National Service & Legislative Headquarters
807 Maine Avenue, S.W.
Washington, D.C. 20024-2410
Phone (202) 554-3501
Fax (202) 554-3581
www.dav.org

FULFILLING OUR PROMISES
TO THE MEN AND WOMEN WHO SERVED

STATEMENT OF
JOY J. ILEM
NATIONAL LEGISLATIVE DIRECTOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairwoman Brownley, Ranking Member Dunn and Members of the Subcommittee:

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

Women are serving in the military in record numbers and represent 10 percent of the veteran population. There are more than two million women veterans in the U.S. today and according to VA it expects women will make up 18 percent of the veteran population by 2040.[1] Women are also turning to VA for care in record numbers and more than half of the women using VA services have a service-connected condition and are eligible for VA benefits and a lifetime of care.[2]

These sociodemographic changes led DAV to release two special reports on women veterans. *Women Veterans: The Long Journey Home* was released in 2014, with a follow-on report in 2018, *Women Veterans: The Journey Ahead.* These reports highlight the changes in this population over time, critical policy implications for VA, what was needed to ensure women veterans have access to high quality health services in all VA sites of care, and most importantly how we could better serve this population of veterans. Our 2014 report looked at barriers women veterans returning from recent deployments faced in readjusting to civilian life after military service. Our

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

new study looks at progress made and more generally, at the needs of a diverse women veterans' population using VA health care today. We very much appreciate this opportunity to discuss the recommendations in our most recent report in relation to the barriers identified in women veterans' pursuit of veteran-centric health care.

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

Understanding VA's specific challenges requires a look back at the changing dynamic of women veterans seeking VA health care services. The number of women seeking VA care has tripled since 2000, growing from about 160,000 to 500,000 today.[3] VA has had to ensure younger women in their childbearing years have access to reproductive health services and that older women veterans, another growing population in VA, have access to age appropriate services for chronic health conditions and sex-specific care. Additionally, the increasing proportion of women veterans with a service-connected condition who use VA care (48 percent in fiscal year (FY) 2000 compared to 63 percent in FY 2015)[4] also required program adjustments and policy changes to ensure quality of care and effectiveness of services for this group. Higher utilization of outpatient services among women veterans, as well as increased rates of purchased care and specialized services all resulted in the need for increased capacity, research, resources and oversight of the Women's Health Program.

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

While there has been significant progress in many aspects of VA health care for women, there are some longstanding issues that still exist. VA's environment of care surveys, which identify deficiencies in privacy, safety and dignity in patient care settings seem to routinely get shortchanged or ignored. In recent reports the GAO (Government Accounting Office) has highlighted these deficiencies and made recommendations about how to correct them.[5] However, little has changed in the way VA collects or submits these surveys or holds its leadership accountable for implementing necessary changes. While Women Veterans Program Managers (WVPMs) are responsible for

[3] Department of Veterans Affairs. News Release. New Text Feature Available Through VA's Women Veterans Call Center. April 23, 2019.
[4] Sourcebook, p. 3
[5] Government Accountability Office. VA MEDICAL CENTERS: VA Should Establish Goals and Measures to Enable Improved Oversight of Facilities' Conditions. GAO-19-21: Published: Nov 13, 2018. Publicly Released: Nov 13, 2018.

managing environment of care surveys, they have no authority to hold facility leadership accountable for accuracy and completion of responses to surveys or to ensure changes are made to correct identified deficiencies.

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

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

Research has also shown that women veterans prefer women clinical providers, particularly when it comes to "sensitive" sex-specific care such as gynecology[6] and express a preference for women's comprehensive health clinics. Veterans who use these clinics express high satisfaction with communication and care coordination.[7] Yet despite the efforts of many policy leaders within VA, there are still many women who lack access to women's clinics and ensuring adequate staffing for such clinics has remained an organizational challenge.

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

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

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

[8] Sourcebook. P. 58

Because these clinics require appropriate staffing levels and space, VA medical center directors must support their growth and maintenance as a high priority.

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

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

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

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

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

contract care.[10] Notably, a GAO study also showed that appointment waiting times for VCP providers were, on average, significantly longer than 30 days as required under VACAA.[11]

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

For example, VA knows that many women have experienced sexual and physical trauma that puts them at risk for a number of adverse life outcomes and health consequences. An integrated system of care allows VA to closely follow these veterans and coordinate their care and provide access to necessary supportive services—which is particularly important to women veterans dealing with intimate partner violence, homelessness or child care issues. Without special coordinated wraparound systems of care, these women could easily fall between the cracks (as was demonstrated in their experiences with VCP). In our 2014 report, *Women Veterans: The Long Journey Home*, DAV discovered this was the case with too many women returning from deployments to Iraq, Afghanistan and other combat zones. The Department of Defense and VA missed critical opportunities for communication and warm handoffs during transitions between systems. While many federal programs and services exist to serve women veterans' readjustment needs, without appropriate support and coordination too many women have been unaware of them or unsure how to access them, as evidenced by lower market penetration rates between male and female veterans—according to VA, only 22 percent of female veterans used VA in fiscal year 2015 compared to 28 percent of male veterans.[12]

Access to community health care services has been necessary and will continue to be so in a system that caters to a small, dispersed population of women. For these reasons VA must ensure the preparedness of network participants within its community care program. According to a RAND study only about two percent of New York providers surveyed were adequately prepared to address veterans' health care needs.[13] For these reasons VA must also ensure that contractors are properly trained about military and veterans' culture, special conditions within the veterans' population and evidenced-based treatments for service-related mental health conditions. VA must

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

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

[12] Sourcebook. Vol. 4. P. 18.

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

provide community partners guidance on how to properly screen and treat certain conditions for which it has expertise such as PTSD and ensure referrals are made back to VA for specialized services when necessary.

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

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

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

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

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

Culture Changes Needed—VA's End Harassment Campaign

As VA transforms its health care system, it must ensure that its facilities offer the safety and privacy in welcoming therapeutic environments that all veterans deserve. Unfortunately, recent research indicates that women veterans still do not always feel safe or welcome at VA health facilities. While this may partially relate to a negative experience with VA staff or the less than optimal aspects of facility design at some facilities or lack of gender-specific supplies for women patients at certain locations, a recent study found that it often stems from male veteran patients who make inappropriate or unwanted comments or sexually suggestive remarks to women veterans or question their right to use VA care. Unfortunately, the percentage of women veterans who claim to have been subjected to sexual harassment in the military approximately 25 percent or 1 in 4,[14] is similar to the proportion of women who report harassment (1 in 4) from other veterans while seeking care at VHA.[15] More importantly, the study found that those that reported harassment were significantly more likely to report either delaying or missing care.

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

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

[14] https://www.mentalhealth.va.gov/msthome/saam.asp accessed 4/29/19.
[15] Women's Health Issues 29-2 (2019) 107–115.
[16] Women's Health Issues 29-2 (2019) 107–115.
[17] https://www.va.gov/ve/docs/storybookWomenVeterans.pdf

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

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

Mental Health Care

Women veterans often have a variety of exposures including combat, military sexual trauma (MST), childhood trauma, and intimate partner violence that place them at risk for developing certain mental health conditions. Eating disorders are also common among survivors of MST.[19] While rates of suicide for women veterans are lower than their male peers, women veterans are twice as likely to commit suicide as women who have no military service. The rate of suicide among women veterans is also accelerating much more quickly than that of male peers. More must be done to understand risk and protective factors for women veterans and to assure there are more gender tailored interventions to prevent suicides among this subpopulation. Specifically, VA health care facilities must ensure that women's mental health champions and MST coordinators, whose positions are collateral duties, have the ability to independently dedicate at least 30 percent of their time to carry out required administrative responsibilities associated with these positions. Suicide prevention remains a top clinical priority for VHA and the Department has developed a number of innovative practices to assure veterans are able to have the level and type of support and services they need to recover from mental health conditions common among veterans.

Substance use disorder (SUD), is also common among women veterans who use VHA, and often co-occurs with other mental health conditions complicating diagnosis and treatment. SUD increases the risk of suicides and can make women vulnerable to intimate partner violence. SUD puts veterans at risk for a spiral of decline: job loss, adverse health effects, homelessness, criminal activity, and family dissolution. To prevent a downward trajectory, VA must ensure women veterans have timely access

[18] Yano, E.M. Advances in VA Women Veterans' Research. Center for the Study of Healthcare Innovation, Implementation and Policy. Briefing to the Advisory Committee on Women Veterans. VA Central Office. May 9, 2018.
[19] DAV Women Veterans Report. 2018 p. 32.

to services offered by VHA including the full spectrum of mental health and substance abuse treatment services from detoxification to rehabilitation. The underlying causes of women's SUDs are often different than men's, and, accordingly, VA should make women-only programs and/or topic-specific programming (based primarily on women's interests such as parenting and safe relationships) more widely available.

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

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

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

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

Congress should consider expansion and permanent reauthorization of retreats if warranted.

Madam Chairwoman, in closing, I want to thank you and the Subcommittee for your continued interest in improving health care programs and services for our nation's women veterans. With major reforms underway at VA, now is the time to address longstanding cultural barriers impacting women veterans' access to the high quality comprehensive gender-sensitive health care they need and deserve. As an organization, DAV also wants to ensure that the role of women in the military and the sacrifices they have made are understood, acknowledged and fully appreciated. Please know that DAV is ready to assist you in your efforts. This completes my statement. I will be happy to respond to any questions you may have.