aware of and well prepared to address the unique health care needs of this demographic group. At the same time, it is equally essential that women Veterans have access to quality primary and specialty care provided by ob-gyns.

Many Veterans Health Administration (VHA) sites have specialized women's health clinics and services available to provide care for women Veterans either on site or through referrals to non-VA health care providers. While I applaud the VHA's Women's Health Services efforts to expand access to and improve the quality of care available to women Veterans, there is still room for improvement.

During my eight years in Colorado receiving referrals for gynecologic oncology from VAs in several states, it was not uncommon for women Veterans to have been delayed in being referred to specialty care. The women I saw described experiences of having to ask repeatedly to be referred to a specialist, and in multiple cases, by the time I saw these patients, it was clear that their delayed access to specialty care had a negative impact on their long-term health. Additionally, women Veterans whom I had identified as ideal candidates for enrollment in clinical trials would either not be permitted to enroll by the VA, or would face significant delays, in some instances missing a key window for certain treatment.

Research regarding women Veterans has increased significantly over the past two decades. And, though limited in scope, we have learned some valuable information about this population, particularly the greater physical and psychiatric morbidity and diminished social support of these women compared with their civilian counterparts. We need to do better by our women Veterans, and a good first step is to improve access and seamless referral to women's health providers—both general ob-gyns and subspecialists like gynecologic oncologists and urogynecologists.

One area where the VA excels is in screening for military sexual trauma. This screening is mandated by the VA for all Veterans seen by VA health care providers and involves brief questions that employ descriptive, nonjudgmental language. ACOG applauds this mandate by the VA and the efforts by the US Department of Defense and encourages the continuation of prioritization of efforts for primary prevention of military sexual trauma.

Thank you for the opportunity provide written testimony. In general, while we have identified some areas needing improvement, ACOG recognizes and appreciates the good work of the VHA in attempting to meet the complex health care needs of women Veterans. We look forward to partnering with the VHA in meeting those needs and stand ready to assist the Committee on Veterans Affairs as you continue to look into this issue.

References: ACOG Committee Opinion 547, Health Care for Women in the Military and Women Veterans, December 2012.

PREPARED STATEMENT FROM KATE O'HARE-PALMER, CHAIR, WOMEN VETERANS COMMITTEE, VIETNAM VETERANS OF AMERICA

Good afternoon Mr. Chairman, Ranking Member Blumenthal, and distinguished members of the Senate Veterans' Affairs Committee. Thank you for giving Vietnam Veterans of America (VVA) the opportunity to submit our statement for the record Fulfilling the Promise to Women Veterans

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 (DVA) 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 BY DEPARTMENT OF VETERANS AFFAIRS

Department of Veterans Affairs (DVA) eligible women veterans are entitled to complete health care including care for gender specific illnesses, injuries and diseases. The DVA 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 for women veterans. What would be routine primary care in the community is referred out to specialty clinics in the VA. Over the last five years the per cent 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.

Vietnam Veterans of America will continue its advocacy to secure appropriate facilities and resources for the diagnosis, care and treatment of women veterans at all DVA hospitals, clinics, and Vet Centers and we ask the Secretary of Veterans Affairs ensure senior leadership at all facilities and Regional Directors be held accountable for ensuring women veterans receive appropriate care in an appropriate environment. Further, we seek that the Secretary ensures:

- 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 there is the creation of an environment 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 any differences in the quality of care.
- That the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value report any significant differences and forward the findings to the Under Secretary for Health, Under Secretary for Operations and Management, the Regional Directors, facility directors and chiefs of staff, and the Women's Health Services Office.
- That every woman veteran has access to a VA primary care provider who meets all her primary care needs, including gender-specific and mental health care in the context of an ongoing patient-clinician relationship.
- That general mental health care providers are located within the women's and primary care clinics in order to facilitate the delivery of mental health services.
- That sexual trauma care is readily available to all veterans who need it and that VA ensure those providing this care and treatment have appropriate qualifications obtained through course work, training and/or clinical experience specific to MST or sexual trauma.
- 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, admission wait times, and geographically responsive to the need.
- That Vet Centers are able to adequately provide services to women veterans.

• 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 the women veteran's needs.
• That all Community Based Outpatient Clinics (CBOC) which do not provide gender-specific care arrange for such care through VA outsource or contract in compliance with established access standards.
• 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, Under Secretary for Operations and Management, the Regional Directors, facility directors and COS, and providers.
• That legislation be enacted to ensure neonatal care is provided for up to 30 days as needed for the newborn children of women veterans receiving maternity/delivery care through DVA.

Senator Dean Heller (NV) (for himself and Ms. Murray) has introduced S. 471 the Women Veterans Access to Quality Care Act, when enacted d into law would improve the provision of health care for women veterans by the Department of Veterans Affairs, and for other purposes and based on our recommendations above VVA fully supports the bill.

HOMELESS WOMEN VETERANS

Over the past two decades we have become increasingly more vested in the recognition and address of the situation of homelessness among Veterans. In looking back VVA well remembers the time when the VA acknowledged that as many as 275,000 Veterans filled these roles. With the legislative creation of the VA Homeless Grant and Per Diem HGPD program and its program growth, the VA and community Veteran service providers have been able to chip away at this deplorable situation of life that existed for so many who served this county in its Armed Forces. Startling is the fact that the percentage of homeless women Veterans has raised from 2% to 6% of the homeless Veteran population and that over the past four years the actual number has doubled.

Currently the VA sites that the number of homeless Veterans has been reduced to 49,933 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 snap shot because it is impossible to have on record all the 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 Accounting 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 Veterans are:

• They are not aware of the opportunities available
• 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.
• 24 percent of VA Medical Center homeless coordinators indicated they have no referral plans or processes in place for temporarily housing homeless women veterans while they await placement in HUD-VASH and GPD programs.
• Nearly 2/3 of VA HGPD programs are not capable of housing women with children.
• The program expense of housing women with children is a disincentive for providers.

VVA believes that it is a very ambiguous plan of the Ending Homeless among Veterans by 2015, but asks the 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 them?" 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 Veteran program to address these needs. The influx of women in the military and one of every ten soldiers serving in Iraq a woman, the female homeless population will only grow and or facilities dedicated to women are vital.

WOMEN VETERANS RESEARCH

Because women veterans have historically been a small percentage of the veteran population, many issues specific to women veterans 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 11 % of the veteran population by 2020 and 12% by 2025.

Vietnam Veterans of America asks the Secretary to conduct several studies specific to women veterans 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 DVA for women veterans.
- 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 veterans. (GAO: March 2010: VHA).
- 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 RECEIVING MATERNITY CARE

VVA asks that particular reflective consideration be given to the following—VVA seeks a change in this section of the proposed legislation that would increase the time for the provision of neonatal care to 30 days, as needed for the newborn children of women veterans receiving maternity/delivery care through the VA. Certainly, only newborns with extreme medical conditions would require this time extension. VVA believes that there may be extraordinary circumstances wherein it would be detrimental to the proper care and treatment of the newborn if this provision of service was limited to less than 30 days. The decision for extended would require professional justification. If the infant must have extended hospitalization, it would allow time for the case manager to make the necessary arrangements to arrange necessary medical and social services assistance for the women veteran and her child. This has important implications for our rural woman veterans in particular. And this is not to mention cases where there needs to be consideration of a woman veteran's service-connected disabilities, including toxic exposures and mental health issues, especially during the pre-natal period, multiple births and 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.

Vietnam Veterans of America will continue its advocacy to secure benefits for all eligible veterans. VVA asks the Secretary to ensure:

- That leadership in all VA Regional Offices (VARO) is cognizant of and kept current on women veterans' issues; that they provide and conduct aggressive and proactive outreach activities to women veterans and; that VBA leadership ensures oversight of these activities.
- That a national structure be developed within VBA for the Women Veteran Coordinator (WVC) positions, located at each VARO.
- That VBA establish consistent standards for the time allocated to the position of Women Veteran Coordinator (WVC) based on the number of women veterans in the area the VARO serves.
- 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 is needed in this regard.
• That all claim 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 the women's needs for privacy, safety, and emotional and physical comfort.
• That 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 (WVPM)

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 2010, Handbook 1330.01, Health Care Services for Women Veterans defines the responsibilities of both the VA Veterans Integrated Service Network (Regional) Director and the Medical Center (VAMC) Director and its enforcement demands this attention. Additionally, both WVPM positions are further defined in the VA 2012, 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 the victims.

According to DOD Sexual Assault Prevention and Response Office (SAPRO), the majority of survivors of MST (71%) are under 24 years old and of lower ranks; whereas the majority of assailants (59.5%) are between 20 and 34 years old and of a higher rank than the survivor. 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. This office should also have a legal advisor on the team.

VVA will pursue legislation that reassigns complaints of military sexual trauma by servicemembers and all alleged perpetrators outside of their immediate chain of command.

TRAVEL FOR VHA TREATMENT

The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. This Directive is not aligned with the military sexual trauma (MST) policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

In light of the limited intensive residential treatment programs within the VA that are both MST specific and gender specific, many women veterans, especially those who are homeless and/or have limited income have difficulty seeking and accessing programs that meet their clinical needs.

Vietnam Veterans of America calls on the Under Secretary for Health to review and reexamine existing VHA policy pertaining to the authorization of travel for veterans, who have been referred by their mental health clinician, to a MST-related specialized inpatient intensive residential treatment programs outside the facilities/

Regions where they are enrolled. Additionally, VVA calls for the provision of these travel funds whether the Veteran is an in-patient or an outpatient also that all medical center clinical staff are advised and fully understand the implementation of this policy.

WOMEN VETERANS STRATEGIC PLAN

The strategic plan FY 2010–2014 and Addendum FY 2011–2015 stated that the goals and integrated objectives were to be implemented and analyzed with published outcomes of performance measures. However, not all programs that serve women veterans have specific performance measures that track the outcome of programs initiated to respond to the needs of women veterans.

Originally, in the Department of Veterans Affairs (VA) Strategic Plan for FY 2010–2014, the only objective that dealt with the women veterans directly was the Integrated Objective 2: Empower Women Veterans. The purpose of the objective is: Promote recognition of contributions of women, ensure VA programs are responsive to the needs of women veterans, and educate women about VA benefits and services.

The Vietnam Veterans of America will continue its advocacy for women veterans. We recommend the VA should collect, analyze and publish data by gender and minority status for every program that serves veterans to improve understanding, monitoring and oversight of programs that serve women veterans. The data collected must be measured and reported to ensure that the needs of women veterans are met.

IN CLOSING

Vietnam Veterans of America has as its' number one legislative priority the issue of accountability; accountability at every level of any agency, Federal, state, or local, that impacts Veterans and their families. It is through this accountability that Vietnam Veterans of America hopes to improve the quality of care and life for all of our Nation's Veterans.

